SOCIAL SUPPORT AND RESILIENCE TO ACCESSING REPRODUCTIVE HEALTH SERVICES AMONG WOMEN WITH PHYSICAL DISABILITIES IN GREATER ACCRA REGION

BY

ESTHER ADU

(10085467)

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ACCEPTANCE

Accepted by the College of Humanities, University of Ghana, Legon, in partial fulfilment of the requirement for the award of a PhD Population Studies degree.

Thesis Supervisors:

21/10/2024

Prof. Stephen Owusu Kwankye
(Supervisor)

Date

22/10/2024

Dr. Adriana Biney
(Supervisor)

Date

22/10/2024

Dr. Lily Kpobi
(Supervisor)

Date

DECLARATION

I hereby declare that this is the result of my research, except for references to other people's work, which have been duly acknowledged. It has neither in part nor in whole been presented for another degree.

Esther Adu

22/10/2024
Date

DEDICATION

I dedicate this research work to my parents, grand mum (Auntie Lucy) of blessed memory, husband and children.

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LIST OF ABBREVIATIONS

Abbreviation	Meaning
AHSPS	Adolescent Health Service Policy
DHIMS	District Health Information System
GDHS	Ghana Demographic and Health Survey
GDHS	Ghana Demographic and Health Survey
GFDOs	Ghana Federation of Disability Organizations
GSS	Ghana Statistical Service
HBM	Health Belief Model
ICPD	International Conference on Population and Development
MIC	Multiple Cluster Survey
NCPD	National Council on Persons with Disability
NDP	National Disability Policy
NGOs	Non-governmental Organizations
NSA	National Survey of Adolescents
PRS	Physical Resilience Scale
PWDA	Persons with Disability Act
PWDs	Persons Living with Disabilities
SEM	Socio-Ecological Model
SPSS	Statistical Package for Social Science
SRH	Sexual and Reproductive Health
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNPF	United Nations Population Fund

ABSTRACT

Access to reproductive healthcare services for women with physical disabilities remains a significant challenge, particularly in developing countries. Despite efforts, such as policy initiatives, awareness campaigns, and inclusive healthcare programs aimed at improving accessibility, these women face numerous barriers, including economic, emotional, attitudinal, institutional, and physical obstacles. While existing research has primarily focused on these challenges, there is a limited exploration of the role of social support and resilience in enhancing access to reproductive healthcare.

A mixed-methods design was employed, incorporating both quantitative and qualitative approaches. Quantitative data were collected through a survey of 203 women with physical disabilities aged 18 to 49 years from various communities, specifically Korle-Gonno, La, Ashiaman, Korle-Bu, Chorkor and Kpone in the Greater Accra Region. Univariate analysis was used to describe the socio-demographic characteristics of the participants. Bivariate analysis was conducted to identify relationships between socio-demographic factors and resilience. Regression analysis was utilized to determine the predictors of resilience and the impact of social support. Qualitative data were gathered from twenty-two (22) of the study participants through in-depth interviews and analyzed thematically to gain insights into the challenges and support systems experienced by the participants, and also resilient strategies.

The quantitative study identified significant economic, emotional, attitudinal, institutional, and physical barriers to accessing reproductive health services. Social support, primarily from parents, plays a crucial role in overcoming these barriers. Educational attainment and stable employment emerged as key predictors of resilience, with higher education levels and secure jobs associated with greater resilience. Despite the positive impact of informational and instrumental support, emotional support showed a negative impact on resilience.

The qualitative study revealed that women with physical disabilities faced challenges of funds, partner rejection, long waiting hours, lack of appropriate public transport, distance to a health facility, and lack of early information and education on reproductive health services in accessing reproductive health services. Additionally, stigma and discrimination, verbal abuse, fragmented services and mobility challenges in accessing reproductive health services were identified. The study identified that women with physical disabilities receive social support, specifically instrumental, informational and emotional to overcome the challenge of access to reproductive health services. Finally, religious practice, a sense of gratitude, problem-solving, personal determination, a desire for motherhood and self-advocacy were identified as resilient strategies used by women with physical disabilities.

The findings underscore the importance of enhancing educational and employment opportunities for women with physical disabilities to build resilience. The study recommended the need for the Disability Act to be fully operationalized by ensuring all health facilities are mobility-friendly, inclusive, and provide non-discriminatory care to better support women with physical disabilities in accessing reproductive healthcare services in Ghana. It is recommended that counseling units include establishing support units in healthcare settings and strengthening disability-sensitive care in reproductive health policies to help women with physical disabilities overcome challenges in accessing reproductive health services. Future research should focus on healthcare providers' perspectives on the impact of social support on the resilience of women with physical disabilities to the challenges in accessing reproductive health services. The impact of religious factors on reproductive health services among women with physical disabilities can be considered.

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

The World Health Organization Global Report on Health Equity for Persons with Disabilities estimated that about 1.3 billion persons have significant disability (World Health Organization, 2022). The report further indicated that 80 percent of persons with disability live in lower and middle-income countries. According to the World Bank Statistics, women experience higher rates of disability than men in South Saharan Africa (SSA) (World Bank, 2012).

An estimated 8 percent of Ghana's population lives with disability (Ghana Statistical Service, 2021). The Ghana Statistical Service (GSS) report indicated that the prevalence among females was higher than the males at 6.7 percent. Notable among the key challenges faced by women with disability is access to and use of reproductive health services (Ghana Statistical Service, 2014).

Sexual and reproductive health rights are basic human rights enshrined in national and international laws. For example, the International Covenant on Civil and Political Rights, the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of Persons with Disabilities, as well as other international and regional instruments, prescribe principles for ensuring the sexual and reproductive health and rights of women with disabilities. Explicitly, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) pledges persons with disabilities the right to access "the same range, quality and standard of free or affordable health care and programs as provided to other persons, including those in the area of sexual and reproductive health and population-based public health programs" (United Nations, 2006). These conventions call for equity in the accessibility to healthcare services without discrimination.

In line with these principles, Ghana enacted the Persons with Disability Act (Act 715) in 2006 to address the rights and well-being of persons with disabilities within the country (ACT, 2006). The Ghana Disability Act emphasizes the commitment to safeguarding the reproductive rights of persons with disabilities through the elimination of discrimination, expanding accessibility, and ensuring equal opportunities for people with disabilities. In addition, one of the international policy frameworks that has contributed to shaping health policies and sexual and reproductive health intervention in Ghana is the 1994 International Conference on Population and Development (ICPD) held in Cairo, Egypt. This framework has guided the development and formulation of health policies such as the Reproductive Health Strategic Plan (RHSP) 2007–2011, the National HIV/AIDS and STI Policy, and the Ghana Adolescent Health Service Policy and Strategy (AHSPS) 2016–2020. Even though these policies have contributed to addressing reproductive health issues within the general population, the needs of persons living with disabilities have not been adequately incorporated into the policies (Mprah et al., 2014). A wider analysis of nine African Union development policies and strategies on education, health, employment and social protection shows a similar trend, with persons with disability inadequately incorporated into policies (Lang et al., 2017).

Despite the existence of these conventions, instruments and policies, the reproductive health and rights of people, especially women with disabilities, have been given less priority, especially in Africa (Lang et al., 2017). Several studies have documented the health constraints that are faced by women with physical challenges (Blair et al., 2022, Nguyen et al., 2019; Barthelemy & Yves, 2013; Boezaart, 2012; Rugoho et al., 2014; van Rooy et al., 2012). These challenges include a lack of disability-specific reproductive health information, poor healthcare provision, physical barriers, and a lack of privacy and respect. It is also a common perception that women with disabilities are incapable of reproduction and in some cases considered unsuitable for sexual relationships and marital unions. For these reasons, many women with disability are denied the right to motherhood (Chikumbu, 2014). However, some recent studies

have suggested that the motivation of women living with disabilities to have children is to gain support and acceptance for better conditions of life in the future (Ganle et al., 2020). Having children is also a way for the woman to be accepted in society as childlessness is regarded as a curse in some circles (Asante-Afari et al., 2023). Despite this societal expectation, organizations such as the Ministry of Health and health-related non-governmental organizations (NGOs) that support reproductive health in society do not give sufficient attention to the reproductive health needs of women living with disability.

The results of these challenges, as indicated in a study by Blair et al. (2022), place a burden on women with disabilities, their families, and the community. Consequently, women with physical disabilities often seek social support to overcome these challenges. Social support has been defined as an emotional and material resource provided to an individual through interpersonal communication (Moak & Agrawal, 2010). Alternatively, social support has been described as an exchange of resources between at least two individuals perceived by the provider or recipient to be intended to promote the health of the recipient (Shumaker and Brownell 1984). Social support is noted to serve as a resource that enables resilience to both external and internal obstacles arising from the challenging conditions faced by the recipient (Dey & Amponsah, 2020; Mathew & Nair, 2017). Resilience is one of the key contributing factors that affect one's quality of life. Resilience in accessing reproductive health services is important for women with disabilities as resilience is assumed to help them to effectively cope with challenges or adverse conditions of pregnancy and postnatal health experiences. There is therefore an urgent need to unravel the challenges physically challenged females are faced with and understand the key contributions social support and other factors offer to build the resilience of these women in sexual reproductive health care in Ghana.

1.2 Statement of the Problem

Globally, it has been estimated that one out of five women lives with some form of disability (United Nations Population Fund, 2023). Furthermore, it has been estimated that 10 percent of the women with disability are of childbearing age (Ahumuza et al., 2014; WHO, 2011). In Ghana, the recent Population and Housing Census estimates that 10.2 percent of women in their reproductive age (15-49) have some form of disability (GSS, 2021). Access to healthcare, including reproductive health services, remains a challenge, particularly for women with disabilities, including women with physical disabilities (WHO, 2022; Ghana Statistical Service, 2014). Women with disabilities, especially those in developing countries, continue to face open discrimination due to the perception that disability is the result of witchcraft or is punishment for wrongdoing by families, parents, or the victims themselves (Akasreku et al., 2018; Rohwerder, 2018). It is still common in some Ghanaian communities that children born with disabilities are kept out of public view, denied formal education, and in some instances, killed at birth (Hervie, 2023; Kassah, 2008). Previous studies have argued that women with physical disabilities face social stigmatization, economic hardships, social segregation, and violence including expulsion from the marital home (Barthélémy & Yves, 2013; Dassah et al., 2019; Devkota et al., 2019).

In some Ghanaian societies, women with a physical disability could be subjected to physical and emotional abuse (Kassah et al., 2014). To further explain this, studies have revealed that most families do not consent or disassociate themselves from marriages that involve persons with disabilities (Nyame 2013; Chanzanagh, Piri & Garjan, 2012). These practices imply that society, in general, holds some hostility and discriminates against people living with disabilities, especially women.

It is against this backdrop that Ghana promulgated several disability policies and laws. These include the Persons with Disability Act (PWDA) in 2006. The Act states that, “A person shall not discriminate against, exploit or subject a person with a disability to abusive or degrading

treatment" (ACT, 2006, p. 4). The National Council on Persons with Disability, established in 2009, came into force to strategize and implement policies affecting the lives of persons with disabilities. Similarly, the Ghana Federation of Disability continues to advocate for the rights of persons living with disabilities in the country. Although these bodies exist and continue to function, people with disabilities continue to experience social injustices and disadvantages, which include discrimination, poverty, and a lack of employment opportunities, education and health. It is also evident in the policy documents' mission and vision statements that priorities have not been given to the socioeconomic and reproductive health needs of people living with disabilities (Mprah et al., 2014).

Whereas there is data on the sexual and reproductive health of persons without disability, data about persons with disabilities, including persons living with physical disability, are given less attention. This is due to the data collection bodies in general, including the Ghana Demographic and Health Survey (GDHS), Multiple Indicator Cluster Survey (MICS) and District Health Information Management System (DHIMS) not specifying data on the reproductive health of persons with disabilities. The Ghana Demographic and Health Survey (GDHS), National Population Policy, Reproductive Health Service Policy and Standards, Adolescent Reproductive Health Policy, National HIV/AIDS and STI Policy, the Criminal Code on Abortion and a National Survey of Adolescents (NSA) indicated that negative perceptions about disability and lack of societal understanding of the concerns of PWD explained the neglect of PWD in sexual and reproductive health (SRH) policies in Ghana (Mprah et al., 2014).

Women with physical disabilities living in Ghana experience a double burden of living with disability and in a disability-challenging environment and structures (Ghana Statistical Service, 2014). As a result of their condition, they are perceived as being dependent and society judges them as being different and gives less attention to health interventions and policies. Most women living with disabilities who decide to have children are frowned upon by society (Nyame, 2013). Society generally perceives that women with physical disabilities should not

have babies since they are presumed not to have the physical ability to raise them. From a medical perspective, women with physical disabilities are faced with more pregnancy complications. They may also have difficulties in safely operating wheelchairs, urinary tract and bladder problems and significant shortness of breath (Gavin, Benedict & Adams, 2006). This notwithstanding, it is established that women with physical disabilities (such as paralysis, cerebral palsy, or multiple sclerosis) are increasingly becoming pregnant (Horner-Johnson et al., 2016; Ganle et al., 2016; Nguyen, 2016; Dean et al., 2017; Lezzoni et al., 2013; Mavuso & Maharaj, 2015). However, it is suggested that these women have a greater likelihood of having caesarean deliveries and pre-term babies (Mitra et al., 2015; Horner-Johnson, Biel, Darney, & Caughey, 2017).

Most studies on the reproductive health of women with physical disabilities have concentrated on Europe and North America (Amjadi et al., 2017; Mitra et al., 2012; Nosek et al., 1995; Smeltzer, 2007; Stuntzner et al., 2020). These studies have focused mainly on challenges and negative reproductive issues with little attention paid to ways to promote resilience.

Resilience has been explained as a person's ability of being able to adapt to adversity, recognizing factors that influence the impact of threats to the successful functioning or development of a person (Masten & Obradović, 2006). While there are several studies in support of resilience on disabilities caused by chronic health conditions (King et al., 2006), intellectual disability (Scheffers et al., 2021; Tali, 2002), parents or caregivers of children with disabilities (Heiman, 2002; Migerode et al., 2012), and coping strategies (Acheampong & Aziato, 2018), specific resilience approaches and interventions are yet to be developed toward the specific reproductive health concerns of women living with physical disabilities in sub-Saharan Africa.

In Ghana, reproductive health issues of women with physical disabilities, in particular, are rarely discussed in the public space; thereby depriving women with physical disabilities or potential mothers of the needed knowledge on overcoming reproductive health challenges with

disability and building reproductive resilience. Generally, studies conducted on the reproductive health of women with physical disabilities in Ghana are few and the focus is mainly on the challenges faced by these women (Acheampong et al., 2020; Ganle et al., 2016). For example, Ganle et al. (2016) found that women living with physical disabilities are faced with numerous barriers, such as lack of ramps, inaccessible doors, hospital beds and toilet facilities, communication challenges and societal prejudice in accessing and utilizing reproductive health services and care (Ganle et al., 2016). In another study, mothers with physical impairments were found to experience difficulty in breastfeeding due to issues relating to interruption of sleep, dysfunctional limbs and the need for those breastfeeding to eat nutritionally adequate foods (Acheampong et al., 2020). Therefore, women with physical disabilities may need support due to their mobility difficulties.

Human populations, regardless of their status, seek social support to overcome challenges in an attempt to improve their health and well-being. Women with physical disabilities are not exempted from social support to overcome reproductive health challenges. Social support is noted to serve as a resource to be resilient to external and internal obstacles due to the challenging conditions of the recipient (Dey & Amponsah, 2020; Mathew & Nair, 2017). Traditionally, the family is viewed as the primary support system for caring for persons with disability in Ghana. However, studies have documented that processes of urbanization have weakened the traditional role of the family and or society support system (Mba, 2010). Although urbanization is assumed to help in improving structures and systems in meeting the needs of persons with disabilities, this may not apply across sub-Saharan Africa. The United Nations Population Division (UN DESA, 2015) underlines that despite an increase in urbanization trends, less attention is being paid to the unique challenges faced by persons with disabilities within the context of structural and social development in the region. This suggests a gap in the alignment of urban development with inclusivity necessary to ensure equitable access and participation for persons with disability. Moreover, the housing designs and service

provisions in urbanized areas of Ghana continue to be formulated without due consideration for the challenges faced by persons living with disabilities. Kportufe (2015) draws attention to the inadequacy of urban planning in tackling the accessibility issues confronted by persons with disabilities.

In addition, information about how women living with physical disability identify and access social support, which has an impact on their ability to manage these difficulties and challenges during pregnancy and early motherhood, is inadequate (Acheampong et al., 2020). Furthermore, the welfare system in Ghana does not provide adequate support and protection for women with disabilities who find themselves pregnant and with children (Ganle et al., 2020; Mfoafo-M'Carthy et al., 2020). Therefore, women with disability often experience a great deal of difficulty without adequate social support and their ability to carry pregnancy and parenting is considered poor, which can result in insufficient mother-to-child attachment (Acheampong et al., 2020; Ganle et al., 2020). The deep-seated stereotypes and perceptions about disability contribute to the lack of support for women with disabilities in their participation in reproduction (Ganle et al., 2020). Evidence suggests that the challenges to reproductive health of women with disabilities constitute the risk factors for poor maternal and child health outcomes (Akasreku et al., 2018; Ganle et al., 2016). According to the WHO, addressing inequalities that affect sexual and reproductive health and rights is essential to ensuring that all women have access to respectful and high-quality maternity care (WHO, 2015).

On the whole, despite the growing evidence on the reproductive health of women with disabilities globally, gaps still exist, particularly among women with physical disabilities in Sub-Saharan Africa. Many studies concentrate on challenges over factors that contribute to their ability to overcome them, while policies tend to be general and overlook the specific needs of these women. In Ghana, the lack of specific information regarding women with physical disabilities and sexual and reproductive health further complicates the issue. Therefore, it is important for research not only to point out barriers but also to identify resilience and social

support to enhance reproductive health outcomes for women with physical disabilities. It is against this background that the present study seeks to explore how women with physical disabilities overcome and adjust to challenges associated with their sexual and reproductive needs in the Ghanaian setting. Additionally, the present study seeks to investigate the social support and resilience of physically challenged females towards reproductive healthcare in Ghana.

1.3 Research Questions

The following research questions guided the study.

i. What difficulties do women with physical disabilities face in accessing reproductive health services?

ii. What are the available social support systems for women with physical disabilities to access reproductive health services?

iii. What factors influence the resilience of women with physical disabilities regarding the challenges they face accessing reproductive healthcare services?

iv. What is the role of social support in strengthening the resilience of women with physical disabilities who face challenges in accessing and using reproductive health services?

1.4 Rationale for the Study

Sexual and reproductive health, human rights and sustainable development are interconnected (Galati 2015). The Sustainable Development Goals explicitly enjoin countries to promote: "universal access to sexual and reproductive health and reproductive rights", and include targets related to Goal 3, to ensure healthy lives and promote well-being for all at all ages; Goal 4, to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all; and Goal 5, to achieve gender equality and empower all women and girls (WHO, 2017). Further, Goal 5 postulates that all forms of discrimination and violence against girls and women

(including those with disabilities) must be eliminated. Investing in sexual and reproductive health and rights saves lives and empowers all girls and young women, including those with disabilities (WHO, 2023; UNFPA, 2019). Protecting and promoting their sexual and reproductive health and rights should therefore be a top priority for countries (UNFPA, 2019). This study, among other things, will bring to light the existing challenges, social support and resilience factors, including contributing factors that affect the protection of women with physical disabilities from negative reproductive health outcomes in Ghana.

Addressing challenges of reproductive health is crucial to building resilience and essential to ensuring women with physical disabilities and their children thrive and contribute meaningfully to society (Kalpakjian et al., 2020; Lezzoni, 2015). There is, therefore, an urgent need to unravel the challenges physically challenged females are faced with and understand the key contributions social support and other factors offer to build the resilience of these women in sexual reproductive health care in Ghana.

Using the social support and resilience approach facilitates the identification of the supportive networks of women with physical disabilities' lives that can be enhanced to overcome barriers in accessing reproductive health services, thereby improving their reproductive health outcomes. Moreover, the utilization of the resilience approach is crucial for providing insight into the factors that contribute to empowering, fostering self-advocacy, and promoting a sense of control over the reproductive health decisions of women with physical disabilities (Aguillard et al., 2022). This would further provide policymakers including the Ministry of Health and Ghana Health Service evidence-based information on the reproductive health resilience situation of women with physical disabilities in urban communities in Accra, which would support the design and implementation of reproductive health programmes and interventions for women living with a physical disability. This can guide the development of more specific and effective policies and interventions.

The selection of Accra as the study area is key to contributing to knowledge on urban health. The urban context offers a unique perspective on understanding the reproductive health and resilience of women with physical disabilities in urban areas where modernization has influenced the social support system. In addition, the urban context provides a better understanding of the reproductive resilience of women with disabilities amidst the rapid growth of the urban population in Ghana (Esantsi et al., 2015). This would help researchers to better understand why women with physical disabilities continue to give birth or become pregnant, although it is stressful, so that appropriate programmes and interventions can be designed to enhance their well-being. Hence, the study will contribute to the resilience and social support literature on persons with disabilities' reproductive health in developing countries from the Ghanaian perspective.

1.5 Objectives

The main aim of the study was to investigate the social support and other factors that influence the resilience of women with physical disabilities' access to reproductive health services.

Specifically, the study seeks to:

i. Investigate the challenges faced by women with physical disabilities in their quest to access reproductive health services.
ii. Examine the available social support systems for women with physical disabilities
iii. Assess the factors that influence the resilience of women with physical disabilities regarding the challenges they face accessing reproductive healthcare services.
iv. Examine the role of social support in strengthening the resilience of women with physical disabilities to the challenges in accessing and using reproductive health services

1.6 Organization of the Study

This study is structured into nine chapters. Chapter One discusses the background of the study, the problem that is being addressed and the rationale for undertaking the research. The objectives for the research are also outlined, and lastly, the research questions that guide the achievement of the study objectives are listed. Chapter Two focuses on reviewing the literature and the theoretical and conceptual frameworks guiding this study. The literature is reviewed in this chapter to ascertain what physical disability is, the various types of physical disability, policies on reproductive health and disability, and the factors that drive women with physical disabilities to have children. The literature review further explores the challenges they encounter during pregnancy, childbirth and motherhood, the mechanisms they adopt to help them cope with their challenges and the available social support system. Resilience factors to these challenges of access to reproductive healthcare services are also discussed. Chapter Three discusses the methodology for the study. Chapter Four mainly describes and discusses the characteristics of the respondents by using simple frequency distributions, summary tables and charts. Chapter Five looks at the challenges women with physical disabilities encounter in accessing to reproductive health services. Chapter Six examines the available social support and the role of social support in strengthening the resilience of women with physical disabilities and their challenges in accessing and using reproductive health services. Chapter Seven further investigates factors that contribute to the resilience to challenges of access to reproductive health among women with physical disabilities. Chapter Eight focuses on the role of social support in strengthening the resilience of the physically challenged in accessing reproductive health services. A summary of the findings of the research, conclusion and recommendations are presented in Chapter Nine.

CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter reviews relevant literature on concepts, empirical studies and theories on access to reproductive healthcare services among women with physical disabilities. This review situates this study within broader scholarly debates, identifies a knowledge gap, and justifies the focus on social support and resilience in addressing access challenges. The literature reviewed for this study is organized around the main concepts, including disability and physical disability. Policies on reproductive healthcare and disability, challenges encountered by women with physical disabilities in the course of their pregnancy and early motherhood, and the means through which women cope with the challenges of access to reproductive healthcare services are discussed. Additionally, the chapter explains the linkages between social support and resilience. Contextual factors such as urbanization, as well as social, cultural, political, technological, economic and environmental factors and how they influence resilience amidst the challenges of access to reproductive health services among women with physical disabilities are also explored.

Lastly, the chapter presents the theoretical and conceptual frameworks that guide the study, focusing on the Social Support Theory, Resilience Theory, Health Belief Model, and the Socio-Ecological Model. Overall, this chapter provides the foundation for addressing the study's objectives and informs the interpretation of the findings presented in this study.

2.2 The Concept and Definition of Physical Disability

The concept of disability has changed over time and can be studied using several definitions and models. The disability perspective has been dominated by the medical model, which views

disability as an impairment in an individual and sees disability as inherently undesirable and must be treated. On the other hand, the social model of disability, which arose towards the end of the 20th century, regards disability as being caused by social exclusion and barriers and not by the individual's impairment. This model holds that society is to blame for providing a disabling environment that does not provide appropriate accommodations for different needs (Oliver, 1990). According to the World Health Organization (WHO), disability is "an overarching term for impairments, activity limitations, and participation restrictions" (WHO 2011). WHO also underlines that it's not solely a health problem but encompasses a wide range of social, physical, and political realities and is often not simply reduced to a health and functional issue for the individual.

In this broader context, the concept of physical disability specifically addresses limitations in a person's physical functioning and mobility. The medical perspective of physical disability focuses on limitations due to paralysis and amputation, which is seen as an area that needs to be addressed medically. However, the social model of disability shows that numerous challenges encountered by persons with physical disabilities originate from environmental and attitudinal barriers. Physical disability is a condition that substantially limits one or more basic physical activities in life (such as walking, climbing stairs, reaching, carrying, or lifting). These limitations hinder the person's ability to perform tasks of daily living. On the other hand, mobility disability is a state of form that makes it difficult for a person to use his hand or foot or is incapable of walking or lifting objects, thereby experiencing difficulty in physical movement (Hur, Park, Kim, Storey & Kim, 2005). This person may or may not use assistive devices such as a wheelchair, crutches, walker, to name a few. For this study, mobility disabilities have been classified under physical disability.

2.3 Disability Landscape and Policies on Persons Living with Disability

According to the World Health Organization, globally, it is estimated that 16 percent of the human population constitutes persons with disability (WHO, 2023). There is a variation of this rate in the context of the general population and specific groups. Persons with disability, specifically women of reproductive age of 15-49 years, for example, constitute approximately 11 percent (Byrnes & Hickey, 2016).

During the last decades, international organizations have initiated efforts at improving many aspects of the lives of PWDs. The United Nations and other Civil Society Organizations have shown growing concerns in addressing the needs and challenges of persons living with disabilities in diverse ways. The Convention on the Rights of Persons with Disabilities, for instance, was unanimously adopted by the UN in May 2006. The United Nations, in this direction, emphasizes the need for governments to promote and ensure the rights of PWDs. As a further effort, the UN Convention on the Rights of Persons with Disabilities in its general principles and specific provisions of Article 25, "recognizes that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination based on disability" (UNCRPD, 2006, p.18). These are an indication of great efforts and resources dedicated to tackling problems facing persons living with disabilities with its political dimension and attention by many governments and the international community at large. The UNCRPDs encourage member states to give recognition of the rights of persons with disabilities through a legal approach to tackling their problems and provisions in all aspects of their many lives. Although challenges remain in the full implementation of the UNCRPDs globally, there is ample evidence that the United Nations Convention on the Rights of Persons with Disabilities (UNCRPDs) has been able to make progress in terms of access to education, employment and healthcare of Persons Living with Disabilities (PWDs) globally (Byrnes & Hickey, 2016).

In Ghana, parliament ratified the Convention on the Rights of Persons with Disabilities in March 2012. To achieve and sustain the goals of the convention various local policies were developed. However, prior to this, the National Disability Policy (NDP) was developed in 2000. The purpose of the policy was to enact appropriate legislation and make functional existing ones, to promote the full integration of persons with disabilities into the national economy, and to protect their rights as citizens of Ghana; to create an enabling environment for them to promote their economic well-being and to enhance their capacity to perform better to improve their socio-economic status; and to create awareness of the plight of persons with disabilities and to whip up national support (including the use of local resources) to promote their welfare. Moreover, there was the development of the National Strategic Plan on Disability and Disability Action Plan, and there have been several policies to enhance the welfare of persons with disabilities, which included child and family welfare policies and many others.

Ghana's policy seems to be a more human-centered approach to tackling disability issues, by laying more emphasis on social welfare issues of economic empowerment of the vulnerable group. To deal with the promotion and protection of rights the Persons with Disability, Person with Disability Act, 2006 (Act 715) was passed to criminalize offenses against a person living with a disability. Moreover, Article 17 of the 1992 Constitution of Ghana states that all persons shall be equal before the law (Clause 1), and shall not be discriminated against on the grounds of gender, race, color, ethnicity, religion, creed, or social or economic status (Clause 2). Likewise, Article 29 of the Constitution makes a special provision for the rights of persons with disabilities. The article protects persons with disabilities against all exploitation, all regulations, and all treatment of a discriminatory, abusive, or degrading nature (clause 4).

Despite progress made in policy development and framework both globally and nationally, it has been reported that these people remain one of the most marginalized and socially excluded groups in many developing countries, including Ghana (Hoseinpoor et al., 2013; Mitra et al.,

2013; Ganle et al., 2016). Nonetheless, PWD continues to face challenges due to a lack of support from institutions mandated to promote and protect their rights and welfare. Also, barriers including inadequate resources, cultural stereotypes and lack of robust monitoring system limit the effectiveness of these policies.

Although policies focus on economic empowerment, the critical role of social support systems in fostering resilience and addressing the marginalization of PWDs must also be prioritized to achieve true inclusivity and equality.

2.4 The Disability Situation in Ghana

Studies have indicated that people with disabilities in Ghana have low access to educational and economic opportunities compared to people without disability (Asuman et. al 2021; Cheshire Leonard 2018). This disparity is more distinct for Ghanaian women with disabilities, in particular, who are faced with a difficult situation like their counterparts in other parts of the world. Studies show that education levels for females with disability are lower as compared to that of males (Naami, 2015; GSS, 2010). Likewise, it has been noted that males with disabilities in employment are more than females with disabilities who are employed (Naami, 2015; GSS, 2010). The lack of opportunities in the employment and educational space is not the only issue affecting women with disabilities, but social and gender-based discrimination has been noted to be affecting women with disability. In a highly gendered society such as Ghana, for example, women with disabilities suffer more discrimination as compared to men. This situation has been attributed to the patriarchal culture, which creates an avenue for women with physical disabilities to be judged harshly because of their bodies as compared to men (Ganle et al., 2016). Similarly, it has been asserted that women with disabilities are more likely to be accused of witchcraft and suffer gender-based violence, including sexual violence than men with disabilities (Ganle et al., 2016).

Regarding sexuality and reproductive health issues facing women with disabilities, studies have suggested that it has largely been ignored (Ganle et al., 2016; Morrison et al., 2014). The reality cited by Kallianes and Rubenfeld (2010) is that both women's and disability rights movements have not invested the needed attention to women with disability, in the area of sexuality, and reproductive freedom.

Nevertheless, a review on disability in sexuality and reproductive health policies, as well as research in Ghana showed PWDs have received little attention (Mprah et al., 2014). It must be noted that the neglect given to the PWDs is not only limited to Ghana but also other resource-scarce countries (Ganle et al., 2014; Ahumuza et al., 2014; Nosek et al., 1995; Trani et al., 2011; Murthy et al., 2014; Mulumba et al., 2014; Reynolds, 2010; Devkota et al., 2019). The situation in Ghana shows a lot of effort is needed to create an enabling and supportive environment, with specific reference to women with physical disabilities within the reproductive age.

2.5 Barriers to Reproductive Health Access of Persons Living with Physical Disability

The United Nations Convention on the Rights of Persons Living with Disability (UNCPRD) (UN, 2006) and other international human rights conventions has contributed to ensuring the fundamental rights to physical, social, and psychological health. The paramount case of reference is the UNCPRD has the right to access an equal range, quality, and standard of free, or affordable healthcare and programs similar to other persons, including services in the area of sexual and reproductive health and population-based public health programs (UN, 2006). Despite the existence of these policies, available evidence shows persons living with disability continue to face challenges in access to reproductive healthcare services. The challenges faced by PWDs, including the physically disabled, affect their quality of health (Becker et al., 1997; Nosek et al., 1995).

Several studies have highlighted different forms of barriers that women with disabilities face in accessing sexual and reproductive health services (Bremer et al., 2010; Beyene et al., 2019;

Mprah et al., 2017; Tarasoff, 2015). These include psychological, informational, physical, attitudinal, cultural, financial, training, resource, transportation, communication, and legal/policy barriers.

Psychological barriers affect the ability of women with disabilities to access sexual and reproductive health services. Tarasoff (2015) highlights that women with physical disabilities often face substantial psychological burdens during the perinatal period. These burdens negatively affect their access to quality sexual and reproductive healthcare. In addressing this burden, an investigation on the psychological needs of pregnant women and new mothers with walking difficulties was conducted in Uganda by Aplot et al. (2019). The study found psychosocial needs of women with physical disabilities throughout pregnancy, childbirth, and the postpartum period. These included acceptance from spouses, families, communities, and healthcare professionals.

Women with disabilities often lack adequate information relating to their sexual and reproductive health. A study in Ghana revealed that these women lack specific or appropriate reproductive health information, thus information given is often general and does not address their specific needs (Ganle et al., 2016). Mprah et al. (2017) revealed a significant gap in the understanding of pregnancy prevention methods for persons with hearing impairment. In addition, issues with the translation of the information on reproductive health and inadequate consultation times with health professionals worsened the informational barriers faced by these women (Clemente et al., 2022; Peta, 2017; Tanabe et al., 2015; Mprah, 2013). Hashemi et al. (2022) stated that informational barriers can be particularly challenging for women with disabilities to access health services including reproductive health services.

For women with disabilities, especially those physically challenged, being unable to access healthcare services is a major barrier. Ganle et al. (2016) stated that physical accessibility problems are among the major barriers that limit adequate interaction between these women and service providers thus preventing them from receiving maternal healthcare services. For

example, studies in Cameroon and Ethiopia, found that reproductive health services including family planning service delivery point are often inaccessible (Bremer et al., 2009; Beyene et al., 2019). In Uganda and Zimbabwe, Ahumuza et al. (2014) and Rugoho and Maphosa (2017), respectively, reported poor physical accessibility and disability-unfriendly infrastructure. Additionally, other studies have revealed the need for a lack of other infrastructure required for special service needs for women with physical disabilities, which includes lower delivery and examination beds, chairs, ramps, and restrooms. The respondents also mentioned the need for specialized outreach services for prenatal and postnatal care and reported long waiting times for medical services.

Negative attitudes and discriminatory behaviours of healthcare providers towards women with disabilities are well-documented in Ghana and other parts of the developing countries. Ganle et al. (2016) noted insensitive and ignorant attitudes of healthcare providers towards persons with disabilities in Ghana. It has been found that service providers frequently exhibit poor understanding and discriminatory attitudes towards the sexual and reproductive health needs of women with disabilities (Lee et al., 2015; Tanabe et al., 2015; Clemente et al., 2022). For instance, studies in Kenya, Nepal, and Uganda have observed that pregnant women face discrimination and lack of respect from health workers (Tanabe et al., 2015). Clemente et al. (2022) identified inadequate professional training and a lack of resources as key challenges for service providers.

The outcome of the above stems from people's cultural values and belief systems. Mprah et al. (2017) and Ganle et al. (2016) highlighted the impact of cultural beliefs on discrimination in Ghana. This issue is also prevalent in other sub-Saharan African countries. In Zimbabwe, Peta (2017) disclosed that many people with disabilities have been living in a culture filled with evil spirits, taboos and witchcraft hence being discriminated against because of their disability. Similarly, traditional beliefs about disability and negative attitudes towards persons with

disabilities were reported in Zambia (Smith et al., 2004). Likewise, Albert and Hurst (2004) noted that persons with disabilities' inability to access healthcare services can be attributed to a complex web of discrimination, which consists of negative social attitudes and cultural assumptions, as well as environmental barriers including policies, laws, structure and services that result in marginalization and social exclusion.

Attitudinal biases of health service providers and poor dissemination of information have been identified as obstacles to access to healthcare services (Becker et al., 1997; Nosek et al., 1995). Ganle et al. (2016) emphasized the need for better training and resources for service providers. In addressing this challenge among health providers, studies have revealed the need for the provision of adequate training and resources (Clemente et al., 2022; Ganle et al., 2016; Lee et al., 2015).

Studies have also noted that women with disabilities consistently face financial obstacles, especially in Africa. Ganle et al. (2016) identified financial issues among women with disabilities in Ghana during the perinatal period. Bremer et al. (2009) and Tanabe et al. (2015) also highlighted financial issues as significant barriers among persons with disabilities in Cameroon. Transportation challenges have been cited by studies on persons with disabilities (Clemente et al., 2022; Ganle et al., 2016; Tanabe et al., 2015). Some of the transportation-related challenges border on issues of affordability and difficulty in locating transportation. For instance, a study in Cameroon reported the unavailability of taxis to transport physically disabled individuals to health facilities (Bremer et al., 2009). In another study, the inability to pay for the cost of travel to health facilities was noted as a major challenge for women with a physical disability. Findings from Ganle et al. (2016) revealed that although women with disabilities do desire institutionalized maternal healthcare, their conditions frequently make it challenging for them to travel for expert treatment and access unfavorable physical health infrastructure. However, access to transportation has been noted as a key need that facilitates access to skilled delivery among women with disabilities (Ganle et al., 2016).

2.6 Physical Disability and Social Support

There is a growing literature on women with disabilities facing numerous barriers in accessing health services, specifically physical, informational, emotional and attitudinal obstacles. Current research seems to give credence to the critical role played by social support in mitigating these challenges and facilitating access to health services for women with disabilities (Hollanda et al., 2015). The issue of whether social support aids women with disabilities in accessing reproductive health services is clouded by the fact that the contribution of social networks is essential, considering their vulnerable status. To portray this, the work's Nosek et al. (2001) reported that women with disabilities who received strong family support are likely to access gynecological services regularly. The family members often provide essential emotional and instrumental support, such as transportation and assistance with physical accessibility. This support enables women with disability to attend medical appointments as expected and receive the necessary care and treatment. Unlike Nosek et al. (2001), Ganle et al. (2020) reported that peer support groups have a positive impact on improving the knowledge and confidence among women with disabilities on reproductive health issues. These findings from the study point to the fact that peer support groups provide the needed informational and emotional support. From the study, these groups provide a platform for sharing experiences, offering advice and disseminating information on reproductive health issues.

In contrast to other studies, Tarasoff (2017) asserted the importance of institutional support in the creation of an inclusive healthcare environment that cares for the specific needs of women with disabilities, including women with physical disabilities. Access to reproductive health services for women with disabilities as cited by the study can be initiated by healthcare institutions by enhancing the adoption of inclusive practices, policies and training healthcare providers on disability awareness and ensuring physical accessibility. Hence, the study concludes that institutional support and familial emotional support are key factors in enhancing

access to and the quality of reproductive healthcare for women with physical disabilities. Morrison et al.'s (2014) study examines the challenges faced by women with disabilities in accessing maternal and newborn health care in rural Nepal and the impact of social support. The study concluded that community health workers and supportive family members play a critical role in bridging the gap in reproductive health services for disabled women in rural areas. Likewise, Devkota et al. (2018) report that women with disabilities who received high levels of social support had better maternal health outcomes and greater access to reproductive health services. The study further revealed that emotional support from family and instrumental support from community health services were particularly beneficial for the PWDs in accessing reproductive health services.

Collectively, these forms of social support are essential for overcoming barriers and improving reproductive health outcomes for women with disabilities.

2.7 Disabilities and Resilience Strategies to Access to Reproductive Health Services

Addressing the unique vulnerability of people with disabilities, including women with physical disabilities is essential for promoting and fostering inclusivity and resilience in the participation and access to reproductive health services. Achieving this goal requires developing, promoting and implementing resilience strategies that enable persons with disabilities, including women with physical disabilities to overcome obstacles in access to reproductive health services. Literature review on resilience and persons with disabilities, including the women with physical disabilities about resilience strategies employed by these segments of the population in overcoming barriers to accessing reproductive health services. This literature review section delved into resilience strategies among PWDs in access to reproductive health services.

In the context of women with disability, resilience can be described as the capacity to adapt, recover, and thrive despite facing significant barriers and challenges, particularly in accessing reproductive health services. Personal qualities, support networks and services such as internal

drive, connectedness, dedication, healthy and helpful outlets, and evolution of thoughts and behaviour have been identified as factors influencing resilience among women with disabilities (Aguillard et al., 2022).

Studies indicate that spiritual beliefs and a strong sense of community support enhance resilience. A study among women experiencing abuse reported social and spiritual support as instrumental to individual recovery, growth and resilience (Anderson et al., 2012). Additionally, spirituality was reported to have a positive association with satisfaction, quality of life, mental health and resilience for individuals with diverse forms of disabilities (Jones et al., 2016). Similarly, a study on the effects of online prayer lessons in building resilience and a sense of personal control among persons with disabilities from Asian and African cities reported that online prayer lesson was a source of resilience in managing their health outcomes (Pandya, 2022). The provision of these dual support systems helps mitigate the impacts of barriers and fosters supportive environments for accessing health services (de la Fuente et al., 2021).

In other studies, self-control skills, such as planning for the future, managing emotions, and setting goals, have been noted to be crucial in managing stress and enhancing resilience (Ronen, 2021). These skills are reported in the study that opined that individuals, including women with physical disabilities, can maintain a sense of control over their circumstances, which is vital for psychological health and resilience.

Positive reappraisal and tenacity, a cognitive process that enables an individual to reinterpret a stressful situation in a more positive light, is a key resilience strategy for overcoming barriers. The tenacity and perceived competence help women with disabilities face and overcome barriers to accessing reproductive health services (Stewart, 2011). This study concludes that resilience factors are strongly associated with higher engagement and lower burnout, indicating better overall well-being.

Furthermore, studies have reported that the ability to adapt to change and maintain a sense of control is another critical component of resilience. Individuals, including women with

disabilities who perceive themselves as capable of managing their health and navigating the healthcare system, are more likely to engage positively with services and experience lower levels of stress and burnout (Delgado et al., 2018).

Setting specific, achievable health goals and executing them is another resilience strategy. This might include scheduling regular health check-ups, setting reminders for medication, or planning transportation for medical appointments. Effective planning helps manage the logistical challenges associated with accessing healthcare services (Smeltzer, 2007).

Positive self-talk helps in dealing with or overcoming psychological stress associated with barriers (Sheldon & Lyubomirsky, 2006; Walsh et al., 2017). Encouraging positive self-talk helps to maintain and improve their ability to manage external challenges. Likewise, increasing knowledge about reproductive health issues is another important strategy of resilience (Tanabe et al., 2015). As indicated in the study, a well-informed individual can make informed decisions. The self-education received from support groups can help women with disabilities recognize and demand appropriate care and services, and this can enable them to overcome fear and any forms of abuse.

McConnel et al. (2008) found that the desire to become a mother provides a sense of purpose and motivation, encouraging women with disabilities to surmount significant challenges. This intrinsic motivation is pivotal in enhancing resilience, as it fosters a proactive approach to seeking necessary health and support. These findings are buttressed by Smeltzer (2007), who reported that women with disabilities often develop a high level of resourcefulness in the pursuit of motherhood.

The study indicated that the desire for motherhood makes women with disabilities locate accessible healthcare providers, utilize adaptive technologies, and seek specialized services. The PWD, including women with physical disabilities ability to adapt and find practical situations is a key aspect of resilience.

Similarly, Lezzoni et al. (2015) found that the desire for motherhood can necessitate frequent intervention with healthcare systems, prompting women to adapt to complex and difficult health systems. Likewise, the desire for motherhood has been identified from studies that make women with disabilities challenge stereotypes and stigma surrounding disability and parenthood (Tefera et al., 2017). These women are able to assert their rights to be mothers. These acts of challenging and changing societal norms is considered a form of resilience strategy (Tarasoff, 2017). Schmied et al. (2012) also reported that women, including women with physical disabilities who engage in empowerment activities such as advocacy, strengthen their resilience and contribute to broader societal change.

To conclude this section, the literature identifies the strategies used by the PWDs, including women with physical disabilities to overcome barriers to access to reproductive health services.

2.8 Theoretical Framework

The study is based on various theories and approaches that analyze the reproductive health experiences of women with physical disabilities. By integrating diverse perspectives of these theories, the research aims to investigate factors that influence access to reproductive health services and strategies adopted by women with physical disabilities faced with diverse reproductive health challenges. This section provides an overview of the theoretical foundations that guide and reveal the relationship between factors influencing reproductive health experiences and the needs of women with physical disabilities. A theory can be defined as "systematically organized knowledge applicable to a relatively wide variety of circumstances devised to analyze, predict or otherwise explain the nature or behaviour of a specified set of phenomena that could be used as the basis for action" (Van Ryan & Heany, 1992). It is against this backdrop that the study used four theories: Social Support Theory, Health Belief Model, Resilience Theory and Socio-Ecological Model.

The Social Support Theory, Resilience Theory, and Health Belief Model were adopted because their constructs align with the study's objectives and were applicable to understanding social

support and women with physical disabilities' resilience to reproductive health experiences. The Social Ecological Model's structure was retained, but its multiple levels of influence were contextually modified and expanded to suit the realities of the study population, which is why it was adapted and not simply adopted.

2.8.1 Social Support Theory

Social Support Theory was developed by Don Drennan-Gala (1995) and Francis Cullen (1994) based on insights from several theoretical traditions. Although the emergence of the theory focused on instrumental, informative, and emotional support as aids to reduce delinquency and crime, it has been applied in other fields of study.

In the field of health, social support is described as functions performed for an individual by social ties, specifically family, friends and networks at influencing health and well-being (Chernomes, 2014; Lai, 2014). Within the context of disability study, it has been observed that social support is an essential resource for protecting and promoting health and wellbeing (Meadan et al., 2010). There are different kinds of social support for influencing the health and well-being of people, including women with physical disabilities and women's access to reproductive health care services.

First, instrumental support is described as practical assistance with transportation, mobility aids, or navigating healthcare systems that can empower women with physical disabilities to overcome logistical barriers and access reproductive health services. The provision of instrumental support has been reported to contribute to a reduction in health complications and mortality (Schultz et al., 2022). Such evidence shows inadequate instrumental support, such as funds to purchase essential medication, could have consequences on the health of women with physical disabilities due to a lack of access to reproductive health care.

Second, informational support is associated with advice, guidance, or useful information that helps individuals, including women with physical disabilities and mothers, access accurate

information about reproductive healthcare services (Liang et al., 2014). The provision of important or valuable information from friends, family and other social ties could offer them the assurance and confidence to access reproductive healthcare services.

Third, emotional support is described as an individual, including the women with physical disabilities receiving empathetic listening, reassurance, and validation of feelings from a family, friends and social network that provides a sense of belonging and acceptance to promote and protect health and wellbeing (Ommen et al., 2008). Emotional support creates avenues for women with physical disabilities and women to obtain help from friends and family members. As cited by Ommen et al. (2008), love is integral to developing a sense of trust and belonging through emotional exchange and interactions with social ties. This situation could help them to express challenges with family members in access to reproductive healthcare services.

Thus, in the context of the study, the social support theory focuses on the identification of support from the family, friends and social network that enable the study population to develop coping mechanisms and resilience to challenges of access to reproductive healthcare services.

2.8.2 Resilience Theory

The theoretical model of resilience guides this study. An integral theme underlying resilience theory is the ability of an individual to overcome or scale over adversity, frustrations and misfortune (Ledesma, 2014).

In this study, resilience in women with physical disabilities is associated with the ability to overcome barriers in accessing reproductive healthcare services. The resilience of a person, as indicated by Greene et al. (2004), showed the influence of diversity, including ethnicity, race, gender, age, sexual orientation, economic status, religious affiliation and physical and mental ability on resilience. For instance, a woman with physical disabilities who is aware of challenges with mobility could use financial support available to pay for the cost of transportation in access to reproductive healthcare services. Nonetheless, a woman with

physical disabilities without better economic status could not be able to overcome the challenge of mobility. This situation implies that favourable internal and external factors play a crucial role in access to reproductive healthcare services. Some shortcomings have been identified in this theory. For example, a shortfall that has been acknowledged in this theory is that it is idealistic. Despite the theory's shortcomings, it is noted to be essential in helping individuals evaluate a given situation to avoid pitfalls or problems (Wright & Masten, 2015).

2.8.3 Health Belief Model

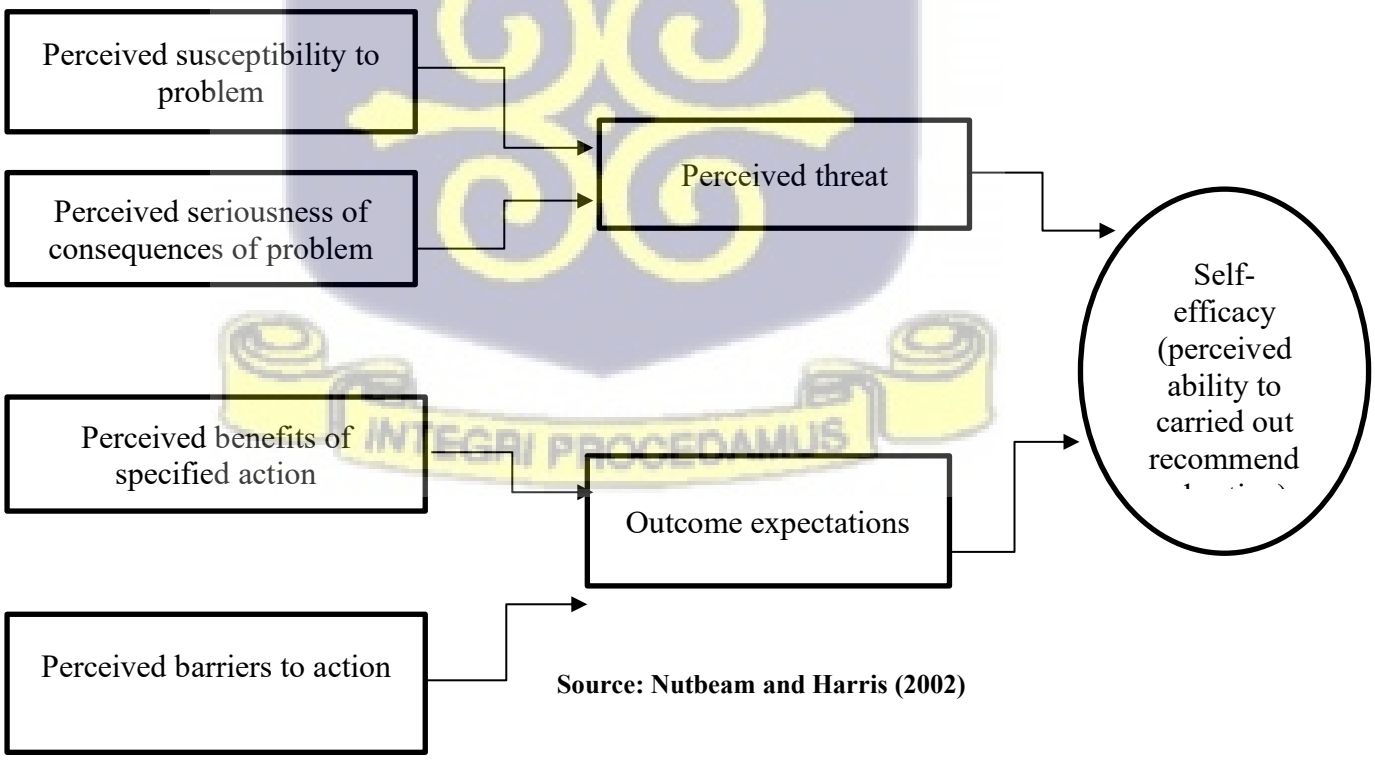
It is one of the longest-established theoretical models designed to explain health behaviour by understanding people's beliefs about health. It was originally articulated to explain why individuals participate in health screening and immunization programmes and has been developed for application to other health behaviour. It is a health theory used to predict health behaviour by Strecher and Rosenstock in 1997 (Becker, 1974; Nugrahani et al., 2017). The model postulates that the likelihood of an individual taking action for a given health problem is based on the interaction between four beliefs. The model predicts that individuals will take action to protect or promote health on the following premise: first, whenever the individual perceives themselves to be susceptible to a condition or problem; second, whenever the individual believes that the problem or condition will have serious consequences; third, whenever the individual believes a course of action is available it will reduce susceptibility, or minimize the consequences; and fourth, whenever the individual believes that the benefits of taking action will outweigh the costs or barriers. In the context of the study, it is used to analyse and understand the perceived vulnerability, perceived seriousness and perceived benefits in access to reproductive healthcare services for women with physical disabilities.

Applied to women with physical disabilities and mother's access to reproductive healthcare services, HBM suggests that the physically challenged pregnant woman or mother who has given birth will access reproductive healthcare services (e.g. attend pre-natal, anti-natal or post-

natal) if they perceive themselves to be vulnerable (due to physiological condition or pregnancy-related complication history) to severe health threat (maternal mortality or giving birth to a disabled child), and believe the benefits associated with engaging in protective behaviour (reducing potential of death during pregnancy) outweigh the costs (money or time spent attending reproductive healthcare services).

The health belief model is noted to be useful when applied to behaviour, particularly prevention strategies such as screening and immunization (Nugrahani et al., 2017). The use of this theory in the domain of the study hinges on the fact that women with physical disabilities and mothers accessing reproductive healthcare services is an intervention to prevent reproductive health problems. Thus, its use could enable the study to get insight into the perceived benefits and vulnerability of women with physical disabilities access to reproductive health care services. Perceived benefits could be defined as the women with physical disabilities and mothers' belief in accessing reproductive healthcare services. Perceived vulnerability is described as a woman with physical disability beliefs about the possibility of experiencing risks or possibility of experiencing reproductive health problems.

Figure 2.1 The Health Belief Model

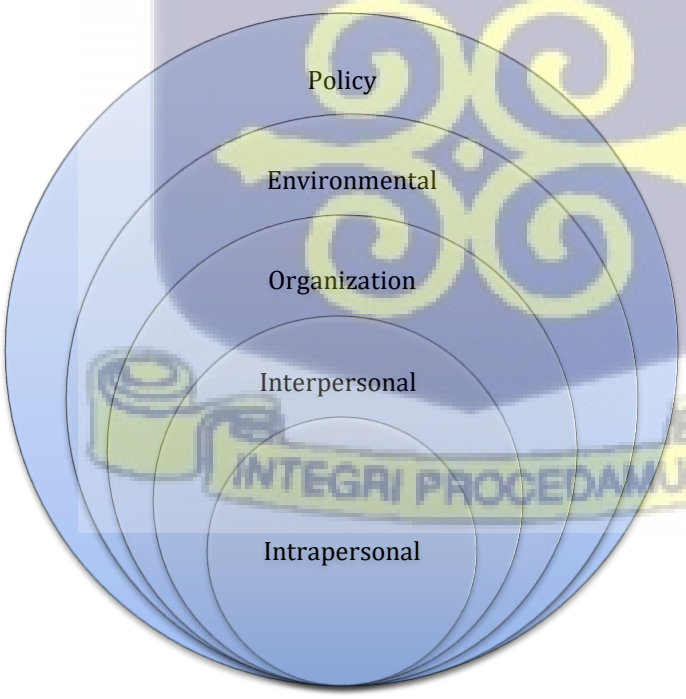


Source: Nutbeam and Harris (2002)

2.8.4 Socio-ecological Model (SEM)

Vulnerable groups, including women with physical disabilities or mothers across the world, require a supportive and enabling environment to overcome challenges, and access to services in society (Amzel et al., 2013; Anderson et al., 2013). Studies have shown that most persons living with disabilities are sexually active in many parts of the world. This situation implies that access to sexual and reproductive health services is important for preventing sexual and reproductive health problems. Despite the availability of reproductive healthcare services for persons living with disabilities, uptake or access remains a challenge. This situation has been traced to constraints at the individual and structural factors in society and the healthcare ecosystem. The acknowledgment of these challenges with access to reproductive healthcare services triggered the passage of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) to equity in access to healthcare services without discrimination (UN, 2006).

Figure 2.2 Bronfenbrenner SEM for Health Promotion



Drawing on the above, this study adopted the Socio-ecological Model. The SEM developed by Bronfenbrenner (1979) has been described as a person-process and context model. The model posits that individuals are caught in a nested system where different parts play a significant role in development. Subsequently, McLeroy et al. (1988) revised the model to develop a framework to encourage behavioural changes related to health. The framework asserted the role of interactions or influence between human beings and their environments. Five layers of influence are included in the framework: (1) intrapersonal, (2) interpersonal, (3) organization (community, healthcare facilities), (4) environmental (cultural norms, physical surroundings), and (5) policy. The expanded revision of the SEM creates the avenue to reinforce the interactions between the individual and environment to enhance access to reproductive healthcare services for women with physical disabilities.

Considering the complexities and challenging issues that continue to confront persons with disabilities the use of SEM to study access to reproductive healthcare services is suitable. The need to consider a broader view of the situation in society cannot be ignored in the analysis. In this study, the adapted conceptual model was used to understand and analyze the interconnected level of influence at the individual, interpersonal, community, institutional and policy levels to overcome the barriers to access to reproductive healthcare services for women with physical disabilities.

The intrapersonal (individual) level acknowledges the socio-demographic factors, such as educational level, which can hinder or facilitate access to reproductive healthcare services for women with physical disabilities. A study reported that a person's level of education could be a key factor in access to healthcare services due to the person's understanding of health literacy (Gwynn et al., 2016). It can also include attitudes, behaviour and skills influencing individual access to reproductive health services. Next, the interpersonal level includes social support from family and friends that could aid the women with physical disabilities or mothers in accessing reproductive healthcare services. For instance, a supportive family could be an asset in

overcoming transportation barriers and other logistical problems to access reproductive healthcare services.

The institutional (organization) level of influence in the study focuses on guidelines, protocols, and procedures that guide and shape the expectations and interactions of both health workers and women with physical disabilities within the healthcare setting. These protocols and guidelines are influenced by policies that are developed at a higher level (National) and subsequently adopted by lower-level operations. It also includes the physical accessibility to health facilities and the attitudes of the healthcare professionals towards women with physical disabilities or mothers in access to reproductive healthcare services.

The community-level factors of influence focus on the physical environment and cultural norms and beliefs culture of members of the community that affect women with physical disabilities in access to reproductive healthcare services.

Finally, the policy level of influence focuses on laws and regulations within the health sector that promote women with physical disabilities access to reproductive healthcare services.

2.9 Conceptual Framework

This study was concerned with enhancing access to reproductive healthcare services for physically women and mothers. Therefore, this framework of the study focuses on multilevel factors that facilitate or hinder access to reproductive healthcare services for women with physical disabilities. The framework is informed by the Socio-Ecological Model (SEM), Social Support Theory, Health Belief Model and Resilience Theory, which guided the identification of the factors that facilitate or hinder women with physical disabilities' access to reproductive healthcare services. Using the Socio-Ecological Model, the framework examines how women with physical disabilities build resilience to the challenges of accessing reproductive health services from a multilevel perspective, recognizing that access to reproductive healthcare is shaped by interacting factors at the individual, interpersonal, community, institutional and

policy levels. Figure 2.3 illustrates these inter-linkages between social and demographic factors, and how they can affect women with physical disabilities' access to reproductive healthcare services.

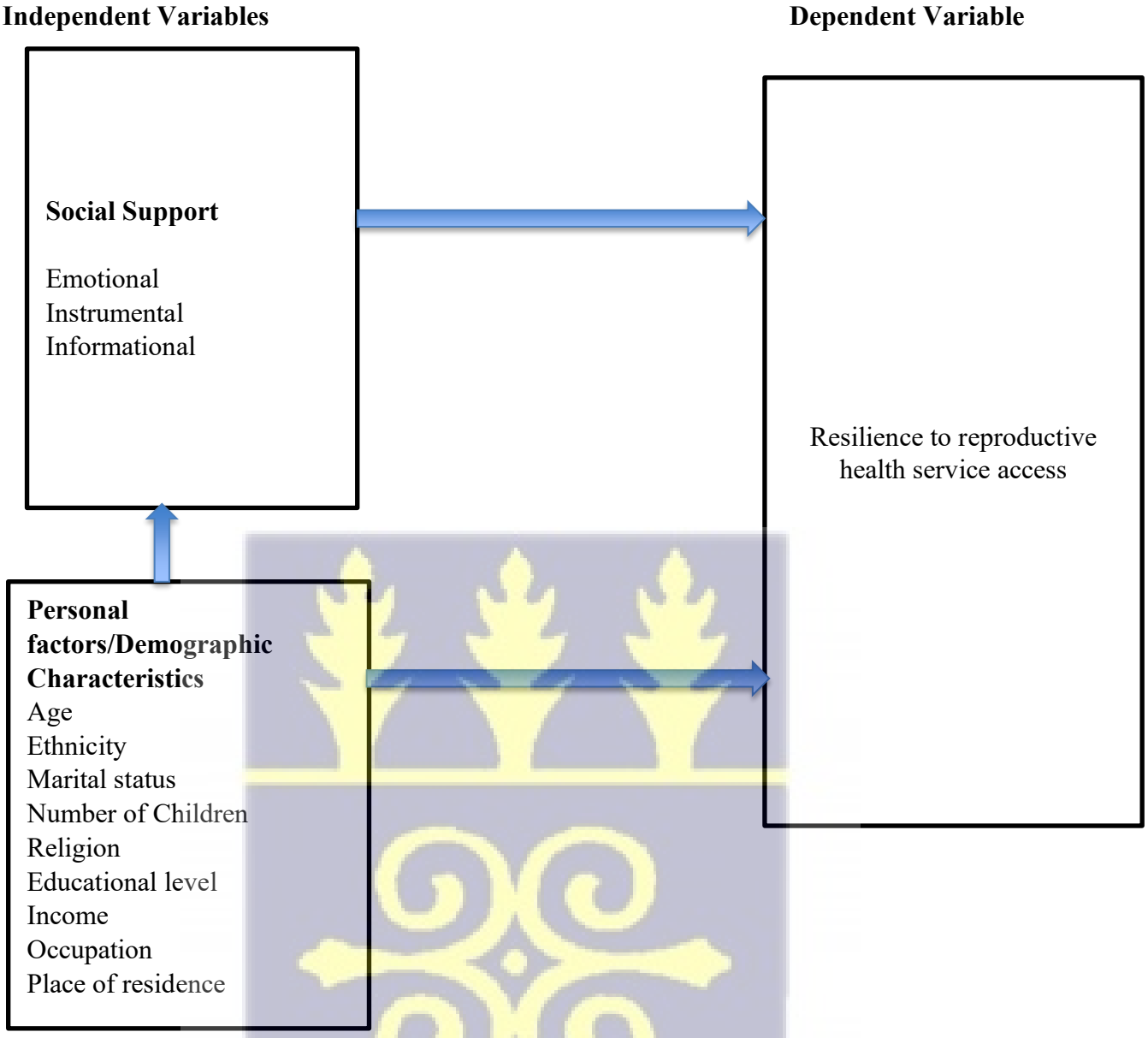
At the individual level, the personal factors or socio-demographic characteristics of women with physical disabilities include age, income, place of residence, educational level, religion, and ethnicity that could contribute to access to reproductive healthcare services. These characteristics may directly or indirectly influence their ability to access reproductive healthcare services The socio-demographic factors can have a direct or indirect effect on the ability of the individual to have access to reproductive healthcare services. For instance, a woman with physical disabilities' current income level may influence access to reproductive healthcare services, in terms of affordability or cost of transportation to the healthcare facility. Even though socio-demographic factors could contribute to access to reproductive healthcare services for women with physical disabilities, they could be limited. In other instances, women with physical disabilities without adequate financial resources may depend on an external form of support.

At the interpersonal level, the framework highlights the role of social support as a determinant of access to reproductive healthcare services, which aligns with the principles of Social Support Theory. However, the kind of social support may have differing level of impacts on the capacity of women with physical disabilities in accessing reproductive health services. In light of this, Figure 2.3 considers social support as a determinant factor that could influence access to reproductive healthcare services for women with physical disabilities. The types of social support are emotional, informational and instrumental resources provided by family, friends and social networks, specifically faith-based organizations or community-based organizations that enable women with physical disabilities access to reproductive healthcare services. Emotional support refers to the love, affection, care and concerns provided by family, friends

and other social contacts of the women with physical disabilities in access to reproductive healthcare services. Instrumental support consists of the financial resources such as money, and logistical support provided by the family or friends to women with physical disabilities for transportation, purchase of medication in access to reproductive healthcare services. Informational support is health-related information and messages provided to women with physical disabilities that enable them to make informed decisions in accessing reproductive healthcare services. Consistent with the Socio-ecological model, the framework recognizes the challenges that are barriers emanating from the individual, community, institution and policy levels that serve as a constraint for the women with physical disabilities and mothers in accessing reproductive healthcare services. The challenges are financial (inadequate or lack of funds); attitudinal (negative comments, behaviour from the healthcare providers, and family); emotional or psychological (stigma, insults, abuse from social ties, society etc.); physical (accessibility within the health facility, in terms of mobility in seeking reproductive healthcare services).

Drawing on the resilience theory, resilience to reproductive healthcare services from the diagram is described as the ability of women with physical disabilities and mothers to overcome challenges and adversity at the individual, and societal level to access reproductive healthcare services. In summary, the diagram of the conceptual framework shows that social and ecological factors are connected and determine access to reproductive healthcare services for women with physical disabilities.

Fig. 2:3 Conceptual Framework Showing Personal Factors, Types of Social Support, Challenges and Resilience to Access Reproductive Health Services



2.10 Summary of the Chapter

Physical disabilities limit basic activities and vary widely, affecting daily tasks; globally, 15 percent of people have disabilities, and in Ghana, the prevalence is 10.6 percent. Despite international efforts like the UNCRPWDs, disabled persons remain marginalized, especially in developing countries, with women facing additional challenges due to societal and gender biases. Ghana's policies, such as the Persons with Disability Act (2006), aim to protect disabled

persons' rights, but implementation gaps persist, especially in reproductive health. Women with disabilities face significant barriers to high-quality sexual and reproductive health services due to various burdens, with studies highlighting poor accessibility, negative attitudes, inadequate infrastructure, cultural stigmas, and financial constraints. Inclusive policies and training are needed to address these disparities. The study investigates the reproductive health experiences of women with physical disabilities using Social Support Theory, Resilience Theory, Health Belief Model, and Socio-Ecological Model to analyze and suggest improvements.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

Access to reproductive healthcare services among women with physical disabilities is shaped by various factors that require a rigorous methodological approach capable of capturing both measurable variables and lived experience. Given the nature of the research problem, the chapter justifies the use of a mixed-method approach, which enabled the integration of quantitative and qualitative evidence in answering the objectives of the study.

This chapter focuses on the research procedures and the methods that were used in the collection of data and data analysis. Specifically, the chapter outlines and describes in detail the study area, study design, target population, data and sources, sampling technique used, research instruments, data processing and analysis, ethical issues and challenges during the fieldwork.

3.2 The Study Area

The Accra Metropolitan Area, La Dade Kotopon Municipal, Kpone Kantamanso Municipal and Ashaiman Municipal in the Greater Accra Region (GAR) were the study areas. The Greater Accra Region provide numerous advantages for the investigation of this study. Although the 2021 Ghana Population and Housing Census, indicated that the Greater Accra Region recorded the lowest percentage of persons with disability among the 16 regions in Ghana, yet it has the largest rehabilitation center for persons with disabilities, which also attracts Ghanaians from different ethnicities across all the 16 regions of Ghana. Interestingly, the 2010 Population and Housing Census revealed that GAR registered the highest percentage (27.5%) of the number of persons living with disabilities in urban areas. Additionally, physical disability was found to be the highest form of disability both in urban and rural areas.

The Greater Accra Region serves as the administrative, political, and economic capital of Ghana. Even though the region has the smallest size of 3,245 square kilometers, representing

1.36 percent of the total land demarcation of Ghana, it has the highest proportion of the country's population of 5,455,692 (GSS, 2021). The region is noted as the central point of Ghana's economy, which attracts many migrants including persons with disabilities. The economic vibrancy of the region creates job opportunities that may attract persons with disabilities seeking employment. The presence of vibrant economic activities within the capital city attracts a high concentration of population. The cities of Accra, Tema and Ashaiman have a heavy concentration of the population in the region and this is projected to increase in a few years. For instance, the Greater Accra Metropolitan Area population is projected to host about 10.5 million Ghanaians by 2040 (GSS, 2024). The current heavy and projected concentration of the population in the region, especially in the cities of Accra, Tema, and Ashaiman, has implications for persons with disabilities in terms of increased challenges in accessing healthcare and social services if infrastructure and policies do not keep up with the growing population.

The combination of a high population density, economic vibrancy, and the anticipated growth in the Greater Accra Region provides a unique background for examining the social support networks and resilience mechanisms of women with physical disabilities in their pursuit of reproductive health services. Examining the experiences of these women within the specified study areas provides valuable insights into the broader issues surrounding social support and resilience in the face of physical challenges, hence informing the development of targeted interventions and policies aimed at improving the reproductive health outcomes of persons with physical disability.

3.3 Study Design

The study adopted a mixed-methods design for purposes of methodological triangulation. This involves the use of both quantitative and qualitative methods to collect and analyze data in a single study. Creswell (2014) and Tashakkori and Teddlie (2003) support the use of a mixed

methods design because the technique has become increasingly popular as a legitimate research design in all disciplines including the social sciences.

According to Creswell (2014), triangulation involves 'within method' triangulation in which the same method is used on different occasions and 'between method' triangulation where different methods are used in the same study. Hence, both a questionnaire-based survey (quantitative method) and in-depth interviews (qualitative method) were used to collect data from the field. The quantitative and qualitative data were used to collect the data at the same time, analyzed independently and combined for meaningful interpretation (Creswell & Plano Clark, 2011). This enabled the researcher to look for mutually supported findings from both methods. Therefore, both quantitative and qualitative elements have equal prominence in informing the study and the results were used for interpretation (Creswell & Plano Clark, 2011; Tashakkori & Teddlie, 1998).

Data analysis was conducted separately, and integrated at the data interpretation stage. Interpretation typically involves discussing the extent to which the data triangulate or converge. These designs were useful for attempting to confirm, cross-validate, and corroborate study findings. According to Dawadi et al. (2021), the application of multiple sources of evidence in a particular study is the best because it helps to enrich the study and also helps one to have a better understanding of the research problem by converging numeric trends from quantitative data and specific details from qualitative data.

3.4 Sources of Data and Study Population

Data for the study was obtained from a primary source. Primary data was collected directly from selected respondents using a questionnaire survey and in-depth interviews. In doing so, the inclusion and exclusion criteria were considered.

For this study 'physical disability' refers to limitations in the mobility of the body as a result of amputations, paralysis, limping and lameness, deformity, and hunched back (Ghana Statistical

Service 2014). All women with physical disabilities within their reproductive ages (15-49 years) and who have given birth within the last five years were included in the study. Specifically, women residing in the Greater Accra Region. However, women with physical disabilities who met this criterion and were not willing to be interviewed were excluded from the study.

3.5 Ethical Considerations

Ethical clearance was obtained from the Ethics Committee for Humanities (ECH) at the University of Ghana. The researcher observed the protocols in the agreement of the study protocols of protecting the rights of respondents. Participants were given consent forms to sign upon their understanding of the purpose of the study and their roles in it. In ensuring anonymity, codes were assigned during data entry instead of names, contact numbers, and other cues that could lead to the identification of participants.

The possible risks associated with the study, such as recounting some unpleasant past experiences during pregnancy and delivery, were all explained to the respondents. The researcher used her knowledge acquired in health and psychology to help respondents deal with such situations. Participants were also made aware that no financial or material rewards were associated with participating in the study. The researcher provided a token of airtime credit to respondents as appreciation for their participation.

3.6 Research Instruments

In consonance with the mixed method design, questionnaires and interview guides were developed to collect the primary data from the field. These types of instruments were chosen because they are most appropriate to solicit the needed information. The question items of the questionnaire and interview guide were extensively based on the review of the literature on women with disability, social support systems and access to reproductive health services.

The survey questionnaire consisted of four sections, which delved into the women's socio-demographic backgrounds, general pregnancy and postnatal-related issues, available social support and resilience to the challenges encountered in their access to reproductive health services. The first section focused on the socio-demographic characteristics (age, education, religion, income, ethnicity, number of children, living arrangement, etc.). The pregnancy and postnatal-related questions were in the second section. The third section covered social support for access to reproductive health services. Section four included scale items that were used to assess the resilience of women with physical disabilities to their most difficult challenges, as indicated in that same section.

The interview guide for women with physical disabilities delved into different thematic areas, including challenges in accessing reproductive health services, coping strategies, available social support and factors that contribute to the resilience to challenges of access to reproductive health services by women with physical disabilities. Interviews were conducted in English, Twi, or Ga. In instances where the respondent could speak English, the researcher translated the interview guide into either Twi or Ga.

3.7 Reliability and Validity

To ascertain the effectiveness of the research instruments, the questionnaire and interview guide were pre-tested with four women with physical disabilities at Korle Gonno. The pre-testing process was important for ensuring the reliability and validity of the data collection instruments before the actual fieldwork process.

In this study, two field workers who had a minimum of first degrees and had experience in data collection were trained. The training was completed within two days. On the first day, field workers read through the questionnaires and the questions were translated in Twi and Ga. In addition, they were trained on appropriate techniques to ask questions without leading interviewees to a particular response, being tactful with regard to sensitive topic areas, etc. This

was followed by a mock interview session. On the second day, field workers piloted the questionnaire and interview guide with four women with physical disabilities in a suburb in the Ablekuma Central Municipal of the Greater Accra Region. Based on the findings from the mock interview, minor corrections were made to the questionnaire and interview guide regarding the structure, wording and framing of the questions. Some questions in the interview guide were refined to improve on probing and prompting for more insightful responses. Through all these measures and processes, interview questions were standardized, thus questions were asked in the same way.

In addition, since the questionnaire included a scale, an internal consistency check with the 17 items measuring resilience was carried out using the Cronbach's Alpha technique. A reliability test was performed and the Cronbach alpha value obtained was 0.812. According to Taber (2018), a value of 0.70 or higher is considered adequate for most research situations.

3.8 Quantitative Data Collection

The purposive sampling technique was employed to select the participants for the quantitative study because of the particular characteristics of the population of interest for the study. Purposive sampling allowed the researcher to select respondents who could answer the research questions (Babbie, 2008). To enhance this technique, the Ghana Federation of Disability Organizations and the Ghana Society of Physical Disability were consulted for a list of women with physical disabilities. Based on this, members who met the selection criteria were selected for the study. To determine the appropriate sample size for this quantitative component of the study, the sample size determination formula by Fisher, Laing, Stoeckel, and Townsend (1998) was adopted (See Appendix for formula). With the help of zonal leaders of persons living with disability, women with physical disabilities were mobilized. Most respondents were interviewed in their zonal meeting places in the following suburbs in Accra and Tema: Chorkor, Korlebu, La, Kpone, Ashiaman, and Korlegonno. Where respondents were not available at the

zonal meeting place, a follow-up call was made to schedule a meeting. Interviews with women with physical disabilities continued until a sample size of 203 mothers was reached.

3.9 Data Collection Procedure for the Study

To recruit women with physical disabilities for the survey and in-depth interviews, a letter of introduction from the Regional Institute of Population Studies of the University of Ghana (see Appendix) was submitted to the Leadership of the Ghana Society of Physical Disability, which explained the purpose of the research and obtained permission and support to have members of the association participate in the study. Together with the help of the Ghana Society of Physical Disability, zonal leaders in the Accra Metropolitan Area, La Dade Kotopon Municipal, Kpone Kantamanso Municipal, and Ashaiman Municipality were contacted for the list of women with physical disabilities (who are in their reproductive age) and had given birth within the last five year. This process facilitated the data collection process as the women with physical disabilities were informed about agreed forthcoming interviews during their zonal meetings through their trusted zonal leaders. The zonal meeting places were used as the venue for the data collection. The use of these meeting places did not introduce bias to the study but enhanced trust, as these zonal meeting places served as neutral and familiar settings for the women with physical disabilities. It also helped with the recruitment of the targeted population of respondents. In all the meeting sessions with clients, the researchers administered the questionnaires and in-depth interviews either in the English language or in the Twi or Ga languages.

Each survey interview began with a briefing session on information about the study, the use of the data being collected, and an estimated time frame of the interview. Women with physical disabilities were educated on the relevance of the research. Respondents were also asked to inform and encourage their friends who are not part of the association but meet the study's inclusion criteria, to participate.

Prior consent was also sought from respondents for the survey interview and audio documentation of the in-depth interview. Upon agreement, participants and the Principal Investigator and/or the trained assistants signed the informed consent form and a copy of the form was given to participants to keep. In a situation where the participants were not able to read and write, questions were explained into their local languages.

Some respondents who completed the survey were invited to participate in the in-depth interviews based on specific criteria designed to provide more insight into answering the objectives of the study. The selection criteria focused on the severity of mobility challenges. Respondents who were fully dependent on wheelchairs, crutches and other mobility devices were recruited to take part in the interview. The focus on this group of respondents is justified by the unique and significant challenges they face in accessing reproductive healthcare services. Where their experiences emphasize the importance of addressing the needs of this highly vulnerable group and generating practical insights for reproductive healthcare interventions.

Interviews were also conducted in a private setting. After a successful interview, women with physical disabilities were given a token of ten (10) cedis for airtime, as a sign of appreciation for their time. All measures employed were to ensure that respondents participated in the study willingly without any form of coercion. Information obtained was kept safe, and privacy was maintained.

3.10 Description of Variables

3.10.1 Dependent Variable

The main dependent variable for this study is the resilience to the challenges of reproductive health. The scale for measuring this was adopted and modified from the Physical Resilience Scale (PRS), which was developed by Resnick et al. (2011). Even though the PRS has been widely used as a measurement tool for resilience among the aged, it is applied to this study for several reasons. First, both the aged and women with physical disabilities with difficulty in

walking may face similar mobility challenges. By utilizing a scale designed for the aged, we acknowledge the shared experiences related to mobility limitations. The Physical Resilience Scale comprises a 17-item measure that focuses on various aspects of resilience associated with recovery following an event that affected you either physically or mentally.

In this study, women with physical disabilities were asked to identify the most difficult challenge they encountered with access to reproductive health services (for example, physical barrier, emotional, attitudinal, economic, etc.) and based on that indicated the extent to which they agreed with each statement outlined in the scale. Table 3.1 below contains the various 17 items.

Table 3.1: Measurement of Dependent Variable (Resilience Scale Question Items)

	QUESTION ITEMS	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
1	I was determined to recover.					
2	I adjusted to the new changes					
3	I used humor to help me through					
4	I believed I could recover					
4	I focused on my remaining abilities, not on what I couldn't do					
6	I accepted the new challenges					
7	I accepted help from others					
8	I figured out how to do my daily activities					
9	The challenging event was so bad, I gave up					
10	I found it difficult to ask for help from others when I needed it					
11	I found the energy to do what I had to do					
12	I saw this challenge as an opportunity					
13	I was determined to regain my prior functional ability					
14	I became a stronger person					
15	I continued to make plans for the future					
16	I learned from it					
17	Since the challenging event, I have not wanted to even do my usual activities					

The question item was rated on a Likert scale ranging from "Strongly Agree" to "Strongly Disagree," on a scale ranging from 1-5. Therefore, each statement signifies a trait associated with resilience. The scale measures an individual response to any adverse situation including determination, adaptation, coping mechanisms, self-belief, social support utilization, goal orientation, and personal growth. The items that measured the determination and beliefs aspect of the women with physical disabilities towards challenges faced included: For example, “I was determined to recover”, “I believed I could recover”, “I accepted the new challenges”, “I was determined to regain my prior functional ability”. These questions provide insight into the women with physical disabilities’ capacity to solve or overcome obstacles in accessing reproductive health services.

Four question items explored the adaptability and personal growth of women with physical disabilities to the challenges they faced in accessing reproductive health services through acceptance and social support: adjusted to the new changes; I accepted help from others; I saw this challenge as an opportunity; and I became a stronger person. These question items queried their ability to adapt to changing circumstances, accept support, and recognize challenges as opportunities for improving themselves. In addition, the following four other items in the scale assessed the ways women with physical disabilities coped with the challenges they encountered in accessing reproductive health services: I used humor to help me through; I focused on my remaining abilities, not on what I couldn’t do; I found it difficult to ask for help from others when I needed it; and I found the energy to do what I had to do. The last three items focused on the positive outlook of current and future orientation: I continued to make plans for the future; I learned from it; and since the challenging event, I have not wanted to even do my usual activities.

Three of the question items in the resilience scale were worded in the negative approach, which required responses on a Likert scale ranging from the negative to the positive (strongly disagree

to strongly agree) with scores from 1-5. To address that, the responses to these negatively worded items were recoded. Scores for responses for these specific items were reversed so that higher scores still indicated higher levels of resilience. Specifically, the responses of 1 were converted to 5, 2 to 4, 3 remained unchanged, 4 to 2, and 5 to 1. The recoding procedure ensured consistency across all items in the resilience scale and ensured that responses were aligned with the resilience construct being measured.

In summary, the resilience of respondents was measured using a 17-question scale on resilience elements on the 5-point Likert scale. An average score for each person based on their answers to the 17 questions was computed, with scores ranging from 1 to 5.

3.10.2 Independent Variables

The independent variable for this study is social support, which ascertains the availability, types and sources of social support for physical disabilities. Availability of social support was assessed by requesting women with physical disabilities to indicate if they receive support in accessing reproductive health services. If yes, they are asked to indicate the types and sources of social support. The study measured social support in three dimensions in this study and these are emotional, instrumental and informational support. Respondents were asked to indicate the types of support received and the sources of each type of support indicated (e.g., peers/association members, husband/partner, parents/relatives, friends, health professionals, religious leaders, or others). Each of type of social support represents the total number of different sources from which support is received, on a scale from 0 (no support received) to 8 (support received from all listed sources). So, a participant can score a minimum of 0 and a maximum of 8.

Sociodemographic characteristics or personal factors of respondents, which also served as independent variables, were measured as age, highest level of education, religious affiliation,

marital status, ethnicity, income level, occupation and place of residence. A further description of the variables and their codes are displayed in Table 3.2.

Table 3.2: Measurement of Independent Variables

Variable Category	Variable	Measurement
Socio Demographic factors	Age	1=20-24 2=25-29 3=30-34 4=35-39 5=40-45 6=45-49
	Highest level of Education	1=None 2= Primary 3=JHS/Middle 4=Secondary 5= Tertiary
	Religion	1=Christianity 2= Islam 3=Traditional
	Ethnicity	1=Akan 2=Ga Dangbe 3=Ewe 4=Others
	Marital status	1=Never married 2=Divorce 3=Cohabitation 4= Married
	Occupation	1=Trade/Business owners 2= Civil/Public Servant 3= Casual worker
	Income Level	1=Less than 200 2=200-500 3=501-1000 4=Above 1000
	Place of residence	1=Urban. 2=Peri urban
Social Support	Do you receive any form of support?	1=Yes 2= No
	What types of support do you receive?	Emotional Support 1=Yes 0=No Instrumental support 1=Yes 0=No Informational support 1=Yes 0=No
	Where do you receive the type of support from?	Source of Support
	Emotional Support	1-Yes 0-No
		Friends
		Husbands
		Parents
		Relative
		Association
		Health Professional
		Religious Leaders
		Other
	Instrumental Support	1-Yes 0-No
		Friends
		Husbands
		Parents
		Relative
		Association
		Health Professional
		Religious Leaders
		Other
	Informational Support	1-Yes 0-No

		Friends
		Husbands
		Parents
		Relative
		Association
		Health Professional
		Religious Leaders
		Other

Source: Computed from field Data (2022)

3.11 Data Processing and Analysis

Data collected from the field were cross-checked and edited to ensure that responses are accurate and that the information given is relevant. The Statistical Package for the Social Sciences (SPSS version 20) was employed to process and analyze the data gathered from the questionnaires.

3.11.1 Univariate Analysis

Univariate analysis was carried out to describe the socio-demographic characteristics of the respondents. The univariate analysis allowed for making descriptive inferences about the targeted population (Babbie, 2007). Therefore, it helped describe the various characteristics of respondents, including the source of livelihood and income levels of the women with physical disabilities. In addition, univariate analysis was used to identify challenges faced by women with physical disabilities when accessing reproductive health services, the types of social support systems available and the distribution of the mean resilience score of respondents to challenges in accessing reproductive health services. Frequencies, percentages and means were conducted and the analyses were displayed in tables and charts.

3.11.2 Bivariate Analysis

Bivariate analysis, consisting of one-way ANOVA with means compared, was used to assess relationships between socio-demographic characteristics and resilience among the respondents. This was used to assess the impact of socio-demographic characteristics on resilience.

Correlation analysis was also performed to examine the strength and direction of the relationships between types of social support and resilience among women with physical disabilities, where -1 indicates a negative relationship, 1 indicates a positive relationship, and 0 indicates no relationship**.** The analysis focused on examining the correlations between Mean Resilience and the three key dimensions of social support in the study: instrumental support, informational support, and emotional support. The variables capturing Mean Resilience, the sums of those receiving instrumental and informational support, and a measure of emotional support were included in the structured dataset. The significance of doing bivariate analysis is to aid in the exploration of the relationships between two variables at a time (Babbie, 2007).

3.11.3 Regression Analysis

Linear regression was adopted to explore the factors influencing resilience among women with physical disabilities in accessing reproductive health services, with a specific focus on the role of social support. Linear regression was performed to examine the influence of independent variables, such as social support and socio-demographic characteristics, on the dependent variable, resilience. The dependent variable, resilience to reproductive health, represents the concept that captures the ability of women with physical disabilities to overcome barriers and utilize reproductive health services. The independent variables in this study include age, education, marital status, number of children, ethnicity, religion, occupation, level of income, and support instrumental, informational, and emotional). The regression model incorporated all independent variables concurrently, allowing a comprehensive evaluation of their collective impact on resilience among women with physical disabilities accessing reproductive health services and identifying the most salient factors contributing to resilience among women with physical disabilities.

3.12 Qualitative Study

3.12.1 Qualitative design and Data Collection

The qualitative study employed a phenomenological design to understand the lived experiences of women with physical disabilities in accessing reproductive health services (Creswell 2014). The semi-structured interview guide was developed to guide the in-depth interviews. Twenty-two mothers were purposively selected for qualitative interviews after the survey. Specifically, criterion purposive sampling was employed to select respondents with more severe mobility challenges and demonstrated rich insights relevant in answering the study objectives (Edmonds & Kennedy, 2017). The process allowed further questions to be asked to provide details about the findings from the quantitative data. The total number of respondents was informed by the principle of data saturation**,** where additional interviews produced no new insight or theme (Creswell 2014).

All interviews were translated and transcribed verbatim from the local languages into English. The purpose of the qualitative method provided respondents to elaborate on the issues and further provided insight into their challenges, social support networks and strategies of resilience to the challenges encountered while accessing reproductive health services. It further reflects the complex issues encountered by the population of study, thereby giving insight into how contextual factors such as cultural and social barriers may influence quantitative results on social support and resilience.

3.12.2 Qualitative Analysis

Recorded in-depth Interviews were transcribed verbatim and audio-taped in-depth interviews were translated and transcribed verbatim in English to enable the information to be analyzed. The thematic analysis method was used to analyze the data. This is a process of identifying, examining and recording patterns or themes in the data. The initial stage of the qualitative analysis involved a thorough reading of all the transcripts to identify initial ideas and generate

codes from participants' interviews on their experiences with challenges, social support and resilience to the challenges in accessing reproductive health services. A combination of deductive and inductive coding was employed during analysis, where the deductive codes were derived from previous studies reviewed (Ronen, 2021; McConnell et al., 2008) and the inductive codes came from the recurring themes in the data.

These themes are important and interesting issues that helped address the research questions. Processing the data into themes helps the researcher to move beyond merely describing issues, but rather helps to do a thorough and rigorous analysis of the issues presented in the data (Maguire & Delahunt, 2017).

3.13 Limitations of the Study

Largely, with support from the leadership of the Physically Disabled Society, targeted participants agreed to be part of the research. However, some challenges and opportunities were experienced. Firstly, some of the participants, especially those whom the researcher went to their homes, were uncomfortable and doubtful about the purpose of the study. These women felt that researchers always take their information without any good outcome for them. However, the presence of their Zonal leaders and the researchers' explanation of the relevance of the research helped in addressing this challenge to an extent.

Another issue that emerged was the postponements and cancellations of interview appointments. There was an instance where some respondents who were booked for interviews were postponed because their babies had to be taken to the hospital. Appointments had to be rescheduled with other women with physical disabilities on different dates. Finally, the interview was conducted but it affected the planned activities for the study.

3.14 Summary of the Chapter

This chapter provided a comprehensive insight into the research process that was adopted in the study. It extended to the details of the study design as well as the particular techniques of data collection including the justification for the choice of study areas. The chapter describes and presents the sampling procedures for the qualitative, quantitative and mixed research methods and ends with a description of data analysis relevant to the research questions and objectives.

CHAPTER FOUR

BACKGROUND CHARACTERISTICS OF RESPONDENTS

4.1 Introduction

Understanding the background characteristics of women with physical disabilities is key to contextualizing their experiences of accessing reproductive healthcare services and to analyzing and interpreting the findings of the study. This chapter, therefore, presents the background characteristics of respondents who participated in the study. The findings discussed in this chapter are derived from the quantitative data and cover the respondents' socio-demographic and socio-economic characteristics. These background characteristics provide an important foundation for understanding the respondents' access to social support and their resilience in accessing reproductive health services, topics which will be explored in subsequent chapters.

4.2 Characteristics of Women with Physical Disabilities

A total of 203 participants participated in the quantitative study. The tables below show the percentage distributions of women with physical disabilities by their socio-demographic characteristics. This section presents the age, educational status, marital status, religion, ethnicity, number of children ever born, and place of residence characteristics of the respondents.

4.2.1 Age of Respondents

The results show that 50.2 percent of respondents fall within the 26–35 age bracket, with only 2.5 percent belonging to the 18–25 age group. This distribution suggests that the study population was predominantly composed of women in their prime reproductive years. The low representation of younger women with physical disabilities may indicate persistent barriers such as stigma, economic constraints, and reduced involvement in the reproductive decision-making process

Table 4.1: Age Distribution of Respondents

Age Category	Frequency	Percentage (%)
18–25	5	2.5
26–35	102	50.2
36–45	65	32.0
46+	31	15.3
Total	**203**	**100**

Source: Fieldwork, 2022

4.2.2 Educational Status

A significant number of the study participants (73.3%) had access to formal education. However, to unpack the issues on education, the study further probed the level of education attained by the study participants (see Table 4.2). The results indicate that 26.2 percent of the study participants had completed JHS/Middle school. This percentage is lower than the data from the 2017/18 Ghana Multiple Indicator Cluster Survey, which recorded 38 percent of women with disabilities had completed junior secondary school compared to 57 percent of women without disabilities. Although formal education was appreciable, a notable proportion of 26.6 percent of respondents reported having no formal education while less than one in ten (7.8%) of the study participants have attained tertiary education, which shows the challenges faced by women with physical disabilities in accessing educational opportunities. Possible reasons for the income level of the family may serve as an obstacle for respondents to the attainment of a tertiary level of education, where expenses are typically higher.

These findings reflect inequalities in Ghana's inclusive education system, where persons with disabilities continue to face financial, infrastructural, and attitudinal barriers (GSS, 2021). This disparity may limit socioeconomic opportunities and access to reliable reproductive health information. The creation of an enabling and supportive environment for the vulnerable group

to access the highest level of education is crucial to providing social and economic empowerment.

Table 4.2: Educational Background of Respondents

Educational Level	Frequency	Percentage (%)
No formal education	54	26.6
Primary	42	20.7
JHS/Middle School	53	26.2
SHS/Vocational/Technical	38	18.7
Tertiary	16	7.8
Total	**203**	**100**

Source: Fieldwork, 2022

4.2.3 Marital Status

The results indicate that 72.4 percent of the women were single, while only 5.4 percent were married. Smaller proportions were divorced (14.8%) or cohabiting (7.4%). Several studies reveal that women with disabilities face stigma, discriminatory cultural beliefs, and misconceptions in relation to their ability to marry or sustain intimate relationships (Akasreku et al., 2018; Rohwerder, 2018 Peta, 2017). The high percentage of single women in this study therefore, reflects broader social exclusion for women with physical disabilities.

Table 4.3: Marital Status of Respondents

Marital Status	Frequency	Percentage (%)
Single	147	72.4
Married	11	5.4
Divorced	30	14.8
Cohabiting	15	7.4
Total	**203**	**100**

Source: Fieldwork, 2022

4.2.4 Religious Affiliation

The majority of respondents were Christians (73.4%), followed by Muslims (15.8%) and those practicing Traditional religion (10.8%). This religious distribution mirrors national patterns (GSS, 2021). Religion plays an important role in shaping reproductive decision-making, attitudes toward disability, and the sources of social support available to women.

Table 4.4: Religious Affiliation of Respondents

Religion	Frequency	Percentage (%)
Christian	149	73.4
Islam	32	15.8
Traditional	22	10.8
Total	**203**	**100**

Source: Fieldwork, 2022

4.2.5 Ethnicity

The majority of respondents were Ga-Dangbe (43.3%), followed by Akan (28.1%) and Ewe (21.2%), with smaller proportions from northern ethnic groups. The predominance of the Ga-Dangbe maybe as a result of the geographical context of the study area. Ethnicity plays a key role in shaping cultural attitudes and values toward disability and community support.

Table 4.5: Ethnicity of Respondents

Ethnic Group	Frequency	Percentage (%)
Ga-Dangbe	88	43.3
Akan	57	28.1
Ewe	43	21.2
Northern Ethnicities	15	7.4
Total	**203**	**100**

Source: Fieldwork, 2022

4.2.6 Children Ever Born

The findings indicate that 43.8 percent of the women had at least two children, while 27.1 percent had one child and 25.1 percent had three children. These results demonstrate that women with physical disabilities often desire and achieve motherhood, aligning with existing studies showing that their aspirations to becoming mothers are similar to those of women without disabilities (Ganle et al., 2020; Prilleltensky, 2003). This emphasizes on the importance of improving on accessible reproductive healthcare services that meets their maternal health needs.

Table 4.6: Number of Children Ever Born

Number of Children	Frequency	Percentage (%)
One	55	27.1
Two	89	43.8
Three	51	25.1
Four or more	8	3.9
Total	**203**	**100**

Source: Fieldwork, 2022

4.2.7 Place of Residence

A little above half of the respondents (54%) lived in peri-urban areas, while 46 percent resided in urban areas. Women with disabilities living across different settings often face challenges related to transportation, availability of specialized health services, and access to disability-friendly reproductive healthcare facilities (Kportufe 2015; Mitra et al., 2013; Ganle et al., 2016). These structural factors may influence the frequency of their utilization of reproductive health services.

Table 4.7: Residential Location of Respondents

Place of Residence	Frequency	Percentage (%)
Urban	93	46.0
Peri-urban	110	54.0
Total	**203**	**100**

Source: Fieldwork, 2022

4.3 Economic Status

The results from Table 4.2 below show that most respondents (77.8%) were engaged in trading or business. It is important to note that the physical or social barriers did not prevent them from engaging in livelihood activities. Besides, a little more than one in ten (11.8%) of the study participants were civil and public servants. With less than 10 percent of respondents having attained tertiary education and 23.2 percent completing secondary school, it is unsurprising that a substantial portion of this population may lack the educational qualifications typically required for civil or public service roles. Other factors, including discriminatory employment practices and stigmatization, may deter women with physical disabilities from seeking employment or getting employed in both the public and private sectors.

From Table 4.8 the study revealed that the majority of the women with physical disabilities and are mothers are paid 200-500 Ghana cedi, representing 39.9 percent.

Table 4.8: Economic Status of Respondent

Variable	Frequency	Percentage
Occupation		
Trade/Business	158	77.8
Civil/Public Servant	24	11.8
Casual worker	21	10.3
Total	203	100.0
Income (Earnings per month)		
Less than 200 cedis	72	35.5

200-500 cedis	81	39.9
501-1000 cedis	32	15.8
Above 10000 cedis	18	8.9
Total	**203**	**100.0**

Source: Fieldwork, 2022

4.4 Summary of the Chapter

The study involved 203 women with physical disabilities. Key findings are that over 50 percent were aged 26-35, with 2.5 percent aged 18-25; 73.4 percent were Christians and 15.8 percent were Muslims; 73.3 percent had formal education; 26.2 percent completed JHS/Middle school, 26.6 percent had no formal education, and 7.8 percent attained tertiary education. Moreover, 72.4 percent were single, 15 percent divorced, and 5.4 percent were married. Additionally, 43.8 percent had at least two children; 43 percent were Ga-Dangbe, 28 percent Akan, 21 percent Ewe, and less than 15 percent were from the northern sector. Furthermore, 54 percent of the respondents lived in peri-urban areas and 77.8 percent engaged in trading/business, and 11.8 percent were civil/public servants. Barriers to higher education and employment were identified, including financial constraints, discriminatory practices, and stigmatization.

CHAPTER FIVE

CHALLENGES FACED BY WOMEN WITH PHYSICAL DISABILITIES IN ACCESSING REPRODUCTIVE HEALTH SERVICES

5.1 Introduction

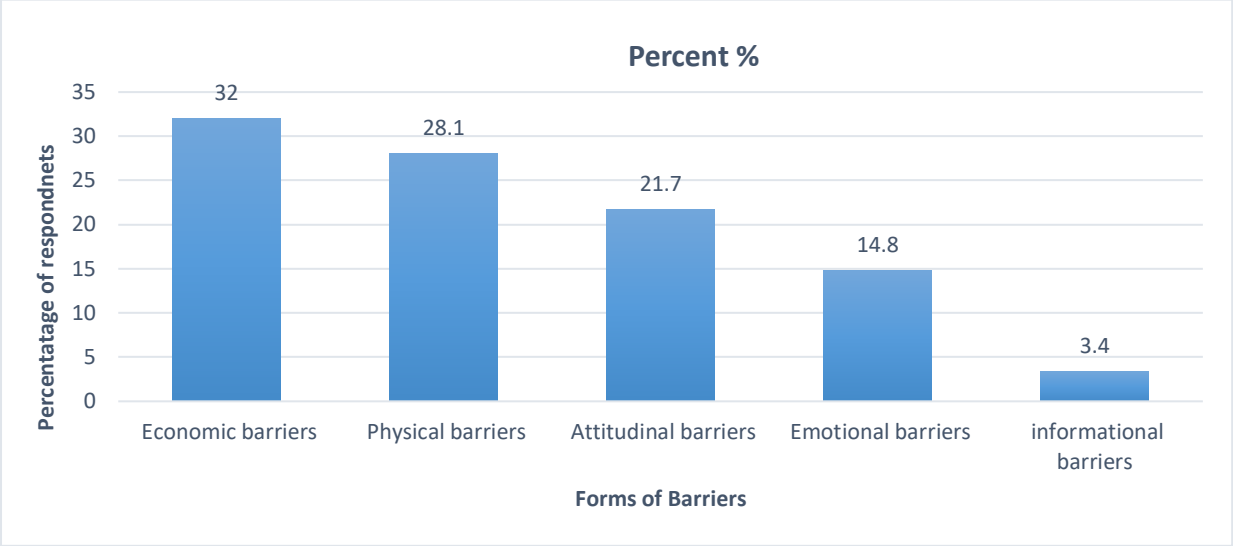
Despite the availability of reproductive health services in Ghana, women with physical disabilities still encounter many barriers that impede their access and use of the services. The challenges primarily come from structural, economic, social, institutional and attitudinal factors. Identification of these barriers is vital to revealing gaps and develop targeted interventions in creating inclusive pathways to reproductive health care services.

This chapter covers the challenges faced by women with physical disabilities while accessing reproductive health services. It presents the findings and discussion of the findings after an analysis of both the quantitative and qualitative data collected through the survey and in-depth interviews with women with physical disabilities, respectively.

5.2 Main Challenges in Accessing Reproductive Health Services

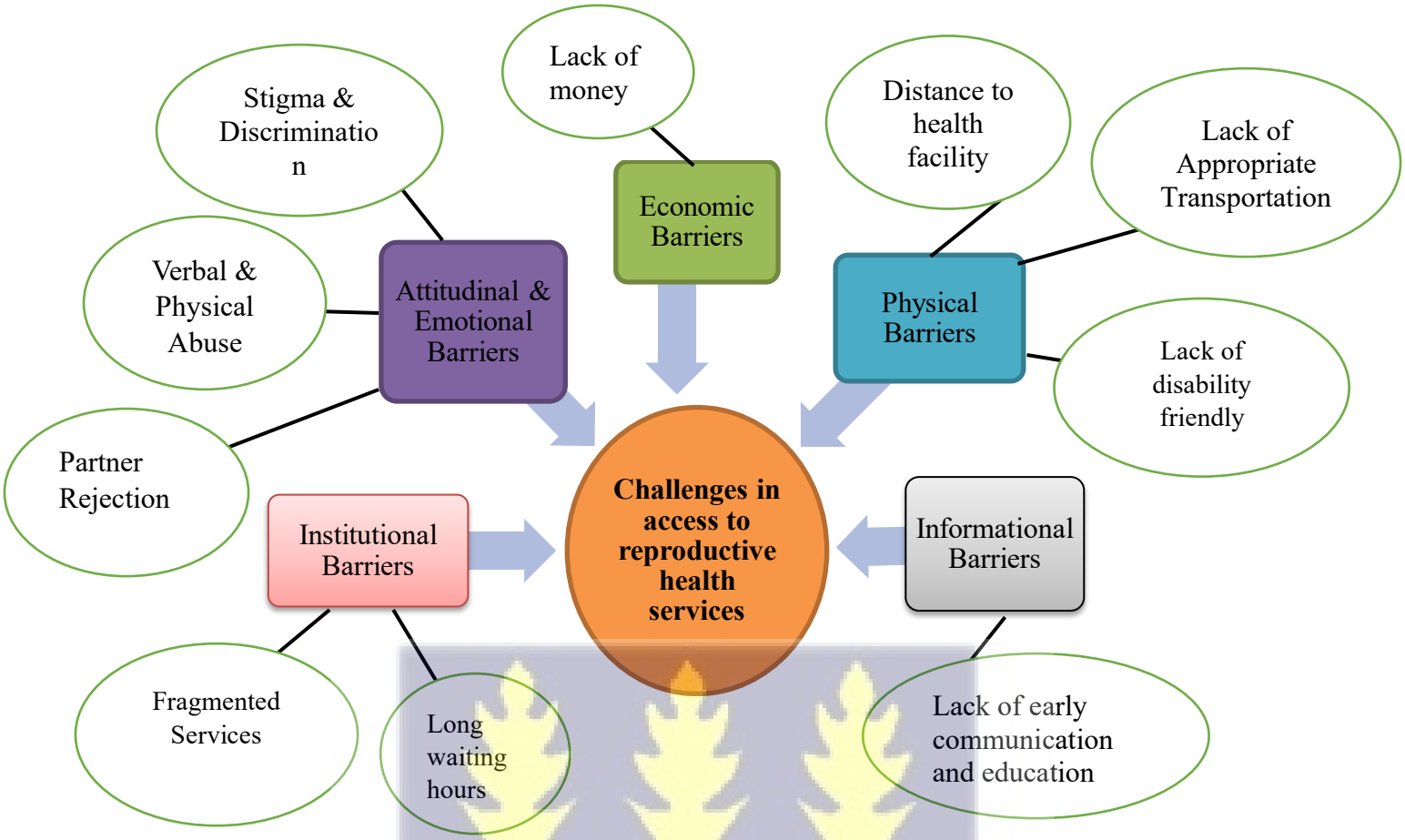
In the survey, respondents were asked to identify their most difficult challenge in accessing reproductive health services. The survey results, as shown in Figure 5.1, indicate that respondents reported varying forms of barriers to accessing reproductive health services. Economic barriers (32%), physical barriers (28%), attitudinal barriers (21.6%), emotional barriers (14.7%) and informational barriers (3.4%) were noted as challenges in accessing reproductive health services among the respondents.

Figure 5.1: Percentage Distribution of Challenges in Accessing Reproductive Health Services



During the in-depth interview, women with physical disabilities further expanded on a range of challenges they encounter in their quest to access reproductive health services. The challenges identified by these mothers were analyzed and grouped under six main themes: physical accessibility, economic, institutional, attitudinal barriers, emotional barriers, and informational barriers. Figure 5.2 provides an overview of the different themes and sub-themes related to these challenges. The following sections provide a more in-depth understanding of the barriers mentioned by women during the survey, through a qualitative assessment of the challenges encountered by women with physical disabilities in accessing reproductive health services.

Figure 5.2: Challenges in Access to Reproductive Health from Interviews



5.2.1 Economic Barrier

The economic barrier was a notable challenge for the respondents in accessing reproductive health services. About 32 percent of the women mentioned this barrier. Invariably, findings from the interviews with the respondents on economic-related barriers pointed to the inability of physically challenged pregnant women to afford health care and lack of financial support. They explained how financial constraints prevent them from attending prenatal appointments, obtaining necessary scans, and following recommended healthcare schedules.

Respondents who complained of having financial challenges had this to say:

Because I was not working when I got pregnant it was difficult getting money to visit the hospital for my normal check-up (C8; 34 year old mother; La)

I didn't have enough money to attend the maternity clinic. So I could not always go on the date that I was expected to come. (C16; 35 year old mother; Ashiaman)

Another mother from Korle Gonno confirmed that:

Things became tougher for me because I didn't have enough money to take care of myself and the baby in my womb. I could not go to the hospital on all the dates I was asked to come. I was only going on days that I had money; (C19; 29-year-old mother; Korle Gonno).

The respondent's narrative shows that access to reproductive healthcare services influenced by finance might serve as a disincentive to the attendance of prenatal, antenatal and post-natal services. These findings may not be glossed over because persons with disabilities seem to have limited economic opportunities due to a complex web of discrimination (Albert & Hurst, 2004). Previous research supports this finding that identified financial challenges as a barrier to the low use of sexual and reproductive health services among persons with disabilities (Burke et al., 2017).

In other instances, women with physical disabilities were faced with an unexpected hospital expense coupled with high transport fares had this to say:

At times, you will go for antenatal and you'll not know that you'll be asked to take a scan, which you may not have enough money to pay for and transport to go home too. Because of my condition, I mostly pick a taxi, which is high [in cost]'. (C18; 42 year old mother Ashiaman)

So sometimes when I think of how much I will pay for taxi fare and what I will spend at the hospital, I don't feel like going at all (C9; 40-year-old mother; La)

Some of the women with physical disabilities were less mobile due to the high cost of transportation, which served as a barrier to access to reproductive health services (Bremer et al., 2009; Smith et al., 2004). As noted from the socio-demographic data, many of the

respondents belong to the low and middle-income group. It may be logical to state that considering their low socioeconomic status, hiring taxis or the purchase of vehicles is beyond them. The alternative option for them may be to use public transport, which is not disability friendly to use in accessing reproductive health services. This finding is similar to a study in India among persons with disabilities that identified boarding public transport as a challenge due to the unfriendly disability nature (Singh et al., 2013). Hence, the cost of treatment, as well as the cost of transportation affects women with physical disabilities desiring to access reproductive health services. The findings of this study emphasize the need for interventions to address financial barriers to reduce the adverse effects of economic constraints on maternal and child health outcomes.

5.2.2 Physical Barriers

Physical barriers in this study refer to issues related to disability-friendly infrastructure, distance to health facilities, and transportation that impact women with physical disabilities' ability to seek to access necessary reproductive health care. The survey results in Figure 5.1 show that physical barriers (28%) were the second challenge in accessing reproductive health services for the respondents.

In the interview, respondents explained how specific physical barriers hinder their access to reproductive health services.

5.2.2.1 Disability-friendly physical infrastructure

Some of the women with physical disabilities narrated the ordeal of crawling upstairs for a lab test, slipping on slippery tiles when accessing washrooms and struggling to find a seating place with crutches. These challenges reveal the need for improved physical infrastructure.

I crawled to climb the stairs to go for a lab test. I saw people staring at me while others tried to help me climb. I became emotional and before I could realize it, tears were just flowing (C2; 36-year-old mother; La)

After I delivered at the hospital, we were not allowed to use the washroom in the maternity ward because it had a problem. It was difficult walking down the stairs to go and pour out urine and climb back. The tiles were very slippery so I had to beg someone to help me dispose of the urine. I felt very uncomfortable calling someone to help dispose of that waste because it is a taboo in culture for someone to come into contact with human waste especially if you are an adult (C11; 40-year-old mother; Ashiaman)

On a day that I don't get to the clinic before 7 am, there will be a lot of pregnant women waiting and I might not find a chair to sit on so i will be standing with crutches until someone gives her chair to me (C7; 32 year old mother; La)

Addressing this challenge, other studies have emphasized having accessible buildings with ramps, elevators, and toilets for persons with disabilities to ensure that there is non-discriminatory provision of medical care services (Ganle et al., 2016).

5.2.2.2 Distance to health facilities and Lack of appropriate transportation

Some women with physical disabilities reported difficulty in getting to the healthcare facility due to the distance and lack of accessible transportation. One of the mothers described her journey to the hospital for antenatal services.

I will walk for almost 30 minutes before getting to the main road to pick up a car to go to the hospital. I had to sit and rest more than twice before I got to the roadside. This was really difficult for me but that is the only way I can get to the health facility. I felt it would have been much easier for me if I was living closer to the hospital (C15; 33-year-old mother; Ashiaman)

Another mother also expressed concern that:

The distance from my house to the clinic was not close. I always felt this heaviness in my leg. My little boy had to push me in the wheel chair to the roadside to pick a car before he goes to school anytime I have to go to the hospital... (C20; 30-year-old mother; Kpone)

The long distance to health facilities may mean that some women might be discouraged from honouring their next appointment antenatal visits or arrive late for appointments. The lack of accessible transportation options has been found to contribute to limiting their access to antenatal health care services. Other respondents expressed difficulties in using commercial minibus vehicles (trotro) due to the design of the door and seats arrangement, which are not friendly for their physical condition. They also mentioned that trotro drivers were often unhelpful given that they will have to waste time helping them board the vehicle. As a result, they often resort to taking taxis, which are more disability friendly but expensive. Respondents had the following to say:

It was difficult picking a trotro because of the high step and small car door I have to pass to get in and out of the car. I didn't feel okay whenever I want to take a trotro because I know if I am not careful I can fall down. So I was mostly going to the hospital by taxi, which was also expensive but I need to protect myself and my baby. (C9; 40-year-old mother; La)

At times when I don't also have enough money to pick a taxi to the hospital I wish to go and pick trotro. But the trotro mates and drivers don't like to pick me because I am holding crutches. I know they think you will waste their time so they will not stop at all even when you stop them. (C21; 35 year old mother; La)

5.3 Discussion on Physical Barriers

Physical barriers such as disability-friendly infrastructure, distance to health facilities, and lack of appropriate transportation were identified in this study. The finding resonates with a study in Ghana, which reported that women with disabilities' desire to access sexual and reproductive health services is hampered by unfavorable physical health infrastructure (Ganle et al., 2017). Similarly, a study in Zimbabwe and Uganda identified the disability-unfriendly infrastructure at the health facilities to discourage persons with disabilities from accessing reproductive healthcare services (Rughono & Maphosa, 2017; Ahumuza et al., 2014; Bremer et al., 2009).

Other studies have also emphasized having accessible buildings with ramps, elevators, and toilets for persons with disabilities to ensure that there is non-discriminatory provision of medical care services (Ganle et al., 2016). For example, respondents' experiences of feeling undermined and humiliated while requesting assistance, even during basic activities like using a toilet facility indicated how central it was to consider the societal norms and attitudes towards the design of infrastructure and the environment.

5.4 Attitudinal and Emotional Barriers

Attitudinal barriers include stigma and discrimination, both within the societal context and healthcare settings, and negative attitudes of healthcare providers, which can lead to misconceptions and neglect. The understanding of these barriers is important for formulating strategies that promote inclusivity of reproductive healthcare for persons living with disabilities. The findings from the survey showed that the third highest proportion of women with physical disabilities faced attitudinal barriers (21.6%) in accessing reproductive health services. Findings from the interview suggest that these attitudinal barriers were noted to persist predominantly in their interactions with healthcare providers. Mothers with physical disabilities highlighted instances of verbal abuse, physical abuse, neglect, stigmatization and discrimination within healthcare facilities. In addition, the findings indicate that the psychological trauma experienced by mothers with physical disabilities in accessing healthcare services predominantly emanates from health workers' attitudes.

During the survey, 14.7% of mothers with physical disabilities indicated emotional barriers to accessing reproductive healthcare services. These findings were evidence from the interview session with the respondents. The results below expound on respondents' experiences of abuse, neglect, and unfavorable attitudes of health workers and how these affected the emotional stability of the mothers.

5.4.1 Verbal and Physical Abuse

Some mothers with physical disabilities shared accounts of being insulted and humiliated within the healthcare setting by healthcare staff. For instance, one participant reported being insulted and beaten by nurses for refusing a suggested cesarean section.

The nurses insulted and beat me because I didn't go on the date I was asked to come and do the surgery. I don't know why they should force me to go for a caesarean section when I think I can give birth by myself as I did for my first child. (C12; 36-year-old mother; Ashiaman)

This respondent questioned the necessity of going through a caesarean section, expressing her belief in her ability to give birth naturally. This raises questions about the communication engagement and decision-making processes within the healthcare system. Furthermore, a 23-year-old mother with physical disability from Ashiaman recollects the insults she endured from a specific nurse, and how that made her reluctant to seek help during childbirth due to fear. Finally, she decided to avoid future pregnancies to avoid the potential recurrence of mistreatment. She had this to say,

What I remember very well when I was pregnant was the insults from one nurse. So on the day that I was going to deliver, I didn't even have the courage to call out for help from the nurses when my baby was coming out. It was one of the mothers who called the nurses to come and help me. Hmm, up till now I don't want to get close to nurses. So, I have decided not to get pregnant to avoid that experience again. (C13; 23-year-old mother; Ashiaman)

Another 32 year old mother with physical disability from Chorkor narrated that,

I visited a nearby clinic when I realised that I was not well and the doctor gave me medication without any check to know whether I was pregnant. I became weak because anytime I took the medicine and I sometimes vomited as well. Because the vomiting was not stopping, so I bought a dewormer from another pharmacy shop closer to my house. For three days I was still not well, so I went to another hospital. And I told the nurse that I had taken dewormer, she became angry and insulted me that, we are our own problem, that is why we give birth to children with

disability. I felt very bad and disgraced because I also have a disability. The nurse's words hurt me even now because she insulted me with my condition as a person with disability. (C; 32-year-old mother, Chorkor)

These forms of abuse not only inflict emotional distress but also challenge the rights and dignity of these mothers in their healthcare decision-making process.

5.4.2 Neglect by Health Workers

Neglect by health workers emerged as another challenge identified by some women with physical disabilities. A mother who delivered at home encountered unwillingness from a healthcare worker to provide her with the child's records book (weighing card) because she delivered her baby at home instead of the healthcare facility. Only after the intervention of her brother did she receive care for her baby.

So, when I sent the baby I delivered at home to the hospital, a nurse told me they wouldn't attend to me because I delivered the child at home. It was a brother who came to beg them before they gave my baby a weighing card. (C12; 36-year-old mother; Ashiaman)

Another mother's experience highlighted the absence of timely medical attention during labour. The nurses failed to provide timely care, leaving her alone until her desperate calls for help were attended to. She narrated:

On the day I was going to give birth, the nurses didn't come to check up on me after I was given a bed. They left me there for a long time. Then I felt that the baby was pushing down, and I had to struggle and shout for help until one of the nurses came to help (C4; 45-year-old mother; Korle bu)

5.4.3 Stigmatization and Discrimination

The stigma and discrimination faced by mothers with physical disabilities extended to maternity care and led to feelings of isolation, anxiety and the perception of healthcare professionals that women with physical disabilities should undergo surgical procedures.

A respondent highlighted the discrimination she faced from healthcare providers as a result of her condition.

I noticed some of the nurses don't want to take care of me anytime I visit. I remember when a midwife assigned a junior nurse to help me go through the ANC session so I could finish and go home early… But the nurse told me she doesn't use her bare hands to touch "things like me". That day I broke down and I cried. I sat and waited for about 3 hours until the midwife came back from her meeting to help me. I have vowed never to set foot at this particular hospital. (C3; 38-year-old physically challenged woman; La)

Other mothers had concerns about bias that can arise from myths and misconceptions about the capabilities of individuals with a disability to handle natural childbirth. They expressed their views below:

You know what, I noticed that the doctors and nurses feel when you have a disability, you should be operated on [through a caesarean section]. When I was going to have my firstborn, I had an operation. The second born too, they wanted to do the same. But I went into labour before the date they asked me to come for the operation. I got to the clinic when the baby's head was about to drop but the nurses at the clinic said I should be sent to the poly-clinic since they don't have what it takes to deliver me through C-S. They refused to attend to me, and I was sent back to the polyclinic, immediately after I got there, the baby came out with no operation. Please the doctors should know that even though we may have disabilities, we can have a normal [vagina] delivery, we can deliver too by ourselves, so they should allow us.

(C10; 35 year old mother; Ashiaman)

These responses from the women with physical disabilities emphasize the need for empathy and understanding of the specific needs of persons with disability in delivering reproductive health services to all persons. They also suggest that health personnel should view women as cases to be studied individually, with the appropriate diagnoses and best health advice prescribed to each woman.

5.4.4 Partner's Rejection

Women with physical disabilities underscored the profound impact of lacking partner support and facing societal stigma during pregnancy, which affected their mental health and hindered their ability to obtain support in accessing reproductive services. Two of the women with physical disabilities shared their experiences with loneliness and abandonment during their pregnancies, due to the absence of partner support and the effects of societal stigma.

I almost regretted becoming pregnant because I was alone and had to go to the hospital alone. At times, I even forget the date to go to the hospital. I couldn't believe that my boyfriend could just deny that he was not responsible for the pregnancy (C2; 36-year-old mother; La)

My boyfriend left me as soon as I told him that I was pregnant. He said he can't marry someone like me. He was listening to his friends. I did not have anyone I could talk to, to understand me. My family members were angry since they felt I had added to their problems of caring for me. I was not prepared to take care of the pregnancy all by myself. It was really tough (C5; 42 year old mother; Korle-bu)

The rejection from partners shows the broader societal discrimination and stigma meted out to women with disabilities thereby limiting them from enjoying meaningful relationships and support during pregnancy. In both narrations, women with physical disabilities experienced emotional pain that needs to be recognized and addressed by the healthcare services.

5.5 Discussion on Attitudinal and Emotional Barriers

Attitudinal and emotional barriers to access to reproductive health services were identified as some of the challenges faced by women with physical disabilities in this study. These attitudinal barriers have been identified and documented in other study settings. Studies in Uganda and the Philippines reported prejudiced attitudes among service providers and also abused women with disabilities seeking sexual and reproductive health services. Lee et al. (2015) and Ahumuza et

al. (2014) ascribed these negative attitudes to the limited awareness of the sexual and reproductive health needs of women with disability, as well as an inadequate understanding of their rights. These studies found that most of the attitudinal barriers emanated from healthcare workers and a few from members of society. Similarly, Yoshida et al. (1999) and Welner (1998) identified the role of healthcare professionals, family members, and broader social networks in constraining the reproductive rights of women with disabilities from seeking reproductive health services including family planning services.

Moreover, societal prejudices and partner rejection identified in the study were noted to contribute to a few stable relationships among women with physical disabilities as documented by Tanebe et al. (2015). Such discrimination is also seen in interactions within healthcare settings, where women with physical disabilities face disrespect and stigma, hindering their access to reproductive health services. This finding is consistent with findings of Mprah et al.'s (2017) study in Ghana, which found that health providers were not responsive to the healthcare needs of the PWDs who seek sexual and reproductive health services. This finding has been buttressed by Beyene et al. (2019) who identified the attitude of health providers to be unfavorable toward PWDs.

Discrimination is of global concern considering its strength to undermine the health of people with disabilities, emphasizing on the need to address these issues (WHO, 2011). Drawing on the social model of disability, women with physical disabilities may feel intentionally excluded from participating and functioning because of their deformity (Inclusion London, 2015; Mitra et al., 2012; Mitra, 2005). The provision of training and education for healthcare service providers on disability inclusion may aid in addressing the attitudinal barriers and improve service provision (WHO, 2009).

The narration by respondents showed that some of the emotional challenges emanated from attitudinal barriers. Negative perceptions and comments from the family, healthcare service providers, and larger society were identified to affect the feelings and moods of respondents. It

became evident that derogatory remarks from healthcare service providers towards women with physical disabilities affected them psychologically. Instances of scolding, verbal abuse and refusal of care during pregnancy and postnatal-related services as narrated by the respondents further compound the distress experienced by women with disabilities. Such abuses not only violate the rights of women with disabilities but also deter them from seeking essential reproductive healthcare services. Healthcare professionals should understand and appreciate the fact that women with disability have the same sexual needs as abled women, which need to be recognized without stigma (Vansteenwesen et al., 2003).

This finding suggests that healthcare service providers need to be oriented in the use of appropriate language in the delivery of healthcare services during counselling and clinic sessions ensuring that women with physical disabilities' needs are adequately met and respected.

5.6 Informational Barriers

It can be observed from Figure 5.1 that informational barriers (3.4%) were the least selected challenge in accessing reproductive health services for the respondents. However, during the interview, one of the key themes was the lack of early communication and education about reproductive health service procedures. Most of the women with physical disabilities expressed concerns about not being informed about the need for a Cesarean section (C-Section) beforehand.

One respondent stated,

My challenge was the time they wanted to perform C-S on me and I was not ready for it because they informed me just a day before the surgery. I didn't know what C-S was all about and I was so much afraid. (C18; 42 year old mother; Ashiaman)

Another mother also expressed frustration about not being informed earlier that she would require a C-Section due to her medical condition;

I was never told I will be going to do C-S until the day I got there to give birth. And I felt they should have told me earlier that I will be going through C-S because of my condition.

(C6; 39 year old mother; Korle Gonno)

The lack of early communication denied some of the pregnant women the opportunity to prepare financially for the procedure; and some mothers reported that they did not know what to expect during antenatal visits and this made them unprepared to undertake some required services from their doctors. A mother said:

At times, you will go for antenatal, and you'll not know that you'll be asked to take a scan, maybe, you may not have enough money to pay for that and transport to go home too. I nearly slept here in the hospital the last time I came here had it not the support of a good Samaritan who offered me a lift to my house. (C1; 32-year-old mother; Chorkor)

Respondents' narrations highlight a crucial aspect of healthcare that needs improvement in effective communication between healthcare providers and patients. Similar findings have emphasized the critical need for effective communication between healthcare providers and patients, particularly regarding major medical interventions (Mesman et al., 2017). Informed consent is essential, especially for major medical interventions like C-Sections, to empower patients in making decisions about their own bodies and healthcare.

Some of the respondents also felt that their concerns were not addressed adequately during antenatal visits, leading to a lack of knowledge and a sense of being ignored. The following was an excerpt of their experiences.

Sometimes persons like us don't get the needed information when we go to the hospital. They think the same information they are giving to all mothers can easily be done by those of us with disability. There was an instance when I went to the antenatal class and the nurse was saying we should exercise. I looked at my situation and the kind of exercise this nurse asked us to do then I asked myself , how can I do that in a wheelchair (C18; 42-year-old Mother; Ashiaman)

This quote aligns with Ganle et al.'s (2016) study, which found that there was generalized health information on reproductive health, but such information is not tailored to the specific or unique needs of the PWDs.

Generally, respondents' narrations revealed an important issue regarding the lack of early communication and education about reproductive health procedures. This resulted in mothers being unprepared for procedures like Cesarean sections (C-Sections), resulting in fear, frustration, and financial unpreparedness. The findings from this study suggest that timely communication and improved institutional care systems are essential to ensure access to reproductive health services for women with physical disabilities. Ganle et al. (2016) reported that lack of knowledge about disabilities and reproductive health services among health providers was a barrier in accessing reproductive health services among PWDs.

5.7 Institutional Care System

In the in-depth interviews, one of the challenges identified by the respondents was the institutional care system. Some of the respondents indicated having problems with long waiting times and fragmented health services as well as mobility challenges.

5.7.1 Long Waiting Times

Respondents highlighted significant challenges related to accessing antenatal and postnatal services, with long waiting times being a major concern. In-depth interviews with participants revealed that waiting times have increased over the years, and individuals no longer have the convenience of bypassing queues but are required to queue for long hours at healthcare facilities. For instance, a 39-year-old mother with physical disability from Korle Gonno shared her experience below:

People with disability were not queuing at the hospital some years ago, but now, we are no longer given that opportunity. I was asked to queue and sometimes I will sit for more than 4 hours until I begin to feel uneasiness around my waist. (C6; 39-year-old mother; Korle Gonno)

5.7.2 Fragmented Health Services

Some women with physical disabilities narrated other barriers encountered due to the fragmented nature of reproductive health service delivery and how this is impacted by their mobility difficulties. This was evident in the experiences of some mothers who recounted instances where they were required to move between different locations to access maternity services, despite difficulty in walking. A mother who described the constant movement and slippery stairs as posing a significant safety hazard to herself and her pregnancy had this to say:

When you get to the hospital, you will be asked to go here for this, move here to go and do that without considering that you have difficulty walking. The movement to access and pay for services is too much. It's so difficult moving with crutches. And the stairs at the hospital were slippery and if you are not careful you would fall with your pregnancy. (C19; 29-year-old mother; Korle Gonno)

5.8 Discussion on Institutional Care System

The institutional care system including long waiting times and fragmented health services, was noted as an additional challenge for women with physical disabilities. The experiences shared by these mothers underline the need for healthcare facilities to be accessible and modelled to be friendlier to the mobility challenges faced by individuals with disabilities. These findings resonate with existing literature documenting the barriers persons with disability encounter in accessing healthcare services, emphasizing the importance of creating inclusive healthcare environments (Ganle et al., 2021; Kassah et al., 2014; Kportufe, 2015; Mesman et al., 2017).

The findings from this study suggest that timely communication and improved institutional care systems are essential to ensure access to reproductive health services for women with physical

disabilities. Policies and strategies developed should focus on addressing these challenges, prioritizing the provision of timely comprehensive information, accommodating mobility needs, and reducing waiting times at healthcare.

5.9 Summary of the Chapter

The survey results highlight various challenges that women with physical disabilities face in accessing reproductive health services. Financial constraints prevent many women from attending prenatal appointments and obtaining necessary scans. High transport costs also deter them from accessing healthcare services. Inaccessible hospital infrastructure, such as stairs and slippery floors, poses significant challenges. Women often struggle with mobility and the lack of disability-friendly transportation options. Discrimination and stigma from healthcare providers are prevalent. Instances of verbal abuse, neglect, and biased attitudes towards Cesarean sections were reported. These negative experiences deter women from seeking necessary care. Emotional distress stemming from healthcare workers' negative attitudes and the lack of support from partners or society leads to mental health challenges. There is a lack of clear communication about medical procedures, such as Cesarean sections, and the importance of prenatal care. Women often feel unprepared and uninformed about what to expect during healthcare visits. Long waiting times and fragmented health services exacerbate the difficulties faced by women with physical disabilities. Mobility challenges within healthcare facilities further hinder their access to services. The study emphasizes the need for interventions to address these barriers, including financial support, improved physical infrastructure, training for healthcare providers to reduce stigma and discrimination, better communication strategies, and more integrated healthcare services.

CHAPTER SIX

SOCIAL SUPPORT FOR WOMEN WITH PHYSICAL DISABILITIES TO ACCESS REPRODUCTIVE HEALTH SERVICES

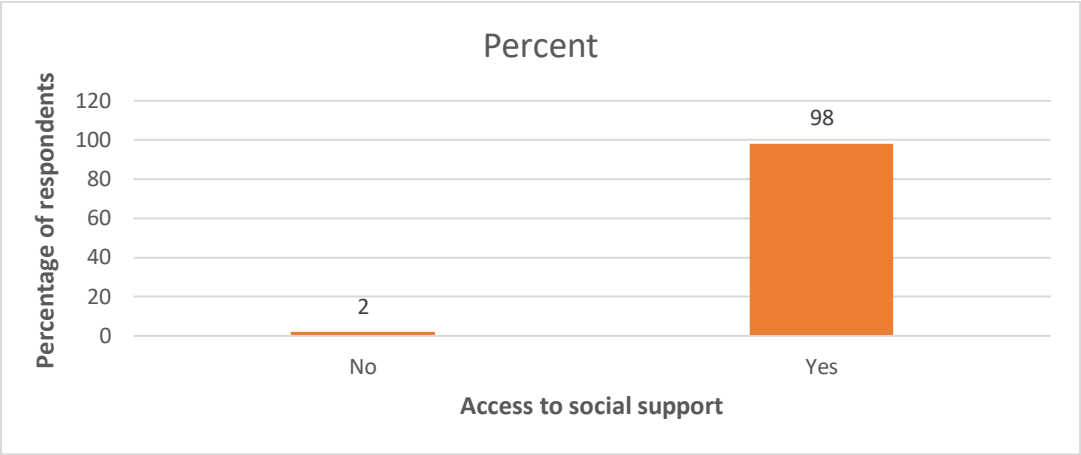
6.1 Introduction

Social support plays a crucial role in assisting women with physical disabilities in navigating the challenges associated with accessing reproductive health services. Given the challenges encountered by these women the availability and nature of social support can influence their ability to access and utilize reproductive healthcare services. Examining the forms and sources of social support provides a background to understanding the nature of social support available to them and how these types of support influence their access to reproductive health services. This chapter focuses on the second objective of the study, which is to ascertain the available social support systems for women with physical disabilities. The chapter focuses on the availability of social support to these women, the types of social support and the sources of these types of social support.

6.2 Access to Social Support

Figure 6.1 explores whether women with physical disabilities and mothers had access to social support. The figure indicates that almost all of them (98%) reported having access to social support. Only 2.0% of the women with physical disabilities and mothers had no access to social support in any form. This shows a strong network of assistance and care for the respondents, which can be crucial in addressing the challenges faced by women with physical disabilities while accessing reproductive health services.

Figure 6.1: Percentage Distribution of Respondents on Access to Social Support



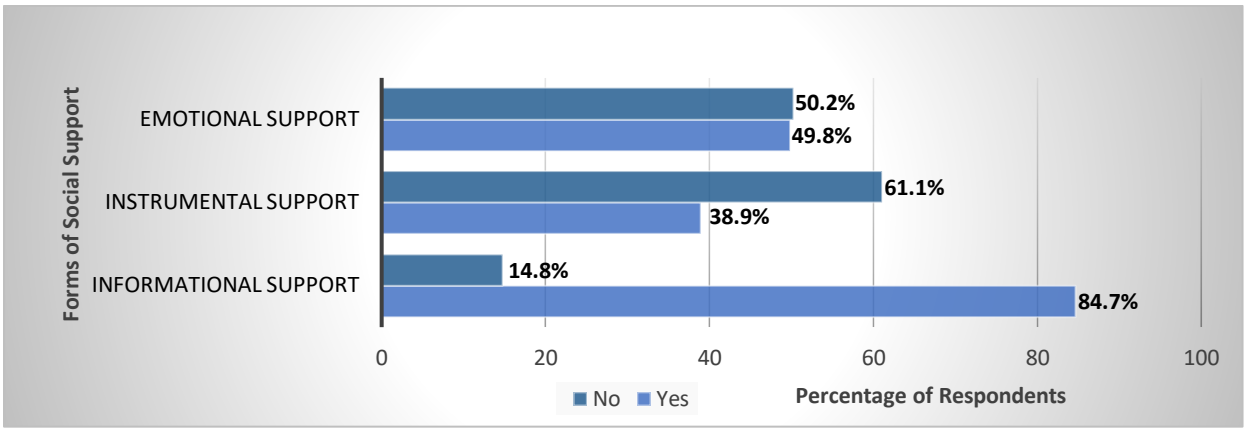
Source: Constructed from field data (2022)

6.3 Forms of Social Support

The study asked women with physical disabilities and mothers about the forms of social support available that aid them in accessing reproductive healthcare services. Figure 6.2 below highlights the forms of social support available to women with physical disabilities to access reproductive healthcare services. The findings show that women with physical disabilities significantly received informational support representing 84.7% as compared to other forms of social support in access to reproductive healthcare services. While the majority of women with physical disabilities reported receiving some form of instrumental support (38.9%), 61.1% of them indicated not receiving this type of support. This suggests that a substantial number of women with physical disabilities may still face challenges in obtaining essential items and services related to their health. This could include difficulties in accessing medications, medical procedures, adaptive equipment, or other necessary resources.

The findings also showed a nearly equal distribution between those who receive emotional support (49.8%) and those who do not (50.2%). Emotional support is key to the mental well-being of women with physical challenges and it is therefore important to recognize and address the mental health needs of women with physical disabilities.

Figure 6.2: Percentage Distribution of Respondents on the Forms of Social Support

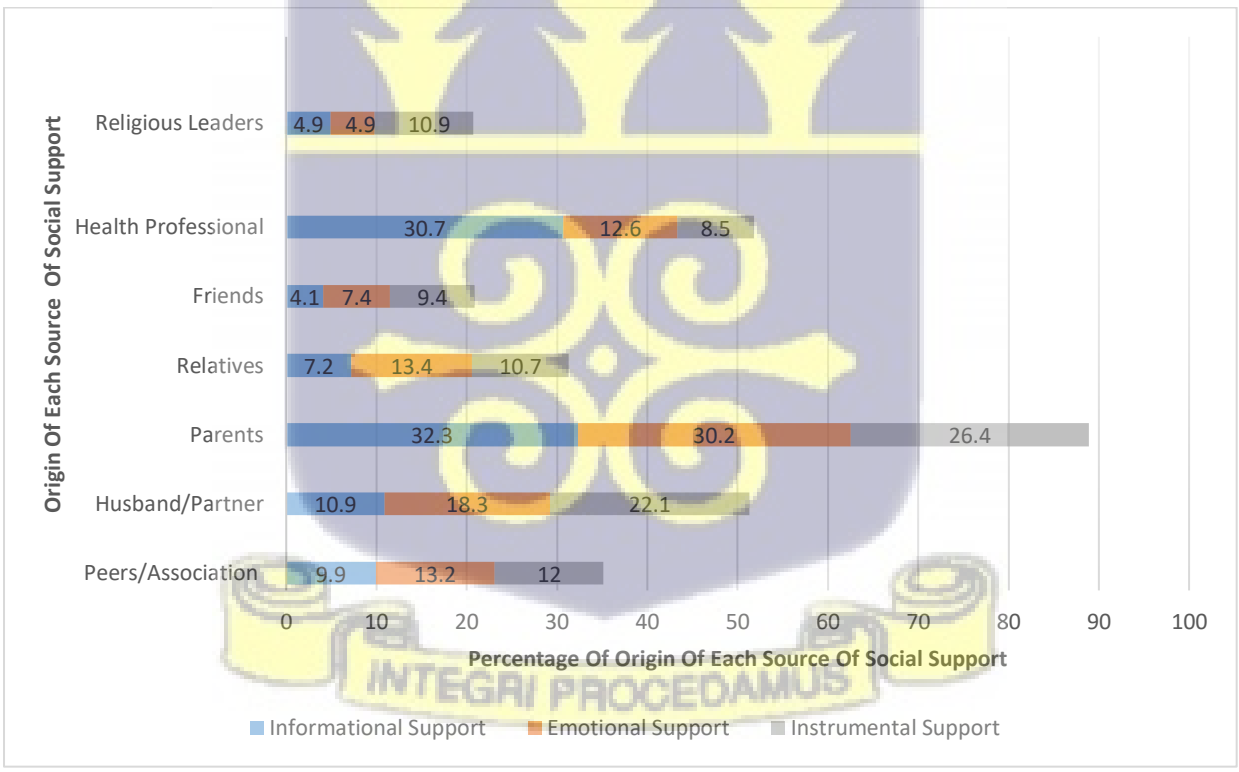


Source: Constructed from field data (2022)

6.4 Source of Each Form of Social Support

The study examined each form of social support and its origin that enabled women with physical disabilities to access reproductive healthcare services.

Figure 6.3: Percentage Distribution of Origin of Each Type of Social Support



Source: Constructed from field data (2022)

Respondents were asked about their sources of emotional, instrumental, and informational support. From Figure 6.3, the majority of women with physical disabilities receive emotional

support from their parents (32.2%), followed by their husband/partner (18.3%). In addition, 26.4% of respondents indicated that they receive instrumental/medical/material support from their parents, followed by their husband/partners (10.9%). A little over 32% of respondents receive informational support from their parents, followed by health professionals (30.7%).

6.4.1 Parents Support

During the in-depth interview, most respondents indicated receiving various forms of social support from their own mothers. Some women with physical disabilities highlighted the reason behind that choice.

Because I live with my mother, she provides all the support I need until the baby grows up. As you can see, I am not able to walk very well so most of the work is done by her and she has been so good to me. (C8; 34 year-old mother; La)

My mother is the one who supports me in taking care of the child whenever I deliver. My husband also cooks for me. I prefer having support from these two to going for someone who will not give me all the attention and support I need. They sacrifice their time to take care of me and my children. (C4; 45 year old mother; Korle Bu)

My mom paid for the hospital bills, bought baby clothes, did the cooking, washed clothes and bathing the baby. (C8; 34 year-old mother; La)

It is evident that even though social support from the mothers is crucial, the various sources of social support from other avenues including partners/husbands also have roles to play. The predominance of support from mothers reflects the gendered dimension of caregiving in which maternal figures are relied upon to provide practical support.

6.4.2 Neighbors Support

To further understand other sources of support for women with physical disabilities, the study revealed that neighbours support aided them in coping with the challenges of accessing reproductive healthcare services. The respondents indicated that sometimes neighbors

voluntarily offered help, which shows the importance of community in reducing some of the reproductive health challenges faced by women with physical disabilities.

The following interview excerpt illustrates this:

"My neighbors assured me of their support. But I didn't want to be a burden on anyone. I do not ask for help but they willingly come to support me with my household chores and errands". (C6; 39-year-old mother; Korle Gonno)

The benevolence of the neighbors shows a high level of awareness of the challenges of women with physical disabilities in the community. The support from the neighbors may be traced to their values or concern for the needy. Such an assertion cannot be conclusive, since further investigation may be needed. Despite this, it is important to note that the continuous support from the neighbors is not sustainable due to relocation and the rising cost of living. In the event of the relocation of neighbors, it implies that the source of support will be truncated. This development can affect the resilience of mothers with physical disabilities.

6.4.3 Support from Associations

Women with physical disabilities have a network of support and resources through groups, such as the Disability Association, which support them to meet their needs in difficult moments. Being a member of the disability group provided a platform for knowledge sharing, emotional support, and the exchange of practical advice, helping women with physical disabilities build resilience and confidence in their journey to accessing healthcare. A mother's encounter with experiences shared by members of an association equipped her with valuable insights into coping with challenges during pregnancy. One mother mentioned:

Yes, at least, experiences of childbirth shared by members of the association, helped me prepare my mind for the challenges that I may experience at the hospital (C10; 35year old mother; Ashiaman)

Another mother shared her experience on how she received support from the disability group she joined:

"Joining the Disability Association has helped me. It is through this association that I got encouraged and learned from the experiences of other mothers. People shared the difficulties they had gone through and said I should be strong". (C18; 42-year-old mother; Ashiaman).

This group or association, although not large or financially viable, is very integral in providing the needed support in meeting the reproductive health care services, in that they usually share similar experiences, which can be a source of help.

6.4.4 Support from Health Professionals

Also available was social capital from professionals in the healthcare sector for women with physical disabilities to benefit from or leverage in times of difficulty.

The following interview excerpt illustrates a compassionate nurse:

"May God bless Auntie Lucy. She is the only nurse who saw the need to assist me whenever I visited the hospital. I have therefore named my daughter after her". (C8; 34-year-old mother; La).

"There was only one nurse called Sisi who was very kind to me. She would do everything for me and sometimes gave me money for transport. Look at this baby dress, this same nurse bought it for my daughter. She had a very kind heart" (C10; 35-year-old mother; Ashiaman).

6.5 Discussion

The results of the data analysis focused on the available social support systems for physically challenged pregnant women. The findings of this study indicate that the majority (98%) of women with physical disabilities and mothers have social support. It shows that a network of support plays a significant role in handling the unique issues among the respondents accessing reproductive health services. These results agree with earlier studies that underscore the significance of social support to enhance health outcomes and quality of life for people with disabilities (Seymour, 2017).

The most common type of social support identified by respondents was informational support (84.7%), which suggests that most respondents received knowledge of reproductive health services and are expected to be empowered. Informational support from the family and other social networks helps to empower people by giving them access to information on available resources and services. However, a study by Nguyen (2020) reported that health information on reproductive health services is unreliable and unavailable in many parts of the world. This evidence cannot be ignored, considering the stereotype persons with disabilities face because of the perception of being asexual.

In comparison with informational support, there was a notable difference in other forms like instrumental support, whereby most of the respondents indicated not receiving financial or practical assistance, with 61.1% not receiving it. This emphasizes the continued difficulties faced by these women when trying to access essential reproductive services related to their health and well-being, as shown in previous studies on barriers to healthcare accessibility for persons with disability (Krahn et al., 2015).

Both the qualitative and quantitative analyses highlighted that most of all types of support come from parents, while partners or husbands give the second highest proportion across all types. This highlights the parents' role in meeting the diverse needs of these women during pregnancy and motherhood. This evidence gives credence that family support is integral, in terms of funds needed to access reproductive healthcare services.

6.6 Summary of the Chapter

The study found that 98% of women with physical disabilities reported having access to social support, indicating strong assistance networks crucial for accessing reproductive health services. Informational support was most common (84.7%), while instrumental support was received by 38.9%, with emotional support nearly evenly split (49.8%). Parents played a major role, providing emotional, instrumental, and informational support, followed by

husbands/partners. In-depth interviews underscored the vital role of parental support in their well-being and child care, alongside contributions from partners/husbands.

CHAPTER SEVEN

THE RESILIENCE OF WOMEN WITH PHYSICAL DISABILITIES TO ACCESS REPRODUCTIVE HEALTH SERVICES

7.1 Introduction

The concept of resilience helps explain how women with physical disabilities adapt and overcome the challenges associated with accessing reproductive health services. Examining resilience within this context provides insights into the factors influence their actions to the challenges that they experience while seeking reproductive health services. This chapter addresses the objective which focuses on assessing the factors affecting resilience of women with physical disabilities in accessing reproductive health services.

The chapter delves into issues concerning the resilience of women with physical disabilities as they face the challenges of accessing reproductive health services. Its sections analyzes the factors of resilience to access reproductive health services with descriptive statistics on the resilience scale, demographic characteristics and qualitative findings. Descriptive statistics derived from the resilience scale were presented to provide quantitative insights into the levels of resilience exhibited by women with physical disabilities in the context of accessing reproductive health services. This quantitative exploration offers valuable data on the distribution, variability, and central tendencies to specific factors of resilience scores with the challenges encountered with access to reproductive health services. In addition to the above, the chapter incorporates qualitative findings that explain the experiences and perspectives of women with physical disabilities as they encounter the difficulties of accessing reproductive health services. Qualitative insights provided an understanding of the unique challenges and coping mechanisms that shape the resilience of these women.

7.2 Descriptive Analysis of Resilience Factors in Access to Reproductive Health Services

The descriptive statistics from Table 7.1 provide an analysis of how participants responded to various statements designed to measure their resilience in the context of challenges in accessing reproductive health services. The analysis further provides insights into respondents' coping mechanisms and attitudes toward overcoming difficulties encountered in accessing reproductive health services.

Table 7.1: Resilience Strategies of Respondents

Descriptive Statistics	N	Mean	Std. Deviation
I was determined to recover	203	4.41	0.513
I adjusted to the new changes	203	4.27	0.506
I used humor to help me through	203	4.04	0.6
I believed I could recover	203	4.13	0.56
I focused on my remaining abilities, not on what I couldn't do	203	4.13	0.474
I accepted the new challenges	203	4.23	0.525
I accepted help from others	203	4.16	0.625
I figured out how to do my daily activities	203	4	0.738
The challenging event was so bad, I gave up	203	3.66	0.872
I found it difficult to ask for help from others when I needed it	203	3.68	0.878
I found the energy to do what I had to do	203	3.8	0.786
I saw this challenge as an opportunity	203	3.75	0.716
I was determined to regain my prior functional ability	203	3.98	0.502
I became a stronger person	203	4.04	0.516
I continued to make plans for the future	203	4.04	0.695
I learned from it	203	4.02	0.54

Since the challenging event, I have not wanted to even do my usual activities	203	3.35	1.263

In examining specific resilience factors from Table 7.1, participants displayed a high level of determination to recover and accept new challenges with a high mean score of 4.41 and 4.23, respectively. This suggests a strong internal motivation and readiness to overcome challenges as they arise. However, there was a good mean resilience score of 3.7 in viewing challenges as opportunities for growth indicating potential for fostering a positive growth-oriented mindset. Women with physical disabilities reported using humor as a coping mechanism (mean = 4.04) indicating the role of positive emotions in their resilience. In addition, respondents showed a good resilience level of energy to carry out their responsibilities, with a mean score of 3.8.

Respondents showed adjusting to new changes with a mean score of 4.27, which suggests that these women with physical disabilities show a high capacity to adapt and coping with unfamiliar environments, procedures, and attitudes in accessing health services. While respondents had a high mean score of 4.16 for accepting assistance from others, they obtained a lower score (3.68) for "I found it difficult to ask for help from others when I needed it". This suggests that while these women may be open to accepting help, there might be some discomfort in asking for it.

Respondents reported feeling a reduced desire to engage in usual activities since the challenging event (mean = (3.35). However, respondents showed resilience in figuring out how to do their daily activities (mean score of 4.00), suggesting adaptive coping mechanisms despite challenges.

Participants expressed determination to regain prior functional ability (mean = 3.98) and high commitment to making plans for the future (mean = 4.04). These findings suggest a good of motivation and a high proactive approach to overcoming challenges among respondents.

Generally, respondents exhibited high resilience in many areas related to the resilience scale questions items in overcoming the challenges they encounter in accessing reproductive health services.

7.3 Relationship between the Demographic Characteristics of Women with Physical Disabilities and Resilience to Challenges in Accessing Reproductive Health Services

To understand the socio-demographic factors influencing resilience among women with physical disabilities in accessing reproductive health services, a bivariate analysis using one-way ANOVA was undertaken to assess the relationships between socio-demographic characteristics and resilience. The tables show the ANOVA results on the socio-demographic variables age, highest level of education, religion, ethnicity, occupation, income, marital status, number of children, and place of residence.

7.3.1 Age

An analysis of variance (ANOVA) was undertaken to know the resilience scores of women to challenges to accessing reproductive health services by the different age groups. Table 7.2 below presents the analysis that showed a statistically significant difference in resilience scores among the different age groups ($F(5, 197) = 2.869$, $p = 0.016$), indicating that age is an influential factor of resilience levels among women with physical disabilities regarding access to reproductive health service challenges. The highest mean resilience score is observed in the age group 30-34, with a score of 3.8975 indicating that women with physical disabilities aged 30-34 may have resources that might have contributed to higher resilience among the studied groups. Meanwhile, the lowest mean resilience score is found in the age group 20-24, with a score of 3.6471 suggesting that respondents within the 20-24 age group might face more challenges or have fewer resources to contribute to building their resilience to the challenges encountered in accessing reproductive health services.

Table 7.2: Age Distribution

	N	Mean	Std. Deviation	Std. Error
20-24	3	3.6471	0	0
25-29	35	3.7882	0.2745	0.0464
30-34	66	3.8975	0.37649	0.04634
35-39	52	3.707	0.23801	0.03301
40-44	36	3.7075	0.34256	0.05709
45-49	11	3.7219	0.37305	0.11248
Total	**203**	**3.783**	**0.32724**	**0.02297**

ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	1.468	5	0.294	2.869	0.016
Within Groups	20.163	197	0.102		
Total	**21.631**	**202**			

7.3.2 Education

The results in Table 7.3 show the results of the one-way ANOVA on education indicates a statistically significant difference in resilience levels among women with physical disabilities based on their highest level of education attained ($F(4, 198) = 16$, $p < 0.001$). The results of the Tukey's HSD test for multiple comparisons (Appendix D) showed that respondents with no education exhibit significantly lower mean resilience to the challenge of accessing reproductive health compared to those with Junior High School/Middle School education ($p < 0.001$), Secondary education ($p < 0.001$), and Tertiary education ($p = 0.018$). This means that higher education levels are associated with high resilience in overcoming challenges to accessing reproductive health services.

There were statistically significant differences in mean resilience to challenges of access to reproductive health services between women with primary education and those with secondary education (p = 0.001), as well as between secondary and tertiary education groups (p = 0.018). However, there were no significant differences in mean resilience between women with primary education and those with no formal education or between Junior High School/Middle School and Tertiary education groups. The latter may indicate that minimal education does not significantly improve an individual's resilience. Overall, the results underscore the importance of educational attainment in building resilience among women with physical disabilities in the context of accessing reproductive health services. This finding could be explained by the previous studies that have indicated that education may enhance women's autonomy and help them to access services more easily (Matsumura & Gubhaju, 2001).

Table 7.3: Descriptive on Education

	N	Mean	Std. Deviation	Std. Error
None	54	3.5599	0.2713	0.037
Primary	25	3.7035	0.4923	0.098
JHS/Middle School	61	3.8746	0.231	0.03
Secondary	47	3.9825	0.2419	0.035
Tertiary	16	3.7243	0.2219	0.055
Total	**203**	**3.783**	**0.3272**	**0.023**

ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	5.28	4	1.321	16	0
Within Groups	16.3	198	0.083		
Total	**21.6**	**202**			

7.3.4 Religion

Table 7.4: Religious Distribution

	N	Mean	Std. Deviation	Std. Error
Christian	149	3.7904	0.3437	0.02816
Islam	32	3.7647	0.31305	0.05534
Traditional	22	3.7594	0.22667	0.04833
Total	**203**	**3.783**	**0.32724**	**0.02297**

Anova

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	0.031	2	0.016	0.144	0.866
Within Groups	21.6	200	0.108		
Total	**21.631**	**202**			

The scores on resilience observed across the different religious groups are quite similar, with respondents of Christian faith having a slightly higher mean score (3.7904) compared to Muslim women (3.7647) and women practicing traditional religions (3.7594). In addition, these differences are minimal. Further to this, the ANOVA test (p-value =0.866) results show that the differences in mean resilience scores between the religious groups are not statistically significant, which implies that religion does not play a significant role in influencing the resilience levels of respondents in accessing reproductive health services.

7.3.5 Ethnicity

Similar to the results on religion, there was no statistically significant difference in mean resilience and women's ethnic groups ($F(6, 196) = 0.115$, $p = 0.951$) as shown in Table 7.5 below.

Table 7.5: Ethnicity Distribution

	N	Mean	Std. Deviation	Std. Error
Akan	56	3.7584	0.26608	0.03556
Ga-Adangbe	87	3.8087	0.36694	0.03934
Ewe	43	3.8126	0.30383	0.04633
Other	17	3.6574	0.34315	0.08323
Total	**203**	**3.783**	**0.32724**	**0.02297**

ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	0.04	3	0.012	0.115	0.951
Within Groups	21.6	199	0.109		
Total	**21.6**	**202**			

7.3.6 Occupation

The ANOVA on the impact of the type of occupation revealed a statistically significant difference in resilience mean scores based on occupation ($F(2, 200) = 11.73$, $p < 0.001$). The results from the table below indicated that casual workers had lower resilience (M= 3.4762) compared to women with physical disabilities working as traders/business owners (M=3.8109 or civil/public servants (M=3.8676) This corroborates the findings of several studies that indicate that women with paid occupations or stable income sources are more economically independent and consequently have better access to services (Khanal et al., 2014; Paudel & Pitakmanaket, 2010). The low resilience scores among casual workers may be the result of job insecurity and unstable income, which could significantly impact the resilience of this group of women. These results highlight that occupation is a significant contributor to resilience, with more stable occupations being associated with greater resilience.

Table 7.6: Occupational Distribution

	N	Mean	Std. Deviation	Std. Error
Trade/Business	158	3.8109	0.3111	0.025
Civil/Public Servant	24	3.8676	0.2609	0.053
Casual worker	21	3.4762	0.3607	0.079
Total	**203**	**3.783**	**0.3272**	**0.023**

ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	2.27	2	1.136	11.73	0
Within Groups	19.4	200	0.097		
Total	**21.6**	**202**			

7.3.7 Income

The one-way ANOVA found a statistically significant difference in mean resilience scores among individuals with different income levels ($F(3, 199) = 8.128$, $p < 0.001$). This means that income level is a significant factor influencing resilience. Women with physical disabilities with lower income (earning less than 200 Ghana cedis) have the lowest mean resilience while those making between 501 and 1000 Ghana cedis exhibit the highest. This finding suggests that lower income limits or forego medical appointments, necessary treatments or medications whereas higher income allows women with physical disabilities to effectively manage the logistical challenges associated with accessing healthcare. This finding aligns with the socio-ecological model theory, which posits that the personal income of a person determines the individuals' ability to access and utilize health services.

Table 7.7: Income Distribution

Income Level	N	Mean	Std. Deviation	Std. Error
Less than 200 cedis	72	3.652	0.3274	0.039
200-500 cedis	81	3.8751	0.3413	0.038
501-1000 cedis	32	3.886	0.2285	0.04
1001-2000 cedis	18	3.7092	0.2062	0.049
Total	**203**	**3.783**	**0.3272**	**0.023**

ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	2.36	3	0.787	8.128	0
Within Groups	19.3	199	0.097		
Total	**21.6**	**202**			

7.3.8 Marital Status

The table below shows a one-way ANOVA performed to compare the effect of different marital statuses on mean resilience to the challenges of accessing reproductive health services. The findings indicate a statistical difference in resilience levels among women with physical disabilities based on their marital status ($F(3,199)=7.49$, $p<0.001$), which means that marital status has a role in the resilience of respondents in accessing reproductive health services.

Table 7.8: Marital Status Distribution

	N	Mean	Std. Deviation	Std. Error
Single	147	3.8459	0.3166	0.026
Divorced	30	3.6529	0.2791	0.051

Cohabitation	15	3.5725	0.3554	0.092
Married	11	3.5829	0.279	0.084
Total	**203**	**3.783**	**0.3272**	**0.023**

ANOVA

	Sum of Squares	**df**	**Mean Square**	**F**	**Sig.**
Between Groups	2.2	3	0.732	7.49	0
Within Groups	19.4	199	0.098		
Total	**21.6**	**202**			

Single women with physical disabilities had higher resilience scores compared to those who were divorced, cohabiting, or married. Some of the probable reasons for this outcome could be that single women with physical disabilities might have different social support structures and fewer family responsibilities compared to married or cohabiting women which allows them to have more time and energy to focus on their health and well-being.

7.3.9 Number of Children

The ANOVA table shows that there was no significant difference in resilience scores among women with physical disabilities based on the number of children ($F(4,198) = 0.767$, $p = 0.548$). This means that the number of children does not appear to be a factor that influences the resilience of respondents to the challenges they encounter while accessing reproductive health services. However, women with physical disabilities with four children demonstrated slightly higher mean resilience ($M = 3.9647$, $SD = 0.2551$) compared to other groups. Nonetheless, the differences are not statistically significant in the study.

Table 7.9: Descriptive on Number of Children

	N	Mean	Std. Deviation	Std. Error
1	55	3.7925	0.2467	0.033
2	89	3.7964	0.3565	0.038
3	51	3.7301	0.322	0.045
4	5	3.9647	0.2551	0.114
6	3	3.8039	0.8326	0.481
Total	**203**	**3.783**	**0.3272**	**0.023**

ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	0.33	4	0.083	0.767	0.548
Within Groups	21.3	198	0.108		
Total	**21.6**	**202**			

7.3.10 Place of Residence

The findings show no significant differences in resilience between urban and peri-urban residences. Thus, place of residence does not appear to be a major factor influencing the resilience of women with physical disabilities in accessing reproductive health services.

Table 7.10: Place of Residence Distribution

	N	Mean	Std. Deviation	Std. Error
Urban	93	3.8	0.303	0.03
Peri urban	110	3.7	0.344	0.03
Total	**203**	**3.8**	**0.327**	**0.02**

ANOVA

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	0.3	1	0.29	2.7	0.1
Within Groups	21	201	0.11		
Total	**22**	**202**			

7.4 Qualitative Findings on Factors Contributing to Resilience in Accessing Reproductive Health Services among Women with Physical disabilities

Through in-depth interviews with women with physical disabilities, factors that contribute to their resilience to overcome the obstacles in accessing reproductive health services were highlighted as problem-solving, Self-advocacy, desire for motherhood, personal determination and religious practice.

7.4.1 Adaptation

There are diverse strategies available for solving an identified problem. The women with physical disabilities indicated they have developed ways of addressing the challenges in accessing reproductive health services. Adaptation to the situation was employed by the respondents. The mother with physical disability asserted that they are most compelled to adapt, recognizing the limitations of familial support;

"At a point, I realized support from my family would not be there forever. So I'd rather look for ways of solving my problem than wait for someone to help me all the time. So I had to learn how to do things on my own". (C20; 30-year-old mother; Kpone)

Despite the challenges faced by respondents, one of them account underscores the importance of building supportive connections within the healthcare setting. She built relationships with nurses to gain assistance;

"Over time I got used to the challenges that I was facing. I made friends with most of the nurses so they helped me with my needs easily. I was able to ask any question that I didn't understand concerning my pregnancy." (C2; 36-year-old mother; La).

7.4.2 Self Advocacy

Women with physical disabilities and mothers continue to suffer abuse, as a result of the impact of their condition. A respondent narrated that to avert such abuse, she reacted to the insults from the healthcare provider as a form of Self-advocacy. The interview excerpt below illustrates this:

"For me, I don't keep quiet when you insult me, I speak my mind so that they will know that we are also humans. There was a time that I went to report a nurse to an in charge and made sure she apologized to me for looking down on me. Me, I won't leave you when you insult me" (C4; 45-year-old mother; Korle-bu)

The findings from the study have highlighted the lapses in the healthcare system in terms of conduct towards the disadvantaged group. It shows that these respondents are susceptible to emotional and psychological abuse. The negative attitude of these healthcare providers may serve as a disincentive not to seek reproductive healthcare services. There is increasing recognition across the world that the rights of persons living with a disability need to be respected by all individuals and institutions (UN 2021). Awareness creation of patient rights has to be intensified in our quest to achieve the SDGs on the reduction of child and maternal mortality. The call for relevant authority within the healthcare ecosystem to ensure healthcare providers create a supportive environment for women with physical disabilities.

7.4.3 Desire for Motherhood (Prioritizing Baby's Well-being)

In many African societies' motherhood is considered an important stage of life for most women, regardless of their status. This desire of motherhood serves as an intrinsic motivation for women with physical disabilities to endure all the difficulties in accessing reproductive healthcare services and finally meeting their motherhood desires. In the study, despite facing insults and negative attitudes, the desire for motherhood of women with physical disabilities made them prioritize the health and well-being of their unborn children, using this focus as a source of strength:

I think first of the baby in my womb and because of my situation, I need the help of the doctors to look after me and my baby. So, I don't even mind them when they are not nice to me. All I think of is for baby to be well for me. (C1; 32-year-old mother; Chorkor)

I always had my mind prepared that I was in the hospital because of myself and the baby. So, I don't even focus on how people will look at me or treat me. I didn't respond to the insults because I knew I would still be going to the hospital. I knew it would not be good for me and the baby if I didn't go back to the hospital (C8; 34-year-old mother; La)

I tell myself that I know why I am at the hospital, that is for the sake of the health of my unborn baby so I don't focus on the problems I face but on what will help me deliver my baby safely". (C19; 29-year-old mother; Korle Gonno)

A 33-year-old mother with physical disability reflects on her pregnancy journey with hope in the face of a daunting situation that the child will become her support system:

What kept me going through the pregnancy was the hope that my baby would one day be "my leg and everything". So I didn't think about any other thing. (C15; 33-year-old Mother; Ashiaman)

Another mother's narration reflects the thoughts of a woman who considers motherhood as a source of strength and happiness driving her to overcome challenges and obstacles in accessing reproductive health services.

The thought of having my own child made me stronger. I get happy and when I begin to think that I am going to have a child who will understand me and love me. C7; *32-year-old mother, La*)

Suppressing and learning to regulate negative emotions were used to adapt to the challenges in accessing reproductive services. The respondents were aware of the personal challenges of their

situation and therefore cultivated the habit of controlling these negative emotions through positive self-talk. The following interview excerpt illustrates this:

"*The times when I didn't have money, I cry until I get to the point where I will say to myself that it is well". (C21; 35-year-old mother; La)*

7.4.4 Personal Determination

Many of the respondents had a sense of tenacity in facing the challenges associated with reproductive health issues. It was evident from the findings that the women with physical disabilities encouraged themselves and submitted to the requests and demands of the health care providers in accessing reproductive health services:

"I got to know what the nurses like and don't like. I made sure that I looked neat and put up smiles all the time. I was also doing whatever they asked me to do. The nurses were very happy and liked me". (C9; 40-year-old mother; La)

"*I encouraged myself because I see it to be a blessing to get pregnant with my condition. Because I see some women who have no disability but are not able to get pregnant. I thank God for allowing me to also carry a baby. ..so that helped me endure all the problems". (C2; 36-year-old mother; La)*

A further engagement with the respondents on the coping strategy revealed that the women with physical disabilities before the delivery of the baby were proactive but not reactive, in terms of materials and other resources required for maternity. They engaged in economic ventures to enable them to save some money to pay medical bills. For example, a physically challenged shared how she was able to save.

"I had to work very hard to save some money for myself and the baby that I was going to give birth to. That was what I used to pay for my hospital bills". (C14; 30-year-old mother; Ashiaman).

You know what, before the pregnancy, I had made some savings through a SUSU group, because I knew I didn't have any support. This helped me to pay the hospital bills. I also was able to buy things for the baby before I delivered (C21; 35 year old mother; La)

Some respondents also adopted making difficult decisions about their reproductive health to manage economic conditions having acknowledged the social and economic challenges associated with having a baby. This knowledge serves as a source of a constraint not to have a baby. The following interview excerpt illustrates this:

"For me, I decided not to get pregnant again. I have had two abortions because I don't have enough money to take care of another pregnancy since my baby is been taken care of by my parents alone. I don't want to put another burden on them again". (C11; 40-year-old mother; Ashiaman)

7.4.5 Religious Practice

Religion is an integral part of African society. The women with physical disabilities and pregnant women indicated their commitment to religious practice and the use of artefacts as a source of coping strategy used to deal with reproductive health services. Prayers and sense of gratitude were a religious practice used by women with physical disabilities to overcome challenges to accessing reproductive health services. Mothers who prayed and used religious artefacts said:

"My sister, you know pregnancy comes with a lot of difficulties. Had it not been "small, small" prayer I wouldn't be alive. My pastor prayed over water for me to be drinking every morning. He offered me this wristband as a form of protection against all evil spirits that will rise against me". (C13; 23-year-old mother; Ashiaman-)

"Whilst at the hospital, there was this church group that always came around to pray for pregnant women in the labour ward. This pastor saw me and told me that he was moved by the Holy Spirit to support me. And that was my breakthrough. He has been praying for me and my child. And gives me money every month". (C17; 30-year-old mother; Chorkor).

Although material support from friends and healthcare professionals was important to the women with physical disabilities, seeking spiritual or divine help was evident. Practices such as drinking blessed water and wearing protective wristbands showed a spiritual shield against the difficulties of pregnancy, demonstrating a link of faith and resilience. This is normally the case in a deeply-religious society where events of life are attributed to nature. Nonetheless, there is a need to create awareness among women with physical disabilities to understand or appreciate the importance of seeking healthcare. The continuous dependence on divine help or prayers may be detrimental to their health and well-being. Hence a balance between spiritual and physical help needs to be highlighted to them.

A sense of gratitude towards their circumstances, recognizing that their situation was better than others facing similar challenges, contributed to a positive mindset. A respondent had this to say:

When I saw that my situation was better than other women who had no disability but could not give birth on their own, I stopped worrying and thanked God because I had support from my parents (C 3;38 year old mother; La)

This gratitude acted as a buffer against despair, allowing them to focus on the support received from their parents.

7.5 Summary of the Chapter

The findings revealed a diversity of resilience by women with physical disabilities in their seeking reproductive health services. Despite societal stigmas and personal challenges, these women draw strength from various sources, showcasing the power of community support, religious faith, problem-solving skills, and an unwavering determination to embrace motherhood. Their stories underscore the need for inclusive healthcare practices that recognize and support the unique needs of physically challenged individuals on their journey to parenthood.

CHAPTER EIGHT

THE ROLE OF SOCIAL SUPPORT IN STRENGTHENING THE RESILIENCE OF WOMEN WITH PHYSICAL DISABILITIES IN ACCESSING REPRODUCTIVE HEALTH SERVICES

8.1 Introduction

The chapter addresses the study's objective on the role of social support in strengthening the resilience of women with physical disabilities in accessing reproductive healthcare. For these women, access to reproductive health services is impeded by various barriers, including physical, financial, informational, and attitudinal challenges, which makes social support a valuable resource in building resilience to these challenges.

This chapter thus examines the relationship between social support and the resilience of women with physical disabilities in accessing reproductive health services. Correlations and regression analysis were performed between different forms of social support (specifically instrumental, informational, and emotional support), demographic characteristics and the resilience of women with physical disabilities to identify factors that influence their ability to overcome barriers and access essential reproductive healthcare services.

In addition to the above, the chapter incorporates qualitative findings that explain the experiences and perspectives of women with physical disabilities as they encounter the difficulties of accessing reproductive health services. Qualitative insights provide an understanding of the unique challenges, coping mechanisms, and support systems that shape the resilience of these women.

8.2 Social Support and Resilience of Women with Physical Disabilities to Access Reproductive Health Services

This table presents correlations between different types of social support (instrumental support, informational support, emotional support) and resilience among women with physical disabilities in accessing reproductive health services.

Table 8.1: Correlation Matrix on the Type of Social Support and Resilience

Variable	Instrumental Support	Informational Support	Emotional Support
Instrumental Support	1		
Informational Support	.630**	1	
	0		
Emotional Support	.603**	.663**	1
	0	0	
Resilience	.203**	.229**	-0.062
	0.005	0.001	0.381

Correlation is significant at the 0.01 level (2-tailed)

The correlations indicate a relationship between different forms of social support and the resilience of women with physical disabilities in accessing healthcare services. As shown in Table 8.1, instrumental and informational support demonstrate a positive and statistically significant association with resilience, as shown by the Pearson correlation coefficients of 0.203 and 0.229, respectively, both with p-values of less than 0.01. These findings suggest that increasing instrumental and informational support may lead to an increase in the resilience of women with physical disabilities in accessing reproductive healthcare services. Therefore, both information and instrumental support help women with physical disabilities overcome instrumental and informational barriers (transportation to healthcare facilities, financial assistance, physical aid, health education) they encounter. On the other hand, emotional support

shows a non-significant negative correlation with resilience, with a Pearson correlation coefficient of -0.062 and a p-value of 0.381. This indicates that emotional support had a diminishing effect on their resilience making it less impactful without instrumental and informational in this context.

8.3 Linear Regression Analysis of Social Support and Socio-Demographic Factors on Resilience in Accessing Reproductive Health Services

In this section, we present a comprehensive interpretation of the regression analysis results conducted to explore the relationship between various types of social support, socio-demographic factors and resilience in access to reproductive health services among women with physical disabilities. The analysis aimed to elucidate the nuanced interplay of the types of social support, age, education, religion, ethnicity, marital status, income, source of income, and number of children in shaping resilience in health service access within this marginalized population. The results are presented in Table 8.2.

Table 8.2: Linear Regression Model Showing Types of Social Support, Socio-Demographic characteristics, and Resilience among Women with Physical Disabilities in Accessing Reproductive Health Services

Predictor	Coefficient	Std. Error	Sig.
(Constant)	3.678	0.401	0
Emotional Support	-0.101	0.03	p< 0.001
Instrumental Support	0.056	0.022	0.012
Informational Support	0.056	0.026	0.037
Highest Level of Education			
None (RC)	-	-	-
Primary	0.215	0.068	0.002
JHS/Middle School	0.255	0.062	p<0.001
Secondary	0.309	0.072	p<0.001
Tertiary	0.047	0.109	0.665
Occupation			
Civil/Public Servant (RC)	-	-	-
Casual worker	-0.498	0.117	p<0.001
Trade/Business	-0.214	0.111	0.056
Income Level			

less than 200 (RC)	-	-	-
200-500 cedis	0.105	0.052	0.046
501-1000 cedis	-0.051	0.083	0.537
Above 1000 cedis	-0.197	0.128	0.126
Religion			
Traditional (RC)	-	-	-
Islam	-0.218	0.093	0.02
Christian	-0.093	0.091	0.307
Age Group			
20 - 24 (RC)	-	-	-
25-29	0.166	0.31	0.593
30-34	0.197	0.31	0.527
35-39	0.13	0.31	0.676
40-44	0.08	0.311	0.797
45-49	0.069	0.317	0.829
Ethnicity			
Other (RC)	-	-	-
Ewe	-0.1	0.096	0.299
Ga-Adangbe	0.01	0.085	0.907
Akan	-0.06	0.099	0.548
Number of Children	0.004	0.025	0.863
Marital Status			
Married (RC)	-	-	-
Cohabitation	0.034	0.114	0.766
Divorce	-0.047	0.101	0.64
Single	0.12	0.084	0.154
Place of Residence			
Urban (RC)	-	-	-
Periurban	0.006	0.055	0.916

The analysis from Table 8.2 reveals how the different types of social support impact resilience to the challenges in accessing reproductive healthcare services among women with physical disabilities. The findings showed instrumental support to be positively related to resilience in access to healthcare services among women with physical disabilities (β = coefficient = 0.056, p = 0.012). Further, informational support was positively related to resilience in access to reproductive healthcare services among women with physical disabilities (β = coefficient = 0.056, p = 0.037). This suggests that the increment or enhancement of instrumental and

informational support tends to increase or enhance the resilience of women with physical disabilities in their access to reproductive health services.

Nonetheless, the findings showed emotional support to be negatively related to resilience in access to reproductive healthcare services among women with physical disabilities (coefficient = - 0.101, p = 0.001). This suggests that the increment or enhancement of emotional support decreases the resilience of women with physical disabilities in their access to reproductive healthcare services. These findings highlight the importance of prioritizing specific interventions for instrumental and informational social support networks in enhancing resilience to accessing reproductive health services among women with physical disabilities, while considering the potential impact of emotional support in finding a balance to build resilience.

The regression analysis also shows how different demographic factors influence the resilience of respondents to the challenges in accessing reproductive health services. Higher levels of education significantly increase resilience among women with physical disabilities in accessing reproductive health services. The coefficient of resilience for women with primary education is higher when compared with those with no level of education, with a coefficient = 0.215, p-value = 0.002. Those with JHS/Middle School education show higher resilience with a coefficient value of 0.255; $p < 0.001$. Those with secondary education show a higher increase in resilience than those without education, and the coefficient value is 0.309; $p < 0.001$. Hence, increasing levels of education lead to a significant increase in resilience for women with physical disabilities. The findings of the study align with existing research on the positive impact of education in accessing reproductive health services in Africa. Ogundele et al.'s (2020) studies in Ghana and Nigeria highlight the potential of education to improve access to reproductive health. The study specifically noted the importance of education in improving access to maternal health services (Ogundele et al., 2020). However, participants with tertiary education did not show a significant difference in resilience concerning access to reproductive

health services compared to those without education (p-value = 0.665). Although the finding may not be significant, there could be some potential explanation. The possible reason for this outcome could be that society believes that highly educated women with physical disabilities should be able to take care of themselves because of improved economic opportunities owing to the attainment of a higher level of education, which may facilitate access to healthcare services. However, despite their educational achievement, these women with physical disabilities are still faced with additional barriers of stigmatization in the labour market, health facilities, and society at large.

Religious affiliation also plays a role in resilience. As shown on the table, Muslim women are less resilient compared to those practicing traditional religions, with a B value of -0.218 (p=0.020). This finding suggests that being Muslim is associated with lower resilience in this context. In addition, there is no statistically significant difference for women with physical disabilities following the Christian faith compared to traditional (p-value = 0.307). The significant difference in access to reproductive health services between Islamic and traditional religions may be from cultural and religious norms surrounding reproductive health, which could influence resilience in healthcare-seeking behaviors and attitudes towards certain services.

From the data presented in the table, respondents with a monthly income above 500 cedis and 1000 cedis show lower levels of resilience compared to those with a monthly income of less than 200 cedis (coefficient = -0.051 and coefficient = -0.197, respectively, nonetheless, this is not statistically significant (p-value =0.091). Surprisingly, women earning between 200 to 500 cedis per month exhibit higher resilience compared to the reference category (coefficient = 0.105, p = 0.046). This finding suggests that women with physical disabilities in lower-income brackets are associated with greater resilience. The likely reason for this finding could be that women with physical disabilities who receive lower income might have stronger social support networks in their family or networks that could contribute to their resilience. This was

confirmed by a study by Orthner et al. (2004) that identified relational and social support as an asset for predicting positive outcomes for low-income families in building resilience. Furthermore, Berkman et al.'s (2000) work emphasizes the importance of these social relationships in determining health outcomes, suggesting that social support can mitigate the adverse effects of low income on well-being.

Occupation is another significant factor influencing the resilience of women with physical disabilities in accessing reproductive health services. Respondents who work as Casual workers have a significant negative coefficient (B =-0.498, $p<0.001$), suggesting that being in casual employment reduces resilience compared to those in civil or public service (reference category). Although not statistically significant, engaging in trade or business reduces resilience, with a B value of -0.214 ($p=0.056$). This finding implies that women employed in casual work or trade/business might face greater economic instability or lack of job security compared to those in civil/public service, which may contribute to disparities in resilience with regard to access to reproductive health services.

As shown in Table 8.2, being in any of the age groups compared to the reference category (18-24) is not significant. This means that age within these categories may not significantly influence respondents' resilience in accessing reproductive health services. Previous studies have indicated that factors including education, social support and socioeconomic status have a strong influence on access to reproductive health services rather than age (Bearinger et al., 2007).

Ethnicity, whether Ewe, Ga-Adangbe, or Akan, did not significantly impact resilience compared to other ethnicities. This may be a result of cultural differences in attitudes towards resilience in the face of challenges. Differences in socioeconomic status and levels of education among ethnic groups may also play a role in influencing access to healthcare services.

Marital status was not a predictor of resilience in the model. Cohabiting and divorced women with physical disabilities showed no significant impact on resilience compared to the married

in accessing reproductive health services. Although single women showed a positive relationship with resilience, it was not statistically significant. These variations in access to reproductive health services based on marital status suggest that factors other than marital status might be more influential in determining resilience concerning access to health services among women with physical disabilities.

Place of residence, whether urban or peri-urban, did not significantly affect resilience. The number of children did not significantly influence the resilience of women with physical disabilities in accessing reproductive health services (β = [coefficient = 0.004, p = 0.863). The lack of significance for the number of children shows that the size of the family does not impact on access to reproductive health services. As indicated by Conger and Donnellan (2007), strong support networks and resources can mitigate the effects and economic stress of a larger family size.

8.4 Qualitative Findings

8.4.1 Role of Social Support in Building Resilience to Access to Reproductive Health Services

The role of the various forms of social support in building resilience to the challenges of accessing reproductive health services among women with physical disabilities was explored. Mothers with physical disabilities highlighted the significance of emotional, financial, familial, and community support in overcoming challenges and successfully going through the reproductive health journey. Respondents provided insights into the support systems that were adopted through the challenging circumstances they encountered. Social support helped them to pay for medical bills, transportation and acquire economic skills and took care of their babies. On the other hand, some of the respondents explained how social support worsened their challenges to access reproductive health services. The nature and sustainability of the social support system in building resilience are highlighted in this section. Therefore, this section

seeks to explore how social support played a role in solving or helping women overcome the challenges that pregnant and postpartum physically disabled women face.

8.4.1.1 Emotional Support

Emotional support emerged as one of the forms of support identified by respondents. The encouragement, prayers, and courage provided by family members, particularly mothers, played a key role in enabling these women with physical disabilities to access reproductive health care. For instance, a 38-year-old physically challenged woman highlights how her mother's emotional support gave her the courage to visit the hospital alone during a challenging pregnancy.

Because of what people will say, I was feeling shy to go to the hospital at the beginning of my pregnancy. But my 75-year-old mother gave me the courage to go to the hospital for the first time. She will go with me every time I go to the hospital. Without her, I don't think I would have had the courage to do so. (C3; 38 year old mother; La)

In another instance, a mother said:

Yes, my mum supported me in caring for my baby when we went home. She was even the one who reminded me of my date for my six weeks check-up (C6; 39-year-old mother; Korle Gonno)

While other women with physical disabilities received emotional support from their mothers, other women with physical disabilities experienced instability and conflicts in their support systems over time. To know the availability and sustainability of emotional support, respondents were asked whether these forms of support were consistent and sustainable. A 32-year-old mother said:

No because, my mum came to take care of me and my child briefly, and she went back to the village. She asked me to contact the family of my supposed husband to help me because she was busy caring for my sick father in the village (C7; 32-year-old mother; La)

Another mother experienced a similar fluid system of social support:

I was fighting my mother any time that I needed her to help me and the baby. My mother was not helping me with bathing my baby or doing anything for me. Hmmm.. she only comes in to support me when there is money for her, otherwise, I will have to do the things myself or find someone else to help me. I was begging people to help me care for my baby after delivery. (C9; 40-year-old mother; La)

This highlights the need for a consistent and understanding network of emotional support that adapts to the evolving needs and challenges faced by these mothers.

8.4.2 Instrumental Support

8.4.2.1 Financial Support

Financial support is another key component that influences the ability of women with physical disabilities to access reproductive health services. Some women with physical disabilities indicated that financial assistance from family members, particularly parents and partners, is crucial in paying for antenatal care and medical procedures. Some mothers mentioned that financial support from their parents enabled them to afford routine antenatal care and contributions from their partner. A mother who received financial support from her parents narrated that:

The money I received from my parents enabled me to go for all my antenatal visits. I don't get so worried…. Yes, my parents have been very helpful in making sure that I get what I need every month. (C11; 40-year-old mother; Ashiaman)

Another mother who out of the father's benevolence worked to secure money for daily expenses commented that:

My father gave me his washing bay to manage and this helped me earn some income on my own to cater for myself and baby (C13; 23-year-old mother; Ashiaman)

Additionally, a respondent indicated a supportive partner in helping her face the challenges during pregnancy and motherhood. The following interview excerpt illustrates this:

The support and love I have from my husband eased most of my challenges as a pregnant woman and mother. He virtually took care of my hospital bills, and transportation, and supported my mother when she came over to help me. I must say I am one of the most fortunate ones to have him as a partner. (C14; 30 year old mother: Chorkor)

8.4.3 Physical Support

Physical assistance, including attending to daily living, safety and transportation, play a critical role in ensuring access to reproductive health. Respondents narrated that family members, particularly spouses, siblings, and friends, often step in to provide practical help. This assistance helped mothers deal with challenges in hospitals, caring for their children and aiding in post-delivery check-ups.

The extracts below underscore the role of a supportive family and community that recognizes the physical limitations of these mothers, thereby facilitating their access to essential healthcare services.

My friend helped me in so many ways. She will come home and pick me up to the hospital. I don't think I would have been able to go there alone. (C16; 35-year-old mother; Ashiaman)

I don't think I would have been able to walk all through that bush road to the hospital for Antenatal sessions if my husband was not around. This helped me. (C15; 33-year-old mother; Ashiaman)

8.5 Suggestions on Improving Support of Respondents to Enhance their Resilience in Accessing Reproductive Health Services

Respondents provided their perspectives on how they can be supported. They highlighted issues of accessibility, autonomy, and empowerment in improving their resilience in access to reproductive health.

A mother stressed the importance of accessible infrastructure and environment in assisting their movement and reducing their reliance on others for help.

I believe that people should be made aware of the support that we need as women who are physically challenged. Sometimes you see people want to help, and it sometimes makes you feel like you couldn't do things by yourself. This is all because the houses we live in, the cars we sit in, and our roads make us look like need people around us to help. So, I think the government should put people in charge to make sure that buildings, cars and the environment make it easy for us to move with no assistance. It becomes so worrying when you are pregnant and can't even turn your leg around in a car (C20; 30-year-old mother; Kpone).

The above result is consistent with the cited literature, which highlights the crucial need for inclusive design and accessible environments for persons with disabilities (Imrie, 2012). It was noted that the physical environment was vital for PWDs and had a significant impact on their level of participation in various life aspects (Imrie & Luck, 2014). Therefore, policy reforms and interventions to improve accessibility can reduce the identified problem of PWD obstetric care experiences.

Other mothers also indicated the need to improve the nature of social support. In the process of providing social support, some mothers recommended the need for health workers to consider their preferences and capabilities regarding childbirth and their health in addressing the challenge of undermining their capabilities out of fear of keeping them safe. For instance, it was emotionally draining when some women with physical disabilities reported being scheduled for cesarean section for fear of not being able to deliver by themselves because of their condition. Below are some of their experiences:

Health workers should also be made aware that we can deliver on our own and allow us to do so. I know the doctors think of protecting us by recommending that we deliver through C-S. But I think it is the fear of losing us and the baby that makes them think this way which makes things harder instead of easier for us. Before I gave birth to this baby, my mother and doctor were afraid of my condition. They were so worried about my safety and the baby's, so my mother agreed to the recommended cesarean section even though I wanted to give birth the natural

way. I was always thinking about it. I felt like I wasn't trusted to do what other women could do simply because of my physical condition. I think we should be allowed to do things, instead of assuming we can't because of our physical condition (C10; 35-year-old mother; Ashaiman).

Well, while I know health workers support us, I think it is good for them to see us as part of deciding about our health. Instead of assuming what they think we can and cannot do based on what they have heard. This sometimes makes me feel you are looking down on me. (C18; 42-year-old mother; Ashaiman).

These findings align with patient preferences and shared decision-making in a maternity care study which emphasizes that this process reduces unnecessary procedures and interventions (Gee & Corry, 2012). Thus, while attempting to protect women with physical disabilities through cesarean sections, collaborative conversations should be conducted with them to appreciate their choices and provide support that suits their unique situation.

Other respondents highlighted the need to train healthcare providers on education on disability awareness and respectful communication.

I think health workers need to be educated on our challenges so they can understand our condition. They should know how to talk nicely to us so we can have the motivation to visit the hospital when we get pregnant. (C3; 38-year-old mother; La).

Other respondents also recommended the need to revise guidelines to give preferential treatment to women with disabilities during maternity care.

We should be helped when we get to the hospital because we are not strong like other people who can walk normally. There should be a rule that will allow us not to join the queue when we visit the hospital (C6, 39-year old mother; Korle Gonno).

Improving healthcare practices involves understanding the abilities of women with physical disabilities to manage their health and well-being (Shakespeare, 2017). Through the promotion

of respectful interactions, healthcare providers can build supportive environments that encourage the autonomy and dignity of all persons including those with disabilities.

In addition, respondents indicated the importance of various support systems including familial, association and government to help increase disability awareness, education, and counseling to address the unique challenges faced by women with physical disabilities during pregnancy and childbirth.

I think families should be made aware that we also have the same need to have children except that our condition will require their support (C9; 40 year-old mother; La).

I think we should be given some form of counseling when we get pregnant because we go through a lot of problems (C16; 35-year-old mother; Ashaiman).

The government should support us through the Disability Association to be able to take care of ourselves from pregnancy to delivery (C4; 45-year-old mother; Korle Bu).

The findings above underscore the importance of integrated support systems in promoting the health and rights of physically challenged people (Morris et al., 2011). Through the integration of medical, social, and advocacy services, such support systems may help pregnant women with challenges cope with the challenging journey of pregnancy, and delivering their babies.

In summary, the narratives of women with physical disabilities show that it is important that policies enacted address structural barriers, promote autonomy in decision-making, and promote all-inclusive support systems towards achieving equity in delivering reproductive health services for all individuals, regardless of their physical challenges.

8.6 Discussion on Social Support and Resilience

The study sought to find out the role of social support in building resilience. Both quantitative and qualitative data were gathered to answer this objective. Findings revealed a positive

relationship between instrumental supports with resilience among women with physical disabilities accessing reproductive health services. This finding aligns with the Social Support Theory, which explains that assistance such as financial and logistical support directly enhances these women's ability to cope with and adapt to the challenges that they encounter in accessing reproductive health services, as illustrated in the conceptual framework.

This was confirmed in the in-depth interview where women with physical disabilities indicated the importance of practical assistance and access to relevant information they received from family and healthcare providers. Most respondents indicated that most of their mothers catered for their hospital bills, baby clothes, and domestic work. Resilience is assured through practical services support as financial and transportation assistance and medical visits serve as protective factors which builds their capacity to adapt to the challenges of accessing reproductive health services as articulated by the Resilience Theory.

Likewise, the provision of information (informational support) empowers individuals with the necessary knowledge on how to function within healthcare systems so that they can pursue their needs. This was shown in both regression and correlation analysis that informational support had a significant positive relationship with resilience among women with physical disabilities accessing reproductive health services. However, during the in-depth interviews, narrations by the women with physical disabilities in the study showed that they lacked access to timely and relevant information about their healthcare needs, predominantly concerning procedures like Cesarean sections. This lack of early communication affected the birth preparedness of these mothers and also excluded them in the decision-making. These findings underscore the need for improved patient-provider dialogue and informed consent processes. Studies have shown that positive social support of high quality can enhance resilience (Ozbay et al., 2007).

In both the correlation and regression analyses, emotional support emerged as a complex factor, showing a negative relationship with resilience. This finding was both contrasted and confirmed by the narratives from respondents during the in-depth interview, where emotional support was

sometimes seen as a source of strength and also had adverse effects. These were exemplified by a mother who shared how her husband's encouragement keeps her going, especially during challenging times. The study participants' accounts of positive experiences highlighted the significance of emotional support in improved psychological well-being, as evidenced by previous studies (Bos et al., 2013; Tugade & Fredrickson, 2004).

Others also narrated that emotional social support did not help build their resilience in this study, and worked against enabling some of the women with physical disabilities to be equal to other abled women. For instance, the guidance provided by healthcare workers was emotionally draining when some women with physical disabilities reported being scheduled for cesarean section because the reason of not being able to deliver by themselves because of their pelvic condition. Some mothers recalled occasions when doctors did not want them to have a natural birth, fearing for their safety and that of their babies, to protect them but rather made them feel incapable or unable to do things on their own. The effect of this guidance support was found not to enhance resilience in this study and worked against enabling some women with physical disabilities to exhibit their capability of having a natural birth.

Typically, emotional support forms part of a critical aspect of resiliency (Masten, 2001); but this study indicates that emotional consolation without addressing the practical needs of women with physical disabilities may undermine their resilient capacity. This finding challenges the assumptions of social support theory by demonstrating that emotional support, when delivered in a disempowering manner, may function as a limiting factor in building resilience. This implies that the quality of support is key to boosting resilience, as shown in a study by Migerode et al. (2012). This study found that the quality of social support plays a key role in boosting resilience since it mediates the impact of a child's disability on parents' quality of life.

It is important to note that respondents' positive and negative emotional experiences are shaped by their social environment as observed with the Socio-Ecological Model, which emphasizes that individual resilience is influenced by interactions across interpersonal (family and

partners), institutional (healthcare system), and societal levels. This aligns with de Jong et al.'s (2012) study, highlighting the significant impact of the surrounding context on individual experiences.

8.7 Summary of the Chapter

The study found that instrumental and informational support positively influence resilience among women with physical disabilities, aiding in overcoming barriers like transportation and financial burdens. Emotional support, however, had a complex impact on resilience. Higher education levels (primary, middle school, secondary) increased resilience, while tertiary education did not. Muslim women had lower resilience compared to those practicing traditional religions. Lower income brackets were associated with higher resilience. Casual work and trade/business negatively impacted resilience, while civil/public service had a positive influence. Factors like age, ethnicity, marital status, residence, and number of children did not significantly predict resilience. Overall, social support, education, religious affiliation, income, and occupation played crucial roles in predicting resilience in accessing reproductive health services for respondents.

CHAPTER NINE

SUMMARY, CONCLUSION & RECOMMENDATIONS

9.1 Summary of Findings

Effective intervention strategies for improving access to reproductive healthcare services for women with physical disabilities require empirical data. While existing studies have explored challenges with access to sexual and reproductive health services for women with physical disabilities in developing countries, research on social support and resilience remains limited. The main objective of this study was to investigate the social support and resilience factors that influence women with physical disabilities' access to reproductive health services. Firstly, the study aimed to examine the challenges faced by women with physical disabilities in their quest to access reproductive health services. Second, identify the available social support systems for women with physical disabilities to access reproductive health services. Third, identify the factors affecting the resilience of women with physical disabilities regarding the challenges they face accessing reproductive healthcare services. Fourth, examine the role of social support in strengthening the resilience of women with physical disabilities to the challenges in accessing and using reproductive health services.

The social support theory, resilience theory, social model on disability, health belief model, and socio-ecological model were used to explain social support and resilience of women with physical disabilities in access to reproductive healthcare services. This study contributes knowledge by providing empirical evidence on the challenges, social support, and resilience-related issues within the scope of reproductive health accessibility for women with physical disabilities. The study was informed by the need for objective insight, and thus employed a mixed methods design, consisting of quantitative and qualitative approaches to answer the research questions. Univariate, Bivariate and Regression analyses were used for the quantitative data. Qualitative data were analyzed using a thematic approach. The summary of the findings,

conclusions and recommendations for policy and future studies is in the ensuing sections of this chapter.

9.1.1 Socio-demographic Characteristics of the Study Participants

Quantitative data were collected by administering a survey questionnaire to 203 women with physical disabilities between the ages of 18 to 45 years in Ashiaman, Korle-Gonno, Korle-Bu, La, Chorkor and Kpone. A significant number of the study participants had access to formal education while less than a third of respondents (26.6 %) had no formal education. The results indicate that more than half of the respondents had completed JHS/Middle school, while less than 10% (7.8%) of the study participants have attained tertiary education. The main ethnic groups involved in the study were Ga-Adangbe, Akan and Ewe, with 8.3% representing other ethnic groups such as Mamprusi.

A significant number of respondents identified as Christian (73.4%). The results also showed that many of the women with physical disabilities (72.4%) are single, while approximately 15% are divorced and 5.4% are married. Additionally, 43.8% of these women had given birth to at least two children in their lifetime. The results show that more than half (54%) of the study participants reside in the peri-urban area. Economically, respondents were involved in trading or business, civil/public service or casual labour. However, their earnings were generally low with the majority earning below 1000 Ghana cedis per month.

9.1.2 Challenges in Access to Reproductive Healthcare Services

Despite the availability of reproductive healthcare services, there are challenges in accessing reproductive healthcare services. Challenges encountered by women with physical disabilities in this study included economic, emotional, attitudinal, institutional and physical barriers. Being guided by the Socio-ecological theory, understanding the challenges in access to reproductive healthcare services are reflection of individual, institutional and community-related issues. Participants identified economic barriers as a primary obstacle to accessing

reproductive health services. The issue of financial problems has been noted in various studies from the narratives of PWDs (Ahumuza et al., 2024; Clementel et al., 2022; Rugoho & Maphosa, 2017).

Regarding emotional and attitudinal barriers, participants reported issues of abuse, stigma and discrimination, neglect and partner rejection. The emergence of emotional and attitudinal related issues towards PWDs in access to reproductive health services has been found in other studies (Becker et al., 1997; Albert & Hurst, 2004; Nosek et al., 1995; Ahumuza et al., 2014). Such a situation leads to a sense of fear and the need to always get all requests from the service providers fulfilled to avoid abuse. To avoid the abuses and negative attitudes from healthcare providers, and due to financial difficulties, participants sometimes avoid clinic appointments.

Participants identified physical barriers such as a lack of disability-friendly infrastructure, distance to health facilities, and lack of appropriate transportation as significant challenges in accessing reproductive healthcare services. The study results revealed that the built environment, in terms of the infrastructure, is not always disability friendly. In addition, the study revealed institutional barriers such as long waiting hours and fragmented services.

In a nutshell, both the quantitative and qualitative findings affirm the existence of barriers that continue to confront women with physical disabilities in accessing reproductive health services in Ghana.

9.1.3 Social Support for Women with physical disabilities Accessing Reproductive Health Services

The study result revealed that women with respondents received various forms of social support. The types of social support were instrumental, emotional, and informational. The most reported form of social support received by respondents was informational and the least reported form of support was instrumental support. This finding reflects the challenges

indicated by respondents, which shows economic barriers as the most common challenge and informational barriers as the least faced obstacle by women.

Respondents' sources of social support were friends, parents/relatives, health professionals, religious leaders, husbands or partners, and peers/association members. However, the main source of all three types of social support (instrumental, informational and emotional) originates from parents. Despite complaints about the provision of social support from parents, women with physical disabilities continue to rely on their parents due to their vulnerability. The findings of the qualitative and quantitative study validate the importance of social support to women with physical disabilities in accessing reproductive healthcare services.

9.1.4 Resilience & Social Support of Women with Physical Disabilities in Access to Reproductive Healthcare Services

Regarding objective 3, which sought to examine factors affecting the resilience of women with physical disabilities in accessing reproductive healthcare services, one-way ANOVA and regression models were conducted. For the one-way ANOVA results, several demographic factors emerged as influencing the resilience of women with physical disabilities in their quest to access reproductive health services. It was discovered that age was a significant factor in influencing resilience, where respondents within the age group of 30-34 years exhibited the highest resilience level, while those between the ages of 20-24 showed the lowest resilience level. Education emerged as a significant determinant of resilience, with higher education levels associated with higher resilience scores. In particular, respondents with no formal education had significantly lower resilience compared to women in the Junior High School/Middle School, Secondary and Tertiary education categories. In addition, occupation and income were other notable factors influencing resilience, with stable occupations (Civil/Public servant and Trade/business) and high income being associated with greater resilience. Women in civil or public service and trade or business specifically had higher resilience than those in casual work.

In this context, respondents with financial stability and job security tend to show greater resilience in overcoming the challenges in accessing reproductive health services. Moreover, marital status played a role, where single women with physical disabilities significantly exhibited higher resilience compared to those who are divorced, cohabiting or married. Meanwhile, factors such as religious affiliation, ethnicity, place of residence, and the number of children did not significantly impact the resilience of women with physical disabilities.

Generally, demographic factors such as age, education, occupation, income, and marital status significantly influence resilience levels. Others such as religious affiliation, ethnicity, number of children, and place of residence, did not show significant associations.

The linear regression analysis aimed to provide insight into the complex relationship between socio-demographic factors, social support and resilience in accessing reproductive health care among women with physical disabilities. Education emerged as a key predictor of resilience, where primary education, JHS/Middle School or secondary education showed a positive impact with higher resilience. Contrarily, tertiary education did not influence resilience significantly. In addition, religious affiliation is observed to influence resilience, such that the Islamic faith exhibited reduced resilience compared to traditional religion. Occupations such as casual work and trade/business are associated with significantly lower access to reproductive health services compared to civil/public servants. Interestingly, income in the range of 200-500 cedis slightly improves access, whereas higher income levels do not have a significant effect. Other factors, including age, marital status, ethnicity, place of residence, and the number of children, did not significantly influence the resilience of respondents in accessing reproductive health services in the study. Largely, findings from both analyses underscore the significance of education and stable employment in enhancing access to reproductive health services.

Additionally, the qualitative result showed that women with physical disabilities had developed various strategies to enhance their resilience in accessing reproductive healthcare services. The

strategies were represented under six main themes including problem-solving skills, self-determination, self-advocacy, desire for motherhood, sense of gratitude and religious practices. The final objective sought to identify the role of social support in strengthening resilience, using results from linear regression models, correlations and in-depth interviews. Instrumental and informational support positively impacted the resilience of respondents. Women with physical disabilities narrated the importance of social support from family, neighbors, associations and health professionals in reducing the financial burden and empowering them to access reproductive health services. Nonetheless, respondents lacked timely and relevant information on medical procedures on their reproductive health, which affected their birth preparedness and excluded them from decision-making processes.

The findings on instrumental and informational support were in line with what other studies have found concerning social support and resilience (Schultz et al., 2021; Park et al., 2020; Liang et al., 2014; Cutrona & Russell, 1990). However, the findings of this study present a different view from existing literature, as emotional support appears to have a negative association with resilience or does not enhance resilience among women with physical disabilities in accessing reproductive health services. A contrast to the commonly accepted view that emotional support generally contributes to resilience (Park et al., 2020; Cutrona & Russell, 1990). Surprisingly, emotional support impacted negatively in both the regression and correlation analysis in this study.

One of the explanations for the negative impact of emotional support and resilience could be the unique vulnerability of women with physical disabilities. Respondents may face numerous challenges, including difficulty in accessing healthcare, stigma, and economic hardships which may explain their vulnerability, leading them to receive higher levels of emotional support from their social networks. In such circumstances, emotional support might provide comfort but may not address their key challenges to be able to access reproductive health services. This situation underlines the limitations of emotional support when it is not coupled with the resources needed

to overcome systemic and institutional barriers. Without addressing this practical support such as providing appropriate transportation to clinics, funds to pay for medical bills and ensuring accessible facilities, emotional support alone may have limited help in contributing to resilience.

Another possible explanation, perhaps, is that the emotional support provided is perceived negatively as pity by respondents. It is sometimes possible that when emotional support is offered to them, it reinforces a sense of not being capable or dependent, further eroding their resilience, as some mothers narrated in their experience with the Cesarean section. This means that emotional support, when not communicated appropriately, may send the message that the women are weak and cannot do anything for themselves and that emotional support devalues the women's self-worth. These findings can be explained with the Socio-Ecological Model (SEM), which acknowledges that resilience is formed by multiple levels of influence, including individual, interpersonal, institutional, and societal factors. Emotional support operates mainly at the interpersonal level, whereas resilience in this context may be more influenced by structural factors at the institutional level.

9.2 Conclusion

This study set out to investigate the challenges, social support and resilience of women with physical disabilities in accessing reproductive health services in the Greater Accra Region. In line with previous studies, this study revealed that women with physical disabilities continue to face significant challenges, including economic, emotional, attitudinal, institutional, and physical barriers to accessing reproductive health services. These challenges clearly exist on multiple levels, as indicated in the Socio-Ecological Model. Individual constraints, like income and education, interpersonal factors including stigma, discrimination, and partner rejection and institutional barriers, such as long waiting times, fragmented services, and inaccessible infrastructure, collectively influence the resilience of women with physical abilities in accessing reproductive health services.

Both quantitative and qualitative methods were used to elicit information on how social support and other factors impact the resilience of women with physical disabilities to the challenges of accessing reproductive health services. The analysis showed that education was a significant predictor of resilience, with respondents with formal education exhibiting greater resilience than those with no formal education. The type of employment was also a significant factor; women with physical disabilities working in the trade or business sector, or in the public or civil service, showed higher resilience than casual workers. These results imply that gaining education and stable employment are essential for building resilience, a finding consistent with resilience theory, which highlights the importance of protective socio-economic resources in helping these women adapt to the challenges in accessing reproductive health services.

Interestingly, resilience was not significantly impacted by age, marital status, ethnicity, and place of residence, the number of children and higher income levels in the regression analysis, demonstrating their limited impact when other factors are controlled, even though they were significant in the ANOVA. Interestingly, women with physical disabilities of the Islamic faith had lower resilience compared to those of traditional faith, suggesting that resilience may be impacted differentially by religious or cultural circumstances.

The study emphasized the positive impact of informational and instrumental support in strengthening the resilience of women with physical disabilities when it comes to obtaining reproductive health services, whereas emotional support did not significantly enhance their resilience. This finding indicates the need for a more holistic approach to providing emotional support, ensuring that it does not affect these women's capacity to overcome any barrier in accessing reproductive health services.

The overall study indicates the importance of education, stable employment and social support (instrumental and informational) in building resilience among women with physical disabilities. Nonetheless, emotional support requires practical interventions to avoid negative impacts on the resilience of women with physical disabilities. These conclusions support the study's

framework, demonstrating that resilience in accessing reproductive healthcare emerges from the interaction of personal abilities, interpersonal relationships, and institutional conditions, as conceptualized within the Socio-Ecological Model, Social Support Theory, and Resilience Theory.

9.3 Recommendations

9.3.1 Recommendation for Policy and Practice

The following recommendations are made from the study's findings and conclusions. First, the study's results showed that several women with physical disabilities continue to face infrastructural challenges in accessing reproductive healthcare services. These findings underscore the need for the Disability Act to be adhered to, especially in making all health facilities accessible to persons with disability. The study recommends the need for the Ghana Health Service to audit and retrofit facilities per the Ghana Disability Act 2006 (Act 715), by adding ramps, elevators, wide doorways, and accessible restrooms, and ensuring new constructions comply with the Act's requirements.

Most women with physical disabilities reported high counts of abuse, discrimination and other forms of human rights violations. The findings further buttress the need for the Ghana Health Service to address the significant challenges that prevent the achievement of inclusive reproductive healthcare services. Therefore, the study recommends that the Ministry of Health (MOH) and Ghana Health Service (GHS) strengthen existing complaints and establish counseling units within health facilities to address concerns and reprimand deviant healthcare service providers. This could include ensuring that they are equipped with adequate resources and empowered to achieve their objectives. Additionally, there should be sensitivity training as well as the development of a Standard Operating Procedure (SOP) for healthcare providers to offer inclusive, non-discriminatory care, thereby making the reproductive health policy more

effective in practice. This SOP would help provide appropriate and uniform service delivery across the health facilities in the country.

The findings also highlight the need for more targeted interventions within the Reproductive Health Policy. This suggests that the MOH and GHS, in collaboration with the Ghana Federation of Disability Organizations, should integrate patient-centered care models into the national reproductive health policies and guidelines with specific consideration for the needs of women with disabilities, including women with physical disabilities. The implementation of this will promote a stronger sense of autonomy. In addition, reproductive health-based intervention in-service training modules on supportive and empowering content for women with disabilities should be developed to enhance health providers' communication skills and sensitivity towards PWDs. Moreover, advocacy tools and educational materials that address the unique reproductive health needs of women with disabilities should be developed and disseminated.

Since parents (mostly mothers of respondents) were the main source of support, it is recommended that the Ministry of Health, Ghana Health Service, and NGOs collaborate to provide caregiver support services, including counseling, and offer financial aid for women with physical disabilities. This would empower and improve access to reproductive health services for these women.

Recognizing the positive impact of informational and instrumental support on resilience, the Ghana Federation of Disability Organizations and other non-governmental organizations' efforts should focus on strengthening social support networks for these women. This could involve peer mentoring programs through their association, and partnerships with other health organizations to provide practical assistance and guidance on reproductive health services.

Lastly, findings on emotional support highlight the need for stakeholders including healthcare policymakers, service providers and advocacy groups, to prioritize integrated support systems

that combine instrumental, information and emotional support interventions in improving the resilience of women with physical disabilities accessing reproductive health services.

9.3.2 Recommendations for Future Research

As the findings revealed the impact of emotional and informational support on resilience, for future studies, the study recommends the exploration of the perspectives of health professionals in the provision of social support services for women with physical disabilities to inform interventions and strategies of reproductive health service delivery for women with physical disabilities. In addition, future research should explore other contextual, psychological, and interpersonal factors that reduce the impact of emotional support to develop and implement specific measures that help make a positive impact in different cultural and social settings. Additional longitudinal research on emotional support may help provide an understanding of the emotional support and lack of resilience results. The study also suggests a comparative analysis between rural and urban populations with physical challenges to provide different perspectives on the influence and roles of social support and resilience within varied community settings.

Given the influence of religion in this study, examining ways in which religious and cultural backgrounds affect women with physical disabilities' ability to access reproductive health services and how these variables can be used to improve support structures. Furthermore, the study recommends an exploration of partner neglect of women with physical disabilities in access to reproductive healthcare services.

REFERENCE

Acheampong, A. K., & Aziato, L. (2018). Suicidal ideations and coping strategies of mothers living with physical disabilities: A qualitative exploratory study in Ghana. BMC Psychiatry, 18(1), 1–8. https://doi.org/10.1186/s12888-018-1938-x

Acheampong, A. K., Aziato, L., Marfo, M., & Amevor, P. (2020). Breastfeeding and caring for children: A qualitative exploration of the experiences of mothers with physical impairments in Ghana. *BMC Pregnancy and Childbirth, 20*(1), 1–10. https://doi.org/10.1186/s12884-020-03028-1

ACT, D. (2006). Persons With Disability Act, 2006 Act 715. *ACT 715*, 17.

Aguillard, K., Hughes, R., Gemeinhardt, G. L., Schick, V., & McCurdy, S. (2022). "They Didn't Ask." Rural women with disabilities and experiences of violence describe interactions with the healthcare system. *Qualitative health research*, *32*(4), 656-669.

Ahumuza, S. E., Matovu, J. K. B., Ddamulira, J. B., & Muhanguzi, F. K. (2014). Challenges in accessing sexual and reproductive health services by people with physical disabilities in Kampala, Uganda. Reproductive Health, 11, 59. https://doi.org/10.1186/1742-4755-11-59

Ahumuza, S. E., et al. (2024). Economic vulnerabilities and healthcare access among persons with disabilities during the post-pandemic recovery. *African Journal of Disability*, *13*, 114–125. doi.org

Akasreku, B. D., Habib, H., & Ankomah, A. (2018). Pregnancy in disability: Community perceptions and personal experiences in a rural setting in Ghana. *Journal of Pregnancy, 2018*. https://doi.org/10.1155/2018/8096839

Albert, B., & Hurst, R. (2004). *Disability and a human rights approach to development*. Disability Knowledge and Research (KAW).

Amjadi, M. A., Simbar, M., Hosseini, S. A., & Zayeri, F. (2017). The sexual health needs of women with spinal cord injury: A qualitative study. *Sexuality and Disability, 35*(3), 313–330. https://doi.org/10.1007/s11195-017-9495-7

Apolot, R. R., Tetui, M., Ekirapa-Kiracho, E., Arinaitwe, J., Akulume, M., Namutamba, S., & Kiwanuka, S. N. (2019). Maternal and newborn health needs for women with walking disabilities; "the twists and turns": A case study in Kibuku District Uganda. *International Journal for Equity in Health*, *18*(1), Article 43. doi.org

Amzel, A., Toska, E., Lovich, R., Widyono, M., Patel, T., Foti, C., Dziuban, E. J., Phelps, B. R.,Sugandhi, N., Mark, D., Altschuler, J., & The Child Survival Working Group of the interagency Task Team on the Prevention and Treatment of HIV-infection in Pregnant Women, Mothers, and Children. (2013). Promoting a combination approach to paediatric. *Education Policy Analysis Archives* Vol. 30 No. 152.

Anderson, M., Elliott, E. J., & Zurynski, Y. A. (2013). Australian families living with rare disease: experiences of diagnosis, health services use and needs for psychosocial support. *Orphanet Journal of Rare Diseases*, 8(22)1-9. https://doi.org/10.1186/1750-1172-8-22

Anderson, L. L., Mapel Lentz, S., & Larson, S. A. (2018). Physical disability and health disparities. In *Advances in exercise and health for people with mobility limitations* (pp. 41-59). Cham: Springer International Publishing.

Anderson, K. M., Renner, L. M., & Danis, F. S. (2012). Recovery: Resilience and growth in the aftermath of domestic violence. *Violence Against Women*, *18*(11), 1279–1299. doi.org

Asante-Afari, K., Doku, D. T., & Darteh, E. K. M. (2022). Transition to motherhood following the use of assisted reproductive technologies: Experiences of women in Ghana. *PloS one*, *17*(4), e0266721. https://doi.org/10.1371/journal.pone.0266721

Asante-Afari, K., Nantomah, B., Yendaw, E., & Borbor, F. M. (2023). Going through treatment: experiences of women who sought assisted reproductive technology treatment in five selected hospitals in Ghana. *Culture, Health & Sexuality*, *26*(3), 421-432.

Asuman, D., Ackah, C.G& Agire-Tettey, F. (2020). Disability and Household Welfare in Ghana: Costs and Correlates. J Fam Econ Iss 42, 633-649(2021). https://doi.org/10.1007/s10834-020-09741-5

Babbie, E. (2007). *The practice of social research* (11th ed.). Wadsworth.

Babbie, E. (2008). *The basics of social research* (4th ed.). Wadsworth Cengage Learning.

Barthélémy, T.-U., & Yves, S. T. (2013). Reproductive health needs of physical handicapped females in Kinshasa, DR Congo. *Open Journal of Obstetrics and Gynecology, 03*(01), 180 183. https://doi.org/10.4236/ojog.2013.31a033

Bearinger, L. H., Sieving, R. E., Ferguson, J., & Sharma, V. (2007). Global perspectives on the sexual and reproductive health of adolescents: Patterns, prevention, and potential. The Lancet, 369 (9568), 1220-1231. https://doi.org/10.1016/S0140-6736(07)60367-5

Becker, N., Thomsen, A. B., Olsen, A. K., Sjøgren, P., Bech, P., & Eriksen, J. (1997). Pain epidemiology and health related quality of life in chronic non-malignant pain patients referred to a Danish multidisciplinary pain center. *Pain*, *73*(3), 393-400.

Becker, M. H. (1974). *The health belief model and personal health behavior.* Health Education Monographs, 2(4), 324–508. https://doi.org/10.1177/109019817400200405

Berkman, L. F., Glass, T., Brissette, I., & Seeman, T. E. (2000). *From social integration to health: Durkheim in the new millennium.* Social Science & Medicine, 51(6), 843–857. https://doi.org/10.1016/S0277-9536(00)00065-4 (sciencedirect.com

Beyene, G. A., Munea, A. M., & Fekadu, G. A. (2019). Modern contraceptive use and associated factors among women with disabilities in Gondar City, Amhara Region, north west Ethiopia: a cross sectional study. *African journal of reproductive health*, *23*(2), 101-109.

Biel, F. M., Marshall, N. E., & Snowden, J. M. (2017). Maternal body mass index and regional anaesthesia use at term: prevalence and complications. *Paediatric and perinatal epidemiology*, *31*(6), 495-505.

Blair, A., Cao, J., Wilson, A. & Homer, C. (2022). Access to, and experiences of, maternity care for women with physical disabilities: A scoping review. *Midwifery, 107.*

Boezaart, C. (2012). A constitutional perspective on the rights of children with disabilities in an educational context. *July*, 300–302.

Bos, A. E. R., Pryor, J. B., Reeder, G. D., & Stutterheim, S. E. (2013). *Stigma: Advances in theory and research.* Basic and Applied Social Psychology, 35(1), 1–9. https://doi.org/10.1080/01973533.2012.746147

Bremer, K., Cockburn, L., & Ruth, A. (2010). Reproductive health experiences among women with physical disabilities in the Northwest Region of Cameroon. *International Journal of Gynecology & Obstetrics*, *108*(3), 211–213. doi.org

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA:

Burke, E., Kébé, F., Flink, I., van Reeuwijk, M., & le May, A. (2017). A qualitative study to explore the barriers and enablers for young people with disabilities to access sexual and reproductive health services in Senegal. *Reproductive Health Matters, 25*(50), 43–54. https://doi.org/10.1080/09688080.2017.1329607

Byrnes, L., & Hickey, M. (2016). Perinatal care for women with disabilities: clinical considerations. *The Journal for Nurse Practitioners*, *12*(8), 503-509.

Chanzanagh, E. H., Piri, A., & Garjan, A. E. (2012). The disabled and their everyday life experiences in Iranian culture. *International Journal of Social Sciences and Humanity Studies, 4(1), 175-184.*

Chen, Y., Hicks, A., & While, A. E. (2014). Loneliness and social support of older people in China: a systematic literature review. *Health & social care in the community*, *22*(2), 113-123.

Cheshire, L. (2018). Disability Data Review: A collation and analysis of disability data from 40 countries. *Leonard Cheshire, UK https://www. disabilitydataportal. com/fileadmin/uploads/lcdp/Documents/report-web_version. pdf*.

Chikumbu, M. (2014). Challenges faced by disabled youth in sexual relationships. *unpublished thesis, Connect, Zimbabwe*

Chernomes, W. M. (2014). Social support. In J. J. Fitzpatrick & G. McCarthy (Eds.), Theories guiding nursing research and practice: Making nursing knowledge development explicit (pp. 85–101). Springer Publishing Company. https://psycnet.apa.org/record/2014-24759-006

Clemente, K. A. P., Silva, S. V. D., Vieira, G. I., Bortoli, M. C. D., Toma, T. S., Ramos, V. D., & Brito, C. M. M. D. (2022). Barriers to the access of people with disabilities to health services: a scoping review. *Revista de Saúde Pública*, *56*, 64.

Conger, R. D., & Donnellan, M. B. (2007). An interactionist perspective on the socioeconomic context of human development. *Annual Review of Psychology, 58, 175-199.* https://doi.org/10.1146/annurev.psych.58.110405.085551

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). SAGE Publications.

Creswell, J. W., & Plano Clark, V. L. (2011). *Designing and conducting mixed methods research* (2nd ed.). SAGE Publications.

Cullen, F. T. (1994). Social support as an organizing concept for criminology: Presidential address to the Academy of Criminal Justice Sciences. *Justice Quarterly, 11*(4), 527–559. https://doi.org/10.1080/07418829400092421

Cutrona, C. E., & Russell, D. W. (1990). *Type of social support and specific stress: Toward a theory of optimal matching.* In B. R. Sarason, I. G. Sarason, & G. R. Pierce (Eds.), Social support: An interactional view (pp. 319–366). Wiley.

Dassah, E., Aldersey, H. M., McColl, M. A., & Davison, C. (2019). Healthcare providers' perspectives of providing primary healthcare services to persons with physical disabilities in rural Ghana. *Primary Health Care Research & Development*, *20*, e108.

Dawadi, S., Shrestha, S., & Giri, R. A. (2021). Mixed-methods research: A discussion on its types, challenges, and criticisms. *Journal of Practical Studies in Education, 2*(2), 25-36. https://doi.org/10.46809/jpse.v2i2.20

de Jong Gierveld, J., & Tesch-Römer, C. (2012). *Loneliness in old age in Eastern and Western European societies: Theoretical perspectives.* European Journal of Ageing, 9(4), 285–295. https://doi.org/10.1007/s10433-012-0248-2

de la Fuente, J., López-García, M., González-Torres, M. C., & Luis, E. O. (2021). The role of resilience in the psychological and emotional well-being of people with disabilities. *Disability and Health Journal, 14*(2), 101029. https://doi.org/10.1016/j.dhjo.2020.101029

Dean, L., Tolhurst, R., Khanna, R., & Jehan, K. (2017). 'You're disabled, why did you have

sex in the first place?' An intersectional analysis of experiences of disabled women with regard to their sexual and reproductive health and rights in Gujarat State, India. *Global health action*, *10*(sup2), 1290316.

Delgado, G. R. E., Velázquez, D. E., Pérez, J. P., & Jiménez, M. (2018). Resilient factors in students with disabilities. *International Research Journal of Management, IT and Social Sciences, 5(2), 23-31.*

Devkota, H. R., Kett, M., & Groce, N. (2019). Societal attitude and behaviours towards women with disabilities in rural Nepal: pregnancy, childbirth and motherhood. *BMC pregnancy and childbirth*, *19*, 1-13.

Devkota, H. R., Murray, E., Kett, M., & Groce, N. (2018). Are maternal healthcare services accessible to vulnerable group? A study among women with disabilities in rural Nepal. *PLoS One*, *13*(7), e0200370.

Dey, N. E. Y., & Amponsah, B. (2020). Sources of perceived social support on resilience amongst parents raising children with special needs in Ghana. *Heliyon, 6*(11), e05569. https://doi.org/10.1016/j.heliyon.2020.e05569

Drennan-Gala, D. (1995). *Delinquency and high school dropouts: Reconsidering social correlates*. University Press of America.

Edmonds, W. A., & Kennedy, T. D. (2017). An Applied Guide to Research Designs Quantitative, Qualitative, and Mixed Methods (2nd ed.). Sage Publications.

Esantsi, S. F., Onyango, F., Asare, G. Q., Kuffour, E., Tapsoba, P., Birungi, H., & Askew, I. (2015). Understanding the reproductive health needs of adolescents in selected slums in Ghana: a public health assessment.

Fisher, A. A., Laing, J. E., Stoeckel, J. E., & Townsend, J. W. (1998). *Handbook for family planning operations research design* (2nd ed.). New York, NY: Population Council.

Galati, A. J. (2015). Onward to 2030: Sexual and Reproductive Health and Rights in the Context of the Sustainable Development Goals. *Guttmacher Policy Review*, *18*(4).

Ganle, J. K., Apolot, R. R., Rugoho, T., & Sumankuuro, J. (2020). "They are my future": Childbearing desires and motivations among women with disabilities in Ghana-implications for reproductive healthcare. *Reproductive Health, 17*(1), 1–12. https://doi.org/10.1186/s12978-020-01000-y

Ganle, J. K., Baatiema, L., Quansah, R., & Danso-Appiah, A. (2020). Barriers facing persons with disability in accessing sexual and reproductive health services in sub-Saharan Africa: A systematic review. *PLOS ONE*, *15*(10), Article e0238585. doi.org

Ganle, J. K., Otupiri, E., Obeng, B., Edusie, A. K., Ankomah, A., & Adanu, R. (2016). Challenges women with disability face in accessing and using maternal healthcare services in Ghana: A qualitative study. *PLoS ONE, 11*(6), 1–13 https://doi.org/10.1371/journal.pone.0158361

Ganle, J. K., Ofori, C., & Dery, S. (2021). Testing the effect of an integrated-intervention to promote access to sexual and reproductive healthcare and rights among women with disabilities in Ghana: *A quasi-experimental study protocol.* Reproductive Health, 18(1), 206. https://doi.org/10.1186/s12978-021-01253-1

Ganle, J. K., Parker, M., Fitzpatrick, R., & Otupiri, E. (2014). A qualitative study of health system barriers to accessibility and utilization of maternal and newborn healthcare services in Ghana after user-fee abolition. *BMC Pregnancy and Childbirth*, *14*, Article 425. doi.org

Gee, R. E., & Corry, M. P. (2012). Patient engagement and shared decision making in maternity care. *Obstetrics & Gynecology*, *120*(5), 995–997. doi.org

Gavin, N. I., Benedict, N. B., & Adams, K. E. (2006) Health service use and outcomes among disabled Medicaid pregnant women. *Women's Health and Illness, 16*, 313-322.

Ghana Statistical Service (2010). *Ghana population and housing census 2014*. Ghana Statistical Service, Accra.

Ghana Statistical Service (2014). *Ghana population and housing census 2014*. Ghana Statistical Service, Accra.

Ghana Statistical Service. (2021). *Ghana 2021 population and housing census: Economic activity* (Vol. 3E). Ghana Statistical Service, Accra.

Ghana Statistical Service (2022). *2021 population and housing census*. Accra: Statistical Service.

Ghana Statistical Service. (2024). *Population projection 2021–2050: Thematic report*. https://statsghana.gov.gh/gssmain/fileUpload/pressrelease/10_World%20Population%20Day%202024%20press%20release%20from%20GSS_shared.pdf

Ghana Statistical Service. (2014). *Ghana Population and Housing Census 2010: National Analytical Report*. Ghana Statistical Service. http://www.statsghana.gov.gh

Greene, R. R., Galambos, C., & Lee, Y. (2004). Resilience theory: Theoretical and professional conceptualizations. *Journal of Human Behavior in the Social Environment, 8(4), 75-91*. https://doi.org/10.1300/J137v08n04_05

Gwynn, K. B., Winter, M. R., Cabral, H. J., Wolf, M. S., Hanchate, A. D., Henault, L. & Paasche-Orlow, M. K. (2016). Racial disparities in patient activation: evaluating the mediating role of health literacy with path analyses. *Patient Education and Counseling*, *99*(6), 1033-1037.

Hashemi, G., Wickenden, M., Bright, T., & Kuper, H. (2022). Barriers to accessing primary

healthcare services for people with disabilities in low and middle-income countries, a Meta-synthesis of qualitative studies. *Disability and rehabilitation*, *44*(8), 1207-1220.

Heiman, T. (2002). Parents of children with disabilities: Resilience, coping, and future expectations. *Journal of Developmental and Physical Disabilities, 14*(2), 159–171. https://doi.org/10.1023/A:1015219514621

Hervie, V. M. (2023). Social inclusion of children with intellectual disabilities in Accra, Ghana: Views of parents/guardians and teachers. *Children and Youth Services Review*, *147*, 106845. https://doi.org/10.1016/j.childyouth.2023.106845.

Holland-Hall, C., & Quint, E. H. (2017). Sexuality and disability in adolescents. *Pediatric Clinics*, *64*(2), 435-449.

Horner-Johnson, W., Darney, B. G., Kulkarni-Rajasekhara, S., Quigley, B., & Caughey, A. B. (2016). Pregnancy among US women: Differences by presence, type, and complexity of disability. *American Journal of Obstetrics and Gynecology*, *214*(4), 529-el.

Horner-Johnson, W., Biel, F. M., Darney, B. G., & Caughey, A. B. (2017). Time trends in births and cesarean deliveries among women with disabilities. *Disability and health journal*, *10*(3), 376-381.

Hoseinpoor, Z., & Ranjdoost, S. (2013). The relationship between moral intelligence and academic progress of students third year of high school course in Tabriz city. *Advances in Environmental Biology*, *7*(11), 3356-3362.

Hur, H. K., Park, S. M., Kim, S. S., Storey, M. J., & Kim, G. Y. (2005). Activity intolerance and impaired physical mobility in elders. *International Journal of Nursing Terminologies and Classifications*, *16*(3-4), 47-53.

Imrie, R. (2012). *Universalism, universal design and equitable access to the built environment.* Disability & Rehabilitation, 34(10), 873–882. https://doi.org/10.3109/09638288.2011.625382 (tandfonline.com

Imrie, R., & Luck, R. (2014). *Designing inclusive environments: Implications for the built environment and social participation of disabled people.* Disability & Rehabilitation, 36(16), 1347–1354. https://doi.org/10.3109/09638288.2013.845018 (tandfonline.com)

Inclusion London (2015). *Disabled women and girls: Report on barriers to participation and equality.* London, UK: Inclusion London. Retrieved from https://www.inclusionlondon.org.uk/resources/reports/disabled-women-and-girls/

Jones, E., Pike, J., Marshall, T., & Ye, X. (2016). Quantifying the relationship between increased disability and health care resource utilization, quality of life, work productivity, health care costs in patients with multiple sclerosis in the US. *BMC Health Services Research*, *16*, 1-9.

Kallianes, V., & Rubenfeld, P. (1997). Disabled women and reproductive rights. *Disability & Society*, *12*(2), 203-222.

Kalpakjian, C. Z., Kreschmer, J. M., Slavin, M. D., Kisala, P. A., Quint, E. H., Chiaravalloti, N. D., Jenkins, N., Bushnik, T., Amtmann, D., Tulsky, D. S., Madrid, R., Parten, R., Evitts, M., & Grawi, C. L. (2020). Reproductive health in women with physical disability: A conceptual framework for the development of new patient-reported outcome measures. *Journal of Women's Health, 29(11), 1427-1436.* https://doi.org/10.1089/jwh.2019.8174

Kassa, T. A., Luck, T., Bekele, A., & Riedel-Heller, S. G. (2014). *Sexuality and sexual reproductive health of disabled young people in Ethiopia: A study on knowledge, attitude and practice.* Globalization and Health, 12, 5. https://doi.org/10.1186/s12992-016-0142-3

Kassah, A. K. (2008). Begging as work: A study of people with mobility difficulties in Accra, Ghana. *Disability and Society, 23*(2), 163–170. https://doi.org/10.1080/09687590701841208

Kassah, B. L. L., Kassah, A. K., & Agbota, T. K. (2014). Abuse of physically disabled women in Ghana: Its emotional consequences and coping strategies. *Disability and Rehabilitation*, *36*(8), 665–671. doi.org

Khanal, V., Adhikari, M., Karkee, R., & Gavidia, T. (2014). *Factors associated with the utilisation of postnatal care services among the mothers of Nepal: Analysis of Nepal Demographic and Health Survey 2011.* BMC Women's Health, 14, Article 19. https://doi.org/10.1186/1472-6874-14-19

King, G., Willoughby, C., Specht, J. A., & Brown, E. (2006). Social support processes and the adaptation of individuals with chronic disabilities. *Qualitative Health Research, 16*(7), 902–925. https://doi.org/10.1177/1049732306289920

Kort-Butler, L. A. (2017). Social support theory. In C. J. Schreck (Ed.), *The Encyclopedia of Juvenile Delinquency and Justice* (pp. 819–823). Wiley-Blackwell.

Krahn, G. L., Walker, D. K., & Correa-De-Araujo, R. (2015). *Persons with disabilities as an unrecognized health disparity population.* American Journal of Public Health, 105(S2), S198–S206. https://doi.org/10.2105/AJPH.2014.302182

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

Lai, G. (2014). Social support and illness. In W. C. Cockerham, R. Dingwall, & S. R. Quah (Eds.), *The Wiley Blackwell Encyclopedia of Health, Illness, Behavior, and Society* (pp. 2191–2195). Wiley. doi.org

Lang, R., Schneider, M., Kett, M., Cole, E., & Groce, N. (2019). Policy Development: An Analysis of Disability Inclusion in a Selection of African Union Policies. *Microeconomics: Welfare Economics & Collective Decision-Making eJournal*. https://doi.org/10.1111/dpr.12323.

Lee, K., Devine, A., Marco, M. J., Zayas, J., Gill-Atkinson, L., & Vaughan, C. (2015). Sexual and reproductive health services for women with disability: a qualitative study with service providers in the Philippines. *BMC women's health*, *15*, 1-11.

Ledesma, J. (2014). Conceptual frameworks and research models on resilience in leadership. *Sage open*, *4*(3), 2158244014545464.

Leonard Cheshire. (2018). Bridging the gap: Examining disability and development in four African countries. London: Leonard Cheshire.

Lezzoni, L., I., Yu, J., Wint, A.J., Smeltzer, S.C., & Ecker, J.L.(2013). Prevalence of current pregnancy among US women with and without chronic physical disabilities. *Med Care*, *51*(6), 555-562. doi:10.1097/MLR.0b013e318290218d

Lezzoni, L. I., Wint, A. J., Smeltzer, S. C., & Ecker, J. L. (2015). Physical accessibility of routine prenatal care for women with mobility disability. *Journal of Women's Health*, *24*(12), 1006–1012. doi.org

Liang, H., Guo, X., & Hao, Y. (2014). *Social support, resilience, and subjective well-being among older adults living alone in China.* Journal of Population Ageing, 7(1), 43–62. https://doi.org/10.1007/s12062-013-9090-y

Lin, Y., Adesina, O., Asuma, B. S., Chen-Charles, J., Chalasani, S., Cluver, L., ... & Rudgard, W. E. (2025). Community health workers and adolescent health and well-being across sub-Saharan Africa: A systematic review. *medRxiv*, 2025-09.

Maguire, M., & Delahunt, B. (2017). Doing a thematic analysis: A practical, step-by-step guide for learning and teaching scholars. *All Ireland Journal of Teaching and Learning in Higher Education (AISHE-J)*, *9*(3), 3351-33514.

Masten, A. S., & Obradović, J. (2006). Competence and resilience in development. *Annals of the New York Academy of Sciences, 1094*, 13–27. https://doi.org/10.1196/annals.1376.003

Masten, A. S. (2001). *Ordinary magic: Resilience processes in development.* American Psychologist, 56(3), 227–238. https://doi.org/10.1037/0003-066X.56.3.227

Mathew, R. T., & Nair, B. P. (2017). Quality of life and resilience in relation to perceived social support among mothers of children with learning disability. *Indian Journal of Health and Wellbeing, 8*(7), 665–667. https://search.proquest.com/docview/1961771363?accountid=136549

Matsumura, M., & Gubhaju, B. (2001). *Women's status, household structure and the utilization of maternal health services in Nepal.* Asia-Pacific Population Journal, 16(1), 23–44

Mavuso, S. S., & Maharaj, P. (2015). Access to sexual and reproductive health services: experiences and perspectives of persons with disabilities in Durban, South Africa. *Agenda, 29*(2), 79–88. https://doi.org/10.1080/10130950.2015.1043713.

Mba, C. J. (2010). Population ageing in Ghana: Research gaps and the way forward. *Journal ofAging Research, 2010*. https://doi.org/10.4061/2010/672157

McConnell, D., Aunos, M., Pacheco, L., Savage, A., Hahn, L., & Feldman, M. (2021). Screening for parental intellectual disability: A first step in planning and delivering equitable support services? *Journal of Family Social Work*, *24*(4), 282-298.

McConnell, D., Llewellyn, G., & Bye, R. (2008). Providing services for parents with intellectual disabilities: Parent needs and service constraints. *Journal of Intellectual and Developmental Disability, 33*(2), 133-141. https://doi.org/10.1080/13668250802037647

McLeroy, K. R., Bibeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programs. *Health Education Quarterly, 15*(4), 351–377. https://doi.org/10.1177/109019818801500401

Meadan, H., Stoner, J. B., & Angell, M. E. (2010). Review of literature related to the social, emotional, and behavioral adjustment of siblings of individuals with autism spectrum disorder. *Journal of developmental and physical disabilities*, *22*, 83-100.

Mesman, J., et al. (2017). Quality of communication in maternity care: A qualitative study. *Health Expectations*, *20*(5), 1022–103

Mfoafo-M'Carthy, M., Grischow, J. D., & Stocco, N. (2020). Cloak of invisibility: A literature review of physical disability in Ghana. *SAGE Open, 10*(1). https://doi.org/10.1177/2158244019900567

Migerode, F., Maes, B., Buysse, A., & Brondeel, R. (2012). Quality of life in adolescents with a disability and their parents: The mediating role of social support and resilience. *Journal of Developmental and Physical Disabilities, 24*(5), 487–503. https://doi.org/10.1007/s10882-012-9285-1

Mitra, M., Manning, S. E., & Lu, E. (2012). Physical abuse around the time of pregnancy among women with disabilities. *Maternal and Child Health Journal, 16*(4), 802–806. https://doi.org/10.1007/s10995-011-0784-y

Mitra, S., Posarac, A., & Vick, B. (2013). Disability and poverty in developing countries: a multidimensional study. *World Development*, *41*, 1-18.

Mitra, S., Posarac, A., & Vick, B. (2012). *Disability and social participation in developing countries: A cross-country analysis. World Development, 40*(10), 2110–2121. https://doi.org/10.1016/j.worlddev.2012.04.031

Mitra, S. (2005). *The capability approach and disability. Journal of Disability Policy Studies, 16*(4), 236–247. https://doi.org/10.1177/10442073050160040501

Mitra, M., Long-Bellil, L. M., Smeltzer, S. C., & Iezzoni, L. I. (2015). A perinatal health framework for women with physical disabilities. *Disability and Health Journal*, *8*(4), 499-506.

Mitra, S., Yap, J., Hervé, J., & Chen, W. (2023). Inclusive statistics: A disaggregation of indicators by disability status and its implications for policy. *Global Social Policy*, *23*(1), 39-66.

Moak, Z. B., & Agrawal, A. (2010). The association between perceived interpersonal social support and physical and mental health: results from the National Epidemiological Survey on Alcohol and Related Conditions. *Journal of Public Health*, *32*(2), 191-201.

Morris, M. A., et al. (2011). Training of health care professionals in the provision of care for people with disabilities and the role of peer-led training. *Journal of Continuing Education in the Health Professions*, *31*(3), 147–154. doi.org

Morison, T., & Herbert, S. (2019). Rethinking 'risk' in sexual and reproductive health policy: The value of the reproductive justice framework. *Sexuality Research and Social Policy*, *16*(4), 434-445.

Morrison, J., Basnet, M., Budhathoki, B., Adhikari, D., Tumbahangphe, K., Manandhar, D., ..& Groce, N. (2014). Disabled women′ s maternal and newborn health care in rural Nepal: A qualitative study. *Midwifery*, *30*(11), 1132-1139.

Mprah, W. K. (2013). Perceptions about barriers to sexual and reproductive health information and services among deaf people in Ghana. *Disability, CBR & Inclusive Development*, *24*(3), 21-36.

Mprah, W.K., Anafi, P., & Sekyere, F.O. (2014). Does disability matter? Disability in sexual and reproductive health policies and research in Ghana. *International Quarterly Community Health Education*, *35*(1), 21–35.

Mprah WK, Anafi P and Addai Yeboah PY (2017). Exploring misinformation of family planning practices and methods among deaf people in Ghana. *Reproductive health matters*, 12;25(50):20-30. doi.org/10.1080/09688080.2017.1332450

Mulumba, M., Nantaba, J., Brolan, C. E., Ruano, A. L., Brooker, K., & Hammonds, R. (2014). Perceptions and experiences of access to public healthcare by people with disabilities and older people in Uganda. *International journal for equity in health*, *13*, 1-9.

Murthy, G. V. S., John, N., Sagar, J., & South India Disability Evidence Study Group. (2014). Reproductive health of women with and without disabilities in South India, the SIDE study (South India Disability Evidence) study: a case control study. *BMC women's health*, *14*, 1-7.

Naami, A. (2012). The unemployment of women with physical disabilities in Ghana: Issues and recommendations. https://doi.org/10.1080/09687599.2011.644930

Naami, A. (2015). Disability, gender, and employment relationships in Africa: The case of Ghana. African Journal of Disability, 4(1) Article 95. https://ajod.org/index.php/ajod/article/view/95

Nguyen, A., Liamputtong, P., & Horey, D. (2019). Reproductive Health Care Experiences of People with Physical Disabilities in Vietnam. *Sex Disability, 37*, 383–400. https://doi.org/10.1007/s11195-019-09581-8

Nguyen, A. (2020). *Challenges for women with disabilities accessing reproductive health care around the world: A scoping review.* Sexuality and Disability, 38(3), 281–300. https://doi.org/10.1007/s11195-020-09630-7

Nguyen, T. T. A., Liamputtong, P., & Monfries, M. (2016). Reproductive and sexual health of people with physical disabilities: a metasynthesis. *Sexuality and Disability*, *34*(1), 3-26.

Nosek, M. A., Young, M. E., Rintala, D. H., Howland, C. A., Foley, C. C., & Bennett, J. L. (1995). Barriers to reproductive health maintenance among women with physical disabilities. *Journal of Women's Health, 4*(5), 505–518. https://doi.org/10.1089/jwh.1995.4.505

Nosek, M. A., Hughes, R. B., Swedlund, N., Taylor, H. B., & Swank, P. (2003). Self-esteem and women with disabilities. *Social science & medicine*, *56*(8), 1737-1747.

Nosek, M. A., Young, M. E., Rintala, D. H., Howland, C. A., Foley, C. C., & Bennett, J. L. (2001). *National study of women with physical disabilities: Final report*. Center for Research on Women with Disabilities.

Nugrahani, R. R., Budihastuti, U. R., & Pamung-Kasari, E. P. (2017). Health Belief Model on the Factors Associated With the Use of Hpv Vaccine for the Prevention of Cervical Cancer Among Women in Kediri, East Java. *J Epidemiol Public Health, 2*(1), 70–81. DOI: 10.26911/-theicph.2017.009.

Nutbeam, D., & Harris, E. (2002). *Theory in a nutshell: A practical guide to health promotion theories* (2nd ed.). Sydney: McGraw-Hill.

Nyame, J. (2013). Are we men enough? An intersectional analysis of lived experiences of men with physical disabilities in Accra-Ghana (Master's thesis, International Institute of Social Studies, The Hague, Netherlands)

Ommen, O., Janssen, C., Neugebauer, E., Bouillon, B., Rehm, K., Rangger, C., & Pfaff, H. (2008). Trust, social support and patient type—associations between patients perceived trust,

supportive communication and patients preferences in regard to paternalism, clarification and participation of severely injured patients. *Patient education and counseling*, *73*(2), 196-204.

Ogundele, O. J., Pavlova, M., & Groot, W. (2020). Socioeconomic inequalities in reproductive health care services across sub-Saharan Africa: A systematic review and meta-analysis. Sexual & Reproductive Healthcare, 25, 100536. https://doi.org/10.1016/j.srhc.2020.100536

Oliver, M. (1990). The politics of disablement. *Palgrave Macmillan*. https://doi.org/10.1007/978-1-349-20895-1

Orthner, D. K., Jones-Sanpei, H., & Williamson, S. (2004). *The resilience and strengths of low-income families.* Family Relations, 53(2), 159–167. https://doi.org/10.1111/j.0022-2445.2004.00006.x

Ozbay, F., Johnson, D. C., Dimoulas, E., Morgan, C. A., Charney, D., & Southwick, S. (2007). *Social support and resilience to stress: From neurobiology to clinical practice.* Psychiatry (Edgmont), 4(5), 35–40. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2921311/

Pandya, S. P. (2022). Building Resilience and Sense of Control among Adults with Sensory Disabilities as They Grow Older: Examining the Effect of Prayer. *Journal of Disability & Religion*, *26*(1), 87-111.

Park, S., & Sheets, V. L. (2020). *The role of perceived social support and coping in resilience and health outcomes.* Journal of Community Psychology, 48(7), 2025–2040.

Paudel, D. R., & Pitakmanaket, O. (2010). *Utilization of maternal health services in Nepal.* Journal of Health and Allied Sciences, 1(1), 28–37. https://doi.org/10.37107/JHAS.90

Psychology, 1, 73–82.

Peta, C. (2017). Disability is not asexuality: the childbearing experiences and aspirations of women with disability in Zimbabwe. *Reproductive health matters*, *25*(50), 10-19.

Prilleltensky, O. (2003). A ramp to motherhood: The experiences of mothers with physical disabilities. *Sexuality and Disability, 21*(1).

Resnick, B., Klinedinst, N. J., Yerges-Armstrong, L., & Magaziner, J. (2011). Resilience in older women: The role of health-promoting behaviors and physical activity. *Geriatric Nursing, 32*(3), 210–218. https://doi.org/10.1016/j.gerinurse.2011.02.001

Reynolds, C. R. (2010). Behavior assessment system for children. *The Corsini encyclopedia of Psychology*, 1-2.

Rohwerder, B. (2018). Disability stigma in developing countries. *K4D Helpdesk Report, 26*. https://assets.publishing.service.gov.uk/media/5b18fe3240f0b634aec30791/Disability_stigma_in_developing_countries.pdf

Ronen, T. (2021). The positive power of planning and setting goals. *Journal of Positive Psychology, 16*(3), 365-375. https://doi.org/10.1080/17439760.2020.1835643

Rugoho, T., & Maphosa, F. (2017). Challenges faced by women with disabilities in accessing sexual and reproductive health in Zimbabwe: The case of Chitungwiza town. *African Journal of Disability*, *6*(1), 1-8.

Rugoho, T., Wright, P., Stein, M. A., & Broerse, J. E. (2020). Sexual and reproductive experiences of youth with disabilities in Zimbabwe. *Afr. Disability Rts. YB*, *8*, 31.

Sarpong, K. (1974). *Ghana in Retrospect: Some respects of Ghanaian Culture*. Accra, Tema Ghana: Publishing Corporation.

Sameroff, A., Gutman, L. M., & Torres, P. E. C. (2020). Pregnancy in women with physical disabilities. *Resilience and Vulnerability: Adaptation in the Context of Childhood Adversities, 36*(1), 88–96. https://doi.org/10.5539/ass.v11n15p159

Scheffers, F., Moonen, X., & van Vugt, E. (2021). Assessing the quality of support and discovering sources of resilience during COVID-19 measures in people with intellectual disabilities by professional carers. *Research in Developmental Disabilities, 111*(February), 103889. https://doi.org/10.1016/j.ridd.2021.103889

Schultz, B. E., Corbett, C. F., & Hughes, R. G. (2022, July). Instrumental support: A conceptual analysis. In *Nursing Forum* (Vol. 57, No. 4, pp. 665-670).

Schultz, K. S., Solberg, V. S. H., & Cavanaugh, C. (2021). *Workplace social support and resilience: A meta-analytic review.* Journal of Vocational Behavior, 127, 103553. https://doi.org/10.1016/j.jvb.2021.103553

Schaefer, C., Coyne, J. C., & Lazarus, R. S. (1981). The health-related functions of social support. *Journal of Behavioral Medicine, 4*(4), 381–406. https://doi.org/10.1007/BF00846149

Schmied, V., Johnson, M., Naidoo, N., Austin, M. P., Matthey, S., Kemp, L., ... & Yeo, A. (2012). Maternal mental health in Australia and New Zealand: A review of national policies and guidelines. *Journal of Advanced Nursing*, *68*(11), 2410–2424. doi.org

Seymour, M., Giallo, R., & Wood, C. E. (2017). *The psychological and physical health of fathers of children with autism spectrum disorder compared to fathers of children with long-term disabilities and fathers of children without disabilities. Research in Developmental Disabilities, 69*, 8–17. https://doi.org/10.1016/j.ridd.2017.07.018

Smeltzer, S. C. (2007). Pregnancy in women with physical disabilities. *JOGNN - Journal of Obstetric, Gynecologic, and Neonatal Nursing, 36*(1), 88–96. https://doi.org/10.1111/j.1552-6909.2006.00121.x

Singh, A., Sharma, R., & Sharma, M. K. (2013). Evaluation of disable friendliness of a railway transport facility in Ludhiana city of Punjab, India. *International Journal on Disability and Human Development*, *12*(3), 301–306. doi.org

Smith, E., Murray, S. F., Yousafzai, A. K., & Kasonka, L. (2004). Barriers to accessing safe motherhood and reproductive health services: the situation of women with disabilities in Lusaka, Zambia. *Disability and rehabilitation*, *26*(2), 121-127.

Stuntzner, S., MacDonald, A., Dalton, J. A., Brna, P., Gordon, K., Dooley, J., García Reyes, L. E., Sabouripour, F., Roslan, S. B., Jones, N., Presler-Marshall, E., Stavropoulou, M., Smeltzer, S. C., Levine, K. A., Maxwell Peprah Opoku, N., Gyamfi, N., Badu, E., French, A. L., Strnadova, I.,

Shakespeare, T. (2017). *Disability: The basics* (2nd ed.). Routledge. https://www.routledge.com/Disability-The-Basics/Shakespeare/p/book/9780415812693 (routledge.com)

Sheldon, K. M., & Lyubomirsky, S. (2006). Achieving sustainable new happiness: Prospects, practices, and prescriptions. In A. Linley & S. Joseph (Eds.), *Applied positive psychology: A new decision-making framework* (pp. 115–131). Cambridge University Press.

Stewart, M., Barnfather, A., Magill-Evans, J., Ray, L., & Letourneau, N. (2011). Brief report: An online support intervention: Perceptions of adolescents with physical disabilities. *Journal of adolescence*, *34*(4), 795-800.

Taber, K. S. (2018). The use of Cronbach's alpha when developing and reporting research instruments in science education. *Research in Science Education, 48*(6), 1273–1296. https://doi.org/10.1007/s11165-016-9602-2

Tali, H. (2002). Parents of children with disabilities: Resilience, coping, and future expectations. *Journal of Developmental and Physical Disabilities, 14*(June).

Tanabe, M., Nagujjah, Y., Rimal, N., Bukania, F., & Krause, S. (2015). Intersecting sexual and reproductive health and disability in humanitarian settings: risks, needs, and capacities of refugees with disabilities in Kenya, Nepal, and Uganda. *Sexuality and disability*, *33*, 411-427.

Tarasoff, L. A. (2015). Experiences of women with physical disabilities during the perinatal period: a review of the literature and recommendations to improve care. *Health Care for Women International*, *36*(1), 88-107.

Tarasoff, L. A. (2017). Experiences of women with physical disabilities in accessing reproductive health care. *Sexuality and Disability, 35*(3), 263-276. https://doi.org/10.1007/s11195-017-9471-2

Tashakkori, A., & Teddlie, C. (Eds.). (2003). *Handbook of mixed methods in social and behavioural research*. SAGE Publications.

Tashakkori, A., & Teddlie, C. (1998). *Mixed methodology: Combining qualitative and quantitative approaches.* Thousand Oaks, CA: Sage Publications.

Tefera, B., van Engen, M. L., Van der Klink, J. J. L., & Schippers, A. (2017). *The grace of motherhood: Disabled women contending with societal denial of intimacy, pregnancy, and motherhood in Ethiopia.* Disability & Society, 32(10), 1510–1533. https://doi.org/10.1080/09687599.2017.1361385

Tugade, M. M., & Fredrickson, B. L. (2004). *Resilient individuals use positive emotions to bounce back from negative emotional experiences.* Journal of Personality and Social Psychology, 86(2), 320–333. https://doi.org/10.1037/0022-3514.86.2.320

Trani, J. F., Bakhshi, P., Bellanca, N., Biggeri, M., & Marchetta, F. (2011). Disabilities through the Capability Approach lens: Implications for public policies. *Alter*, *5*(3), 143-157.

United Nations. (2006). *United Nations Convention on the Rights of Persons with Disabilities*

(UNCRPD). United Nations.

United Nations. (2021). *Disability-inclusive language guidelines*. UN Geneva. https://www.ungeneva.org/sites/default/files/2021-01/Disability-Inclusive-Language-Guidelines.pdf

United Nations DESA. (2019). *Disability and development report: Realizing the sustainable development goals by, for and with persons with disabilities*. Stylus Publishing, LLC.

United Nations Population Fund. (2023). *State of world population 2023: 8 billion lives, infinite possibilities: The case for rights and choices*. UNFPA

UNFPA, 2019. Sexual and reproductive health and rights: an essential element of universal health coverage. *Background document for the Nairobi summit on ICPD25 – Accelerating the promise*

Van Rooy, G., Amadhila, E. M., Mufune, P., Swartz, L., Mannan, H., & MacLachlan, M. (2012). Perceived barriers to accessing health services among people with disabilities in rural northern Namibia. *Disability & Society*, *27*(6), 761-775.

Van Ryn, M., & Heaney, C. A. (1992). What's the use of theory? *Health Education Quarterly*, *19*(3), 315-330.

Vansteenwegen, A., Jans, I., & Revell, A. T. (2003). *Sexual experience of women with a physical disability: A comparative study.* Sexuality and Disability, 21(4), 283–290. https://doi.org/10.1023/B:SEDI.0000010070.46481.17

Walsh, S., Cassidy, M., & Priebe, S. (2017). *The application of positive psychotherapy in mental health care: A systematic review.* Journal of Clinical Psychology, 73(6), 638–651.

Welner, S. L. (1998). Screening issues in gynecological malignancies for women with disabilities: Critical considerations. *Journal of Women's Health*, *7*(3), 281–285. doi.org

World Bank (2012). *World Development Indicators.* Washington, DC.

World Health Organization & World Bank (2011). *World report on disability 2011*. World Health Organization. https://iris.who.int/handle/10665/44575

World Health Organization (2023). Investing in sexual and reproductive health and rights: *Technical brief*. https://cdn.who.int/media/docs/default-source/reproductive-health/uhl-technical-brief-srhr.pdf?sfvrsn=ceca4027_1&download=true

World Health Organization. (2022). *World Health Organization global report on health equity for persons with disabilities.* Geneva, Switzerland.

WHO, UNFPA (2009). *Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA guidance note.* Geneva: WHO.

World Health Organization (2011). World report on disability. In *World report on disability* (pp. 24-24).

World Health Organization. (2015). *State of inequality: Reproductive, maternal, newborn and child health*. https://www.who.int/publications/i/item/9789241564908

World Health Organization (2017). Sexual and reproductive health: *Fact sheet on Sustainable Development Goals (SDGs): Health targets*. https://iris.who.int/handle/10665/340880

Wright, M. O. D., & Masten, A. S. (2015). Pathways to resilience in context. *Youth resilience and culture: Commonalities and complexities*, 3-22.

Yoshida, K. K., Li, A., & Odette, F. (1999). Factors that influence the pregnancy and childbirth experiences of women with physical disabilities: A qualitative study. *Developmental Medicine & Child Neurology*, *41*(7), 481–488. doi.org

APPENDICES

Appendix A: Ethical Clearance

UNIVERSITY OF GHANA
ETHICS COMMITTEE FOR THE HUMANITIES
(ECH)

P. O. Box LG 74, Legon, Accra, Ghana

My Ref. No…ECH 218/ 21-22 …

November 10, 2021.

Esther Adu
Regional Institute for Population Studies
University of Ghana
Legon

ETHICAL CLEARANCE
(ECH 218/ 21-22)

The protocol title below has been reviewed and approved by the ECH Committee.

TITLE OF PROTOCOL: **SOCIAL SUPPORT AND RESILIENCE OF PHYSICALLY CHALLENGED FEMALES TO REPRODUCTIVE HEALTH CARE IN GHANA**

PRINCIPAL INVESTIGATOR: **ESTHER ADU**

Please note that the final review report must be submitted to the Committee at the completion of the study. Your research records may be audited at any time during or after the implementation. Any modification of this research project must be submitted to ECH for review and approval prior to implementation.
Please report all serious adverse events related to this study to ECH within seven (7) days verbally and in writing within fourteen (14) days.
This certificate is valid till November 09, 2022. You are to submit annual reports for continuing review.

Please accept my congratulations.

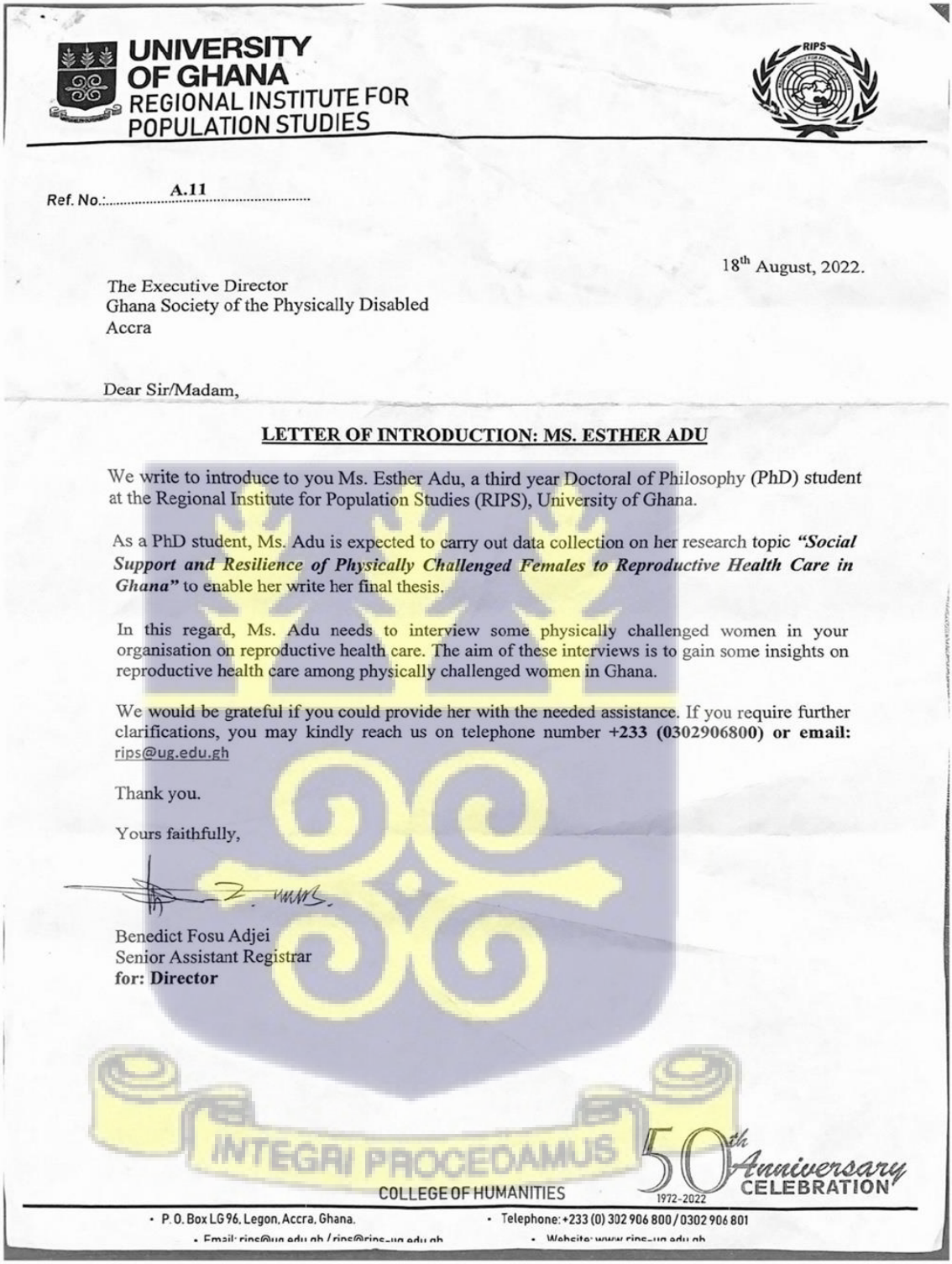
Yours Sincerely,
Professor C. Charles Mate-Kole

ECH Chair

Cc: Professor Stephen Kwankye, Regional Institute for Population Studies, UG

Tel: +233-303933866 Email: ech@ug.edu.gh

Appendix B Letter of Introduction



UNIVERSITY OF GHANA
REGIONAL INSTITUTE FOR POPULATION STUDIES

RIPS

Ref. No.: A.11

18th August, 2022.

The Executive Director
Ghana Society of the Physically Disabled
Accra

Dear Sir/Madam,

LETTER OF INTRODUCTION: MS. ESTHER ADU

We write to introduce to you Ms. Esther Adu, a third year Doctoral of Philosophy (PhD) student at the Regional Institute for Population Studies (RIPS), University of Ghana.

As a PhD student, Ms. Adu is expected to carry out data collection on her research topic ***"Social Support and Resilience of Physically Challenged Females to Reproductive Health Care in Ghana"*** to enable her write her final thesis.

In this regard, Ms. Adu needs to interview some physically challenged women in your organisation on reproductive health care. The aim of these interviews is to gain some insights on reproductive health care among physically challenged women in Ghana.

We would be grateful if you could provide her with the needed assistance. If you require further clarifications, you may kindly reach us on telephone number **+233 (0302906800) or email:** rips@ug.edu.gh

Thank you.

Yours faithfully,

Benedict Fosu Adjei
Senior Assistant Registrar
for: Director

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COLLEGE OF HUMANITIES

50th Anniversary CELEBRATION 1972-2022

• P. O. Box LG 96, Legon, Accra, Ghana. • Telephone: +233 (0) 302 906 800 / 0302 906 801
• Email: rips@ug.edu.gh / rips@rips-ug.edu.gh • Website: www.rips-ug.edu.gh

Appendix C: Questionnaire for Physically Challenged Mothers

UNIVERSITY OF GHANA

REGIONAL INSTITUTE OF POPULATION STUDIES

QUESTIONNAIRE FOR PHYSICALLY CHALLENGED MOTHERS

TOPIC: SOCIAL SUPPORT AND RESILIENCE OF PHYSICALLY CHALLENGED FEMALES TO REPRODUCTIVE HEALTH CARE IN GHANA

Start time of survey: _____

Location of interview: _____

Interviewer's name: _____

Date……

Hello, my name is …….. I am a student from the Regional Institute for Population Studies, University of Ghana, Legon. We are conducting a survey on the Social support and resilience issues of women with physical disabilities towards access to reproductive health services in Accra. Would be most grateful if you participate in this survey by answering some questions that relate to the work you do, your experiences with access to reproductive health services when you were pregnant and after delivery, the kind of challenges you encounter/encountered and how you were/ are able to overcome those challenges.

Whatever information you provide will be kept confidential and anonymous. Your name will not be written on this form, and will never be used in connection with any of the information you give me. You do not have to answer any question that you do not want to answer, and you may end this interview at any time you want to. But, honest answers to the questions will be appreciated. This interview may take averagely about 45 minutes. Thank you. Please may I start now?

YES, CONSENT GIVEN..... 1

NO, CONSENT IS NOT GIVEN..... 2

SECTION 1: DEMOGRAPHICS

Now I would like to ask you some background information about yourself.

No.	Question	Response	Code
101	What is your age?	_____	
	Have you ever attended school?	YES □ NO □	1 2
102	What is the highest level of education you have attained?	None □	1
		Kindergarten □	2
		Primary □	3
		JHS/Middle School □	4
		Secondary □	5
		Tertiary □	6
103	What is your religion?	Christian □	1
		Islam □	2
		Traditional □	3
		No religion □	4
		Other (specify)_____	96

104	What do you consider as your ethnic background? What ethnicity are you?	Akan □ Ga/Dangme □ Ewe □ Guan □ Gruma □ Mole-Dagbani □ Grusi □ Mamprusi □ Kussasi □ Other, specify_	1 2 3 4 5 6 7 8 9 96
105	What is your source of income and Livelihood	Trade/Business □ Farming □ Civil/Public Servant □ Casual labour □ Other, specify_____	1 2 3 4 96
106	Are you paid or do you earn cash or in kind for this work or are you not paid at all?	Cash Only □ Cash And Kind □ In Kind Only □ Not Paid □	1 2 3 4
107	How much did/do you earn for this work per month?	Record Amount (Gh¢)	

108	Please tell me your marital status?	Single □ Married □ Divorced □ Cohabitation □ Widow □	1 2 3 4 5
109	Number of children ever born? _____		
	What are the ages of your children?	1. First Child ……. 2. Second Child …… 3. Third Child…… 4. Fourth Child ……. 5. Fifth Child……. 6. Other, Specify……..	
110	How many people are in your household (including) yourself? _____	1-3 □ 4-6 □ 6-9 □	1 2 3
111	How many rooms are in this household? _____	1 □ 2 □ 3 □ 4 and more □	1 2 3 4

112	How many rooms are used for sleeping? _____	1 □ 2 □ 3 □ 4 and more □	1 2 3 4
113	Type of place of residence	Urban □ Peri urban □	1 2

SECTION 2 PREGNANCY AND POSTNATAL RELATED QUESTIONS

Now I am going to ask you questions about your most recent pregnancy in the last 5 years and your use of post-natal services and family planning.

201. How many times have you become pregnant? _____

202. Did you visit the hospital when you were pregnant with your last child?

1. Yes [ ]
2. No [ ]

203. How many times did you visit the hospital during your pregnancy?_____

204. How much did you spend (on average) on each visit? Record Amount _____

205. Who provided the funds for the payment?

1. Self [ ]
2. Support from friends, organization [ ]
3. Insurance [ ]

206. Where did you deliver your last child/children?

1. Hospital/Clinic [ ]
2. TBA [ ]
3. Maternity Home [ ]
4. Home [ ]
5. Other (specify)_____

207. Is there any reason for the selection of your choice in 206 above?

1. Distance [ ]
2. Professional advice [ ]
3. Insurance [ ]
4. Cost [ ]
5. Attitude of service providers [ ]
6. Infrastructure [ ]
7. Other (specify)_____

Post Natal services

208. Do/did you take your last child/ children for post-natal services?

1. No (if no, skip to Q210) [ ]
2. Yes [ ]

209. If yes how much on average do/did you spend? Record Amount_____

210. If No why ?

1. Distance [ ]
2. Professional advice [ ]

3. Insurance [ ]
4. Cost [ ]
5. Attitude of service providers [ ]
6. Infrastructure [ ]
7. Other (specify)…….

Family Planning

Now I would like to talk about family planning - the various ways or methods that a couple can use to delay or avoid a pregnancy.

211. Sometimes people use something to prevent themselves from getting pregnant. Have you heard of any of these methods?

1. Yes [ ]
2. No [ ]

212. If yes to Q211, do you use any these methods?

1. Yes [ ]
2. No [ ]

213. If yes to Q212., which of the method do you use?(Tick all that Apply)

1. Condom [ ]
2. IUD (It's a loop or coil placed inside them by a doctor or a nurse who can prevent pregnancy for one or more years.) [ ]
3. Injectables (Women can have an injection by a health provider that stops them from becoming pregnant for one or more months. [ ]
4. Pill (.Women can take a pill every day to avoid becoming pregnant) [ ]
5. Implants. PROBE: Women can have one or more small rods placed in their upper arm by a doctor or nurse which can prevent pregnancy for one or more years. [ ]
6. Withdrawal. PROBE: Men can be careful and pull out before climax. [ ]

7. Lactational Amenorrhea Method (LAM) (PROBE: Up to 6 months after childbirth, before the menstrual period has returned, women use a method requiring frequent breastfeeding day and night. [ ]
8. Male Sterilization (Men can have an operation to avoid having any more children.) [ ]
9. Female Sterilization (Women can have an operation to avoid having any more children.) [ ]
10. Other

(Specify)……

214. If No to the choices in above. Why do you not use a family planning method? _____

SECTION 3:

SOCIAL SUPPORT IN RELATION TO ACCESS AND USE OF REPRODUCTIVE HEALTH SERVICES

Now I would like to ask you about some of the forms of support you receive and from whom.

301. Do you receive any form of social support?
    1. Yes [ ]
    2. No [ ]

302. If yes what are the types of social support you receive as a pregnant physically challenged woman? Tick all that applies
    1. Emotional Support (counseling and guidance) [ ]
    2. Instrumental/medical/material Support (food, medication, wheel chair, clothes etc) [ ]

3. Informational Support (health education) [ ]

4. Others Specify……..

303. Where do you receive these supports from?

A. Emotional Support (Tick all that apply)

1. Peers/Association Members [ ]	2. Husband/Partner [ ]	3. Parents/Relatives [ ]	4. Relatives [ ]
5. Friends [ ]	6.Health Professional [ ]	7. Religious leaders [ ]	8. Other, specify [ ]

B. Informational Support (Tick all that apply)

1. Peers/Association Members [ ]	2. Husband/Partner [ ]	3. Parents/Relatives [ ]	Relatives [ ]
5. Friends [ ]	6.Health Professional [ ]	7. Religious leaders [ ]	8. Other, specify

C. Instrumental Support (Tick all that apply)

1. Peers/Association Members [ ]	2. Husband/Partner [ ]	3. Parents/Relatives [ ]	Relatives [ ]
5. Friends [ ]	6.Health Professional [ ]	7. Religious leaders [ ]	8. Other, specify [ ]

SECTION 4: RESILIENCE

This is the final section in the questionnaire. I would like you to please answer Q 400 and agree or disagree with each statement I am about to ask you.

400. What has been your most difficult challenge to access and use of reproductive health services _____ (e.g Physical Barriers, Emotional, Informational, Attitudinal Barriers and Economic Barrier).

When faced with challenges:

		Strongly Agree	Agree	Neither Agree nor disagree	Disagree	Strongly disagree
401	I was determined to recover.					
402	I adjusted to the new changes					
403	I used humor to help me through					
404	I believed I could recover					
405	I focused on my remaining abilities, not on what I couldn't do					
406	I accepted the new challenges					
407	I accepted help from others					
408	I figured out how to do my daily activities					
409	The challenging event was so bad, I gave up					
410	I found it difficult to ask for help from others when I needed it					
411	I found the energy to do what I had to do					

412	I saw this challenge as an opportunity					
413	I was determined to regain my prior functional ability					
414	I became a stronger person					
415	I continued to make plans for the future					
416	I learned from it					
417	Since the challenging event, I have not wanted to even do my usual activities					

Thank you for taking the time to answer my questions. Is there anything else you want to mention or ask?

End time of survey:_____

END OF SURVEY

Appendix D: In-depth Interview for Physically Challenged Mothers

UNIVERSITY OF GHANA

REGIONAL INSTITUTE OF POPULATION STUDIES

In-depth interview for Physically Challenged Mothers

Name of interviewer: _____

Signature_____

Physically challenged Mother's code number: _____

Caregiver code number: _____

Section 1

Socio-demographic background

1. Sex: Male [ ] Female [ ]
2. Age: _____
3. Highest educational level: No education [ ] Primary [ ] JHS/Middle [ ] Secondary [ ] Tertiary [ ]
4. Employment status: Unemployed [ ] Full-time [ ] Part-time [ ]
5. Place of work: At home [ ] Away from home, nearby [ ] Away from home, far away [ ]
6. Ethnicity: Akan [ ] Ga-Dangme [ ] Ewe [ ] Guan [ ] Mole-Dagbani [ ] Other [ ]
7. Religion: Christian [ ] Islam [ ] Traditional/Spiritualist [ ] No religion [ ]
8. Marital status: Never married [ ] Married [ ] Living together [ ] Divorced/separated [ ] Widowed [ ]
9. Number of children:
10. Living arrangement: Living with the physically challenged mother in the same household [ ] Not living with the physically challenged mother in the same household [ ]
11. Locality of residence: _____

Section 2

Challenges and Coping Strategies

1. Can you share your experience with accessing reproductive health services? (probe to know the following (Is/Was she given priority when you visit the hospital for healthcare services or any other preferential treatment experiences)

2. What are the challenges you faced as physically challenged pregnant woman and mother in accessing reproductive health services? (Prompt: (Probe for financial issues, stigmatization, discrimination, infrastructure, service provision etc)
3. How do you cope with challenges faced regarding access to and use of reproductive health services after delivery? Probe on specific areas of coping with these challenges (Probe for financial issues, stigmatization, discrimination, infrastructure, service provision)
4. How do you cope with challenges to the access and use of reproductive health services after delivery? Probe on specific areas of coping with these challenges (Probe for financial issues, stigmatization, discrimination, infrastructure, service provision etc)

Section 3

Supporting systems available to physically challenged pregnant women and mothers

1. Where do you receive social support from and why? Probe further on the following and find out why those mentioned were the source of social support.
2. What specific kinds of support do you get from these social groups?
    a. How have these forms of support been helpful in improving your access to reproductive health services?
3. Have these forms of support been consistent and sustainable? How? Why would you

say this?

4. How do you think support for physically challenged pregnant women and mothers could be improved?
5. How has the social support you receive helped you to cope with life as a pregnant woman and mother?
6. How did/does social support play a role in solving or overcoming the challenges you mentioned earlier that pregnant and postpartum physically disabled women face?
    a. How did/does social support play a role in worsening the challenges?

Section 4

Factors to building resilience among physically challenged mothers

1. Describe what factors you felt helped you become successful as a physically challenged mother (probe from pregnancy to early motherhood) despite the challenges you mentioned with access and use of reproductive health services.
    a. Prompts: Illustrate answer with case example(s) (in relation to individual (making meaning out of adversity/positive outlook), family, social and environmental factors
2. What do you perceive to be the factors that prevent pregnant and postpartum women with physical disabilities from succeeding in pregnancy and motherhood for women with physical disabilities? Prompts: Illustrate answer with case example(s).

Is there anything else you want to mention or ask?

Thank you for taking the time to answer my questions.

Appendix E: Tukey HSD : Mean Resilience Score

Multiple Comparisons : AGE

(I) What is your age?	(J) What is your age?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
18-25	26-35	-0.20185	0.14741	0.359	-0.5499	0.1462
	36-45	-0.07292	0.14763	0.874	-0.4215	0.2757
26-35	18-25	0.20185	0.14741	0.359	-0.1462	0.5499
	36-45	.12893*	0.04576	0.015	0.0209	0.237
36-45	18-25	0.07292	0.14763	0.874	-0.2757	0.4215
	26-35	-.12893*	0.04576	0.015	-0.237	-0.0209

*. The mean difference is significant at the 0.05 level.

Multiple Comparisons: occupation

Dependent Variable: Mean RESILIENCE						
Tukey HSD						
(I) What is your source of income and Livelihood	(J) What is your source of income and Livelihood	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Trade/Business	Civil/Public Servant	-0.05678	0.06816	0.683	-0.2177	0.1042
	Casual worker	.33468*	0.07226	0	0.164	0.5053
Civil/Public Servant	Trade/Business	0.05678	0.06816	0.683	-0.1042	0.2177
	Casual worker	.39146*	0.09297	0	0.1719	0.611
Casual worker	Trade/Business	-.33468*	0.07226	0	-0.5053	-0.164
	Civil/Public Servant	-.39146*	0.09297	0	-0.611	-0.1719

Multiple Comparisons: Income

Dependent Variable: MeanRESILIENCE

Tukey HSD						
(I) How much did/do you earn for this work per month?	(J) How much did/do you earn for this work per month?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Less than 200 cedis	200-500 cedis	-.22313*	0.0504	0	-0.3537	-0.0925
	550-1000 cedis	-.23407*	0.06611	0.003	-0.4054	-0.0628
	1050-2000 cedis	-0.05719	0.082	0.898	-0.2697	0.1553
200-500 cedis	Less than 200 cedis	.22313*	0.0504	0	0.0925	0.3537
	550-1000 cedis	-0.01094	0.06497	0.998	-0.1793	0.1574
	1050-2000 cedis	0.16594	0.08109	0.175	-0.0441	0.376
501-1000 cedis	Less than 200 cedis	.23407*	0.06611	0.003	0.0628	0.4054
	200-500 cedis	0.01094	0.06497	0.998	-0.1574	0.1793
	1050-2000 cedis	0.17688	0.09168	0.219	-0.0607	0.4144
Above 1000 cedis	Less than 200 cedis	0.05719	0.082	0.898	-0.1553	0.2697

	200-500 cedis	-0.16594	0.08109	0.175	-0.376	0.0441
	550-1000 cedis	-0.17688	0.09168	0.219	-0.4144	0.0607

*. The mean difference is significant at the 0.05 level.

Multiple Comparisons: Marital Status

Dependent Variable: Mean RESILIENCE

Tukey HSD

(I) Please tell me your relationship/marital status is?	(J) Please tell me your relationship/marital status is?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Single	Divorced	.19300*	0.06261	0.012	0.0308	0.3552
	Cohabitation	.27339*	0.08471	0.008	0.0539	0.4929
	Married	.26305*	0.09769	0.038	0.0099	0.5162
Divorced	Single	-.19300*	0.06261	0.012	-0.3552	-0.0308
	Cohabitation	0.08039	0.09883	0.848	-0.1757	0.3364
	Married	0.07005	0.11016	0.92	-0.2154	0.3555
Cohabitation	Single	-.27339*	0.08471	0.008	-0.4929	-0.0539
	Divorced	-0.08039	0.09883	0.848	-0.3364	0.1757
	Married	-0.01034	0.12406	1	-0.3318	0.3111
Married	Single	-.26305*	0.09769	0.038	-0.5162	-0.0099
	Divorced	-0.07005	0.11016	0.92	-0.3555	0.2154
	Cohabitation	0.01034	0.12406	1	-0.3111	0.3318

*. The mean difference is significant at the 0.05 level.

Appendix F: Sample Size Calculation

This formula is given as: $n_f = \frac{n}{1 + \frac{n}{N}}$

Where: n_f = the desired sample size (when population is less than 10,000), n = the desired sample size (when population is greater than 10,000), N = the estimate of the target population size. In order to get n, Fisher et al. (1998) provided another formula, which is $n = \frac{z^2 pq}{d^2}$

Where: n= the desired sample size (when the population is less than 10000) z= the standard normal deviation, usually set at 1.96 which corresponds to 95 percent confidence level; p= the proportion of the target population has similar characteristics. q= 1.0-p; and d= the degree of accuracy desired, this is usually set at 0.05 With (z) statistic being 1.96, degree of accuracy (d) set at 0.05 percent and the proportion of the target population with similar characteristic (p) at 90 percent which is equivalent to 0.90, then "n" is:

$n = \frac{(1.96)^2 (0.90)(0.10)}{0.05^2}$

Where n=138 was obtained. Taking into consideration that the population of women with physical disability who have given birth in the last five years is 600 (estimates from the Ghana Society of Physical Disabled Greater Accra) putting this and the calculated figure of "n" into the formula, the sample size for the study was calculated as follows: $n_f = 138$ $n_f = \frac{138}{1 + \frac{138}{600}} = 206.$


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