

UNIVERSITY OF GHANA
SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES



**EXPERIENCES OF MOTHERS OF CHILDREN WITH HEARING IMPAIRMENT: A
STUDY AT THE ASHANTI SCHOOL FOR THE DEAF, JAMASI-ASHANTI REGION,
GHANA**

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**THIS THESIS IS SUBMITTED TO THE UNIVERSITY OF GHANA, LEGON IN
PARTIAL
FULFILLMENT OF THE REQUIREMENT FOR THE AWARD OF MPhil IN
NURSING DEGREE**



AUGUST, 2025

DECLARATION

I, FAUSTINA AMORO hereby declare that this research on “Experiences of mothers of children with hearing impairment; a study at the Ashanti School for the Deaf, Jamasi-Ashanti Region, Ghana” is the result of my work produced under the abled supervision of Dr. Gwendolyn Patience Mensah and Miss Patricia Avadu and that all ideas and information from other people’s work, which were used in this thesis, have been duly cited and referenced.



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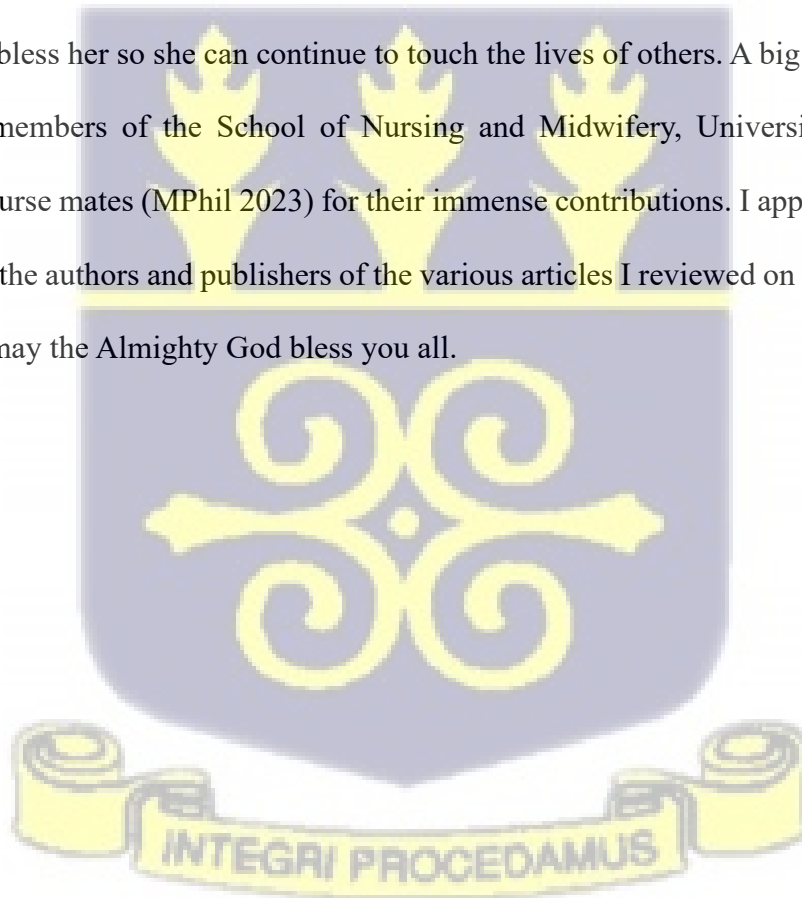
DEDICATION

This work is dedicated to my lovely parents and siblings who have been supportive in my studies, without whom I could not have succeeded in my academic endeavour. Dr. Bethran Yeboah deserves special mention for his support, understanding and sacrifices throughout the period.



ACKNOWLEDGEMENT

I thank the Almighty God, for his divine favour, care and protection throughout my life and especially during the period of the study. My profound gratitude goes to the participants, who willingly consented to be part of the study. It is their contributions that formed the fulcrum of the study. I thank the headmaster and staff of the Ashanti school for the deaf, for their selfless support. I wish to extend my sincerest gratitude to my supervisors for their priceless roles they played. I am most grateful to Dr. Gwendolyn Patience Mensah for her exhibition of patience, dedication, zeal and foresight, few of her many possessed qualities, that inspired me throughout the study encounter. It was a gratifying honour to work with her, and it is my prayer that the Almighty God will continue to bless her so she can continue to touch the lives of others. A big thank you goes to all the faculty members of the School of Nursing and Midwifery, University of Ghana, not forgetting my course mates (MPhil 2023) for their immense contributions. I appreciate the diverse views shared by the authors and publishers of the various articles I reviewed on the subject matter. Thank you and may the Almighty God bless you all.



ABSTRACT

Most deaf children are born to parents with hearing. The negative impact of caring for children with chronic illness has been identified among others and as such impedes their own health and well-being. How parents deal with these challenges is significant for their overall well-being and as a result, this study seeks to explore the experiences of mothers of children with hearing impairment. Exploratory- descriptive qualitative design was selected for the study using in-depth face-to-face interviews. Purposive sampling was used to select participants. Audio recordings were transcribed verbatim manually, cleaned and sorted into a Word document after which data was exported to ATLAS.ti version 7 where themes and subthemes were generated and analyzed.

Overall, 4 major themes and 12 subthemes were obtained from the study. The major themes included; information sharing experiences of mothers, garnering resources by mothers, mothers' early responses and cultural and religious cooperation among mothers and healthcare professionals. The study revealed that the participants employed different methods of communicating with their children, either through sign language and or written language. Mothers also disclosed that they were able to provide for themselves all their basic needs primarily because they had some means of employment, however, they occasionally received some form of assistance from other individuals, social and religious groups. Additionally, the mothers were ready anytime to respond to the needs of their children with assistance from school-appointed representatives. Finally, the mothers disclosed that although they had diverse religious and cultural practices, they do not interfere with their responsibilities as parents while caring for their children in healthcare settings and as a result, there was positive cooperation, respect among themselves and all healthcare professionals. All mothers disclosed experiencing some form of challenges as parents caring for children with chronic illnesses. However, they also appreciated the need to cooperate with different professionals for health information and occasionally seek financial support to improve upon their own health and wellbeing.

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ABBREVIATIONS AND ACRONYMS

ABBREVIATIONS

MEANING

DHH	Deaf and Hard of Hearing
EI	Employment Insurance
GJB2	Gap Junction Beta-2
HCPs	Health Care Professionals
KATH	Komfo Anokye Teaching Hospital
NHIS	National Health Insurance Scheme
PTA	Parent Teacher Association
WHO	World Health Organisation



CHAPTER ONE

INTRODUCTION

1.1 Background

According to the World Health Organization (WHO, 2024a), a person who is not able to hear well as someone with normal hearing at a hearing threshold of 20 dB or better in both ears is considered to have hearing loss (Wagatsuma et al., 2022; WHO, 2024a). It can happen when any part of the ear is not working in the usual way which can involve the outer ear, middle ear, inner ear, hearing (acoustic) nerve, and auditory system. Hearing loss can be mild, moderate, moderately severe, severe or profound, and can affect one or both ears (Humes, 2018; WHO, 2024a). Major causes of hearing loss include congenital or early onset childhood hearing loss, chronic middle ear infections, noise-induced hearing loss, age-related hearing loss, and ototoxic drugs that damage the inner ear (Mulwafu, 2020). It has been estimated by the WHO (2024) that by 2050 nearly 2.5 billion people are projected to have some degree of hearing loss with at least 700 million will require hearing rehabilitation. Of these, over one billion young adults are at risk of permanent, avoidable hearing loss due to unsafe listening practices and hence contribute to additional 1.40 USD per person to require hearing care services globally (WHO, 2024).

Hearing loss and deafness affect people of all ages. Currently, more than 1.5 billion people (nearly 20% of the global population) live with hearing loss (Ren et al., 2019) with over 5% of the world's population representing 430 million people requiring rehabilitation to address their disabling hearing loss. 432 million adults and 34 million children suffering from hearing loss can be caused by many different factors (WHO, 2024). The three basic categories of hearing loss are sensorineural hearing loss, conductive hearing loss and mixed hearing loss. Children who have hearing impairment, have

trouble hearing or understanding some or all sounds (Brodie et al., 2018). This can happen when there is a problem with one or more parts of the ears, the nerves that send sound signals from the ears to the brain and the part of the brain that makes sense of these signals (Sherry, 2021). Hearing loss in children can be present at birth (congenital) or developed later in childhood (Leung & Leung, 2019). Congenital hearing loss can be hereditary (genetic) or caused by infections during pregnancy, including infection with cytomegalovirus or rubella (Sheffield & Smith, 2019). Hearing loss is more common in babies who are in the neonatal intensive care unit (NICU) (Nair et al., 2021). Hearing loss can be an isolated condition or a feature of a syndrome that causes additional symptoms. Genetic testing can help determine the cause of hearing loss in some cases. Acquired hearing loss can be caused by infectious diseases, such as meningitis or recurrent ear infections, as well as trauma and certain medications.

The impacts of hearing loss are broad and can be profound. They include a loss of the ability to communicate, with others delayed language development in children, which can lead to social isolation, loneliness and frustration particularly among older people with hearing loss (Dammeyer et al., 2019). Children with hearing loss and deafness in developing countries rarely receive any schooling. Also, persons with hearing loss may face stigma since the disorder has a number of undesirable consequences, including cognitive and social impairment (Heffernan et al., 2016). In the labour market, individuals with hearing loss are more likely to have lower wages and higher unemployment rates (Zhou et al., 2021). There is also some evidence that hearing loss is related to depression, cognitive decline, and dementia. Therefore, there is a need to explore the experiences of mothers whose children have hearing impairment in the Ashanti region.

Low and middle-income countries including Africa and Sub-Saharan Africa bear a disproportionate burden from hearing loss (Ozawa et al., 2018). WHO estimates that global hearing aid production covers just 3% of the need in these countries (Haile et al., 2021). However, many of the impacts of

hearing loss can be mitigated through early detection and interventions. These include specialized education programs and sign language instruction for young children and their families. Assistive technologies including hearing aids, cochlear implants, closed captioning and other devices can help people with hearing loss at any age (McMahon et al., 2021). People may also benefit from speech therapy, aural rehabilitation and other related services (Sharma et al., 2020).

Children with hearing loss will have to live with such a condition for a long time, as it cannot be cured (Haile et al., 2021). This will affect the condition of the family, especially the mother, and also, other family members (Nomaguchi & Milkie, 2020). Feelings of loss and uncertainty are felt by parents of children with hearing loss (Skarzynski et al., 2020), leaving parents feeling hopeless about their children's condition, and fear of the children's future and that of facing the outside world. Parents will experience depression if this condition continues. Parents who provide care for children with hearing loss can have their health disrupted both physically and mentally. Continuous sadness and anxiety without followed up by proper coping mechanisms will affect mothers' mental health (Harris et al., 2021). Parents suffer the feeling of being ostracized from the community, including isolation by the family to being neglect from the family and community. Exclusion from the community is also a major obstacle for mothers that prevents them from accessing the available support.

Wanjiru et al. (2015) explored parental contributions to the learning processes of deaf children in Kenya. Although the parents discussed making educational materials available to their deaf children, they were unaware of the learning processes, assessments and educational services available to their children. Parents also recounted the challenges of raising their children. They described their children as aggressive and unable to socialize with other children in the community.

The deaf children tended to demonstrate behaviour that could be considered aggressive towards their non-deaf counterparts. This, according to the parents, led to hostility between them and their neighbours (Badzis & Idris, 2019).

Extensive research documents show that parents of children with hearing impairment face multifaceted challenges, with mothers often experiencing heightened stress as primary caregivers. The initial diagnosis typically elicits profound emotional distress, including grief, guilt, and anxiety about the child's future communication and social development (Gunjawate et al., 2023). Establishing effective communication remains a critical stressor, as parents navigate complex decisions about communication modalities (e.g., sign language, oralism) while managing barriers to parent-child bonding (Elliott et al., 2022). Additionally, parents encounter substantial systemic burdens, including coordinating healthcare, audiological services, early intervention programs, and educational support, which demand significant advocacy efforts and logistical management (Favot et al., 2021). Socioeconomic impacts are also pronounced, with families reporting financial strain from hearing technology costs, reduced employment opportunities, and social isolation due to stigma or limited community inclusivity (Kanji, 2021). Consequently, studies consistently report elevated levels of chronic stress, anxiety, and depression among these parents compared to those of typically developing children, though resilience often develops through social support and positive reframing over time (Khoza-Shangase, 2025; Ormel et al., 2022).

Mothers of children with hearing impairment face a complex interplay of structural, informational, and socio-cultural barriers that significantly compound the challenges of caregiving. These factors are particularly pronounced in resource-limited settings like Ghana and pose substantial obstacles to maternal well-being and effective child support.

1. Resource Acquisition Challenges

Acquiring essential resources for their children presents mothers with significant financial, logistical, and systemic hurdles. Poverty is a primary barrier, rendering costly assistive devices like hearing aids and cochlear implants, along with necessary batteries and maintenance, inaccessible for many families (Abel et al., 2019; Khoza-Shangase, 2019). Even when devices are theoretically available through public health initiatives, geographic disparities in service provision mean mothers in rural or peri-urban areas often face long and expensive journeys to audiological centers, incurring substantial transportation costs and lost income (Olusanya, 2012; Okyere et al., 2019). Furthermore, the scarcity of qualified professionals (audiologists, speech therapists, ear-nose-throat specialists) and inconsistent supply chains for hearing aid parts or repairs create chronic delays and interruptions in accessing and maintaining necessary technology (WHO, 2021; Opoku et al., 2022). This constant struggle for basic resources consumes considerable maternal time and energy, diverting attention from other caregiving needs and personal well-being.

2. Information Sharing and Access Deficits

Mothers frequently encounter critical gaps in obtaining timely, accurate, and comprehensible information. Delayed diagnosis remains a pervasive problem, often due to limited newborn hearing screening programs and lack of awareness among primary healthcare providers, delaying crucial early intervention (Swanepoel et al., 2013; Olusanya et al., 2014). Post-diagnosis, information provision is often inadequate or overwhelming. Healthcare professionals may lack the time, training, or culturally appropriate materials to explain complex audiological information, communication options (sign language vs. oralism), or available support services effectively (Jackson et al., 2008; DesGeorges, 2003). This leaves mothers navigating critical decisions with incomplete understanding. Communication barriers extend to educational settings. Mothers report difficulties in communicating effectively with teachers at schools for the deaf, especially if they

themselves are not fluent in sign language, hindering their ability to support their child's learning and monitor progress (Opoku et al., 2022). Reliance on fragmented informal networks (other parents, community members) for information can lead to misinformation or inconsistent advice (Khoza-Shangase, 2019).

3. Cultural and Religious Influences

Deeply held cultural beliefs and religious interpretations profoundly shape mothers' experiences and coping strategies, often adding layers of difficulty. Stigma and negative societal attitudes towards disability are widespread. Mothers may experience blame, shame, or social isolation due to cultural beliefs that attribute a child's deafness to ancestral curses, parental sin, or witchcraft, significantly impacting their mental health and social support (Ebrahimi et al., 2016; Gona et al., 2010; Opoku et al., 2022). Fatalistic religious interpretations can lead some families to prioritize prayer and spiritual healing over seeking medical intervention or early educational support, potentially delaying critical services (Bademosi, 2020). Conversely, religious communities can also be vital sources of emotional support and practical aid. Cultural norms regarding family roles and disclosure may pressure mothers to bear the caregiving burden silently or discourage open discussion of the child's disability outside the family, limiting access to potential community support or services (Continisio et al., 2023; Zyl et al., 2023). The reliance on traditional healers alongside or instead of biomedical services, driven by cultural beliefs, can further complicate the care pathway and resource allocation (Bademosi, 2020). Navigating these complex and sometimes contradictory cultural and religious expectations creates significant internal conflict and stress for mothers.

Significant knowledge gaps persist, particularly regarding non-Western contexts. Most evidence originates from high-income Western countries (e.g., North America, Europe), while low

and middle-income regions like Sub-Saharan Africa remain critically underrepresented (Ndegwa et al., 2024). This omission is problematic given that cultural perceptions of disability, resource availability, and support systems vary substantially across settings. For example, in Ghana, limited access to hearing technology, specialized education, and community rehabilitation services likely shapes unique caregiving challenges not captured in existing literature (Okwere et al., 2019). Furthermore, while mothers bear disproportionate caregiving burdens, few studies explicitly center their lived experiences using qualitative methodologies, resulting in insufficient depth on their coping strategies, emotional trajectories, and unmet needs (Opondo, 2024). Quantitative dominance in the field also overlooks nuanced cultural and contextual factors influencing maternal adaptation in resource-constrained environments like rural Ghana (Whicker et al., 2019).

In Ghana, Owoo (2016) revealed that an estimated 110,000 and 211,000 people are deaf and have difficulty hearing people although the exact number of people with hearing impairment is unknown. Adadey et al. (2019) also indicated that there were no extensive studies to determine the national burden of hearing loss in Ghana. However, according to their study, it was revealed that the burden of acquired hearing loss was higher in adults than children, women than men, and people working in a noisy environment. They further disclosed that regarding the genetic cause, specific founder mutations in GJB2 gene (R143W, L79P, V178A, R184Q, A197S, I203K, and L214P) was the only identified genetic cause of hearing impairment in Ghana, but the other hearing impairment genes were not investigated. Hearing disorders have many complications, particularly in the context of the Ghanaian traditional society, it is viewed as a curse brought on by various attributes such as being punishment for crimes done by those with impairments or their family members, or the result of witchcraft, magic, or sorcery (Alhassan & Ridwan, 2022). As a result, parents, particularly mothers, of

children who exhibit any "abnormality," such as behavioural or physical illnesses, may face stigma, fear, blame, and social rejection. (Currie & Szabo, 2020)

Studies have indicated that parents with hearing impairment unlike those without hearing impairment themselves are likely to have the same communication systems as their deaf children and thus they would have less difficulty communicating with and supporting these children compared to parents without hearing impairment who to a greater extent experience various challenges in the family and the society (Continisio et al., 2023; Khoza-Shangase, 2019; Whicker et al., 2019). According to Continisio et al. (2023), there have been increasing challenges experienced by mothers and family caregivers of children with hearing impairment despite the many strategies that have been outlined over the years to help deaf children and mothers cope with their social environment some of which include; empowering families so that deaf children would likely learn their natural language (sign language) early on at home and acquire the necessary skills to interact with the wider community causing a lot of challenges for their mothers, to themselves and their family as a whole. The study therefore explored the experiences of mothers of children with hearing impairment in Ashanti School for the Deaf and how well they are able to cope with their very well-being.

1.2 Statement of the problem

The experience of raising a child with a hearing impairment presents profound and multifaceted challenges for parents, particularly mothers who often assume the primary caregiving role. A critical factor underpinning these challenges is the linguistic barrier: most deaf children are born to hearing parents who do not acquire sign language as their first language at home. This fundamental communication disconnect has a well-documented propensity to cause significant developmental delays in language acquisition, literacy, and social-emotional skills, alongside

increased risks of behavioural problems among these children (Bigler et al., 2019; Fitzpatrick et al., 2019; Mweri, 2016). Beyond the core linguistic hurdle, parents navigate a complex landscape of stressors. Owing to the challenges enumerated despite the potential availability of some resources such as hearing aids and specialised schools, studies consistently indicate that caring for children with hearing loss is significantly more stressful and distinct in its demands compared to raising typically hearing children (Jackson et al., 2008; Khoza-Shangase, 2019; Whicker et al., 2019).

Mothers and caregivers frequently report experiencing substantial physical, social, and emotional burdens. These burdens are exacerbated by systemic deficiencies, including the limited availability of appropriate educational institutions and accessible healthcare facilities specifically equipped for children with hearing impairment, often necessitating long-distance travel to access essential services (Khoza-Shangase, 2019). Furthermore, children with hearing impairment and their families routinely encounter stigma and social marginalisation stemming from limited community awareness and understanding of hearing loss, compounding the stress experienced by family caregivers (Continisio et al., 2023; Ebrahimi et al., 2016; Khoza-Shangase, 2019; Zyl et al., 2023). The resultant social isolation and negative societal attitudes place significant additional strain on maternal well-being.

While assistive devices, such as hearing aids or cochlear implants, coupled with rehabilitation practices, have been shown to improve language development outcomes for some deaf children (Cupples et al., 2018; Zyl et al., 2023), their potential is severely curtailed in resource-constrained settings like Ghana. Widespread poverty creates significant barriers, rendering these technologies inaccessible for many deaf children (Abel et al., 2019). Consequently, regardless of technological access, the imperative for functional communication often leads

families to prioritise enrollment in schools for the deaf, such as the Ashanti School for the Deaf, where sign language is the primary mode of instruction, representing a crucial pathway for children to acquire language and communication skills. However, this reliance on specialised schools does not alleviate the profound communication challenges faced by hearing parents within the home environment.

The context of Ghana, and specifically the Ashanti Region, intensifies these challenges. Despite mandates like the Children's Act of Ghana (1998) and policies promoting free, compulsory basic education for all children, service provision remains inadequate. The Ashanti School for the Deaf stands as the sole educational institution for deaf children in Ghana's second most populous region, yet it reportedly lacks sufficient facilities and resources (Ghana Statistical Service, 2018; Opoku et al., 2022). Critically, research indicates that a significant proportion of children at this school are born to hearing parents, creating persistent communication barriers that impede everyday family functioning, access to healthcare, and the meeting of basic needs (Opoku et al., 2022). While sending children to school to learn sign language is a strategy employed by parents to foster their child's communication, bonding, and future well-being, the mothers themselves endure considerable, often unacknowledged, hardships. In their unwavering commitment to fulfilling their legal and caregiving responsibilities until adulthood, mothers frequently prioritize their child's needs above their own, neglecting their physical and mental health, which can lead to significant negative health consequences (Opoku et al., 2022; Ebrahimi et al., 2016).

Therefore, a critical problem exists: Mothers of children with hearing impairment attending the Ashanti School for the Deaf face a constellation of unique and severe challenges rooted in linguistic barriers, systemic resource constraints, socioeconomic pressures, pervasive stigma, and the relentless demands of caregiving within a specific Ghanaian context. These challenges

profoundly impact their daily lives, emotional well-being, and physical health, yet their specific lived experiences, coping mechanisms, and support needs within this under-researched setting remain inadequately explored and understood. Empowering these mothers requires a deep, contextualised understanding of their realities to inform effective support systems that address their holistic well-being as they navigate the lifelong journey of raising a child with a hearing impairment.

1.3 The purpose of the study

The purpose of the study was to explore the experiences of mothers of children with hearing impairment at the Ashanti School for the Deaf.

1.4 Objectives of the study

The research objectives included; To

1. describe information sharing experiences among mothers of children with hearing impairment at Ashanti School for the Deaf. (information sharing)
2. explore the resource acquisition practices among mothers of children with hearing impairment at Ashanti School for the Deaf. (garnering resources)
3. describe mothers' early responses to the health needs of their children with hearing impairment at Ashanti School for the Deaf. (proximity)
4. examine the cultural and religious factors affecting the cooperation of mothers of children with hearing impairment at Ashanti School for the Deaf and healthcare professionals (cultural and religious cooperation).

1.5 Research Questions

The questions formulated for the study were:

1. What information-sharing experiences do mothers of children with hearing impairment at Ashanti School for the Deaf have?
2. What resource acquisition practices do mothers of children with hearing impairment at Ashanti School for the Deaf have?
3. How early do the mothers respond to the needs of their children with hearing impairment at Ashanti School for the deaf?
4. What are the cultural and religious factors that affect the cooperation between mothers of children with hearing impairment at Ashanti School for the deaf and healthcare professionals?

1.6 Significance of the study

The findings from this study are expected to help healthcare professionals, particularly nurses, understand the experiences of mothers of children with hearing impairment in caring for the needs of their children and ensuring their overall well-being as their primary guardians. An understanding of this will enable healthcare workers particularly nurses plan individualized and family-centered care for the children to meet their specific needs using a non-prejudicial, non-stigmatized approach to enhance, improve and promote the well-being and quality of life of these particular patients and their families.

The findings of this study will also assist the Department of Social Welfare and other organizations on the need to put out initiatives that are aimed at supporting mothers caring for their children with hearing impairment. Also, instead of stigmatizing families of children with hearing impairment, the entire public will be educated about their role in assisting them. As a result, it will help in the development of advocacy campaigns in local communities and larger Ghana populations. The findings of this study will again contribute to the literature on the experiences of mothers of

children with hearing impairment in Ghana, as well as serve as a platform for future research into the grey areas that will arise from this study.

1.7 Operational definitions

Hearing impairment: the inability of an individual to hear sounds adequately.

Children: boys and girls aged between 6-17 years of age.

Mother: a female primary/biological caregiver within the family or a secondary caregiver appointed by law to care for children below 18 years of age.

Experiences: practical knowledge, skill, or practice derived from direct observation or participation in events or in a particular activity.

Deaf: lacking the power of hearing or having impaired hearing.

1.8 Organization of the Thesis

The first chapter of this work consists of; an introduction, background of the study, problem statement, purpose of the study, objectives, research questions, significance of the study and the operational definitions. Chapter Two offers a review of relevant literature done in line with the theoretical framework guiding the study. Chapter Three explains the various research processes which constitute the methodology. These include; the research design, setting, target population, inclusion and exclusion criteria, sampling size and technique, data collection tool and procedure, data management, analysis and methodological rigour. In Chapter Four, the findings of the study are presented. In Chapter Five, the findings of the study are discussed. These were all done in relation to the guiding theoretical framework. The sixth and final chapter contains the summary of the entire work, implications, limitations and conclusions. It further offered some recommendations for improvements.

CHAPTER TWO

LITERATURE REVIEW

THEORETICAL FRAMEWORK OF THE STUDY/ LITERATURE REVIEW

2.1 Introduction

This section reviewed studies done in relation to mothers' experiences caring for their children with hearing impairment. Databases such as PUBMED, Science Direct, Google Scholar, SAGE and Semantic Scholar were consulted. Search items included mothers' and caregivers' experiences and well-being with children with hearing impairment, quality of life of mothers of children with hearing impairment, sociocultural practices of mothers of children with hearing impairment and family-centred with children with disabilities and hearing impairment to retrieve relevant literature for the study. Research articles relevant and used for the study ranged from 2018 to 2024. However, articles that are older but classical and relevant to the topic with empirical quality were also included in the review. The literature review was organized based on the objectives of the study and the constructs of the theory of family care during critical illness. This chapter was presented as follows;

1. Theoretical framework.
2. Literature review on Information sharing experiences of mothers of children with hearing impairment. Resource acquisition practices of mothers of children with hearing impairment. Mother early responses to the needs of their children with hearing impairment. Cultural and religious factors affecting mothers of children with hearing impairment with healthcare professionals.
3. Summary and conclusion.

2.2 Theory of family care during critical illness

The theory of family care during critical illness was developed in South Africa in critical care units by de Beer and Brysiewicz (2019). It was developed to address challenges confronting family caregivers, their functioning and integrity with the involvement of healthcare professionals in a way that empowers them to take control of the determinants of their health as they go through the process of caring for their loved ones.

The theory has five constructs with the dependent constructs being the empowerment of the family caregiver by healthcare professionals to overcome their challenges, improve their well-being (physically, psychosocially, emotionally and spiritually) and quality of life as well as the well-being and quality of life of those they are caring for. The other four independent constructs namely; information sharing, proximity, garnering resources and, cultural and religious cooperation come together to empower family caregivers.

According to the theory, empowerment reflects the phase of transition from feeling powerless to improved personal capacity to take control of factors that affect health negatively. Empowerment serves as a positive influencer to manage physical, emotional, cognitive and environmental barriers to quality health with the help of healthcare professionals who integrate them into the care of their loved ones.

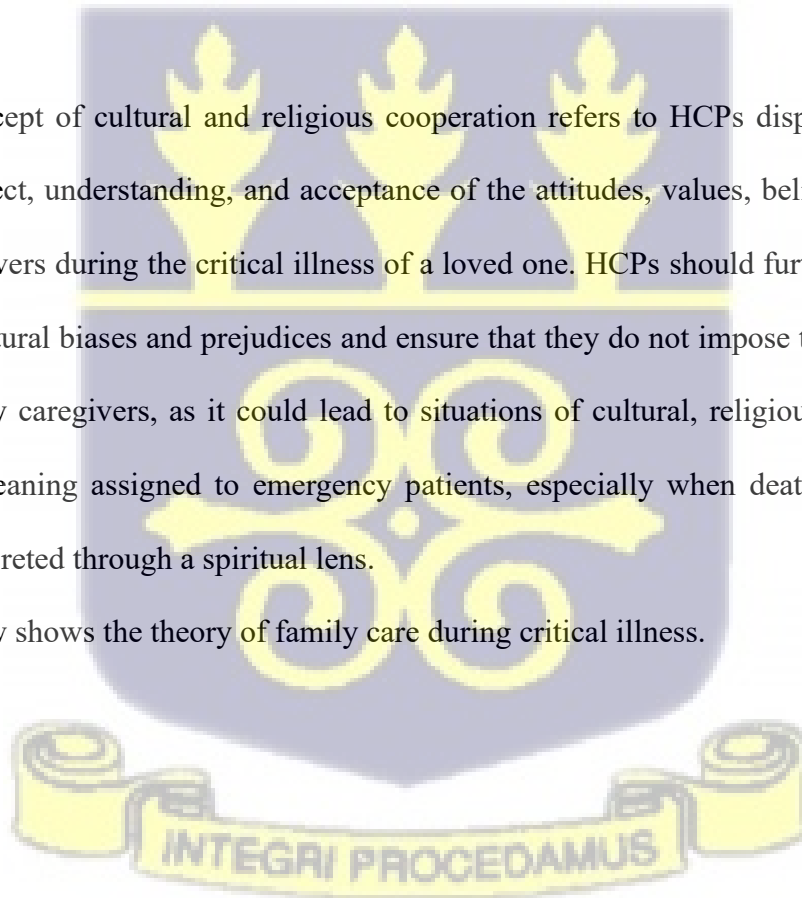
Information sharing refers to the exchange of necessary data or facts about the critical illness between healthcare professionals and family members, which increases the knowledge base of both parties. When family members receive information about the patient's condition, treatment, prognosis or outcome, their knowledge increases, enabling them to better deal with the critical illness of a loved one which serves to contribute to psychosocial support of family members and that, providing information to family members about the patient's care reduces anxiety associated with the unfamiliar critical care environment.

Proximity refers to being flexible about the family's access to the patient and making it easier for them to be (physically and psychologically) close to their loved ones. Such closeness allows family caregivers to monitor the situation, track the care given to the patient, and develop trust and confidence in the care. This is supported by Harvey (2018) who reported that family caregivers felt a strong need to be close to the patient to see what was going on.

Garnering resources refers to family caregivers acquiring resources for themselves, concerning both material and non-material resources. Syed et al. (2020) suggest that because family caregivers often feel they need to stay near their emergency patients, it is important to provide ready access to fluids and nutrition (e.g., coffee stations and vending machines) in the waiting area.

The concept of cultural and religious cooperation refers to HCPs displaying a sense of awareness, respect, understanding, and acceptance of the attitudes, values, beliefs, and practices of family caregivers during the critical illness of a loved one. HCPs should further also be aware of their own cultural biases and prejudices and ensure that they do not impose these on either the patient or family caregivers, as it could lead to situations of cultural, religious, or professional conflict. The meaning assigned to emergency patients, especially when death is inevitable, is frequently interpreted through a spiritual lens.

The figure below shows the theory of family care during critical illness.



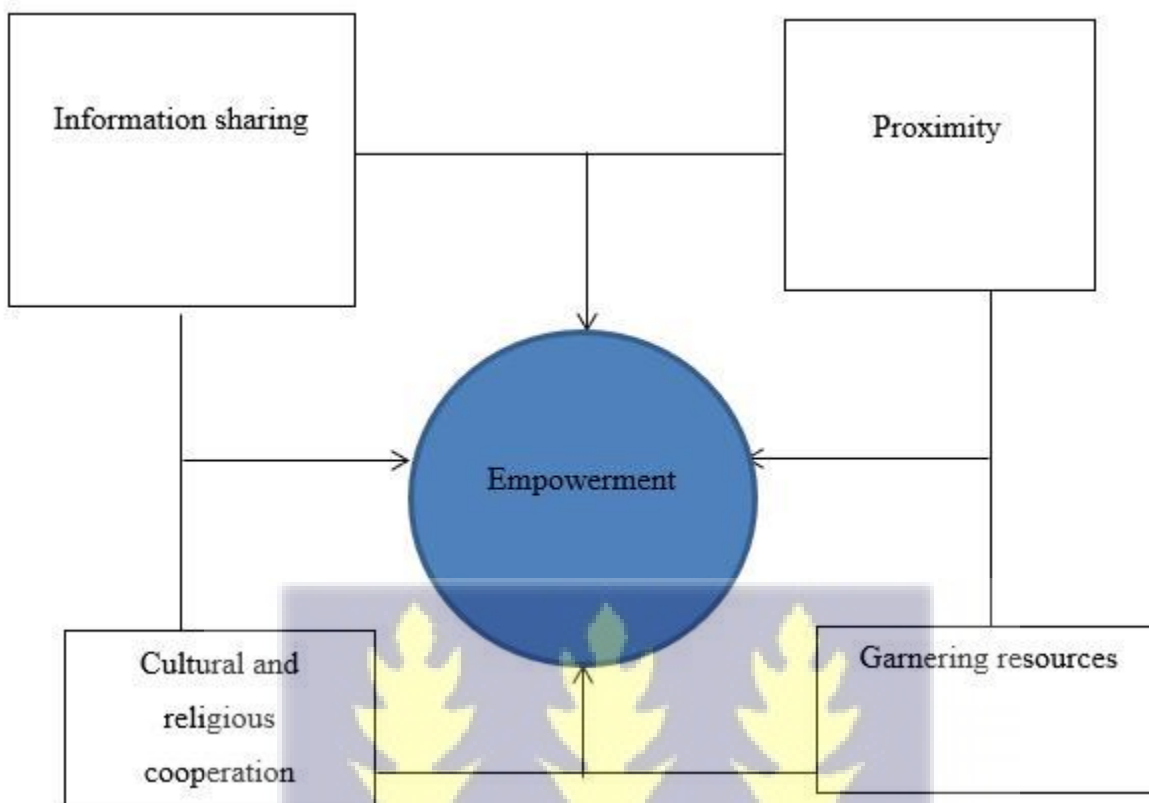


Figure 2. 1: Theory of Family Care during critical illness from de Beer& Brysiewicz,2019

The model was found suitable for this study because familial worries and anxieties are anticipated and occur in instances of severe illness or injuries. These can be mitigated by the assistance of healthcare professionals who are first able to recognize, diagnose, determine the severity of illness and plan specific action or management to meet the needs of the children. As it is the responsibility of guardians (primary or secondary) mandated by the legislature to ensure a safe and healthy environment for their children to grow and develop (Children Act of Ghana, 1998), healthcare professionals plan care with guardians by providing adequate information pertaining to their ward's health, help them organise resources including education, health

resources and providing emotional and psychological support for parents to empower them to serve as the primary health advocates for these children. This process is facilitated by the HCPs, who, in allowing time to engage with a patient's family, create a perception of partnership. This interaction suggests respect for the person and the situation and contributes to family caregivers feeling dignified and cooperated fully with all plans, and processes towards recovery hence this model was selected for the study.

The theory has been developed with respect to healthcare service delivery and access in the South African context and hence resonates with the challenges and possible solutions for implementation in many other African countries including Ghana to promote positive therapeutic partnerships among healthcare professionals, patients and their family caregivers. (de Beer & Brysiewicz, 2019; Vaismoradi et al., 2016; Vogel et al., 2023)

The constructs of the theory have been applied in other studies involving family caregivers of patients and their involvement with healthcare professionals. This is seen in a study by Harvey (2018) who indicated that family caregivers felt a strong need to be close to the patient to see what was going on. Also, it was revealed by I. H. Syed et al. (2020) that because family caregivers often feel they need to stay near their loved ones when ill or at the emergency department, it was also of significance for them to maintain adequate nutrition and hence obtain the necessary resources for themselves to stay healthy while taking care of their loved ones.

2.3 Literature Review

A family caregiver or informal caregiver refers to an unpaid person who takes care of a patient in an acute or chronic condition in and out of the healthcare setting who can be a family member, neighbour, or friend (Fernández-Carro & Vlachantoni, 2019; Schmidt et al., 2016). A

mother according to the Children's Act of Ghana (1998), is a female biological or primary guardian who has the primary duties and responsibility of taking care of children below 18 years of age.

They are mandated by law to provide food, shelter, clothing and a safe environment for children to grow, develop physically, emotionally, and psychologically as well as protection from illness, harm and danger. Mothers represent biological or primary guardians and are mandated to provide safe, healthy and enabling environments for children in their care to grow and develop and have quality of life as they grow (The Children's Act of Ghana, 1998). Some of their duties include dressing, bathing, serving meals, providing timely and quality healthcare access and services, administering medication, and communicating with medical staff. Mothers in general represent the informal support systems for children and according to Fernández-Carro and Vlachantoni (2019), the concept of mothers as part of informal support systems identified in many studies across the world puts them in positions to help take care of their loved ones when they are unwell and receiving treatment from all manner of causes.

Social and family networks over the years have been instrumental in the healthcare industry globally in providing care for loved ones who suffer different forms of illness, ranging from chronic illness, critical care, people living with disabilities, and children with hearing impairment among others Fernández-Carro and Vlachantoni (2019). Despite caring for their loved ones in different circumstances, these informal caregivers or people belonging to these social support systems experience varying degrees of emotional, physical, spiritual or psychological stress which cause a ripple effect on the loved ones they care for Lauritzeen and Jelte (2019). Regardless of the severity of a patient's illness, there can be a burden on both the patient and the mother who may have different experiences when caring for individuals with life-threatening or disabling conditions.

According to Riffin et al. (2019), an estimated 14.9 million caregivers assisted 7.6 million care recipients, with more than half of the caregivers reporting burden related to caregiving. The majority of whom were females, adult and child caregivers were in poor health for which mothers play significant roles as female caregivers. However, mothers who perform these responsibilities have the right to quality of health and life as stipulated by WHO (2024c) and are therefore entitled to being at their optimum health level because their importance in the health industry cannot be overstated because they help provide enabling environments for their loved ones to recovery. Numerous studies conducted in Africa and beyond have identified challenges the informal social support system goes through while performing their enumerated roles.

Maternal caregiving for children with hearing impairment represents a profound and sustained challenge, demanding significant adaptation to managing chronic critical conditions, as illustrated by the family care theory (Eggenberger & Nelms, 2007; Svavarsdottir, 2005). The initial diagnosis often precipitates a crisis phase, evoking intense grief, shock, and uncertainty about the child's future communication and development, fundamentally disrupting family equilibrium (Kurtzer-White & Luterman, 2003; Young & Tattersall, 2007). This crisis necessitates rapid maternal adaptation, thrusting mothers into the primary role of navigating complex healthcare, educational, and rehabilitative systems to secure essential services and technologies for their child (Jackson et al., 2008; DesGeorges, 2003). Chronic systemic stressors, including pervasive poverty limiting access to hearing aids or cochlear implants, geographical barriers to specialized services, and shortages of qualified professionals, create relentless demands on maternal resources, mirroring the sustained burden described in critical illness care models (Abel et al., 2019; Olusanya, 2012; WHO, 2021; Svavarsdottir, 2005).

Mothers frequently encounter significant informational deficits, experiencing delays in diagnosis due to limited newborn screening and receiving inadequate, complex, or overwhelming explanations about communication options and support pathways post-diagnosis (Swanepoel et al., 2013; Jackson et al., 2008). Communication barriers extend into the educational sphere, hindering effective collaboration between mothers unfamiliar with sign language and educators at schools for the deaf (Opoku et al., 2022). Cultural and religious factors profoundly shape the caregiving experience, with pervasive stigma, beliefs attributing deafness to ancestral curses or sin, and fatalistic interpretations often leading to delayed intervention and increased maternal isolation and psychological distress (Ebrahimi et al., 2016; Gona et al., 2010; Mprah et al., 2013; Opoku et al., 2022). Consequently, mothers of children with hearing loss consistently report elevated levels of chronic stress, anxiety, depression, and physical exhaustion compared to mothers of typically hearing children, significantly impacting their well-being and family functioning (Zaidman-Zait, 2008; Whicker et al., 2019; Continsio et al., 2023).

Family care theory emphasises the dynamic interplay between caregiver burden and resilience, acknowledging that mothers develop coping strategies and find strength through social support networks, religious faith, positive reframing, and witnessing their child's progress (Eggenberger & Nelms, 2007; DesGeorges, 2003; Zyl et al., 2023). However, within resource-constrained settings like Ghana, where systemic support is often lacking and stigma remains potent, maternal resilience is constantly tested, and the chronic nature of managing the child's needs creates an enduring caregiving trajectory comparable to long-term critical illness management (Opoku et al., 2022; Svavarsdottir, 2005). Empowering these mothers requires interventions that address the multifaceted stressors (resource limitations, information gaps, cultural barriers, and emotional toll) within their specific socio-cultural context, aligning with

family-centred care principles essential for sustainable caregiving (Jackson et al., 2008; Olusanya, 2012; WHO, 2021).

2.3.1 Information sharing among mothers of children with hearing loss (Information Sharing)

According to de Beer and Brysiewicz (2019), the sharing of information in the healthcare context refers to the exchange of necessary data or facts about the illness (medical state) between HCPs, mothers and or other family members directly involved in the care of their loved one. Furthermore, they disclosed that information sharing increases the knowledge base of both parties and thus serves as a resource for being aware of determinants of one's own health and how to take control of them by utilizing the available resources and ultimately empowering them to improve and maintain their wellbeing and quality of life. Mothers tend to gain insight relating to sick children and therefore serve as primary non-paid caregivers and advocates of the good health and well-being of their children.

A study conducted by Røe-Indregård et al. (2022) involving the traditional father–mother–child model family in Norway revealed that a majority of mothers can communicate with their children aged between 18 months and 56 months in their homes compared to their fathers. As a result, mothers can identify challenges and or progress in communication, and speech development rather earlier compared to their fathers. It can therefore be inferred from the study that if mothers of children with hearing impairment communicate more often with their children, at early ages using multiple mediums they would be able to identify challenges that are associated with speech and hearing and seek medical attention. By so doing, mothers serve as positive sources of information when communicating with healthcare providers in order to aid in the assessment and

planning of care to meet their needs. Within the same year, He et al. (2020) revealed in their study on “The link between hearing impairment and child maltreatment among Aboriginal children in the Northern Territory of Australia”, revealed that among all the participants, 56.1% of their study participants had a record of hearing loss or unilateral hearing loss and those that with history of contact with child protection services, 56.7% had a record of hearing loss or unilateral hearing loss. It was also revealed that children with moderate or worse hearing loss had a higher risk of child maltreatment including physical abuse than children with normal hearing stemming from maternal and community-level factors. The maternal factors contributing to maltreatment could stem from the lack of language comprehension between mothers with normal hearing and children with hearing impairment and as a result, mothers are unable to meet standard maternal care stipulated by including the ability to share information about children to health workers, teachers and relevant stakeholders (Bess et al., 2020; Khoza-Shangase, 2019; Whicker et al., 2019).

The study further disclosed that a list of family and community-level awareness strategies to preventing maltreating children with hearing impairment and unilateral hearing loss and indicated that, information sharing between services was a critical first step in addressing the challenges faced by these children, which under the legislation are the fundamental responsibilities of guardians. Some limitations were that not all children with hearing impairment accessed the health screening exercises; also, the sample used for the study was not randomly sampled and prone to sampling bias hence it is not suitable for generalizability in the general population of children with hearing impairment. In another study by Bunning et al. (2020), they disclosed in their study on “Empowering self-help groups for caregivers of children with disabilities in Kilifi, Kenya: Impacts and their underlying mechanisms” that family caregivers particularly mothers and children with disabilities suffered and experienced stigma and discrimination. Chronic childhood

medical disease conditions including hearing impairments are known to be disabilities and therefore according to the study, mothers suffered discrimination and stigmatization. They also disclosed that mothers were blamed for giving birth to a child with deformities for example for having inappropriate relations such as incest or extramarital conduct. It was also revealed that mothers were at times held responsible for undesirable environmental effects such as drought and told of the disability being a result of punishment by God for engaging in witchcraft. These according to the mothers made them feel alone and not accepted in the community before an intervention. After introducing an intervention to promote awareness of the medical conditions the children suffered, it was revealed that the mothers felt accepted in the community as well as empowered to perform their caregiving roles for their children with disabilities. Mothers' empowerment ensures that members of the family take responsibility for providing a safe and good environment for their children to grow including sharing adequate health information with stakeholders involved in healthcare (Khoza-Shangase & Kanji, 2021).

On the other hand, a study conducted in 2023 by Jaredet et al., revealed that among immigrant children with hearing loss on understanding barriers to timely diagnosis and intervention revealed that there was a significant difference in age at diagnosis and time to the intervention (39.7, 31.5, 75.8 months, $p < .001$ and 24.6, 29.2, 48.9 months, $p = .001$, respectively). Age at diagnosis and intervention were associated with birthplace ($p = .005$, $p = .0005$, respectively) but not preferred language ($p = .667$, $p = .343$, respectively) which could serve as a barrier to sharing information and communicating with healthcare practitioners although. The study revealed maternal mode of communication and interaction with immigrant children with hearing impairment and mode of communication did not affect medical information sharing, diagnosis and seeking health services from healthcare workers for their children. It can be inferred

that in populations where this occurs, maternal challenges associated with hearing loss could be lessened compared to areas where mothers have challenges.

2.3.2 Resource acquisition among mothers of children with hearing impairment (Garnering resources by mothers)

Garnering resources refers to “family members acquiring resources for themselves, with reference to both material and non-material resources” (de Beer & Brysiewicz, 2019). According to them, they described material resources as the physical primary needs necessary for their upkeep and well-being while caring for their relatives whereas the non-material resources relate to hope. Together both of these resources contribute to improving the wellbeing and quality of life of family members when caring for their sick relatives.

Wolff et al. (2020) indicated that to ensure that mothers have optimum help and all the resources to help take care of themselves to take care of their loved ones who were experiencing some activity limitation when sick, they asked for help from healthcare professionals when performing their caregiving roles. Help from healthcare workers serves as a resource for them to feel empowered. Mothers of children with hearing impairment are responsible for specific roles to their children when hospitalized and incapacitated to perform normal activities of daily living. The physical assistance provided for them by these professionals helped empower them to take active control over the burdens and stress associated with performing these roles for their sick children (Imran Haider Syed et al., 2020; I. H. Syed et al., 2020) which also made them confident and skillful in executing these tasks (Ying et al., 2018). Within the same year, a study by Ribe et al. (2018) also indicated that the level of education of parents was an important resource for family members when caring for their sick loved ones. It was revealed that parents who had a higher level

of education had improved physical well-being and hence improved physical functioning of members of the family when their children were unwell. It can therefore be inferred from the study that female parents (mothers) tend to have improved overall well-being if they had a higher level of education.

Although patient-centred interventions, as well as family-centred interventions, have been put in place by healthcare professionals as health resources to assist mothers caring for sick children to improve their skills and competence, it was revealed by Chow et al. (2024) that some of the outcomes of the interventions depending on the severity of their relative's illness such as children with permanent hearing loss can put a toll on the family's resources such as increased financial costs, limit family routine and cause many other health problems among the family members themselves however mothers were determined to endure for the general health independence for their children.

Wolff et al. (2020) appreciated that caring for relatives when sick was burdensome however mothers and other family caregivers were also the main source of assistance for the patients. In view of this, this group of non-paid caregivers (mothers and other family caregivers) were expected to provide support for their loved ones. Wolff and colleagues revealed that some mothers called for assistance to be provided with health information about their children's (relatives) illness from healthcare professionals, to better equip them to take care of their children with hearing impairment as well as themselves as they served as advocates as well and thus receive them appropriately.

Hailu et al. (2024) also indicated that many family caregivers and mothers go through many challenges while caring for their loved ones and oftentimes ignore their own needs. However, despite the challenges they face such as dealing with medical costs, time, activity limitations, they are able to deal with financial costs and pay more attention to their loved ones when they are

unwell. In as much as some mothers were at times unprepared to take up some roles, they often sacrificed their time, financial resources and work to be able to garner enough resources to actively get involved in the care of their children (Fox et al., 2022). Within the same year, Zen and Shin (2022) revealed that spouses tend to have emotional relationships and therefore they are able to influence each other towards the performance of physical roles. Hence in the context of the African mother–father and child family membership, good emotional relationships among spouses serve as an important health resource for improving the quality of life of themselves and their children with varying degrees of medical disorders including those with hearing impairment (Røe-Indregård et al., 2022) and hence they are able to acquire all the resources their children need in order to grow and develop.

Another important non-material resource is the mother's emotional well-being. According to Feron (2016), emotional wellbeing is a positive sense of enabling an individual to function in society to meet the demands of everyday life, to have the ability to recover effectively from illness, change or misfortune. Many studies including those of Ojifinni and Uche (2022), Lee et al. (2022) and Gutowska (2022) have all revealed the negative implications of caring for loved ones with severe illness or disabilities. Nonetheless, according to Mathy (2022), it was revealed that the majority of family caregivers including mothers (55%) asked and received physical and emotional support from healthcare professionals which empowered them to perform their roles as caregivers in the social support system. Thus, mothers of children with hearing impairment will receive the necessary help to improve their own mental and emotional well-being if they should ask for it from healthcare workers.

2.3.3 Mothers' early response to the needs of the child with hearing impairment (Proximity)

The relevance of proximity or access to sick relatives can improve both patients' and caregivers' well-being by experiencing the feeling of belongingness and providing emotional support which fosters trust in the care being offered by healthcare professionals (de Beers & Brysiewicz, 2019). As a result, the concept of family-centered care addresses the concerns of access and family caregivers especially when it involves children, according to Gerlach and Varcoe (2021), child–family–centered care approaches when utilized in providing care help bridge health inequalities among children with chronic diseases and disabilities. This ultimately promotes trust and confidence in health services and professionals and decreases levels of anxiety for both patients and relatives when accessing and receiving care.

A study conducted by Prasopkittikun et al. (2020) indicated in their study that all their respondents who were nurses agreed that family strengths and individuality were the most important components of family-centred care. They indicated that nurses realized the importance of parents as a part of medical and nursing care, as they were major caregivers who knew their children best. According to the nurses' opinion, each family had different strengths, in particular to the readiness for the provision of care for the sick children and therefore encouraged them to take active roles in the care of their sick children although they were not fully aware of the disease process and medical treatment. Within the same year, a study conducted by Ekberg et al. (2020) on parents' questions to clinicians within pediatric hearing habilitation appointments for children with hearing impairment, was revealed that a total of 89 questions were directed to the clinicians in the appointment sessions. Although the questions were mostly designed as polar (yes/no) questions they covered several action and topical agendas. It was revealed that the majority of the questions not only attributed to soliciting for only information but were towards concerns about

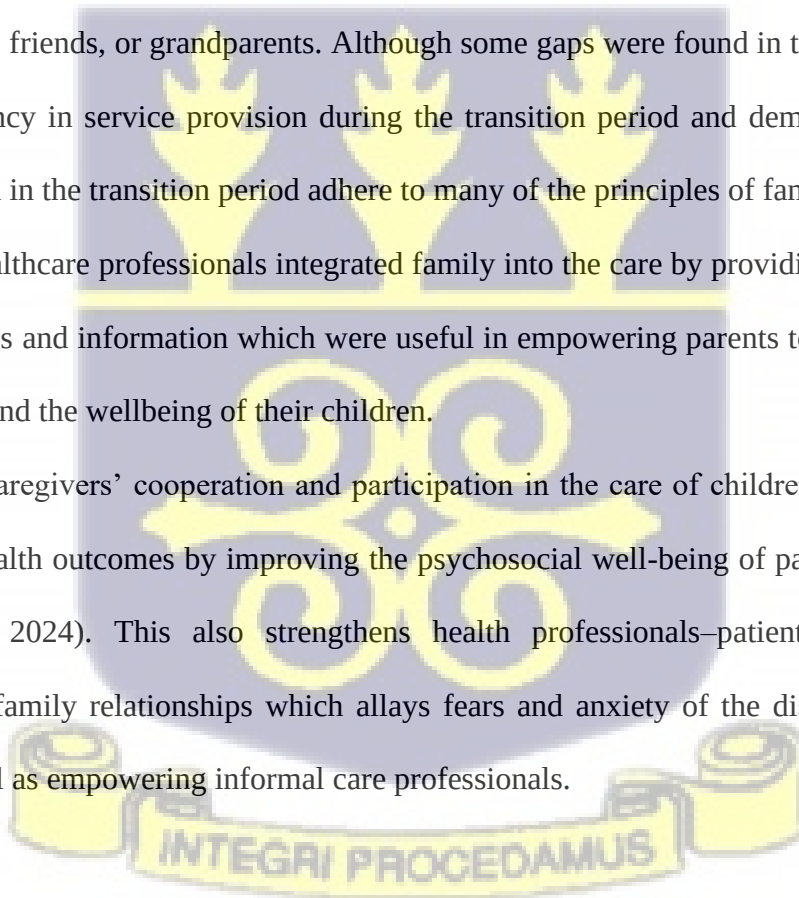
the disease process and outcomes as well as to receiving reassurance from healthcare professionals. It was concluded from the study that although parents did not ask a large number of questions during the appointments their questions performed important functions and hence practitioners should encourage parents to ask more questions when accessing care with their children but should not be seen only as soliciting for information but their ability to ask questions in relation to their functions. This helps in building their capacity to take up roles and responsibilities towards improving health outcomes.

Botes and Langley (2016) indicated in their study that at least two people accompanied their loved ones to the emergency department when they fell sick and reported seeking medical attention. This enforces the number of caregivers that take up responsibilities for their loved ones as informal social support structures. Nickbakht et al. (2021) study on family-centred care in transition to hearing intervention revealed a theme that focused on how professionals work with families and what they work on with families, during early intervention services, including family/provider partnership, informed choice and decision-making, social and emotional support, family–infant interaction, and use of assistive technologies. From the study, ten families reported that they received empathy and open communication from professionals. Five families also reported that professionals focused on their concerns and thus boosted their confidence. More so, nine families also reported having been introduced to playgroups, parent mentors, and adult role models which mitigated anxieties and fear of the outcomes of their condition with only, however, a few families reporting that they had not received information about adult role models. The study also revealed that all professionals who participated in the study reported that at the beginning of their service, they arranged for a home visitation to provide information and establish rapport with families. Six professionals also explained that, during their home visits, they tried to establish open

communication with families by “listening to them and advocating for them.” Furthermore, most professionals in the study also described how they provided families with social and emotional support as well as different sources of information to help families select EI centres.

The study finally indicated that all professionals reported that families had been informed of available social support, including peer support groups, parent mentors, and adult role models and also shared resources that they offer to family, friends, and grandparents of children with hearing impairment. These resources provided fundamental information about hearing impairment, the needs of children with hearing impairment and their parents, and things to do or avoid. Two professionals reported that these resources were given to parents to pass on to other family members, friends, or grandparents. Although some gaps were found in the study such as a lack of consistency in service provision during the transition period and demonstrated that the services engaged in the transition period adhere to many of the principles of family care, it can be gathered that healthcare professionals integrated family into the care by providing them access to relevant materials and information which were useful in empowering parents towards improving their wellbeing and the wellbeing of their children.

Family caregivers’ cooperation and participation in the care of children with disabilities help improve health outcomes by improving the psychosocial well-being of parents and patients (Mestre et al., 2024). This also strengthens health professionals–patients and or health professionals – family relationships which allays fears and anxiety of the disease process and outcomes as well as empowering informal care professionals.



2.3.4 Cultural and religious factors affecting mothers of children with hearing impairment (cultural and religious cooperation).

The concept of cultural and religious cooperation according to de Beer and Brysiewicz (2019) refers to HCPs displaying a sense of awareness, respect, understanding and acceptance of the attitudes, values, beliefs and practices of family members during the critical illness of a loved one. WHO (2024b) defines health as the complete state of physical, emotional state of an individual not merely the absence of disease or infirmity. Again, the organization stipulates that health is a fundamental human right inalienable to any human regardless of age, sex and gender. Further, WHO (2021) also describes well-being as encompassing quality of life and the ability for people to contribute to the world with a sense of meaning. The state of well-being is perceived in many dimensions such as financial, educational, social, physical, mental, and organizational ultimately leading to improvement in the quality of life of the individual and hence since family caregivers serve as a social support system and unpaid healthcare givers their perspectives, have been integrated into models of family centered care (Noguchi et al., 2022). According to WHO (2021), together with many other studies, cultural and religious backgrounds and perspectives should be taken into consideration and respected as they serve as a source of meaning, support as well as comfort with the propensity to foster a good sense of belongingness and well existential interconnectedness which ultimately improve people's mental health. Informal healthcare personnel in the form of family relations, friends need to be in an excellent state of mental health to serve as good advocates for the sick individuals (Coppola et al., 2021).

A year prior, Marti-Garcia et al. (2020) when describing the experiences and consequences of care among family caregivers of patients in the terminal phase of their illness revealed that spiritual and psychological factors such as praying to God, and reading the Quran helped them. Their study also revealed that some caregivers believed the illness to be a divine test that patients might pass proudly. They concluded that their belief system was adaptive and helped calm them while performing their roles. It was revealed that a safe relationship with God, a spiritual relationship with others as well as positive religious coping were attributed to positive outcomes such as improved, increased spiritual growth towards tension and then positive psychological adjustment and a better quality of life. (Aggarwal et al., 2023)

Another study by Bunning et al. (2020) on “Empowering self-help groups for caregivers of children with disabilities in Kilifi, Kenya revealed that family caregivers and children with disabilities suffered and experienced stigma and discrimination within their society. They also disclosed that mothers were blamed for giving birth to a child with deformities for example, for having inappropriate relations such as incest or extramarital conduct. It was revealed that mothers were at times held responsible for undesirable environmental effects such as drought and told of the disability being as a result of punishment by God for engaging in witchcraft. As part of mitigating stigma, healthcare professionals perform duties and offer services that seek to empower caregivers to promote health and well-being.

2.4 Summary of Literature

From the literature above it is evident that all mothers agree to have a form of duty of caring for their loved ones when they are unwell. Almost all of the mothers agree to some extent that they are affected, physically, emotionally, psychologically and spiritually when caring for children with

disabilities and severe diseases. However, they are willing to overlook their burdens and utilize healthcare professionals as important human resources in health to help them navigate through the challenges confronting them with respect to the health status of their loved ones. In conclusion, mothers agree that they need to be equipped and empowered to obtain and maintain a positive health status to better perform their role of caregiving.



CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter discusses the research design and the method used to conduct the study. It also described the study setting, the various techniques used to select the sample, collect and analyse the data. The strategies employed to ensure rigour and obtain ethical clearance were outlined.

3.2 Research Design

Research design aims to direct the approach used in a study which determines how data relevant to the study will be gathered (Sileyew, 2019). A qualitative approach specifically an exploratory-descriptive design was employed in this study. This design was to explore and describe the phenomenon being studied. Hunter et al. (2019) disclosed that an exploratory-descriptive design is a combination of both exploratory and descriptive study designs for which the explorative research examines a phenomenon of interest, rather than simply observing and recording incidents of the phenomenon of interest. It then also goes on to suggest that the descriptive element is used to gain insight and inform decisions and care. For this reason, the design provided insight into the experiences of mothers of children with hearing impairment compared to when either of the components of the design is used individually.

In addition, the qualitative approach is the optimum approach for obtaining rich insights into individuals' experiences, beliefs, desires, values, and motivations (Corner et al., 2019). The qualitative method aims at answering questions about the what, how and or why of a given situation rather than measuring and quantifying the effects of the phenomenon (Flick, 2018). This

design therefore offered the researcher the avenue to gain much insight on the experiences of mothers of children with hearing impairment.

3.3 Philosophical Underpinning

The philosophical foundation of this study is rooted in constructivism, which posits that knowledge and reality are not objectively discovered but subjectively constructed through individuals' lived experiences and social interactions. In constructivist thought, meaning is not fixed or absolute it is co-constructed between the researcher and participants, shaped by cultural, historical, and relational contexts (Lincoln & Guba, 1985). This aligns with the current study's aim to explore the lived experiences of mothers of children with hearing impairment at the Ashanti School for the Deaf, where individual and collective meaning-making is deeply embedded in socio-cultural norms, beliefs, and lived realities.

Constructivism is particularly suitable for research in healthcare and disability-related contexts where participants' perspectives, coping mechanisms, and social positioning influence how they interpret and respond to challenges (Guba & Lincoln, 1994). The philosophical stance of this study therefore recognises that the realities of these mothers are multiple, fluid, and context-bound, requiring an approach that is sensitive to subjectivity and grounded in human experience. To operationalise this philosophical position, a qualitative research approach was adopted. This approach provides the flexibility and depth necessary to explore complex, emotional, and nuanced human experiences. It allows for an in-depth exploration of participants' beliefs, values, motivations, and social dynamics, offering a more holistic and empathetic understanding than what is achievable through quantitative approaches (Mohajan et al., 2022). Specifically, qualitative inquiry is well-suited for answering what, how, and why questions rather than measuring variables

or quantifying cause-and-effect relationships (Flick, 2018). This made it the most appropriate design for capturing the deeply personal and socially embedded experiences of mothers caring for children with hearing impairment in a culturally specific Ghanaian setting.

This study acknowledges that the mothers' experiences are not just data but subjective truths that hold intrinsic value. Their narratives are shaped by their unique positions as caregivers within a Ghanaian context characterised by limited resources, strong communal ties, religious beliefs, and sociocultural expectations. Thus, this philosophical stance offered a means to interpret how these mothers make sense of their realities, resist stigma, seek support, and sustain caregiving under challenging conditions.

3.4 Research Setting

The study was conducted at the Ashanti School for the Deaf, located at Jamasi in the Sekyere South district of the Ashanti Region of Ghana. The school was established in 1977 as the only Special Education Institution in the region built by the Government purposely to educate and train children with hearing impairment to adjust to society. (Sekyere South District Health Directorate, 2022)

It has five departments namely; Kindergarten, Primary, Junior High, Vocational and a Blind unit with each department having a head. The school runs both Basic and Vocational education programmes with the option of either entering a Senior Secondary Technical School for the Deaf or, pursuing Vocational courses such as dressmaking, carpentry, catering or kente weaving after completing Junior high school. Currently, the school has a population of about 560, with 63 teachers and over 50 non-teaching staff. The school is residential and boarding and lodging fees are funded by the Government of Ghana. As a result of the geographical position of the school,

most parents from other regions such as Brong Ahafo, Central, and the Northern outside the main catchment Area (i.e. Ashanti Region) prefer to send their children with hearing impairment to the school. (Sekyere South District Health Directorate, 2022)

3.5 Study population

The population for this study consisted of all mothers taking care of children with hearing impairment enrolled in the Ashanti School for the Deaf. This population was chosen because mothers play traditional roles in the care and upbringing of their children including making educational choices for them.

3.5.1 Inclusion criteria

1. Mothers aged above 18 years with children with hearing impairment enrolled in the Ashanti School for the Deaf.
2. Mothers whose children are enrolled in Ashanti School for the Deaf and consent to be part of the study.
3. Mothers who can express themselves in English or Akan language.

3.5.2 Exclusion criteria

1. Mothers of children with hearing impairment who are enrolled at Ashanti School for the deaf but were physically sick during the data collection period.
2. Mothers with hearing impairment whose children are enrolled at Ashanti School for the Deaf.

3.6 Sampling method and size

Sampling is the process of selecting a subset of items from a defined population for inclusion in a study (Guest et al., 2013). A purposive (judgmental) sampling technique was used for this study.

Purposive sampling is a non-probability sampling method where the researcher tries to obtain samples that appear to be representative of the population and that will most benefit the study. This technique also gave the researchers the flexibility to decide what purpose they wanted the participants to serve even before going to search for them (Bryman, 2016). This technique enabled the researcher to deliberately recruit mothers of children with hearing impairment to give valuable information reflecting their experiences on their own well-being. This ensured that the sample gathered gave the right data for the study and also gave an understanding of the data collected. In doing this, the sample size for this study was guided by saturation.

Guest et al (2020), explained data saturation as when data gathered is analysed to the extent that no new information or very little information is collected in relation to the study being conducted. Data was gathered until no new information was forthcoming indicating data saturation has been reached. Based on this assertion, eighteen (18) mothers constituted the sample size for the study.

3.7 Data Collection Tool

Data was collected through in-depth face-to-face interviews in a semi-structured format. Face-to-face interviews are a data collection technique in which data is collected through personal interaction between the researcher and the participant. This offers an opportunity to build rapport with participants, gain a deeper understanding of their experiences and capture nonverbal cues. A modified interview guide (Appendix C) from Guion (2011) was used to gather data from the study participants. Questions in the interview guide were open-ended and formulated based on the constructs of the theoretical framework used in this study. Overall, there were five sections on the data collection tool. The first section consisted of sociodemographic characteristics. The second section captured information sharing experiences of mothers. The third section also asked

questions pertaining to how mothers garner resources for themselves when caring for their sick children. Subsequently, the fourth and fifth sections asked questions about how early mothers respond to the needs of their children and how they can cooperate with healthcare professionals based on their cultural and religious practices.

3.8 Piloting of the data collection tool

The interview guide was piloted using two mothers of children with hearing impairment at the ENT Unit of Agona Government Hospital. The relevance of this endeavour was to offer the researcher the opportunity to assess the clarity of the questions, rephrase them where required, and sharpen his interview skills for the actual study. Data collected were not included in the analysis of the main study.

3.9 Procedure for data collection

This followed the attainment of ethical approval from the Ghana Health Service. Permission to enter the Ashanti School for the Deaf was obtained with an introductory letter (Appendix A) from the School of Nursing and Midwifery, University of Ghana and Ghana Health Service.

Afterward, permission was obtained from the headmaster of the Ashanti School for the Deaf using an introductory letter from the School of Nursing and Midwifery, University of Ghana through the Sekyere South District Director of Health. The letter indicated the purpose of the study and served as a supporting document for the ethical clearance to obtain data and information from the mothers of the children with hearing impairment.

Participants were informed that participating in the study was strictly voluntary as they have the right to withdraw from the study at any time they wish to do so. Contacts (phone numbers) of the mothers were taken from sociodemographic archives of parents in Ashanti School for the Deaf for

scheduling of date and time for the interview. An information sheet (Appendix D) stating clearly the research topic, purpose, objectives and confidentiality was provided. The participants who could read, write, and consent to partake in the study verbally were provided with an informed consent form (Appendix E) to sign and those who could not read and write were asked to thumbprint before the interview.

Preconceived ideas and personal views about the research topic were 'bracketed'. In addition to the interview and recording, nonverbal communications were also recorded in a field note. Data was collected in English and Akan language to allow participants to freely express themselves particularly those who do not have control over the English language.

A face-to-face interview was conducted. Voice recorders were the devices used to capture the various meeting sessions that lasted between 30 and 60 minutes, approximately 45 minutes. Probing was used to elicit more information. Follow-up questions were also used to help address questions and other sensitive issues that were missed and or skipped to gather more information on the topic of interest. The interviews were conducted at the sole decision and comfort of the participants.

3.10 Data Analysis

Thematic analysis was used to analyze transcribed text (data) to generate specific themes and subthemes. Thematic analysis is a commonly used method for identifying and analysing patterns in qualitative data (Clarke & Braun, 2013; Vaismoradi et al., 2016). Clarke and Braun (2013) six phases of Reflexive thematic analysis (Familiarisation with the data, Generating initial codes, Searching for themes, Reviewing themes, Defining and naming themes and Writing up) were used for analysing the data.

Upon concluding each interview, data quality and validity were ensured through a process of cross-verification, wherein the interview notes were systematically compared with the corresponding voice recordings. This method facilitated the identification of any omitted, incomplete, or contradictory information, thereby enhancing the integrity and accuracy of the data collected. Those identified were cleaned. Voice calls were made for all participants to clarify specific information in order to ensure data completeness and validity after the first face-to-face engagement. The responses which were recorded in Twi were also translated and manually transcribed in English before ensuring quality data output. Professional transcribers, fluent in both Akan and English and experienced in qualitative research, produced verbatim transcripts first in Akan. This preserved the original linguistic and cultural context. This ensured the capture of nuances, idioms, emotional tone, and culturally specific concepts within their original linguistic framework. Coding was done bilingually, noting key Akan terms.

To minimise meaning loss, a subset of key passages was independently back-translated from English to Akan by a different bilingual researcher. Any discrepancies between the original Akan and the backtranslation were flagged and addressed to resolve ambiguities and ensure conceptual fidelity.

After the transcription of each audio interview, the output was edited by comparing the transcribed data with the original audio recording recordings verbatim. All typographical errors were corrected; punctuation marks were corrected to give it meaning and re-edited for completeness and accuracy and saved to specific file names for easy identification for each participant. All Word documents after editing were grouped and saved onto the principal investigator's laptop computer.

ATLAS.ti version 7 was the data analysis tool of choice. The final saved Word document was then uploaded onto the ATLAS.ti software. The first part of the analysis consisted of

describing and allocating initial codes to responses from the participants. This was done for all participants. After the codes were assigned, the relationship between them was examined and sets of related codes were grouped into specific themes and subthemes together with participants' specific comments or quotations. Data was cleaned to ensure quality and readability and saved as new hermeneutic units from which reports were generated.

3.11 Data management

Interviews were audio recorded, transcribed and organised into themes on a personal computer in an encrypted file and backed up on a weekly basis. All electronic files were protected by a password. Only the researcher and the research supervisors had access to the data. All hard copies of data were kept under lock and key. Unique identification codes were used on the consent form, participant information sheets and also to name audio recordings. All materials, including the audio recordings and the electronic documents, were stored on a secure storage device not connected to the internet and were only accessible to the investigator. After the study, the data will be kept for a minimum of 5 years upon completion of the project. The information (without names) could be used in future research and will remain in a secure location. Findings may be published and/or presented at the University of Ghana and scientific conferences in Ghana and internationally.

3.12 Ethical consideration

Introductory letter for the study were obtained from the University of Ghana – School of Nursing and Midwifery (SONM) (Appendix A), Sekyere South District Health Management

Team, while ethical clearance was obtained from Ghana Health Service Ethical Review Committee, with the number GHS-ERC-050-09-23(Appendix B).

Participants signed a written informed consent form voluntarily to participate in the study after the objectives and purpose of the study had been explained to them in their preferred language to clearly understand. In addition, participants were informed that participation is voluntary so only those who met the criteria and were willing to participate were involved. Additionally, participants were assured of privacy, anonymity, and confidentiality of information as well as their right to withdraw from the study at any point they wished to without any repercussions to their person.

Participants were informed about the voluntary nature of the study, and personal information was only collected with their explicit consent. Interviews and data collection were conducted in secure settings, allowing participants to feel comfortable and avoid unwanted exposure of their private details.

To protect participants' identities, no personally identifiable information (such as names, addresses, or contact details) was attached to the data. Instead, unique codes or pseudonyms were assigned to each participant, ensuring that individual responses could not be traced back to specific individuals.

All data collected during the study were securely stored, with access restricted to the research team. Participants were assured that their responses would only be used for the purposes of the research and not disclosed to third parties. Additionally, any potentially identifying details in the findings were altered or omitted to prevent recognition of participants.

3.13 Methodological Rigour

In qualitative research, the extent to which the researcher is able to prove, that the findings of the study actually portray the real experiences of the participants is termed rigour. Hence, the principle of trustworthiness was employed for the rigour of this study.

3.13.1 Credibility

This describes how confident the researcher is with regards to the truth in the findings, taking into consideration the study design, the participants and the context (Shufutinsky, 2020). To ensure the credibility of this study, the principal investigator engaged the participants for a relatively long period. The engagement took the form of a conversation, observation and noting down important non-verbal cues. The researcher also used reflexivity to be mindful of the influence his personal experience can have on the study (Shufutinsky, 2020) and to prevent that. The research was done together with the researcher's supervisors through a series of audits which was paramount in ensuring the researcher's discovery was the true reflection of the real experience of the participants.

3.13.2 Transferability

Munthe-Kaas et al. (2020), describe transferability “as an assessment of the degree to which the context of the review question and the context of studies contributing data to the review finding differ according to a priori identified characteristics (transfer factors)”. To ensure transferability, the researcher ensured that, the background information of the participants was clearly presented, as well as the context and the setting. The researcher also kept audit trails of all events, procedures and engagements to ensure that others can assess the transferability or otherwise of the study.

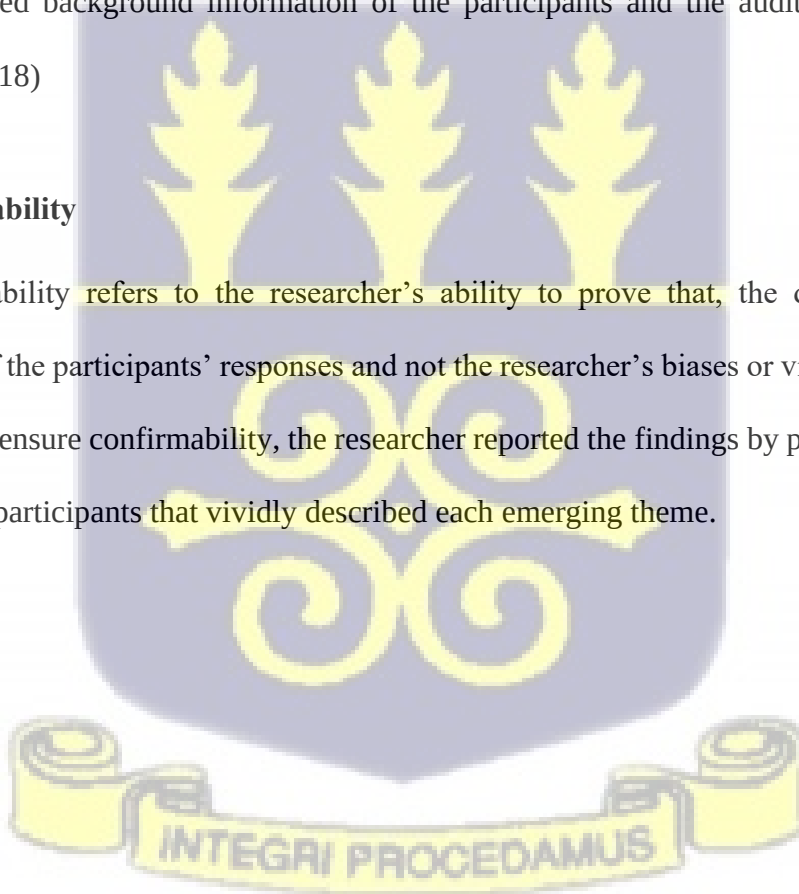
3.13.3 Dependability

Dependability in research refers to the stability and consistency of findings over time. It ensures that if a study were repeated under the same conditions, similar results would be obtained (Lincoln & Guba, 1985). In qualitative research, dependability is akin to reliability in quantitative research, focusing on the consistency of the research process, including data collection, analysis, and interpretation. To establish dependability, researchers often use strategies like an audit trail or peer review. (Hadi & José Closs, 2016)

To ensure this, the researcher worked closely with the supervisors throughout the study whilst the detailed background information of the participants and the audit trails were kept. (Forero et al., 2018)

3.13.4 Confirmability

Confirmability refers to the researcher's ability to prove that the data is the actual representation of the participants' responses and not the researcher's biases or viewpoints (Polit & Beck, 2008). To ensure confirmability, the researcher reported the findings by providing verbatim quotes from the participants that vividly described each emerging theme.



CHAPTER FOUR

FINDINGS

4.1 Introduction

This chapter presents the findings for the study after analysing the responses from the participants, which sought to explore the experiences of mothers of children with hearing impairment at the Ashanti School for the Deaf. The section also presents the organisation of themes and subthemes generated with respect to the objectives for the study and the sociodemographic characteristics. The chapter is divided into sections, the first section focuses on the socio-demographic characteristics of participants. The remaining sections and subdivisions present the findings according to the study objectives and research questions.

4.2 Justification for Organising Findings Around Objectives and Theoretical Framework

Organising research findings around the study's objectives and its guiding theoretical framework constitutes a rigorous and essential approach in qualitative research on maternal experiences of childhood hearing impairment. This structure ensures the findings directly and transparently address the research questions and the stated aims. Furthermore, it provides vital theoretical coherence, integrating the empirical data with the conceptual models. This integration demonstrates how the findings extend existing theoretical constructs within the specific context, moving beyond mere description to offer explanatory depth.

The approach enhances the trustworthiness of the analysis by making the interpretive process transparent, showing how the theory shaped the understanding of the data in relation to the objectives. It maximises the practical relevance of the findings for stakeholders like policymakers, clinicians, and educators, as insights related to each specific objective are

identifiable. It also allows the research to address the inherent complexity and interconnectedness of mothers' experiences holistically. This structure facilitates meaningful comparison with other studies grounded in similar frameworks and reflects an analytical process where the researcher actively uses theory to interpret the significance of themes in answering the research questions. Within the context of Ghanaian mothers raising children with hearing loss, facing unique cultural, economic, and systemic challenges, this approach is particularly critical. It ensures the findings are contextually grounded in addressing locally relevant objectives while simultaneously possessing the explanations derived from theoretical engagement, ultimately generating meaningful and actionable implications for supporting maternal well-being and family resilience in this specific setting.

4.3 Socio-demographic characteristics

Overall, eighteen (18) participants were recruited for the study after reaching data saturation. The sociodemographic data of the participants were age, sex, place of residence, hometown, marital status, occupation, level of education, relationship with child, age of child and age of diagnosis of hearing impairment. From the study analysis, all the participants were females. The majority of them stayed in towns within Ashanti Region, with only one who had relocated to the Western Region (Wiawso Ntrentreso). Three of the participants were farmers, one nurse, additional three were unemployed and the remaining eleven were traders. With respect to their marital status, four were single, four were married, five were divorced and the remaining five were widowed. Ten of the participants had their maximum level of education up to junior high school, four at form four and the three also had form five level of education. Only one of the participants did not receive any form of education. The minimum age of the mothers was 37years, the highest was 64years for one in each category and the remaining were between the highest and minimum age ranges. Concerning the

relationship with the sick child, two of the participants were grandmothers performing caregiver roles and the remaining sixteen were biological mothers of the children. The minimum age of child for which a diagnosis was established was 1 year and the highest age was 9 years while the remaining 16 were between 1 and 9. All the children whose caregivers were participants of this study were aged below 18 years with the oldest being 17 years and the youngest being 10 years. The findings of the sociodemographic characteristics have been presented in Table 4.1 below.



Table 4. 1: Sociodemographic characteristics of study participants

ID	AGE	sex	Hometown	Place of stay	Occupation	Marital status	Education	Relationship	Age of diagnosis	Age of child
1	54	F	Manso Nkran	Effiduase	Trader	Divorced	Form 4	Granddaughter	4	13
2	53	F	Nsuta Amoaman	Aboabo	Nurse	Single	Form 5	Mother	2	17
3	37	F	Effiduase	Dadiase	Trader	Married	JHS	Mother	9	10
4	46	F	Naama	Maakro	Trader	Divorced	JHS	Mother	5	17
5	64	F	Manso Atwedie	Effiduase	Farming	Widowed	Form 4	Grandmother	5	11
				Dadiase						
6.	40	F	Buoho	Atonso	Unemployed	Single	JHS	Mother	1	17
7	44	F	Wiawso	Wiawso	Trader	Widowed	JHS	Mother	3	16
			Ntrentreso	Ntrentreso						
8	45	F	Obuasi	Kronum	Trader	Married	JHS	Mother	2	17
9	50	F	Manso Nkwanta	Mowire	Trader	Divorced	Form 4	Daughter	4	16
10	46	F	Atwima	Atwima	Farmer	Divorced	Form 5	Mother	2	10
			Techiman	Techiman						
11	38	F	Boko	Tech	Trader	Married	JHS	Mother	9	10
				Maxima						
12	42	F	Bekwai	Kwadaso	Trader	Divorced	JHS	Mother	5	17
14	45	F	Kotwi	Sofoline	Unemployed	Single	JHS	Mother	2	17
13	49	F	Pakyi	Santasi	Farming	Widowed	No Education	Mother	5	11

15	44	F	Tarkwa Bogoso	Ejisu	Trader	Widowed	JHS	Mother	4	16
16	55	F	Anwiankata	Kronum	Trader	Married	Form 4	Mother	3	17
17	50	F	Offinso	Maakro	Unemployed	Single	Form 5	Mother	8	17
18	46	F	Manso Nkran	Atwima	Trader	Widowed	JHS	Mother	4	16
				Techieman						

Source: Researcher's field data, 2024



4.4 Organization of themes and sub-themes

Four main themes were developed according to the theoretical framework and study objectives and 12 sub-themes emerged from the data collection. The main themes include information sharing experiences, garnering resources, mothers' early responses, and cultural and religious cooperation of mothers of children with hearing impairment. Table 4.2 below shows the details of the various themes and sub-themes. The findings are summarized in the table below.

Table 4. 2: Themes and sub-themes

Themes	Subthemes
Information sharing experiences	i. Signs and observation ii. Written conversation
Garnering resources	iii. School mothers' reports i. Self-sustainability ii. Familial support iii. Social support iv. Religious support
Mothers' early responses (Proximity)	i. Living together at home ii. family caregiver- school mother relationship
Cultural and religious cooperation	i. Health workers recommendation ii. Health worker cooperation iii. Religious practices

Source: researchers field data 2024

4.5 Information sharing experience

Being a mother comes with some responsibilities, which includes ability to communicate effectively with health care providers in order to facilitate appropriate management of disease conditions when ill. As a result, mothers from this study indicated that they perform several roles,

however, in order to communicate effectively with their children, three factors determined their ability to do so. Firstly, where and whom the children were living with primarily before attending school for the deaf. Secondly, who cares for them in the boarding school and finally whom and where they live when they are on vacation. With respect to these three situations, three subthemes were developed which included signs and observations noticed and shared by children, communicates by writing, and communication by school mothers.

4.5.1 Signs and observations

Participants disclosed how they are able to share their experiences with healthcare practitioners. Primarily, they revealed that at different stages during their children's development and diagnosis, different modes of communication were used between themselves and their children in order to understand them and have meaningful conversation between themselves and among healthcare professionals. Most of the participants revealed that their children when young could not make sentences and words and as a result, they could not share anything they were experiencing except that the parents who were living with them and close with them observed visible and physical signs and symptoms which they would presume as a medical illness. After this observation, they then report to healthcare facilities where they are able to share all information to medical practitioners regarding the health status of their wards. This can be seen in some responses below;

“Maybe, if I sense my child might have headache, I act or sign using my hands on my forehead signaling as a headache to see whether my child will respond in an affirmative way. And she also responds by touching a body part such the stomach and squeezes her hands tight to show the severity of the pain, if it is headache, my child puts her hand on her head and with the other hands, she tightens the fist. This is considered abnormal and I tell the nurses and doctors before some labs are done for him” - P2

“Okay, in the beginning, when very young, she could not speak so as a mother in order to know she is not well, you will have to see if she is quiet or vomiting or even running temperature and sometimes she appears very dull and I will send her to the hospital. Over

there, the health professionals will engage you the mother in a lot of conversation to know what is wrong and how to help you” – P5

Ten of the participants also indicated that just when the children were growing at home, they could point exactly where they were feeling discomfort even though they the parents initially had challenges determining what was being communicated to them. Over time they were able to wrap their heads around, interpret and also communicate to health professionals in order to receive the maximum care. As a result, it was quite significant for the parents to be closer with their children in order to detect or identify any changes that may occur to be able to seek for any form of assistance. This is evident by:

“Since she’s grown up, she just points to the things she needs or she will sometimes touch her body to complain if she’s having pain. Her eye has been operated before at Offinso Hospital. Yeah, and because she was enrolled in deaf school, we have been privileged to learn some of their sign language hence, i communicate with her to tell me all her needs and worries so when we go to the hospital. I tell them my child is deaf and I interpret what she had signed to them and I also share whatever information to her to comply with every procedure and stay calm” P - 4

“I first asked my granddaughter what’s wrong with her so she will show me the affected part, so I then tell the health professionals the complaints. You need to try your best to communicate with her yeah you have to” P8

Additionally, a few of the participants indicated that they are able to get some information pertaining to their children’s health by school officials who were taking care of their children. According to them, the children have institutional caretakers whom they refer to them as school mothers. They perform the roles of a mother and therefore the children are able to communicate effectively with them in school using sign language. The school mothers are also able to communicate and relay health information to the mothers for them to be abreast with the health status of their children which serves as a medium through which biological mothers get information from school mothers and share with healthcare professionals.

“They call us from school, particularly the school mothers and after taking the initial treatment and she’s still not recovered for instance, we go and take her back home and she’s able to tell us what exactly is wrong with her so we then take her to the hospital, and when the doctor asks us and we show or tell her complaints, sometimes I will tell her the doctor is asking what is wrong with you and she will point where exactly is paining her” P-10

Overall, it was demonstrated by all the mothers that they were very involved in the care of their children regardless of the challenges they went through and were willing to go every extent to obtain the necessary assistance from healthcare professionals at their own expense in order to help them care appropriately for them.

4.5.2 Written communication

Participants also disclosed that they are able to share information effectively with healthcare professionals after they were sent to school through different medium. Most of the participants indicated that when their children are unwell, their children are able to use other medium such as writing their complains for their mothers to clearly appreciate and understand them before being sent to seek assistance. In view of this, the mothers indicated their children’s health came first and they communicate what their children were going through before sharing what they themselves have been experiencing including their challenges with the healthcare professionals. This is revealed by;

“We the mothers have been taught sign language from their school but I can only do very little. Because of this, my child also writes whatever he needs so anytime I don’t understand what he signs to me, he writes for me and I also do likewise. We also do this at the hospitals as method of communicating with the healthcare professionals. Although it takes longer much a longer time, we are able to share vital information among ourselves and this has been very helpful” P – 6

“When she went to that school, the way of communication has changed for the better, the way we usually communicated, and for instance I used to ask her through the little sign language I know to ask whether she was sick. After starting the school, we couldn’t use that same way to communicate so it was very difficult for me but because she can write,

she writes it down for me so we are able to communicate through writing and because of that I am now able to communicate effectively with her any other person if I am representing her” P-11

4.5.3 School mother reports

School mothers are people who are paid by the school to represent biological mothers in helping with performance of activities of daily living, supervising house chores and overseeing the sanitary and health needs of the children. All the mothers revealed that when children are sent to schools, there were people called school mothers who were responsible for taking care of them when they close, with financial and material support from mothers at home. As a result, when children fall sick at home, children report to the school mothers who in turn assess the intensity of the illness or symptoms and sends them to seek healthcare services from health professionals. The participants indicated that the school mothers have their phone numbers and therefore communicates the outcome of the illness to them. Should there be the need for further care services, the mothers then report to the school where the children are sent to receive extra and secondary healthcare services. This is evidenced by the following reports;

“They have school mothers at school who have knowledge in sign language. Their school is a boarding school so when they are sick, they report to them and then are taken to seek medical attention but when they come on vacation, we do it ourselves. I am still learning the sign language though. You have to know this because he is permanently deaf and cannot hear so you have to. So, when in school, the schools give me every information concerning his health because she acts in my place over there” – P 7

“They call us from school especially after sending her to the hospital. They have school mothers in school who make payment for cost of everything but you will have to pay for the cost of treatment incurred by the school mothers. They then in turn share all health information to us the mothers and at times we send them for further care if the need be. This also helps us to communicate effectively to the health professionals which goes a long way to help in his recovery” – P – 17

Overall, these statements reflect how mothers of children with hearing impairment are able to assess information from their sick children and share among themselves, the school mothers and

healthcare professionals to get adequate information that seeks to empower them to better take care of themselves and their children. The mothers revealed their ability to learn sign language both at home before they were sent to school and after school. This has really equipped them and improved their own wellbeing, that of their children and other siblings.

4.6 Garnering resources

In as much as mothers care for their sick children, it is also vital for them to be in the best optimal health to carry out their duties and as a result they should be able to offer and provide for themselves their basic needs while doing so. When mothers are able to get enough resources, emotionally, physically and financially among others, they are able to equip and empower themselves to do better in caring for themselves and their children or grandchildren. This study revealed the different ways these mothers are able to obtain different forms of resources while taking care of their children. Some revealed that they were self-sufficient, while others also disclosed that they received some assistance from other family members, other social support group and religious organizations.

4.6.1 Self sustainability

Majority (17) of the mothers from this study revealed that they had been solely responsible for the care of these children with specific needs since their birth and although their fathers were available, they bailed out on them after their diagnosis, however they are able to care for themselves and their children with resources from their own earnings through their resilience. This is evidenced by;

“The father told me he has no money from the very beginning when my sister recommended to send her for care, throughout my struggles, since I brought her from my mother’s place to Kumasi” - P5

“As for the child’s father, he has moved into his own apartment, and since my child grew from kindergarten one till JHS, we don’t hear from him at all. Even one day, she said her teacher called him and what he said on the phone was not responsive, so I have advised her not to call him again so by God’s grace I am able to get some for her and satisfy all her healthcare, growth and developmental needs by myself only and none from anybody” – P7

“If possible, I go for loan. I have a lot of loans to settle, I can’t provide more as I used to provide because I cherish her, she can even wash our clothes, she can cook” - P- 12

“so, to be able to fend for my daughter, I have joined a group for some savings “susu” for her so, this “susu” I collect it monthly, and I am not able to save in large amount, because this area is not in the city, and the sales are not so often, so I do my best to save GHc5.00 daily so, by the end of the month, I am given GHc150.00, then I save that so, when there is any eventuality or vacation, and I am called then I use the amount saved for her. So, this is how I manage these situations” P – 15

Only one of the married indicated that she had all the assistance of their husband in the early stages of the child’s development during the stages of diagnosis from different health facilities ranging from Komfo Anokye Teaching Hospital to Korle Bu Teaching Hospital. However, she lost her husband along the way and she now has to do all by herself. Although she revealed that it was difficult, she has decided not to give up on herself and her child. She further revealed that she has to be strong for them both. This is evidenced by;

“So, I took him to KATH and when I went there, I was made to go through series of examinations and laboratory testing. I was referred to Korle Bu Teaching Hospital and it was very stressful. I nearly gave up on everything through the ups and downs, however, I had strong assistance from my husband which was very beneficial during those difficult times although I lost my husband about 10 years ago, he was very helpful. P– 7

Overall, all the mothers were of the view that they were primarily responsible for their children’s growth and development and therefore they are willing to do everything possible to stay alive as long as they can in order to care for the needs of their children. They claimed these children

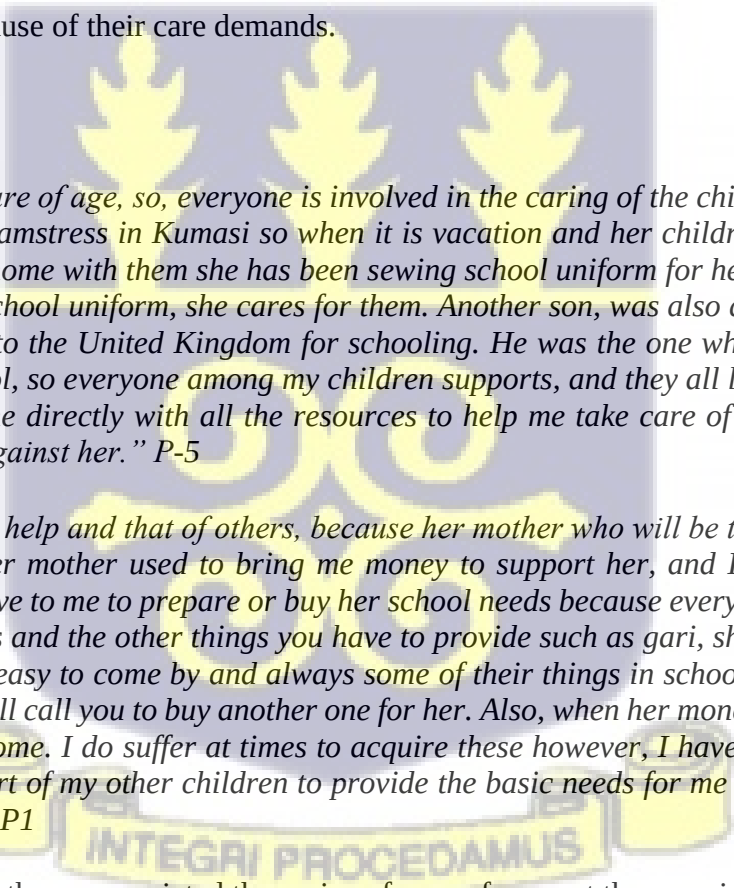
need special attention compared to other children and as a result, they have to be there for them at all times.

4.6.2 Familial support

Caring for children with some deficiencies in hearing and speaking have some challenges stemming from individual, familial, societal and cultural factors. However, in order to care for all the needs of these children, assistance from immediate social support systems is very vital.

Some of the mothers (5) revealed that they get some support from family members predominantly from siblings, and from those who were living with their grandmothers in order to help them care for these children because of their care demands.

This is revealed by;



“My children are of age, so, everyone is involved in the caring of the child. Everyone, one of them is a seamstress in Kumasi so when it is vacation and her children are returning, she also goes home with them she has been sewing school uniform for her too, most of the clothing and school uniform, she cares for them. Another son, was also a teacher, but has now travelled to the United Kingdom for schooling. He was the one who enrolled her to the Deaf School, so everyone among my children supports, and they all love her too. They also provide me directly with all the resources to help me take care of her. They do not discriminate against her.” P-5

“Oh, by God’s help and that of others, because her mother who will be there to help is no more alive. Her mother used to bring me money to support her, and I save what other siblings will give to me to prepare or buy her school needs because every term you have to pay school fees and the other things you have to provide such as gari, shito among others which are not easy to come by and always some of their things in school get missing and the teachers will call you to buy another one for her. Also, when her money gets finish, you have to send some. I do suffer at times to acquire these however, I have made it possible with the support of my other children to provide the basic needs for me to stay healthy to support her” - P1

Overall, the mothers appreciated the various forms of support they receive from their family members in providing the necessary financial and other material resources for them in order to render care for their younger siblings with the disorder.

4.6.3 Social support

Support from individuals, groups, institutions either governmental or non-governmental other than that from family members have been demonstrated to assist vulnerable individuals to promote the health and wellbeing and that of their dependents. All the mothers described the support they received from the school mothers as enormous when their children were in schools. They disclosed that the school mothers even make payments for all the hospital bills incurred when the children are sent to the hospital to receive care before calling the mothers to tell them. Additionally, they disclosed that the school mothers helped them perform all basic duties they the mothers would have done. Although immaterial this form of assistance was described by all the study participants to be very significant and relieving for them. This is evidenced by;

“As for that, her madam sends her to the hospital, so she calls afterwards that she was not well, and the bill is sent to me. I then send her some money. However sometimes, I may ask if there was a need for me to come and pick her home... But usually, she tells me she has been treated at the hospital and is doing well, hence there will be no need” P – 3

“Oh, the time they phoned me, I was working at a place called Hiakosi by the school mother. when they called me, I was the only one on duty but I was close to a teacher here so, I gave the teacher the direction the day they called. The teacher even did not know the location of my child was, but went to brought her to me. The school mother had made all the payments after sending the child to the hospital and done all necessary things for the child. In fact, she has been very helpful all these years. P – 4

Four of the participants from this study revealed that they received some form of financial and material support from both governmental and non-governmental institutions in different areas which goes a long way to empower them to better take care of the wellbeing of their children. This is evidenced by;

“As for help, we once visited Faadi Mampong education office for some support. They were kind enough to give us monetary assistance of GH¢250.00 on one instance to help us”. P – 8

“We tend to get some assistance from Social Welfare on a yearly base in the form of food and drinks and at times some PTA dues. As a result, you ought to be ready to pay for everything as a parent and if the support from Social Welfare arrives, it cushions you as well. Indeed, they are also supportive. It really helps us a lot. Thank God” P– 15

Additionally, two of the mothers also indicated that in their absence if the children needed any form of assistance, they have other people in the society where they communicate with them to offer the necessary assistance before their arrival. This according to the mothers, were a very good source of support to them.

“So, all the time, her class teacher and the school mother called me that she was sick and other times that she has finished up all her items. They had already sent her to the hospital but they needed me to get her to the hospital for further treatment so I went for her and sent her as requested. After she was fine, then I sent her back to school. If I am prompted earlier, that same day. Her house madam who they call her school mother usually sends her to the Hospital, so when I visit, then the madam will tell me she was sick, then I make payment based on the bills” – P 7

“We reside close to the clinic so, if it happens that she is sick in my absence, they call me and then I direct them to take her NHIS card and send her to the clinic and there is also a nurse at the facility who I relate well with, so the nurse also facilitates her care for me. Again, there is a seamstress close to our house so when she needs anything too, she goes there and the woman gives the thing to her or sometimes calls me when I come then I reimburse her. All of them have been good to me. I thank them”- P13

All the mothers therefore appreciated all the various forms of support from all the people who had in one way or the other helped in any aspect of their children’s growth and development.

4.6.4 Religious support

Religious and spiritual support were also additional source of spiritual empowerment for the mothers. They disclosed that they received both material and immaterial support from church members and the whole organizations. According to half of the participants, this provided some form of relief and belongingness for them which has also been instrumental in helping their spiritual and mental growth.

“Especially for widows like me, the church supports us at times. They can put money in an envelope and present to those of us who are widows, and also those who are worthy also give us money because the churches also teach members how to give. Some even give secretly, you may not even know those who may be giving those gifts” - P5

“I remember when she was not able to walk, the congregation placed her on file that every Friday prayers were offered for her until by God’s grace she was able to walk. As at now we still keep praying, but looking at her condition, many may interpret as still spiritual leading to that. We know spiritual cause of illness as well as physical exist, so to maintain a good relationship with my God, I still pray” - P12

Although a small proportion of the mothers disclosed that they did not receive any material or financial assistance from the organization they still pray for them which they admitted was helpful as well. This is evidenced by;

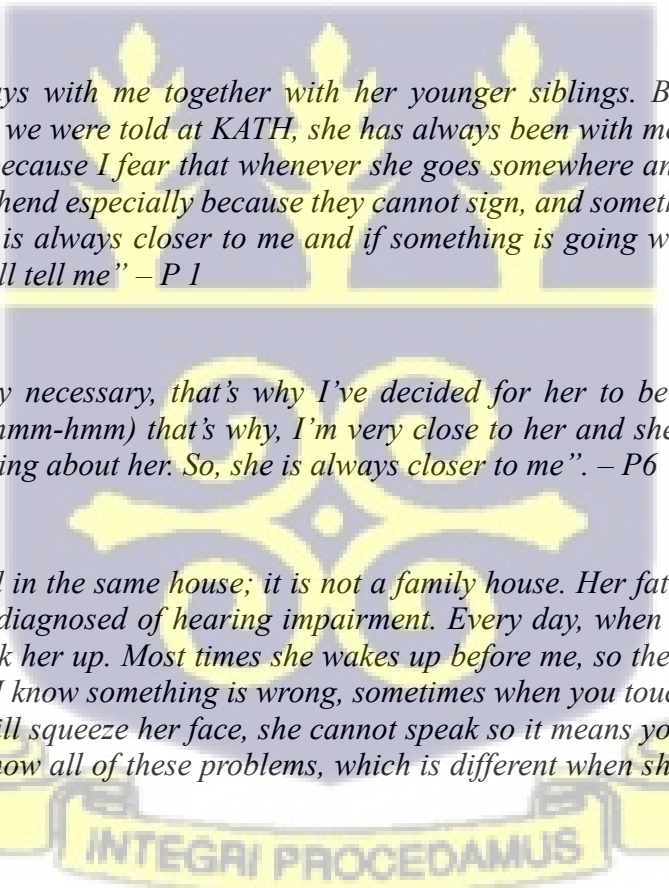
“Our church is very small so we don’t have enough members so we are unable to provide financial assistance. However, if it is prayers, we all pray together and my pastor knows my situation so he also leads the congregation to pray for us too” – P 9

4.7 Mothers early response (proximity)

Mothers and caregivers’ responsibilities have been enshrined in any legislations and customary law and as a result most mothers or caregivers tend to appreciate their responsibilities through learning from their parents, family members and through culture. Mothers demonstrate a wide range of activities in order to get closer to their relatives when ill particular if they are primary caregiver primarily responsible for these children. When others have close proximity to their children. they are able to identify their children’s needs and act accordingly. It was revealed from this study that, there are two main scenario that affect mothers’ proximity both positively and negatively. Primarily, the mothers revealed that they live with the children when in the house. However, when they are in the boarding school, they are in the care of the school mother who communicate with them at home.

4.7.1 Living together

Part of parental roles and responsibilities include providing shelter, food, clothing and healthy and safe environment for children to grow and develop regardless of their health status. The study participants appreciated their responsibilities as mothers and as a result they were responsible for providing all the needs of their children regardless of their own socioeconomic status. Majority of the mothers revealed that children were living with them from birth until they were diagnosed with hearing impairment after which they were put in special schools to help with their development and as a result, they were able to observe, identify and experience at first hand, the health challenges of their children. This is revealed by;



“My child stays with me together with her younger siblings. Because of her special condition after we were told at KATH, she has always been with me. He does not even go for a holiday because I fear that whenever she goes somewhere and she is not well, they cannot comprehend especially because they cannot sign, and something bad might happen to her. So, she is always closer to me and if something is going wrong, then I can see it early or she will tell me” – P 1

“Yeah, it’s very necessary, that’s why I’ve decided for her to be with me at my place (interviewer; mmm-hmm) that’s why, I’m very close to her and she will always make me aware of anything about her. So, she is always closer to me”. – P6

“We have lived in the same house; it is not a family house. Her father is not with us ever since she was diagnosed of hearing impairment. Every day, when I wake up, i go to her room and check her up. Most times she wakes up before me, so the moment I see her still sleeping, then I know something is wrong, sometimes when you touch her, she will be very hot, and she will squeeze her face, she cannot speak so it means you have to get closer to her to get to know all of these problems, which is different when she goes to the boarding school” – P 12

Only two of the participants indicated that the children were with their mothers in a different town. However, they were brought to them after these mothers were facing challenges and as such, they have assumed parental roles and responsibilities because they are now

permanently staying with them and have been responsible throughout their schooling period. This is evidenced by;

“The child is my grandchild, he is 17 years now, but still going to school. He is in primary six now because he did not start school early. He was diagnosed when he was 7 years, but his father upon hearing his diagnosis has run away. Nobody knows his where about, and as for his mother she is not doing so well so he now stays with me while attending school. He goes to school and when on vacation, he comes back here” – P5

Furthermore, all the mothers also revealed that their children had been put in school for the deaf, which is a boarding school. They only come home during vacation and or ill health which needed further assessment and treatment. The mothers indicated that they did not allow them to spend holidays anywhere but home. This was because the mothers disclosed that they felt very safe when the children were with them at home because they stated they would be in better situation to detect any signs of ill-health mainly because of their ability to effectively communicate with their children. This is evidence by;

“For my child, she will be 18 years coming September, I don’t allow her to go anywhere because me myself I am now learning how to do the sign language very well she has been teaching me and her siblings which is quite different from the usual one at home where we used to point out things. So, in this case, if you don’t understand or even know something small you cannot understand or see her health challenges if she is not well. Because of this she is always here with me when she comes on vacation. So, I monitor her very well” - P13

“For my child, she doesn’t fall sick often. Until she got that problem, she was well, she doesn’t fall sick. Since then, she has been brought from school sick on one occasion. Nowadays, her complains is about her menstrual pains and it is very worrying and disturbing. She will be crying at times because of the pains, but since I am a nurse, I am able to handle it any time. I fear that if she should be with anybody, they cannot take care of her like I will do it myself” – P2

The consensus for all the mothers was that they preferred the child stay with them in the same house. This was because according to the mothers, it was quite hectic taking care of them and as a result, much attention and dedication is needed in doing this. Hence, they prefer dealing with these challenges themselves towards promoting their general health and wellbeing.

4.7.2 Positive family caregiver- school mother relationship

Based on the needs of the children with hearing impairments, specialized schools have been established to help with the educational and vocational needs. To help fulfil this, individuals who perform some caregiving roles have also been available to help promote the general wellbeing of the children while in school. These individuals known as school mothers help the children in performing their activities of daily living which includes helping them meet their healthcare needs. All the mothers indicated they had very good interpersonal relationship with the school mothers because they were good and responsible people that were very competent in helping their children in their absence.

“Please, usually the school mother pays all the cost and later inform me of all the cost after payment made, hence I should reimburse her. I then send her what I earn. At times I will have to plead to refund money in two or three days when I don’t have money on me. Because she knows if I have the money at hand, I won’t hesitate but send it upright she gets to make all the payment” P- 7

“There are people who are called school mothers. hey bath the children, feed them, wash their clothes for them and groom them for school. They are able to sign very well so they are able to communicate effectively with the children and if they have any challenges. They get to know all these and then tell us at appropriate times” P -9

“The school mothers really help us. They do lot for us while we concentrate on other things. When the children are in school, we have no challenge with them - P16

Again, all the mothers revealed that since the school mothers are available with the children in school which is part of the school policy, they were happy to have an adult caring for them because they appreciated their children had deficits and appreciated the duties of the school mothers. They revealed that the school mothers provide first aid services, send the children to receive healthcare services when either of them reports sick even before the mothers are called to be informed about the news and because of their roles, the mothers have established excellent relationship with them

hence, if there is the need for mothers' presence or involvement in primary or secondary healthcare they are informed at appropriate times. This is evidenced by;

"As for that when she is sick, her madam sends her to the hospital, so she calls afterwards that she was not well, and the bill is sent to me, then I probably send her some money, so at times I may ask if there was a need for me to come and pick her home... But usually, she tells me she has been treated at the hospital and is doing well, hence there will be no need"- P 5

"When the school mother calls you from school and asks you to come because your child is sick, you have to go on the same day but if for some reasons you couldn't go on the same day, you have to go the next day. If you have been called by your ward's teachers that she's sick, you need to go on the same day or the next day. Recently she fell from a storey building and broke her leg, they did whatever they could yet to no avail so they called me, I went for her and I took her to the hospital for treatment for about two weeks, she recovered fully before I sent her back to school" – P8

"They call us from school and after taking the initial treatment and she's still not recovered (interviewer; mm-hmm) for instance, we go and take her back home and she's able to tell us what exactly is wrong with her so we then take her to the hospital, so the doctor will ask us and we show or tell her complaints, sometimes I will tell her the doctor is asking what is wrong with you and she will point where exactly is paining her. So, it is very important to have good relationship with the one taking care of your child in school. That is the only way you can be involved in their care If they are not in your personal care" – P11

Overall, all the mothers appreciated the significance of establishing a good relationship between the school mothers and themselves in order to be informed about their children wellbeing and help them get all the assistance material and their children's will need immaterially.

4.8 Cultural and religious cooperation

In eliciting responses from the mothers, all of them revealed healthcare practitioners were involved in the care of their children from the early stages from primary level of care to tertiary level. At the same time, they disclosed that they have not experienced any bizarre or negative

attitude from healthcare professionals in relation to their belief systems or cultural practices. However, they have been assisted at every stage even if they did not agree with them.

4.8.1 Health workers recommendation

Some of the participants also indicated in their quest to get the best or resources for their children, some of the healthcare workers themselves had belief systems that aligned with theirs and as a result, they gave some recommendations to them, which yielded positive outcomes. Four of the participants indicated that some of the health workers made recommendations for them to try alternate medicine together with what they have been doing. This is revealed by;

“They were reluctant for me to send him for herbal medication, so, it was one nurse who told me to be persistent and insisted on my right to send her for alternative treatment, and she was in support of us, because she had similar condition. Even as a nurse, she had a problem with her child, and if she had listened to them, her child would have died, so it was herbal medication that saved her child. Therefore, I agreed to do similar and opted to be discharge so I try that and frankly at that time, it helped but later when we realized she was delaying as compared with the other kids, we brought her to the hospitals for some other labs and later referred to KATH” – P -8

“When I delivered her in the hospital I stayed there for two weeks before she was discharged. It appeared that every month she would be admitted. She could not sit straight as if there were no bones in her body and her neck when she was one year old. They did whatever they had to do, so some of the doctors told me that it was not a disorder that is being managed in the hospital and therefore we can try herbal medication at hospital XXX, therefore we too because the doctors have said that, we went home and did that. After two months the child could sit and play after the herbal treatment. However, when he got to about 18 months old, he could not say mama or dada, which prompted us to seek additional help. We tried everything and they finally told us that she cannot hear after they tested her in a small room at KATH” – P 15

4.8.2 Healthcare workers cooperation

In as much as all the participants revealed that they agreed to work with healthcare professionals in the hospitals for the complete recovery of their children. They also indicated that

they were open to try other sources if they were not getting the satisfaction or results, they were seeking for while receiving orthodox. Nonetheless, they were also willing to discuss with the healthcare professionals of any opinions they might have. A third of the participants indicated that they opted to be discharged home from the hospital to seek alternate sources of medicine in an attempt to ensure the recovery of their children. Although sometime the healthcare professionals had different opinions, they were obliged to cooperate with them because they respected the rights of the patients and their mothers.

“Yes, it was a doctor that informed me that, after three weeks, I haven’t seen any improvement, hence wanted her to be discharged so that I send her for herbal treatment. The health workers did not say anything. In the morning the doctor that went on ward rounds, I prompted the doctor who was a friend to my sister, so, I requested for a discharge of my daughter because I could not see any improvement, so they discharged her for me for herbal treatment” - P2

“So, we forced for them to discharge us, hence we went to Obuasi. When we went to Obuasi she was growing lean, that even when she was lying on one’s leg, one could count all her ribs. And her hair was all going off, so others claimed it was convulsion, so we started herbal medication. Over time, it improved, she gained some weight, her hair stopped falling off” - P11

Overall, the mothers who opted to seek herbal medication agreed that both herbal and orthodox medical services were necessary and as a result they were willing to take their chances with any of them.

4.8.3 Religious practices

All the participants indicated that they believed in a supernatural force and power to help cure their children completely. However, they all believed that healthcare professionals were also people who were integral in empowering them to take care of themselves and their sick relatives and as a result, they were ready to respect the recommendation of the healthcare professions while at

the hospitals. Four of the participants indicate that they prayed every day when on the hospitals but do not do so disturbing which did not affect their roles and that of the nurses and doctors.

“No, they never did that. The nurses and doctors did not have any issues with me. They did their jobs effectively. They even used to call me “maame sofo” because I will always be praying for her. The health workers did not stop me from praying for my child when I decided to, because I was not smearing anything on her or applying any local medication to her body. I was just doing what they asked and I also attached my prayers to it” – P 1

“I usually prayed silently, as I bow my head, no one know what I am saying please I pray silently in my head. I know that when you are sick, I believe it is the hospital you seek for care, so I belief that whatever medication given to my child it will work” – P6

Only one of the participants indicated that although she had beliefs in supernatural forces, she had to pray at home instead of the hospital because she feared the practitioners might complain although none of them did. This is evidenced by;

“That is why I am saying, if it is prayers, it is not in the hospital I am going to pray, it is when I get home, I pray for all my children, even if I will pray at the Hospital, I will not let the Nurses see me pray, I will do it secretly and I knew they saw me do that but they never complained. They would often will wait for me to finish everything I am doing before they came to me. In fact, I will say they respect my views and my belief systems” – P- 17

4.9 Summary of key findings

The study used a total of 18 study participants, 16 of whom were biological mothers and 2 grandmothers. The majority of them were from the Ashanti Region and living within Ashanti region with one exception who was living in the Western Region. All of the participants were living together with the children. The participants also indicated that they are able to share information about the children and themselves with the healthcare professionals because they believed that healthcare professionals were instrumental in their health and wellbeing. The majority of the participants also revealed that they were self-dependent. This was because they had bitter

experiences from partners and as a result, they have empowered themselves to the best they can to take care of themselves primarily although they were ready to receive other forms of assistance from individuals and organizations. All the mothers disclosed that whenever the children were with them, they responded immediately to the health needs of the children. However, when they were in school, they were dependent on the school mothers who all revealed that that have been up to the task over the years. Finally, the participants also revealed that the healthcare professionals do not discriminate against them even if they have different motives, religious and cultural beliefs but rather they cooperate with them towards providing the best services for their children.



CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Introduction

The findings of the study have been discussed in relation to literature with emphasis on the four main themes as well as the subthemes in this chapter. The themes that were developed from the theoretical framework which are aligned with the study objectives focused on the experiences of mothers of children with hearing impairment at the Ashanti School for the Deaf. This chapter also contains an explanation of the significant implications of the findings. The findings of this study generally revealed that mothers of these children with hearing impairment go through many challenges while performing their responsibilities. However, with respect to healthcare needs, they were willing to integrate healthcare professionals to empower them to better care for their children.

5.2 Health information sharing among mothers (Family Care givers) and Healthcare Professionals

All the study participants revealed that they were directly involved in the care of the children and as a result, they were ready to put their children's health and safety first towards early recovery. They indicated that they served as intermediaries between their children and healthcare professionals because they were knowledgeable in identifying observable signs from their children and interpreting them to health professionals. This according to them creates an enabling environment for them to engage in meaningful health advice, teaching and learning to help equip them to better care for themselves and their children. This result is consistent with studies from de Beer and Brysiewicz (2019) who disclosed that sharing information between healthcare professionals and family caregivers helps improve well-being and quality of life.

The study further revealed that other people who have been legally and institutionally accepted other than biological mothers were also instrumental in sharing health information among biological mothers, the children themselves and healthcare professionals. All the mothers in the study expressed deep appreciation for the contributions of the individuals they referred to as 'school mothers.' These individuals played a vital role in identifying the healthcare needs of the children and assisting them using sign language, which the mothers believed was often more effective than their own efforts. This is findings of Opoku et al. (2020) which concluded that mothers benefit significantly from individuals referred to as "school mothers" within special education settings. These caregivers assist by identifying children's healthcare needs and providing sign language support, which helps bridge communication gaps between children, their mothers, and healthcare professionals. The study's findings is also consistent with Bunning et al. (2020), Maluleke et al. (2021) and (Wakimizu et al., 2022) who disclosed that mothers experienced a lot of challenges caring for their children with disabilities and as a result, help groups when introduced assisted and empowered mothers to perform their caregiving roles. Therefore, based on the roles of the school mothers as part of help groups provided by the institution to help mothers, provide a safe and enabling environment for the children to grow which include sharing adequate health information, both studies are consistent.

The study also revealed that older children were able to communicate with their mothers through written conversations, however, only mothers who had adequate levels of education were able to have meaningful communication through this medium. This they indicated served as a good source of information sharing between the mothers themselves and their children which provided greater insights to the mothers to share with the healthcare professionals in order to help provide better healthcare services in return.

This is consistent with the findings of Fobi and Oppong (2019) which indicated that older children with strong literacy skills often rely on written interactions with their parents, which becomes a crucial tool for families who may not be fluent in sign language. Such skills are particularly empowering for children and help bridge communication with healthcare providers, enhancing family-centered care. Their study on the communication approaches in Ghanaian education for Deaf and Hard of Hearing (DHH) children highlight that parents with adequate educational levels are better able to engage in written communication with their children, particularly as children get older. This written exchange allows parents to share essential health and educational insights with healthcare providers, leading to more informed and tailored healthcare interventions for their children

5.3 Garnering Resources by Mothers

Both tangible and intangible resources for parents and their children are necessary inputs for health and wellbeing of children. Therefore, when mothers are able to gather adequate proportions of physical, emotional, spiritual, and psychological resources they are able to improve much upon them.

The findings from this study revealed that the majority of the mothers were self-sustainable and self-sufficient and as a result, they relied on themselves only to obtain all the resources they needed in order to better care for the growth, development and well-being of their children. Particular among them were their ability to finance their basic needs regardless of the challenges they go through and also without regards to the level of their education and socioeconomic status. This therefore is in tandem with study from Davitas et al. (2018) who revealed in their study that some healthcare needs and

interventions integrated in the care of the children made mothers more resilient towards acquiring health independence for their children.

The study also revealed that the mothers tend to get support from family members and other social and religious groups which were both material and immaterial for themselves and their children. This result is therefore consistent with the study from Riffin et al. (2019) who disclosed that it was significant to receive some support because when the family caregivers asked for support for their sick children, they received the necessary assistance from health professionals who were taking care of them which served as a good source of extrinsic motivation and empowerment to assist these mothers. Similarly, as disclosed by Zen and Shin (2022), emotional relationships also served as good sources of resilience because from their study, they revealed that emotional support from spouses helped improve the wellbeing of the family caregivers including mothers in their study and their children. Although the findings of this study revealed that majority of these women did not receive adequate emotional support from their partners, they received some comfort and other tangible support from the religious organization they belonged to and based on the emotional support they received, helped empowered them to care for their children. Both studies appear to be consistent with each other.

Additionally, the study also revealed that the majority of the mothers sought and received assistance from social groups such as social welfare and educational offices as well as healthcare professionals to help them adequately perform their caregiving responsibilities. This study's outcome is also in tandem with Hoffstädt et al. (2023) and Mathy (2022) studies which revealed

that their study participants obtained adequate support from healthcare professionals both physically and emotionally that also motivated and empowered them.

5.4 Early response by the mother to the needs of the child with hearing impairment

The study findings revealed that before, during and after diagnosis of hearing impairment, the mothers were supported by healthcare professionals to cope and live with their children with these disorders. As a result, to ensure their appropriate well-being, the mothers disclosed that they lived close to their children to identify their healthcare challenges. This was significant because the study indicated that they could better explain and discuss well with the healthcare professionals because of their closeness with their children to obtain the appropriate healthcare interventions from them to help bridge the gap between healthcare access for parents, and their children with hearing impairment. This finding is thus consistent with Gerlach and Varcoe (2021), who revealed that child-family care approaches when utilized appropriately improve the general well-being of both mothers and children with chronic diseases and disabilities.

Additionally, the study also revealed that all the mothers appreciated the role of the school mothers in responding to the healthcare needs of their children when in school. The study further disclosed that these school mothers also helped in rendering appropriate healthcare services by way of responsive visitation to healthcare professionals and as a result all the mothers integrated the school mothers as major stakeholders in the wellbeing of their children. Therefore, based on the hearing deficits of these children, healthcare professionals and providers also appreciate and respect the strengths and weaknesses of these children and their families and hence tailor healthcare services to meet their needs with the inclusion of all these health stakeholders. Therefore, these findings are consistent with Prasopkittikun et al. (2020) who revealed that respecting and appreciating all the strengths and

weaknesses was vital in implementing family centred care approach to help in timely response to the patients' needs by the relevant stakeholders responsible for maintaining the health and wellbeing of these children. Hence both mothers and healthcare professionals recognizing the role of the school mothers while in school in the absence of the mothers helped improve the general wellbeing of the children by seeking timely health interventions.

The overall outcome of their role in promoting the health and well-being of these children is also consistent with Botes and Langley (2016) who also disclosed that at least two people were involved in the care of their loved ones at the emergency department when they are unwell. Similar to this study, the school mothers always accompanied the children to receive care and cover all costs before their biological mothers from different geographical locations show up. The study findings also revealed that caring for the healthcare needs of these children before they are adults does not solely depend on the mothers but the school mothers as well together with healthcare professionals particularly when they are in school. With the availability of these other stakeholders, all the mothers disclosed that they were content with the duties of school mothers in relation to seeking early treatment in their absence and as a result it also empowered the mothers to focus on their jobs to provide all the necessary financial and other material and immaterial resources that would be relevant in ensuring that their children obtain quality healthcare services. This finding is consistent with the work of Nickbakht et al. (2021), who emphasized the importance of healthcare providers collaborating with families during early intervention. They highlighted the significance of informed choice and decision-making, as well as the role of family-child interactions in promoting healing and providing social and emotional support. Therefore, on the premise of all the mothers appreciating and choosing school mothers as stakeholders in healthcare decision-

making and early access to health interventions, the findings are consistent with both studies, Botes and Langley (2016) and Nickbakht et al. (2021).

5.5 Cultural and Religious Cooperation among mothers and health care professionals

Family-centred care ensures that the well-being of both children and families is promoted in a way that is respectful and responsive by healthcare professionals. Therefore, to achieve this, all stakeholders responsible for child development including parents, families and healthcare professionals cooperate among themselves. The study findings therefore revealed that healthcare professionals cooperated well with the study participants from the time of diagnosis and any time the children fell sick and needed any form of assistance to help them achieve health independence. Even though on many occasions, the health professionals did not agree with their choice to receive alternate medical services based on their belief system and culture, they were respected and appreciative. This finding is in tandem with Kuribayashi et al. (2022) and Badriyah et al. (2025) who disclosed that it was vital to integrate the perspectives of parents into family-centred care to achieve overall good health and well-being of both parents and their children because it provided a source of meaningful support and comfort.

The study also revealed that some health workers themselves shared similar sentiments with some of the study participants and as a result, gave some recommendations and support to the mothers, especially in seeking alternate healthcare services which yielded some positive findings in the course of the illness. This result was found to be consistent with Bunning et al. (2020) on self-help groups for caregivers of children with disabilities in Kenya. In their study, they appreciated that caregivers including mothers of these children with disabilities suffered isolation and discrimination in their communities, however when some of the healthcare professionals rendered some services to them, it served as a source of empowerment to improve upon their health and wellbeing. It also helped take

better care of their children although the study did not suggest healthcare professionals recommended study participants to seek alternate sources of treatment.

Additionally, the study revealed that healthcare professionals respected and appreciated the mothers' belief system and religious practices such as belief in praying to a supernatural being. This was because it was also beneficial in improving their emotional, spiritual and overall wellbeing. This finding is also consistent with Triana and Sudjarmiko (2021) who disclosed that caregivers' belief system and a safe relationship with spiritual entities as well as positive religious coping was attributed to lifestyle and behavioural adjustment which was necessary for promoting spiritual and overall well-being.



CHAPTER SIX

SUMMARY, CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

6.1 Introduction

The findings made during the study have been summarized in this chapter. The study's objectives, methodology, and key conclusions are all included in the summary. The chapter also includes the conclusions drawn in light of the key results as well as implications for the key stakeholders and recommendations. Since this study cannot be regarded as comprehensive on the subject, further areas of investigation were also recommended in further studies.

6.2 Summary

The research sought to explore the experiences of mothers of children with hearing impairment at the Ashanti School for the Deaf. The study employed an exploratory-descriptive design using a qualitative approach. The study was based on the theory of family care during critical illness developed in 2019 in South Africa. The research was based on the four main constructs of the theory which were the foundations for the specific objectives of the study. Ethical approval was given by the Ghana Health Ethics Review Committee (attached as Appendix B). The researcher also sought permission from the Director of Health Services at the Sekyere South District and the Headmistress of the Ashanti School of the Deaf to gain access to study participants. Interviews were then conducted between April to June 2024 using a semi-structured interview guide (attached as Appendix C). All interviews were recorded and transcribed verbatim.

The theoretical framework, theory of family care during critical illness was the foundation for the study objectives and development of semi-structured interviews after which thematic analysis was used to analyze the responses. Four themes were the constructs of the theoretical framework, with 12 subthemes. The main themes were similar to the specific objectives of the study which were

information-sharing experiences, resource acquisition, mothers' early responses and cultural and religious cooperation among mothers of children with hearing impairment at Ashanti School for the Deaf.

Saturation was achieved after the eighteenth participant after which no new information was obtained. The results of the study revealed that only two participants were grandmothers while the remaining were biological mothers of the child. Additionally, the majority of them were traders who were raising the children with hearing impairment alone by themselves while only two reported they received support from their husbands. With respect to the first theme information sharing experiences, three subthemes namely; signs and observation, written conversations and school mothers' reports emerged.

Again, concerning the second theme, garnering resources, four subthemes emerged which included self-sustainability, because they were solely responsible for taking care of the child alone. Another subtheme family support emerged because the participants also indicated that they occasionally received both tangible and intangible support from members of the family. The third subtheme, social support revealed that support from social welfare and Ghana education service provided some form of assistance occasionally and finally, religious support from their spiritual affiliations cannot be over emphasised.

Concerning the third theme, two subthemes were developed. They included living together at home, where mothers indicated they stayed in the same house with children before putting them in school and during vacations. Additionally, the participant had a good relationship with the school mothers who were taking care of the children when in school and as a result, they were able to communicate effectively about the challenges with the health of children in the absence of the biological mothers while at school.

The final major theme cultural and religious cooperation also had three subthemes emerging; health worker recommendation where some healthcare workers recommended other forms of treatment for these mothers, and cooperated well with the mothers by respecting their religious-spiritual principles and practices.

6.3 Implications

Overall, the findings of this study have implications for nursing practice, nursing education, nursing research and policy.

6.3.1 Nursing Practice

Findings from the study revealed that mothers of children with hearing impairment are the closest of all healthcare stakeholders with their children who have numerous challenges caring for their needs regardless of their socioeconomic status, knowledge level or marital status. They however appreciated the significance and roles of healthcare providers in the care of their children and themselves when unwell. Therefore, to promote quality health services in a manner that is safe and responsive to meet the needs of these people, there is the need for proper adoption and integration of individualized and family-centred care approaches to bridge the gaps between healthcare inaccessibility.

Additionally caring for children with permanent hearing impairment has demonstrated to be very challenging as the children need specialized healthcare, education and vocational services. As a result of this burden, mothers or parents tend to deal with emotional and psychological challenges therefore it is vital to integrate multidisciplinary nursing care services by way of integrating mental healthcare services for mothers and parents to help deal with emotional and psychological stressors and cope appropriately with their children's disorders.

The study identified that some of the nurses recommended alternate medical services to the parents. Although it was helpful as parents had the right to disclosure of information including access and opportunities to alternate medical practices, it must be captured in the standard operating procedures of the institution where all nurses are equipped enough to provide full disclosure of information appropriate to patients and family before consent to medical treatment and document appropriately.

6.3.2 Nursing Education

The study revealed that there were different informal stakeholders involved in the care of children with hearing impairment at different times in their lives while growing, however, healthcare workers were the main source of information for family caregivers. It is imperative then, for curriculum planners to include courses in nursing training programmes that will enhance the knowledge and skills of nurses in the area of collaborative practice. This will enable nurses to coordinate information from all other professionals that may be linked to the care and rehabilitation of these children to effectively communicate with family caregivers.

Additionally, continuous professional development among nursing staff is a significant reservoir of knowledge to improving health and well-being for parents of children with special needs living with permanent hearing loss. Further, targeted in-service training may be instrumental in obtaining adequate practical evidence-based knowledge and skills necessary for improving quality health outcomes for parents of children with hearing impairment.

6.3.3 Nursing Research

This study can be replicated in many regions of Ghana among mothers, fathers and significant family caregivers of children with hearing impairment to obtain diverse perspectives

about their experiences of having to care for children with hearing impairment and their wellbeing. Additionally, other stakeholders were identified in the study, particularly the school mothers in the specialized schools and other teachers. It will be important for studies to be conducted both quantitatively and qualitatively to determine the challenges and lived experiences of caring for and teaching children with hearing impairment as well as their coping mechanisms.

6.3.4 Policy Formulation

The findings of the study revealed that caring for children with permanent hearing impairment was expensive and as a result, they needed some form of assistance. They expressed that although the social works department assists in some way, their assistance according to them delayed and not consistent. It is necessary to re-evaluate social services policies to help parents of children with hearing impairment.

Hearing assistive devices are costly and as a result, parents are unable to afford them for their children. It is significant for the Ministry of Health of Ghana, the National Health Insurance Authority and relevant stakeholders to work collaboratively to ensure appropriate pricing and financing that is feasible to parents.

6.4 Limitations

The limitation of this study was that it was conducted among mothers of children with hearing impairment in only one school in Ghana, the Ashanti School for the Deaf, Jamasi. Therefore, the experiences of mothers from other regions were not studied. Again, although the sample size for this study is appropriate for the design, it may likely not be a true representation of all mothers of children with hearing impairment. Possibly, the findings may therefore differ from those in other regions.

Finally, the study focused on only one group of parent, female and as a result, there were no experiences of male partners or fathers of children with hearing impairment, which may also provide useful insights.

6.5 Conclusion

It was revealed from the study that the majority of the children suffered from hearing impairment at a very early age and mothers had to deal with major challenges ranging from those associated with the establishment of appropriate diagnoses to challenges of having to learn homemade sign language to communicate effectively with their children. The mothers however disclosed that enrolling children in school has been instrumental in assisting them to communicate effectively between themselves and their children as well as communicate effectively with healthcare professionals in times of ill health for the best of medical and nursing services to be rendered. They concluded that the school's services have helped mitigate these challenges.

Again, the mothers revealed that they experienced challenges associated with their children's upbringing including the high cost of medical services, educational services and other support services. Despite these challenges, they appreciated that there was the need to obtain and allocate resources for themselves to improve their physical, mental and emotional well-being. Based on this, all the mothers demonstrated a high sense of resilience in caring for their children and also meeting their personal daily needs.

Further, the mothers had a sense of responsibility to provide all the needs of their children regardless of their financial status. They were only a phone call away from their children who were ready to respond to needs of their children. Again, they had made all necessary arrangement with the school mothers to assist in the care of their children at all times. Hence, it can be concluded

that the mothers responded appropriately to the needs of their children and they continue to perform these roles.

The findings from the study also revealed that mothers requested assistance from healthcare professionals when receiving healthcare services. It was revealed there was no form of discrimination, stigmatization or neglect by healthcare professionals based on cultural and religious differences but a peaceful collaboration each time they assessed healthcare in any healthcare facilities in Ghana. Based on this, it can be concluded that caregivers receive and use multidisciplinary means to equip and empower themselves.

6.6 Recommendations

From the study, two main recommendations can be made: recommendations for policy action and for future research.

6.6.1 Recommendation for policy action

Based on the outcome of this study, several recommendations can be made to improve the care of children with hearing disorders and improve parental home, familial and societal conditions to improve the well-being and development of the children and parents.

It is recommended that policies be developed and implemented with fidelity, monitored and evaluated periodically to prioritize these vulnerable children and the parents to offer appropriate resources and support to them. This encompasses access to affordable healthcare services, subsidies on transport charges, and access to vocational training services in all regions of Ghana to help equip them with skills that will be beneficial to them in the future. This will help relieve mothers of some form of stress to help with activities of daily living.

It is also recommended that after establishing a diagnosis, healthcare institutions also prioritize the care of these children by way of integrating family centred care approach in the management through the identification of parental and family strengths, limitations, resource availability and planning individual and family-specific interventions to help in the care of children of hearing impairment. Again, the development of standard operating procedures specifically for families of children with hearing impairment where mental healthcare access and coverage is significant in promoting the psychological and emotional well-being of all parents.

A multidisciplinary approach involving the integration of religious organizations, healthcare institutions and other non-governmental organizations use their platforms and medium to help provide adequate health information and sensitization to communities and to the general public periodically to abort and or improve societal stigmatization and discrimination. Using this same approach, it is recommended that emphasis be placed on empowering parents and families with coping mechanisms that will help them sail through the various challenges to be faced.

6.6.2 Recommendation for future research

Future research is significant to explore the perspectives and experiences of fathers and extended family members living with children with hearing impairment from socio-cultural perspectives within the contest of Ghana to provide useful insights to assist appropriate integration of family.



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APPENDICES

Appendix A – Letters of introduction and support from the school of Nursing and Midwifery for ethical clearance.

**UNIVERSITY
OF GHANA**

SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

Ref. No: 10929692

8th June, 2023

The Chairperson
Ghana Health Service
Ethics Review Committee
Accra, Ghana.

Dear Sir/Madam,

LETTER OF INTRODUCTION – ETHICAL CLEARANCE

I write to introduce to you **Ms. Faustina Amoro**, an MPhil. Nursing student at the School of Nursing and Midwifery, University of Ghana, Legon.

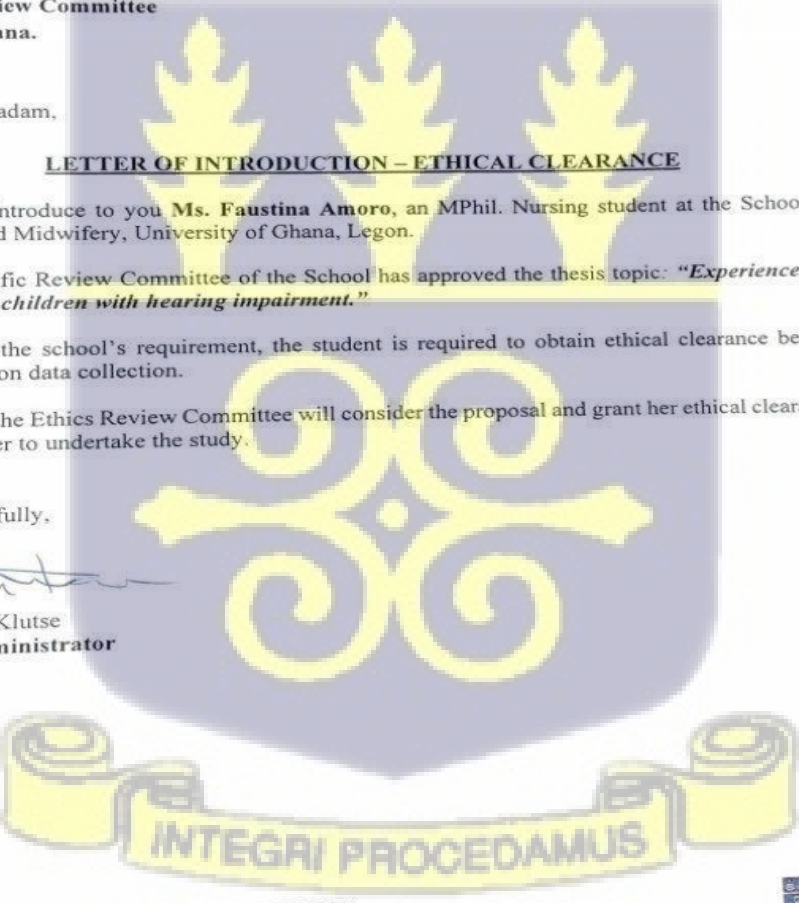
The Scientific Review Committee of the School has approved the thesis topic: *“Experiences of mothers of children with hearing impairment.”*

As part of the school’s requirement, the student is required to obtain ethical clearance before embarking on data collection.

I hope that the Ethics Review Committee will consider the proposal and grant her ethical clearance to enable her to undertake the study.

Yours faithfully,


Charles A. Klutse
School Administrator


INTEGRI PROCEDAMUS



P. O. Box LG 43, Legon, Accra, Ghana | Tel: +233 (0) 303 970 801
Email: nursing@ug.edu.gh | Website: www.nursing.ug.edu.gh

SUPPORT LETTER FROM SUPERVISOR



SCHOOL OF NURSING AND MIDWIFERY
COLLEGE OF HEALTH SCIENCES

Department of Adult Health Nursing

Ref. No: 10938792

8th June, 2023

The Chairperson
Ghana Health Service
Ethics Review Committee
Accra, Ghana.

Dear Sir/Madam,

LETTER OF SUPPORT – ETHICAL CLEARANCE

This letter is to support the application for ethical clearance for **Ms. Faustina Amoro**, an MPhil Nursing student in the Department of Adult Health Nursing, School of Nursing and Midwifery, University of Ghana, Legon.

As part of the programme, she is to undertake a research on the topic *“Experiences of mothers of children with hearing impairment.”*

I hope that the Ethics Review Committee will consider the proposal to enable her collect data.

Thank you.

Yours faithfully,

A handwritten signature in black ink, appearing to read "Gwendolyn Mensah".

Dr. Gwendolyn Patience Mensah
Research supervisor





UNIVERSITY OF GHANA
DEPARTMENT OF ADULT HEALTH
SCHOOL OF NURSING

Ref. No.:

26th September, 2023

The Chairman
Ethics Review Committee
Ghana Health Service
Accra, Ghana

Dear Sir/Madam,

**LETTER OF SUPPORT – ETHICAL CLEARANCE (MS. FAUSTINA AMORO –
STUDENT ID: 10929077)**

I write in support of an application for ethical and scientific approval by Ms. Faustina Amoro for her research work. The applicant is an MPhil. Nursing student at the Department of Adult Health Nursing, in the School of Nursing and Midwifery, University of Ghana, Legon.

She is to carry out a research as part of the programme, and she proposes to investigate the “Experiences of mothers of children with hearing impairment: A Study at the Ashanti School for the Deaf, Jamasi-Ashanti Region, Ghana.

I am optimistic that her application will be considered.

Thank you.

Yours faithfully,


Mrs. Patricia Avadu
Co-Research Supervisor



DATE: 27TH JUNE, 2023
 ()

Core Values
 People Centeredness
 Teamwork
 Professionalism
 Discipline
 Innovation and Excellence
 Integrity

No: 0241-219139

LETTER OF INTRODUCTION
MS FAUSTINA AMORO – STUDENT
UNIVERSITY OF GHANA LEGON
EMPLOYEE NO. 1340716

I wish to officially introduce to you the above named staff who is a Nurse and pursuing masters programme in the University of Ghana-Legon.

Ms. Faustina Amoro has been given permission to carry out her research study in the Sekyere South District on the topic **"Experience of mothers of children with hearing impairment"**. The student intends to use your institution for the main study site for the research.

This is for academic purpose and all outcomes will be kept confidential. Her respondent will be the mothers of your students.

Kindly accord her the needed assistance she may need.

Thank you,

MR. ROBERT MENSAH
(DDHS)

TO:

**THE DIRECTOR
ASHANTI SCHOOL FOR THE DEAF
JAMASI-ASHANTI**

INTEGRI PROCEDAMUS

Appendix B - Ethical Approval Letter from Ghana Health Service

GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

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



My Ref: GHS/RD/ERC/Admin/APP/23/696
Your Ref. No:

Research & Development Division
Ghana Health Service
P. O. Box MB 180
Accra
Digital Address: GA-G50/EH3
Mob: +233-50-3539896
Tel: +233-302-900628
Email: ethics.research@ghs.gov.gh
27th November 2023

Faustina Amoro
SDA Hospital
P.O. Box 24
Wiamease-Ashanti Region

The Ghana Health Service Ethics Review Committee has reviewed and given approval for the implementation of your Study Protocol.

GHS-ERC Number	GHS-ERC: 050/09/23
Study Title	Experiences of Mothers of Children with Hearing Impairment: A Study at the Ashanti School for the Deaf, Ashanti Region, Ghana
Approval Date	27 th November, 2023
Expiry Date	26 th November, 2024
GHS-ERC Decision	Approved

This approval requires the following from the Principal Investigator

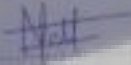
- Submission of a yearly progress report of the study to the Ethics Review Committee (ERC)
- Renewal of ethical approval if the study lasts for more than 12 months.
- Reporting of all serious adverse events related to this study to the ERC within three days verbally and seven days in writing.
- Submission of a final report after completion of the study.
- Informing ERC if study cannot be implemented or is discontinued and reasons why.
- Informing the ERC and your sponsor (where applicable) before any publication of the research findings.

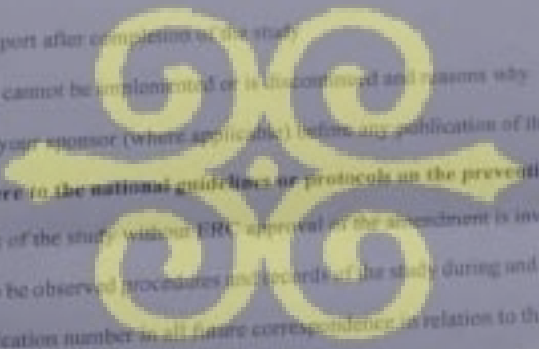
You are kindly advised to adhere to the national guidelines or protocols on the prevention of COVID-19

Please note that any modification of the study without ERC approval or the amendment is invalid.

The ERC may observe or cause to be observed procedures and records of the study during and after implementation.

Kindly quote the protocol identification number in all future correspondence in relation to this approved protocol.

SIGNED: 
Mr. Ken Wellington
(GHS ERC Chairperson)


INTEGRI PROCEDAMUS

CC: The Director, Research & Development Division, Ghana Health Service, Accra

Appendix C – Semi-structured Interview Guide

INTERVIEW GUIDE (DATA COLLECTION INSTRUMENT) FOR EXPLORING
EXPERIENCES OF MOTHERS OF CHILDREN WITH HEARING IMPAIRMENT: A STUDY
AT THE ASHANTI SCHOOL FOR THE DEAF, JAMASI- ASHANTI REGION, GHANA

PART 1

Socio- demography. Tell me about yourself

1. What is your profession?
2. Where are you from?
3. Where do you stay?.....
4. What is your current age? Give range
5. What is your highest level of education?
6. What is your marital status?
7. What is your relationship with the patient?
8. When was your child diagnosed with hearing impairment?.....

PART TWO: INTERVIEW QUESTIONS

A. Objective 1. Information sharing experiences

1. Share with me what you know about hearing impairment?

Probe into how and when child was diagnosed and when parents were informed

2. Share with me how health information about your child is shared among you, your child and healthcare professionals.

Probe into the medium used and frequency

B. Objective 2. Mothers' early responses to child's needs (Proximity)

3. Share with me how you are able to get access to your child when he is unwell
4. Describe what you do in such instances.

Probe into the impact or significance of getting close to your child when ill.

C. Resource acquisition (Garnering of resources)

5. How are you able to mobilise resources for yourself as you take care of your child?
6. Describe how you mobilise resources from the time your relative is sick to receive treatment at any level

Probe into how physical, psychosocial, spiritual and economic resources (material and immaterial resources) are acquired

D. Cultural and religious factors affecting cooperation

1. How does your spirituality come in when you are caring for sick relative?
2. How do healthcare professionals perceive your spiritual practices when caring for your child?
3. Describe how your cultural practices impact your child's wellbeing.

Appendix D – Participant Information Sheet

Participant Information Leaflet and Consent Form

This sheet must be given to all prospective participants to enable them to know enough about the research before deciding to or not to participate

Project Title: EXPERIENCES OF MOTHERS OF CHILDREN WITH HEARING IMPAIRMENT; A STUDY AT THE ASHANTI SCHOOL FOR THE DEAF, ASHANTI REGION, GHANA

This Informed Consent Form has two parts:

- Information Sheet (to share information about the survey with you).
- Certificate of Consent (for signatures if you agree to participate).

PART 1: Information sheet

- ***Introduction***

My name is Faustina Amoro, I am a Final year M.Phil. Student at University of Ghana (School of Nursing and Midwifery- College of Health Sciences). I am undertaking this investigation as a master degree academic requirement on ‘EXPERIENCES OF MOTHERS OF CHILDREN WITH HEARING IMPAIRMENT; A STUDY AT THE ASHANTI SCHOOL FOR THE DEAF, ASHANTI REGION, GHANA.’

The outcomes of this inquiry will provide a useful material to add to academic knowledge and subsequent similar researches.

- *All the information collected from you will be treated very confidential. Nothing you say will be linked to you or traced to you.*

Principal Investigator: Faustina Amoro, Department of Adult Health, School of Nursing and Midwifery, College of Health Sciences, University of Ghana, Post Office Box LG 43, Legon, Accra – Ghana.

General Information about Research

Purpose(s) of research:

Your participation in this study will be greatly appreciated. The objective of this study is to explore the experiences of mothers of children with hearing impairment specifically, to explore how information is shared among family care givers and healthcare professionals, resources are garnered by mothers, how parents get close to their children and how parents cultural and religious practices contribute to wellbeing. This study is purely for academic purposes.

Procedure of the research, what shall be required of each participant and the approximate total number of participants that would be involved in the research:

If you volunteer to serve as a study participant, you will be asked to participate in an interview. The interview will gather information to provide better understanding of wellbeing when living with hearing impairment. The interview answers and information will be captured with an audio recorder and a paper note. The audio recording will allow us to revisit our discussion to ensure the accuracy of your answers and make the research comprehensive. This is a secret discussion therefore I will not report your names or who said what. Your privacy is important to us and all recorded data will be stored on a secure device. Your name will NOT be included in the final report about this meeting. If you do not wish to have your interview session audio recorded, you will not be allowed to participate in the study.

Risk(s):

Participants may potentially experience some psychological discomfort or emotional distress from asking their views about their own wellbeing when they are involved in taking care of their loved ones. Anyone expressing or reporting discomfort will be reminded their participation is completely voluntary and that they are not obliged to complete the interview. They will be reminded they can stop at any time during the study and they can choose not to answer certain questions during the interview.

Benefit(s):

To begin, your participation in this study will aid health care professionals to provide timely and appropriate information and support to family caregivers to improve their quality of life as well as that of their children. It will reveal special characteristics surrounding the stress, anxiety and psychological situation experienced by caregivers when caring for their children with hearing

impairment. It will provide a useful material to add to academic knowledge and subsequent similar researches.

Confidentiality:

All personal information obtained from you will be treated as confidential. No names will be recorded, instead, a study ID will be used, which will be a unique number assigned to each participant. The researcher will only ensure that you have signed or thumb printed appropriately before the interview commences. Answers from the interview and other information will be captured using audio recorder. All materials, including the audio recordings and field notes, will be stored on a secured storage device not connected to the internet, and will only be accessible to the investigator. After the study, the data will be kept for a minimum 5 years upon completion of the project. information (without names) could be used in future research and will remain in a secure location. Findings may be published and/or presented at University of Ghana and scientific conferences in Ghana and internationally.

Duration:

The interview will take about 30 - 60 minutes.

Voluntariness:

Your participation is voluntary and you can decide to stop the interview at any time. If you are receiving any hospital services, your participation or non-participation will not alter your required medical care, and participation is not required for you to receive hospital care and services. If you



decide not to participate in the study, your decision will not be questioned and in no way influence the training of your child in the school.

Alternatives to participation:

If you choose not to participate, this will not affect your ability to access health services at the locations where the study is being conducted.

Withdrawal from the research:

Participants can choose to withdraw from the research at any time without having to explain yourself. You may also choose not to answer any question you find uncomfortable or private.

The consequence of withdrawal:

There will be no consequence, loss of benefit or care if you choose to withdraw from the study. Please note, however, that some of the information that may have been obtained from you without identifiers (name etc), before you chose to withdraw, may have been modified or used in analysis reports and publications. These cannot be removed anymore. We do promise to make good effort to comply with your wishes as much as possible.

Costs/Compensation:

You will be refreshed with snacks after the conversation with the researcher. If the conversation takes place outside your home or the workplace, you will be given Ten Ghana cedis as transportation in addition to the snacks.

Whom to Contact:

If you have any concerns or questions about the research now or later, please contact

THE RESEARCHER:

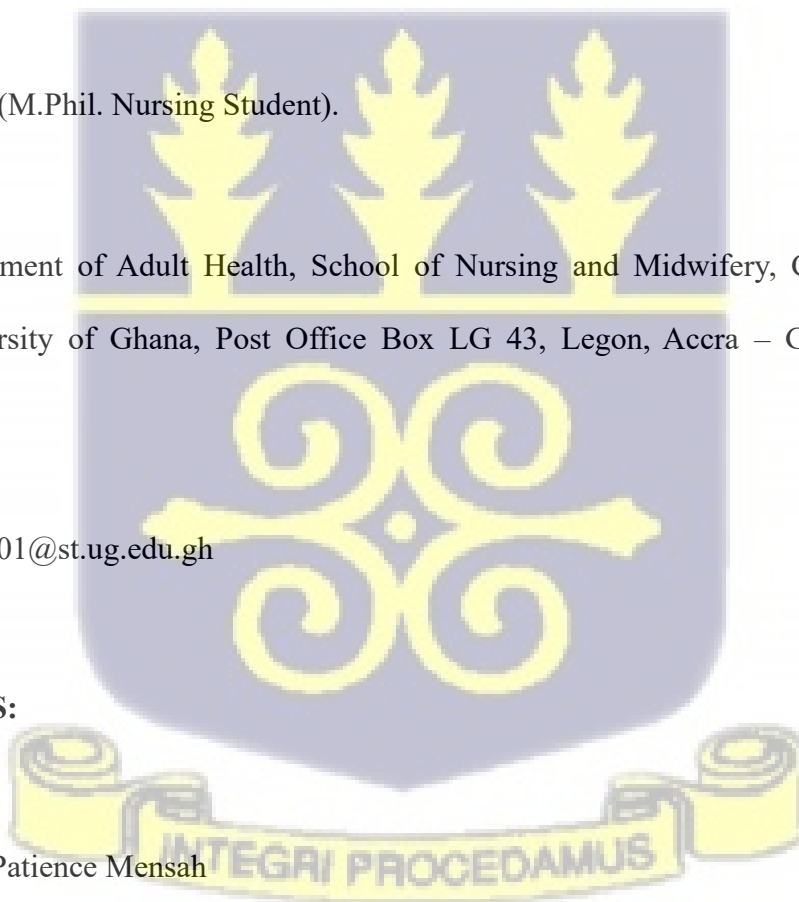
Faustina Amoro (M.Phil. Nursing Student).

Address: Department of Adult Health, School of Nursing and Midwifery, College of Health Sciences, University of Ghana, Post Office Box LG 43, Legon, Accra – Ghana. Telephone: 0207577487

E-mail: famoro001@st.ug.edu.gh

SUPERVISORS:

Dr. Gwendolyn Patience Mensah



Department of Maternal and Child Health, School of Nursing and Midwifery, College of Health Sciences, University of Ghana, Post Office Box LG 43, Legon, Accra – Ghana. Telephone: 0208127756

Email: gpmensah@ug.edu.gh

Miss Patricia Avadu

Department of Adult Health, School of Nursing and Midwifery, College of Health Sciences, University of Ghana, Post Office Box LG 43, Legon, Accra – Ghana. Telephone: 0244560130

Email: patavad62@yahoo.co.uk

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of the Ghana Health Service. If you have any questions about your rights as a research participant, you can contact:

The Chairperson

Institutional Review Board

Ghana Health Service

PMB, Accra.



APPENDIX E - CONSENT FORM

**This sheet must be given to all prospective participants to enable them to know enough
about the research before deciding to or not to participate**

Project Title: EXPERIENCES OF MOTHERS OF CHILDREN WITH HEARING IMPAIRMENT; A STUDY AT THE ASHANTI SCHOOL FOR THE DEAF, ASHANTI REGION, GHANA

This Informed Consent Form has two parts:

- Information Sheet (to share information about the survey with you).
- Certificate of Consent (for signatures if you agree to participate).

PART 1: Information sheet

- ***Introduction***

My name is Faustina Amoro, I am a Final year M.Phil. Student at University of Ghana (School of Nursing and Midwifery- College of Health Sciences). I am undertaking this investigation as a master's degree academic requirement on '**EXPERIENCES OF MOTHERS OF CHILDREN WITH HEARING IMPAIRMENT: A STUDY AT THE ASHANTI SCHOOL FOR THE DEAF, ASHANTI REGION, GHANA.**'

The outcomes of this inquiry will provide a useful material to add to academic knowledge and subsequent similar researches.

- *All the information collected from you will be treated very confidential. Nothing you say will be linked to you or traced to you.*

- **Principal Investigator:** Faustina Amoro, Department of Adult Health, School of Nursing and Midwifery, College of Health Sciences, University of Ghana, Post Office Box LG 43, Legon, Accra – Ghana.

- **General Information about Research**

- **Purpose(s) of research:**

- Your participation in this study will be greatly appreciated. The objective of this study is to explore the experiences of mothers of children with hearing impairment specifically, to explore how information is shared among family care givers and healthcare professionals, resources are garnered by mothers, how parents get close to their children and how parents cultural and religious practices contribute to wellbeing. This study is purely for academic purposes.

- **Procedure of the research, what shall be required of each participant and the approximate total number of participants that would be involved in the research:**

- If you volunteer to serve as a study participant, you will be asked to participate in an interview. The interview will gather information to provide better understanding of wellbeing when living with hearing impairment. The interview answers and information

will be captured with an audio recorder and a paper note. The audio recording will allow us to revisit our discussion to ensure the accuracy of your answers and make the research comprehensive. This is a secret discussion therefore I will not report your names or who said what. Your privacy is important to us and all recorded data will be stored on a secure device. Your name will NOT be included in the final report about this meeting. If you do not wish to have your interview session audio recorded, you will not be allowed to participate in the study.

Risk(s):

Participants may potentially experience some psychological discomfort or emotional distress from asking their views about their own wellbeing when they are involved in taking care of their loved ones. Anyone expressing or reporting discomfort will be reminded their participation is completely voluntary and that they are not obliged to complete the interview. They will be reminded they can stop at any time during the study and they can choose not to answer certain questions during the interview.

Benefit(s):

To begin, your participation in this study will aid health care professionals to provide timely and appropriate information and support to family caregivers to improve their quality of life as well as that of their children. It will reveal special characteristics surrounding the stress, anxiety and psychological situation experienced by caregiver when caring for their children with hearing impairment. It will provide a useful material to add to academic knowledge and subsequent similar researches.

Confidentiality:

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Duration:

The interview will take about 30 - 60 minutes.

Voluntariness:

Your participation is voluntary and you can decide to stop the interview at any time. If you are receiving any hospital services, your participation or non-participation will not alter your required medical care, and participation is not required for you to receive hospital care and services. If you decide not to participate in the study, your decision will not be questioned and in no way influence the training of your child in the school.

Alternatives to participation:

If you choose not to participate, this will not affect your ability to access health services at the locations where the study is being conducted.

Withdrawal from the research:

Participants can choose to withdraw from the research at any time without having to explain yourself. You may also choose not to answer any question you find uncomfortable or private.

The consequence of withdrawal:

There will be no consequence, loss of benefit or care if you choose to withdraw from the study. Please note, however, that some of the information that may have been obtained from you without identifiers (name etc), before you chose to withdraw, may have been modified or used in analysis reports and publications. These cannot be removed anymore. We do promise to make good effort to comply with your wishes as much as possible.

Costs/Compensation:

You will be refreshed with snacks after the conversation with the researcher. If the conversation takes place outside your home or the workplace, you will be given Ten Ghana cedis as transportation in addition to the snacks.

Whom to Contact:

If you have any concerns or questions about the research now or later, please contact

THE RESEARCHER:

Faustina Amoro (M.Phil. Nursing Student).

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Your rights as a Participant

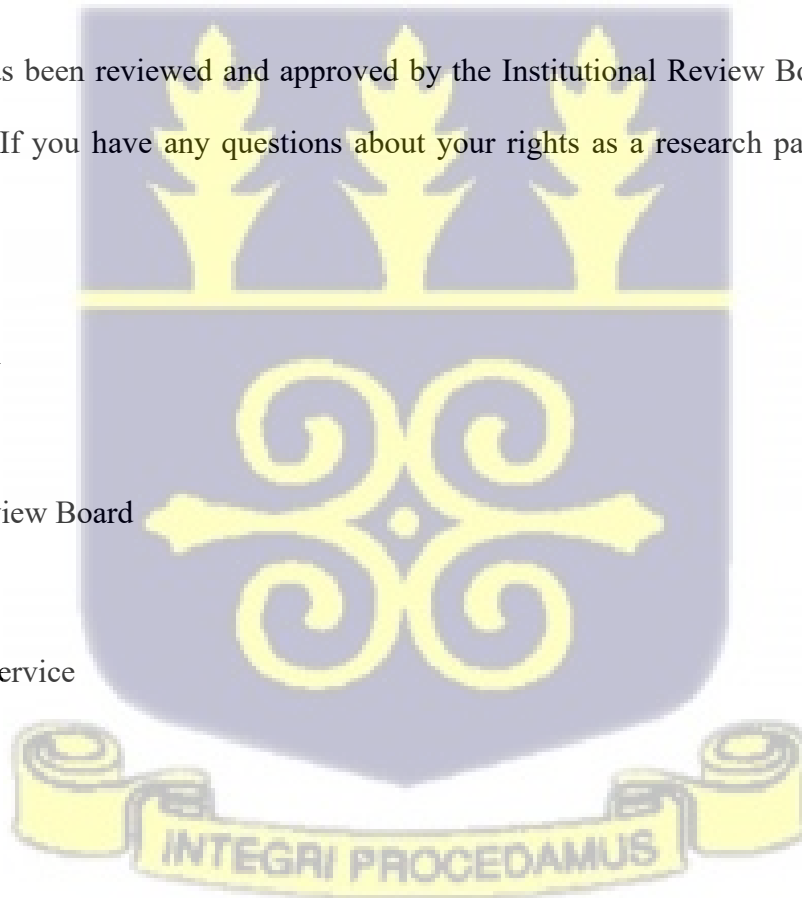
This research has been reviewed and approved by the Institutional Review Board of the Ghana Health Service. If you have any questions about your rights as a research participant, you can contact:

The Chairperson

Institutional Review Board

Ghana Health Service

PMB, Accra.



PART II: Certificate of Consent

Statement of Person (Interviewer) obtaining informed consent:

I _____ have fully explained this research to participant and have given sufficient information about the study to enable the prospective participant make an informed decision to or not to participate.

Signature (Interviewer) _____ Date: _____

Statement of Participant:

I have read the information on this study/research or have had it translated into a language I understand. I have also talked it over with the interviewer to my satisfaction.

I understand that my participation is voluntary (not compulsory).

I know enough about the purpose, methods, risks and benefits of the research study. I want to take part in it.

I understand that I may freely stop being part of this study at any time without having to explain myself.

I have received a copy of this information Sheet and consent form to keep for myself.

Name of Participant: _____

Signature/Thumb Print: _____ Date: _____

Statement of Witness (Process for Non-Literate Participants):

A literate witness must sign (this person should be selected by the participant and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

I _____ (Name of Witness) certify that information given to participant (Name of Participant above), in the local language, is a true reflection of what I have read from the study Participant Information Sheet, attached and the individual has had the opportunity to ask questions. I certify that the participant has given consent voluntarily. A copy of this consent form has been provided to the participant.

Witness' Signature (Maintain if participant is non-literate): _____

Date: _____

