

**LOCATING AND ACCESSING SERVICES FOR
COMMUNICATION DISABILITY IN GHANA: THE
PARENT PERSPECTIVE**

BY

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LANGUAGE THERAPY**



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DECLARATION

I, **LETICIA AFI GOMADO** hereby declare that this dissertation which is being submitted in partial fulfillment of the requirements for the degree of MSc in Speech and Language Therapy is the result of my own independent research project and that, except where otherwise other sources are acknowledged with explicit references and are included in the reference list, this work has not previously been accepted in substance for any degree and neither is it being concurrently submitted in candidature for any degree.

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DEDICATION

This research dissertation is dedicated to my parents Mr. Thomas Atsu and Mrs. Agnes Atsu.

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Glory and honor to the Almighty God for His grace mercy and favor upon me. Heavenly father, you have constantly taught me to say it is well even in times of trouble. Thank you for this beautiful journey.

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ABSTRACT

Introduction: Early childhood intervention for communication delays and disabilities has been identified as a key issue in improving outcomes for children. However, early intervention services for communication disability in Ghana are extremely limited. In the absence of widely available early intervention services, finding appropriate services for children with communication disabilities can be a challenging issue for families. There is limited evidence on the barriers and facilitators to finding and being able to continue with, communication disability for early intervention services in Ghana. As communication disability services grow in Ghana, an understanding of both the barriers and facilitators faced by families in finding and accessing early intervention services will help in planning and promoting early intervention services effectively. This type of information should ultimately ensure that early intervention services for communication disability develops, which are increasingly accessible to families.

Aim: This study specifically aimed to determine barriers and facilitators to accessing and maintaining services for communication disability in Ghana.

Methodology: A mixed methods survey was employed for the present study. Questionnaires, which included a mixture qualitative and quantitative data, were used to gather and explore the perspectives and experiences of parents in finding and accessing early intervention services of communication disabilities for their children. A convenience sampling method was used. Thirty (30) parents of children of 8years and below with a communication disability currently attending an early intervention service completed the questionnaire. Content analysis was used to analyze the qualitative data. Descriptive analysis was used for the quantitative data.

Results: Service related factors, social factors, geographical location of centres and individual factors were categories of barriers to early intervention services identified by parents, and included: limited information, lack of services, lack of community support, financial issues, psychological, distance, time and geographical location. Factors that reportedly appeared to facilitate access to early intervention included referrals from other healthcare professionals, information within the community, improvement in child with therapy and favourable personal

factors. Participants described the influence of socioeconomic factors on access to communication disability services.

Conclusion: Parents in this study identified a range of barriers and facilitators likely to influence access to early intervention for children with communication disabilities. Information of this nature provides important information that may be used to guide service delivery, policy development and research in Ghana.

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CHAPTER ONE

INTRODUCTION

1.1. BACKGROUND OF THE STUDY

Early intervention for communication disability is important to promote inclusion within society, which will enable children with developmental delays and disabilities to achieve their potential (Odom, Samuel, Buysse, & Soukakou, 2011). In developed countries, early intervention is an important part of public health care services designed to decrease the incidence and degree of disabilities such as communication disability (Warren, 2000). The early intervention programs are community-based and designed holistically involving families and professionals. The impact of early intervention on individuals helps to reduce the developmental deficits which may have affected academic and social outcomes across the lifespan (Roberts & Kaiser, 2012).

In Africa, early intervention for communication disabilities is underdeveloped (Van der Linde, Kritzinger, & Redelinghuys, 2009; Warren, 2000). In countries such as Nigeria, early intervention receives little attention and intervention (Somefun, Lesi, Danfulani, & Olusanya, 2006). The early intervention services for communication disability in Ghana are extremely limited due to a series of reasons which include the cost of services, transportation difficulties, geographical factors and many other factors (Kruk, Chukwuma, Mbaruku, & Leslie, 2017; Lodenstein et al., 2017). Without widely available early intervention services, finding suitable and available services for children with communication disability can be challenging for parents. Also, without access to communication disability services, the general well-being of both the individual and family members may be affected (Hilari & Botting, 2011; Dalton, Cruickshanks, Klein, Wiley, & Nondahl, 2003)

With the introduction of new programs for training speech and language therapy in Ghana, both awareness of communication disability and the availability of services for speech and language therapy are gradually beginning to improve (Crowley et al., 2013; Wylie, Mcallister, Davidson, & Marshall, 2013). With professional development of speech and language therapy in Ghana, it will ultimately contribute to early intervention programs. An understanding of where and how families seek services will assist growing services to understand where services, and information about

services, should be provided. Using such information will help services to be more reachable to all children with communication disability as well as their families.

Apart from limited service availability, a range of potential barriers may exist to families accessing the few early intervention services for communication disability in Ghana. These may include cultural, economic and geographical barriers. Cultural barriers to early intervention may include resources and intervention techniques that are culturally inappropriate. For instance, in South Africa, English Additional Language speakers who are non- mother tongue speakers of English and are from indigenous language and cultural backgrounds are evaluated by speech and language therapists who do not speak or understand an African language (Mdlalo, Flack, & Joubert, 2016). Resources for speech and language therapy in Ghana are typically not culturally-friendly (Pascoe & Norman, 2011). Using culturally and linguistically appropriate interventions is important. For instance, children in Zaire performed poorly as against their United States counterparts on various assessments which include non-verbal forms, extensively performed to be culturally appropriate to determine their mental abilities. The supposedly culture-fair assessment which has basic knowledge about world activities may be unsuitable when used somewhere. The assessments which originated from a research and theory of Western psychology, has some basic foundations and suppositions with how the world operates which may be unsuitable in other cultures(Pascoe & Norman, 2011), hence, effective therapy is sometimes not attained (Bunning, Gona, Newton, Charles, & Hartley, 2014; Topouzghanian & Mijiyawa, 2013; Verdon, Blake, Hopf, Pham, & Mcleod, 2016; Wylie, Mcallister, Davidson, Marshall, & Law, 2012). As a result, families may not see the relevance of therapy. It is currently unclear what impact this has on service access or family perception on services. There are a few Ghanaian local contents resources for services of speech and language therapy (Crowley et al., 2013). Augmentative and Alternative Communication cards were used to purchase food items on the local market. Also, Osei-Bagyina (1984) designed a resource for testing articulation in Twi (local language). The cost of therapy services is another barrier that may impede access to early intervention of communication disability in sub-Saharan Africa such as Ghana. Findings by Wylie et al. (2013) suggest that, in sub-Saharan Africa about two-thirds of the inhabitants with communication disability receiving speech and language services pay for the services. Due to the therapeutic nature, families need to attend regularly. Due to the cost associated with services, the wealthy living in urban cities can

afford these services, leaving the poor and needy without access to services (Crowley et al., 2013; Jochmann, 2006).

Families who search for early intervention services regularly face stigmatization from the society in sub-Saharan African countries. This form of stigmatization is often associated with the individuals and their families, which makes it difficult for the establishment of communication disability services (Jochmann, 2006; Stephens, Owusu, Parchment, & McKay, 2015). Inclusive programs are not easily available and accessible to individuals with communication disabilities (Guralnick, 2005).

Geographical barriers such as population size, division of rural-urban areas and dangers associated with flooding (Hopf & Mcleod, 2015) within countries relate to the provision of services. According to Wylie et al. (2013), speech and language therapy services across sub-Saharan Africa are predominantly provided in urban areas, with about 94% of speech and language therapists working in urban areas. Within these urban areas, poor transport networks mean that travelling to early intervention centres can be time-consuming and costly, which could potentially limit access to families.

Finding communication disability services in a country where services are poorly developed can be particularly challenging for families. Allied health workers in corporation with early educators work in early intervention services. Although there is a need for services, sub-Saharan Africa has an inadequate allied health workforce to provide the necessary services, including speech and language therapists (Gupta, Castillo-Laborde, & Landry 2011; Wylie et al., 2016).

In Ghana, few speech and language therapists are available to contribute to early intervention for communication disability (Wylie et al., 2016), also amongst competing healthcare priorities; advocacy for development in early intervention has not been a priority. In higher income countries, public health services ensure early intervention is mandatory and regular for children (Van der Linde et al., 2009).

1.2. PROBLEM STATEMENT

Early intervention services for communication disability in Ghana are extremely limited. By improving community awareness of disability issues, help-seeking measures of parents concerned about the communication development of their children will intensify. As speech and language therapy grows, it is likely that early intervention options for families will gradually become more available. To ensure that families are able to effectively locate and access early intervention services, it is important to understand where and how parents of children with communication disabilities in Ghana typically seek help and information. An understanding of where families seek help and information can assist in informing developing services on how best families can find appropriate services. Understanding the challenges parents face in locating and accessing services may assist in developing early intervention services to address issues in service accessibility.

In Ghana, no study has been conducted on how people locate and access early intervention services, or the things which facilitate or impede their access. In view of this, there is a need to carry out a study to know the facilitators and barriers to service delivery. This research sought to explore how parents locate early intervention services for communication disabilities and the barriers and facilitators to accessing them.

1.3. AIM OF THE STUDY

The study aimed for speech and language therapists to understand barriers and facilitators parents face in accessing services, even as services emerges and grows in Ghana. As speech and language therapists understand the barriers and facilitators, models will be designed to suit service accessibility and availability.

1.4. OBJECTIVES OF THE STUDY

This study sought to understand barriers and facilitators to both locating and continuing to access early intervention, as experienced by parents enrolled at an early intervention services for their

children with communication disability between August and October 2018. The following are the study objectives:

- To identify barriers described by parents in locating appropriate early intervention services for children with communication disability.
- To identify barriers faced by parents in receiving ongoing early intervention services for communication disability.
- To determine the factors which facilitate locating appropriate early intervention services among communication disability children.
- To determine the factors which facilitate receiving ongoing appropriate early intervention services among communication disability children.

1.5. RESEARCH QUESTIONS

- What are the barriers to finding appropriate communication disability services?
- What are the barriers to receiving appropriate communication disability services?
- What are the facilitators for finding appropriate communication disability services?
- What are the facilitators to receiving ongoing appropriate communication disability services?

1.6. SIGNIFICANCE OF THE STUDY

The significance of the study is to advance understanding of barriers and facilitators to both locating and maintaining early intervention services for communication disability in Accra, Ghana. Improved understanding of the barriers and facilitators to finding and receiving early intervention services may assist service providers to plan services and address issues which compromise service access. Information obtained will assist policy makers to plan and implement initiatives that improve access to early intervention services for children in Ghana.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

The skill to communicate is of importance to human existence. Humans convey their desires and wishes, mingle, send messages and engage in activities in the community through communication. Therefore, communication is vital to everybody. It all begins with the first communicative cries after birth, through the development of skills in speech and language till the acquisition of adult language. The highest period in the acquisition of speech and language occurs from birth to about five years old and communication skills improve through to adolescence.

Communication disability occurs across the entire lifespan, even though they are not usually identified as such. In developed countries such as the U.S., U.K. and Australia, much research on speech and language therapy has been done but in under-developed countries, little research has been conducted (Gill, 2009). Speech and language difficulties influences areas of social integration such as reading and writing skills, psychological well-being and acquiring profitable skills for employment in a vibrant labor force (Law, Reilly, & Snow, 2013).

Communication disability in sub-Saharan Africa, though is still developing, remains of low priority (Mdlalo, Flack, & Joubert, 2016; Wylie et al., 2013). According to (Ghana Statistical Service, 2016), the population of Ghana is estimated around 29 million and with a limited workforce of speech and language therapists, finding services for communication disability is challenging for individuals and families.

Early intervention services remain the best way to minimize communication disability in children. Early communication and language difficulties pose problems of learning disabilities and disorders in behavior (Warren, 2000). In sub-Saharan Africa, due to poor health care services, incorporating early intervention services into public health care is difficult to attain. It is recommended to be the first step in preventing or minimizing communication disability in children (Van der Linde et al., 2009). This will also help children with communication disability integrate well into society.

Related literature is reviewed under the following sub-headings:

1. Communication
2. Communication disability
3. Causes of communication disability
4. The impact of communication disability
5. Early intervention
6. Factors which promote early intervention
7. Identified barriers to early intervention
8. Communication disabilities in developed and developing countries

2.2. COMMUNICATION

Communication is an act conveying information from one person to the other. For communication to be effective there is the need for feedback from the communication partner to ensure the process in two ways. According to Littlejohn and Foss (2008), communication can be explained with two definitions: - communication is the formal and orderly way of exchanging possible course of action and suggestions with the assumption that, the mindset of the communicator is relayed in a desired manner. Also, he defined communication as the imparting of facts, whereby the message is not automatically accepted or have a clear idea. He mentioned that there are three fundamental aspects of communication; the first is the observational level, which links fragmented parts of information. The second aspect is the intentionality level. This has to do with having a purpose for communication. The third and final level is the regularizing judgment, which checks the successfulness or effectiveness of communication.

Research by Zadeh et al. (2018), define communication as a broadly sophisticated varying mode of movements. The three particular ways in which humans present their thoughts include; - language, visual and sense of hearing. Effective communication goes beyond only back-and-forth presentation of ideas, but it captures the affective nature and aim of the information (Munodawafa,

2008). It assembles these four skills – occupied listening, nonverbal communication, controlling stress and declaring you in a confident manner. Listening and understanding the message being conveyed and making the communicating partner feel heard and understood all play a role in communication. Effective communication is more spontaneous than following a particular order. Identified barriers to effective communication include; language barriers - communication with lots of jargons and abbreviations, physical barriers -the geographic distance between sender and receiver, attitudinal barriers - attitudes we put up during communication and psychological barriers -individual differences in behavior and mentality (Jureddi & Brahmaiah, 2016).

Munodawafa (2008 in press), defined communication as the channeling of spoken and unspoken information. It comprises a transmitter, a recipient and a mode of relaying the information. During the transmission of the information, its clearness could be twisted and this is often termed as barriers to communication. Communication activities can have two main divisions, that is; large population (mass media) and well-defined population (group media). Mass media focuses on communicating with a large population base but group media targets a well-defined population with peculiar features.

Due to the important nature of communication, the well-being of patients is critical to communication between patients and health professionals. Health communication helps inform a patient about his or her condition as well as management of the condition. This helps in following assigned medical recommendations and living a health-conscious life. Decisions made are mutually agreed by the health professional and patient, this helps patients to build trust in health professionals. Unfortunately, most patients have often evaluated their relationship with their physicians insufficient (Beck, Daughtridge, & Sloane, 2002; Munodawafa, 2008).

In Africa, communication has evolved over the years. Ogbondah and Siddens (1999), mentions communicating with the use of drums, gongs, masks and puppets as non- verbal traditional means of communication in Nigerian culture. Verbal and in person form of communication were mainly used by traditional communities. Verbal traditions account past experiences farther from the present which were highly specific and local. The information was spoken, sung or mentioned on musical instrument (Madzingira, 2001). Other oral forms included: poetry, topical or political songs, proverbs and prose narratives as forms of communicating (Finnegan, 1974). The traditional means of communication also identifies the mode of control or ownership and model (Wilson,

1987). Age is also seen to play a significant role on communication in Africa, for instance, if wishes and commands of an elder are disregarded, it is believed that an illness or tragedy can happen to the violator (Giles, Makoni, & Dailey, 2007).

Though the traditional means of communication was a continuous means of disseminating information, entertaining and educating the society, western civilization and external manipulations has not totally taken over. Rather, the system which operates in urban communities has accepted to manipulate western media system to enhance the socio-economic development. That is, due to socio-economic activities, some traditional systems no longer operate but contextualized to suit the African setting. For instance, fire as a means of communicating was to attract people or create awareness to people nearby of a happening but this does not occur any longer except in mountainous areas (Wilson, 1987).

The changing means of communication through technology, affords sub-Saharan Africa the opportunity to interact worldwide. Though in sub-Saharan Africa, infrastructure is the least developed, technology is advancing with benefits derived from ICT services but unfortunately, those in the rural areas have limited access. Computer usage has increased tremendously as well as internet service providers. Telecommunications also provide wired and wireless telephone services from various mobile services and cellular telephones. Accessible telephone networks also balance computer networks which include internet and other Wide Area Networks (WANs) (Madzingira, 2001).

2.3. COMMUNICATION DISABILITY

Communication disability may mean an individual has difficulty speaking, understanding or interacting in appropriate ways (ASHA, 1993). About 40% of children with communication disability have a primary speech disorder. Communication disability can be a primary disability, where an individual has solely a communication deficit (Broomfield & Dodd, 2004). Examples of a primary communication disability include speech and language delay or stammering. For a secondary communication disability, it is a communication disability which is part of a broader disability (ASHA, 1993). Secondary communication disabilities such as cerebral palsy, hearing difficulty, common developmental and emotional difficulties (Rosenbaum et al., 2007) include

communication disabilities as part of other existing disabilities such as cerebral palsy (Rice, Warren, & Betz, 2005). Down's syndrome. Rossetti (2001) describes communication delay as everything that impedes the capability of a child to relate to his surroundings in an ordinary way.

Parada-Toro, Gomez-Quiro, & Treviño-Siller (2017) define communication disability in two-fold namely; speech disorders and language disorders. They define speech disorders as difficulty with the production of required sound to speak or challenges with the use of the voice. The inability to comprehend or the usage of words in context either verbally or non-verbally is described as a language disorder. There is also difficulty in trying to communicate with others. Children with communication difficulties often have difficulty in processing language, initiating communication with others and analyzing the appropriate response. These difficulties are usually seen in three areas of school: reading and writing and use of language, use of numbers and mathematics and general use (Harrison, McLeod, Berthelsen, & Walker, 2009). Children of kindergarten-age mostly experience specific language impairment (SLI), affecting about 7.5% which can be equated to at least one or two children in a class (Rudolph, 2017). Normal school children with speech disorders represent about 5% of the population while pediatric speech and language therapy caseload represent about 70 % (Fox, Dodd, & Howard, 2002).

Disability in Africa is often associated with disadvantage, discrimination and exclusion. People with communication disability are not left out of stigmatization (Wegner & Rhoda, 2015). Even amongst people with disabilities, persons with communication disabilities are frequently perceived poorly. According to Wickenden (2013), people with communication disability are denied their human rights fundamentally. Persons with disabilities are seen as 'burdens' in the family and the society at large. They are often recognized as problematic and of no benefit (Topouzkhian & Mijiyawa, 2013). Children with disabilities in Ghana have historically been abused (Kassah, Kassah, & Agbota, 2012) and sometimes killed as a result of their disability (Bayat, 2015). Such historical and cultural practices in Africa are some of the barriers to the development of, and access to, services for communication disability (De Andrade & Ross, 2005; Jochmann, 2006; Wegner & Rhoda, 2015).

Ghana is a fast growing country with an estimated geographical area of 238 540 km² (Frenken, 2005) and a population of almost 29 million occupants (Ghana Statistical Service, 2016).

According to the 2000 population census, Ghana ranks highest in population growth, though a decline was recorded between 1984 to 2000 ranging from 3.0% to 2.7% (National Population Council, 2006). Unfortunately, in Ghana, no epidemiological study has been conducted on communication disability in children of school-going age (Osei-Bagyina, 2000). Therefore, the true prevalence of communication disability among school-going age in Ghana remains uncertain and unknown. Unlike Ghana, a wide variation in prevalence approximates exists internationally for communication disability among school-going age.

2.4. CAUSES OF COMMUNICATION DISABILITY

Disability can be caused by many factors which include age or gender (Patel, 2008). These factors can either be congenital, developmental or acquired and an individual may display any or a combination of the two. An acquired disability may arise as a result of an accident, injury or illness. For instance, in Spain, a high prevalence of traffic injuries is recorded and this affects their general well-being as well (Palmera-Suárez, López-Cuadrado, Fernández-Cuenca, Alcalde-Cabero, & Galán, 2018). One of the several disorders that interrupt normal development in children is developmental delay (Durkin, 2002). Congenital conditions are often present at the prenatal stage. They are usually referred to as birth defects or congenital abnormalities, disorders or malformations. They pose a potential impact on an infant's health, development and/or survival (Silva, Couto, & Molini-Avejonas, 2013).

In a WHO report by (Cameron, Nixon, Parnes, & Pidsadny, 2005) about the causes of disability in Africa, five (5) main causes were outlined namely, infectious disease, trauma or accidents (mostly road accidents), congenital and noninfectious diseases, malnutrition due to lack of essential nutrients and other constant health conditions.

Also, the International Classification of Functioning, Disability and Health (ICF) used a model that incorporates biological, psychological and social factors in the biopsychosocial approach for the classification of disability. The physical and social attitudes make up the environmental factors of people. Personal factors are characteristics of a condition that is not directly health-related but affects the functional level of a person (Threats & Worrall, 2004).

In India, the main causes of speech disability include; paralysis, mental illness, voice disorder and injury to the head. Others include; hearing impairment, cleft palate/lip, medical- surgical intervention, old age and unknown causes (Patel, 2008). In Fiji Hindi, the causes of communication disability are grouped into four areas, namely, external, internal, supernatural and unknown factors (Hopf, Mcleod, McDonagh, & Rakanace, 2017).

Developmental disability causes differ, it may be as a result of injury or irregularities growing in the nervous system as a result of genetic factors, lack of adequate nutrition, infections, exposure to environmental pollutions, birth complications, trauma and poverty (Durkin, 2002)

In Africa, although people believe disability is as a result of medical and biological factors such as harmful polio vaccines, accidents etc. spiritual belief about the cause of disability is widespread (Wegner & Rhoda, 2015). This includes the involvement of witches to harm an individual as well as one possessing an impure blood. It is also believed that being disturbed in an individual's inner spirit can also be a cause of disability (De Andrade & Ross, 2005; Reynolds, 2010). The attitudes and values of disability are complex in Tanzania; the focus is mainly about the role of God in an individual's life. Members of the community believe disability is an aspect of God's plan and that people with disability are playing their part. In the past, some were of the view that, misfortunes were the causes of disability (Stone-MacDonald, 2012). Beliefs of people about the cause of communication disability may affect where and how people with disabilities seek services. Wylie et al. (2017) found that people in Ghana may seek services from a wide range of sectors if they were to experience communication disability, including the healthcare, religious, traditional belief and educational sectors. This may reflect differing beliefs about the cause of communication disabilities.

In sub-Saharan Africa, motor-related injuries are known as main reasons for communication disability. Motor- related conditions are usually grouped into three main areas namely; factors related to the human being, external conditions and vehicle conditions (Tarimo, 2012).

In Ghana, according to Osei-Bagyina (2000), the causes of child language disorders include; convulsion, measles and jaundice as predominant causes. Others causes are injury to the head, Down's syndrome, marasmus, prematurity, hypoxia, fever, Caesarean surgery and delayed delivery.

2.5. THE IMPACT OF COMMUNICATION DISABILITY

Communication disability has an adverse impact on people. Around the world, it is recognized that communication disability has a range of impacts on people (Hilari & Botting, 2011), affecting their quality of life (Dalton et al., 2003). In Ghana, people with communication disability are not given equal opportunities and society marginalizes them in all aspects of their lives, including the political arena (Sackey, 2015). Healthcare accessibility is unequal and limited (Grut, Mji, Braathen, & Ingstad, 2012; Murphy, 2006). They frequently experience employment difficulties and economic hardship due to their communication disability (Ruben, 2000). People with communication disability are seen as bad omens in the society. They are hit, abused (Kassah et al., 2012), beaten, teased, insulted, laughed at, ostracized, and even killed as a result of their disability (Goggin, 2009).

Individuals and family members of children with communication disabilities experience psychological and emotional stress as a result of the negative approach towards them (Friehe, Bloedow, & Hesse, 2003). The reaction from society can affect areas of educational attainment, personality improvement and professional development. Withdrawal from society is also faced, due to difficulty communicating with others (Gill, 2009). Families therefore hide these individuals or act as if they do not exist due to ignorance or being vulnerable. Families especially mothers are always exposed to sometimes permanent care, discrimination, blame-placing spiritual calamity on the child and the risk of socioeconomic difficulties that varies in different societal context (Stephens et al., 2015). Fatigue, lack of support and fear of the future are also experienced by these families (Michalik, 2015).

In times of war, people with communication disabilities may have difficulty communicating their desires. This is because; they may lack understanding of the situation at hand to seek basic amenities. This may contribute to being hurt or even losing their lives (Battle, 2015). Marshall and Barrett (2018) confirm how refugees with communication disability are abused or denied their human right due to lack of education on sexual and reproductive health.

2.6. EARLY INTERVENTION

Early intervention is recognized as fundamental in reducing the impact of communication disability in children (Van der Linde et al., 2009; Rice et al., 2005).

Early intervention services are services provided by multidisciplinary teams to young children (typically 0 – 3 years) who experience or are at risk of experiencing, delay or disabilities (World Health Organization, 2003). Early intervention does not only involve managing and treating individual children, it also provides suitable support systems for families and is community-based. It is the initial step to providing essential services for every child to attain his or her potential and play a significant role in society.

In developed countries, early identification is considered a significant part of the welfare of the child (Van der Linde et al., 2009). Early intervention services are often accessible in more developed countries. For instance, in the United States of America, the American Academy of Pediatrics ensures that early childhood abnormalities are recognized. The United Kingdom also ensures measures are implemented to regulate adequate observation and screening. The Australian Early Development Index makes sure teachers identify children with developmental difficulties for advance planning of healthcare programs (Scherzer, Chhagan, Kauchali, & Susser, 2012).

Early intervention for developmental delay and disability is important in sub-Saharan Africa. As infant mortality declines, the incidence of disability and developmental delay rise amongst competing health care priorities. Advocacy for and developments in early intervention has not been a priority or essential in the development of a child. Various factors influence the reception and application of early discovery and intervention, though there is limited information. These range from attitudes of clinicians, limited training, uncertainty about treatment, unavailable referral process, time constraints, cost of services, being indecisive about how or where to refer, lack of knowledge and ignorance (Scherzer et al., 2012).

Everyone is entitled to quality healthcare, irrespective of where you come from (World Health Organization, 2003). In Africa, primary health care is not easily accessible to all citizens due to a range of factors, which include; the cost of services, transportation difficulties, geographical factors and many other factors (Kruk, et al., 2017; Lodenstein et al., 2017). Given challenges in

basic health care services provision, communication disabilities are often not seen as a priority (Fagan & Jacobs, 2009).

In South Africa, early identification service through the public health sector is rare and often disorganized. Public health interventions are intended to help with the prevention of early speech and language difficulties. It is mostly designed to be accessible and beneficial to the community. This also creates awareness among the public, professionals and policy-makers concerning problems in relation to communication disabilities (Van der Linde et al., 2009; Theunissen & Swanpoel, 2008).

In Ghana, though early intervention is not formally practiced but only in a few instances (Stephens et al., 2015), the possible type suitable will be the family-oriented early intervention services (Alliston, 2007). This is due to the nature of the extended family members in raising a child (Takyi & Gyimah, 2007).

2.7. FACTORS WHICH PROMOTE EARLY INTERVENTION

An improvement in outcome has the probability to affect the general well-being of people with communication disability if appropriate early intervention services are found (Dalton et al., 2003; Warren, 2000).

Research by (Guralnick, 2005; Van der Linde et al., 2009) outlines measures to promote early intervention services. These include;

- screening and referral programs being made available to all parents
- monitoring phase should ensure full contribution from children and parents in different activities and settings
- a convenient and reliable access point
- joint interdisciplinary assessment
- preventive programmes
- early intervention measures
- stressor assessment
- initiating comprehensive programmes
- effective evaluation

- planning for transitions

In high-income countries, early detection of children with developmental delays is regarded as essential for child welfare practice. The United Kingdom, United States of America and Australia have measures to ensure its implementation and developmental or behavioral screening tools as well as diagnostic and evaluation tools are used.

In Ghana, factors that can promote early intervention include; awareness creation, health care involvement and culturally relevant systems. In South Africa, a milestone development tool for examination is integrated into a health booklet for newborn infant mothers. Also, an all-embracing community planning and participation are necessary to help appreciate developmental health objectives as well as the use of preventive interventions such as support. With the introduction of early detection, regular child welfare will help reduce the impact of communication disability (Scherzer et al., 2012).

Another factor to promoting early intervention among children is by teaching parents to serve as primary intervention agents (Kummerer & Lopez-Reyna, 2006). This will help reduce the extent of disability in society.

2.8.2.8 IDENTIFIED BARRIERS IN EARLY INTERVENTION

International agencies such as WHO, UNICEF, USAID primarily focus on the improvement of nutritional values and decreasing contagious diseases. International non-governmental organization concentrate on eradicating diseases coupled with other extensive developmental activities. Little or no attention is given to early identification of children with any kind of deficits (Scherzer et al., 2012).

Families seeking early intervention services often encounter the risk of being stigmatized. Though stigmatization can happen at any point in the system, the initial encounter can create lifelong effects. Accesses to inclusive programs are often not universally available to people with communication disability (Guralnick, 2005).

Limited management of referrals and enthusiasm to deal with issues concerning development since there is lack of progress between pediatrics and providers of early intervention (Jiminez, Barg, Guevara, Gerdes, & Fiks, 2012).

Countries with low-income and middle-income, among prevailing factors of barriers in early intervention services are health staff having little or no knowledge about child development (Scherzer et al., 2012). The focus is dominantly on treating acute childhood diseases. Also, the screening tools used in these countries are now becoming known and familiar. Examples include the Kenya caregiver reports on development (Abubakar, Holding, Van de Vijver, Bomu, & Van Baar, 2010), (Gladstone et al., 2010) the assessment development tool in Malawi, the Bangladesh Rapid Neurodevelopment Assessment Instrument (Khan et al., 2010) and the screening tool development for indigenous children in Australia (D'Aprano, Carapetis, & Andrews, 2011). These screening devices are usually expensive and difficult to apply during regular care; often they might be culturally inappropriate and unreliable. These make screening irregular, inefficient or sometimes absent. In Africa, parents usually have well-built principles and traditions about the growth of children and healthcare. Due to ignorance, parents may not be aware of the significance of delay in development or the existence of nervous system dysfunctions as well as the health clinician (Van der Linde et al., 2009; Scherzer et al., 2012).

Confidence of parents in managing a child with disability status also poses challenges in early intervention services. These may lead families in choosing an isolated preschool as an educational program. Referral systems are ineffective in deprived communities and this is due to inadequate access to early intervention amenities, the scarcity of amenities and knowledge limitation of early intervention services benefits (Van der Linde et al., 2009).

2.9. COMMUNICATION DISABILITIES IN DEVELOPED AND DEVELOPING COUNTRIES

In developed countries, services for communication disabilities has grown over the years (Edgar & Rosa-Lugo, 2007) and speech and language therapists have been satisfied with their job over the years even with more caseloads. Communication services have developed in many areas in the developed countries including the transport services where transport services provide disability

training for staff members to educate them. This helps to provide better services to people with communication disability (Bigby et al., 2017). Healthcare providers including nurses are also educated in communication strategies appropriate for patients with communication disability. These strategies help to alleviate frustration and increases patients quality of life (McGilton et al., 2018). Also, communication disability oriented questions are included in national-census practices, questions concerning the availability and accessibility of services are asked to help improve services (Wylie et al., 2013).

Communication disability services in developing countries are of low priority. Services are often a replication of developed countries services. In developing countries, services can be broadly separated into those accessed through education, through health services and development of communication disability model (Bigby et al., 2017). Also, parents gather information by the use of technology or travelling to access relevant information for their children (Stephens et al., 2015). In developing countries, access to therapy services is usually the prerogative of the urban and wealthy, with most being located in the cities (Crowley et al., 2013 ; Jochmann, 2006). Wylie et al. (2016) reported that in sub-Saharan Africa, speech and language therapy is predominantly urban, with about 94% of them accounted to be based in the city. Crowley et al.(2013) also identified few services for speech and language therapy in Ghana which all are located in urban settings.

Even in refugee dominated areas, rights of individuals with communication disabilities are limited. There is an increased risk of sexual and gender abuse due to numerous factors. These include; stigmatization (Stephens et al., 2015), limited education on sexuality, identified as an easy target, discreditation, reduced ability to report and service providers lacking understanding (Marshall & Barrett, 2018).

The issue of stigmatization cripples the advancement of effective communication disability services in developing countries (Jochmann, 2006; Stephens et al., 2015; Stone-macdonald, 2012). For example, in 2013, the president of the Republic of Ghana nominated a lawyer for a ministerial position. He had a visual impairment and some chiefs protested the nomination describing it as an

'abomination'. These critics continued to say that, some portions of tradition does not permit persons with a disability to hold a high office (Sackey, 2015).

There is also the lack of governmental and private support in service provision for people with communication disability. For example, AwaaWaa2 in Ghana is one of the limited early intervention centers (Stephens et al., 2015).

Reports by (Hopf & Mcleod, 2015; Wylie et al., 2013) also described barriers in communication disability services in developing countries into five broad areas.

Structural barriers are limitations in the way services are distributed and delivered, for example, if services are only available in the mornings and an individual is unable to leave work in the morning, the individual may not be able to access services. Cultural barriers refer to a mismatch between approaches taken by services, and beliefs of the population. For example, health services may not be accessed by people who have strong spiritual beliefs, as they may believe the health worker may not accept them. Some may also be seeking help from the pastor or other spiritual advisors. Linguistic barriers are often associated with language diversity. There may be a linguistic mismatch between persons with communication disability seeking services and the languages of the service providers. Geographical barriers are frequently linked to the distribution of services within a country or region. Health services are frequently based in urban centers making it difficult for people living in rural areas to travel long distances in order to access services. Financial barriers include the high cost of services, or the costs incurred when people need to take time off work to attend centers. The financial barriers may contribute to reduced access to services. Wylie, McAllister, Davidson and Marshall (2016, 2018) reported a range of financial, geographical, linguistic, cultural barriers to impacting SLT services in sub-Saharan Africa.

In Ghana, there are few speech and language therapists and therefore limited SLTs are available to contribute to early intervention for communication disability (Wylie et al., 2016). This limits accessibility and availability of services.

CHAPTER THREE

METHODOLOGY

3.1. INTRODUCTION

The chapter presents the theoretical assumptions supporting this research and details the research strategies. It gives a description of the data collected and data analyzed within the study. It outlines the study sites, study population, data collection procedure, materials used in the study, qualitative and quantitative methods. Data management and ethical considerations of the study are also addressed in this section.

3.2. STUDY DESIGN

A cross-sectional descriptive study, using a mixed methods survey, was used. A cross-sectional approach gathers information from a sample of individuals at a particular time as a basis for deducing the characteristics of the sample (Hall, 2016).

A cross-sectional survey takes a brief impression of the population and qualities associated with a phenomenon at a given point in time. These studies usually involve one contact with the study population and are typically inexpensive to undertake (Setia, 2016).

This research was based on a descriptive survey design, using mixed methods which incorporated both quantitative and qualitative data.

A mixed methods survey (Frels & Onwuegbuzie, 2013; Morse, 2005) was used for the study. The survey included both quantitative and qualitative data. A mixed methods research uses both qualitative and quantitative data, either sequentially or concurrently (Morse, 2005). Whilst this study used a single data collection instrument, this may be considered a concurrent mixed method design (Creswell, 2009) which collected qualitative and quantitative data in a single method. The use of mixed data types ensures that a range of relevant knowledge is able to be gathered in response to the research questions (Johnson & Onwuegbuzie, 2011).

3.3. STUDY SITE

This study was carried out at AwaaWaa2 (Haatso) which is located in the Greater Accra Region of Ghana. AwaaWaa2 was chosen as the study site for this research because it is an early intervention center which aims to support children with primarily communication difficulties and their parents/caregivers and is currently the only known early intervention centre specifically for children with communication disability in Accra.

Furthermore, AwaaWaa2 operates a range of services including direct intervention using small group work with a focus on communication; provision of facilitators in school to assist inclusion and parent and carer training (Stephens et al., 2015).

3.4. POPULATION

This research draws participants from the population of families identified with children with communication disabilities, in Accra, Ghana. A sample of thirty (30) participants (parents/primary carers) was used. This research project is a small-scale early exploration of a little-researched topic. Whilst this is a mixed methods survey, the survey contains substantial qualitative data. Sample sizes in qualitative research are typically lesser than those observed in quantitative research as the aim of the method is a richer exploration of a topic (Creswell, 2009; Sandelowski, 1995). This sample size permits appropriate in-depth analysis of the qualitative data, given that this is an exploratory study conducted as part of a Master's degree programme. It is hoped that further larger scale studies may build on the findings of this early exploration.

3.5. SAMPLING

Convenience sampling was selected for the rationale of this study. Convenience sampling is a non-random sampling in which members of a distinct population meet certain criteria, considering ease of access, geographical closeness, convenience at a certain time or the readiness to partake are considered for the reason of the study (Sedgwick, 2013). Convenience sampling or 'accidental samples' approach was selected because- it was inexpensive and effortless and the subjects were

readily obtainable and reachable to the researcher (Etikan, Musa, & Alkassim, 2016). The limitations of convenience sampling cannot be ignored. Convenience sampling can sometimes present poor quality data and may not have academic credibility (Marshall, 1996). Also, the issue of bias and outliers pose challenges in convenience sampling (Farrokhi & Mahmoudi-Hamidabad, 2012). However, convenience sampling was selected in this instance, as little is known about the population of people with communication disability, in Accra, Ghana. Few records or data bases exist to enable random sampling. Despite the challenges, convenience sampling was selected, as it may allow a rapid exploration of a hypothesis that may later be explored using some form of probability sampling (Battaglia, 2008). Whilst selection bias is inherent in all convenience sampling, to limit the issue of bias, all parents meeting the selection criteria below, who attended the centre for training were given the opportunity to participate in the survey. Data was collected during two separate training sessions to attempt to attract as many participants as possible.

3.6. INCLUSION CRITERIA AND EXCLUSION CRITERIA

3.6.1. Inclusion

With inclusion in the study, parents or primary carers were required to meet all of the following selection criteria:

- Have a child with a communication disability attending Awaawaa2. Note: This study did not aim to limit the type of communication disability and included both children with a primary communication disability, where the individual has solely a communication deficit or a secondary communication disability, which is part of a broader disability.
- Have a child of 0 - 8 years with a communication disability. This age range was selected due to the focus on early intervention, which is typically within the first years of life. Use of the age range 0-8 focussed on the early developmental period and early years in school.
- Be able to provide informed consent.

3.6.2. Exclusion

- Parents were excluded from the study if they were unable to give informed consent or below 18 years of age.

This age was selected as children are not considered adults until the age of 18 years in Ghana, and this may impact informed consent. Whilst including younger parents may have been useful, it is likely the number would have been very small.

- Carers who did not have primary responsibility for the child e.g. paid caregivers were not considered primary carers.

Literacy level or languages other than English was not an exclusion criterion as parents requiring support to complete the study were given the option to complete the survey orally.

3.7. MATERIALS

A purpose-designed questionnaire was developed and used in the study to collect data (Appendix E). This questionnaire was designed to collect information in a written form. The questionnaire consisted of 4 sections. The first section captured the demographics of children and their parents. The second and third sections of the questionnaire sought to find the facilitators and barriers to finding and maintaining services for communication disability. The fourth section asked about future suggestions for improving communication disability services in Ghana.

3.8. PROCEDURE

Following a discussion and formal approval by the early intervention centre, twenty-two (22) parents of children below the age of 8 years were recruited during a parent meeting organized by the school. Before the conference, all parents were given a participant information sheet by the researcher. Parents who were interested approached the data collection table, signed a consent form and were given a questionnaire. Questionnaires took 10-15 minutes to complete. The researcher was available in case of questions or clarifications. Locked boxes were made available for participants to return the questionnaires. Questionnaires were also completed with the assistance of the researcher if parents requested this. Unique identification numbers were marked

on each consent form and survey to link data, in case a participant wished to withdraw at a later point.

Drinks (non-alcoholic) were served clients as they undertook the survey. Drinks were used to help participants comfort whilst they completed the questionnaire outside. No other payment or benefit was provided to participants.

3.9. DATA MANAGEMENT

Data generated from the study were treated with confidentiality. Questionnaire responses from participants were coded using unique identifiers to ensure confidentiality, in accordance with ethical requirements. Records were held securely under a locked cabinet and accessibility was only for the researcher. Electronic records were password protected. No identifying information was added in the survey.

3.10. DATA ANALYSIS

Data obtained from the study included demographic information and open-ended questionnaire responses from parents and primary carers of children with communication disability.

Qualitative data was analyzed using qualitative content analysis as described by Elo & Kyngäs (2008). Qualitative content analysis is a systematic and objective approach to describing and quantifying phenomena (Bengtsson, 2016; Elo & Kyngäs, 2008).

The inductive approach to qualitative content analysis was used. Induction refers to an approach which seeks to discover the main ideas from within the text, without prior assumptions or theories (Elo & Kyngäs, 2008). The following steps, as described by Elo and Kyngäs (2008) were undertaken in analysis of the data:

Phase 1: Preparation phase

1. Deciding on the unit of analysis. Concepts rather than words were selected as the unit of analysis for this research. This was decided due to the qualitative nature of the analysis. Words, and word frequencies, were not selected, as participants may have used a range of different terms or descriptions to represent a single idea. Use of concepts focused the analysis on the underlying meaning in the text (Hsieh & Shannon, 2005).

2. Making sense of the whole of the data. The responses to each open ended question were collated together in a single document. The text was read and re-read to enable familiarization with the data and the messages within each open-ended survey response.

Phase 2: The organizing phase

3. Open coding. The reviewed and coded. Open coding involved writing notes and headings about the main messages while reading. Each response was read several times.
4. Coding sheets. The headings and main ideas relating were collated onto a single sheet.
5. Grouping. After the open coding, similar ideas were grouped together. The aim of grouping data was to reduce the number of main concepts by placing similar items together.
6. Categorizing. Each group of data was carefully considered by reviewing all the coded content. The category was defined and labelled in order to increase understanding. Clusters of data were
7. Abstraction. The main categories were reviewed for meaning with groups of similar items within each category grouped together as sub-categories. Category labels were more abstract whereas subcategory labels were closer to the data.

Phase 3: Reporting

Categories: Categories and sub-categories were clearly labeled and linked to the research questions.

Quantitative data, including categorical data, were analyzed descriptively. The quantitative data was related to the demographics of participants. This data was either continuous or categorical. Continuous data (i.e. age), to describe the demographics of participants was analyzed using descriptive statistics (mean, median and mode). The categorical data were described using frequency counts and presented graphically (Agresti, 1996).

3.11. ETHICAL CONSIDERATIONS

Ethical approval from the Ethics and Protocol Review Committee (EPRC) of the School of Biomedical and Allied Health Sciences (SBAHS), University of Ghana was granted on January 30,2018 (Ref: SBAHS-ASLT.//AA/5A/2017-2018) and a copy of the approval is also included (Appendix D). Written permission was also sought from AwaaWaa2. This was because AwaaWaa2 was the main study site acted as a gatekeeper to participants. As first hand information

was obtained from parents on their premises, permission needed to be sought. Informed consent was obtained from participants or before enrolment into the study and a Participant Information Statement (PIS) (Appendix A) was included to inform the participant about the study. The methods and objectives of the study as well as the process of assessment were also completely clarified to participants to ensure they were able to give informed consent.

3.12. ESTABLISHING TRUSTWORTHINESS

A key issue in qualitative methodology is ensuring that the data collection and analysis result in findings which are trustworthy. This involves recognizing consistency, patterns or models in the data and verifying these, to ensuring analysis is reliable and valid (Satu et al., 2014). A number of strategies were used in this study to maximize trustworthiness of the research to attempt to ensure findings most closely depicted parents' viewpoints (Murphy & Dingwall, 2007).

These included:

- (1) frequent debriefing and data review sessions between the researcher and supervisors to make explicit the interpretations within the coding,
- (2) peer review of coding to maximize trustworthiness during data analysis, and
- (3) creating a clear audit trail during analysis.

Debriefing and data review with supervisors were used to ensure coding processes were clearly laid out and check that coding and data interpretation was consistent. Peer review involved consensus coding, with a peer SLT research student. During peer review of coding, discussion and reflection occurred where any inconsistencies in interpretation occurred, until a consensus agreement was reached. Peer review is a strategy in which data, interpretations and conclusions are shared with colleagues to clarify, correct errors and provide further information where necessary (Smith, 2006). Creating an audit trail is an important activity which lays-bare the processes and decisions used in a qualitative analysis, and improves the trustworthiness of analysis (Moon, Brewer, Januchuski-Hartley, Adams, & Blackman, 2016). In each stage of analysis, research logs and notes were made, with tables of preliminary findings stored for comparison to the subsequent stage findings. This document trail made clear the steps and decisions within the analysis.

CHAPTER FOUR

RESULTS

4.1. INTRODUCTION

This chapter outlines the descriptive analysis of the demographic data on participants and the results of the content analysis of participant descriptions of barriers and facilitators of access to early intervention. Analysis of the data yielded eight major categories that best described the experiences of parents finding and maintaining services for their children with communication disability.

All respondents (22) were parents of children, rather than primary carers.

4.2. DEMOGRAPHICS

4.2.1. Characteristics of Participants and their Children

Participants in this study were aged between 30 and 65 years (Table 1). The mean age of participants was 39.5 years [mode 38 years, median 38.5 years]. No participant was aged less than 30 years.

In this research, parents described the experiences of finding early intervention services for their children (Figure 1). Children of respondents were aged between 1 and 8 years. The mean age of participants was 4.5 years [mode 3 years, median 4 years]. Over two thirds of the children were female (n=15, 68%).

The ages of admission of children also ranged between 1 to 7 years (Figure 2). The mean age of children was 2.9 years [mode 2 years, median 2 years].

4.2.2. Characteristics of early intervention services received by families in the study.

Participants described their child's access to early intervention services at the study site. Over two thirds of children (n=16, 72%) were aged three (3) years or less when they first began accessing services at the centre, although it is of note that one participant reported that their child commenced early intervention between 7 and 8 years. Almost two thirds of the children (n= 14, 63%) had accessed the services of a speech and language therapy at some point, although notably half of this group had only accessed speech and language therapy services after commencement at early intervention centre (n= 11, 50%). Duration of attendance at the centre varied and formed a bimodal distribution. This is illustrated in (Figure3). To explore the age of the child in relation to how long they have been accessing services, the data were compiled into a table (Table 2). It is evident that older children generally have been at the centre for a longer period (more than 3 years) while 1 – 2 years old children have spent the shortest time at the centre (less than 6months). This confirms parental report of the age their children first began accessing services. It also highlights the age variation of when children begin to access services, with some children commencing services at late age, and others commencing in the first 6-12 months of life. The demographic characteristics and service duration of participants and their children are presented in (Table 1).

Table 1. Questionnaire respondent characteristics

	Number	Percentage (%)
Age range of parents		
18-29	0	0%
30-35	6	27%
36-40	10	45%
41-45	3	14%
46-50	1	5%
51-55	1	5%
56-60	0	0%
61-65	1	5%
Characteristics of children		
Gender		
Female	15	68%
Male	5	23%
N/A	2	9%
Age of admission		
0-3 years	16	72%
4-6 years	5	23%
7-8 years	1	5%
Current Age		
0-3 years	9	41%
4-6 years	8	36%
7-8 years	4	18%
N/A	1	5%
Percentages of children seen by a Speech and Language Therapist		
Yes	14	63%
No	7	32%
N/A	1	36%
Children seen before or after referrals		
Before referrals	7	32%
After referrals	7	32%
N/A	8	36%
Duration at AwaaWaa2		
Less than 6,months	11	50%
7months - 12 months	3	12%
More than 1year - 18month	1	5%
More than 2years but less than 2.5years	1	5%
More than 2.5years but less than 3years	1	5%
More than 3years but less than 4years	5	23%

Current Age of Child	Tally	Frequency	fx
(x)		(f)	
1	/	1	1
2	/	1	2
3	/// ///	8	24
4	//	2	8
5	///	3	15
6	//	2	12
7	///	3	21
8	//	2	16
		$\Sigma f = 22$	$\Sigma fx = 99$

$$\text{Mean age} = \frac{\Sigma fx}{\Sigma f} = \frac{99}{22} = 4.5 \text{ years}$$

$$\text{Mode} = 3 \text{ years}$$

$$\text{Median} = \text{The 11th value} = \frac{\Sigma f = 22}{2} = 4 \text{ years}$$

Fig. 1: Sample distribution of current age of children (mean, mode and median)

Admission Age of Child (x)	Tally	Frequency (f)	fx
1	//	2	2
2	### ###	10	20
3	////	4	12
4	//	2	8
5	//	2	10
6	/	1	6
7	/	1	7
8		0	0
		$\Sigma f = 22$	$\Sigma fx = 63$

Mean age = $\frac{\Sigma fx}{\Sigma f} = \frac{63}{22} = 2.9 \text{ years}$

Mode = 2 years

Median = The 11th value $\frac{\Sigma f = 22}{2} = 2 \text{ years}$

Fig. 2: Sample distribution of admission age of children (mean, mode and median)

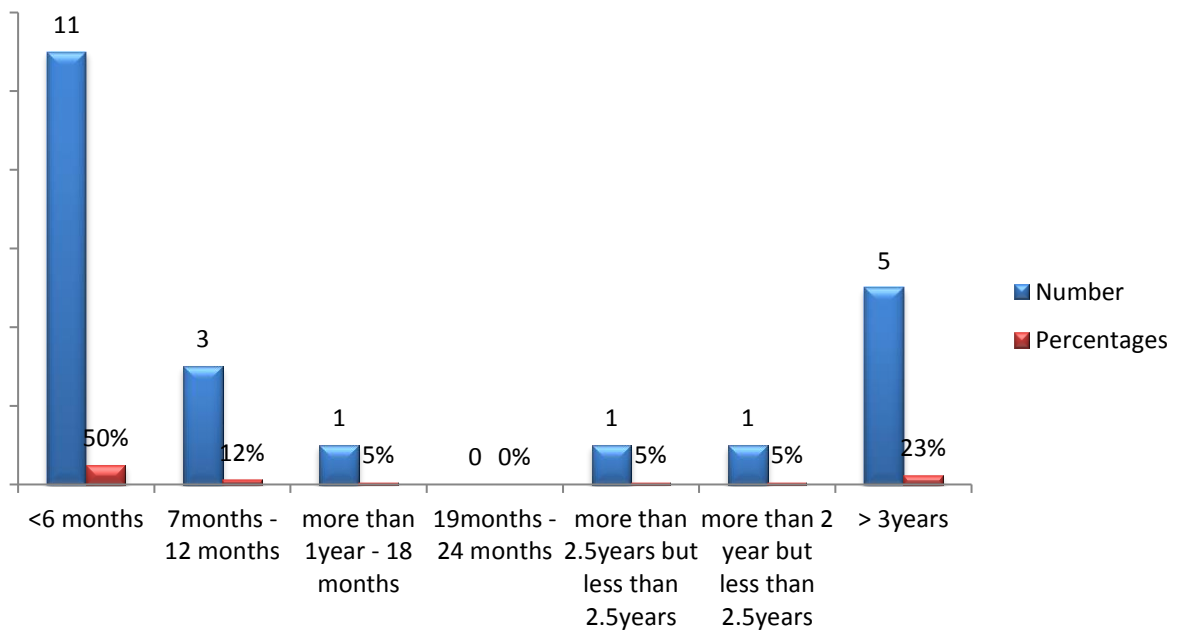


Fig. 3: Duration at AwaaWaa2

The duration children had been attending the centre is provided in Table 1. When considering the duration children had been receiving services at the centre, a bimodal distribution pattern appeared to be evident (Figure 3). Half of the children in the sample (n=11, 50%) had been attending Awaawaa2 for a duration of 6 months or less. This data reveals that a total of 62% (n=14) of the children had been accessing services at the centre for one year or less. In contrast 5 children (23%) had been attending the centre for more than 3 years. The pattern of centre attendance is provided in Figure 3.

To consider if there appeared to be a relationship between the age of the child, and duration of attendance at the centre, the data cross tabulated (Table 2). Whilst the youngest children, aged 1-2 years, had been at the centre for less than 6 months, children in the other age groups showed of mixed profile. Within the older age groups (5-6 years, and 7 years +) children appeared to have a mixed pattern of enrolment at the centre. Whilst 5 of the 10 children in the study who were aged 5 years or more (50%) had been at the centre for more than 2 years, 3 of the children in that age group (30%) had been at the centre for 6 months or less. This finding is relevant when considering the age at which children access 'early' intervention.

	AGE OF CHILDREN AT TIME OF THE STUDY			
	1-2 years	3-4 years	5-6 years	7years
DURATION				
<6 months	2	6	2	1
7 - 12 months		2	1	
13-18 months			1	
19-24 months				
25-30 months			1	
31-36 months		1		
>36 months		1	1	3

Table 2: Duration of how long each child has been at the centre, by age, [Note: data collapsed into 2 year intervals to ensure participant anonymity]

4.3. BARRIERS AND FACILITATORS TO SERVICES ACCESS

Content analysis of qualitative data produced a series of response categories, developed through familiarization with the data, organization of categories and sub-categories and reporting of the categories of data described by participants (Elo & Kyngäs, 2008). The main concepts derived from the data in response to the four research questions are described in this section. A summary of the categories and subcategories derived in response to each research questions are outlined in Table 3 below. Following the table, each research aim is considered in turn, with categories and sub-categories explained below in more detail. Illustrative quotes from parents are included.

Summary of themes derived

Research question	Category	Sub-category- if relevant
1. What are the barriers to finding appropriate communication disability services?	Service related factors Social factors	<ul style="list-style-type: none"> • Limited information on services • Lack of services • Lack of community support • Financial issues • Psychological • Distance • Time
2. What are the barriers to receiving appropriate communication disability services?	Geographical location of centers Individual factors	<ul style="list-style-type: none"> • Geographical location • Financial issues • Psychological • Time
3. What are the facilitators to finding appropriate communication disability services?	Referrals from other health care professionals Information within the community	<ul style="list-style-type: none"> • Internet use • Personal relationship • Public information
4. What are the facilitators to receiving ongoing appropriate communication disability services?	Improvement in child with therapy Favorable personal factors	<ul style="list-style-type: none"> • Economic • Practical help • Motivation

Table 3 Summary of themes derived exploring the views of parents and primary caregivers.

4.3.1. Barriers described by parents in locating appropriate early intervention services for children with communication disability.

Category 1: Service Related factors

Parents of children with communication disability expressed their frustration with the limited accessibility to SLT services and other social factors in finding appropriate services.

Parents indicated three main categories of information in regard to finding appropriate services for communication disability rehabilitation.

Sub-category 1.1: Limited information on services

The first category of data related to the limited information on what services are available in Greater Accra. Almost half (n=10, 45%) of parents reported access to information was a major challenge.

‘Not too many information out there’ – (Participant 3)

‘Finding the right information on services available’ – (Participant 20)

Sub-category 1.2: Lack of services

Parents indicated that a barrier to finding services was the limited number of service providers and centers, making it difficult to find appropriate communication disability services for their children.

‘Very few speech therapists available ...’ – (Participant 1)

‘...lack of speech therapist and centres’ – (Participant 6)

‘Most of this school are few in this country...’ – (Participant 14)

Sub-category 1.3: Lack of community support

Lack of support systems or supportive groups was identified as parents as contributing to difficulty in locating services.

‘...little or no support system for kids with speech disorders’ – (Participant 1)

‘Support group’ – (Participant 15)

Category 2: Social factors

A total of (n=7, 32%) parents reported social factors as a challenge in finding communication disability services for their children. Social factors consisted of a mix of social, psychological, economic and geographic factors which impact the ability to find services (money, time, distance, emotional stress). 4 sub-categories constituted this theme and included:

Sub-category 2.1: Financial issues

Financial issues were recognized as a difficulty in locating services.

'...most of them are expensive' - (Participant 14)

'Money' – (Participant 22)

Subcategory 2.2: Psychological factors

Due to psychological factors, some parents had difficulty locating communication disability services.

'Emotionally tired' – (Participant 10)

'Aggressive' – (Participant 12)

Sub-category 2.3: Distance

A parent identified distance as a barrier in locating services.

'The distance from home to access the right services' – (Participant 15)

Sub-category 2.4: Time

A parent identified time as a barrier to locating services.

'Time factor' – (Participant 17)

4.3.2. Barriers faced by parents in receiving ongoing early intervention services for communication disability.

Two distinct themes were evident in the responses of parents when they were describing barriers to ongoing early intervention services: geography and socioeconomic factors.

Category 1: Geographical location of centers

A commonly expressed challenge of about (n=8, 36%) parents and primary caregivers was the location of centers. These parents reported that they travel long distances in order to continue to

receive services. They indicated that distance between home and the centre was a significant challenge in continuing to receive ongoing services.

Some comments from parents are:

'The location- far away from our residence' – (Participant 4)

'Distance from where I live to AwaaWaa2' – (Participant 6)

'Proximity to where we stay' – (Participant10)

'...distance' – (Participant 18)

'The location – its a bit out of the way for our usual routine (but we really don't mind)' – (Participant 9)

Category 2: Individual factors

A total of (n=11, 50%) of the parents and primary caregivers described socioeconomic factors as a barrier in receiving ongoing services. This theme was made up of 4 subthemes relating to socioeconomic factors. These subthemes described relate to and influence one another, for example time constraints and workloads link to tiredness. Subthemes include included financial issues, transportation, time availability and emotional stress, as barriers in continuing to receive services for their children with communication disability.

Sub-category 2.1: Financial issues

This subtheme related to references to the cost of services, or other associated ongoing costs related with having a child with a communication disability which were seen by parents as challenges or barriers in the ongoing access to early intervention.

'... having to pay extra for therapy lessons aside mainstream school fees' (Participant 1)

'Money to pay for special school services' – (Participant 21)

Sub-category 2.2: Psychological/Psychosocial

One parent reported of being tired in continuing on-going services. This is included as it is reflective of the theme described by parents in finding services.

'...very tiring (emotional) – (Participant 10)

Sub-category 2.3: Time

Parents and caregivers identified time as a barrier to accessing ongoing services. The sub-category time consistent of all references to the time it took to continue to receive services, including waiting times, making time within the family routine.

'Time (busy schedule' – (Participant 2)

Time factor – (Participant 7)

'Long hours of waiting time at both the Neuro Clinic at Korle Bu and the speech and language- (Participant 20)

4.3.3. Factors which facilitate locating appropriate early intervention services for children with communication disability.

Although parents in this study were conscious of the barriers in finding and receiving ongoing services, some indicated that information from child healthcare professionals and information from other sources assisted them to locate services when they were searching.

Category 1: Referral from other child health professionals

Health professionals, especially those working with children, were noted to have informed over half of parents or caregivers about how to find services for communication disability for their children. Responses included:

'A pediatrician at X hospital in X' – (Participant 6)

'Was referred by ENT specialist' – (Participant 8)

'Referred by Neuro Doctors at Korlebu' – (Participant 20)

Category 2: Information within the community

A proportion of (n=5, 23%) of parents of children with communication disability used information obtained in community settings as a means of obtaining information about services. They ranged from the internet, awareness creation and friends. This is stated in the words of some parents:

Sub-category 2.1: Internet use

The internet was noted to be a source of information which helped in locating services for communication disability.

'Through the internet' – (Participant 2)

‘Reading on the internet’ – (Participant 10)

‘Online’ – (Participant 19)

Sub-category 2.2: Personal relationships

Knowledge of people in the community known to participants was identified as source of information. Some participants identified that they found services for communication disability through friends and other personal contacts in the community.

‘Yes, through a friend whose son was already attending AwaaWaa2’ – (Participant 1)

Sub-category 2.3: Public information

Some participants in this study identified that they heard about services for communication disability early intervention through information available publicly.

‘Public education’ – (Participant 15)

4.3.4. Factors which facilitate ongoing access to appropriate early interventions services for children with communication disability.

Two themes were evident when parents and carers described the facilitators they experienced in helping them continue to access early intervention services for communication disability: improvements in the child with therapy, and favorable personal conditions.

Category 1: Improvement in child with therapy

One factor that contributed to parents continuing to receive ongoing services was progress in therapy. A total of (n=6, 27%) parents expressed satisfaction from the outcome of ongoing therapy. Improvement in therapy outcome encouraged parents to keep bringing their children for services. This is illustrated by statements from parents:

‘Results. Results outweigh all inhibitions’ – (Participant 6)

‘The day to day improvement’ – (Participant 16)

‘The improvement seen in the child’ – P 4

‘Sees Improvement’ – (Participant 7)

Category 2: Favorable personal conditions

A majority of (n=15, 68%) of parents reported diverse forms of favorable conditions that made it possible for them to continue receiving ongoing services. These conditions range from support from family and paid workers, dedication from parents, sponsorship and affordable packages, time availability, communication between service providers and parents and finding the right services. The extracts below illustrate these responses:

Sub-category 2.1: Economic

Some participants reported that economic conditions contributed to facilitating ongoing services.

‘Finances are very good (get sponsors)’- (Participant 10)

‘We can currently afford’ – (Participant 18)

Sub-category 2.2: Practical help

Some participants in the study reported that they get help from family members and other people.

‘Having a driver and nanny to bring my child to the center’ – (Participant 1)

‘Facilitator is committed’ – (Participant 5)

‘I have support both my side and my husband’ – (Participant 14)

‘Family aid’ – (Participants 21)

Sub-category 2.3: Motivation

Some participants mentioned their motivation was a factor which contributed to facilitating ongoing services.

‘Dedication’ – (Participant 2)

‘Determination to make my son improve greatly’–(Participant 5)

‘Motivation that she can be helped here’–(Participant18)

‘The constant communication between staff and parent’ – (Participant 4)

This chapter has provided an overview of the descriptive/quantitative and qualitative results of the study. The following chapter will discuss these findings.

CHAPTER FIVE

DISCUSSION

5.1. INTRODUCTION

This chapter discusses the results of the present study in relation to the relevant literature. Implications of the findings as well as limitations of the study are also discussed.

5.2. DISCUSSION OF RESULTS

This study was to explore the experiences of parents in locating and accessing communication disability services for their children in Ghana but only parents were obtained for the survey.

Children need to get to early intervention early. Figures in this small study indicated that some children are accessing early intervention after 5 years. Ideally, children would receive support in the early years. We need to address barriers to services to ensure children can access services as early as possible for their best outcomes.

Respondents revealed diverse experiences of finding and maintaining services. Communication disability services for children are minimal in Ghana, thus, remains unreachable to the majority of children with communication disability in the country. AwaaWaa2 as an early intervention service was purposely designed for children with communication disabilities; therefore, it accepts referrals from every part of the country. Even though the aim was to exclusively care for children with communication disabilities, due to unavailable services, it has included providing support for children with developmental difficulties (Stephens et al., 2015).

This study revealed service related factors, including limited information on services, lack of services and lack of community support as major barriers in locating services. Existing research indicates that developing countries often have limited access to services (Crowley et al., 2013; Jochmann, 2006). Even in the face of limited services, parents described challenges in locating the few available services. In finding appropriate services, parents described limited information available when they were looking for services. This limitation presents a major barrier to access for early intervention services. The issue of limited information on services does not encourage

services for early intervention for children with communication disability (Van der Linde et al., 2009; Stephens et al., 2015).

Lack of support-based systems mentioned by parents found in this study as a barrier to early intervention, resonates with research that people with communication disabilities are given little or no support which affects their quality of life (Michalik, 2015).

Social factors such as money, time, distance and emotional stress were also found in this research to have also contributed to the barriers experienced by parents and caregivers to finding appropriate communication disability services. This supports the findings of previous research regarding costs of therapy. With regard to the cost of services, studies have reported that about two-thirds of people in sub-Saharan Africa pay for services (Wylie et al., 2013). Additionally, costs of therapy services and early intervention are likely to be high given the therapeutic nature of services, and the need for children to attend regularly (Wylie et al, 2018). Finding a suitable time for therapy was a barrier faced by some parents and sometimes, when they find the services, they have to wait for hours in long queues. Transport may also add both to the time and to cost, creating barriers to parents and as service providers and centers are mostly in urban cities, therefore parents have to find means of transportation in accessing services (Crowley et al., 2013; Jochmann, 2006). Distances was considered a barrier in this research, consistent with evidence that developing therapy services for communication disability are few, and primarily based in urban cities (Wylie et. al., 2013). Parents travel long distances in order to locate the few available centers. Communication disability does not only affect the individuals but their families as well. This confirms the essence of counseling for parents sometimes in locating appropriate services (Friehe, Bloedow, & Hesse, 2003). Parents in this study indicate that they are emotionally stressed, as they travel to access available services

Parents reported a number of barriers in accessing ongoing early intervention services, including geographical location of centers and individual factors such as financial issues, psychological and time. Parents reported that geography and travel was a barrier to ongoing service access. Travelling long distances can be a drain on one's life and limit productive time at work; parents sometimes have to stop working in order to provide therapy and care for the child. Receiving ongoing services at distant locations with queues can be stressful for parents as well as the child. This is because; early intervention services in Accra are few, expensive, and not easily accessible (Stephens et al., 2015). Finding a convenient time for therapy services could be a drain for

families. As the professions of speech and language therapy grow, public awareness of communication disability will also increase, making services easily accessible and available to all. In spite of the challenges parents encountered in finding and maintaining communication disability services. One category of response, referral from other health workers, especially child healthcare providers, was seen by parents to help them locate services for their child. These included doctors, pediatricians, neuropsychiatrists and E.N. T. specialists. These child healthcare professionals played a major role in informing parents about communication disability services for their children. Child health care professionals help to identify the red flags in children, which eventually leads to early intervention (Scherzer et al., 2012). Early intervention services help in the reduction of communication disability impact on children (Van der Linde et al., 2009). It will be important for the growing profession of speech and language therapists to work closely alongside healthcare professionals, including a range of doctors, to inform them about communication disability services and ensure that families can access services. For information within the community, internet use helped in disseminating information. With the advancement of ICT services in Ghana (Madzingira, 2001), parents search to find relevant information on speech and language therapy services. Even when there is little or no information about services, it is likely that parents search for other information to help their children (Martinović & Stričević, 2016) and this includes personal relationship with people. Parents in this study also sought information through public information on communication disability (Theunissen & Swanpoel, 2008).

Seeing improvement in their children was a strong motivator for about 27% of parents in this study, which supported their desire to continue accessing services, despite the challenges they face. This reiterates the point that, with the use of culturally appropriate resources, the progress of therapy will be experienced (OseiBagyina, 1984.; Crowley et al., 2013; Verdon et al., 2016). The hope in improvement shows how parents channel their stress in the hope of an optimistic future for their children (Oti-Boadi, 2017). About 68% of parents reported favorable personal factors helped in receiving ongoing communication disability services. These were outlined by parents; they included economic, practical help and motivation. Parents in this study also reported that being sponsored and paying affordable cost were means for continuation of communication disability services. In Ghana, due to our extended family system (Takyi & Gyimah, 2007), family members may give their unflinching support to parents in caring for their child, although this requires research. This study also shows support from other paid carers. Motivation on the part of parents

also ensured the continuation of ongoing services. Parents mentioned their dedication in service delivery as a factor in the continuation of ongoing services.

5.3. IMPLICATIONS OF THE PRESENT FINDINGS

The present study has described the range of barriers and facilitators experienced by parents in locating and accessing services for their children with communication disabilities. Implications of this study are both for research and practice. Firstly, the study has provided some early data which could be extended for future studies. This offers a small but valuable contribution in building the evidence about intervention for speech and language therapy in Ghana and other developing countries.

Secondly, the present findings have supported and provided some evidence about the relationship between socioeconomic factors and access to services in Ghana (Wylie et. al., 2013). It is important that, with forthcoming development of services and supports in Ghana for children with communication difficulties, the economic costs of services and the impact on access to services be carefully discussed and considered.

This study has also demonstrated the urgency for speech and language therapists to work directly with doctors and other healthcare professionals to ensure they have clear information about services in the community. This will ensure that families can more easily locate services. This study has also shown the importance of having accessible information in the community to support families of children with communication difficulties. Families used the internet and spoke of others they knew to find out about services. If speech and language therapy professionals work on building community knowledge and ensuring information is available on the internet, then families will be able to more readily access the information they need.

Finally, the findings of the present study can serve as a tool to influence policymakers. The study can create awareness and inform policymakers on the need to invest, support and strengthen the barriers and facilitators in finding and maintaining communication disability services in the Ghanaian healthcare system. Investment and support in this area will promote the delivery and expansion of services for speech and language therapy in Ghana.

Future research should extend the findings of this study, using larger sample sizes, greater mix of parent respondents and working across various early intervention services.

5.4. LIMITATIONS OF THE STUDY

Though this study proved successful, there were limitations. First, results from this study cannot be universal to all parents of children with communication disability in Ghana. Results of this study are specific to this group study and offer limited generalizability to the wider population, without further research. The study concentrated on parents living in cities; therefore, it is unknown whether parents living in remote areas of Ghana may have different experiences. Although it is highly likely that similar patterns may be evident for people in other geographical areas, it is important to investigate their experiences for rural communities. Second, parents from a single service offer a narrow representation of families with children with communication disability in Ghana. It is acknowledged that clients of one service may only represent a subset of those seeking services for communication disability in Accra. Further research considering families accessing a range of services would consolidate these findings. Third, the use of the small sample size and the convenience sampling limits the generalizability of the study findings. The characteristics of the sample may have influenced the content of responses, for example, solid representation of respondents with a university level education. A number of parents may not have been accessed, for example, parents from very poor backgrounds. Fourth, in-depth responses were not obtained from parents due to limited time constraints. Also, it is of note that brief qualitative surveys do not allow deeper exploration of responses. However, the information collected in the study provides an important insight into the experiences of families accessing early intervention and may form the basis of future research in Ghana.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1. CONCLUSION

In conclusion, the study explored the experiences of how parents with children with communication disabilities locate and access services in Ghana. Findings from this study highlighted the barriers of finding and maintaining services as well as the facilitators in finding and maintaining ongoing services. However, parents reported on referrals from health workers, improvement in therapy and other favorable factors to cope with challenges in finding and maintaining services. Furthering our understanding on the experiences of parents will enable service providers to design models that will suit service accessibility and availability. Finally, the study improves our knowledge of the experiences of parents of children with communication disability in the Ghanaian perspective.

6.2. RECOMMENDATIONS

The rationale behind the present study was to explore the barriers and facilitators in finding and maintaining services in Ghana. Based on the results and identified limitations of the study, the subsequent recommendations were made for potential research directions.

A similar study should extend this research. This study may be replicated in different parts of Ghana with larger and more diverse sample sizes to build a more robust evidence base.

Secondly, the study was limited by the use of only questionnaires. This was appropriate owing to the early exploratory nature of this research. However, future research in this field could consider the use of in-depth interviews, focus groups and action research to provide information rich with deep insight into the phenomenon under study.

Future studies should also build on these findings by involving family who access other early intervention centres. This will help give a broader understanding of what parents experience in locating and accessing services for communication disability in different settings. Furthermore, future speech and language therapy studies in Ghana should focus on how adults find

communication disability services. This gives information on the pathway adults use in finding services. These pathways can be developed for better services.

Finally, since the present study did not assess parents' satisfaction with service delivery models, it is recommended that future studies elicit parents' satisfaction with service delivery models in Ghana.

6.2.1. RECOMMENDATIONS FOR POLICY MAKERS

With the introduction of new programmes for speech and language therapy in Ghana, team work should be adopted amongst child service providers such as speech and language therapists, audiologists, pediatricians, neuropsychiatrists, E.N.T. specialists, teachers, among others. Emphasis should be placed on health professionals especially child healthcare providers, information on communication disability services in the country should be made available to them. With governmental interest and support in communication disabilities, new therapists should not be centered in the urban cities of Ghana, incentives packages should be provided to encourage them to travel to other remote areas to work.

In order for therapy to be accessible to all, communication disability should be migrated unto the National Health Insurance Scheme (NHIS). This will encourage people with low socioeconomic status to seek early intervention for an improved quality of life and help to begin to address the financial barriers reported in the study.

Information accessibility should be made accessible to all by creating awareness. Awareness creation should be focused on using available mediums of disseminating information and in all local languages as well. Churches, schools, mosques, television and radio programs as well as social media platforms. The new profession of speech and language therapy in Ghana has a significant role to play in building awareness and community familiarity.

Home-based knowledge can be attached with foreign or systematic knowledge for efficiency in therapy (Hopf et al., 2017; Mcallister et al., 2013). Also, community expectations should be considered by developing culturally appropriate resources for effective service delivery (Hopf et al., 2017; Pascoe & Norman, 2011; Pascoe, Rogres, & Norman, 2013). Recruitment of African language speakers for training can be considered in the profession in order to contain the assessment and management of the population. Portions of the speech and language curriculum related to bilingualism, cultural and linguistic diversity needs to be improved for more efficient

preparation of speech and language therapists who will work with diverse speakers and clinicians must go beyond traditional standpoint and explore beyond diverse assessment and intervention (Goulart, Levy, & Rech, 2018).

REFERENCES

- Abubakar, A., Holding, P., Van de Vijver, F., Bomu, G., & Van Baar, A. (2010). Developmental monitoring using caregiver reports in a resource-limited setting: The case of Kilifi, Kenya. *Acta Paediatrica, International Journal of Paediatrics*, 99(2), 291–297.
<https://doi.org/10.1111/j.1651-2227.2009.01561.x>
- Agresti, A. (1996). *An introduction to categorical data analysis* (Vol.135). New York: Wiley.
- Alliston, L. (2007). *Principles and practices in early intervention: A literature review for the Ministry of Education*. Research New Zealand.
- American Speech-Language-Hearing Association (1993). Definitions of communication disorders and variations. Retrieved November 20, 2017, from
<http://www.asha.org/policy/Definitions-of-communication-disorders-and-variation/>.
- Battaglia, M. P. (2008). *Encyclopedia of survey research methods*, 1, 523-526.
- Battle, D. E. (2015). Persons with communication disabilities in natural disasters, war, and/or conflict. *Communication Disorders Quarterly*, 36(4), 231–240.
<https://doi.org/10.1177/1525740114545980>.
- Bayat, M. (2015). The stories of “snake children”: killing and abuse of children with developmental disabilities in West Africa. *Journal of Intellectual Disability Research*, 59(1), 1-10. <https://doi.org/10.1111/jir.12118>.
- Beck, R. S., Daughtridge, R., & Sloane, D. P. (2002). Physician-patient communication in the primary care office: a systematic review. *Journal of the American Board of Family Practice*, 15(1), 25–38. <https://doi.org/10.1002/pon>
- Bengtsson, M. (2016). How to plan and perform a qualitative study using content analysis. *NursingPlus Open*, 2, 8–14. <https://doi.org/10.1016/j.npls.2016.01.001>.

- Bigby, C., Johnson, H., O'Halloran, R., Douglas, J., West, D., & Bould, E. (2017). Communication access on trains: a qualitative exploration of the perspectives of passengers with communication disabilities. *Disability and Rehabilitation*, 1–8. <https://doi.org/10.1080/09638288.2017.1380721>.
- Broomfield, J., & Dodd, B. (2004). The nature of referred subtypes of primary speech disability. *Child Language Teaching and Therapy*, 20(2), 135–151.
- Bunning, K., Gona, J., Newton, Charles, R., & Hartley, S. (2014). Caregiver perceptions of children who have complex communication needs following a home-based intervention using augmentative and alternative communication in rural Kenya: An intervention note. *AAC: Augmentative and Alternative Communication*. <https://doi.org/10.3109/07434618.2014.970294>.
- Cameron, D. L., Nixon, S., Parnes, P., & Pidsadny, M. (2005). Children with disabilities in low-income countries, *Paediatrics & child health*, 10(5), 269–272.
- Creswell, J.W. (2009). Mapping the field of mixed methods research..
- Crowley, C., Biagorri, M., Ntim, C., Bukari, B., Oseibagyina, A., Kitcher, E., ... Laing, A. (2013). Collaborations to address barriers for people with communication disabilities in Ghana: Considering the World Report on Disability. <https://doi.org/10.3109/17549507.2012.743036>.
- D'Aprano, A., L., Carapetis, J. R., & Andrews, R. (2011). Trial of a developmental screening tool in remote Australian Aboriginal communities: A cautionary tale. *Journal of Paediatrics and Child Health*, 47(1–2), 12–17. <https://doi.org/10.1111/j.1440-1754.2010.01883.x>.

- Dalton, D. S., Cruickshanks, K., J., Klein, B., E. K., Klein, R., Wiley, T. L., & Nondahl, D. M. (2003). The Impact of Hearing Loss on Quality of Life in Older Adults, *The gerontologist*, 43(5), 661–668.
- De Andrade, V., & Ross, E. (2005). Beliefs and practices of Black South African traditional healers regarding hearing impairment. *International Journal of Audiology*.
<https://doi.org/10.1080/14992020500188999>.
- Durkin, M. (2002). The epidemiology of developmental disabilities in low-income countries. *Mental retardation and developmental disabilities research reviews*, 8(3), 206–211. <https://doi.org/10.1002/mrdd.10039>.
- Edgar, D. ., & Rosa-Lugo, L. . (2007). The Critical Shortage of Speech-Language Pathologists in the Public School Setting: Features of the Work Environment That Affect Recruitment and Retention. *Language Speech and Hearing Services in Schools*.
[https://doi.org/10.1044/0161-1461\(2007/004\)](https://doi.org/10.1044/0161-1461(2007/004)).
- Elo, S., & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62(1), 107–115.
- Etikan, I., Musa, S. ., & Alkassim, J. . (2016). Comparison of Convenience Sampling and Purposive Sampling. *American Journal of Theoretical and Applied Statistics*, 5(1), 1.
<https://doi.org/10.11648/j.ajtas.20160501.11>.
- Fagan, J., & Jacobs, M. (2009). Survey of ENT services in Africa: need for a comprehensive intervention. *Global Health Action*, 2(1).
- Farrokhi, F., & Mahmoudi-Hamidabad, A. (2012). Rethinking Convenience Sampling: Defining Quality Criteria. *Theory and Practice in Language Studies*, 2(4), 4304.
<https://doi.org/10.4304/tpls.2.4.784-792>.

- Finnegan, R. (1974). How oral is oral literature ?. *Bulletin of the School of Oriental and African Studies*, 37(1), 52-64. <https://doi.org/10.1017/S0041977X00094842>.
- Fox, A. V., Dodd, B., & Howard, D. (2002). Risk factors for speech disorders in children. *International Journal of Labguages & Communication Disorders*,37(2), 117–131. <https://doi.org/10.1080/1368282011011677>.
- Frels, R. K., & Onwuegbuzie, A. J. (2013). Administering quantitative instruments with qualitative interviews : A mixed research approach. *Journal of Counseling & Development*,91(2), 184-194.). <https://doi.org/10.1002/j.1556-6676.2013.00085.x>.
- Frenken, K. (Ed.) . (2005). Irrigation in Africa in figures. *AQUASTAT Survey, 2005 (Vol.29)*. Food & Agriculture Org..
- Friehe, M. J., Bloedow, A., & Hesse, S. (2003). Counseling families of children with communication disorders,*Communication Disorders Quarterly*, 24(4), 211–220.
- Ghana Staistical Service (2016). Projected Population Growth by sex 2010-2016. *Data Production Unit Ghana Statistical Service (GSS)*, 2.
- Giles, H., Makoni, S., & Dailey, R. M. (2007). Intergenerational communication beliefs across the lifespan: Comparative data from India. *Communication Reports*, 20(2), 75–89. <https://doi.org/10.1080/08934210701643701>.
- Gill, E. L. (2009). Attitudes of Rural Kenyans Toward Speech and Language Disorders and Therapy.(Doctoral dissertation, University of Florida).

- Gladstone, M., Lancaster, G. ., Umar, E., Nyirenda, M., Kayira, E., van den Broek, N, R., & Smyth, R. L. (2010). The Malawi developmental assessment tool (MDAT): The creation, validation, and reliability of a tool to assess child development in rural African settings. *PLoS Medicine*, 7(5). <https://doi.org/10.1371/journal.pmed.1000273>.
- Goggin, G. (2009). Asia Pacific Media Educator Disability, Media, and the Politics of Vulnerability Disability, Media, and the Politics of Vulnerability. Retrieved from <http://ro.uow.edu.au/apme/vol1/iss19/2>.
- Goulart, B. ., Levy, S., & Rech, R. . (2018). Multiculturalism skills , health care and communication disorders Competências em multiculturalismo , assistência à saúde e transtornos de comunicação Competencias multiculturales , cuidados en el ámbito de la salud y problemas de comunicación, 34(4), 3–5. <https://doi.org/10.1590/0102-311X00217217>.
- Grut, L., Mji, G., Braathen, S. H., & Ingstad, B. (2012). Accessing community health services: challenges faced by poor people with disabilities in a rural community in South Africa. *African Journal of Disability*, 1(1).
- Guba, E. G., & Lincoln, Y. S. (1989). Fourth generation evaluation. Sage.
- Gupta, N., Castillo-Laborde, & Michel, D., L. (2011). Health-related rehabilitation services : assessing the global supply of and need for human resources. *BMC Health Services Research*, 11(1), 276.
- Guralnick, M. J. (2005). Inclusion as a core principle in the early intervention system, *The developmental systems approach to early intervention*, 59-69.
- Hall, J. (2016). Encyclopedia of Survey Research Methods Cross-Sectional Survey Design, 173–174.

- Harrison, L. ., Mcleod, S., Berthelsen, D., & Walker, S. (2009). Literacy , numeracy , and learning in school-aged children identified as having speech and language impairment in early childhood, *11*(5), 392–403. <https://doi.org/10.1080/17549500903093749>.
- Hilari,K. & Botting,N.(2011).Community disability across the lifespan: The importance of documenting and sharing knowledge about wider impacts.In Hilari,K. & Botting,N.(Eds).The impact of communication disability across the lifespan (1-5). (Guildford,U.K.: J&R Press. doi:10.1177/0265659013484577
- Hopf, S. ., & Mcleod, S. (2015). Services for people with communication disability in Fiji : barriers and drivers of change.*Rural & Remote Health, 15*(3).
- Hopf, S. C., Mcleod, S., McDonagh, S. H., & Rakanace, E. N. (2017). Communication disability in Fiji: Community cultural beliefs and attitudes.*Disability, CBR & Inclusive Development, 28*(1), 112-141. <https://doi.org/10.5463/DCID.v28i1.600>.
- Hsieh, H.-F., & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288. doi: 10.1177/1049732305276687
- Jiminez, M. ., Barg, F. ., Guevara, J. ., Gerdes, M., & Fiks, A. . (2012). Barriers to evaluation for early intervention services: Parent and early intervention employee perspectives. *Academic Pediatrics, 12*(6), 551–557. <https://doi.org/10.1016/j.acap.2012.08.006>.
- Jochmann, A. (2006). Speech and Language Treatment in East Africa.*The ASHA Leader, 11*(2), 8- 33.
- Johnson, R. B., & Onwuegbuzie, Anothony, J. (2011). Mixed Methods Research : A Research Paradigm Whose Time Has Come. *Educational Researcher, 33*(7), 14–26. Retrieved from <http://edr.sagepub.com/content/33/7/14.short>.

- Johnsson, L., Eriksson, S., Helgesson, G., & Hanson, M. G. (2014). Making researchers moral: Why trustworthiness requires more than ethics guidelines and review. *Research Ethics*, 10(1), 29–46. <https://doi.org/10.1177/1747016113504778>.
- Jureddi, D. N., & Brahmaiah, N. (2016). Barriers to Effective Communication. *Journal of English Language and Literature*, 3(2), 114–115.
- Kassah, A. K., Kassah, B. L. ., & Agbota, T. K. (2012). Abuse of disabled children in Ghana. *Disability and Society*. <https://doi.org/10.1080/09687599.2012.673079>.
- Khan, N. ., Muslima, H., Begum, D., Shilpi, A. ., Akhter, S., Bilkis, K., ... Darmstadt, G. . (2010). Validation of Rapid Neurodevelopmental Assessment Instrument for Under-Two-Year-Old Children in Bangladesh. *Pediatrics*, 125(4), e755–e762. <https://doi.org/10.1542/peds.2008-3471>.
- Krefting, L. (2018). Rigor in qualitative research: The assessment of trustworthiness. *American journal of occupational therapy*, 45(3), 214-222.
- Kruk, M. E., Chukwuma, A., Mbaruku, G., & Leslie, H. H. (2017). Variation de la qualité des services de soins primaires au Kenya, au Malawi, en Namibie, en Ouganda, en République-Unie de Tanzanie, au Rwanda et au Sénégal. *Bulletin of the World Health Organization*. <https://doi.org/10.2471/BLT.16.175869>.
- Kummerer, S. E., & Lopez-Reyna, N.A . (2006). The Role of Mexican Immigrant Mothers ' Beliefs on Parental Involvement in Speech – Language Therapy. *Communication Disorders Quarterly*, 27(2), 83–94.
- Law, J., Reilly, S., & Snow, P. C. (2013). Child speech, language and communication need re-examined in a public health context: A new direction for the speech and language therapy profession. *International Journal of Language and Communication Disorders*. <https://doi.org/10.1111/1460-6984.12027>.

- Littlejohn, S. W., & Foss, K. . (2008). Communication Theory and Scholarship. *Theories of Human Communication*, 2–11. Retrieved from http://www.cengagebrain.com/shop/content/littlejohn95877_0495095877_02.01_chapter01.pdf.
- Lodenstein, E., Mafuta, E., Kpatchavi, A. C., Servais, J., Dieleman, M., Broerse, J. E. W., ... Toonen, J. (2017). Social accountability in primary health care in West and Central Africa : exploring the role of health facility committees, 1–16. <https://doi.org/10.1186/s12913-017-2344-7>.
- Madzingira, N. (2001). Culture, communication and development in Africa. Retrieved from <http://scholar.google.com/scholar?hl=en&btnG=Search&q=intitle:Culture,+communication+and+development+in+africa#9>.
- Marshall, J., & Barrett, H. (2018). Human rights of refugee-survivors of sexual and gender-based violence with communication disability. *International Journal of Speech-Language Pathology*, 20(1),44–49. <https://doi.org/10.1080/17549507.2017.1392608>.
- Marshall, M. . (1996). Sampling for qualitative research Sample size. *Family Practice*, 13(6), 522–525. <https://doi.org/10.1093/fampra/13.6.522>.
- Martinović, I., & Stričević, I. (2016).). Information needs and behaviour of parents of children with autism spectrum disorders: parents’ reports on their experiences and perceptions. *Information Research*, 21(4).
- Mcallister, L., Wylie, K., Davidson, B., & Marshall, J. (2013). The World Report on Disability : An impetus to reconceptualize services for people with communication disability, 15(1), 118–126. <https://doi.org/10.3109/17549507.2012.757804>.

- McGilton, K. ., Sorin-Peters, R., Rochon, E., Boscart, V., Fox, M., Chu, C. ., ... Sidani, S. (2018). The effects of an interprofessional patient-centered communication intervention for patients with communication disorders. *Applied Nursing Research*. <https://doi.org/10.1016/j.apnr.2017.11.017>.
- Mdlalo, T., Flack, P., & Joubert, R. (2016). Are South African speech-language therapists adequately equipped to assess English Additional Language (EAL) speakers who are from an indigenous linguistic and cultural background ? A profile and exploration of the current situation. *South African JOurnal of Communication Disorders*, 63(1), 1–5. <https://doi.org/10.4102/sajcd.v63i1.130>.
- Michalik, J. (2015). Quality of life for people caring for family members with disabilities. *Procedia - Social and Behavioral Sciences*, 171, 458–464. <https://doi.org/10.1016/j.sbspro.2015.01.147>.
- Moon, K., Brewer, T. D., Januchuski-Hartley, Adams, V. M., & Blackman, D. A. (2016). A guideline to improve qualitative social science publishing in ecology and, 21(3).
- Morse, J. . (2005). Evolving trends in qualitative research: Advances in mixed-method design. *Qualitative Health Research*, 15(5), 583–585. <https://doi.org/10.1177/1049732305275169>.
- Munodawafa, D. (2008). Communication: Concepts, practice and challenges. *Health Education Research*, 23(3), 369–370. <https://doi.org/10.1093/her/cyn024>.
- Murphy, E., & Dingwall, R. (2007). Informed consent, anticipatory regulation and ethnographic practice. *Social Science and Medicine*, 65(11), 2223–2234. <https://doi.org/10.1016/j.socscimed.2007.08.008>.
- Murphy, J. (2006). Perceptions of communication between people with communication disability and general practice staff. *Health Expectations*, 9(1), 49-59.

- National Population Council. (2006). Ghana ' s Development Agenda and Population Growth : The Unmet Need for Family Planning National Population Council With the support of The POLICY Project, (February), 1–44.
- Odom, S. L., Buysse, V., & Soukakou, E. (2011). Inclusion for Young Children With Disabilities : A Quarter Century of Research Perspectives, 344–356. <https://doi.org/10.1177/1053815111430094>.
- Ogbondah, C., & Siddens III, P. J. (1999). Defining Traditional Forms of Communication in Nigerian Culture within the Context of Nonverbal Communication.
- Osei-Bagyina, A. (2000). Causes of Child Language Disorders in Patients at KATH, Kumasi, Ghana.
- Osei-Bagyina, A. (2000). Incidence of Oral Communication Problems in Patients at KATH, Ghana. *Journal of the Kwame Nkrumah University of Science and Technology, Kumasi, 20*, 1–3.
- Osei-Bagyina, A. (1984). A plan for the construction of an articulation test for the Twi language (Doctoral dissertation, Southern Illinois University at Carbondale).
- Oti-Boadi, M. (2017). Exploring the Lived Experiences of Mothers of Children With Intellectual Disability in Ghana. <https://doi.org/10.1177/2158244017745578>.
- Palmera-Suárez, R., López-Cuadrado, T., Fernández-Cuenca, R., Alcalde-Cabero, E., & Galán, I. (2018). Inequalities in the risk of disability due to traffic injuries in the Spanish adult population, 2009–2010. *Injury, 49*(3), 549–555. <https://doi.org/10.1016/j.injury.2018.02.006>.

- Parada-Toro, I., M., G.-Q. R., & Treviño-Siller, S. (2017). Development and pilot testing of an educational intervention for parents, caregivers and teachers of children with verbal communication disabilities in Mexico, *25*, 790–798. <https://doi.org/10.1111/hsc.12375>.
- Pascoe, M., & Norman, V. (2011). Contextually-relevant resources in Speech-language Therapy and Audiology in South Africa: Are there any? *South African Journal of Communication Disorders*, *58*(1), 2–5. <https://doi.org/10.4102/SAJCD.V58I1.35>.
- Pascoe, M., Rogres, C., & Norman, V. (2013). Are we there yet? On a journey towards more contextually relevant resources in speech-language therapy and audiology. *South African Journal of Communication Disorders*, *60*(1), 2. <https://doi.org/10.7196/sajcd.256>.
- Patel, S. (2008). An Empirical Study of Causes of Disability in India, *6*(2), 1–8.
- Reynolds, S. (2010). Disability Culture in West Africa : Qualitative Research Indicating Barriers and Progress in the Greater Accra Region of Ghana, *17*, 198–207. <https://doi.org/10.1002/oti.303>.
- Rice, M. L., Warren, S. F., & Betz, S. K. (2005). Language symptoms of developmental language disorders: An overview of autism, Down syndrome, fragile X, specific language impairment, and Williams syndrome. *Applied Psycholinguistics*. <https://doi.org/10.1017.S0142716405050034>.
- Roberts, M. Y., & Kaiser, A. P. (2012).). Assessing the effects of a parent-implemented language intervention for children with language impairments using empirical benchmarks: A pilot study. *Journal of Speech, Language, and Hearing Research*, *55*(6), 1655–1670.
- Rosenbaum, P., Paneth, N., Leviton, A., Baxter, P., Morris, C., Goldstein, M., ... Shea, T. M. O. (2007). The Definition and Classification of Cerebral Palsy. *Developmental Medicine and Child Neurology*, *49*, 1–44. <https://doi.org/10.1111/j.1469-8749.2007.00001.x>.

- Rossetti, L. . (2001). *Communication intervention: Birth to three*:New York.Singular.
- Ruben, R. J. (2000). Redefining the survival of the fittest : communication disorders in the 21st century. *The Laryngoscope* , 110(2), 241-241
- Rudolph, J. M. (2017). Case history risk factors for Specific Language Impairment: A systematic review and meta-analysis. *American journal of speech-language pathology*, 26(3), 991-1010.
- Sackey, E. (2015). Disability and political participation in Ghana: an alternative perspective. *Scandinavian Journal of Disability Research*.
<https://doi.org/10.1080/15017419.2014.941925>.
- Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing & Health*, 18(2), 179–183. <https://doi.org/10.1002/nur.4770180211>.
- Satu, E., Kääriäinen, M., Kantse, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative Content Analysis. *SAGE Open*, 4(1), 215824401452263.
<https://doi.org/10.1177/2158244014522633>.
- Scherzer, A., Chhagan, M., Kauchali, S., & Susser, E. (2012). Global perspective on early diagnosis and intervention for children with developmental delays and disabilities, 1079–1084. <https://doi.org/10.1111/j.1469-8749.2012.04348.x>.
- Sedgwick, P. (2013). Convenience sampling. *Bmj*, 347, f6304–f6304.
- Setia, M. S. (2016). Methodology series module 3: Cross-sectional studies. *Indian Journal of Dermatology*, 61(3), 261.
- Shenton, Andrew, K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information*, 22(2), 63–75. <https://doi.org/10.3233/EFI-2004-22201>.

- Silva, G. M. D., Couto, M. I. V., & Molini-Avejonas, D. R. (2013). Risk factors identification in children with speech disorders: pilot study. *Risk Factors and Speech Language Pathology and Audiology*.
- Smith, R. (2006). Peer review: a flawed process at the heart of science and journals. *Journal of the Royal Society of Medicine*, 99(4), 178–182.
- Somefun, O. A., Lesi, F. E. A., Danfulani, B. O., & Olusanya, B. . (2006). Communication disorders in Nigerian children, 697–702. <https://doi.org/10.1016/j.ijporl.2005.09.003>.
- Stephens, T., Owusu, N. A. V, Parchment, T., & Mckay, M. (2015). Meeting the Needs of Children and Families with Communication and other Developmental Difficulties in Accra, Ghana — An Assessment of the AwaaWaa2 Community-based Program, 111–118. <https://doi.org/10.1007/s40609-015-0033-1>.
- Stone-MacDonald, A. (2012). Cultural Beliefs about Disability in Practice : Experiences at a Special School in Tanzania. <https://doi.org/10.1080/1034912X.2012.723947>.
- Takyi, B. K., & Gyimah, S. O. (2007). Matrilineal family ties and marital dissolution in Ghana. *Journal of Family Issues*, 28(5), 682-705.
- Tarimo, H.T. (2012). Motor traffic injuries in sub-Saharan Africa. *Dar Es Salaam medical students' journal*, 19(1), 13-16.
- Theunissen, M., & Swanpoel, D. (2008). Early hearing detection and intervention services in the public health sector in South Africa. *International Journal of Audiology*,47(sup1), S23-S29. <https://doi.org/10.1080/14992020802294032>.
- Threats, T. T., & Worrall, L. (2004). Classifying communication disability using the ICF. *Advances in SpeechLanguage Pathology*, 6(1), 53-62. <https://doi.org/10.1080/14417040410001669426>.

- Topouzkhania, S., & Mijiyawa, M. (2013). A French-speaking speech-language pathology program in West Africa: Transfer of training between Minority and Majority World countries. *International Journal of Speech-Language Pathology*, *15*(1), 58–64.
- Verdon, S., Blake, H. L., Hopf, S. C., Pham, B., & Mcleod, S. (2016). Cultural and linguistic diversity in speech-language pathology. *International Journal of Speech-Language Pathology*, *18*(2), 109–110. <https://doi.org/10.3109/17549507.2015.1122838>.
- Warren, S.F. (2000). The future of early communication and language intervention. *Topics in early childhood special education*, *20*(1), 33–37.
- Wegner, L., & Rhoda, A. (2015). The influence of cultural beliefs on the utilisation of rehabilitation services in a rural South African context: Therapists' perspective. *African Journal of Disability*, *4*(1). <https://doi.org/10.4102/ajod.v4i1.128>.
- Wickenden, M. (2013). Widening the SLP lens : How can we improve the wellbeing of people with communication disabilities globally, *15*(1), 14–20. <https://doi.org/10.3109/17549507.2012.726276>.
- Wilson, D. (1987). Traditional Systems of Communication in Modern African Development An Analytical Viewpoint. *Africa Media Review*, *1*(2), 87-104.
- World Health Organization. (2003). Primary health care: 25 years after ALMA-ATA. Geneva.
- Wylie, K., Mcallister, L., Davidson, B., & Marshall, J. (2013). Changing practice: Implications of the World Report on Disability for responding to communication disability in under-served populations. *International Journal of Speech-Language Pathology*, *15*(1), 1-13. <https://doi.org/10.3109/17549507.2012.745164>.

- Wylie, K., McAllister, L., Davidson, B., & Marshall, J. (2016). Communication rehabilitation in sub-Saharan Africa: A workforce profile of speech and language therapists. *African Journal of Disability*, 5(1), 1–13. <https://doi.org/10.4102/ajod.v5i1.227>.
- Wylie, K., McAllister, L., Davidson, B., & Marshall, J. (2018). Communication rehabilitation in sub-Saharan Africa : The role of speech and language therapists. *African Journal of Disability (Online)*, 7, 1–9.
- Wylie, K., Mcallister, L., Davidson, B., Marshall, J., & Wickenden, M. (2012). Overview of issues and needs for new SLP university programs in developing countries. *In East African Confernce on Communication Disability, Kampala* (pp.12–15).
- Zadeh, A., Liabg, P, P., Poria, S., Vij, P., Cambria, E., & Morency, L.P. (2018). Multi-attention recurrent network for human communication comprehension. *arXiv preprint arXiv: 1802.00923*. Retrieved from <http://arxiv.org/abs/1802.00923>.

APPENDIX A

Participant Information statement



Department of Audiology, Speech and Language Therapy
School of Allied Health Sciences
College of Health Sciences
The University of Ghana
P.O. Box KB 143
Korle Bu

Locating and accessing services of communication disability in Ghana: A parents' perspective.

PARTICIPANT INFORMATION STATEMENT

This research is about finding and assessing services for communication disability in Ghana.

This research seeks to find out about how easy or difficult parents with children with communication disability in Ghana find services for their children.

I hope that understanding more about the ways parents find and maintain services for their children will eventually help to reduce the challenges faced by parents.

You were therefore selected as a possible participant in this study because you are a parent of a child with communication disability who attends Awaawaa2.

This research study will take 5 – 10 minutes of your time to answer a few questions. As part of this study, you will be asked to answer a few questions about the challenges and facilitators of finding services for communication disabilities.

Your participation in this research study is completely voluntary; however, you can tell the interviewer if you do not wish to continue. You can stop at anytime without any ill feeling.

Information collected in this survey will remain confidential. Results from this study may be published in an article or factsheets but no information that can identify will be published. Results from this study may also be used to support future research studies in Speech and Language Therapy.

By giving your consent to take part in this study, you are telling me that you:

- ✓ Understand what you have read
- ✓ Agree to participate in the research study
- ✓ Agree to the use of your personal information but understand that I will not collect or release any information that can identify you.

You will be offered a cool drink while completing the survey. You will not receive payment or anything for your participation.

I would appreciate your time and hope that your input in this survey will go a long way to improve services in communication disability in Ghana.

If you would like to know more after I have finished with this survey, please feel free to contact:

Leticia Afi Gomado (0244692488). If you have any complaint or concerns about the conduct of research study, kindly contact me.

THIS INFORMATION SHEET IS FOR YOU TO KEEP IF YOU WISH TO.

The study is being done by:

Leticia Afi Gomado (Speech and Language Therapy Student, University of Ghana)

This research studies will partly contribute to the degree of Master of Science in Speech and Language Therapy for Leticia Afi Gomado at the University of Ghana under the supervision of Karen Wylie (Speech and Language Therapist) and Dr. Neal Boafo (Audiologist).

APPENDIX B

Consent form



UNIVERSITY OF GHANA

Department of Audiology, Speech and Language Therapy
School of Allied Health Sciences
College of Health Sciences
The University of Ghana
P.O. Box KB 143
Korle Bu

I,..... **[PRINT NAME]**, give my consent to participate in the research project entitled **[LOCATING AND ACCESSING SERVICES FOR COMMUNICATION DISABILITY IN GHANA: A PARENTS' PERSPECTIVE.]**

In giving my consent I acknowledge that:

1. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.
2. I understand that being in this study is completely voluntary and confidential.
3. I understand that any research data gathered from the results of the study may be published. However no information will be used that can identify me.
4. I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher(s) or The University of Ghana.
5. I understand that if I have concerns about the research at any point I am able to contact the research team to discuss any issues I have:

[Leticia Afi Gomado /0244692488]

.....

Signature

.....

Please PRINT name

.....

Date

Unique Identifier (office use only): _____

Researcher:

Name of Researcher

Signature

Date

APPENDIX C

Permission Letter



UNIVERSITY OF GHANA

Department of Audiology, Speech and Language Therapy

School of Allied Health Sciences

College of Health Sciences

The University of Ghana

P.O. Box KB 143

Korle Bu

December 12, 2017

PERMISSION TO CONDUCT RESEARCH STUDY AT AWAAWAA2

Dear Mrs. Amoah,

I would like to ask permission from Awaawaa2 to allow me to conduct a survey among parents and primary caregivers of children who attend your service. This research is part of my Masters in Speech and Language Therapy at the University of Ghana. It is on the topic,

**“LOCATING AND ACCESSING SERVICES FOR COMMUNICATION DISABILITY
IN GHANA: A PARENTS’ PERSPECTIVE”.**

This research is about how families find, and continue to access, services for communication disability in Ghana. Enclosed is the draft survey questionnaire for the study, for your information.

This research will help us find out more about the processes families use to find services for their children, and understand some of the challenges they face in continually accessing early intervention services. As more services for communication disability develop in Ghana, this information will help use to ensure that:

- information about available services is provided in the places where families report looking for help and support

- barriers they face in continuing to access services may be gradually addressed

If possible, I would like to arrange to do the surveying during a one of the parent conferences or training events that you hold at the centre. Each survey would take parents who wish to participate approximately 10 minutes. Participation would be voluntary. Information collected in this survey will remain confidential. The study will receive ethical approval from the University of Ghana's Ethics and Protocol Review Committee. I will provide a copy of the ethical clearance to you before we do the survey. We would provide an information sheet on the research that you could send to parents before the day, so they understand what the research is about.

If you would be interested in greater detail, a copy of the final dissertation can be made available to you. If you agree that I could conduct this study at your centre, kindly sign below acknowledging your consent and permission for me to conduct this research at AwaaWaa2.

Thank you for considering this request. I greatly appreciate your time.

Sincerely,

Leticia Afi Gomado
Speech and language therapy student.

Supervised by:

Karen Wylie
Speech and Language Therapist
University of Ghana

Dr. Neal Boafo
Audiologist
University of Ghana

Approved by:

Signature

Printed name

Date

Table 4: Shows how questions were analyzed

Question No.	Question	What information does it give me	Quantitative / Qualitatively	How did I analyze this data?
1	How long has your child been coming to the centre? Tick the one that best applies	Duration of attending the early intervention centre.	Quantitative	Categorical
2	What was the original concern with your child which brought you to AwaaWaa2?	Concerns of parents	Qualitative	
3	How old was your child when he came here?	Age of admission	Quantitative	Mean, median and mode
4	How old is your child now?	Current age	Quantitative	Graphical presentation + Mean, median and mode
5	Does your child have a diagnosis of a particular condition which affects the communication development: Y/N – if yes, could you please tell me the condition?	Medical diagnosis of the child.	Qualitative	

6	I will ask you to think back to when you were looking for help and try to remember them in the order you went to them. Who and where did you go to before you came to AwaaWaa2?	Qualitative		
7	Was there a particular person who referred you or suggested you come go to AwaaWaa2?	The kind of people(professionals) involved	Qualitative	
8	Did you hear about AwaaWaa2 at a particular place?	Places	Qualitative	
9	Was your child seen by a Speech and Language Therapist before going to AwaaWaa2? If yes.	Seen by a speech and language therapist	Quantitative	Categorical
i	Where	Places	Qualitative	Content analysis
ii	When? (before or after referral)	Before or after referral	Quantitative	Categorical
iii	Who sent you to the SLT or how did you find out about the SLT?	Professionals involved	Qualitative	

10	Are there other things that you think may have helped you to discover these services for your child?	Facilitators to finding services	Qualitative	Content analysis
11	What were some of the things that made it challenging to find the right services for your child?	Barriers to finding services	Qualitative	Content analysis
12	What are some of the challenges you face in being able to continue receiving services for your child?	Barriers to continuing services	Qualitative	Content analysis
13	What HELPS make it possible to keep bringing your child for regular services?	Facilitators to continuing services	Qualitative	Content analysis
14	What are your ideas about things which could be done to make it easier for families to FIND services?	Future facilitators to finding services	Qualitative	

15	What are your ideas about things which could be done to make it easier for families to CONTINUE services?	Future suggestions to continuing services	Qualitative	
	Age		Quantitative	
	Gender		Quantitative	
	Child's communication difficulty		Qualitative	
	Number of living children		Qualitative	
	Birth order of child attending the centre (living children)		Qualitative	
	Educational level		Qualitative	
	Current employment		Qualitative	

APPENDIX D



UNIVERSITY OF GHANA SCHOOL OF BIOMEDICAL AND ALLIED HEALTH SCIENCES

30th January, 2018.

Ref. No.:

Ms. Leticia Afi Gomado
Dept. of Audiology, Speech and Language Therapy,
SBAHS,
Korle Bu.

Dear Ms. Afi Gomado,

ETHICS CLEARANCE

Ethics Identification Number: SBAHS – ASLT. //AA/5A/2017-2018.

Following a meeting of the Ethics and Protocol Review Committee of the School of Biomedical and Allied Health Sciences held on Tuesday 30th January, 2018. I write on behalf of the Committee to approve your research proposal as follows:

TITLE OF RESEARCH PROPOSAL: “LOCATING AND ACCESSING SERVICES FOR COMMUNICATION DISABILITY IN GHANA: PATIENTS’ PERSPECTIVE”

This approval requires that you submit three-monthly review reports of the protocol to the Committee and a final full review to the Committee on completion of the research. The Committee may observe the procedures and records of the research during and after implementation.

Please note that any significant modification of the research must be submitted to the Committee for review and approval before its implementation.

You are required to report all serious adverse events related to this research to the Committee within seven (7) days verbally and fourteen (14) days in writing.

As part of the review process, it is the Committee’s duty to review the ethical aspects of any manuscript that may be produced from this research. You will therefore, be required to furnish the Committee with any manuscript for publication.

This reviewed report is valid till 31st. August, 2018

Please always quote the ethical identification number in all future correspondence in relation to this protocol.

Thank you.

Yours sincerely,


Dr. S. D. Amanquah
(Chairman, Ethics and Protocol Review Committee)

Cc: Dean
School Administrator
Head, Dept. of Audiology, Speech and Language Therapy

COLLEGE OF HEALTH SCIENCES

• Telephone: +233 (0) 302 687 975 P. O. Box KB 143, Korle Bu, Accra, Ghana. • Email: sbohs@chs.ug.edu.gh • Website: www.chs.ug.edu.gh

APPENDIX E

Questionnaire



Department of Audiology, Speech and Language Therapy
School of Allied Health Sciences
College of Health Sciences
The University of Ghana
P.O Box KB 143
Korle Bu

SURVEY

You have a child who attends AwaaWaa2 for early intervention. To begin with, I would like to understand a little about your child, and why they come to the centre:

1. How long has your child been coming to the centre? Tick the one that best applies.

Less than 6 months

More than 2years but less than 2.5years

7 months – 12 months

More than 2.5 but less than 3years

More than 1 year – 18 months

More than 3 years

More than 18 months – 2 years

2. What was the original concern with your child which brought you to AwaaWaa2?

.....

3. How old was your child when he came here?

.....

4. How old is your child now?

.....

5. Does your child have a diagnosis of a particular condition which affects the communication development: Y/N – if yes, could you please tell me the condition?

.....
.....
.....

SECTION 2: FINDING SERVICES

In the next section, I am interested in understanding how people find the services they need for their children.

We know that it not always easy for parents to find the services they need. I would like to understand more about how **YOU** and your child came to find AwaaWaa2.

1. I will ask you to think back to when you were looking for help and try to remember them in the order you went to them. Who and where did you go to before you came to AwaaWaa2?

.....
.....
.....

2. Was there a particular person who referred you or suggested you come go to AwaaWaa2?

.....

3. Did you hear about AwaaWaa2 at a particular place?

Doctors

Teacher

Religious leaders

Family members

Radio

Health Service

Other

4. Was your child seen by a Speech and Language Therapist before going to AwaaWaa2?

YES

NO

If yes,

I. Where?

.....

II. When? (before or after referral)

.....

III. Who sent you to the SLT or how did you find out about the SLT?

.....

5. Are there other things that you think may have helped you to discover these services for your child?

.....
.....
.....

6. What were some of the things that made it challenging to find the right services for your child?

.....
.....
.....

SECTION 3: CONTINUING TO ACCESS SERVICES

We know that some people find it difficult to keep bringing their children for services. In this section, I am interested in both the things that **YOU** have found that make it difficult to bring your children for services and what makes it possible or easier.

- 7. What are some of the challenges you face in being able to continue receiving services for your child?

.....
.....
.....

- 8. What **HELPS** make it possible to keep bringing your child for regular services?

.....
.....
.....

SECTION 4-THE FUTURE

As services develop in Ghana, we would like to make it easier for families to find the services they need and be able to access ongoing services.

- 9. What are your ideas about things which could be done to make it easier for families to **FIND** services?

.....
.....
.....

- 10. What are your ideas about things which could be done to make it easier for families to **CONTINUE** services?

.....
.....

Lastly, I would like to gather some information about you.

Age:.....

Gender: Male Female

Child's communication difficulty:.....

Number of living children:.....

Birth order of child attending the centre (living children):.....

Educational level:.....

Current employment:.....