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EXPERIENCE OF YOUNG PEOPLE WITH DISABILITIES ACCESSING SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN KORLE KLOTTEY IN THE GREATER ACCRA REGION

BY

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DECLARATION

I, Edmund Mawusinu Yao Agbeve, do hereby declare that this thesis is the result of my research. This research was carried out under the supervision of Dr. Franklin Glozah of the Department of Social and Behavioural Sciences of the School of Public, University of Ghana. This work has not been submitted either in part or in whole elsewhere for the award of any other degree. All references cited in this work have been duly acknowledged.

11th August, 2022

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EDMUND MAWUSINU YAO AGBEVE DATE

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DR. FRANKLIN GLOZAH DATE

(SUPERVISOR)

DEDICATION

This dissertation is dedicated to the Almighty God for guiding me through this programme and to Dr. Erma Manoncourt for her financial support and guidance; you made this dream of mine possible.

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ABSTRACT

Background: There are misconceptions regarding the sexuality of people with disabilities, which can make it difficult for them to form connections with others, particularly those of the opposite sex. The negative attitudes of healthcare staff towards persons with disabilities seeking information on sexual and reproductive health services adds to the stereotypes about the sexuality of people with disabilities.

Objective: The main objective of the study was to assess factors associated with access to SRH services among young people with disabilities.

Methods: A qualitative study was conducted to explore the experience of young people with disabilities ability to access sexual and reproductive health services. Purposive sampling and Convenience sampling procedures were used to select 26 participants. The study used Focus Group Discussions which aided in generating ideas and opinions from the participants. NVivo 10 software was used for data analysis.

Results: Young people with disabilities reported knowing about and using Sexual and Reproductive Health services such as contraceptives; however, they were reliant on others to accompany them to service providers, limiting their access to confidential services. Financial barriers, provider attitudes, and accessibility due to their disability were the most significant barriers to SRH services.

Conclusion: Young people with disabilities are aware of what they require, but they are unable to obtain it due to a variety of constraints. The attitude of health service providers remains a major challenge; cost limits their ability to access SRHS; and communication is a barrier, particularly for those with hearing impairments who are unable to communicate with service providers in sign language

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LIST OF ABREVIATIONS

AIDS – Acquired Immune Deficiency Syndrome

DALYs – Disability Adjusted Life Years

GFD – Ghana Federation of Disability Organisations

HIV – Human Immune Deficiency Virus

ICPD25 – International Conference for Population and Development 25

PWDs – Persons with Disabilities

SRH – Sexual Reproductive Health

SRHR – Sexual Reproductive Health and Rights

SRHS – Sexual Reproductive Health Service

STIs – Sexually Transmitted Infections

UN – United Nations

UNFPA – United Nations Population Fund

UNICEF – United Nations Children’s Fund

WHO – World Health Organisation

YPWDs – Young People with Disabilities

CHAPTER ONE

INTRODUCTION

1.0 Background

According to the State of the World's Population report 2014 produced by the UN Population Fund, there were 1. 8 billion young people aged 10 to 24 years old, with the poorest countries experiencing a youth bulge (Das Gupta et al., 2014).

The International Conference on Population and Development (ICPD25), held in Nairobi, Kenya in 2019, reiterated young people's exceptional needs and vulnerabilities; the conference also called for access to an inclusive and age-appropriate information, education, and young people-friendly comprehensive, excellent, and timely services for all adolescents and youth, particularly girls, to enable them to decide on their choices about their sexuality and racial identity. It also called for the adoption of integrated and broad approaches to reproductive health. Furthermore, the ICPD25 highlighted the importance of removing social obstacles that prohibited young people from receiving reproductive health services, as well as programmes and policies that met the demographic realities of young people (UNFPA, 2019).

Sexually transmitted infections (STIs) were very common in teenagers and young adults, with reported cases of syphilis, gonorrhea and chlamydia increasing in recent years; receiving good-quality reproductive health information and STI care that would protect them against STIs or reduce the symptoms of an infection was challenging for them due to a variety of barriers (Keller, 2020).

The UN estimated that globally almost 180 million of young people in the age bracket 10 -24 suffered from a form of disability, and a vast majority of these young people (150 million) lived in developing countries (Groce et al., 2014).

Injuries such as those caused by car accidents, falls, fires, and acts of violence such as child abuse, juvenile violence, intimate partner violence, and war and conflict account for a large portion of disabilities (World Health Organization, 2005). The UN Children's Fund (UNICEF) study in 2006 indicated that young people under 18 participated in armed conflicts and over 300 million young people lived in countries affected by armed conflicts and warfare. Young people with disabilities were said to be part of the poorest and most disregarded of the entire global population. They faced social isolations, poverty and discrimination. Despite the rights guaranteed to them by laws they often lacked basic health care and were not allowed to attend school or to find work. Compared to their non-disabled peers, they were at greatly increased risk of physical and psychological abuse and sexual exploitation.

In many places, societies held the belief that young people with disabilities were asexual and or could not be abused; there were misconceptions regarding the sexuality of people with disabilities, which can make it difficult for them to form connections with others, particularly those of the opposite sex. People also believed that people with disabilities were sexually impotent and asexual, and hence don't feel sexual desire; the negative attitudes of healthcare staff against women with disabilities seeking information on sexual and reproductive health services were adding to the stereotypes about the sexuality of people with disabilities (Peta, 2017).

Access to sexual and reproductive health information was often not available to them, where available they were unable to access them due to provider's inability to communicate with them or lack of disability friendly facilities. There were very few educational programs that catered to the reproductive health needs of young people with disabilities. For example, in several countries, young people with disabilities frequently did not receive HIV/AIDS advice because facilities were physically inaccessible, materials were not available for those with visual impairments, and providers were unable to communicate in sign language. Furthermore, the majority of health care professionals are unaware of disability issues and, as a result, are unwilling or unable to address them, Yousafzai, et al, 2005 as cited by (Groce et al., 2014). The lack of social acknowledgment of their sexuality had several negative consequences for them. Parents may not acknowledge their children as sexual beings and discouraged them from expressing any form of sexuality (Menon & Sivakami, 2019).

1.1 Problem Statement

The Population and Housing Census of 2010 in Ghana, indicated that three percent of the country's population had various forms of disability. Two percent of that population are said to be young people (Ghana Statistical Service, 2013). A disaggregated data of the 2010 Population and Housing Census of children, adolescent and young people indicated the following: between the ages of 0 and 9 years a disability was reported by 1.4 percent of males and 1.3 percent of females, respectively. The report further revealed that among adolescents 1.7 percent of adolescent boys aged 10-14 and 1.9 percent of adolescent males aged 15-19 had some form of disability, respectively. The numbers were 1.6 percent and 2.0 percent, among female teenagers of the same ages.

The report showed that though the same number of youth aged 20-24 years stated some form of disability (2.1%) in both men and women, the proportion in the 25-35 age range was slightly higher, with 2.6 percent of males and 2.4 percent of females reporting some sort of disability (Ghana Statistical Service, 2013).

When compared to young people in developed countries, young people in developing countries had a higher disease burden and mortality rate (Mokdad et al., 2016). SRH issues contributed a substantial percentage of disability-adjusted life years (DALYs) in youth; with the highest disability recorded with disability– adjusted life years for age group 10 -24 years in Sub Saharan Africa (Fatusi, 2016).

Globally, universal healthcare is regarded as an essential human right. To that end, international laws exist to protect the rights and well-being of people with disabilities (PWDs).

Young disabled people, in particular, are more likely to face discrimination and prejudice than their peers without disabilities (Ganle et al., 2020; Mitra et al., 2013). Largely, in the perspective of sexual and reproductive health and rights they are neglected (Morrison et. al., 2014). There was also evidence that young people with disabilities faced hurdles when seeking sexual and reproductive health services (Ganle et al., 2020). Some studies have also focused on health care barriers confronting persons with disabilities (Badu et al., 2016). People with disabilities were frequently denied the opportunity to live sexually healthy lives; they faced structural barriers which prevented them from expressing their sexuality and accessing SRH services. According to a study of young people with hearing and visual impairments in Ghana, 87 percent of respondents reported encountering an impediments in their pursuit for SRHS; the study also revealed that young people aged 20-24 reported the highest percentage of barriers to SRHS access (88 percent) of any age group (88 percent hearing impaired and 88 percent visually impaired).The same proportion of males and females (87%) said they had ever encountered a barrier in obtaining SRHS, (Seidu, 2020). According to the study, the high cost of health care was the most pressing issue for 29 percent for men (27 percent deaf and 45 percent blind) and 27 percent of women (27 percent deaf and 29 percent blind). Physical impediments were identified as a challenge by 28% of men (28% deaf and 36% blind) and 23% of women (22 percent deaf and 28 percent blind) (Seidu, 2020).

Seidu, 2020, in his study reported that for young people with disability who had never used SRHS before stated that their reasons for non-use were communication issues (56 percent) and physical impediments (21 percent). Only 9.6% said distance to service location was the reason they did not use it. The study revealed that, 27 percent of respondents (27 percent of men and 29 percent of women) have sought STI treatment at some point in their lives. 14 percent of males (28 percent hearing impaired and 37 percent visually impaired) reported using contraception at some point in their lives. Thirty-one percent of the men (31 percent deaf and 32 percent blind) reported having received HIV testing and counseling. Females stated that they sought HIV testing and counseling 16% of the time (16 percent hearing impaired and 11.8 percent vision impaired).

While some SRH research in Ghana has been centered on the disabled, others have only paid attention to people with hearing impairment (Mprah, 2013). Other studies have considered them in the context of disabled women as well (Ganle et al., 2020), with some paying attention on the health barriers that people with disabilities face (Eric Badu, Peter Agyei-Baffour, 2015), service providers' attitude (Badu et al., 2016) and attitudes toward sexual and reproductive health challenges (Mprah, 2013).

Despite the increasing amount of research on SRH concerns in Ghana, not enough research on the usage of Sexual Reproductive Health Services amongst young persons with visual, hearing, and mobility disabilities has been conducted in a single study.

1.2 Research Questions

1. What are the experiences of young people with disabilities with access to SRH services?
2. What are the challenges associated with accessing SRH services among young people with disabilities?
3. How do young people with disabilities experience satisfaction with access to SRH services?

1.3. Research Objectives

The foremost objective of this study was to assess factors associated with access to SRH services amongst young people with disabilities in the Korle Klottey Municipal of the Greater Accra Region.

The specific objectives of this study are:

1. To explore the experiences of young people with disabilities on accessing SRH services.
2. To identify the challenges associated with accessing SRH services among young people with disabilities.
3. To explore how young people with disabilities experience satisfaction with access to SRH services?

1.4. Significance of the study

This study could help fill the gap in research by using qualitative research methodology to understand the experiences of young people with disabilities access to reproductive health services (visual, hearing and mobility disability). These findings also have the potential to have a big impact on policy. The conclusions of this study may have various policy implications. First, it has the potential to inform policymakers about the Sexual Reproductive Health and Rights needs of young people with disabilities, which could aid the development of programmes tailored to their needs. Addressing this marginalised group's Sexual Reproductive Health and Rights requirements can help to favourably impact their behaviour. It will further provide an opportunity to persuade policymakers to design policies and interventions that can provide young people with disabilities with special knowledge of their rights. On this premise, initiatives focusing on specific area of discipline can be developed and communicated with them.

1.5. Justification

There are misconceptions about people with disabilities' sexuality, which can impede their relationships with others, particularly those of the opposite sex. People also have the misconception that people with disabilities are sexually impotent and asexual, and thus do not experience sexual attraction. The negative attitudes of healthcare personnel toward women with disabilities seeking information on sexual and reproductive health services contribute to the myths about the sexuality of people with disabilities (Peta, 2017).

Peta (2017), further posits that some healthcare providers still have cultural perceptions of disability and believe that people with disabilities are asexual. As a result, they anticipate that people with disabilities who visit health care facilities will only report issues related to their disability. This makes it difficult for some people with disabilities to access healthcare, particularly when it comes to reproductive health. Persons with disabilities are considered the world's largest minority group, so issues affecting them would have direct and indirect effects on the individual, family, society, and country as a whole. However, people with disabilities face discrimination in many aspects of their daily lives, making them vulnerable to neglect and stigma, which can exacerbate the disability's impact on their psychosocial well-being (Warner & Adams, 2016).

To be able to develop practical policies to address the barriers that young people with disabilities face in accessing sexual and reproductive health, knowledge of these barriers is required, which must be contextualised in order to provide contextual and feasible solutions. As a result, this study will contribute to the generation of relevant evidence that can be used to design interventions to address the barriers to accessing SRH services among young people with disabilities. This evidence could be used to improve the development of context-specific interventions to meet the SRH needs of young people with disabilities. This research will also contribute to existing knowledge.

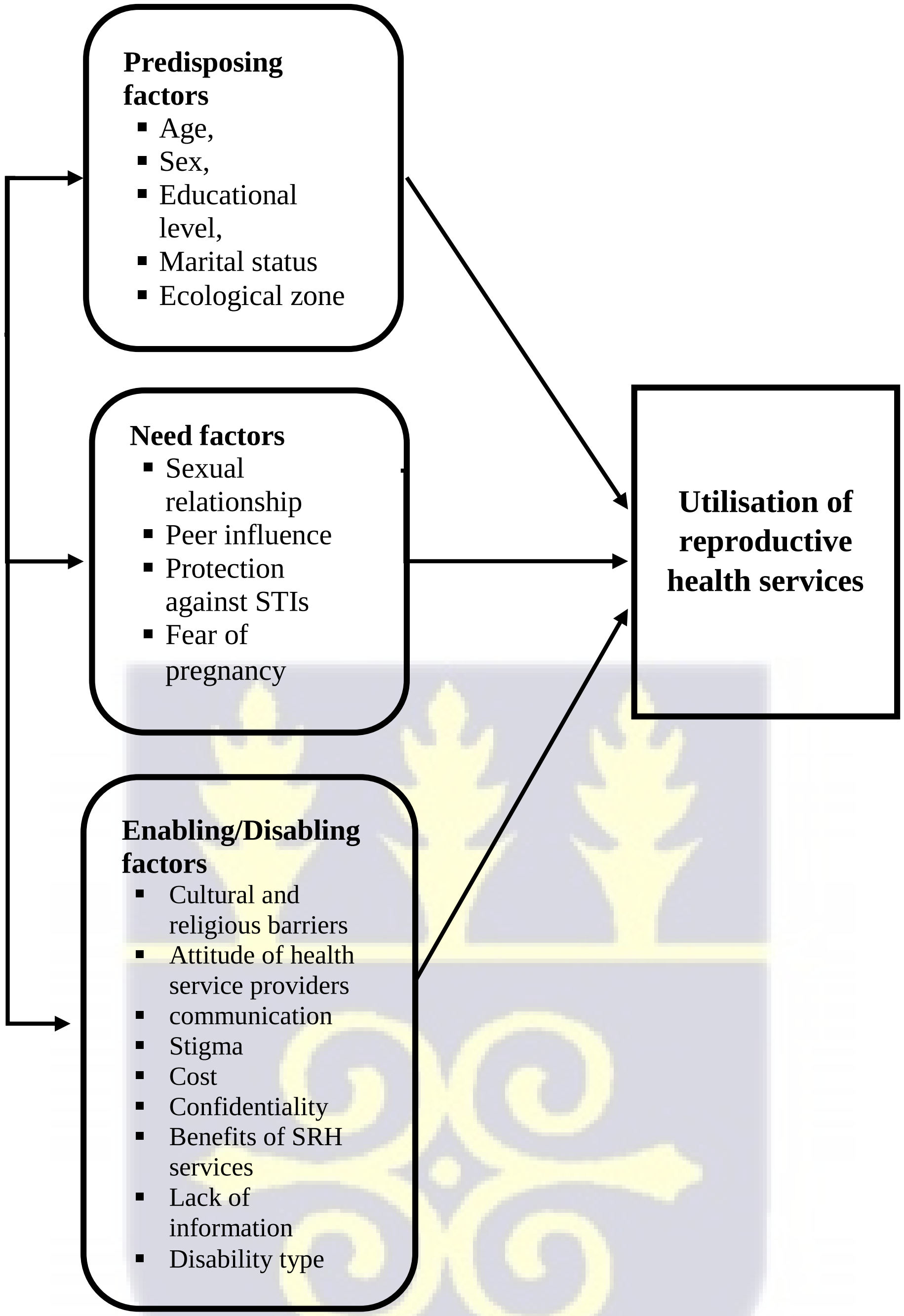
1.6. Conceptual Framework

Figure 1 is a conceptual framework summary illustrating potential barriers to the utilisation of reproductive health services among young people with disabilities. The conceptual framework attempts to link the various factors that are likely to influence YPWDs' access to SRH. The barriers are broadly classified into three categories. The categories include predisposing factors, needs factors, enabling and disabling factors.

Predisposing factors are essentially an individual's demographic characteristics, that is, specifically gender and age as "biological imperatives." (Andersen & Davidson, 2014); religion, education, ethnicity, health attitude, and social relations (such as family status) are examples of reasons that influence health habits, (example, principles, behaviours, health and its related service awareness) (Andersen, 1995; Andersen, 2008); Community social and demographic structure, organisational and mutual beliefs, political and contextual factors, such as social and political viewpoints and cultural norms, all of which influence individuals to consume health services. The model’s enabling factors are defined as external to the individual but impactful in their decision to use health services. Organisational and financial issues are conditions that allows the use of health services (Andersen & Davidson, 2014; Babitsch et al., 2012). These issues have an impact on both the person and the experiential levels. Individual funding considerations include an individual's wealth and wages, as well as the effective cost of medical care, which is decided by premium and the person's health coverage status (Andersen, 2008). Admission to a consistent source of treatment, as well as care quality, are governed by individual organisational considerations. They also consider the time it takes to get to the health centre, the mode of transportation used, and the time it takes to receive medical attention. The state of one's health and the need for medical care to improve or maintain one's health are major determinants of health care utilisation. The ability to access care including whether it is available, quick and convenient, and affordable should ideally be the primary predictor of healthcare consumption, but other factors also play a role. The term "access" is frequently used to describe conditions or characteristics that influence initial contact with or use of services. Even if care is available, a variety of factors can influence how easily it is obtained; independent of need, a variety of factors influence health care utilisation. Some of the characteristics reflect biological or environmental differences between population groups, such as disproportionate living in polluted environments, access to nutritious food and appropriate housing, and education linked to more effective health-care usage (National Academies of Sciences Engineering and Medicine, 2018).

This model was selected because of its multilevel principle that allows the study to determine both individual and situational factors influencing the use of reproductive health services by Ghanaian youths with disabilities.

Figure 1: Conceptual framework showing factors to utilisation of reproductive health services among young people with disabilities



Conceptual framework adapted from Seidu, 2020

CHAPTER TWO

LITERATURE REVIEW

2.0. Introduction

This section presents relevant related literature on the subject under study by researching various books and journal articles.

2.1. Concept of Disability

Disability issues are complex, dynamic, multifaceted, and contentious topic, according to (WHO, 2011). The concept of disability is severally contested; this has fuelled contentions over disability models. Nonetheless, many definitions agreed to by medicalised professionals and legal bodies finds commonalities in United Kingdom legislation. *“someone who has a physical or mental impairment that has a substantial and long-term adverse effect on his or her ability to carry out normal day-to-day activities”* (Scullion, 2014). Historically, disability has been defined in general nursing as a medical condition or illness that deviates from biological or social norms, resulting in dependency (Scullion, 2014).

The United Nations Statement on the Rights of the Disabled describes: *a person with disability “as any person unable to ensure himself or herself, wholly or partly, the necessities of a normal individual and/or social life, as a result of deficiency, either congenital or not, in his or her physical or mental capabilities.”*

Individuals in the United States of America were classified as disabled in the year 2000 if they had a long-term condition such as impaired vision, hearing, or loss of vision, a situation that significantly limited one or more basic physical activities such as walking up stairs or walking, or a psychological issue, a minimum period of 6 months that produced difficulty with education, attentiveness, cleaning, dressing, or moving around the house (Waldrop & Stern, 2003).

Debates about what disability is or is not and how it should be measured continue to rage in the fields of philosophy, health, and the social sciences. However, agreement has been reached, as evidenced by the International Classification of Functioning, Disability, and Health (ICF, 2001) and the United Nations Convention on the Rights of Persons with Disabilities (UN Convention on the Rights of Persons with Disabilities) (2006). The ICF and the Convention define disability as the result of complex interactions between a person's health conditions and aspects of their physical, social, and psychological environment that impede their full and effective participation in society. A person(s) with a disability is defined as someone who is unable or limited in their ability to perform specific activities/tasks due to the loss of function of some body part as a result of impairment or malformation (Ghana Statistical Service, 2014).

2.2. The Global Situation of Disability

According to the World Health Organisation and the World Bank's first World report on disability, more than a billion people worldwide are disabled today. According to 2010 population estimates - 6.9 billion, with 5.04 billion aged 15 and over and 1.86 billion aged under 15 - and 2004 disability prevalence estimates (World Health Survey and Global Burden of Disease), there were approximately 785 (15.6 percent) to 975 (19.4 percent) million persons 15 years and older living with disability. Around 110 (2.2%) to 190 (3.8%) millions of these people had significant functional difficulties. Over a billion people (or roughly 15% of the world's population) are estimated to be disabled, including children.

People with disabilities have poorer health outcomes, less access to education and employment opportunities, and are more likely to be poor than those without disabilities. People with disabilities frequently do not receive the necessary health care services. According to research, half of people with disabilities cannot afford health care. People with disabilities are also more than twice as likely to believe that health care providers' skills are insufficient.

While disability is associated with disadvantage, not all people with disabilities are equally disadvantaged. Much depends on where they live and whether they have equal access to health, education, and employment, among other things. There has been significant progress in making the world more accessible for people with disabilities, but much more work is needed to meet their needs. However, few countries have adequate mechanisms in place to fully address the health priorities and needs of people with disabilities.

The report further indicates that because of its bidirectional relationship with poverty, disability is a development issue: disability may increase the risk of poverty, and poverty may increase the risk of disability. A growing body of empirical evidence from around the world indicates that people with disabilities and their families are more likely than those without disabilities to face economic and social disadvantage. Disability can worsen social and economic well-being and poverty through a variety of channels, including the negative impact on education, employment, earnings, and increased disability-related expenditures. Children who are disabled are less likely to attend school, resulting in fewer opportunities for human capital formation and lower employment and productivity in adulthood.

People with disabilities are more likely to be unemployed and earn less money even when they are employed. The severity of the disability appears to worsen both employment and income outcomes. People with disabilities have a more difficult time benefiting from development and escaping poverty due to employment discrimination, limited access to transportation, and a lack of resources to promote self-employment and livelihood activities. Persons who are disabled may incur additional costs as a result of their disability, such as those associated with medical care or assistive devices, or the need for personal support and assistance, and thus frequently require more resources to achieve the same outcomes as non-disabled people because their households are likely to be poorer than non-disabled people with comparable incomes due to higher costs. Households with a disabled member are more likely to face material hardship, such as food insecurity, substandard housing, a lack of access to safe drinking water and sanitation, and insufficient access to health care.

Poverty may increase the likelihood of disability. A study of 56 developing countries discovered that the poor had worse health than the wealthy. Poverty can cause the onset of health conditions associated with disability, such as low birth weight, malnutrition, a lack of clean water or adequate sanitation, unsafe work and living conditions, and injuries. Poverty may increase the likelihood that a person with an existing health condition will become disabled, for example, due to an inaccessible environment or a lack of access to appropriate health and rehabilitation services.

Despite the widely acknowledged link between disability and poverty, efforts to promote poverty alleviation and development reduction have not always included disability adequately.

2.3. Disability in Africa

As life expectancy rises, so do the rates of disability caused by the diseases; the World Disability Report published by WHO in 2011, the prevalence of severe and moderate disability is higher in Africa than in many other regions of the world, particularly among younger (60 years) people. Although there is limited evidence in the literature, it is assumed that the causes are related to infectious diseases and injuries. According to several publications, the prevalence of disability in the general population ranges from 1.7 percent in Mali (14) to 17.1 percent in Sierra Leone (15).

The prevalence of disability in Cameroon was recently estimated in a survey of 1,617 adults aged 18 and up. A study in a Cameroonian health district found that many disabilities, such as orthopaedic problems (primarily fractures), infectious diseases, and neurological disabilities (primarily hemiplegia, hemiparesis, and monoplegia), were caused by traffic accidents and ineffective medical interventions. Congenital abnormalities, trauma, polio, and leprosy were reported to be the most common causes in Mali, whereas mental health disabilities were linked to war and postwar experiences in Liberia (Cannata et al, 2022).

Young people with disabilities (YPWD) frequently face higher levels of discrimination and severe social, economic, and civic disparities than their non-disabled peers. Exclusion, isolation, and abuse, as well as a lack of educational and economic opportunities, are all too common for many young people. Their fundamental rights are frequently violated, and societal acceptance is frequently out of reach. People with disabilities have worse health outcomes, lower educational attainment, lower economic participation, and higher poverty rates than non-disabled people. One reason for this disparity is that people with disabilities face barriers to service access. These challenges are exacerbated in underserved communities.

Adolescents and young people in Ethiopia are generally more vulnerable to sexual and reproductive health (SRH) issues. Despite these enormous challenges, they have limited access to high-quality sexual and reproductive health services. Even when compared to other African countries, young Ethiopians' health seeking behaviour is very limited, particularly in terms of sexual and reproductive health. Some of the behaviours and challenges can be attributed to a lack of youth-friendly services that assure confidentiality, service providers' biases against this segment of the population, and a lack of community awareness. YPWD in Ethiopia, like in other developing countries, are more likely than the general population to be illiterate, unemployed, and impoverished. They frequently lack equal access to information and education for a variety of reasons ranging from physical access to classrooms and service areas to varying special learning needs. There is also a scarcity of useful, youth-friendly, and easily accessible information about sexuality and relationships for YPWD. Furthermore, there aren't enough positive, open, and respectful spaces for YPWD to talk about disability and sexuality/relationship issues. In turn, a lack of access to training and educational programmes impedes the development of qualified personnel (Kassa et al, 2016).

In a study in Zimbabwe, the findings showed that all women with disabilities who have given birth to a child or children faced enormous challenges in childbearing; participants who had no prior childbearing experiences at the time of the study aspire to have biological children of their own. Persons with disabilities' sexuality is commonly regarded as communally problematic, a practise that in and of itself is a symbol of discrimination (Peta, 2017).

A study in Uganda found that the main challenges that PWDs face when attempting to access SRH services in Kampala are poor physical accessibility, negative attitudes of health workers, and long queues at health facilities. High service costs, as well as the fact that health workers are unfamiliar with, or even fearful of, PWDs. It is worth noting that female PWDs faced these challenges at a higher rate than their male counterparts (and this is true across all challenges). For example, while only 55% of males reported poor physical accessibility as a barrier to accessing SRH services, 80% of females reported the same. Similarly, while only 50% of male PWDs reported negative attitudes of health workers as a barrier to accessing SRH services, 75% of females reported the same challenge (Ahumuza et al, 2014).

2.4. Types of Disability

The nature of the impairment is used to classify disabilities. Far or near sightedness, which occurs when a person has difficulty in seeing far or close objects, or when an individual is incapable seeing completely, is an example of visual impairment. The severity of the condition varies; many people with this disorder can get spectacles or contact lenses, which solves the problem and allows them a good vision (Crow, 2008).

Complete and partial blindness, which occurs when a person loses sight in an eye or both, is another type of impairment. Crow classifies colour blindness as a mild disability. Deafness is defined as a partial or total inability to hear; it is classified as a disability and is classified into two categories: hard of hearing and deaf. Hearing impairment is defined in India's Rights of Persons with Disabilities Act, 2016 as – "*Deaf*" *"means persons having 70 dB hearing loss in speech frequencies in both ears. "Hard of hearing" means person having 60 dB to 70 dB hearing loss in speech frequencies in both ears"*(John, 2020).

Physical disability is a type of disability in which a person's or persons' movement is limited. This can happen as a result of limb or body part damage, paralysis, or other types of impairment of that limit mobility. Assistive technologies such as wheelchairs and crutches are used to help them get from one end of the room to the other (McDaniel, 2013).

Multiple Disabilities refers to the occurrence of two or more incapacitating situations that impede learning or other important life functions at the same time. These impairments could be a combination of motor and sensory in nature (Hess-Klein, 2017).

2.5. Disability in Ghana

The dilemma of people with disabilities was brought to light in 1943, when the 37th General Military Hospital in Accra was established. The purpose of the unit's formation was to reintegrate African soldiers who had been injured during WWII; in 1947, volunteer organisations took over this programme (Badu et al., 2016).

The state took over the functional aspect of the work in 1950; the advocacy aspect was left to the voluntary organisations at the time (Grischow, 2006)

Grischow (2006), claims that after the 'John Wilson' report revealed that 100,000 Ghanaians were disabled, the government launched a massive registration programme in 1960. The registration results informed the government of the day about the need to establish several rehabilitation units and special education programmes across the country to meet the special learning needs of people with disabilities. Dr. Kwame Nkrumah launched the programme to aid the country's effort to reintegrate people with disabilities into the labour force (Grischow, 2006). In 1969, a Legislative Instrument (632) which regulated labour was approved to end discrimination against people with disabilities. The law made job allocation for people with disabilities mandatory in all offices across the country; a 0.5 percent quota was set aside in all offices, according to the Danish Council of Organisations of Disabled People in 2006.

The Disability Policy of 2000 was created to address the needs of people with disabilities. It aimed to ensure that PWDs received adequate training, technical aids, and support services that would improve their ability to engage in tasks and challenges in a dignified manner. The policy's main goal was to guarantee that by 2020, PWDs were actively involved in the national development process through equal opportunities that would improve their lives. The policy also aimed to raise public awareness about the rights of people with disabilities. The National Disability Policy was unable to achieve many of its goals due to a lack of appropriate legal backing. However, the policy paved the way for the Disability Act of 2006 (Act 715), (Ghana Statistical Service, 2014).

2.5.1. The Disability Act 2006 (Act 715)

The disability Act (Act 715) was approved by Parliament in 2006; six years after the adoption of the National Disability Policy. The Act gives an opportunity to PWDs, civil society organisations and Ghanaian people in general, to interact with government through advocacy, lobbying, and political pressure that will make government and other duty-bearers as stated in the law responsive (Ghana Statistical Service, 2014).

The Act has eight major sections all aimed at advancing the course of PWD in the country:

"Section one of the act provides for the rights of PWD, section two focuses on employment, section three looks at education for PWD, section four concentrates on transportation and five on health. The sixth section of the Act focuses on miscellaneous provisions while the seventh and eighth sections talk about the establishment of the National Council for Disability and its administrative and financial provisions" (Ghana Statistical Service, 2014).

The National Council on Persons with Disability was established when the Act came into force. The role of the council is to propose policies and strategies that will enable PWDs enter and actively participate in national development processes. Officially inaugurated in 2009, it is supposed to coordinate all disability related activities; serve as watchdog and monitor the implementation of the Act (Ghana Statistical Service, 2014).

2.5.2. Associations of Persons with Disability

The movement to sustain conversations on disability in Ghana started before 1963. The movement was often founded and led by expatriates. By 1963 the disabled themselves decided to establish self-help groups which would help them express themselves, share their concern, needs and aspirations. With increased interest in disability issues at all levels; there was a shift from advocacy towards a mixed of service delivery and advocacy in the early 1980s. the increased interest led to the formulation of basic principles, and human rights oriented declarations and policies.

The Federation of Disability Associations (FODA) was the first disabled umbrella body to be established in 1987, the Norwegian Association of the Disabled (NAD) and Disabled People International (DPI) supported in its formation. The group later changed its name to the Ghana Federation of Disabled People (GFD).

Founded in 1987, it is the national umbrella organisation of PWDs; its current membership is made up of the Ghana Association of the Blind (GAB), Parents Association of Children with Intellectual Disability (PACID), Society of Albinos Ghana (SOAG), Ghana Society of the Physically Disabled (GSPD), and Share Care Ghana – for people with neurological difficulties, Ghana National Association of the Deaf (GNAD) (Slikker, 2009). GFD commenced work with a branch in Accra, the federation began to receive complains from its member organisations in 2007 and 2008 that it was unable to fulfill its role as an umbrella organisation because of its concentration on international policies and activities. The members averred the umbrella organisation lacked awareness of the needs of PWDs at the grass root level as a consequence of its focus on international activities and policies. GFD admitted this problem and undertook a decentralisation process; it currently has about 20 district branches (Slikker, 2009). The mission of the organisation is to make the public aware of the capacities and capabilities of PWD and to ensure the equal opportunities of PWDs through advocacy, lobbying and collaboration with other important partners. GFD provides a mutual platform for Organisation of Persons with Disabilities (OPWD) and manages the Ghana National Disability Network, a platform of organisations, institutions and individuals working in the area of disability to promote the rights of PWDs at policy levels (Ghana Statistical Service, 2014)

2.5.3. Traditional Perception of Persons with disability in Ghana

Persons with disability continue to suffer marginalisation, discrimination and stigma because of societal myths and perceptions about PWDs; these myths and misperceptions are traditionally deeply rooted in superstition and cultural belief systems. It is believed that PWDs are cursed or being punished for a sin she or he has committed or atoning for sins committed by parents or ancestors (Rerief & Letšosa, 2018). Pregnancy and birth are considered a blessing among Ghanaians, it is therefore characterised with high expectations; therefore, when a child is born with disability, families are unable to explain the reason why the child is disabled except to say that the anger of the gods have visited them.

Avoke (2002) posits that it is generally believed that children born with intellectual disabilities are ‘children of the rivers and forests’ in many communities in Ghana. Such children were taken back to the rivers or forests under the pretext of aiding them ‘return to where they came from’.

Crocodiles, and snakes are believed to have some special powers in typical traditional communities; thus any brutality against them could lead to an individual giving birth to a child with disability. Avoke (2002) as cited in (Agbenyega, 2003) expounds further that derogatory tags and cruel treatment were meted out to people with disabilities and that these were warranted by the strong belief that disability was the result of curse placed on an individual by the gods, for committing crimes in the community or against the gods.

Some have viewed disability in Ghana as the work of witchcraft, juju, sorcery and magic (Agbenyega, 2003). Many also hold the view and believe that parents can exchange any body part of the child spiritually with money such that the part so exchanged will become defective.

For this reason, rich families who have disabled relatives are viewed with mixed feelings and are branded “sikaduro” (juju money). In certain communities in Ghana, people with epilepsy are thought to be possessed by demons that torment them through seizures and fits, (Agbenyega, 2003). Among the Ewes for instance, persons with epilepsy are tagged ‘dzeanyikplatowo’, a disparaging phrase which translates ‘falling down sicknesses’. Such persons are not allowed to be touched when seizure occurs for fear of passing on the demons.

In some parts of the Volta and Northern Regions of Ghana, Dogbe (1995), posits that certain eye disease is thought to be a penalty from the gods for crimes committed by victims or their family members.

2.5.4. Composition of Persons with Disability

According to Ghana Statistical Service, 2010 Population and Housing Census Report (Ghana Statistical Service, 2014), three percent of Ghanaians are considered to be disabled. Largely, the percentage of females (3.1%) with disability is marginally higher than males (2.9%). The report indicates that there are more PWDs in rural areas than urban centres. More than forty (40.1%) identified as sight/visually impaired, followed by physical disability (25.4%), with speech impairment accounting for the lowest percentage (13.7%).

2.5.5. Age Distribution of Persons with Disabilities

The 2010 Population and Housing Census report 2014, indicates that person 65 years and above accounts for the highest percentage of all PWDs (22.2%). The report further indicates that other age groups accounts for less than 10% each. Persons aged 15 – 19 makes up 6.9% and 55 – 59 4.7%.

2.5.6. Status of Persons with Disability

The PHC report suggests that for every 10 PWDs aged 12 years and older about four are married and 27.3 percent are never married. The percentage of PWDs who are married about four out of 10 persons aged 12 years and older with disability are married and 27.3 percent are never married. The report further states that the percentage of persons with disability who are married differs by sex and habitation. Forty-seven percent of males and 34.4% of females are married. Largely, the percentage of married PWDs is greater in the rural areas than in the urban centres. For example, males in rural areas who are married is 49% as compared to 44.3% of males in urban centres.

2.5.7. Educational Level of Persons with Disability

For every ten (10) PWDs aged 3 years and older four (4) have no formal education; 17.4% have had primary school education. PWDs educational levels vary by sex and residence. Females have a higher percentage of no formal education as compared to males in both rural and urban settings. A significant percentage of females with disability (58.3%) in rural areas have no formal education; males with no formal education in rural areas accounts for 40.7% (Ghana Statistical Service, 2014).

2.5.8. Economic Activity Status of Persons with Disability

A significant percentage of PWDs (54.1%) aged 15 years and older are engaged in a form of employment whiles three percent are unemployed. The percentages vary by sex and location yet the patterns are similar. The percentage of males employed is (52%) whiles that of females is (47%).There are more PWDs employed in rural areas than urban centres for both females and males (Ghana Statistical Service, 2014).

2.6. Sexual and Reproductive Health and Rights

The World Health Organisation (WHO) defines sexual health and rights as the *"state of physical, emotional, mental and social well-being in relation to sexuality, and not merely the absence of disease, dysfunction or infirmity; sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all people must be respected, protected and fulfilled,* (WHO, 2015)*"*. It generally apply human rights theory to sexuality and reproduction, with four distinct disciplines of sexual and reproductive wellbeing: sexual health, sexual rights, reproductive health, and reproductive rights (Family Care International, 2015; Renzaho et al., 2017)

Access to accurate information (for example, receiving and seeking sexuality-related information) and a selection of effective, affordable, and safe contraception to maintain one's SRH (Family Care International, 2015; Renzaho et al., 2017).

Access to information, according to a human rights framework, gives an individual the choice and freedom to make decisions whether or not to be interested in sex; choosing a partner, pursuing a safe and satisfying enjoyable sexual life, consenting adults sexual relations, trying to decide on a partner, whether the individual would like to marry or not, protection from sexually transmitted infections (STIs), and whether or not the individual wants to have a child(ren) – family planning (Family Care International, 2015; Renzaho et al., 2017), asserts that good sexual reproductive health, as well as the availability and accessibility of health and information services for YPWDs, are critical. To achieve sexual health, it must be progressive and respectful in its approach to sexuality and sexual relationships; there must be the opportunity to have gratifying and safe sexual experiences free of coercion, discrimination, and violence. Every person's sexual rights must be protected, respected, and fulfilled. According to the Committee on Economic, Social and Cultural Rights, the right to the highest attainable standard of health should have the following four basics, accessibility, acceptability, availability and quality (Centre for Reproductive Rights, 2019).

The availability of facilities, goods, and services, including programmes that promote access to services should all be considered in terms of care accessibility (Evan et al., 2006).

2.7. The Right to Health

The right to health is regarded as one of the universal human rights; it is a right that all people must have, and the United Nations defends it. This right includes the right to health care as well as the right to a healthy social environment, which includes nutrition, sanitation, housing, and safe drinking water. According to the World Health Organisation (1946), the right to health is a fundamental part of our human rights and our understanding of life in dignity (Dommen, 2003).

The United Nations health agency WHOs preamble describes health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. The preamble further states that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition".

More than just medical treatment, social care, and the right to be healthy are included in the right to health. It includes the freedom to a diversity of services and environments that the government must provide which is essential for the realisation and preservation of good health (Odoom et al., 2013). Though, everyone is entitled to benefit from the right to health, people with disabilities are unable to exercise it.

2.8. Utilisation of Sexual and Reproductive Healthcare Services among Young People

Numerous research has found varying stages of use of medical care (SRHS) among young people. In one study (Kassa et al., 2016a) it was discovered that only 26.1 percent of respondents had used Sexual and Reproductive Health Services (SRHS). They explained that the low use of SRHS was due to differences in the study participants' characteristics (out of school young people with disability versus young people without disability). They went on to explain that the results of low SRH service utilisation among young people with disabilities (YPWD) can be suggestive of service inconvenience and young people's lack of information for YPWDs. Researchers discovered that 35.5 percent of young people in Ethiopia used sexual reproductive health services in a similar study (Birhanu et al., 2018).

Another study found that 41.2 percent of study respondents had used reproductive health services (Ayehu et al., 2016). Despite the fact that this result was nearly twice that of (Kassa et al., 2016), the outcome of both studies remained fewer than 50%, indicating a lower use of SRHS. The low level of utilisation was attributed to time factor and socio-cultural practices between the different research sites. According to (Alemu & Assefa, 2014), 21.5 percent of study participants had ever used reproductive health services like family – planning , STD cure, education, information, and communication. It also proposed that the minimal level of utilisation could be attributed to parental opposition to their children attending adolescent clinics, as well as an absence of information on where to find services.

According to a related finding of (Addo, 2015), in the 12 months preceding their survey, not more than half (47%) of participants used reproductive health services. The inclination for abstinence, feelings of shyness when meeting with health service providers, mostly in situations of opposite sex, and the cost of obtaining reproductive health services all contributed to low utilisation.

The findings of a study by (Bam et al., 2015) revealed a minimal usage of SRHS (9.2 percent) among respondents. Females used services at a lower rate (4.3 percent) than males (12.5 percent). In other related studies, 33% (33.3%) of utilisation was reported (Alemu & Fantahun, 2011).

In a similar study (Burke et al., 2017) it was also discovered that a significant number of young people with disabilities had not utilised knowledge or services; reason for non-use was the absence of information about where to find such services. Some studies indicated a marginal usage of SRH service; however, other studies show a significant number of SRH service use. According to (De Visser & O'Neill, 2013), respondents used 76 percent of SRH services. In another study conducted respondents used SRH services at a high rate (63.8 percent) (Motuma, 2012). According to (Arulogun et al., 2013), respondents used SRHS 95 percent of the time. (Feleke et al., 2013) in their study discovered that 79.5 percent of women used family planning services. The high level of utilisation recorded could be attributed to the assistance they receive from non-governmental organisations to access health care. It is also possible that school officials will ensure that YPWDs receive healthcare when they become ill.

2.9. Challenges to Utilisation of Sexual and Reproductive Healthcare Services among Young People

A review of works revealed numerous obstacles to young people seeking reproductive health services. These are the difficulties that people face when attempting to obtain SRHS.

Geographic inaccessibility, long queues at the health facility, and negative health provider attitudes are prominent among these challenges (Ahumuza et al., 2014), discovered that when young people sought reproductive health services, they faced challenges such as negative health provider attitudes, long lines at the health facility, high service costs, marginalisation/social discrimination, and poor physical accessibility.

Similarly (Ayehu et al., 2016) reported that the key barriers remained a lack of skilled health providers, high service and commodity costs, no space for young people to ensure privacy, and disapproving service providers. The leading obstacle to accessing reproductive health services was identified as health workers' negative and disrespectful attitudes toward young people, particularly young people with disabilities (Tanabe et al., 2015).

Another study (Rugoho et al., 2014) also established that the foremost challenges YPWDs faced were disability unfriendly infrastructure, negative perception of health personnel towards them and the absence of trained personnel for people disabilities.

2.10. Barriers to Utilisation of Sexual and Reproductive Healthcare Services among Young People

A number of obstacles towards the use of SRH by disabled young people have been identified. Communication barriers (Kuffour, 2013) as cited in (Society & Organisations, 2016), social attitudes and cultural norms (Mprah, 2013), high cost of services, geographical barriers, political barriers (lack of adopted strategy by government to promote health seeking behaviours of

YPWDs), poor interpretation of sign language (Mprah, 2013), illiteracy among young people with disabilities, privacy not existing at health centres (Mprah, 2013).

These obstacles have been documented all over the world as contributing to their inability to access services. The following barriers have been identified as contributing to young people's inability to use SRH services: Policy restrictions, operational hurdles (operational hours, transportation costs), a lack of information, and a sense of uneasiness, fear of medical procedure, belief that services are not meant for them (Senderowitz, 1999).

Despite the fact that some of the hurdles have been reduced or eliminated, there are still many obstacles that prevent young people from accessing SRH services. In one study, the barriers included social stigma (fear of embarrassment), provider behaviour, and high cost, among others (Biddlecom et al., 2007).

For (Birhanu et al., 2018), they posited in their study that, the barriers to the use of SRH services among Ethiopian youth were a lack of information, a sense of shame, limiting cultural norms, a lack of privacy, a lack of services, and a lack of confidentiality (Thongmixay et al., 2019) stated in its study that traditional and religious beliefs, absence of information, parental behaviours, poverty, and the quality and user-friendliness of services were identified as the prime hurdles. Furthermore, long wait times, high costs, and a long distance to the facility were identified as the most significant barriers to young people accessing reproductive health care.

In this findings (Merkel et al., 2008), also posited geographic inaccessibility remained a significant barrier for young people seeking reproductive health services. In (Shariati et al., 2014) study, they identified the obstructions that hindered young people from accessing SRH services, such as cultural hurdles – taboos, lack of government adoption, and non-use of religious potentials. Another study by (Badu, & Agyei-Baffour, 2015), showed that medical equipment barriers, physical barriers to health care, and communication barriers were found to be the most common. Many studies have identified the barriers that young people, including those with disabilities, face when seeking reproductive health care (Dehne & Riedner, 2001).

2.11. Models on Disability

The Models on disability are used to define disabilities, based on these models society and government are able to develop strategies to meet the needs of persons with disabilities. Models are a systematic organisation of theoretical elements that epitomises the link between or amongst concepts (Altman, 2001). De Visser & O'Neill, (2013) posit that models are means of turning concepts into practice. Many models have been established over time to make sense of disability, however the following are the most widely known models: social model, medical model and biopsychosocial model.

2.11.1. Social Model of Disability

The social model of disability views disability as socially created and is a result of society's lack of consciousness and concern about persons who may need some adjustments to live full, productive lives. This model is referred to by some as the barriers model, it views the medical analysis, ailment or injury as having no part in disability. Instead, society is considered as the cause of disability, which is considered a consequence of an environment created for the able-bodied majority (Smeltzer, 2007).

This model emerged from the academic and political reasoning of the Union of Physically Impaired Against Segregation (UPIAS); the document, first issued in the mid-1970s, posited that persons were not disabled because of their intellectual deficits, rather because of the limiting obstacles they face in society (Oliver, 1996).

Furthermore, Oliver asserted that, unlike the medical model, the social model assumes that an individual is incapacitated as a result of architectural, behavioural, and social barriers erected by the public. According to the model, disability is the result of societal oppression, bias, and discrimination against disabled people.

This model entails society erecting economic, health, legal, cultural, and architectural obstructions to inhibit people with disabilities from fully participating in social life. Situations that limit a disabled person's ability to work also limit the person's capacity to contribute meaningfully (Groce et al., 2014; Palmer & Harley, 2012).

The distinction between disability (social exclusion) and impairment (physical limitation), as well as the claim that disabled people are burdened, are fundamental components of the social model, as defined by UPIAS in its Fundamental Principles of Disability (Oliver, 2013).

Disability has been defined as a disadvantage or limitation of activity caused by a modern organisation that fails to consider the needs of people with disabilities, thereby excluding them from communal activities (Shakespeare, 2007). Shakespeare posits that, in this model, impairment is differentiated from disability; the former is personal and confidential, whereas the latter is structural and public. Though medics including other health professionals focus on treating disability, the real issue is accepting disability and eliminating it. In this model, disability is described as a social construction – a link between people with disabilities and a disabling society. This model views disability as a social creation – a linkage among people with disabilities and a disabling society. It is constructed on the following key assumptions: (1) The most significant difficulties that disabled people face are the result of social behaviours rather than practical limitations, (2) Public policy designs and shapes all man-made environments, and (3) public policies reflect current public attitudes and values in a democratic society (Stein & Stein, 2007).

2.11.2. Medical Model of Disability

The medical model or illness approach is based on the idea that disability is caused by disease or trauma, and that the purpose or solution is professional intervention. Disability is seen as a departure from normalcy, and it is the responsibility of people with disabilities to receive care that is decided and enforced by health professionals who are regarded as experts. Disability is viewed as a state that exists within an individual in this model (Smeltzer, 2007).

Stein & Ashley, (2007), explains that, the medical model of disability is based on the idea that people with disabilities face challenges and obstacles as a result of physical, sensory, or intellectual deficiencies. It terms disability as a diseased condition in the clinical context, implying that medical and paramedical practitioners play a critical role in treating these issues in such a way that they represent normalcy as much as possible. People with disabilities are physically and mentally inferior to their able-bodied peers. The bio-medical model of disability considers it as a flaw or illness that should be treated medically. It identifies impairments in the bodies or minds of disabled people that are caused by a disease, an accident, or another health situation to necessitate curative attention in the form of medication and restoration. Recovery, care, and therapeutic attention/treatment are all critical in rehabilitating the individual to normalcy or near-normalcy. According to (Stein & Ashley, 2007), People with disabilities are thought to be unable to perform social tasks due to medical conditions that interfere with a variety of key life accomplishments. As a result of this belief, disabled people remain systemically barred from certain social realms of life, limiting their involvement in the numerous undertakings of society, or they are systematically excluded from certain social realms of life.

2.11.3. Bio-Psychosocial Model of Disability

According to the biopsychosocial model of disability, disability is a combination of an individual's health and the community in which he or she lives (Peta & Ned, 2019). This model acknowledges both the social and medical models' provisions, assuming that they are insufficient on their own because they are interconnected. As a result, a disabled person's job prospects and full participation in social activities are influenced by the individual's health conditions and care, as well as academics, training and skills including contextual aspects such as culture, facilities and the workplace; as a result, this model assumes that disability ensues when the aforementioned conditions fail to function or perform to their maximum potential (Peta & Ned, 2019).

George Engle proposed the biopsychosocial model of disability in 1980. The model is based on a theory that combines the social and medical models of disability in that it considers human impairments and negative cultural influences as factors influencing disability discrimination (Penney, 2013). The social model of disability asserts that disability is caused by social exclusion and prejudice toward disabled people, whereas the medical model contends that disability is caused by individual impairments that distinguish disabled people from non-disabled people. The biopsychosocial model of disability seeks to connect the social and medical models of disability by offering a compromise solution. The biopsychosocial model generates a more integrated and holistic definition of disability by combining both the social and medical models (Bath et al., 2014). As a result, this model claims that disorders are caused by physical or biological problems that need medical care. Besides this, people must find means to include disabled people in societal, financial, and political activities by providing them with resources and equal chances (Bath et al., 2014).

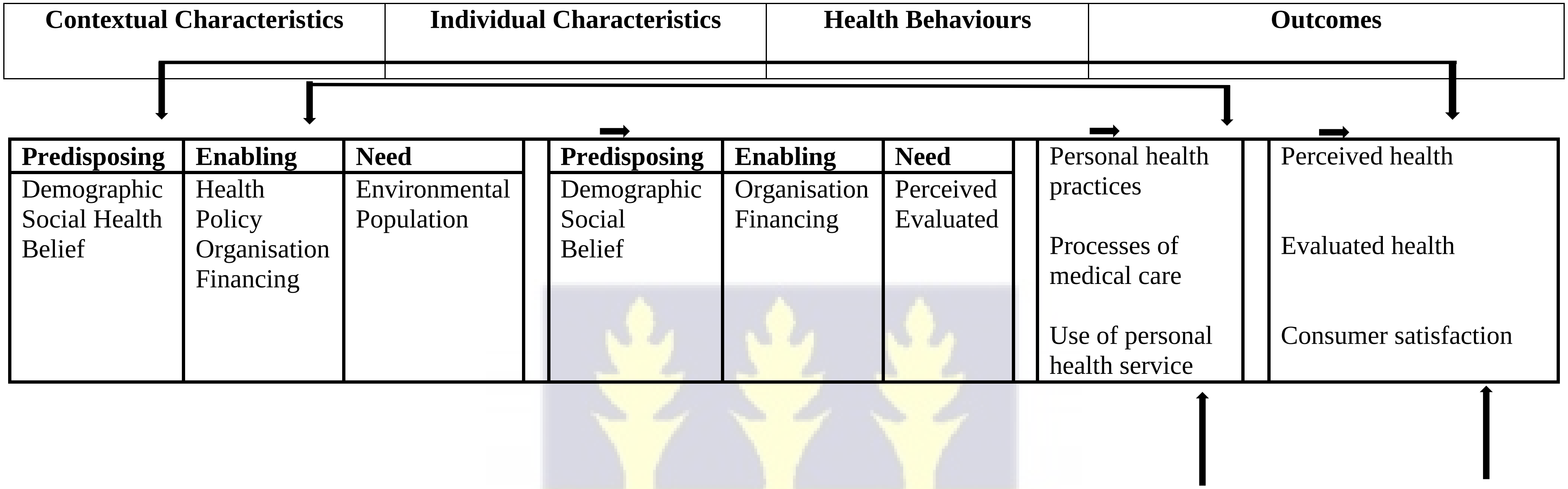


Figure 2: Health Services Utilisation Model Source: adapted from Seidu, 2020

CHAPTER THREE

METHODS

3.0. Introduction

This section presents the methods to be used in the study. It covers areas such as the research design, description of the study area, the population for the study, sample size, sampling procedure, method of data collection and data collection instrument. Pretesting of the research instrument, data management, data analysis and ethical considerations are also discussed.

3.1. Research Design

This study used a descriptive phenomenology design – it allowed participants of the study to share their lived experiences. A phenomenological study describes the meaning of several individuals' lived experiences of a specific concept of phenomenon; it focuses on describing what all participants have in common as they experience a phenomenon. Phenomenology methodology differs from most other research methodologies in that the goal is to describe a lived experience rather than explain or quantify it in any way. Phenomenology is solely concerned with the study of the experience from the participants' point of view; thus, the methodology does not include a hypothesis or any preconceived notions about the data collected. The primary goal of phenomenology is to reduce individual experiences with phenomena to a description of universal essence (a grasp of the very nature of the thing). To that end, qualitative researchers identify a phenomenon (an object of human experience). The inquirer then collects data from people who have witnessed the phenomenon and creates a composite description of the essence of the experience for all of the individuals. These descriptions include what they saw and how they felt.

Interviews, conversations, participant observation, action research, focus meetings, and analysis of diaries and other personal texts are all used in phenomenology. In general, the methodology is intended to be less structured and more open-ended in order to encourage participants to share specifics about their experiences. Surveys and questionnaires, which are commonly used in other research methods to collect information from participants, would be too structured and would limit the participant's ability to freely share. In other words, phenomenology places a premium on subjectivity. The goal of phenomenological research methods is to maximise the depth of information gathered, less structured interviews are the most effective. The phenomenology designed allowed the researcher to gain a deeper understanding into their experience of accessing sexual and reproductive health (Makunika, 2021).

The study was conducted at the premises of the Ghana Federation of Disability Organisations in Accra, Ghana. A purposive sample of 26 young people with disabilities were recruited.

3.2. Approach for the study

Focus Group Discussion was the approach used as the primary data collection method.

3.2.1. Focus Group Discussion

A focus group is a research method that gathers a small group of people to answer questions in a moderated environment. The group is chosen based on predefined demographic characteristics, and the questions are designed to shed light on an interesting topic (Nyumba et al, 2017). The method seeks data from a specifically selected group of individuals rather than a statistically representative sample of a larger population (Mishra, 2016). Focus group responses are open-ended, broad, and qualitative. They go deeper and get closer to what people are really thinking and feeling, even if their responses are more difficult, if not impossible, to record on a scale. The primary goal of focus group research is to elicit respondents' attitudes, feelings, beliefs, experiences, and reactions in situations where other methods are ineffective.

The Focus Group allowed the researcher to collect more information in less time; it also shed light on the complex issue of young people with disabilities gaining access to sexual reproductive health and rights services. The focus group interviews were conducted on the 3rd to 4th February, 2022.

3.3. Study Area

The research was conducted in Adabraka, a suburb of Accra's Korle Klottey Municipality. The Accra Rehabilitation Centre for Persons with Disabilities is located within the municipality, as is the Ghana Federation for Disability Organisations (the mother association that coordinates all disability issues in Ghana). The presence of these institutions allows young people with disabilities seeking vocational training and support to meet on a regular basis.

3.4. Profile of the Area

The Korle Klottey Municipal Assembly (KoKMA) is one of Ghana's two hundred and sixty (260) municipal assemblies, and one of the twenty-nine (29) in the Greater Accra Region, which is located in the south eastern part of the country, diagonally between 5°32''50' N and 0°11''15' W, and 5°38''0' N and 0°7''50' W. The Municipal Assembly was created in 2019 and inaugurated on February 19th, 2019. It was carved out of the Accra Metropolitan Assembly. The Assembly was created by the Local Government Act of 1993 (Act 462), which was later amended by Legislative Instrument (LI) 2365 to become the Local Government Act of 2016 (Act 936) (Korle Klottey Municipal Assembly, 2021b). Based in Accra, with Osu as the administrative headquarters. The Municipality's administrative offices are currently located at Circle, adjacent to Freedom and Justice Park. The Municipal Assembly is spread out over a 12 square kilometer area. It is bordered on the north by Ayawaso Central, on the south by the Gulf of Guinea, on the east by La Dade-

Kotopon Municipal, and on the west by the Accra Metropolitan Assembly. It has a total population of 121, 723 people (GSS PHC 2010), with females accounting for 52.7 percent and males accounting for 47.3 percent. This figure was expected to rise to 148,903 in 2018, 153,702 in 2019, and 158,658 in 2020, with the Municipality's population rising to 163,772 in 2021 (Korle Klottey Municipal Assembly, 2021a).

The population's age distribution reveals that the 20-24 age group has the largest population density. The 25-29 age group follows closely behind. These figures are higher than predicted, and the surge of migrants into the municipality could be to blame. The age categories of 90-94 and 95+ each accounted for 0.1 percent of the total. The population of KoKMA is young, with a relatively broad base of many children and a bloated mid-base of youth and a tiny number of senior people. Adolescents and young adults (15-29 years old) now make up 31.8 percent of the population. The age dependency ratio is 50.1 percent, whereas the regional figure is 53.4 percent. Nuclear households (head, spouse(s), and children) accounted for 26.7 percent of the KoKMA homes, while nuclear extended households (head, spouse, children, and head's relatives) accounted for 14.3 percent. Only 6.1 percent of the total number of households were headed by a single person. The Total Fertility Rate is 2.2, which is lower than the regional average of 2.6, according to the 2010 population data (Korle Klottey Municipal Assembly, 2021a).

The Municipality is also focusing on improving access to quality healthcare and nutrition as part of its Medium-Term Plan. According to the Municipal Health Directorate's data (MHD); the Municipality's health facilities are divided into five sub-districts and 29 CHPS zones, with 20 functional zones. Adabraka (6 CHPS), North Ridge (2), Osu (7 CHPS), Tema station (2 CHPS), and Tudu (3 CHPS), (Korle Klottey Municipal Assembly, 2021a). There are 24 major private health facilities in the municipality (Ghana Hospitals, 2021).

The Ghana Federation of Disability Organisations (GFD) is situated in the Korle Klottey Municipality of the Greater Accra Region. GFD is the foremost organisation for all disability issues in Ghana. It currently has seven (7) members making up the organisation; the members include: Ghana Association of Persons with Albinism (GAPA), Ghana Blind Union (GBU, Ghana National Association of the Deaf (GNAD), Ghana Society of the Physically Disabled (GSPD), Inclusion Ghana (IG), Mental Health Society of Ghana (MEHSOG) and Sharecare Ghana. The Federation has a rehabilitation centre for its members which provides life skills training for members to contribute meaningfully to their society (GFD, 2021).

Figure 1: Map of Korle Klottey. Source: Ghana Statistical Service

3.5. Study population

The study population included young people with disabilities – visual impairment, hearing impairment and physically challenged who were between the age group 18 -35 years who are members of the Ghana Federation of Disability Organisations located in the Korle Klottey Municipality.

3.6.0. Inclusion criteria

Young people between the ages of 18-35 with disability.

Must be a member of the Ghana Federation of Disability Organisations (GFD)

3.6.1. Exclusion criteria

Participants who met the selection criteria but were absent during data collection due to illness or absence from the venue were excluded.

3.7. Sample Size Determination

Since qualitative analysis is typically used to understand the depth rather than the significance of a social problem, a limited sample size is allowed to allow the researcher to understand the depth of the issue under investigation (Miles & Huberman, 2014). When using focus group discussion, according to (Guest & Johnson, 2006), 90 percent data saturation would be achieved after holding 3-6 focused group discussions (FGD). As a result, 26 participants were interviewed for this research.

3.8. Sample Procedure

In this study, a purposive sampling and convenience sampling procedures were used for the study. Purposive sampling enabled in the selection of individuals with in-depth knowledge of the topic and who satisfied the researcher's established criteria. The researcher approached the Ghana Federation of Disability Organisations with the intention of acting as gatekeepers to various persons with physical impairments who have had any prior experience obtaining reproductive health care. Through the Ghana Federation of Disability Organisations at Adabraka in the Korle Klottey municipality, a purposeful sample technique was used to pick both persons with mobility, hearing, and vision challenges. The researcher met with members of GFD in Adabraka to brief them on the study's goal, after which contact information for those who were interested was collected and contacted later. Persons with vision, hearing, and mobility challenges were later contacted in person as part of the recruiting process to further explain the study's goal and selection criteria. The researcher recruited participants for the study using convenience sampling because they were readily available at the Ghana Federation of Disability Organisations. It also allowed the participants to self-select if they wished to participate in the study.

3.9. Data Collection Instrument

Data was collected using Focus Group Discussions guide developed by the researcher. The guide was an open ended question which allowed participants to freely express themselves. The use of the guide helped the researcher to collect factual data on young people with disability's experience of accessing sexual and reproductive health services. In all nine (9) questions were asked in the guide; it can be found in Appendix D. It also had a portion that collected the socio demographic data of participants.

All discussions held with participants were recorded with a digital recorder after permission had been sought from them. Field notes taken during the discussions were later translated into data.

3.10. Data Collection Procedure

The Discussions took place at the rehabilitation centre of the Ghana Federation of Disability Organisations located in Adabraka. Averagely, the discussions lasted a minimum of 45 minutes.

Information about YPWDs' socio-demographic and economic characteristics (age, religion, type of job, disability type), were collected.

The study used Focus Group Discussion (FGD) among young people 18 – 35 years with disabilities. The focus group discussions had a small group of five participants with a moderator led an open discussion; five FGD sessions was held. The FGD aided in generating ideas and opinions from the participants. The discussions lasted a minimum of 45 minutes and a maximum of 60 minutes. The discussions were structured around a set of carefully predetermined questions which ensured a free flowing conversation among participants.

3.11. Pretesting Data Collection Instrument

Two Research Assistants were trained to assist in the data collection and pretesting of the instrument. A pretesting helped inform the instrument during the final data collection process. A pretesting was undertaken at the Ghana Society for the Socially Disadvantaged located in Kaneshie a suburb of Accra. The Focus Group Discussion guide was pre-tested among 5 (2 visually impaired and 3 physically challenged) young people with disabilities to help reframe any issues that were vague, no changes were made to the interview guide.

3.12. Quality Assurance

A variety of controls were introduced to ensure data consistency and analytic rigour. To begin, my research assistants were trained on a variety of aspects of the research and data collection tools, including how to describe the study's main goal and data collection technique, how to ask questions using the appropriate disability terminologies, how to show empathy amongst others; research assistants were trained on the 28th of January, 2022.

Participants with visual impairments and those who are physically challenged were placed in the same focus group. Participants with hearing impairment had their own focus group discussion.

The interviews were conducted in Twi and Ga for participants with visual impairment and physical disability and Ghanaian sign language for participants with hearing impairment.

The Principal investigator ensured that the venue for the focus group discussions was ready and conducive for participants to engage in the conversation, refreshment was made available for participants; the other moderators also assisted in ensuring that venue was ready and conducive for participants to engage in the conversation. Furthermore, in order to ensure data accuracy, I (the Principal Investigator) was actively involved in supervising the research assistants during the data collection process. Finally, I met with my research assistants on a regular basis to go through the data collection process and discussed how our personal biases could affect the data. The continuous reflexivity process enabled me to delineate my assumptions, biases and beliefs that may influence the participants or the research in general; ensured that relevant questions were posed during the data collection process, minimising our personal biases.

3.13. Data Processing and Analysis

The data was analysed using a descriptive phenomenological analysis approach. All audio recorded interviews in Ga and Twi languages were transcribed into English by the Principal Investigator and the research assistants who understood and spoke Ga and Twi languages fluently. The transcripts that were not in English were translated into English. The sign language interviews were transcribed into English by a sign language interpreter. The PI and all research assistants conducted back-to-back translations on selected transcripts to ensure transcription accuracy and all mistakes were fixed. Transcripts were revised to remove grammatical errors while maintaining the original context. To obtain a general understanding of the results, edited transcripts were read many times. For data coding, all transcripts were imported into NVivo 10 software.

3.14. Variables

3.14.1. Dependent Variable

Utilisation of Sexual Reproductive Health Services

3.14.2. Independent Variables

Age, Sex, Educational level, Marital status, Ecological zone, Sexual relationship, Peer influence Protection against STIs, Fear of pregnancy, Cultural and religious barriers, Attitude of health service providers, Communication, Stigma, Cost, Confidentiality, Benefits of SRH services, Disability type.

3.15. Ethical Consideration

Ethical approval for the study was obtained from the Ghana Health Service Ethical Review Committee, (Approval reference number: GHS-ERC:030/11/21).

3.16. Informed consent

During data collection, written and verbal consent was obtained from the head of the Ghana Federation of Disability Organisations (GFD) as well as the study participants. Individuals were asked to sign or thumbprint an informed consent form. Participants who were unable to sign (due to vision impairment) were asked to thumbprint or provide verbal informed consent

3.17. Anonymity and Confidentiality

To maintain anonymity and confidentiality, all personal data were treated confidentially by withholding participant names. Participation in the study was entirely voluntary, and respondents were free to opt out if they so desired; there were no consequences. Information gathered from participants would be stored for two years before being safely discarded; data files have been password protected, the study PI, Co – PI and supervisor were the only persons with direct access to research files. Hard copy and electronic data will be kept in sealed file cabinets.

3.18. Compensation to participants

Participants were compensated; the cost of transportation to the interview venue was reimbursed. They were also refreshed at the end of each focus group discussion session.

3.19. Benefits to participants

This study created the platform for participants to share their experiences of accessing SRH services. The outcome of the study will enable the disability fraternity to develop advocacy strategies and messages that will help in their ability to access SRH services across the country. The study will further help clear any myth associated with persons with disabilities accessing sexual and reproductive health services.

3.20. Risks

There were no risks associated with this study. However, participants who may have had a bad experience in the past accessing SRH services were reminded of it.

CHAPTER FOUR

RESULTS

4.0. Introduction

This chapter presents the study's findings on the various research objectives. The study investigated the experiences of young people with disabilities in accessing sexual and reproductive health services, the challenges associated with accessing sexual and reproductive health services, and satisfaction with access to sexual and reproductive health services.

4.1. Demographic characteristics of participants

The demographic characteristics of participants was manually calculated.

Participants within the age category 18-24 years were seven (7), for those who fell within the age bracket 25-29 years were nine (9) and participants who were within the age bracket 30 -35 years were ten (10). In terms of religion, twenty-one (21) of the participants identified as Christian, three (3) as Muslim, and two (2) as belonging to another religion. In terms of occupation, nineteen (19) of the participants reported being in trade school, while seven (7) reported being in formal employment. Seven (7) participants reported hearing impairment, six (6) were visually impaired, and thirteen (13) were physically challenged.

4.2. Experiences of young people with disabilities accessing Sexual and Reproductive Health Services.

Young people with disabilities experiences were in relation to knowledge on contraception and use; experiences with accessing Sexual Reproductive Health; Sources of Sexual and Reproductive Health Information; Sources of Sexual and Reproductive Health Services; Factors that determine YPWDs choice of SRH services and information; and Sources of support network.

4.2.1. Participants knowledge on contraception and use

In terms of participants' knowledge on contraception and use, the findings show that most of the participants exhibited some knowledge on sexual and reproductive health. The experiences are shared below

> *"You can do family planning. they'll inject you and it can take like two years or three years. if you do that and have sex you will not be pregnant".* **(Female, visually impaired, 29 years).**

> *"To explain, it means like two married people who are giving birth but gets to a point where they realise that the childbirth is getting too much or they want to control the birth so goes to the hospital for something called family planning, either you take an injection or there is something they put in your hand. Or if you deliver at the facility you will be sterilised to cease birth for good. But the family planning has different durations. so mostly the couple agree to undertake a method".* (**Female, physically challenged, 32 years).**

A number of the participant however had no knowledge on contraception according to their expressions. These are some of their statements.

> *I don't know much about contraceptives.* **(Female, visually impaired, 27 years)**

> *"I don't have much experience accessing SRH services but I do get some information".* **(Female, visually impaired, 18 years).**

4.2.2. Experiences with accessing Sexual Reproductive Health

With regards to their individual experiences on accessing sexual and reproductive health services and information, participants' contributions showed that they were well informed of the methods that suited their preferences while a few participants said they had no knowledge on this category of services. Some of their shared experiences are stated below.

> "*Oh, yes, I probably can, I did. I won't hide it. I went to a private hospital. I didn't go to a public hospital because public hospitals sometimes are mean and can ridicule so I decided to go to the private hospital. When you go to the public hospital, we'll have more people there and curious to know what you have come to do. the case that sent me to the private hospital was to seek abortion care, let me be frank here. So they gave me some drugs. and all of a sudden I fell asleep. And all by the time I woke up, I realized*

> *that they had done D&C (Dilation and Curettage). I remember that the drug that I took was yellowish”.* (**Female, hearing impaired, 35 years).**

> *“I also have not experienced SRH services but have received some information before”.* (**Female, visually impaired, 28 years).**

4.2.3. Sources of Sexual and Reproductive Health Information

In exploring the sources of Sexual Reproductive Health information, participants mentioned quite a number of sources. Below are individual narratives of where they receive SRH information.

With regards to where participants get their SRH information, a number of them mentioned the health facility.

> *“Yeah, well, I will say that I got my information and knowledge when I got pregnant and started attending antenatal. That was where I first got my information. Yes, when I got pregnant and started attending hospital”.* **(Female, hearing impaired, 35 years).**

The focus group discussion revealed that a number of the participants received SRH information from their family members.

> *"If there is an elderly person at home or any female, you can talk to the person and explain what is happening. if it needs herbal medication to solve it, it can help, otherwise, you go to the hospital and inform the doctor for prescriptions".* **(Female, visually impaired, 28 years).**

Some participants associated their source of SRH information to radio and TV broadcast.

> *"Radio is the network I know, when I need information and cannot go to the hospital, you can hear the number of the doctors who come and educate on the radio then you call to ask for information".* **(Female, visually impaired, 27** ***years)***

> *"I access SRH information from the media especially radio".* **(Female, visually impaired, 28 years).**

The role played by schools in the provision of SRH information was appreciated by a number of participants.

> *"About that one, some of us who have gone to school small know about a few things because the school teaches about some of the reproductive issues. and now the increase of technology has made*

> *some of the information available where people are teaching on radio and television so if you listen to them, you get some advice for your use".* **(Female, physically challenged, 32 years)**

The Church was mentioned by some study participants as a place they ever sought SRH information from.

> *"I sought my advice and information from counsellors, I stopped using condom when I turned 12 years old. I met a prophet who told me that wearing a condom was a sin. He further went to say that if I don't stop using condom I will suffer sicknesses like malaria, typhoid, diabetes, he further went on to say that I would grow lean like a broom. I became worried about what the pastor told me; I asked God if what the pastor said was true".* **(Male, physically challenged, 23 years).**

Findings discovered that friends are also a source of SRH information for the participants.

> "*we hear it from the PPAG and church people and those who have some experiences also share it and give us information".* **(Female, visually impaired, 18 years).**

The study findings revealed that meeting grounds was a place YPWDs receive SRH information from.

> *"And also, for me, I also get some of this information from my friends".* **(Male, hearing impaired, 35 years).**

Evidence from the study showed that some YPWDs got their SRH information from online.

> *"And also, for me, I also get some of this information from the social media. on social media and when I go to social media for example, Facebook I see some posts there I read them also"* **(Male, hearing impaired, 35 years)**

> *"I'm on a WhatsApp platform that shares regular SRH information; we exchange a lot of knowledge and also direct them to facilities".* (**Female, hearing impaired, 24 years).**

4.2.4. Sources of Sexual and Reproductive Health Services

To know who provided them with SRH services, the focus group discussion revealed some major sources.

Among the providers of SRH services for PWDs, submissions from the participants said theirs was from their organisations.

> *"We get it here; we get it here from the organization (Ghana National Association for the Deaf – GNAD) the organization used to organize training workshops for us"* **(Female, hearing impaired, 34 years)**

> *"Our mother organisation makes it possible for us to access sexual and reproductive health information and services by hosting workshops for us".* **(Male, hearing impaired, 34 years)**

The findings indicated that a number of the participants sought SRH services from herbal sellers

> *"I mostly prefer herbal medication even to the hospital".* **(Female, visually impaired, 26 years).**

The SRH services rendered by over-the-counter medicine sellers were acknowledged by a number of the participants for reasons best known to them.

> *"I can go to drug store and buy that thing they use for test to test myself".* **(Female, visually impaired, 27 years).**

> *"I will go to a drugstore because maybe my menses is not coming so I will rather go and buy the kit and test before I know what the problem is. it will be fast for me. that one if i do it and don't see any result then I can think of hospital"*. (**Female, visually impaired, 27 years).**

The findings showed that health professionals were mentioned by the participants as providers of SRH services.

> *"When I go to my home town I can visit the hospital over there"*. **(Female, visually impaired, 26 years).**

> *"For me anytime something is happening to me and it's severe, I go to the hospital so they can do check-ups and provide medicines"*. (**Female, physically challenged, 32 years).**

4.2.5. Factors that determine YPWDs choice of SRH services and information

Participants were asked some the factors that determined their choice of accessing SRH information and services. Four main sub-themes were derived from their narratives.

A significant number of participants alluded that professionalism of health staff was a determining factor to the choice of where they accessed SRH services.

> *"I look at confidentiality of the facility, whether they ensure your privacy and will not tell anyone about what you have come to do".* **(Male, physically challenged, 30 years)**

> *"The attitude of the service provider towards me will determine my decision to want to access sexual and reproductive health services and information. The welcoming and smiling nature of the one providing the service will influence my decision*" **(Female, hearing impaired 24 years)**

One of the factors that determined YPWDs choice of accessing SRH services was availability.

> *"I will go to a drugstore because maybe my menses is not coming so I will rather go and buy the kit and test before I know what the problem is. it will be fast for me. that one if i do it and don't see any result then I can think of hospital".* **(Female, visually impaired, 27 years).**

> *"I will go to the polyclinic because that is where I know when I go, I can be rescued. that is where I can get solution to my problem".* **(Female, visually impaired, 27 years)**

Participants also indicated that recommendation by others was what drove their choice to where they accessed SRH services.

> *"My choice to access sexual and reproductive services and information is based on recommendation from my peers who have used the services of the facility".* **(Female, hearing impaired, 35 years).**

> *"Actually I can say that it is open, but then it depends on like they said the information we get, maybe somebody will tell you that Oh, I have been to this place before and I enjoyed the services, good services. So, when we get this information that they provide quality services, then we also decide that let me go there to also assess that quality services".* (**Male, hearing impaired, 35 years).**

The desire for safety and trust was agreed by the participants as a factor that determined their choice of accessing SRH services.

> *"I believe in doctors and the machines they use. because they will check to know exactly what is wrong with you before they prescribe medication so I don't just get up to take any medication. and I was advised by a doctor to never try self- medication so I go there whenever I have issues".* (Female, **visually impaired, 28 years)**

> *"I believe that the health personnel at the hospital or clinic will provide me with the right information and services"*. **Female, physically challenged, 32 years**

4.2.6. Sources of support network

The study sought to understand whether participants received help from support networks in accessing SRH services. Social relations outside the family, the churches, NGOs, family, face-to-face with health professionals, and online chat with health professionals.

Social relations outside the family such as friends and classmates were mentioned by majority of the participants as their source of support network with regards to SRH issues.

> *"Friends at home are my support network, we sit to discuss some of these issues and it helps me a lot"*. **(Male, physically challenged, 20 years)**

> *"Some of our teachers here have become our support network, they give us all the support we need as students. They provide us with some of the SRH information we need"*. **(Male, physically challenged, 28 years)**

Some participants of the study appreciated the church as their source of support when it matters of SRH arises.

> *"I'm a member of my church's youth group so I rely on them. They teach us some of these things".* **(Male, physically challenged, 30 years)**

> *"My church remains my support network, when I need support I go to my pastors who directs on me what to do".* **(Male, physically challenged, 20 years).**

A few participants revealed NGOs as their source of support network.

> *"We sometimes get support from NGOs and our mother organisation GNAD*". **(Female, hearing impaired 24 years).**

> *"This time around we don't have trusted people. I may trust someone but if I narrate the issue to someone and the person is not able to offer any help. so if I get the contacts of PPAG and co I will rather call them, there are no networks I am aware of except what I have mentioned".* (**Female, visually impaired, 28 years).**

Majority of the participants acknowledged the family as their source of their support network in matters concerning SRH.

> *"For me, I don't have any problem as far as my sister is around and even if I have to go to the hospital, sometimes there are people who pay transportation fee for me".* **(Female, visually impaired, 26 years).**

> *"If anything happens especially, pregnancy, it is the one who impregnated me that will hear it first. I will contact him first before hospital, maybe the man will know someone. wherever the person is, there is phone to call so we contact the right people".* **(Female, visually impaired, 27 years).**

A number of participants said their support network was face-to-face with health professionals.

> *"When it comes SRH services deaf ladies prefer that doctors and nurses provide them with services and information. They hardly go to the hospital with a sign language interpreter because of privacy issues. I have adopted ways to communicate with nurses and doctors when I go to the hospital with my female friends who need information and services, I'm able to read lips, I write and also use gestures".* **(Male, hearing impaired, 35 years).**

> *"The private hospital I used to go to they really love deaf people. when you enter the place they ensure that you get all the necessary services that you needed. They provide quality service and they're kind to persons with disabilities".* **(Female, hearing impaired, 35 years).**

Online chat with health professionals was only mentioned by one participant as a source of support network for SRH service.

> *"Radio is the network I know, when I need information and cannot go to the hospital, you can hear the number of the doctors who come and educate on the radio then you call to ask for information".* (**Female, visually impaired, 27 years).**

4.3. Challenges Associated with Accessing Sexual and Reproductive Health Services.

The challenges faced by young people with disabilities in accessing sexual and reproductive health services included barriers to accessing sexual and reproductive health services and information, satisfaction with access to sexual and reproductive health services, and ways to overcome barriers to accessing SRH services and information.

4.3.1. Barriers to accessing Sexual and Reproductive Health Services and Information

The study also aimed at discovering the barriers young people persons with disabilities experience in accessing SRH services. A wide range of barriers were commonly mentioned by the participants.

A good number of the participants said long waiting times at health facilities discouraged them from accessing SRH services.

> *"We prefer going to the private hospitals apart from the expenditure, at the government hospitals they will waste your time, you will sit there and once they realise you are a deaf person, they will just throw their hands to tell you wait, they will be doing wait, wait and before you realise you have spent the whole day over there so we prefer going to the private hospital than the government hospitals. I went to a government hospital and I was the first to drop my card before the rest of the people came but when they started calling names I was the one they called last. Probably because my sister was deaf they called her and she did not hear them".* (**Female, hearing impaired, 32 years**).

> *"Sometimes too the long queue at the hospital is very discouraging; it doesn't get to your turn to see the doctor, you will go home and come back the following day and still not see the doctor. It can take you up to a week to see the doctor. This situation is discouraging".* **(Male, physically, challenged, 28 years).**

A significant number of the participants revealed that transportation barriers prevented them from accessing SRH services.

> *"I'm unable to access SRH information and services at the facility because I don't have a guide who will take me there. The cost of transport too is on the high side; I may have to take a taxi which is expensive. Trotro too will leave you in the middle of your journey. The attitude of some nurses too, when you go to the hospital you will find some of the nurses on their phone, they will not pay attention to you coming to seek health care*". **(Male, physically challenged, 30 years).**

> *"Usually when you go to the private hospitals they are good but the amount you pay is very high. If the hospital is far from our home it prevents us from accessing services because we do not have the money to pay for transportation".* (**Female, hearing impaired, 35 years).**

Language barrier was mentioned by a large portion of the participants as a challenge they face in accessing SRH services.

> *"Sign language interpretation is a major challenge for us, when there are very educative sexual and reproductive health programme on TV or radio we do not benefit from it. We are unable to communicate with doctors so in the end we are given wrong medication". (***Female hearing impaired, 24 years).**

> "*Communication is a major barrier for us, because we are deaf people in other for you to get quality services doctors have to diagnose you very well but because they are not able to communicate with you they hardly understand what really is affecting you and as a result of that they give wrong diagnosis and medication*". **(Male, hearing impaired 35 years).**

Discrimination from health staff and other people was bewailed by majority of the participants which restricted them from accessing SRH services.

> *"The challenge is, when some people see men in any relationship with a person with disability, they begin to ask questions like, is this the person you want to walk with, and say that the other people will also contract disability"*. (**Female, visually impaired, 27 years).**

> *"When you go to Kaneshie Poly Clinic they provide very poor service. At the 37 Military hospital they usually do not accept deaf people. they don't provide services to deaf people, they prefer the rich people; the moment they find out you are a deaf person they hardly attend to you"*. **(Female, hearing impaired, 34 years).**

A number of participants bemoaned how YPWDs were being mishandled by health care workers. Bad attitude of service providers (34.6%) was mentioned as a common barrier they feel nervous about when accessing SRH services.

> *"Sometime a go a friend went to the hospital and he didn't like what the nurse did. My friend was diagnosed with an STI at the hospital. The nurse was a friend to my friend's girlfriend. When she went home she went to inform my friend's girlfriend that her boyfriend was diagnosed with an STI. This led to the breakdown of the relationship. My friend was not happy with the behaviour of that nurse".* **(Male, physically challenged, 30 years).**

> *"The interest to attend to deaf person is not there. They do not have the passion to provide services for deaf people. The people at Adabraka Poly Clinic are not serious, we don't see any seriousness in the work they do here. There is this nurse who knows basic sign language but sometimes when you go there she will pretend she has not seen you, she will not mind you and pretend that like she has no knowledge of sign language***". (Male, hearing impaired, 35 years).**

It was obvious from the Focus Group Discussion that many YPWDs face financial constraints in accessing SRH services.

> "*Another challenge is when something is worrying you and go to the hospital you may not be able to pay all the bills so if you have small money you'll use it to buy some medicine and take. I haven't experienced that personally". (***Female, visually impaired, 26 years).**

> *"As for money issues, persons with disability face that a lot. they tell you there is government subsidises but you don't see it. sometimes they ask you to write letters to the district to access funds but it is a problem".* (**Female, visually impaired, 28 years).**

Unfair criticism from other people was stated by some of the participants as among the barriers they face in accessing SRH services.

> *"In some of the hospitals they understand your condition and then provide service for you but in some other hospitals they do not understand your condition so they will not allow to do what you want to do; they make us queue for a long time and when you get tired you will return home and because of the suffering you will not return to the hospital. The cost of transportation to the facility is also a barrier for us".* **(Female, hearing impaired, 34 years**.).

> *"There was this deaf lady whom I accompanied to the hospital and immediately we got there they started stigmatising us; they started mocking us saying look at this deaf lady she is also pregnant, as if deaf people are not human beings and don't have feelings. So you can see that even accessing sexual and reproductive health services is a problem".* **(Male, hearing impaired, 35 years)**

4.4. Satisfaction of Access to Sexual and Reproductive Health Services

4.4.1. Ways to overcome the barriers in accessing SRH services and information

The availability of S|RH services could be available for persons with disabilities to access but environmental and social factors could create limitations to their access. The focus group discussions generated how the various challenges mentioned by participants could be addressed and these had been put into some categories;

A number of the participants said ensuring availability of SRH services was fundamental to getting more disabled persons using SRH services.

> *"I would prefer the nurses to organise regular SRH outreaches into our schools and communities. They should also organise radio discussions and share knowledge about SRH. On Tuesdays on state owned Obonu FM a nurse comes on to teach health related issues,*

> *I prefer initiatives like this”.* **(Male, physically challenged, 30 years)**

> “*We would like it very much if services are brought to the doorsteps of PWDs. It will reduce the struggle PWDs go through accessing SRH services or information”.* **(Male, physically challenged, 23 years)**

Some of their submissions mean that training/employing language interpreters could also reduce the stress some PWDs especially the deaf encounter in accessing SRH services.

> *“At least they should also employ a proficient sign language interpreter in all the government hospitals. That deaf person will benefit from the services of the sign language interpreter. If they do not have the intention to do that then they should select those who are interested to learn the sign language to come and learn the sign language to become more proficient so that they will deploy them to the hospitals”.* **(Male, hearing impaired 35 years).**

> *“To overcome those barriers, there should be special people that will take care of us, or those who handle us should be persons with disabilities who understand the situation and know much about us*

> *so that the barriers will be taken away”.* (**Female, visually impaired, 27 years).**

Majority of the participants indicated that to overcome the barriers disabled persons face in accessing SRH services, there may be the need to providing free SRH services to this group of the population.

> ***“****Reproductive health service should be made free for PWDs”.* (**Female, visually impaired, 28 years).**

> *“Sexual and productive health services and information should be free for young people with disabilities”.* (**Female, visually impaired, 26 years).**

Enforcing laws that aim at protecting PWDs was stated by some of the participants as one of the many ways of overcoming the barriers PWDs endure to access SRH services.

> “*The government must put a law in place that will stop people from discriminating against PWDs”.* (**Female, visually impaired, 26 years).**

Many of the participants also mentioned that sensitising people against discrimination.

> *“There should be education. the public should be educated to treat persons with disability well. they should be taught how to care for persons with disabilities and provide help rather than maltreating*

> *them. Now there are radio and Tv stations they can use to teach everyone about how to care for persons with disability. There should also be laws to sanction the people who do not treat persons with disability well".* (**Female, physically challenged, 32 years)**.

> "*Health workers should be trained in how to handle persons with disabilities".* (**Female, visually impaired, 28 years).**

It was noted among the participants that if health facilities could make provisions for disability desk to ensure confidentiality, many YPWDs could be motivated to access SRH services there.

> *"There should be a disability desk in all public health facilities; a special place where if you have disabilities and you go to the hospital you will go to that point to get all the services that you need".* **(Female, hearing impaired, 24 years).**

> *"A special doctor should be dedicated to the issues of PWDs in all health facilities in the country. Health practitioners should ensure confidentiality and privacy between patients and practitioners. The state should create a special unit that caters for the needs of PWDs".* **(Female, hearing impaired, 24 years**).

CHAPTER FIVE

DISCUSSION

5.0. Introduction

The findings from the focus-group discussions were discussed in this chapter and compared to the literature. The qualitative study investigated the experiences of young people with disabilities in accessing sexual and reproductive health services, the barriers to accessing sexual and reproductive health services, and satisfaction with access to sexual and reproductive health services.

5.1. Experiences of young people with disabilities on accessing SRH services.

The findings indicate that majority of young people with disabilities showed significant knowledge about contraceptives. This is in line with some studies by (Kassa et al., 2016a; Tanabe et al., 2015) that revealed that many young people with disabilities have significant understanding of contraceptives and use. In an Ethiopian study to assess the knowledge, attitude, and practice of young people with disabilities, it was discovered that the majority of study participants had heard of family planning (Kassa et al., 2016b). On their individual level of experiences on accessing sexual and reproductive health services and information, a large portion of participants indicated that they were well informed about methods that best suited their needs. Less than half of all participants indicated that they had no knowledge about contraception.

On where they source their information on SRH, a significant number of participants said health facilities were their preferred go to place (Casebolt, 2020) confirms this in its report. Other participants posited that radio, TV, family and friends were their source of SRH information, this result is consistent with (Kassa et al., 2016b) who found in their study that young people with disabilities sourced their SRH information from radio, TV, family and friends.

School also played a very vital role in the respondents' ability to access sexual and reproductive health information; some participants said school afforded them the opportunity to receive the needed SRH information. It also emerged from this study that young people with hearing impairment were heavily relying on the usage of social media to access very important SRH information, their preferred medium for sourcing SRH information via social media was WhatsApp, Facebook and the Ghana Health Service website.

Another finding in this study concerned sexual violence; a female visually impaired participant expressed concern about rape. While she did not claim to have been raped, she did say that females with visual impairment had been victims, she suggested that females with disabilities be 'forced' to stay indoors so that they do not become victims.

A male participant with mobility impairment stated that he began having sex with his teacher when he was 11 years old, after his teacher expressed her love for him; he appeared happy recounting his many experiences. According to studies, YPWDs are frequently subjected to sexual violence by those who care for them (Burke et al., 2017).

It was further observed that one of the critical SRH services available and patronised by young people with hearing impairment was Comprehensive Abortion Care (CAC) offered by the private hospitals; they expressed satisfaction with the level of care offered them. It is however worrying to note that abortion care has become a substitute for contraceptives.

Some YPWDs said they relied on institutions like the Planned Parenthood Association of Ghana (PPAG), Ghana National Association for the Deaf (GNAD) and the church to access SRH information. Whiles the church played a role in providing counselling services for participants it also became an avenue for giving some misleading information. A male participant narrated his experience about how his prophet told him to stop using condom because its usage could lead to him to getting malaria, typhoid and diabetes. He further stated that the prophet told him he would grow lean.

5.2. Challenges associated with accessing SRH Services.

Barriers to accessing services were identified as being disability-specific. Stories about physical disabilities impeding mobility in health care facilities, as well as limitations in health workers' ability to communicate effectively with people with hearing disabilities during consultations were heard. The ability of young people with disabilities to access services confidentially and anonymously is shaped by their reliance on others to be accompanied to a health service; these observations were consistent with a study undertaken by Burke et al., 2017.

Another challenge associated with accessing SRH services among participants was cost; this was a major hurdle for all respondent; the findings of this study is consistent with (Casebolt, 2020) who identified cost as a major barrier to accessing SRH service by women with disabilities. Other barriers noted in this study was the fear being discriminated, negative attitude of health professionals; the results are consistent with studies conducted in different environments such as Uganda. (Ahumuza et al., 2014), Ethiopia (Ayehu et al., 2016), (Tanabe et al., 2015) Kenya and Uganda and Ghana (Ganle et al., 2020).

Long waiting time at the facility emerged as another major barrier for YPWDs in this study, this finding is also corroborated by (Tanabe et al., 2015). Other participants also indicated that transportation arrangement was not favourable for them hence making it difficult for them to access SRH services. Due to taboos or fear, participants reported being unable to discuss sexuality issues with their family members (Burke et al., 2017) reported similar findings in their study.

Those with hearing impairments faced a particularly difficult communication barrier, requiring the assistance of family members. Young people with physical disabilities also faced physical barriers to accessing health care, such as stairs in health care facilities that made it difficult for them to get around, or having to be accompanied by someone to gain access.

Participants from all disability groups and genders reported that they needed to be accompanied to health services by a family member or friend. Informants with physical impairments frequently had to ask a friend or family member to accompany them, and those with hearing impairments reported always needing to be accompanied to a health centre by a family member due to communication barriers. Some male participants stated that they were sexually active but had no one to discuss it with other their friends.

5.3. Satisfaction with Access to SRH Services

The majority of participants preferred private facilities over government ones; this study finding is not consistent with findings from (Burke et al., 2017; Kumi-Kyereme et al., 2020) who indicated that young people with disabilities preferred using government facilities, citing concerns about poor treatment in state-run facilities. Some participants expressed satisfaction with the SRH services provided by the hospital's doctors, and they also expressed trust in the hospital's equipment, this finding is consistent with (Tanabe et al., 2015) who indicated in their study findings that YPWD in Nepal were happy with SRH services provided by health service providers. Majority of participants stated that their decision to seek SRH services at a specific facility was influenced by recommendations from trusted friends who had previously used the facility. They were also pleased with the help they received from social relationships such as friends and classmates; in (Badu & Agyei-Baffour, 2015) study revealed that persons with disabilities who did not live with their families experienced physical and communication barriers whiles accessing health care. Some participants mentioned institutions such as the Ghana National Association for the Deaf and the Planned Parenthood Association of Ghana as providing access to SRH services and information. Other participants also expressed satisfaction with churches for providing them with SRH information and services.

While state-run facilities were chastised for not providing the best services to YPWDs, it was worth noting that the family planning unit of the Greater Accra Regional Hospital, also known as Ridge Hospital, was highly commended by participants for providing quality SRH services and information to YPWDs; they stated that the waiting time for YPWDs at the unit was very short and staff showed them respect and care.

Others held the view that state-run facilities did not really care about them, Kaneshie poly clinic, Adabraka poly clinic and 37 military hospital were all criticised for their seeming disinterest in providing care for YPWDs, they held a strong view that 37military hospital was for only people who were rich and could afford the services being rendered by the hospital.

5.4. Limitation of the Study

There are some limitations to consider with the study; the results of this was taken from data collected from 26 young people with disabilities. It is therefore impossible to generalise it as the true situation of young people with disabilities across Ghana. The study did not also consider the views of health service providers with regards to health service challenges reported by participants.

Finally, because data collection was largely based on participants' lived experiences with regard to their reproductive health history, recall bias was very likely.

CHAPTER SIX

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

6.0. Summary

The objective of this study was to assess factors associated with access to SRH services amongst young people with disabilities in the Korle Klottey Municipal of the Greater Accra Region

The study examined the experiences of young people with disabilities in accessing sexual and reproductive health services, the challenges associated with accessing sexual and reproductive health services, and satisfaction with access to sexual and reproductive health services.

Key findings of the study showed that cost was a hindrance to their ability to access reproductive health services and utilisation, communication barrier especially for young people with hearing impairment also emerged from the findings. The negative attitude of health service providers towards young people with disabilities was also reported in the result of this study.

6.1. Conclusion

Young people with disabilities, like any other young person, want to have access to sexual and reproductive health services, but they face numerous obstacles. The health systems have not been built to respond to their needs. Health services providers also lack the expertise to provide services for young people with disabilities; they do not possess the needed skills to provide sign language interpretation for those with hearing impairment.

It is also evident from the study that cost and confidentiality are very critical considerations young people with disabilities make when deciding on taking up SRHS.

6.2. Recommendations

The following are recommendations made based on the key findings of this study:

1. That the Adolescent Health Unit of the Family Health Division of Ghana Health Service should partner other partners like United Nations Population Fund (UNFPA), the Planned Parenthood Association of Ghana, Marie Stopes Ghana to expand access to SRH services and information to these critical but vulnerable population. They must also adopt social media platforms like Facebook, Twitter, WhatsApp with tailor made SRH messages for young people with disabilities.
2. It is further recommended that Ghana Health Service and its partners will liaise with media houses especially the Ghana Broadcasting Corporation which provides public broadcast services to provide tailor made SRH information to persons with disabilities especially sign language interpretation for those with hearing impairment.
3. Ghana Federation for Disability Organisations should provide trainings on sexual abuse to their members, the Federation should also liaise with the Department of Social Welfare, the Domestic Violence and Victims Support Unit of the Ghana Police Service to take up cases of sexual violence for redress.
4. It is recommended that government intervenes with subscription waivers, for this population in order for them to have access to SRHS when necessary. Given that many study participants stated that one of their main barriers to accessing SRH services was cost, financial or voucher schemes for young people with disabilities accessing free or subsidised SRH services should be implemented.

5. The Ministry of Health as a matter of urgency must ensure that sign language interpreters are available in major state-run facilities to enable YPWDs to access critical SRH services and information.
6. It is further recommended that Ghana Health Service liaises with Ghana Federation of Disability Organisations to undertake a retraining of staff on how to provide SRH services and information to YPWDs.
7. It is recommended that Ghana Health Service will immediately take steps to ensure that health service providers at the Adabraka and Kaneshie policlinics would be retrained on how to provide health care for young people with disabilities.
8. It is also recommended to the 37 Military hospital to ensure that their staff are retrained on how to provide care for young people with disabilities.
9. It is further recommended that the Greater Accra Regional Hospital – Ridge would be transformed into a learning hub for other government owned health facilities on how to provide health care services including sexual and reproductive health to persons with disabilities including young people.
10. Ghana Health Service together with its partners must create a special mobile clinic for young people with disabilities in their communities; this would help in reducing barriers they face in accessing services and information.
11. Finally, stakeholders including the UNFPA, PPAG, Marie Stopes, GFD, GHS, must adopt existing strategies like short code, short messaging services, telephone help line for YPWDs which would allow them access to information.

6.3. Future research

A similar study should be carried out on a larger scale to include a larger sample size and to investigate the viewpoints of other stakeholders in order to gain a comprehensive understanding of the experiences of young people with disabilities in accessing sexual and reproductive health services, the challenges associated with accessing sexual and reproductive health services, and satisfaction with access to sexual and reproductive health services

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APPENDICES

APENDIX A

INFORMED CONSENT

TITLE OF STUDY: Experience of Young People with Disabilities Accessing Sexual and Reproductive Health Services in Korle Klottey in The Greater Accra Region

I purposively selected you as a participant to provide in-depth knowledge of this subject at hand. As a result, I would like to invite you to take part in a Focus Group Discussion to share your experiences with sexual and reproductive health services.

As this is a qualitative study, I will lead you through a group discussion with my research assistants. A sign language interpreter will be made available for participants who will need it. The Focus Group Discussions will be recorded and transcribed after they have lasted a minimum of 45 minutes and a maximum of 60 minutes. You can ask for the recorder to be turned off at any time if you do not want your thoughts to be captured.

Pseudonyms will be used to safeguard your privacy. Personal data will be kept private as well; information gathered will be stored for two years before being safely discarded.

Because your participation in this study is entirely voluntary, you have the option of not participating at all or withdrawing at any time.

Please note that some of the questions asked may prove a bit embarrassing.

After reading this, I am completely aware of what is expected of me in this study and have decided to participate.

Date: Participant’s signature

Date: Researcher’s signature

APENDIX B

INTERPRETERS' STATEMENT

To the best of my abilities, I translated the purpose and contents of the Participants Information Sheet into Twi, Ga, Ewe, and Sign language for the participant's correct comprehension. All of the participant's queries, as well as any clarifications he or she requested, were answered to his or her satisfaction.

Name of Interpreter:

Signature of Interpreter:

Date:

Contact Details:
:

STATEMENT OF WITNESS

I was present when the purpose and contents of the Participant Information Sheet were read and satisfactorily conveyed to the participant in the language he/she understood (English/Twi/Ewe, Ga, Sign language).

Name:

Signature: OR Thumb Print

APENDIX C

INVESTIGATOR STATEMENT AND SIGNATURE

I confirm that the participant was given adequate time to read and understand about the study. All queries and clarifications raised by the participant have been answered.

Researcher's name:

Signature:

Date:

If you have further questions or issues regarding this study, which require clarification, you may contact: **Edmund Mawusinu Yao Agbeve – 0243934088**

Dr. Franklin Glozah, University of Ghana (Supervisor) – 0572000534 or email: fglozah@ug.edu.gh

The Ghana Health Service Ethics Review Committee Administrator, Nana Abena Apatu may also be contacted on **0503539896**, or by email: **ethics.reseach@ghsmail.org** for further clarification on ethical issues and participant rights.

APENDIX D

Focus Group Discussion Guide

Research Topic: Experience of Young People with Disabilities Accessing Sexual and Reproductive Health Services in Korle Klottey in the Greater Accra Region.

Demographic characteristics:

Age	Religious background	Occupation	Disability type

TO DO

Greet participants

Make sure participants are comfortable

Introduce self and purpose of meeting

Ensure that participants have read formation sheet and understands it

Check that participants have signed consent form

Notify participants of start of interview and start recording

1. Do you have knowledge of any contraceptive and use?
2. What have been your experiences accessing SRH services?
3. Where do you source your advice and information on SRH?
4. Where do you currently access SRH information and services?
5. What key factors determine your choice of where you would access SRH information and services?
6. Do you have any support network you rely on?
7. What barriers do you face in accessing SRH information services?
8. Where would you prefer to access SRH information and services?
9. How would you suggest ways to overcome barriers to SRH information and services?

APENDIX E

Edmund Mawusinu Yao Agbeve,

School of Public Health,

College of Health Sciences,

University of Ghana – Legon

21st October, 2021.

The Chairperson,

GHS – Ethics Review Committee,

P.O. BOX MB 109,

Accra – Ghana.

Dear Sir/Madam,

APPLICATION FOR ETHICAL CLEARANCE

I am a master's student in Public Health at the University of Ghana.

I am writing to request ethical permission to conduct a study on the topic **"Experience of Young People with Disabilities 18 – 35 Accessing Sexual and Reproductive Health Services in Korle Klottey in the Greater Accra Region"** as part of the Master of Public Health degree programme.

I hope you will give this application your consideration and approval.

Thank you.

Yours Sincerely,

Edmund Mawusinu Yao Agbeve

Edmund Mawusinu Yao Agbeve,

School of Public Health,

College of Health Sciences,

University of Ghana – Legon

21st October, 2021.

The Executive Director,

Ghana Federation of Disability Organisations,

Accra – Ghana.

Dear Madam,

PERMISSION TO CONDUCT RESEARCH

I am a master's student in Public Health at the University of Ghana. As part of my academic requirement I'm required to undertake a research that contributes to knowledge.

My topic is **"Experience of Young People with Disabilities 18 – 35 Accessing Sexual and Reproductive Health Services in Korle Klottey in the Greater Accra Region"**.

I'm by this letter requesting to use some selected members of your organisation as my study population.

Please find herein a summary of my research proposal.

I hope my request will meet your kindest consideration and approval.

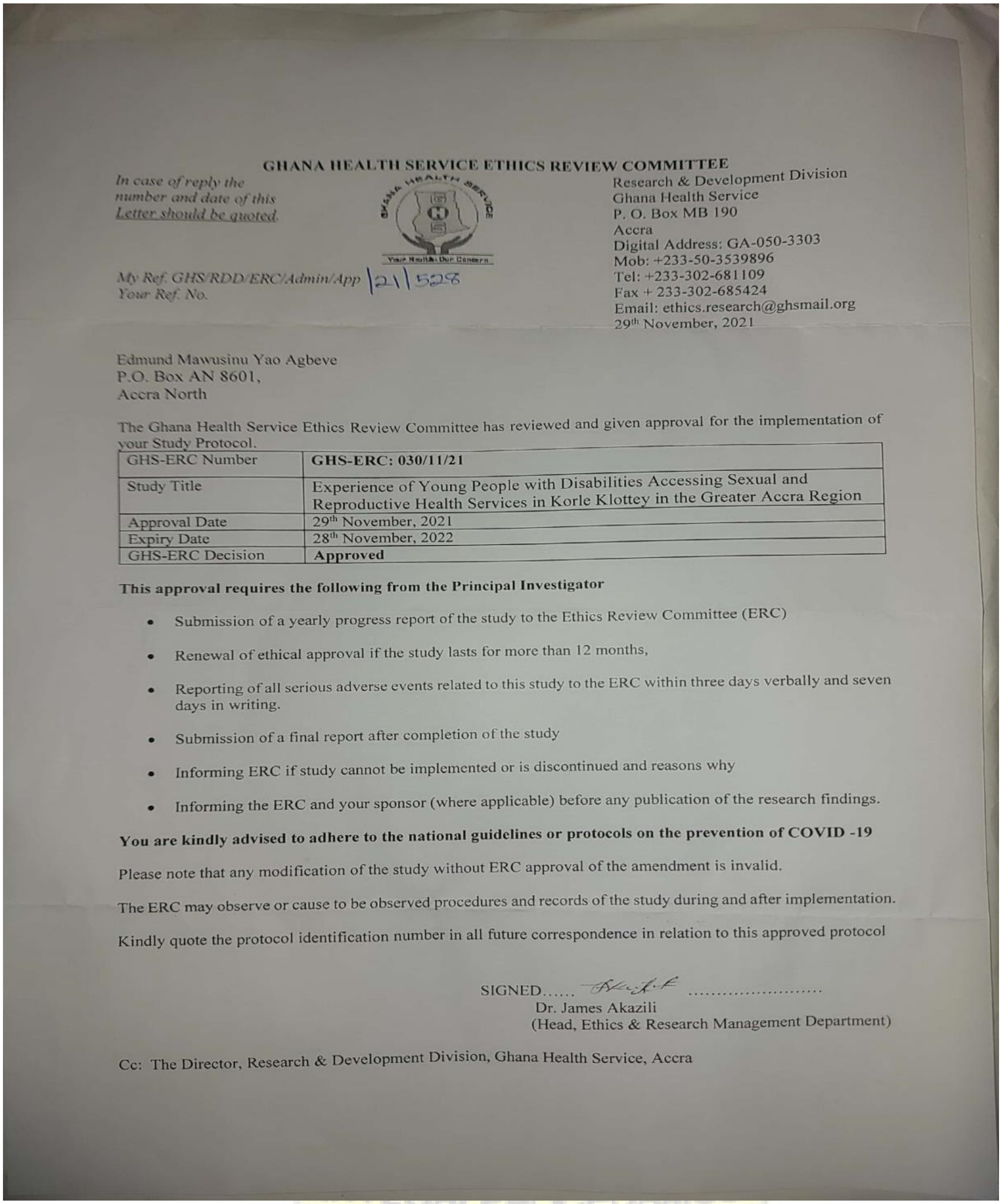
Thank you.

Yours Sincerely,

Edmund Mawusinu Yao Agbeve

APENDIX F

Ghana Health Service Ethical Clearance Approval Letter



GHANA HEALTH SERVICE ETHICS REVIEW COMMITTEE

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

Research & Development Division
Ghana Health Service
P. O. Box MB 190
Accra
Digital Address: GA-050-3303
Mob: +233-50-3539896
Tel: +233-302-681109
Fax + 233-302-685424
Email: ethics.research@ghsmail.org
29th November, 2021

My Ref. GHS/RDD/ERC/Admin/App /21/528
Your Ref. No.

Edmund Mawusinu Yao Agbeve
P.O. Box AN 8601,
Accra North

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

GHS-ERC Number	**GHS-ERC: 030/11/21**
Study Title	Experience of Young People with Disabilities Accessing Sexual and Reproductive Health Services in Korle Klottey in the Greater Accra Region
Approval Date	29th November, 2021
Expiry Date	28th November, 2022
GHS-ERC Decision	**Approved**

This approval requires the following from the Principal Investigator

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

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

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

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

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

SIGNED…… ……………………
Dr. James Akazili
(Head, Ethics & Research Management Department)

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

APENDIX G

Demographic characteristics of participants

Characteristics	N
Age	
18-24	7
25-29	9
30-35	10
Religious background	
Christian	21
Muslim	3
Others	2
Occupation	
Trade	19
Formal employment	7
Disability type	
Hearing impairment	7
Visual impairment	6
Physically challenged	13