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SOCIO-ECONOMIC FACTORS INFLUENCING ACCESS TO HEALTHCARE BY PERSONS WITH DISABILITIES IN THE KUMASI METRO

BY

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DECLARATION

I declare that I have personally undertaken the study and all sources duly acknowledged

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I have supervised the student in conducting this study. She has my permission to submit it for assessment.

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ABSTRACT

It is estimated that about 15% of the world's population live with disabilities of various types, and the number is increasing due to the rise of chronic diseases, injuries, car crashes, falls, violence and other causes such as ageing. Of this total, 80% live in lowincome countries; most are poor and have limited or no access to basic services, including healthcare and rehabilitation facilities.

The general objective of the study was to find out the Socio-Economic factors influencing access to healthcare by persons with disabilities in the Kumasi Metro. Qualitative study was carried out. Purposive sampling was used to select the respondents for the study (persons with disabilities and healthcare workers). A case study design was adopted with Kumasi metro as the case, structured interview and focus group discussions were also employed to collect data from the respondents of the study. In all 15 interviews were conducted, 10 in-depth interviews with health workers and 5 focused group discussions with persons with disabilities. Data was analysed based on the themes that emerged during the discussions and responses have been paraphrased to support the data. The study found that the major social factors that influence access to healthcare are cultural explanation of disability, stigmatization, and attitude of health care workers towards persons with disabilities. The economic factors include, cost of treatment and assistive devices, unemployment, poverty, transportation problems.

In view of the various findings, it is recommended that there should be review of national health policy programs and implementation to ensure that the needs of persons with disabilities are adequately catered for. Also there should be effective public education for the general public concerning disability.

DEDICATION

I dedicate this work to Almighty God


NYANSAPƆ WƆSANE NO BADWENMA

ACKNOWLEDGEMENT

I thank God for how far he has brought me.

I also wish to express my appreciation to Dr. Peter Agyei-Baffour who guided me during this write-up.

Finally, to all those who helped me in diverse ways, I say may God richly bless you and grant you all your heart desires.

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FULL MEANING OF ABBREVIATIONS USED IN THE STUDY

ABBREVIATION	MEANING
UNCRPD	United Nation’s Convention on the Rights of Persons with Disability
WHO	World Health Organization
GSS	Ghana Statistical Service
GoG	Government of Ghana
NHILG	National Health Insurance Law of Ghana (Act 852) 2012
NIH	National Institutes of Health
CESCR	Committee on Economic, Social and Cultural Rights
UN	United Nations
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRC	Convention on the Rights of the Child
PWDs	Persons With disabilities
DPOs	Disabled People’s Organisation

CHAPTER ONE

INTRODUCTION

1.0 Background of the Study

The WHO estimates that about 15% of the world's population live with disabilities of various types, and the number is increasing due to the rise of chronic diseases, injuries, car crashes, falls, violence and other causes such as ageing. Of this total, 80% live in low-income countries; most are poor and have limited or no access to basic services, including healthcare and rehabilitation facilities (WHO 2006).

Disability as a social phenomenon cuts across all spheres of society and requires support from all sectors. It is noted that persons with disabilities are not a homogeneous group but are varied in terms of the nature of their disability and their mental, physical and social needs.

According to the World Health Organization (2011), Disability is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment per the report of WHO is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person's body and features of the society in which he or she lives. Disability is part of human life and people, especially children, with disabilities can be found in every society, every culture and every community throughout the world. People are either born or made disabled through circumstances and events (WHO, 2011).

Globally, stigmatization and discrimination against persons with disabilities is a matter of public health concern. This is due to the fact that many people with disabilities are challenged twice; on one hand, they struggle with disabilities that result from the impairment and on the other, they are stereotyped and prejudiced due to misconceptions about their conditions (Corrigan and Watson, 2002).

In both low-income and middle-income countries in Africa, it is estimated that between 76 percent and 99 percent of people with serious disabilities do not have access to the treatment they need for their health problems (Faydi et al., 2011; World Health Organization, 2008). Across the world, people with disabilities receive negative publicity and are stigmatized and discriminated against in spite of growing evidence of the importance of healthcare for disabled people and development (Sadik et al, 2010). Access to healthcare by disabled people has an impact on varied development outcomes and is a basis for social stability because it serves as a key determinant of well-being and quality of life (WHO, 2010).

Disability is also seen in Ghana as a result of witchcraft, sorcery, 'juju' and magic (Avoke, 1997). Before the era of Christianity and missionary activities, Ghanaians were purely traditionalists, believing in all sorts of inanimate objects. Some Ghanaians believe that people with epilepsy are filled with demons that sometimes torment and throw them on the ground, when they so wish (Agbenyega, 2002). In the Akan tribe, persons with epilepsy are labelled 'Twafuo,' derogatory tribal language that literally means 'falling down sicknesses'. No one is allowed to touch or be near them when the convulsion occurs, with the belief that anyone who does so will also be possessed with the demons.

1.1 Problem Statement

Supporting health needs is an essential contribution towards achieving inclusion and social justice. Compared with other populations, persons with disability often have poorer health and a lower life expectancy (Emerson and Baines, 2010). While it is clear that persons with disability can be healthy, it is understood that they experience a different level of health than their non-disabled peers. They have very high rates of health problems that are often not diagnosed or appropriately treated (WHO, 2001). Diagnosis and treatment of persons with disability are often hampered by a lack of training of health professionals, communication barriers, a lack of co-ordinate care, insufficient health outreach programs and a lack of appropriate policies. In the absence of equal access to health care or an inclusive health care system, persons with disability are at serious risk of delayed diagnoses, secondary co-morbidities, persistent abuse, depleted social capital, and isolation (Stein et al, 2009).

Through structured processes, disabled people have historically found themselves in powerless, subordinate positions and have consequently suffered discrimination, oppression and exclusion through a resulting lack of control over their lives, economic dependency and disadvantage, stereotyping and labelling processes. This constitutes a struggle in confronting issues of human differences negatively (from name-calling and bullying to media images rather than valuing them or even perceiving them neutrally (Scambler, 1984).

Most people with disability are unable to access quality healthcare due to the problems they go through when they visit health centres. The problems they go through are usually as a result of the misconceptions about and stigma attached to their condition. The experience of stigma is characterized by shame, blame, secrecy, labelling, isolation, social exclusion and discrimination. Since stigma is often rooted in social attitudes, persons with disability in Ghana are often disliked, rejected, shunned and could experience sanctions, harassment, and even violence (Agbenyega, 2003; Avoke, 2002; Baffoe, 2013).

Notwithstanding internationally mandated conventions calling for equal rights for all persons, in many communities within the Metro, disabled people are still denied access to adequate health care. Negative attitude towards persons with disabilities are as a result of the differing views about what causes disability, cultural explanation of the condition, high unemployment and poverty among disabled people coupled with rooted discrimination against persons with disabilities in the health system of the country make it difficult for persons with disabilities to access adequate healthcare in the Kumasi Metro.

1.2 Research Questions

The questions that rose were:

- What role do socio-economic factors play in persons with disabilities' access to healthcare?
- What is the general attitude of health workers towards persons with disabilities?

1.3 Study Objectives

The general objective of the study was to find out the Socio-Economic factors influencing access to healthcare by persons with disabilities in the Kumasi Metro.

The specific objectives were to:

- Investigate the social factors that influence access to health care by persons with disabilities in the Metro.
- Find out the economic factors influencing access to healthcare by persons with disabilities in the Metro
- Ascertain the attitude of health workers towards persons with disabilities who visit health centres to access healthcare.

1.4 Justification and significance of the study

There are several international and local laws that aim at ensuring that access to healthcare is a universal right to all people irrespective of your status or condition. In recognition of the fact that persons with disabilities are vulnerable members of the community that need additional protection, the UN Convention on the Rights of Persons with Disabilities (CRPD) entered into force on 3 May 2008. The CRPD obligates states to provide equal access to health care and related services for persons with disability. Article 25 which is the overarching health provision in the CRPD states that:

> State Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender sensitive, including health-related rehabilitation.

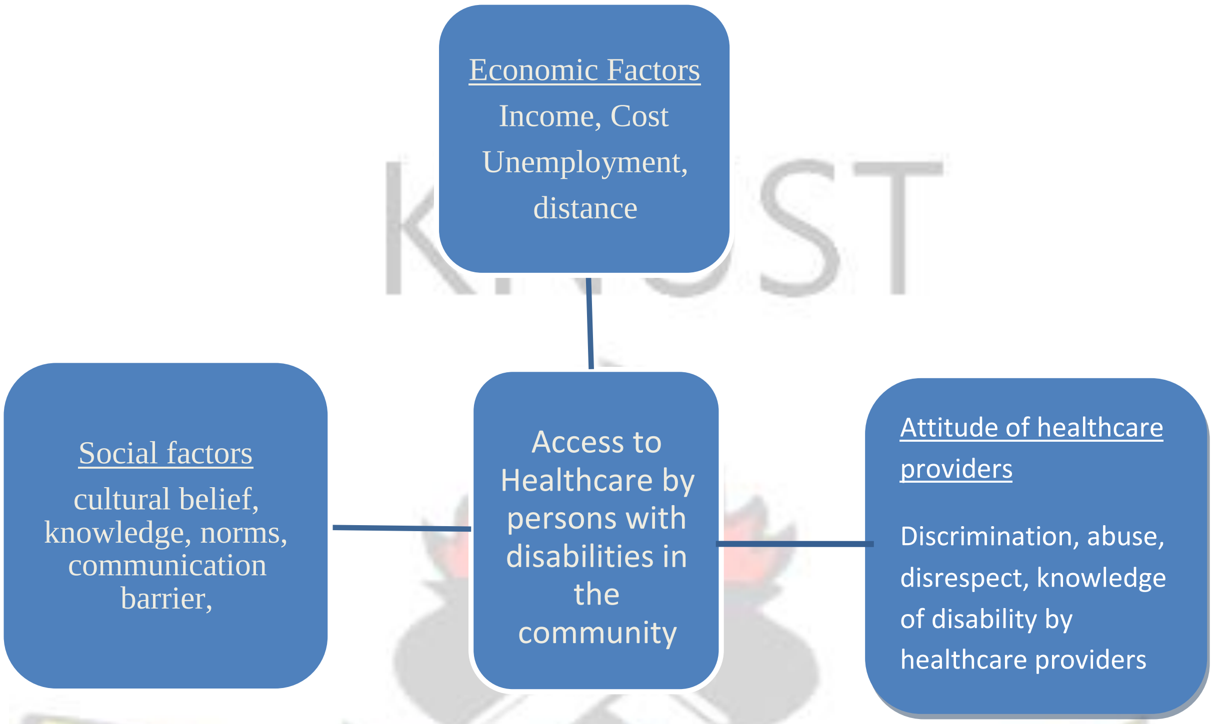
The Disability Law of Ghana in sections 32, 33, 34, 35 and 36 mandate the Ministry of Health to formulate health policies that shall provide for free general and specialist medical care, rehabilitative operation treatment and appropriate assistive devices for persons with disability. Include the study of disability and disability related issues in the curricula of training institutions for health professionals to develop appropriate human resources to provide general and specialized rehabilitation services. Include education on disability and disability issues in health care programs. The Ministry of Health in collaboration with the Ministries responsible for Education and Social Welfare shall provide for the periodic screening of children in order to detect, prevent and manage disability. The Ministry of Health in collaboration with District Assemblies and the Ministry responsible for Social Welfare shall establish and operate health assessment and resource centres in each district and provide early diagnostic medical attention to mothers and infants to determine the existence or onset of disability.

Again, the National Health Policy of Ghana developed in 2007 has as its central theme "Creating Wealth through Health". The mission of the Ministry of Health as stated in the policy document is to contribute to socio-economic development and wealth creation by promoting health and vitality, ensuring access to quality health, population and nutrition services for all people living in Ghana and promoting the development of a local health industry (Ministry of Health, 2007).

Despite these laws that ensure that the rights of persons with disabilities are protected in their quest to access healthcare, they are unable to effectively access quality healthcare like their non-disabled counterparts. Access to healthcare continues to be the preserve of the few privileged individuals in the country, contrary to the expectations of international and local laws as well as national development policies. This study was therefore important to bring to the fore the difficulties persons with disabilities face in accessing healthcare in the Metro.

1.5 Conceptual Framework

Figure 1 showing the framework of the various concepts and variables associated with socio-economic factors influencing persons with disabilities' access to healthcare



Source: Author's Construct (2014)

The following factors; social factors and economic factors, were conceptualized as those that influence access to health care by persons with disabilities in the community. The social factors consist of cultural belief, knowledge, norms, communication barrier. Economic factors include income, cost, unemployment and distance. And attitude of health care providers. Although attitude of health workers is a social factor but was captured separate in the conceptual framework of this study because it is an objective which the researcher sought to address. One of the strongest and most consistent predictors of a person's morbidity and mortality experience is that person's socioeconomic status (SES). This finding persists across all diseases with few exceptions, continues throughout the entire life span, and extends across numerous risk factors for disease. The significant impact of SES on disease makes its definition and measurement of critical importance. SES is a complex phenomenon predicted by a broad spectrum of variables that is often conceptualized as a combination of financial, occupational, cultural, attitudinal and educational influences. These dimensions of SES are interrelated and work together to demonstrate how the different forces work together to affect persons with disabilities' access to healthcare. For example, income reflects spending power, housing, diet, and medical care; occupation measures prestige, responsibility, physical activity, and work exposures; and education indicates skills requisite for acquiring positive social, psychological, and economic resources.

1.7 Organization of the study

The work was structured into six chapters; Chapter one contains the general introduction, Literature review in chapter two, chapter three covered methodology, Data presentation and findings in chapter four, discussion is captured in chapter five and recommendations, conclusion and suggested area for further study in chapter six.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter contains review of related materials written by authors on the issues under investigation. The review is divided into the following sub-headings based on the objectives;

- Healthcare as a right
- Social factors influencing access to healthcare by disabled people
- Economic factors
- Gaps in the Literature

Symbolic interaction theory which believes that people interact in their environment based on symbols and shared meanings they hold about those symbols. People behaved towards persons with disabilities based on the common symbol of impairment and their shared meaning concerning what constitutes disability especially the real cause of it. The same way the value of something plays a role in a people's ability to purchase or access it.

2.1 Healthcare as a right

The right to health is a universal human right, meaning that it is a right everyone is entitled to. In broad terms, this right can be understood to encompass *a right to health care* and *a right to 'healthy' social conditions* such as adequate sanitation, nutrition, housing and safe drinking water. These two components must be available, accessible, accepting and quality for all persons. It is important to note that the right to health is not a limitless right to medical treatment or social care, nor should it be understood as the right to be healthy. Instead, it should be understood as the right to enjoy a variety of facilities and conditions which the State is responsible for providing, and which are necessary for the attainment and maintenance of good health (Inclusion Ghana, 2013). The right to health has been enshrined in international and regional human rights treaties, as well as national legislation all over the world, including Ghana. For example, the right can be found in the Universal Declaration of Human Rights (1948); the African Charter on Human and Persons' Rights

(ACHPR, 1981) the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1966); Convention on the Elimination of All Forms of Discrimination Against Women (1979); and the Convention on the Rights of the Child (CRC, 1989).

Of all international conventions, the ICESCR provides the most comprehensive outline of the right to health. The ICESCR states that everyone has the right to enjoy "the highest attainable standard of physical and mental health". It also states that in order for the right to health to be realized, Governments must take steps that:

- *Reduce infant mortality and ensure the healthy development of the child;*
- *Improve environmental and industrial hygiene;*
- *Prevent, treat and control epidemic, endemic, occupational and other diseases; and*
- *Create conditions to ensure access to health care for all.*

The UN Committee on Economic, Social and Cultural Rights, which monitors compliance with the ICESCR, adopted a General Comment on the Right to Health in 2000. According to the General Comment, the right to health contains four elements:

- **Availability:** A sufficient quantity of functioning public health and health care facilities, goods and services, as well as programs.
- **Accessibility:** Health facilities, goods and services accessible to everyone.

Accessibility has four overlapping dimensions: non-discrimination, physical accessibility, economical accessibility (affordability), and information accessibility.

- **Acceptability:** All health facilities, goods and services must be respectful of medical ethics and culturally appropriate as well as sensitive to gender and lifecycle requirements.
- **Quality:** Health facilities, goods and services must be scientifically and medically appropriate and of good quality. Of all international conventions, the ICESCR

provides the most comprehensive outline of the right to health. In recognition of the fact that persons with disabilities are vulnerable members of the community that need additional protection, the UN Convention on the Rights of Persons with Disabilities (CRPD) entered into force on 3 May 2008. The CRPD obligates states to provide equal access to health care and related services for persons with disabilities, and represents the first legally binding international instrument that specifically protects the rights of some 650 million such persons worldwide. It is also the first treaty in which non-governmental organisations were present during negotiations and could make interventions. Persons with disabilities participated as members of organisations of persons with disabilities, state delegations, and UN organisations. Partly due to this inclusive process, the CRPD has received wide support, with Ghana having signed and ratified the instrument.

The core principles of the CRPD include respect for human dignity, non-discrimination, full participation, social inclusion, equality of opportunity, and accessibility. Rights relating to equal access to health care are set out in separate articles on health, habilitation and rehabilitation, personal mobility, accessibility, women with disabilities, children with disabilities, and general obligations, amongst others.

Article 25, which focuses on health, not only ensures the right of persons with disabilities to equally enjoy “the highest attainable standard of health without discrimination on the basis of disability”, but also requires states to provide free or affordable general and specialist health services. Moreover, Article 25 mandates that health-care professionals must always obtain “free and informed consent”. States must also work towards “raising awareness of the human rights of persons with ID”. Article 26 (Rehabilitation and habilitation) requires States to “organize, strengthen and extend comprehensive habilitation and rehabilitation services and programmes” while ensuring that programming supports community participation, is voluntary, and is located as close as possible to persons with disabilities in their own communities, including rural areas.

Article 4 (General obligations) mandates governments to take specific action, include promoting the availability of assistive devices, providing accessible information, promoting research on assistive technologies, advancing universal design (i.e., accessible for all persons), and training professionals working with persons with disabilities.

Article 25 which is the overarching health provision in the CRPD states:

State Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender sensitive, including health-related rehabilitation. In particular,

States Parties shall:

a. *Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes;*

b. *Provide those health services needed by persons with disabilities specifically because of their disabilities, including early identification and intervention as appropriate, and services designed to minimize and prevent further disabilities, including among children and older persons;*

c. *Provide these health services as close as possible to Person's own communities, including in rural areas;*

d. *Require health professionals to provide care of the same quality to persons with disabilities as to others, including on the basis of free and informed consent by, inter alia, raising awareness of the human rights, dignity, autonomy and needs of persons with* *disabilities through training and the promulgation of ethical standards for public and private health care;*

e. *Prohibit discrimination against persons with disabilities in the provision of health insurance, and life insurance where such insurance is permitted by national law, which shall be provided in a fair and reasonable manner;*

f. *Prevent discriminatory denial of health care or health services or food and fluids on the basis of disability.*

State compliance with the CRPD has precipitated worldwide domestic law reform, as well as consideration of how these laws will be effectively implemented. In Ghana, the Disability Law (Act 715) was created in 2006, prior to the CRPD entering into force in 2008. The Disability Law contains several sections regarding health care for persons with disabilities, being the following:

Medical treatment

Section 31. *The Ministry of Health in formulating health policies shall provide for free general and specialist medical care, rehabilitative operation treatment and appropriate assistive devices for persons with total disability.*

Training of health professionals

Section ***32***. *The Ministry of Health shall include the study of disability and disability related issues in the curricula of training institutions for health professionals to develop appropriate human resources to provide general and specialized rehabilitation services.*

Health programmes

Section 33. *The Ministry of Health shall include education on disability and disability issues in health care programmes.*

Periodic screening of children

34. The Ministry of Health in collaboration with the Ministries responsible for Education and Social Welfare shall provide for the periodic screening of children in order to detect, prevent and manage disability.

Establishment of assessment centres

35. The Ministry of Health in collaboration with District Assemblies and the Ministry responsible for Social Welfare shall establish and operate health assessment and resource centres in each district and provide early diagnostic medical attention to mothers and infants to determine the existence or on set of disability (Disability Act of Ghana, 2006).

As at 15th November 2013 the legislative instrument, which is needed to implement the Disability Law, has not yet been finalized by the Government of Ghana (GoG). In fact, a review of the Disability Law to ensure it is compliant with the CRPD is currently underway, suggesting this law may be reformed in the near future. For this reason, Inclusion Ghana is using the ICESCR and the CRPD as the basis for its analysis of the right to health care, as any future Disability Law in Ghana must, at minimum, be in compliance with these Conventions (Inclusion Ghana, 2013).

A health care system that ensures persons with disability enjoy this right to health care has been referred to as ‘inclusive healthcare.’ In other words, it is ‘an effective response to the needs of patients, not just in terms of treatment of health predicament, but also by addressing the overall well-being through understanding, informing, involving, counselling and respecting the individual (Lindsey, 1992).

2.2 Social Factors influencing Access to healthcare by disabled people

Perceptions of health status may influence health behaviours, including attendance at health care services, and how health needs are communicated. A study on people with epilepsy in rural Ghana, for example, found that spiritual beliefs surrounding epilepsy influenced health and seeking of treatment. Another study in rural areas of the Gambia reported that only 16% of 380 people with epilepsy knew that preventive treatment was possible; of the 48% of people with epilepsy who had never used treatment, 70% did not know that clinics offered treatment for seizures (Coleman et al, 2002; WHO, 2011). It has been documented by some scholars that people with intellectual impairment in minority ethnic communities have also been found to be less likely to use health care services. An Australian study on women with mental health conditions and physical, sensory, and intellectual impairment found that self-perceptions regarding sexuality, painful past experiences associated with reproductive screening, and memories of themselves before disability were all barriers to seeking health care. In another example, people who experience disability as they age may “normalize” their symptoms as “just part of ageing” rather than seeking appropriate treatment. When the cause of a disease or impairment is not well understood and it is treated as mystery, it tends to elicit fear from others (Sontag, 2001).

Indeed, societal knowledge, understanding and beliefs about disability have been shown to be a cause of disability stigma.

The misconceptions and myths about disability are often aggravated by the incorrect health education messages from health workers, which most often do not explain to the community members how disability is not spread. When there is uncertainty about how a disease is transmitted, the multiple interpretations of the cause and spread that ensue have the propensity to fuel stigmatisation of individuals suffering from the disease (Ogden and Nyblade, 2005).

Stigma has always had a moral dimension, as apparent in the meaning of the word ‘stigma’, which according to Goffman, is to “expose something unusual and bad about the moral status of the bearer” (Goffman, 1963 p.11). Consequently, individuals who are perceived to be a threat to societal values will be stigmatised. The belief in this society that adopting certain ‘socially unacceptable lifestyles’, such as disrespect for taboos, norms and cultural beliefs could cause disability has been reported in other settings. Such moral positions can make people think that individuals who have disability or families who have disabled people among them have themselves to blame because they undermined social morals. This can lead to societal attitude of condemnation towards those with the condition (Stangor and Crandall, 2000; Dodor, 2009).

Other societies believe that illness is the result of supernatural phenomena and promote prayer or other spiritual interventions that counter the presumed disfavour of powerful forces. Cultural issues play a major role in patient compliance. One study showed that a group of Cambodian adults with minimal formal education made considerable efforts to comply with therapy but did so in a manner consistent with their underlying understanding of how medicines and the body work. For example the Asians or Pacific Islanders are a large ethnic group in the United States. The extended family has significant influence, and the oldest male in the family is often the decision maker and spokesperson. The interests and honour of the family are more important than those of individual family members. Older family members are respected, and their authority is often unquestioned (McLaughlin and Braun, 1998).

All cultures have systems of health beliefs to explain what causes illness, how it can be cured or treated, and who should be involved in the process. The extent to which patients perceive patient-education as having cultural relevance for them can have a profound effect on their reception to information provided and their willingness to use it. Western industrialized societies such as the United States, which see disease as a result of natural scientific phenomena, advocate medical treatments that combat microorganisms or use sophisticated technology to diagnose and treat disease (National Institutes of Health, 2013).

Among Asian cultures, maintaining harmony is an important value; therefore, there is a strong emphasis on avoiding conflict and direct confrontation. Due to respect for authority, disagreement with the recommendations of healthcare professionals is avoided. However, lack of disagreement does not indicate that the patient and family agree with or will follow treatment recommendations. Among Chinese patients, because the behaviour of the individual reflects on the family, mental illness or any behaviour that indicates lack of self-control may produce shame and guilt. As a result, Chinese patients may be reluctant to discuss symptoms of mental illness or depression. Some subpopulations of cultures, such as those from India and Pakistan, are reluctant to accept a diagnosis of severe emotional illness or mental retardation because it severely reduces the chances of other members of the family getting married. In Vietnamese culture, mystical beliefs explain physical and mental illness (McLaughlin and Braun, 1998).

Health is viewed as the result of a harmonious balance between the poles of hot and cold that governs bodily functions. Vietnamese don’t readily accept Western mental health counselling and interventions, particularly when self-disclosure is expected. However, it is possible to accept assistance if trust has been gained. Russian immigrants frequently view U.S. medical care with a degree of mistrust. The Russian experience with medical practitioners has been an authoritarian relationship in which free exchange of information and open discussion was not usual. As a result, many Russian patients find it difficult to question a physician and to talk openly about medical concerns. Patients expect a paternalistic approach-the competent health care professional does not ask patients what they want to do, but tells them what to do. This reliance on physician expertise undermines a patient's motivation to learn more about self-care and preventive health behaviours. Although Hispanics share a strong heritage that includes family and religion, each subgroup of the Hispanic population has distinct cultural beliefs and customs. Older family members and other relatives are respected and are often consulted on important matters involving health and illness. Fatalistic views are shared by many Hispanic patients who view illness as God's will or divine punishment brought about by previous or current sinful behaviour. Hispanic patients may prefer to use home remedies and may consult a folk healer, known as a curandero. As can be seen, each ethnic group brings its own perspectives and values to the health care system, and many health care beliefs and health practices differ from those of the traditional American health care culture (National Institutes of Health, 2013).

Cultural differences affect patients' attitudes about medical care and their ability to understand, manage, and cope with the course of an illness, the meaning of a diagnosis, and the consequences of medical treatment. Patients and their families bring culture specific ideas and values related to concepts of health and illness, reporting of symptoms, expectations for how health care will be delivered, and beliefs concerning medication and treatments. In addition, culture specific values influence patient roles and expectations, how much information about illness and treatment is desired, how death and dying will be managed, bereavement patterns, gender and family roles, and processes for decision making (McLaughlin and Braun, 1998).

Care giving responsibilities and gender can also be barriers to health care. Women are the typical caregivers in most societies and these responsibilities can be a barrier to their receiving care or for obtaining care for members of the family. Gender may also be a barrier. For example, there is a common perception that males, more than females are impatient and unwilling to wait for a scheduled appointment or to go to an inconvenient location for care. Several aspects of a person’s culture can influence his or her tendencies to seek eye and vision care. There may be differences in perceived susceptibility to disease, distrust of doctors and the health care system; a fear or belief that they will not be treated with respect nor have their cultural beliefs considered. For example, pride, or the belief that suffering in silence is their fate, has been cited in the African American community as a barrier to seeking dilated eye exams. Language difficulties may be a problem. For example, Spanish-speaking Hispanics reported far worse health status and access to care than did English-speaking Hispanics (39% vs17% in fair or poor health, 55% as against 23% uninsured, and 58% as against 29% without a personal doctor) and received less preventive care (WHO, 2012).

Attitude of health workers towards persons with disabilities

Primary care consultations can take longer for people with disabilities than for people without disabilities. Adults with intellectual impairment often require extra time for examinations, screening, clinical procedures, and health promotion. Health-care practitioners are often not reimbursed for the additional consultation time they spend with people with disabilities and the disparities between actual cost and reimbursement can be a disincentive for service providers to provide comprehensive health care. Short consultations may leave little time for service providers to understand and address the sometimes complex health care needs of people with disabilities (Aulangnier, 2005).

Communication barrier

Communication difficulties between people with disabilities and service providers are regularly cited as an area of concern. Difficulties can arise when people with disabilities attempt to make appointments with service providers, provide a medical history and description of their symptoms, or try to understand explanations about diagnosis and management of health conditions. Inaccurate case histories may be provided to healthcare practitioners when information is supplied by caregivers, family members, or others. Service providers may feel uncomfortable communicating with people with disabilities. For example, many health-care providers have not been trained to interact with people with serious mental illness, and feel uncomfortable or ineffective in communicating with them. An investigation into Deaf women's access to health care in the United States found that health-care workers often turn their heads down when talking, preventing deaf women from lip-reading (Ubido et al, 2002).

Failure to communicate in appropriate formats can lead to problems with compliance and attendance. A survey commissioned by the Zimbabwe Parents of Handicapped Children's Association found that people with disabilities were excluded from general HIV/AIDS services because counseling and testing were not offered in sign language for people with hearing impairments, and education and communication materials were not offered in Braille for people with visual impairments.

Some people with disabilities may have multiple or complex health needs, including rehabilitation, which require input from different service providers. These needs may extend across services in different sectors such as the education and social sectors. People with disabilities who require multiple services often receive fragmented or duplicative services. They may also encounter transitional difficulties when care is transferred from one service provider to another, such as when transitioning from child to adult services and from adult services to elderly services (Banda, 2006).

Lack of communication between service providers can hamper coordinated service delivery. Primary health-care professionals' referrals to specialists often lack sufficient information, for example. Conversely primary health-care professionals frequently receive inadequate consultation reports from specialists, and discharge summaries following hospital admission may never reach the primary care doctor (Bodenheimer, 2006)

Knowledge of disability by health workers

The attitude of health workers towards persons with disabilities is in most cases rooted in the cultural beliefs and their understanding of disability especially what causes it. Their perceptions usually take over their professional demands. The attitude can be explained from the work of Goffman as he shows how non-stigmatized individuals behave towards stigmatized people.

Interactions between stigmatised and non-stigmatised individuals are often characterised by uncomfortable moments and this can generate a lot of anxiety for both parties. During the interactions, both stigmatised and non-stigmatised individuals focus on what they say, do and the implications of their actions (Goffman, 1963), and this creates anxiety during the interactions. The possibility of encountering such interactions can lead both stigmatised and non-stigmatised individuals to adjust their lives so as to avoid meeting each other. Indeed, Goffman pointed out that stigmatised individuals do avoid interaction with non-stigmatised (Goffman, 1963).

Societal norms and expectations dictate that interactions among members in society occur between non-stigmatised individuals. Therefore when it becomes necessary for non-stigmatised individuals to interact with stigmatised individuals, this necessitates changes to the social norms and expectations. The disruption, which often results in the development of new ways of interaction between the two, can generate anxiety for both parties (Hebl et al., 2000; Dodor, 2009).

The non-stigmatised may experience fear in the interaction because the stigmatising attribute may pose a danger. The fear may be either physical or social. In physical fear the non-stigmatised may be afraid of the possibility of contracting the stigma from the stigmatised, as in most contagious diseases, while in social fear the anxiety is the loss of social status through association with the stigmatised. Both physical and social fear can make the non-stigmatised to avoid association with the stigmatised.

When non-stigmatised individuals are aware of the devalued social identity of the stigmatised, this can either consciously or unconsciously activate cultural stereotypes about the stigmatised, and can influence the behaviour of the non-stigmatised towards the stigmatised. There is also the tendency for the non-stigmatised individual to interpret the stigmatised person's past and present in terms of the stigma (Jones et al., 1984). Individuals who possess stigmatising attributes are conscious of the fact that they may be targets of prejudice and discrimination, and this shapes and defines their day to day activities Moreover, because of the ever-present possibility of being stigmatised, they are always careful in interactions with non-stigmatised individuals and this result in uncomfortable and awkward moments. The experiences of others may also affect the stigmatised individual's sense of vulnerability to stigmatisation (Goffman, 1963; Jones et al., 1984).

Furthermore, based on dominant cultural beliefs, stigmatised individuals are aware of the fact that they possess a stigmatising attribute. Consequently, when interacting with nonstigmatised individuals, the stigmatised individuals will be concerned with the salience of the stigma and will want to minimise and reduce attention to it so as to normalise the interactions (Goffman, 1963; Major and O'Brien, 2005).

However, individuals with visible stigmas cannot use concealment to cope with the stereotypes, prejudice, and harassment that their stigma may trigger. Under such circumstances, the stigmatised will experience stigma threat, and may feel anxious that their behaviour may confirm what others already believe about them. As a result, the stigmatised is very careful during such interactions, looking for meaning and intents in the statements of the non-stigmatised person, and may also be concerned with damage to his/her self-esteem during the interactions. They may also get confused about the behaviour of the non-stigmatised and wonder whether what they say or do is dependent on their social identity or personal qualities (Crocker et al., 1998, Major and O'Brien, 2005).

2.3 Economic factors influencing access to healthcare by persons with disabilities

Cost of treatment

A review of the 2002–2004 World Health Survey reveals that affordability was the primary reason why people with disabilities, across gender and age groups, did not receive needed health care in low-income countries. For 51 countries 32–33% of nondisabled men and women cannot afford health care, compared with 51–53% of people with disabilities. Transport costs also rank high as a barrier to health care access in low-income and high-income countries, and across gender and age groups (WHO, 2011).

Health services are funded through a variety of sources including government budgets, social insurance, private health insurance, external donor funding, and private sources including nongovernmental arrangements and out-of-pocket expenses. The World Health Survey *(2004)*showed that the rate at which people with disabilities pay with current income, savings, or insurance is roughly the same as for people without disabilities, but paying with personal means varies between groups: paying with insurance is more common in high-income countries, while selling items and relying on friends and family is more common in low-income countries, and people with disabilities are more likely to sell items, borrow money, or rely on a family member.

Public health systems theoretically provide universal coverage, but this is rare. No country has ensured that everybody has immediate access to all health care services. In the poorest countries only the most basic services may be available. Restrictions in public health sector expenditure are resulting in an inadequate supply of services and a significant increase in the proportion of out-of-pocket expenditure by households (World Health Report, 2010). In many low-income countries less than 1% of health budgets are spent on mental health care, with countries relying on out-of-pocket payments as the primary financing mechanism. Some middle-income countries are moving towards private sector provision for treatments such as mental health services (*Dixon, 2006*).

Unemployment

People with disabilities experience lower rates of employment, are more likely to be economically disadvantaged, and are therefore less likely to afford private health insurance. Employed people with disabilities may be excluded from private health insurance because of pre-existing conditions or be “underinsured” because they have been denied coverage for a long period (*11*), or are excluded from claiming for treatment related to a pre-existing condition, or must pay higher premiums and out-of-pocket expenses (White, 2002).

Analysis from the 2002–2004 World Health Survey across 51 countries showed that men and women with disabilities, in high-income and low-income countries, had more difficulties than adults without disabilities in obtaining, from private health care organizations or the government, payment exemptions or the right to special rates for health care. Furthermore people with disabilities experienced more difficulties in finding out which benefits they were entitled to from health insurance and obtaining reimbursements from health insurance. This finding was most evident in the age group 18–49 with some variability in the older age groups across income settings (WHO, 2011).

The Survey also found that disabled respondents in 31 low-income and low middleincome countries spend 15% of total household expenditure on out-of-pocket health care costs compared with 11% for nondisabled respondents. People with disabilities were also found to be more vulnerable to catastrophic health expenditure across gender and age groups, and for both low-income and high-income countries as defined by the World Bank. For all countries, 28–29% of all people with disabilities suffer catastrophic expenditures compared with 17–18% of nondisabled people, but low-income countries show significantly higher rates than high-income countries across sex and age groups (WHO, 2011).

Social health insurance systems are generally characterized by mandatory payroll contributions from individuals and employers. These employer-based systems may be inaccessible for many adults with disabilities because they have lower employment rates than people without disabilities. Even employed people with disabilities may not be able to afford insurance premiums associated with employer-based health insurance plans. While disabled people working in the informal sector or for small businesses are unlikely to be offered insurance (Gottret and Schieber 2006:WHO, 2011).

Health system financing options determine whether health services – a mix of promotion, prevention, treatment, and rehabilitation – are available and whether people are protected from financial risks associated with using them. Contributions such as social insurance and co-payment for health services must be affordable and fair, and take into account the individual’s ability to pay. Full access will be achieved only when governments cover the cost of the available health services for disabled people who cannot afford to pay. A range of health financing options can increase the availability of health care services to the general population, and improve access for individuals with disabilities (Kruk and Freedman, 2008).The World Health Report in 2010outlines an action agenda for paying for health that does not deter people from using services including: raise sufficient resources for health by increasing the efficiency of revenue collection, reprioritizing government spending, using innovative financing, and providing development assistance; remove financial risks and barriers to access; promote efficiency and eliminate waste (WHO, 2011).

While improving access to affordable, quality health care pertains to everyone, the evidence presented above suggests that people with disabilities have more health care needs and more unmet needs. Having insurance (public, private, or mixed) can increase disabled people's access to, and use of, health care services. Having insurance improves a variety of outcomes including an increase in the likelihood of receiving primary care, a decrease in unmet needs (including for special care), and a reduction in delays or in foregoing care. Insurance for a wide range of basic medical services can improve clinical outcomes, and can reduce the financial problems and the burden of out-of-pocket payments for families. Subsidizing health insurance can also extend coverage to persons with disabilities. In Taiwan, China the health insurance scheme pays for part of the insurance premium for people with intellectual disabilities according to their level of disability (Ayanian, 2000).

Some governments have targeted funding to primary care doctors and organizations to support health care of people with the greatest need. Care Plus – a primary health care initiative in New Zealand – provides an additional approximately 10% capitation funding to primary health organizations to include services such as comprehensive assessments, individual care plan development, patient education, and regular follow-ups, as well as better-coordinated and lower cost services. Medicare, a United States government social insurance scheme, provides additional payment to primary care physicians for physicianpatient-family-nurse conferences to facilitate communication, support lifestyle changes, and improve treatment compliance. The programme improved functioning of elderly people with heart conditions and has the potential to lower total health care expenditures.

Many governments also extend financial assistance to disabled people's organizations and nongovernmental organizations for health (Meng, 2007).

Transportation

Transport for people with disabilities is often limited, unaffordable, or inaccessible. The majority of disabled participants in a United States study said that transportation problems were a major barrier to accessing health care. A study in the Republic of Korea suggested that transportation barriers were a likely factor in keeping people with severe physical and communication impairments from participating in population screenings for chronic diseases (WHO, 2011).

2.4 Gaps in the Literature

Several works have been done on access to healthcare by people without specific focus on disabled people in General. Most of the studies that relate to disability are restricted to specific disability for instance mental health without recourse persons with disabilities in general. In Ghana for instance it was difficult to lay hands on past studies that focus on disabled people and their access to healthcare.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter contains information about the various methods employed in carrying out the study into the Socio-Economic factors that influence access to healthcare by persons with disability in the Kumasi Metro. Qualitative study type was adopted with Kumasi metro as the case, purposive sampling was employed and in-depth interviews and focused group discussions were the tools for data collection. Data were grouped in themes for easy coding and analysis guided by the research questions and objectives.

3.1 Study Area

The study was conducted in the Kumasi Metro of the Ashanti Region of Ghana. With a population of 1,989,062 in 2012, Kumasi is the largest city in the Ashanti region. The largest and native ethnic group is the Ashanti. Approximately 70% of Kumasi population is Akans, 28% Atheists, with a smaller number of adherents 2% to Islam.

Administratively, the metro is divided into 10 sub-metros, namely; Asawasi Sub- Metro, Asokwa Sub-Metro, Bantama Sub Metro, Kwaadaso Sub-Metro, Manhyia Sub- Metro, Nhyiayeso Sub-Metro, Oforikrom Sub-Metro, Suame Sub- Metro, Subin Sub-Metro, Tafo Sub- Metro. However, the Metropolitan Health Services are organized around five (5) Sub Metro Health Teams; namely, Bantama, Asokwa, Manhyia North, Manhyia South and Subin. The city has a number of health facilities in both the public and private sectors. Notable is the Komfo Anokye Teaching Hospital (KATH), which is a national autonomous hospital. In addition, there are over two hundred (200) known private health institutions and 13 Industrial Clinics in the metropolis. People patronize the public health facilities more than the private ones. This is attributable to the fact that relatively higher fees are charged by the private health facilities coupled with the fact that some of the sophisticated and essential equipment are obtained at the public health facilities (Ghana Statistical Service, 2012).

3.2 Study Design

A Case Study design was employed for the study. A case could represent a single community, institution or organization. In this study, Kumasi Metro was used as a case. Special attention was placed on the Department of Social Welfare in the Kumasi Metro as a source of information, by relying on persons with disabilities' register and did an extensive and in-depth investigation on how socio-economic factors influence access to healthcare by persons with disability.

3.3 Type and Purpose of the study

The purpose of the study was to have an exploration of how the various socio-economic factors influence access to healthcare by persons with disabilities. The researcher aimed at exploring the underlying reasons why persons with disabilities are unable to adequately access healthcare. Therefore qualitative study was conducted in order to understand issues from the perspective of the society, organisation or setting and resists the tendency to impose meanings on issues. It has particular strengths in exposing facts that are discrepant with the researcher's prior assumptions and is well suited to answering questions that seek to understand why things happen rather than quantifying them (Murphy et al., 1998). It also allows a more in-depth discussion of issues, thereby providing elaborated detail of phenomena that are difficult to convey with quantitative methods using standardized questionnaires.

3.4 Study Populations

The target population of this study was all persons with disabilities living within the Kumasi Metro, leaders of Disabled Peoples Organization (DPOs) in the Metro as well as healthcare providers in the Kumasi Metro. The study population was persons with disabilities and leaders of DPOs who have been registered with the Department of Social Welfare in the Kumasi Metro as well as healthcare workers at the Kumasi South Hospital in the Asokwa Sub-Metro. (Estimated number registered by the department as at the time of data gathering was 361. Out of this number, 201 were males and 160 females, with 281 being those with difficulty in moving and 135 and 45 being difficulty in seeing and others).

3.4.1 Sampling Units, frame and Size

The sampling units for this study was all registered persons with disabilities and leaders of the various disabled groups who are registered with the Department of Social Welfare and healthcare workers at the Kumasi South Hospital.. The Register of persons with disabilities at the Department of Social Welfare was used as the frame from which the respondents were drawn. In this study, the researcher used 43 respondents in which 33 were persons with disabilities and their leaders with the remaining 10 representing healthcare workers.

3.4.2 Sampling Technique

A purposive sampling strategy was adopted in selecting the research participants. Persons with disabilities who have been registered with the department of social welfare for a year or more were included in the study. Health workers from the Kumasi South

Hospital were used to represent the healthcare providers. Asokwa Sub-Metro is the

Largest Sub-Metro within the Kumasi Metro and also it has the highest number of disabled people who have been registered with the Department of Social Welfare. Therefore in choosing a health centre it was important to consider the hospital that could be found within this sub-metro. These two reasons coupled with the capitation policy under the National Health Insurance Scheme in the Ashanti Region where individuals are expected to choose a hospital where they want to attend influenced the researcher's decision to select the Kumasi South Hospital.

3.5 Sources of Data and Methods of Data Collection

Structured Interview and focus group discussion were used as a means of collecting information from the respondents. The two instruments were both used to collect data from persons with disabilities respondents. The reason was that each tool will complement the other in other to get adequate information from the respondents. Five discussions were done on two different days. In order to get all individuals involved, two of the discussions were intentionally set aside to comprise all males and all females for one each with the remaining three being mixed. With regards to the health workers, only interview was used to collect information from them. Audio tapes were also used to record the proceedings in order to guide the transcription and translation of responses. The reason was that it was difficult in getting all of them at a point in time for them to have group discussion. It was also important to avoid the temptation of disrupting their work. Books, journals and the internet served as the secondary source of information for this study.

Table 3.1 showing the composition of focus group discussion participants and the number of discussions held

Days of discussion	sex of participants		Number of participants
Day one	**Males**	**Females**	
First discussion	4	3	7
Second discussion	3	5	8
Third Discussion	6	-	6
Second day			
First discussion	-	5	5
Second discussion	5	2	7
Total	**19**	**14**	**33**

Source: Author's field work (2014)

3.6 Data Handling and analysis

Qualitative study allows a more in-depth discussion of issues, thereby providing elaborated detail of phenomena that are difficult to convey with quantitative methods using standardized questionnaires. Words rather than figures were used to explain the data. However, the demographic characteristics of the respondents have been presented with tables. Paraphrase of all or parts of the responses given by the respondents have been presented in the findings. Since most of the discussions were done in the local dialect (Twi), there was a translation from Twi to English. The audio tapes and field notes taken during the interactions were used to compare with the translated version of the data in order to ensure that the transcriptions actually presented the true meaning of whatever was said by the respondents. After that, the researcher used the audio tapes and field notes to cross-check the transcripts to ensure that they were accurately translated and transcribed to preserve the meanings of participant's words and statements. After the translation and editing, the agreed on data was grouped into headings or themes for easy coding, identification and analysis. The research objectives and questions guided the researcher in the categorization of the edited information into presentable formats based on the various themes developed out of the data. Similar responses were put under the same headings based on the various categories that were developed based on the specific research objectives.

Parts or segments of texts or quotes that relate to the interpretations are used paraphrased and presented in the findings.

3.7 Ethical Issues

The researcher sought for Ethical approval from the Committee on Human Research, Publication and Ethics at the Kwame Nkrumah University of Science and Technology, School of Medical Sciences and Komfo Anokye Teaching Hospital.

On the field, the purpose of the study was explained and verbal consent obtained from every participant to tape-record the discussions. The respondents were assured of confidentiality and anonymity and were also informed that the information retrieved was for academic purposes. To ensure this, the researcher did not record identifiers such as names, street and contact numbers of respondents during the interaction. Participation in the research was voluntary and respondents took part in the study from their own will. In order to conceal the identity of the participants, they were not asked to provide information (name, house number, staff number) that could assist third party readers to identify them. However, demographic information like age, sex, disability type and occupation were collected.

3.8 Limitations of the study

Certain problems were encountered in the course of the study. They included the problem of getting access to appropriate literature and other related reading materials as well as funding. In an attempt to manage the above mentioned limitations certain strategies were adopted: In obtaining information the researcher regularly visited the library and the internet in order to gather information for the work. With respect to funding, the researcher raised funds from personal coffers to meet the cost of the research.

CHAPTER FOUR

DATA PRESENTATION AND FINDINGS

4.0 Introduction

This Chapter provides data from the field and the major findings that were realized. The findings have been grouped into sub-sections in line with the questions asked which were also guided by the specific objectives of the study.

4.1 Demographic Characteristics of respondents

The demography of research participants are crucial in ascertaining the nature of, and the kind of respondents used for the study. It was therefore important to gather information about the respondents. The demographic information collected included; sex, age, religion, disability type, and department or position of healthcare providers.

Sex and Age of individuals play significant role in their life, attitude and behaviour within a particular social setting. The sex of the respondents was evenly distributed between both sexes. Thus data were collected from both males and females. More males than females were used in terms of the disabled respondents. However, there were more females than males regarding the health workers. This could be attributed to the sex distribution of the two different populations (disabled people and health workers). The age of the respondents was that of young people especially the health workers.

Individuals' physical conditions affect them differently and their reactions toward issues are determined by their conditions. The nature and type of disability influences the person's health seeking behaviours. There were four main disability groups that were found as far as the register from which the respondents were selected was concerned.

These were; difficulty in seeing, difficulty in moving, difficulty in hearing and others.

Table 4.1showing the demographic characteristics of respondents

Variables	Frequency (n=43)	Percentage (%=100)

Age group		
Below 20 years	8	19
20-29 years	11	25
30-39years	16	37
40years and above	8	19
Sex of respondents		
Male	24	56
Female	19	44
Religion of respondents		
Christianity	23	53
Islam	11	26 9
Traditional	4	12
Others	5	
Disability Type		
Difficulty in Moving	18	55
Difficulty in Seeing	6	18 9
Difficulty in Hearing	3	18
Others	6	
Position of healthcare workers		
Senior staff	6	60
Junior Staff	4	40
Unit/Department of healthcare workers		
Administration	2	20
Nursing	5	50
Medical	2	20
X-ray	1	10

Source; field work (2014)

4.2 Social factors influencing access to healthcare by disabled people

This section contains information on the various social factors that influence persons with disabilities' access to healthcare. There were several social factors that were identified as the major factors that influence access to healthcare by persons with disabilities. Notable among them were, cultural interpretation of disability, stigmatisation of disability, inadequate information, spiritual explanation of disability

4.2.1 Cultural interpretation of disability

Cultural explanation of disability played a major role in determining whether persons with disabilities will access healthcare or not. The cause of disability is usually explained from the cultural and belief system of the people. They believed that most disability conditions are caused by individuals' disobedience to norms or taboos. It was therefore important that the individual with the condition appreciate this and ask for forgiveness from the gods rather than attending modern hospitals for healthcare.

> *………Most people believe that we are disabled because our forefathers and family members did something wrong against the gods and we are paying the price* (Male respondent, focus group discussion).

> *…………….I think that some of them are as a result of their parents' or their own disrespect for norms and traditional rules in their communities that is why they are suffering from disability* (healthcare provider, individual interview).

4.2.2 Stigmatisation of disability

As a result of the various cultural interpretations associated with disability, most of persons with disabilities face stigmatisation especially individuals who have mental disability. The stigmatisation of their condition is not only by their family members but also by their friends and the members of the larger society. When people see them at the hospital, they express surprise. The respondents indicated that individuals who belonged to families that have strong beliefs for cultural and traditional rules suffer the most. Such stigma discourages people from seeking care for disability-health-related problems. As the respondent below explains:

> *…………..When people see me at the hospital, they murmur among themselves "Ah, you are wasting our time, you are a nut and you are this and you are that," so at the end of the day I do not find it pleasant to visit the hospital* (Female respondent, focus group discussion).
>
> *…………..That is true! (Referring to the previous speaker) I remember I went to a hospital and the nurse asked the people who were going to see the doctor to allow me to go first and the kind of statements and insults poured on me after the nurse had left deterred me from going back to the same hospital for further check-ups and treatment* (male respondent, focus group discussion).

4.2.3 Religious interpretation of disability

Another social factor which is linked to cultural beliefs is religious interpretation of disability. Since disability is mostly explained from the spiritual point of view, most persons with disabilities tend to visit traditional rulers in their communities for treatment. The reason for this is the culturally specific belief that traditional healers are called by the gods to help their communities (*dunsini)* and therefore have power to free people from spiritual illness.

> ……….. *I was taken to a traditional healer in my hometown for about one year without any improvement. My family members thought that I could be healed by the man but my condition was still worsening. When we later visited the hospital, I was told that my vision could have been savaged if I had come earlier for surgery* (female respondent, individual interview)
>
> …….*I do not attend modern hospital because their treatments are unable to change my condition. I will rather go to the herbalist for treatment instead of hospital because that is where I believe my healing can come from* (male respondent, focus group discussion).

Some of the respondents also revealed that they were Christians and visit the prayer camps for healing rather than the hospital. They also hold the belief that disability conditions can be best treated or handled by spiritual men of God who have been given the power to cast out demons.

> …… *I attend prayer meetings and prayer camps for healing whenever I am sick. This is because I believe that sometimes our sickness is not something that hospital medicine can cure especially we persons with disabilities* (female respondent, focus group discussion).

It was however found that, if the treatment does not improve the patient's condition, he or she eventually seek out a public health clinic, sometimes accompanied by family members or even by the traditional healer.

4.2.4 Inadequate information

The study found that there is inadequate f information and knowledge concerning the treatability of certain disability condition especially mental health in the society. The general public is often not aware of lesser known disability conditions illness and therefore they do not seek health care services. The respondents see this partly as a result of policy makers, politicians, and health reforms being focused on general-health-related problems of the non-disabled people without any attention paid to persons with disabilities.

> *……….Madam (referring to the facilitator) do you think that there is any hospital in Ghana that can cure my illness? If you do please tell me because I do not think my condition can be reversed* (Female respondent, focus group discussion).

In relation to inadequate information, the study found that most persons with disabilities do not have adequate information about medical treatment and the use of prescribed drugs. They indicated that there were times in which they are reluctant to take their medicine due to side effects (such as impotence) or due to the fact that they do not trust or believe that the medication will actually help.

> *………Truly speaking, I remember sometime a go I went to the hospital, and when I came home a showed the drugs they game me to a friend and He told me he got chicken pox when he also took the same drugs that I had been given, so out of fear, I dumped the drugs and went to a nearby pharmacy to by some pain killers for myself* (Male respondent, individual interview).

The social factors that influence accesses to health care by persons with disabilities were, cultural explanation of disability which included disability as a result of punishment, juju, sorcery and magic, stigmatisation of disability, religious interpretation of disability and inadequate information about treatment and healthcare.

4.3 Economic Factors influencing access to healthcare by persons with disabilities

Several economic reasons were identified as the major factors that influence access to healthcare by persons with disability in the metro. They included high unemployment among persons with disabilities, cost of treatment and assistive devices, transportation.

4.3.1 Unemployment

Unemployment among persons with disabilities was identified as an economic factor that influences persons with disabilities' access to healthcare. They indicated that most of them were not employed and for that matter did not have money to attend hospital for treatment. As a result of this most persons with disabilities found it difficult to visit the hospital when they are ill and could not meet the basic needs in life.

> *……………Menni adwuma biara ye (meaning I do not have a job) so in times when I am sick I am unable to go to hospital for the needed treatment* (female respondent, individual interview).

4.3.2 Cost of Treatment and Assistive devices

The study found that the cost involved in the attendance of hospitals scared PWDs away. High unemployment and poverty have resulted in PWDs unable to pay their hospital bills. Most of them indicated that they did not go to hospital regularly due to the cost involved. They were aware of the existence of health facilities but the cost involved in accessing the services provided by these hospitals always prevent them from seeking healthcare. Starting from hospital card or folder to dispensary, at every stage one has to pay money even if you have health insurance card. The most difficult of all is when one is supposed to go for surgeries. The average cost of visiting a hospital is GH¢ 50_GH¢ 100 per single visit. This according to them is relatively very costly and could not afford.

> *……It is not that I would not like to go to the hospital, but if I go, who will bear the cost involved? I therefore visit the local drug store and get some pain killers for myself* (Female respondent, focus group discussion).

> *……….I will go to the hospital regularly if the government makes it free for those of us who are disabled. Otherwise modern hospital will not be a preferred place of treatment for poor people like me (*female respondent, focus group discussion).

The cost of treatment was not only a factor relating to cost that was identified. Some of the respondents also indicated that the cost of assistive devices is also costly and are unable to purchase them. They revealed that there was no point in going to the hospital if you are told to buy equipment to aid you and you are unable to meet the cost.

> *……………I was told to get a pair of crutches to aid my movement but because of the cost, I am still using this stick* (male respondent, individual interview).

4.3.3 Transportation

Lack of transport is identified as one of the economic reasons for PWDs not accessing health care in general. PWDs especially the difficulty in moving pointed out that they found it difficult to join the public transport due to the inaccessible nature of these commercial cars. They are unable to have space that will accommodate them and their assistive devices especially those who use wheelchairs. The embarrassments of having someone to carry them at the back, in their arms and also to push them in their wheelchairs to far places where the hospitals are located deter them from going to the hospital.

> *…….I find it difficult to board cars to aid my movement all because of my wheelchair. So when I am sick, I stay at home and send people to go and buy drugs for me just to avoid the difficulty of boarding commercial cars* (female respondent, individual interview).

4.4 Attitude of health workers towards persons with disabilities

The study found certain attitudinal factors within the healthcare system that influence PWDs' access to healthcare. Some of the attitudinal factors were: abuse of PWDs, lack of cross cultural understanding, maltreatment of PWDs people and communication problem between PWDs and healthcare providers.

4.4.1 Abuse and maltreatment of persons with disabilities by healthcare workers Most of the respondents pointed out that the attitudes and behaviours of health workers towards PWDs, especially the way they relate and talk to them is shameful. They reported various incidents they were aware of and involved in where different categories of health professionals passed derogatory comments about them.

> *……. I was pregnant and went for antenatal care, and a nurse looked at me and said you too you have feelings? She went further to say that I should check myself before I do certain things. This really hurt me and never went to that hospital again* (female respondent, individual interview). **…..***I went to the*

> *hospital with my wife, and when we went to the consulting room, the look on the doctor's face alone told me that she was surprised to see that my wife who is non-disabled married a PWD like me* (Male respondent, focus group discussion).

> *……I have similar experience. I remember a doctor requested to see my husband secretly and when he came back, he said the doctor asked him what influenced his decision to marry me* (female respondent, focus group discussion)

The abuse of PWDs was not only expressed by persons with disabilities but healthcare providers themselves. Some of the hospital staff indicated that they have also witnessed occasions where their colleague staff have verbally abused PWDs who come to the hospital;

> *…..Some of my colleagues laugh at PWDs who come to the hospital for treatment especially disabled women who come to the hospital and are pregnant* (male healthcare provider, individual interview).

> *……I remember sometime ago a person with disability reported one of our staff to us about how harsh the staff talked to him. We at the administration hear some of these cases but are not many and frequent* (hospital administrator, individual interview)

4.4.2 Shunning and avoiding persons with disability

Most healthcare providers, particularly, the nurses stated that given the option, they would avoid interacting PWDs. The reason they gave was that most of the disabled people are difficult to work with and some of them are impatient. However, because it is exceedingly unprofessional to do so, they unwillingly treat and work with them;

……Truly speaking, if I have my own way, I would not work with any person with disability because most of them are very aggressive and violent to some extent (healthcare provider, individual interview).

> *……Do you know that most of these persons with disability are impatient and always want to have their way out even if they come to meet other people* (healthcare provider, individual interview).

The revelation by the healthcare providers concerning shunning and avoiding PWDs at the hospital was not different from that of the PWDs themselves. PWDs gave account of how deliberately health workers avoid them at the hospital;

> *….Some of the nurses do not sometimes want to take your folder to a doctor for you to be treated just because you are physically different from them* (female respondent, individual interview).

4.4.3 Communication barrier between person with disability and healthcare providers

The study found that most of the staffs were not able to understand the culture and language of individuals or communities. Healthcare providers are sometimes unable to communicate effectively with PWDs to explain to them the results of their diagnosis and prescriptions. This lack of communication becomes more difficult when the patients are hearing impaired. Sign language and the local dialect become problematic for health workers to communicate effectively with PWDs;

> ……..*It is difficult to explain things to the difficulty in hearing people and this hospital does not have sign language interpreters to help us explain diagnosis and prescription to them when they come to the hospital* (healthcare worker, individual interview).

> .....*Healthcare providers do not appreciate our conditions and are unable to give us full information about our condition and what to do*
> (female respondent, individual interview).

CHAPTER FIVE

DISCUSSION

5.0 Introduction

This chapter discusses the major findings realized from the study in line with reports and findings by other scholars. The discussion has been presented under sub-headings based on the specific objectives of the study.

5.1 Social factors influencing access to healthcare by disabled people

There were several social factors identified as the major factors that influence access to healthcare by PWDs. Notable among them were, cultural interpretation of disability, stigmatisation of disability, inadequate information, spiritual explanation of disability Cultural explanation of disability played a major role in determining whether PWDs will access healthcare or not. The cause of disability is usually explained from the cultural and belief system of the people. They believed that most disability conditions are caused by individuals' disobedience to norms or taboos. It was therefore important that the individual with the condition appreciate this and ask for forgiveness from the gods rather than attending modern hospitals for healthcare. This expression by the respondents was similar to the findings of Dodor (2009) when he studied into tuberculosis stigma in Ghana and found that people explained the cause of TB from the cultural perspective and concluded that individuals suffer because of their own careless lifestyle. It is also not different from the writings of Avoke (2001) and Agbenyega(2002) that disability in Ghana is explained from the supernatural point of view and there is no reason an individual or family can give for a disability except when the individual has offended the gods. When the cause of a disease or impairment is not well understood and it is treated as mystery, it tends to elicit fear from others (Sontag, 2001).

As a result of the various cultural interpretations associated with disability, most of PWDs face stigmatisation especially individuals which have mental disability. The stigmatisation of their condition is not only by their family members but also by their friends and the members of the larger society. When people see them at the hospital, they express surprise. The respondents indicated that individuals who belonged to families that have strong beliefs for cultural and traditional rules suffer the most. Such stigma discourages people from seeking care for disability-health-related problems. The finding is not different from what Inclusion Ghana (2013) found when it studied access to healthcare by people with intellectual disability in Ghana. It found that as a consequence of stigmatisation, family members taking mentally disabled persons to health care facilities might run in to other members of their community and thereby risk stigmatisation by association, making them reluctant to put themselves in this situation.

Another social factor which is linked to cultural beliefs is religious interpretation of disability. Since disability is mostly explained from the spiritual point of view, most PWDs tend to visit traditional rulers in their communities for treatment. The reason for this is the culturally specific belief that traditional healers are called by the gods to help their communities (*dunsini)* and therefore have power to free people from spiritual illness. Some of the respondents also revealed that they were Christians and visit the prayer camps for healing rather than the hospital. They also hold the believe that disability conditions can be best treated or handled by spiritual men of God who have been given the power to cast out demons. Again this finding re-echoes the reasons why disability is explained from the cultural point of view as reported by (Dodor, 2009). It is also in line with the findings of WHO (2011) that perceptions of health status may influence health behaviours, including attendance at health care services, and how health needs are communicated. A study on people with epilepsy in rural Ghana, by WHO (2011) found that spiritual beliefs surrounding epilepsy influenced health and seeking of treatment. Other societies believe that illness is the result of supernatural phenomena and promote prayer or other spiritual interventions that counter the presumed disfavour of powerful forces (McLaughlin and Braun, 1998).

It was however revealed by the respondents that, if the treatment does not improve the patient's condition, he or she eventually seek out a public health clinic, sometimes accompanied by family members or even by the traditional healer.

The study found that there is inadequate information and knowledge concerning the treatability of certain disability condition especially mental health in the society. The general public is often not aware of lesser known disability conditions illness and therefore they do not seek health care services. In relation to inadequate information, the study found that most PWDs do not have adequate information about medical treatment and the use of prescribed drugs. They indicated that there were times in which they are reluctant to take their medicine due to side effects (such as impotence) or due to the fact that they do not trust or believe that the medication will actually help. The respondents see this partly as a result of policy makers, politicians, and health reforms being focused on general-health-related problems of the non-disabled people without any attention paid to PWDs. The findings supports the study by Coleman et al (2002) quoted in WHO (2011) in rural areas of the Gambia which reported that only 16% of 380 people with epilepsy knew that preventive treatment was possible; of the 48% of people with epilepsy who had never used treatment, 70% did not know that clinics offered treatment for seizures (Coleman et al, 2002; WHO, 2011). It also finds light in another report that revealed that the misconceptions and myths about disability are often aggravated by the incorrect health education messages from health workers, which most often do not explain to the community members how disability is not spread. When there is uncertainty about how a disease is transmitted, the multiple interpretations of the cause and spread that ensue have the propensity to fuel stigmatisation of individuals suffering from the disease (Ogden and Nyblade, 2005).

5.2 Economic factors influencing access to healthcare by persons with disabilities

Several economic reasons were identified as the major factors that influence access to healthcare by PWDs in the metro. They included: high unemployment among PWDs, cost of treatment, and assistive devices and transportation.

Unemployment among PWDs was identified as an economic factor that influences PWDs' access to healthcare. They indicated that most of them were not employed and for that matter did not have money to attend hospital for treatment. As a result of this most PWDs found it difficult to visit the hospital when they are ill. As a result of the high unemployment rate among PWDs, most of them are relatively poor and could not meet the basic needs in life which included quality healthcare. Poverty is also seen as one of the economic factors which prevent PWDs from accessing healthcare. The findings again supports the findings of White (2002) that people with disabilities experience lower rates of employment, and are more likely to be economically disadvantaged, and are therefore less likely to afford private health insurance. Employed people with disabilities may be excluded from private health insurance because of preexisting conditions or be "underinsured" because they have been denied coverage for a long period or are excluded from claiming for treatment related to a pre-existing condition, or must pay higher premiums and out-of-pocket expenses (White, 2002).

The study found that the cost involved in the attendance of hospitals scared PWDs away. High unemployment and poverty have resulted in PWDs unable to pay their hospital bills. Most of them indicated that they did not go to hospital regularly due to the cost involved.

They were aware of the existence of health facilities but the cost involved in accessing the services provided by these hospitals always prevent them from seeking healthcare. Starting form hospital card or folder to dispensary, at every stage one has to pay money even if you have health insurance card. The most difficult of all is when one is supposed to go for surgeries. This finding is not different from the review of the 2002– 2004 World Health Survey which reveals that affordability was the primary reason why people with disabilities, across gender and age groups, did not receive needed health care in low-income countries. For 51 countries 32–33% of nondisabled men and women cannot afford health care, compared with 51–53% of people with disabilities. Transport costs also rank high as a barrier to health care access in low-income and high-income countries, and across gender and age groups (WHO, 2011).

The cost of treatment was not only factor relating to cost that was identified. Some of the respondents also indicated that the cost of assistive devices is also costly and are unable to purchase them. They revealed that there was no point in going to the hospital if you are told to buy equipment to aid you and you are unable to meet the cost.

Lack of transport is identified as one of the economic reasons for PWDs not accessing health care in general. The PWDs especially the difficulty in moving pointed out that they found it difficult to join the public transport due to the inaccessible nature of these commercial cars. They are unable to have space that will accommodate them and their assistive devices especially those who use wheelchairs. The embarrassments of having someone to carry them at the back, in their arms and also to push them in their wheelchairs to far places where the hospitals are located deter them from going to the hospital. The WHO (2011) report also supports this finding. WHO reports that Transport for people with disabilities is often limited, unaffordable, or inaccessible. The majority of

PWD participants in a United States study said that transportation problems were a major barrier to accessing health care. A study in the Republic of Korea suggested that transportation barriers were a likely factor in keeping people with severe physical and communication impairments from participating in population screenings for chronic diseases (WHO, 2011).

5.3Attitude of Healthcare providers towards person with disabilities

The study found that most of the staffs were not able to understand the culture and language of individuals or communities. Healthcare providers are sometimes unable to communicate effectively with PWDs to explain to them the results of their diagnosis and prescriptions. This lack of communication becomes more difficult when the patients are hearing impaired. Sign language and the local dialect become problematic for health workers to communicate effectively with PWDs. The revelation by the respondents supports the finds of Ubido et al (2002) that Communication difficulties between people with disabilities and service providers are regularly cited as an area of concern (Ubido et al, 2002).

Most healthcare providers, particularly, the nurses stated that given the option, they would avoid interacting with PWDs. The reason they gave was that most of PWDs are difficult to work with and some of them are impatient. However, because it is exceedingly unprofessional to do so, they unwillingly treat and work with them. The findings again support the writings of Jones and others that when non-stigmatised individuals are aware of the devalued social identity of the stigmatised, it can either consciously or unconsciously activate cultural stereotypes about the stigmatised, and can influence the behaviour of the non-stigmatised towards the stigmatised. There is also the tendency for the non-stigmatised individual to interpret the stigmatised person's past and present in terms of the stigma (Jones et al., 1984).

The revelation by the healthcare providers concerning shunning and avoiding PWDs at the hospital was not different from that of the PWDs themselves. PWDs gave account of how deliberately health workers avoid them at the hospital. The study found certain attitudinal factors within the healthcare system that influence PWDs access to healthcare. Some of the attitudinal factors were: abuse of PWDs, lack of cross cultural understanding, maltreatment of PWDs and communication problem between PWDs and healthcare providers. Most of the respondent pointed out that the attitudes and behaviours of health workers towards PWDs, especially the way they relate and talk to make it shameful. They reported various incidents they were aware of and involved in which different categories of health professionals passing derogatory comments about them. The findings of Dodor (2009) in Ghana about TB stigma in which healthcare providers deliberately avoid and shun TB patients due to the stigma attached to the condition is similar to the findings of this study where healthcare providers shun and avoid PWDs who come to their facility for healthcare

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter provided the conclusions drawn based on the findings from this study and also the recommendations made to ensure that PWDs are able to access quality healthcare as well as areas identified where further studies could be carried out.

6.1 Conclusion

A qualitative study was conducted to investigate into the Socio-Economic factors that influence access to health care by persons with disabilities in the Kumasi Metro. The study collected data from PWDs in the Metro who have been registered by the Department of Social Welfare and healthcare providers from the Kumasi South Hospital. Focus Group Discussions and Individual Interviews were used to collect data. Purposive sampling was used to select sample for the study.

6.1.1 Demographic Background of Respondent

Sex and Age of individuals play significant role in their life. The sex of the respondents was evenly distributed between both sexes. Thus data were collected from both males and females. More males than females were used in terms of the disabled respondents. However, there were more females than males regarding the health workers. This could be attributed to the sex distribution of the two different populations (persons with disabilities and health workers). The age of the respondents was that of young people especially the health workers. Most of them were Christians with few being Muslims, traditionalists and others also not having any religious inclination. There were differences in the religious background of the respondents.

Individuals' physical conditions affect them differently and their reactions toward issues are determined by their conditions. The nature and type of disability influences the person's health seeking behaviours. There were four main disability groups that were found as far as the register from which the disabled respondents were selected was concerned. These were; difficulty in seeing, difficulty in moving, difficulty in hearing and others. Majority of the respondents were in the senior staff ranks.

6.1.2 Social Factors influencing access to healthcare by persons with disabilities

The study found that there were several social factors that influenced persons with disabilities' access to healthcare in the Metro. The social factors that influence Access to health care by persons with disability are, inadequate information about treatment and healthcare, visit to traditional healers and fetish priest as well as prayer camps, stigmatization of disability, cultural explanation of disability which included disability as a result of punishment, juju, sorcery and magic.

6.1.3 Economic Factors influencing access to healthcare by persons with disabilities

Various economic reasons were identified as the major factors that influence access to healthcare by PWDs in the metro. They included: high unemployment among PWDs, cost of treatment and assistive devices, transportation,

Unemployment among PWDs was identified as an economic factor that influences PWDs' access to healthcare. They indicated that most of them were not employed and for that matter did not have money to attend to hospital for treatment. As a result of this most PWDs found it difficult to visit the hospital when they are ill.

As a result of the high unemployment rate among PWDs, most of them are relatively poor and could not meet the basic needs in life which included quality healthcare.

6.1.4 Attitude of Healthcare providers towards persons with disabilities

The study found certain attitudinal factors within the healthcare system that influence PWDs' access to healthcare. Some of the attitudinal factors were: abuse of PWDs, lack of cross cultural understanding, maltreatment of PWDs and communication problem between PWDs and healthcare providers.

6.2 Recommendations

In view of the findings of the study the following recommendations have been made.

1. Stakeholders such as government and NGOs must embark on effective public education to bring to the notice of the general public the meaning and cause of disability in order to reduce the rate at which disability is explained from the cultural point of view.
2. In addition, the public education must also be extended to health professionals in order to reduce the stigmatisation of disability which results in abuse and maltreatment of PWDs by healthcare providers
3. Again, it is recommended that Government policy exempts all persons with disabilities from paying the registration and processing fee of the National Health Insurance Scheme. This will ensure that the cost of accessing healthcare which continues to be a burden among disabled people will be addressed.
4. The Ministry of Health should ensure that at every district, regional and training hospital there are health professionals that have received detailed training on working with PWDs. This will help to promote good relationship between healthcare workers and PWDs. It will also enhance effective communication between them.

6.3 Area for further study

This area has been suggested for further studies. Cost of assistive devices and how they improve the wellbeing of persons with disabilities.

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APPENDICES

APPENDIX I

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY COLLEGE OF HEALTH SCIENCES DEPARTMENT OF COMMUNITY HEALTH CENTRE FOR DISABILITY AND REHABILITATION STUDIES

TOPIC: Socio-Economic Factors influencing access to healthcare by persons with disabilities in the Kumasi Metro

INTERVIEW GUIDE FOR PERSONS WITH DISABILITIES

Introduction: I am a Postgraduate student at the Centre for Disability and Rehabilitation Studies of the Department of Community Health, KNUST. I am researching into the socio-economic factors that influence access to healthcare by persons with disabilities. Please find time to respond to the following questions for me

SECTION I: DEMOGRAPHIC CHARACTERISTICS OF PERSONS WITH DISABILITIES

1. Sex of respondents
2. Age of respondents
3. Religious background
4. Disability type

SECTION II: SOCIAL FACTORS THAT INFLUENCE ACCESS TO HEALTHCARE

5. What is your general understanding of your condition (disability)?
6. What in your opinion was the cause of your condition (disability)?
7. How often do you attend hospital?
8. What social reason influences your attendance to the hospital?
9. Do you have any other alternative as a source of healthcare apart from the hospital?
10. Do you communicate effectively with the healthcare workers when you visit the hospital?

SECTION III: ECONOMIC FACTORS THAT INFLUENCE ACCESS TO HEALTHCARE

11. Employment status
12. What is the main economic reason which influences your access to healthcare?
13. Who is responsible for your medical bills whenever you visit the hospital?
14. How do you move from your house to the hospital?
15. Do you use any assistive device? How did you get it?
16. Is there any hospital in your community where you live?

SECTION IV: ATTITUDE OF HEALTHCARE WORKERS TOWARDS PERSONS WITH DISABILITIES

17. How do health workers relate to you whenever you visit the hospital for treatment?
18. Do you understand the terms used by healthcare workers to describe your condition?
19. Are you able to ask them for further explanations when you do not understand?
20. Have you had any experience where healthcare worker abused you?
21. If you are maltreated by a healthcare worker, will you report him/her to the authorities?
22. What do you want policy maker to do for you to improve your access to healthcare?

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Introduction: I am a Postgraduate student at the Centre for Disability and Rehabilitation Studies of the Department of Community Health, KNUST. I am researching into the socio-economic factors that influence access to healthcare by disabled people. Please find time to respond to the following questions for me

SECTION I: DEMOGRAPHIC CHARACTERISTICS OF HEALTHCARE PROVIDERS

1. Sex of respondents
2. Age of respondents
3. Religious background
4. Department in which respond works
5. Rank or Position of respondent

SECTION II: GENERAL QUESTIONS FOR HEALTHCARE WORKERS

6. What is your general understanding of disability and its cause?
7. How often do persons with disabilities come to this hospital for treatment?
8. What do you think is the reason why persons with disabilities do not usually attend hospital?
9. What is the nature of interaction that exist between you and persons with disabilities who come to the hospital for treatment?
10. Do you think persons with disabilities understand the medication prescriptions they are given?
11. What is your general reaction towards persons with disabilities who ask for further explanation to their prescriptions?
12. How do you feel around persons with disabilities?
13. Does this hospital have special department to handle or treat persons with disabilities?

Q: Has there been a day when you maltreated a person with disability or a colleague of yours maltreated a person with disability?