Exploring the sexual and reproductive health issues of visually impaired women in Ghana

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Sexuality and disability

Sexuality is defined by the World Health Organisation (WHO) as:

“a central aspect of being human throughout life [that] encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships.”

But for persons with disabilities the fact of the matter is that sexuality is subdued or neglected. Shakespeare describes the sexuality of persons with disabilities, something that has been in:

“distress, and exclusion, and self-doubt for so long that it was sometimes easier not to consider it, than to engage with everything from which so many were excluded.”

Women who are visually impaired are a significant part of those “so many who are excluded” from mainstream sexuality and sexual rights activities in spite of all the human rights instruments that seek to protect and uphold human sexuality and sexual rights. Such instruments have covertly or overtly expressed sexual rights as human rights and they include the United Nations Convention on the Rights of Persons with Disabilities (CRPD),

the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa,

and the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW).

Scaaf points out that in CRPD, the Articles on the rights to health, liberty and security, freedom from exploitation, violence and abuse and respect for home and the family, all recognise sexuality. Additionally, the Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa requires States Parties to advance the reproductive health needs of all women and this is specifically expressed in Article 14 of the Protocol. Similarly, Article 2 of the CEDAW also requires States to denounce all forms of discrimination against women as well as to ensure the “equality of men and women” in national laws.

Sexuality in a Ghanaian school for the blind

Sexuality is one of the areas that are least recognised, and that are most oppressive, for women who are visually impaired because of the complexities that surround the terrain of sexuality in Ghana. Notably, we have to grapple with cultural attitudes that surround sex, in a context where premarital sex is forbidden and frowned upon. A survey conducted by Krugu et al in one region of Ghana found that, historically, adolescent girls were scared and ashamed discussing sex and never dared asking adults about sex. Similarly, in the School for the Blind that I attended in the 1980s, which enrolled persons with visual impairment from kindergarten through to middle school (equivalent to grades 1–10), and ran a handicraft section for persons older than 18 years, we were not permitted to openly discuss issues around sexuality nor date the opposite sex.

During the 1970s–1980s, comprehensive adolescent sexuality education was not taught in Ghanaian schools, rather it was embedded in Home Science where puberty and home management were taught. One of the ways we learnt about...
our sexuality was in science-related disciplines. We obtained bits and pieces of information on human sexuality and human biology from subjects such as General Science and Agricultural Science. Apart from these, some adult students or seniors (mainly those enrolled at the handicraft section) and few of the staff would mention to us – usually very briefly – the consequences of engaging in pre-marital sex, such as becoming pregnant and dropping out of school. Safe sex options, such as condoms and contraception, were never mentioned in any of those discussions, so we had no adequate knowledge to prevent unplanned pregnancies or sexually transmitted infections.

To shield the students from sexual practices and teenage pregnancies, the school authorities had an unwritten rule not to admit any person who acquired visual impairment after age 12. They believed that children who acquired visual impairment after this age might already have had some sexual experience, and therefore, such students might constitute a risk by influencing visually impaired students already attending the school. This unwritten rule has been corroborated by several persons who were denied admission into the two main Schools for the Blind (personal communication). Another technique aimed at preventing us from sexual exploration was constant monitoring. School staff turned themselves into “spies or secret agents”, who watched us closely for any sexual activity and discussions.

For those of us who were already enrolled in the Schools for the Blind, talking about sex or even mentioning it was regarded as taboo and as young people we resorted to only whispering words associated with sexuality. When teachers or housemothers (caregivers) and seniors wanted to speak with any of the older girls about sex, menstruation and related issues, that conversation would happen behind tightly closed doors, in meetings which usually started late at night, when all the young children were presumably asleep.

However, some of us (both females and males) explored our sexuality by engaging in different kinds of sexual activities, including masturbation. Many suffered the consequences of engaging in sex with limited, if not nil knowledge, for example, ending up with an unwanted pregnancy after having unsafe sex. One of my female friends at the school was credited with introducing masturbation. She and other girls were caught many times masturbating and fondling themselves. The term “fingering” was popularly used to describe the behaviour of the girls and whenever they were caught “fingering”, they were lashed. This “fingering” act was regarded by staff and seniors as deviant behaviour. As such, some staff and workers in the school questioned whether the girls were possessed by evil spirits which needed exorcising.

But, reflecting upon my time in the school, after meeting people of various sexual orientations, I ask myself whether the girls could have been lesbians or of other sexual orientation. Generally, Ghanaian society does not openly recognise non-heterosexual orientations, and so mutual masturbation between persons of the same sex is especially frowned upon. Despite the societal belief in the lack of sexuality of disabled people, my experience suggests that many visually impaired girls are very interested in exploring their sexuality.

Newell and Goggin indicate that even today, to be a person with disability connotes the absence of privacy, to be measured by cannot-do rather than can-do, having to be constantly appreciative and obedient or submissive, among other things. Morris further articulates this when she states that, “the reality of those perceived as different [is that] there is always a danger that the ‘other’ will be seen as not quite human”. These assertions are very true: we were constantly monitored for some of these “not quite human” behaviours, which undermined our personal private spaces. The “not quite human” behaviours that warranted punishment included but were not limited to speaking to or holding hands with the opposite sex, even in daylight. It was very common for us to see or walk into some staff (especially those resident) in the school or their family members. They watched us to see if they could catch us having or presumed to be having sex or suspected to have been discussing sex and the like. Most gatherings of people were misconstrued as a meeting to devise ways to have sex secretly. Hence, these “spies” were a common sight, always lurking in corners and sitting on banisters to listen to our conversations. In addition, some of them would also quietly enter and hide in our classrooms or dormitories where two or more students were either learning, conversing or even playing cards, just to wait and see if anyone would be having sex, fingering or conversing about sexuality-related issues.

During my time in the School for the Blind, anybody who was caught having sex or being involved
in other forms of sexual activity was punished severely. The punishment ranged from intense caning, to scrubbing of bathrooms and toilets for days, or weeks of suspension. While punishment is allowable for non-compliance to Ghanaian school rules and Regulations, we felt that the caning of those who involved themselves in sexual activities at the School for the Blind was done at the school general assembly in the presence of all the students, teachers and non-teaching staff, in order to shame and humiliate them and frighten the rest of us. If someone was caught twice or thrice, the person was dismissed entirely from the school. It was also common for those who usually played with the opposite sex to be branded as abofra boni (a bad child). We were constantly admonished not to play with boys because we would get pregnant, but as to how the pregnancy would come about, nobody would adequately explain.

Notwithstanding, some of the female students got pregnant while in the school, and they as well as their boyfriends were sent home. It was not clear whether the men responsible for those pregnancies were students, staff or outsiders, since some females declined naming the fathers of their unborn babies. After some years, a few of the students that were sent home for “pregnancy offences” dared to come back to school, but were only re-admitted into the handicraft section, which implied that they were regarded as sub-standard students who did not deserve to be enrolled into the mainstream school curriculum or activities. Those who could not bear the shame of coming back to the same school, but who had rich parents or guardians, went to the other School for the Blind. We had two Schools for the Blind then, with one located at Akropong-Akwapim in the eastern region and Wa in the upper west region of Ghana. The very bad roads made transportation between these schools very expensive and difficult. As such, unless one’s parents or guardians were financially endowed or lived in a town, city or village relatively close to a School for the Blind, the person would have to give up school. These students were also made to believe that their pregnancies were due to them being hard to control or that nature had punished them because they did not conform to societal norms.

As the years journeyed on, however, I understood that the perceived prevalence of sexual activities and pregnancies was not limited to the Schools for the Blind alone, but even more widespread in mainstream schools.

The literature indicates that adolescent pregnancies are still prevalent in Ghana and across Africa. The Chronicle Newspaper reported over 700,000 teenage pregnancies across Ghana in 2014 alone. According to Woog et al, 40% of pregnancies among 15–19-year-old girls in 33% of African countries are unintended. Both girls and boys in Ghanaian schools who engage in pre-marital sex are found out by their school authorities have received punishment. But the punishment meted out to some of the visually impaired girls and boys was heavy-handed, since some of the victims denied the claims of sexual activities levelled against them. In retrospect, I believe the residential nature of the School for the Blind (unlike other elementary schools where pupils went home every day), and the culture of silence and secrecy around sex, led staff to exaggerate the prevalence of sexual activities in the school. The staff and workers expected us to behave like some of the past students who were portrayed to be obedient, calm and causing no troubles. I feel they played down the fact that we were first and foremost human beings with diverse interests and choices. Rather, they wanted to mould us to fit the visually impaired persons they knew.

Later, when I came to work for an organisation for the Blind, I noted that several visually impaired young girls attending the other School for the Blind also got pregnant and dropped out of school. The worst part was that sometimes, some of these youngsters tried clandestine abortion with very crude methods and drugs. The organisation I worked for stepped in to save the life of one such young girl, who attempted terminating her pregnancy through self-medication, which resulted in severe complications and almost ended her life. For some of the young girls and women with visual impairment with whom I dealt directly in my work, the problem was that they received incorrect sexual information from conversations with friends. They did not have any other trusted sources to verify the correctness of the information, since sexual and reproductive health (SRH) information is not available in formats that can be independently accessed by persons with visual impairment.

**Barriers to access**

Murphy and Young reveal that persons with disabilities experience distinctive obstacles to sexual
health and that these obstacles can lead to sexual exploitation and assault, unplanned pregnancy and sexually transmitted infections. Among the “distinctive obstacles” that hinder us from accessing reproductive health services, for example, are prejudice and mobility issues.

According to Garland-Thomson, women with disabilities have been labelled as asexual and unattractive. In this vein, some friends and family members find it incongruous to involve us in discussions around sex. A number of the adolescent and adult women I worked with further divulged that family members thought it was unimportant to involve them in discussions on sexuality by saying “oh, as for you, you don’t need this” (personal conversation). Shakespeare further indicates that, “prejudice is not just interpersonal, but it is also implicit in cultural representation, in language and in socialisation”. The expression of prejudice through language can be drawn upon to interpret the perception that the bodies of persons with disabilities are “public properties”. In her book Pride and Prejudice, Morris states that “our physical difference makes our bodies public property”; hence, non-disabled women feel free to question disabled women about personal issues, such as pregnancy. For example, in an empowerment workshop organised for visually impaired women, a participant recounted her first experience in an antenatal clinic, where another woman questioned her being pregnant and openly verbalised her apprehension about the pregnancy of the visually impaired woman. Clearly, the woman assumed that the visually impaired woman did not possess a “normal” body for mothering.

Another obstacle to access for those with impaired vision is the inability to move independently in unfamiliar places. This problem is compounded in most parts of Ghana by haphazard sited of structures, a myriad of uncovered culverts and the lack of tactile signs to enable those of us who are visually impaired to move with relative independence from one point to the other. In Ghana, caregivers for persons with disabilities are most commonly our relatives or our own children. Thus, in order to attend to access SRH services, those of us without children draw on our friends or close relatives. Some of my friends are accompanied by their children, which they find awkward and an intrusion into their privacy. In the absence of any other alternative, some of them choose to avoid reproductive health services entirely in order to preserve their privacy and dignity.

Apart from the challenges above, other systemic challenges exist that hinder women with disabilities from accessing SRH information and services, including policy barriers. The limitations of the Ghana Disability Act (Act 715) and the Ghana Adolescent Reproductive Health Policy are just two examples.

Act 715 enacted in 2006 is not very progressive in its tenets when juxtaposed to contemporary thinking around disability. For example, there is no specific article on women with disabilities and the concepts of non-discrimination and equality are not adequately expressed in the Ghana Disability Act. Though Ghana has signed and ratified the CRPD, the Legislative Instrument to enable us to incorporate the tenets of the Convention into our national laws is still being discussed. Additionally, the 2000 Ghana Adolescent Reproductive Health Policy did not adequately recognise and address the above-mentioned prejudice, negative attitudes and accessibility concerns confronting adolescents with disabilities when accessing sexual and reproductive healthcare and services. Sadly, the provision of reproductive health services for persons with disabilities is portrayed as the sole responsibility of the private sector in the policy.

Conclusion

With limited or nil knowledge about issues of sexuality, a number of female students with visual impairment, including some of my close friends, dropped out of school due to unwanted pregnancies. Even though we could have been offered the opportunity to learn about issues of sexuality, certain practices and attitudes discussed above hindered such learning. As a result, instead of growing up to be useful citizens who can contribute to the development of the nation, some of these girls with visual impairment were reduced to begging on the street.

To make sexual and reproductive healthcare and information more accessible to persons with disabilities in Ghana and to create a conducive environment, I am drawing on my personal experience to propose a number of initiatives, specifically bearing in mind the needs of visually impaired girls and women in Ghana.

First, it would be important to develop healthcare workers’ appreciation that negative attitudes
towards the sexuality of disabled people create barriers that affect disabled people’s access to reproductive health services and information. Furthermore, women’s groups, civil society organisations and government agencies, for example, should raise awareness on disabled adolescent SRH. Such campaigns should directly target adolescents with visual impairment, rather than referring them to the Ghana Blind Union and the Ministry of Gender, Children and Social Welfare.

The Ghana Blind Union and the government should also work together to create a safe confidential space or platform and a trusted “channel” (such as TeleLink) for women who are visually impaired to discuss sensitive issues such as sexuality and reproductive health. To enable such a platform the government and Ghana Blind Union should lobby mobile network providers to allocate toll-free lines solely for this purpose as part of their corporate social responsibility. Interested public medical service personnel could volunteer to facilitate in order to provide accurate and appropriate

information and clarify misconceptions relating to SRH.

In order to facilitate access to SRH services, a volunteer corps such as the Medical Companion service should be established to assist women who are visually impaired to attend medical appointments and access reproductive health services where required. This approach allows persons with disabilities to consult with medical staff in the absence of close family members, in cases where the interference or involvement of such members is not preferred or required by the person with the visual impairment.

Finally, initiatives with regard to the sexuality, and the SRH and rights of young visually impaired people in Ghana have lacked focus and integration. The government, disabled people’s organisations and civil society organisations have to work together to remove every barrier impeding women and adolescent girls with visual impairment from realising their SRH rights, which are now recognised to be human rights.

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