Exploring misinformation of family planning practices and methods among deaf people in Ghana*

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Abstract: Having a good knowledge of family planning methods is vital for reducing maternal morbidity and mortality resulting from unintended pregnancies and unsafe abortions. In this paper, we highlight deaf people’s ability to discern various misconceptions about pregnancy, with the aim of assessing their level of knowledge on pregnancy prevention methods. The article is derived from a sexual and reproductive health (SRH) needs assessment involving participants residing in two cities and a senior high school in Ghana. The needs assessment involved three focus groups with 26 participants, a survey with 152 respondents, and an interview with one health professional. Apart from the health professional, all the remaining participants were deaf people. Findings from the study indicated that more than half the participants lacked familiarity with pregnancy prevention methods. The findings of this study confirm other studies that there is a general lack of knowledge on SRH issues among deaf people in Ghana. Thus, although this study focused on prevention of unwanted pregnancy, which is just one component of SRH issues, the study provides insights into the broader SRH needs of the deaf community and calls for making these issues visible for policy-making. DOI: 10.1080/09688080.2017.1332450

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Introduction

Globally, unintended pregnancy is a major medical, social, and public health problem, often resulting in unsafe abortions and deaths. Studies indicate that the proportion of women reporting unintended (unwanted and mistimed) pregnancies and unmet need for contraception remains high in developing countries and many women are dying annually from pregnancy-related complications, of which 99% occur in developing countries.1 It is estimated that 14 million unintended pregnancies occur in sub-Saharan Africa every year, with almost half occurring among young women aged 15–24 years.2 Although a 2015 report indicated that 69% of births in Ghana in 2014 were planned, indicating a 7% decline of unintended pregnancies from 2008, the proportion of unintended pregnancies is still high; 24% of pregnancies in 2014 were mistimed and 7% were unwanted.3

Family planning has been prioritised by many governments as a strategy to assist women to avoid adverse effects of unplanned pregnancies.4 Modern contraceptive methods provide safer and more effective ways of preventing pregnancies and allowing couples to exercise their rights and make responsible reproductive decisions.5 Through the use of contraceptive methods, couples are able to plan when to have children and how to space the children they want to have. Effective use of contraceptive methods will therefore have immense social and health benefits for both mothers and their children.6

The government of Ghana has adopted family planning as the primary strategy for managing the birth rate and the country’s population.3 Consequently, there is a growing desire by the government to make family planning services accessible

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to both men and women. The overall goal of the family planning programme is to assist couples and individuals to achieve their preferred reproductive goals and improve on their general reproductive health. As part of efforts to increase the utilisation of family planning services, there is a drive to improve the level of knowledge of contraceptive methods among couples as it is believed that good knowledge is an important factor determining access to and appropriate use of family planning methods.

It has been observed that inadequate knowledge and misinformation can lead to poor acceptance and wrong use of contraceptive methods. Misinformation can lead to misconceptions about family planning and be a barrier to uptake. For example, misconceptions about the potential side effects of contraceptives, harmful outcomes, as well as negative stereotypes about persons who use contraceptive methods, could hinder use. Additionally, beliefs that family planning methods are meant only for people who are married, and are not suitable for the unmarried or individuals who are expected to have children, could discourage acceptance. Access to good quality information and the availability of contraceptive options are therefore crucial for the success of any family planning programme.

Deaf people face serious access problems due to their unique communication needs; they encounter more challenges accessing health care than their hearing counterparts. Deaf people are seldom included in SRH outreach programmes; common sources of information on pregnancy prevention such as the radio and television are not accessible to them because these sources do not incorporate their communication needs, and there is a lack of health information and education in the sign language. For example, information dissemination from educational campaigns on general SRH issues (including pregnancy) is conducted mainly in the mass media and written materials such as posters and brochures. However, low educational attainment and literacy among deaf people make it difficult for them to read and understand written information. Studies have revealed that a typical deaf person lacks adequate literacy to benefit from health education, particularly information from written sources such as brochures and TV programmes that are captioned. Deaf people in Ghana are a vulnerable population because of the challenges they encounter accessing information on health issues, coupled with the high rate of unemployment, low levels of formal education, and poverty. In addition, health professionals, who are the main agent of health information, are unfamiliar with deaf culture and the information needs of the deaf population. Healthcare providers typically have difficulties communicating with deaf people and often underestimate the difficulties of lip-reading and overestimate deaf people’s ability to understand written notes. This reduces interaction between deaf people and health professionals, thus creating barriers when accessing services in the healthcare setting.

Literature on pregnancy and maternal health in the deaf population is generally scarce, suggesting that little has been done on the subject with the deaf population worldwide. This is particularly true in Ghana where there is little disaggregated information on disabled persons. Thus, while pregnancy-related problems are major public health issues for all women of reproductive age in Ghana and there are comprehensive data on the issue among the general population, little is known about the situation among deaf people.

However, given the barriers deaf people encounter when accessing services on health issues generally, the situation among them is likely to be worse. The few studies that have been done on deaf people focused on their level of knowledge on HIV and AIDS and barriers they encounter accessing SRH information. These studies provide some insights into the possible challenges they encounter when utilising information on pregnancy, but they do not provide useful information on their knowledge on preventing pregnancies. This paper bridges this information gap by assessing deaf people’s level of knowledge of pregnancy prevention methods. The paper is one of a series of papers published from a needs assessment that explored a wide range of issues relating to SRH among deaf people in Ghana. Previous papers focused on other aspects of SRH – sources of information on SRH issues, knowledge and attitudes on HIV, and perceived barriers to SRH issues. The paper provides information on another component of the SRH needs of deaf people in Ghana, namely family planning, thus helping to provide more insights into the overall SRH needs of deaf people in Ghana.
Methodology

We conducted a SRH needs assessment with deaf people who were fluent in the Ghanaian Sign Language (GSL) and resident in Ghana. We used mixed methods design, which consisted of three focus groups and a survey. The focus groups made it possible for an in-depth exploration of the topic and generated data needed for the development of the survey instrument. The survey assessed the issue in the larger deaf community. In addition, we had discussions with a SRH professional. Data from the professional supplemented and helped to verify some of the issues raised by the focus group and survey participants.

Mixed methods facilitates triangulation of data collected on the same issue and is capable of investigating, explaining and interpreting complex social issues. Therefore, the use of mixed methods for this study is appropriate because SRH issues in Ghana present complex data collection and interpretation challenges that require the use of more than one data collection method.

Population and sample

The study involved a total of 179 participants, comprising 26 focus group participants (17 males and 9 females), 152 survey respondents (87 males and 65 females) and one male key informant. None of the focus group participants took part in the survey. Only one key informant was included as, at the time of the study, he was the only person available who had experienced working with deaf people on SRH issues. Apart from the key informant, all participants were deaf persons.

We recruited participants from two communities in Ghana: Tamale, a city from the Northern Zone, and Accra from the Southern Zone of Ghana. The reason for selecting these communities was to sample participants with diverse socio-cultural characteristics and to ensure that different perspectives could be represented. Tamale and Accra represent the Northern and Southern sectors of the country, which reflect important differences in culture and socio-economic development. Forty-three participants were recruited from two deaf churches in Accra, 26 from a deaf centre also in Accra, 17 from a deaf centre in Tamale, and 92 from a deaf senior high school located in Accra. Using these locations increased the likelihood of identifying deaf people who had formal education and communicate in GSL because a large number of deaf people fitting these criteria congregate at these locations.

More participants were chosen from the senior high school than from the deaf churches and centres because, as the only public deaf senior high school in Ghana, it admits students from all over the country. Thus it has a diverse deaf population in terms of economic and socio-cultural characteristics, whose views were likely to be more representative of the adolescent deaf population in Ghana. Fewer respondents were recruited from Tamale partly because of the difficulty of getting deaf people with formal education. Many of the educated had migrated to the southern part of Ghana in search of jobs and better educational opportunities. We made efforts to represent females equally since young girls are considered more vulnerable than boys. Respondents from the deaf churches and centres in Accra and Tamale (aged 26 years and above) are referred to as the “adult population” and those from the deaf senior high school (aged 18–25 years) as “adolescents”.

Sampling technique

Purposeful sampling technique was used to select all the participants. The criteria for inclusion in the study included fluency in GSL, educational attainment (that is, anyone who had some formal education), and aged above 18 years. We focused on those with formal education who use GSL because formal education is required to acquire GSL. Interacting with deaf people who do not communicate in GSL would have presented a serious logistical challenge for the study.

Prospective participants from the deaf churches and centres were contacted through text messages and emails that included information about the study and eligibility requirements. We developed written scripts of the recruitment announcements in English that was signed in GSL at introductory meetings. After contacting prospective participants, we arranged to meet the men and women at two different locations to discuss the study objectives and procedures, their remuneration, and issues concerning their privacy and confidentiality. In the deaf high school, verbal permission was sought from the head of the school, and a notice about the study was sent to all teachers and students. We then met the students during their lunch time and provided details about the study and eligibility requirements. We met interested students on an agreed date for screening.
and recruitment. Informed consent was obtained from all participants before recruitment.  

Data collection

Focus groups

We conducted three focus groups: (1) the executives group consisting of seven executives of Ghana National Association of the Deaf (GNAD) who were all male; (2) the adult male group with 10 members, and (3) the adult female group with nine members. Students were not included in the focus groups because we purposively targeted specific adults, who could provide the information we needed to develop the survey instrument. This did not allow us to explore the views of the students in the focus groups.

The focus group guide consisted of open-ended questions and elicited information on participants’ views concerning access to SRH services and information. The broad issues discussed were: (1) sources of information, (2) knowledge on SRH issues, (3) challenges deaf people encounter accessing SRH services, (4) ways to address problems deaf people encounter when accessing SRH services and (5) the role of GNAD in the provision of SRH services. Videotapes and audio recorders were used to recorded proceedings from the focus groups with participants’ permission. While the men’s and the male executives’ focus groups were conducted by a male research assistant, the females’ focus group was conducted by a female research assistant. We assisted the research assistants when probes were needed for clarification or when the discussions went off-topic. The first author and the research assistants are native signers and so all the focus groups were conducted in GSL.

The transcribed data from the three focus groups were analysed separately to differentiate the responses of the three categories of participants: the male executives of the deaf community, male participants, and female participants. Focus group videotapes were converted to DVDs using Adobe premiere video software. Both the DVDs and the voice recordings were transcribed to text format. The transcription of the data from the DVDs was done in two steps: “partial” transcription and full transcription.

The first step (“partial” transcription) involved viewing the DVDs from all the focus groups to identify and transcribe into a Word document issues that had been raised by participants. This was a shortened version of discussions, consisting of only the group discussion information needed for the development of the survey. A verbatim transcription of the DVDs would have delayed the development of the questionnaire, so an abbreviated procedure was employed. The second step was a “full” transcription of the videotapes. The full transcription represented the data from the focus groups that were used to complement survey results from the final survey sample.

Survey

The survey consisted of information drawn from the literature and issues identified by focus group participants. The survey covered a range of issues that include challenges deaf people encounter when accessing SRH services and their knowledge of contraceptive methods. Additionally, the survey has statements on practices that could prevent pregnancy and respondents were asked to indicate whether the statements are true, false or they did not know.

With the exception of respondents from Tamale, whose questionnaires were administered individually, all the questionnaires were administered in groups. For each group session, respondents were gathered in a single room, questionnaires distributed to them, instructions provided, and research assistants helped those who needed assistance. Some of the items were written on blackboards and flip charts to make it easier to explain items to all the respondents at the same time without having to go around assisting each respondent who needed help. The survey items were written in English but GSL was used to explain items to respondents who needed assistance. The survey was conducted by the researchers and their two research assistants.

Basic descriptive statistics were used to analyse and summarise the survey data. Responses to the survey items were entered into an SPSS data file, and cross tabulations were computed to compare response differences across age and gender groups.

Ethical issues

The study was approved by the University of Illinois at Chicago’s (UIC) Institutional Review Board (IRB). As stated previously, verbal permission was sought from the head of the deaf high school before recruitment and the head of the SRH unit at Ada-braka Polyclinic in Accra. In addition, written permission was sought from GNAD. Informed consent was obtained from all participants using the GSL. The informed consent process included giving information about the expected duration of the
survey, how much they would be paid, and confirming that participation was completely voluntary and their decision not to participate would not adversely affect their relationship with the investigator. In addition, they were assured that they were not obliged to answer all questions, had the right to withdraw from the study at any time, and that their names would not be identified in the data. Focus group participants were told that the discussions involved video and audio taping and so those who did not want to be videotaped were advised to withdraw.

Results

Demographic data

Of the 178 deaf people (this excludes the key informant) who took part in the study, two-thirds were from the deaf senior high school, which accounts for the high proportion of respondents with a senior high school education, the relative youth of the sample and large percentage who reported being unmarried (see Table 1).

More males (52.8%) than females participated in the study because fewer deaf females than males have formal education. With respect to onset of deafness, about 70% of the respondents became deaf before the age of 18 years. Little is known about the distribution or prevalence of onset of deafness in the deaf population so it is impossible to assess whether this rate is representative of the larger deaf population in Ghana. However, the large representation of adolescents very likely biased the distribution of onset of deafness in the sample.

Focus groups

Focus group participants discussed deaf people’s knowledge of pregnancy prevention methods. Findings from the discussions indicated that there seemed to be disagreements among the male participants on the issue. A majority (77%) of the men had the perception that deaf people engaged in risky sexual behaviour which could expose them to unwanted pregnancy, while the remainder thought deaf people were knowledgeable and could apply their knowledge to deal with diverse issues relating to pregnancy. The following quotes from two male participants illustrate these divergent views.

“I think deaf people’s level of knowledge of pregnancy is low because it is not easy [for deaf people] to understand problems relating to STIs and STDs and issues relating to pregnancy also need more explanation. I mean deaf people do not know many things on STIs and STDs, teenage pregnancies, and maternal health and how to prevent pregnancies that is why we have a lot of teenage pregnancy among deaf people. This is because we don’t understand many issues about pregnancy prevention provided by health workers and other sources.” (Male participant 3, age 34)

“Many deaf people have knowledge on the use of condoms and other contraceptives as safe measures against pregnancy. Also knowledge on unintended pregnancies and how to prevent them is widely known among the deaf community. We use the knowledge we have on these issues to take measures against pregnancy and other SRH problems.” (Male participant 1, age 29)

There was, however, a consensus among the women regarding deaf people’s lack of knowledge on pregnancy issues. For example, three participants stated that many deaf people were ignorant and unaware of the consequences of unprotected sex such as unintended pregnancies and abortions. As a consequence, they engaged in risky sexual behaviours which often led to unintended pregnancies, mainly among unmarried young deaf people. Two other participants agreed with this assertion and said that ignorance about pregnancy related issues was particularly high among adolescents and those who did not have formal education. They believed that these are reasons for high teenage pregnancies among young deaf women, but they blamed the situation on lack of SRH information in accessible formats for deaf people. A female participant stated:

“It is true that deaf people do not have enough knowledge on pregnancy and engage in sex without protection. Deaf people do not know much about these issues. You see, the TVs and newspapers are not accessible to deaf people, so how can deaf people understand this information from doctors and nurses? Our girls are always getting pregnant. We have serious problems of understanding and using some of the new methods to prevent pregnancy.” (Female participant 4, age 44)

Similarly, all male executives supported the view that deaf people were largely unaware about the consequences of unsafe or unprotected sex. One executive participant explained that teenage pregnancy was common among deaf people
while another said teenage pregnancy, unintended pregnancy, and abortion were common to all Ghanaians including deaf people. On barriers deaf people encounter when accessing SRH services, a majority (90% male and 89.1% female) of the participants blamed staff at the SRH centres of being insensitive to deaf people. A male participant, for example, described how “the staff [at SRH clinics] don’t care and do not give the deaf attention” even though the staff know that their deaf clients have difficulty with communication. He further explained that even

| Demographic                         | Males | Females |
|-------------------------------------|-------|---------|
|                                     | Adolescents (48) | Adults (56) | Adolescents (44) | Adults (30) |
| Age                                 |       |         |                  |            |
| 18–25                               | 48 (100.0) | 44 (100.0) |                  |            |
| 26–35                               | -     | 45 (82.6) | -                | 14 (47.6)  |
| 36–45                               | -     | 3 (4.3)  | -                | 6 (19.0)   |
| 46–55                               | -     | 5 (8.7)  | -                | 7 (23.8)   |
| 56 and above                        | -     | 3 (4.3)  | -                | 3 (9.5)    |
| Marital Status                      |       |         |                  |            |
| Married                             | -     | 23 (41.0) | -                | 11 (38.1)  |
| Unmarried                           | 48 (100.0) | 30 (53.8) | 44 (100.0) | 19 (61.9)  |
| Separated/Divorced                  | -     | 3 (6.1)  | -                | -          |
| Educational Level                   |       |         |                  |            |
| Senior High School                  | 48 (100.0) | 27 (48.6) | 44 (100.0) | 13 (42.1)  |
| Technical                           | -     | 6 (10.8)  | -                | 3 (9.5)    |
| University/Polytechnic/Diploma      | -     | -       | -                | -          |
| Other                               | -     | 23 (40.5) | -                | 14 (48.4)  |
| Age at onset of deafness            |       |         |                  |            |
| Less than 16                        | 36 (75.6) | 46 (82.8) | 41 (92.7) | 24 (81.3)  |
| 16–25                               | 12 (24.4) | 2 (3.4)  | 3 (7.3)  | 4 (12.5)   |
| 26–35                               | -     | 2 (3.4)  | -                | 2 (6.3)    |
| 36–45                               | -     | 2 (3.4)  | -                | 0.0        |
| 46–55                               | -     | 2 (3.4)  | -                | 0.0        |
| 56 and above                        | -     | 2 (3.4)  | -                | 0.0        |
if the staff were willing to help, they were unable to explain the information they provide because they could not communicate in the sign language. Similar sentiments about the attitude of health workers were expressed by two female participants, who alleged that the staff at the SRH centres did not have time to explain SRH information to them during their respective visits, and that the attitude of the staff created problems for deaf people who visited the centres. Another female participant remarked:

“I have never visited those centers. I know many deaf people who also don’t go there due to lack of interpreter services… also the attitude of the workers there is bad. Their behavior makes us uncomfortable. I visited just once they are having a big program and there were interpreters. I am not the only persons who is complaining.” (Female participant 5, aged 45)

An executive of GNAD confirmed the above claims and stated that,

“I once went to the family center but the staff at the centers didn’t have time for me and do not explain anything relating to birth control to deaf people. I went there purposely because of that but they didn’t have time for me. It is true that the staff working at these clinics make things very difficult for deaf people.” (Male GNAD participant 2, aged 39)

Survey
The survey further explored deaf people’s knowledge on pregnancy prevention by examining the ability of respondents to correctly discern statements about practices that could prevent pregnancy. The survey data suggest a general lack of knowledge on practices that could prevent pregnancy among respondents as many of respondents could not identify the correct statements; only a little over one-third of all the respondents (38.7% male and 31.6% female) could identify the correct statements. Also, only about 30% of the respondents (29.0% male and 30.8% female) indicated that a woman can get pregnant if she showers right after sex, and a little over 40% of both sexes (42.5% male and 43.1% female) knew that a woman can get pregnant if she had unprotected sex only once.

Slight differences were observed across groups, with adults generally being more knowledgeable than students, but female adults were the most likely to identify the correct statements, probably because female adults are more likely to be exposed to family planning methods than their male counterparts. Adolescent females were the least knowledgeable on the statements. Table 2 summarises the responses from the respondents.

The correct pregnancy prevention statement that recorded the highest response was “Avoiding sex prevents pregnancy.” However, only less than half of both female and male respondents (41.4% male, 46.2% female) correctly identified this statement as true.

Furthermore, it appears some of the respondents could not differentiate between practices that prevent pregnancy and those that prevent STIs/STDs, which also suggests a lack of knowledge on these issues. Statements on blood transfusion and kissing, for example, are not pregnancy prevention methods, but approximately 16% (13.7% male, 18.5% female) and 9% (10.3% male, 7.7% female) of respondents indicated them as correct statements.

Discussion
This paper explored the level of knowledge on pregnancy prevention among deaf adults and adolescents in Ghana. The findings show a general lack of knowledge on pregnancy prevention methods among the respondents. For example, the survey indicated that just one-third of the respondents knew that a woman could be pregnant if she showers immediately after sex and as many as two-thirds did not know that having unprotected sex only once could lead to pregnancy. This lack of knowledge can lead to unprotected sex or incorrect use of family planning methods among deaf people.

Although this study is limited in scope, the findings highlight possible barriers to accurate information on pregnancy prevention. These findings support claims by focus group participants that deaf people lack knowledge on SRH issues because they have difficulty obtaining information on these issues from health professionals. Most educational programmes on SRH issues in Ghana are organised by health professionals and so they are a major source of accurate and reliable information on SRH issues. However, health professionals are often not the preferred resource of information for deaf people for a number of reasons, notably, their ignorance about the communication needs of the deaf population and negative attitudes.
towards deaf people. Several studies have found that health professionals exhibited ignorance and misunderstanding of the unique communication needs of deaf people.\textsuperscript{11,17,19} It has been observed that deaf adolescents, in particular, have difficulty accessing information on SRH issues due to communication barriers with health professionals.\textsuperscript{20} However, since the current study did not include adolescents in the focus groups, we are unable to identify the kind of challenges they encounter and if these challenges are similar to those encountered by adults.

It could therefore be deduced from the findings that, although the views expressed by focus group participants on the prevalence of teenage and unwanted pregnancies among deaf people were personal, there is the possibility that these problems exist in the deaf community. Data on the general population indicate that teenage and unwanted pregnancies are still high in Ghana.\textsuperscript{3} Even though there are no disaggregated data on the deaf population in this report, the situation is unlikely to be different among deaf people. Indeed, the few studies that have been conducted on the SRH status of people with disabilities\textsuperscript{26} and deaf people\textsuperscript{11} in Ghana support the fact that deaf people lack knowledge on SRH issues and are at high risk of unwanted pregnancies.

| Statement                                                                 | Males Adolescents (48) % | Males Adults (39) % | Females Adolescents (44) % | Females Adults (21) % | Total Male (87) % | Total Female (65) % |
|--------------------------------------------------------------------------|--------------------------|--------------------|---------------------------|-----------------------|------------------|-------------------|
| Withdrawal before ejaculation can prevent pregnancy*                     | 35.4                     | 41.0               | 31.8                      | 42.9                  | 37.9             | 35.4              |
| A woman taking oral contraceptive pills will not get pregnant*           | 25.0                     | 35.9               | 27.3                      | 47.6                  | 29.9             | 33.8              |
| Having sex without protection can lead to pregnancy*                    | 39.6                     | 7.7                | 36.4                      | 28.6                  | 25.3             | 33.8              |
| Avoiding sex prevents pregnancy*                                         | 37.5                     | 46.2               | 40.9                      | 57.1                  | 41.4             | 46.2              |
| Using modern contraceptive methods is protection against pregnancy*      | 20.8                     | 15.4               | 20.5                      | 47.6                  | 18.4             | 29.2              |
| Showering or bathing after sex prevents pregnancy                        | 31.3                     | 28.2               | 27.3                      | 38.1                  | 29.9             | 30.8              |
| A woman cannot get pregnant if she had unprotected sex only once         | 33.3                     | 56.4               | 40.9                      | 47.6                  | 42.5             | 43.1              |
| A woman cannot get pregnant during her first sexual intercourse          | 60.4                     | 64.1               | 18.2                      | 61.9                  | 62.1             | 32.3              |
| Being faithful to one’s partner prevents pregnancy                      | 25.0                     | 30.8               | 34.1                      | 42.9                  | 27.6             | 36.9              |
| Avoiding blood transfusion protects against pregnancy                    | 16.7                     | 10.3               | 20.5                      | 14.3                  | 13.8             | 18.5              |
| Avoiding kissing is a protection against pregnancy                      | 10.4                     | 10.3               | 6.8                       | 9.5                   | 10.3             | 7.7               |

* Indicates correct statement.
It is also important to note that most educational campaigns on SRH issues in Ghana are conducted primarily through the mass media and educational materials such as radio, television, posters, and brochures. However, information disseminated through these channels are not accessible to deaf people in Ghana. For example, information from televisions is not captioned or translated into sign language and deaf people generally have difficulty obtaining information from written sources because of their limited English reading skills. In addition, because persons with disabilities, including deaf people, are considered sexually inactive, they are often excluded from sex education programmes. Informal sources of sex education may not be available to deaf persons because of communication barriers with their parents and hearing peers. Most deaf children are born to hearing parents, who are not fluent in the sign language. As such, deaf children have difficulty obtaining information on sex education from their parents. Studies have confirmed that deaf people in Ghana experience similar communication challenges with their parents. Our findings expand on earlier studies on the HIV/AIDS knowledge base in the deaf community and confirm the low level of knowledge on SRH issues generally among deaf people in Ghana. Thus, in spite of the efforts being made to improve access to SRH services to all Ghanaians, it appears the deaf population has not been adequately reached by these programmes.

The study has limitations. It did not include students in the focus groups, which would have provided them the opportunity to express their concerns in GSL and eliminate many of the linguistic limitations they probably encountered with the survey. The survey required that respondents were able to read and understand English, but it was a bit difficult for some students to read due to their limited English reading skills. This challenge may have affected some of their responses. Also, a focus group would have provided additional qualitative data on adolescents to complement and clarify the survey data. Another limitation relates to the sample size and whether the sample of respondents was representative. For example, both respondents from Tamale and women were under-represented in the study which limited the information obtained from these categories. In addition, the focus of the current study was on deaf people who had some formal education and were able to communicate in GSL. There are an unknown but likely large number of deaf people who do not communicate in GSL and were not included in the current study.

The study has a number of implications for policy-making and service delivery on SRH issues for the disabled community in general and deaf people in particular. Findings from our study point to the need for concerted efforts to design SRH programmes that address the communication needs of the deaf population, particularly those without formal education.

Although family planning services have been prioritised by the Government of Ghana and efforts are being made to increase coverage, it appears these services are not reaching a section of the population and points to the need to reconfigure service delivery to target marginalised groups. The deaf community has unique needs and concerns, so they are unlikely to be reached by programmes meant for the general population. As a result, SRH programmes should be tailored to suit the specific needs and concerns of deaf people, taking into account the language and communication preferences of the deaf community. Consequently, all SRH education interventions for the deaf community should be planned in collaboration with deaf people so that culturally relevant programmes could be designed for them.

Although the study focused on deaf people, the findings have wider implications for the general disabled community. It has been documented that disabled persons have received little attention in SRH policies, research, and programmes in Ghana. As a result, little is known about the SRH status of disabled people. Findings from the current study somewhat reflect challenges the disabled community in Ghana is facing due to the exclusion of their needs in SRH policies and programmes. There is therefore a need for urgent action in the area of research to better explain the SRH experiences and behaviour of the disabled population in Ghana for appropriate policy and programmatic actions. Furthermore, to the extent that cultural considerations are fundamental to SRH planning, the matter of deaf culture and its influence on the behaviour of deaf people must be considered. Future research is needed to understand the relative importance of deaf people’s culture and communication barriers for their vulnerability to SRH problems. This paper nevertheless provides insights and understanding into deaf people’s knowledge base regarding pregnancy issues and thus contributes to the little that has
been done on SRH issues among deaf people in Ghana.

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