Enablers and barriers in accessing sexual and reproductive health services among visually impaired women in the Ashanti and Brong Ahafo Regions of Ghana

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Abstract: The need to improve the sexual and reproductive health (SRH) and rights of women with disabilities is increasingly acknowledged. Unfortunately, women with disabilities in low- and middle-income settings, including Ghana, face several barriers (including structural, financial, physical, social and attitudinal) to accessing SRH services and care. This paper explores the enablers and barriers to accessing SRH services and care among visually impaired women in the Ashanti and Brong Ahafo Regions of Ghana. Qualitative data from in-depth interviews and focus group discussions were collected from 21 visually impaired women, selected through purposive and snowballing sampling techniques. Thematic analysis was used to develop codes, and data were further grouped into emerging themes. The barriers to accessing SRH services and care were financial difficulties and lack of preferential treatment. The enablers which facilitated access to SRH services and care were the support provided by caregivers and friendly relationships with health providers. To address these challenges and promote access, SRH related policies, services and programmes should be inclusive of the needs of visually impaired women, and measures to remove financial challenges to service utilisation and foster positive relationships with health workers, church and community members should be adopted. DOI: 10.1080/09688080.2018.1538849

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Introduction

Sexual and reproductive health (SRH) is a state of physical, emotional, mental and social well-being in all matters relating to the reproductive system, and not merely the absence of diseases, dysfunction, or infirmity. A substantial proportion of the world’s health problems in high, middle and low-income countries arise from the lack of SRH services and care. Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) reaffirms that states ensure access to health services, for women on an equitable basis with men, including, for instance, family planning, pregnancy and antenatal care. For people with disabilities, article 25 of the United Nations Convention on the Rights of People with Disabilities (UNCRPD) entreats Governments to make SRH services and care accessible and inclusive, and on an equal basis to persons without disabilities. Disability inclusion activists and human rights bodies are also advocating for increased access to SRH services and care for

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women with disabilities. The government of Ghana has responded to these calls by passing the Persons with Disability Act 715, to improve the well-being of the 3% of the population (representing 737,743 people) with disabilities. The population with disabilities includes those with visual, hearing, physical speech, emotional and intellectual disabilities.6

Generally, women with disabilities experience compounded vulnerabilities, including higher rates of violence, and lower rates of access to economic and social services, due to intersections relating to gender and disability. Compared with their male counterparts, women with disabilities rank lower in every economic and social services indicator. Whilst there are growing efforts in high-income countries to address the needs, challenges and barriers to accessing SRH services and care for women with disabilities, those in low- and middle-income countries (LMICs) are more likely to be excluded.7–13 Many factors contribute to this exclusion, including negative and stigmatising attitudes at multiple levels (e.g. family, health facilities, societal), inaccurate perceptions that women with disabilities are sexually inactive, and higher levels of sexual and gender-based violence (SGBV). Published papers from LMICs have concluded that women with disabilities have limited understanding of SRH services and care and are thus less likely to access services and care due to a lack of inclusive and accessible information and communication.8,11,13,14

Women with disabilities face numerous access barriers in accessing SRH services and care compared with the general population.7–13 These barriers are interrelated and similar across different settings15 and can be categorised broadly into those related to physical structure, transportation, finance, communication and stigmatising attitudes.9,11,16 Examples of unfriendly physical structure include the lack of ramps, inaccessible doors, hospital beds and toilet facilities and difficult to read medical labels.6,8,11,13,14 The cost of seeking SRH services and care is high and women with disabilities usually have limited income sources due to unemployment.12,17,18 In Nepal, for instance, the perceived high cost of seeking care influenced women with disabilities to opt for SRH care in the home.12 Women with physical disabilities in particular also experience transportation-related difficulties.7,9 Others note that women with disabilities are stigmatised and discriminated against by health workers and community members due to negative perceptions about disability.3,15,19,20 This is transferred to the health facility setting, where women with disabilities do not receive preferential treatment to assist them and often endure long waiting times.10,11 The consequence of these difficulties is that disabled women have poorer health outcomes, secondary co-morbidities and delayed diagnosis.

In Ghana, women with disabilities face many challenges in accessing social services related to health, education, and economic activities.21–23 Due to their double vulnerability, women with disabilities lag behind non-disabled persons in accessing SRH services.17,24 Even though several policies on SRHR have been implemented,25,26 studies have concluded that most of these policies and strategies did not directly recognise people with disabilities.25 Those that targeted people with disabilities, such as the Reproductive Health Service Policy and Standards, were cursory and seemed to be more interested in controlling the reproductive rights of persons with disabilities than addressing their overall reproductive health challenges.25,26

Women with visual impairments have particularly been neglected. Visually impaired women may have different experiences due to the nature of their disabilities, but little is known about their experiences of service utilisation. Some literature on SRH is available on people with hearing impairment.26–28 A search of the literature identified two studies including women with visual impairment, with one focused on maternal health,29 and the other being a personal narrative on sexual and reproductive issues for visually impaired women.30

This study aims to contribute to the gap in the literature by exploring the enablers for and barriers to accessing SRH services and care for visually impaired women in Ghana. The study is facilitated by Pechansky and Thomas’s (1981) theory with the components of access, as accessibility (location), availability (supply and demand), acceptability (consumer perception), affordability (financial and management related costs), and adequacy (organisation).16

Methods
Ethics statement
Ethical approval for this research was obtained from the Committee on Human Research, Publication and Ethics at the Kwame Nkrumah
University of Science and Technology College of Health Sciences. The researchers obtained written permission from the Ghana Federation of Disability Organisations (GFD) and the Ghana Blind Union in the Ashanti Region before conducting the study. Study protocols and interview guides were reviewed by the executives of the Ghana Blind Union and GFD in advance of the interviews. No interviews were conducted without the permission of executives of the disability associations. All study participants provided verbal informed consent, which was witnessed by at least one family member or friend. The participation in the study was voluntary, and so participants could withdraw from the study if they felt any inconvenience. The authors assigned unique identifiers to audio recordings and transcripts to maintain confidentiality.

Study setting and sampling
The study was conducted between September 2016 and May 2017 in the Ashanti region (Kumasi Metropolis, Bekwai Municipality, and the Amansie West District) and Brong Ahafo region (Wenchi Municipality). These two regions were purposively selected due to their geographical location in the middle belt of Ghana. These areas have a mixture of features (geo-political, ethnicities) from the southern and northern parts of Ghana. Qualitative data collection, which involved conducting in-depth interviews (IDI) and focus group discussions (FGDs), were used. The qualitative method helped to explore the subjective experiences of participants on their previous encounter with SRH services and care. A total of 21 visually impaired women (16 years and above) were selected through purposive and snowballing sampling techniques. Seven women were from the Bekwai Municipality, six from the Kumasi Metropolis, two from the Amansie West District and six from Wenchi Municipality. Nine IDIs with visually impaired women and two FGDs (six participants each) were conducted.

The participants were recruited through the support of executives of the Ghana Blind Union (GBU) and GFD. The leaders of the associations in the respective regions provided the research team with the scheduled dates for their meetings. The research team attended two separate meetings of the associations in the Kumasi Metropolis and Bekwai Municipality to recruit participants. During these meetings, all women over 16 years with visual impairment were recruited. In the Amansie West District, a snow-balling approach was used to zone the communities and locate visually impaired women for the study. This sampling was used due to the dispersed nature of the communities, and the lack of preliminary information about the visually impaired women. After each interview session, the research team asked the participants to help locate any visually impaired woman in the catchment area.

Data collection
A voice recorder was used to record all interview sessions. The interviews were conducted by two research assistants; one facilitated the interviews and the other monitored and took notes of information that could not be recorded. All participants were briefed about the research procedures, objectives, dates, venue, and the consent process. Permission was sought for interviews to be recorded. Interviews were conducted in English or the local dialect, Twi. A structured interview guide was used to facilitate the interviews and FGDs. The interview guide covered questions on the enablers and barriers that visually impaired women faced in seeking SRH services and care: the physical location, the structure and physical environment, the process of seeking care, sources of financing, medication costs, caregiver support, available preferential treatment, and health providers’ attitudes.

Data analysis
The voice recorded interviews were transcribed by the research team into a Word document. Thematic analysis was used. This process involved several stages. The qualitative method helped to explore the subjective experiences of participants on their previous encounter with SRH services and care. A total of 21 visually impaired women (16 years and above) were selected through purposive and snowballing sampling techniques. Seven women were from the Bekwai Municipality, six from the Kumasi Metropolis, two from the Amansie West District and six from Wenchi Municipality. Nine IDIs with visually impaired women and two FGDs (six participants each) were conducted.

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Data analysis
The voice recorded interviews were transcribed by the research team into a Word document. Thematic analysis was used. This process involved several stages. The research team read through the transcribed data several times to ensure consistency, accuracy and to identify emerging codes. The codes were assigned unique alphabets and were grouped into themes to develop a framework which guided the interpretation of results. The research team identified each theme and sub-theme and further supported them with verbatim quotes.

Results
Background information of participants
The average age of the participants was 42 years. Forty-five percent were single and 29% had no education. More than a third were unemployed (Table 1). The study developed a framework (Table 2) using the inductive themes emerging from the study. The framework has codes, sub-themes and themes. The major themes were enablers and barriers whilst the sub-themes emerging from the analysis were: financing the costs of care,
transportation, experiencing physical barriers and receiving preferential treatment.

**Paying the cost of care**
The participants mentioned that they financed the cost of care through sources such as relatives (mothers, fathers and grandmothers), church members, individual support and personal funds:

“They prescribed a drug for me for about a month today ... when my church members came to look after me, they did very well ... the pastor collected the prescription and bought the drug for me.” (FGD1, Participant 2)

A few of the participants added that they used savings made from individual giving to finance the cost of care:

“Yes and the help from the community. Benevolence like friends will give me some small money like say 10,000 [GHC 10]... they are saying there is hardship everywhere these days so I shouldn’t be doing that [begging].” (IDI, Participant 3)

“For me I don’t have anyone to help me ... even if the church members will help me, it is only GHC 50 ... which cannot do anything for me so what I do is that when someone give me money to buy food to eat ... I save some to cover the cost of my health care.” (FGD1, Participant 4)

**Financial difficulties**
The participants expressed that they experience financial difficulties due to lack of funds and limited insurance coverage. Some of the participants said that these difficulties prevent them from seeking care or purchasing drugs prescribed by health providers:

“I do not have money to present at the hospital ... and my insurance is expired and I do not have money to ... I tried to go and renew it but they charged GHC 25 cedis but I do not have some so I have stop.” (IDI, Participant 1)

“For money it was challenging for me ... at one point when they prescribed a drug for me I threw the prescription sheet somewhere [no money to buy].” (IDI, Participant 6)

The participants shared experiences of challenging encounters with the existing National Health Insurance Scheme (NHIS). Some participants noted that they need to pay for enrolling or renewing their NHIS subscription. They further expressed that the NHIS does not cover all medical costs, sometimes drugs are not available, so additional

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Table 1. Background information of participants

| Variable               | Number | Percentage |
|------------------------|--------|------------|
| **Age (years)**        |        |            |
| 16–39                  | 9      | 42.86      |
| ≥ 40                   | 12     | 57.14      |
| **Marital status**     |        |            |
| Single                 | 9      | 45.00      |
| Married                | 5      | 25.00      |
| Separated              | 2      | 10.00      |
| Widowed                | 4      | 20.00      |
| **Education**          |        |            |
| No Education           | 6      | 28.57      |
| Junior High School     | 4      | 19.05      |
| Senior High School     | 8      | 38.10      |
| Tertiary               | 3      | 14.29      |
| **Occupation**         |        |            |
| Unemployed             | 8      | 38.10      |
| Trading                | 3      | 14.29      |
| Teaching               | 4      | 19.05      |
| Student                | 6      | 28.57      |
| **Role in Community**  |        |            |
| Community Member       | 12     | 57.14      |
| Student                | 6      | 28.57      |
| Executives of GFD/GBU^  | 3      | 14.28      |

*Mean = 42.23 (SD = 17.15), Median = 50.
^GFD/GBU = Ghana Federation of Disability/Ghana Blind Union.

1GHC or cedi is the Ghanaian currency, 1 GHC = 0.2 USD
payments for some prescriptions and laboratory tests are needed:

“The insurance is there but sometimes when you go, they tell you that there is no drug available so they prescribe for you … even for laboratory or if you make a request for laboratory test, you have to pay for that.” (FGD1, Participant 5)

“It’s better when you don’t even hold the insurance … [.]When you go, they don’t give you the drugs that they are expected to give you … then they give reasons that this one doesn’t cover the insurance so you have to pay, unless paracetamol that the insurance does cover, so when I go to the hospital I incur high cost.” (FGD1, Participant 4)

Additionally, some of the participants shared how they faced economic hardship due to limited opportunities for earning a livelihood, thus impeding their ability to buy food in order to take the medication prescribed by health providers:

“For me, I use the little that I received monthly to pay my hospital bills and even at times after I have gone to buy drugs, it is difficult to get money to buy food to enable me take the drug … so it’s like we don’t have any work in addition to […] so we face economic hardship.” (FGD1, Participant 2)

“When it comes to daily living … please it is very difficult before God and man … for me I stay in a family house … whether I will eat or drink, no one cares about me … everyone cook for their household … no one cares about me … so unless someone gives money when my story touches his heart … I can tell you that sometime I even sleep without eating the whole day … is not that I am not hungry … I experience hunger but I don’t have what to eat … so it’s difficult.” (FGD1, Participant 4)

**Paying for transport**

Whilst most participants visited the health facilities by car, a few used motor tricycles, except one participant, who walked:

“I walked on foot … the hospital is just behind our house … It was the small boy [caregiver.] For instance, he alert me wherever there is steps so that I will raise my leg.” (IDI, Participant 4)

Most participants had their transport cost paid by their relatives (mothers, siblings and grandmothers) whilst a few paid by themselves:

“My sibling who is my mother’s last born brought me small money so I added some to cater for cost associated with the care … and she said she could not get time because she was travelling and nobody was around to support me so I beg the lady to accompany me … even with the family members, apart from my siblings, anyone who accompany me collect money for the services.” (IDI, Participant 4)

Two of the participants further noted that the transport costs sometimes seemed high and unbearable, and resorted to negotiating for a reduced price:

“When I go to the hospital, I pay it by myself … there are some taxi drivers when you ask for reduction in the price that he quotes, then he becomes annoyed … saying that we don’t know what is happening regarding the increased in the price of petrol and other things … sometimes I have to argue with him that it’s not the money from one person that can fill the fuel but the person will still charge the same amount he intent to charge …” (FGD1 Participant 4)

A participant specifically felt that the transport costs presented difficulties especially when paying additional costs for caregivers:

| Table 2. Framework for enablers and barriers in seeking SRH services |
| --- |
| Themes | Sub-theme | Codes |
| Barriers | Financing costs of care | • Paying the cost of care  
• Financial difficulties |
| Transportation | Paying for transport  
Poor support for transport |
| Physical barriers | Encountering barriers |
| Enablers | Preferential treatment | • Preferential treatment  
• Support for transport/from caregivers  
• Health providers attitudes |

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“I have to pay the transport cost of the person to accompany me to the health facility and also pay for my own to the health facility … when it happens like that I encounter financial difficulties … in about two years where I was in short of blood and presented at Asuoyin [health facility], I was in short of finance there, I paid the transport cost for the caregiver and also bought food for him to eat.” (IDI, Participant 1)

Support for transport
Two visually impaired women further noted that they usually receive support from bus conductors whenever boarding a car to the health facility:

“For me I don’t have problem with boarding a car … they hold my hands to support me whenever I am getting down and when I am struggling for boarding, he [bus conductor] always support me for entering into the car …” (FGD1, Participant 3)

“Before God and man, whenever I go to the hospital, I realized that it is God who send the driver and assistant to me … even when I am boarding a car, the assistant conductor support me in taking my seat and do same when I am getting down from the car … I don’t encounter such difficulty with the drivers and assistant.” (FGD1, Participant 4)

However, a participant had a contrary view about assistance:

“I took a Trotro [public transport] … by the time I was getting down I was holding some belongings [load] but the assistant bus conductor did not help me when I asked for such help … he told me: did you ask me to come and board such a car.” (FGD1, Participant 4)

Encountering physical barriers
Most of the participants noted that they did not encounter physical barriers when accessing the health facilities due to the support they received from caregivers. Two of the participants felt that without caregiver support, they could not access the health facility:

“They have to hold my hands before I could use the hospital … if she doesn’t hold my hand I may not see, for example, if there is a car coming it may knock me down and that will be a big family issue.” (IDI, Participant 3)

Preferential treatment
Most participants felt that they did not receive preferential treatment at the health facility. The participants noted that they followed the usual queue until their turn. A participant commented that the nurses felt that other, non-disabled patients may complain if waiting times are skipped:

“When I go to the hospital I follow the queue … even when I get a nurse and inform her that please I have been here for very long and I am not feeling well so help me … she can even tell you that you came to meet people here so you have to follow the queue because when she provide you with that preferential treatment then they will be complaining … so I follow the queue till it reaches my turn.” (FGD1, Participant 2)

Other participants noted that they received preferential treatment when seeking care at the health facility from health providers. Some of the participants automatically received preferential treatment, whilst others felt it depended on the hospital unit and existing arrangements at the facility. For instance, a few participants noted that preferential treatment is usually provided at the outpatient department cards section and consulting room, but not in the dispensary section. Participants commented on this as follows:

“The preferential treatment is there but is not that quick … after you have received your folder and gone through diagnosis [taking vital signs], you will be asked to join the queue but will come close to those in front … you will be asked to be in between those who are in the front and those at the back of the queue …” (FGD1, Participant 5)

“At first what I knew was that when you go to Komfo Anokye [teaching hospital] and you are disabled person, there is a place that you go and write your name … before you take your card, you go there and write your name … for that one they can allow you to seek your care first when the doctor is around but for now I don’t know …” (FGD1, Participant 3)

Health providers’ attitudes
Participants noted that they had friendly relationships with the health providers when seeking health care at the health facility:

“They visit us all the time and even pray for us … if she doesn’t hold my hands I can’t see and if she
Two participants felt that some nurses do not exercise patience:

“It will be necessary that we the blind people are not allowed to follow queue whenever we visit the health facility...we are not expected to follow queue at all but if you don't follow the queue then they shout on you that didn’t you come and meet someone here...some [nurses] do not exercise patience at all so if you are here to interview us, then let the nurses know about this because some do not respect us at all....” (FGD1, Participant 2)

“But there are some health facilities that the nurses do not exercise patience...they do not have time for you to explain the health condition that you present to the health facility...shouting over you.” (FGD1, Participant 3)

Discussion

The study explored the enablers for and barriers in accessing SRH services and care among visually impaired women in Ghana. The emerging themes included financing sources, physical barriers, preferential treatments and health providers’ attitudes. These will be discussed and guided by Pechansky and Thomas’s theory,16 with components of affordability, physical accessibility and adequacy.

Affordability

The affordability component refers to ability to pay for SRH services and care without out-of-pocket expenses and other financial barriers.38 Visually impaired women in this study encountered financial difficulties in seeking care, as also shown in other settings including Uganda,10,17 Cameroon,7 Senegal20 and Nepal,12 where women with disabilities experienced high costs of care. In Ghana, the visually impaired women expressed concerns about the lack of reliable means to cover the cost of medication, including poor insurance policy and coverage, which led to additional payments. The NHIS policy has introduced an exemption of payment for the marginalised, including women and girls with disabilities. Unfortunately, the exemption is usually granted based on the condition that the disabled person is recognised as poor.18 Despite this exemption arrangement, most of the visually impaired women interviewed paid for their NHIS subscription. Even if the subscription were free, the NHIS package does not cover all medical costs, with this additional payment presenting potential financial difficulties.

Visually impaired women financed their transportation cost through relatives, church members, individual support and personal funds. The transportation costs were higher for visually impaired women especially because of the need for additional transport for accompanying caregivers. Women’s poor economic standing compounds the problem, demonstrating the intersections between gender and disability which make visually impaired women face double vulnerability. In Cameroon7 and Uganda,10,17 studies also showed that the high cost of transportation and medical costs presents a burden to women with disabilities, especially when seeking reproductive health services.7,10

Accessibility (physical)

Accessibility refers to the ready availability of services for visually impaired women, by considering the proximity of the health service in terms of time and distance. In particular, it describes the ability of visually impaired women to access the health facility, without facing environmental barriers. In the discussion on transport, some women expressed their appreciation for the support given by bus conductors. At the health facility, the physical environment could be unfriendly for visually impaired women, but the support provided by caregivers helped to remove these barriers. Earlier studies also conclude that people with disabilities faced numerous physical structural and environmental barriers in seeking care, including for SRH services.7,8,11,12,14,39,40 This study underscores the need to reassess and improve the physical structure of health facilities, taking into consideration different disabilities.

Adequacy

Adequacy is used here to describe whether SRH services and care were accommodative or sufficiently organised to be user-friendly to visually impaired women. Some visually impaired women in the current study received preferential treatment at the health facility whilst others did not. The absence of preferential treatment is also reported elsewhere, for example in Uganda,10 India13 and Nepal12. Absences of preferential treatment in previous studies were attributed to poor attitudes of health providers. However, some women with visual impairment in this study had friendly relationships with health providers, in contrast...
with studies from India, Nepal and Uganda where women with disabilities seeking maternal and new-born services felt embarrassed, stigmatised and discriminated against, due to the limited knowledge and perceptions of health workers and community members.10,12,20

Conclusion
This study was conducted to explore enablers and barriers experienced by visually impaired women in seeking SRH services and care in the Ashanti and Brong Ahafo Regions of Ghana. The paper was limited to the views of visually impaired women, without the perspectives of health systems planners, services providers and caregivers. The study concludes that visually impaired women faced several barriers in seeking SRH services and care, which include financial difficulties, caused by poor health insurance coverage, economic hardship, costs of transportation to health facility and lack of preferential treatment at the health facility. Enablers were the support provided by caregivers and friendly relationships with health providers. Findings of the study can inform the development of inclusive policies and the planning, monitoring and delivery of services and care for visually impaired women. To address these challenges and promote access, measures to remove financial challenges, improve physical access and foster positive relationships with health workers, church and community members should be adopted.

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discussions par groupe d’intérêt, ont été recueillies auprès de 21 femmes malvoyantes, sélectionnées par des techniques d’échantillonnage dirigé et en boule de neige. Une analyse thmatique a été employée pour préparer les codes, puis les données ont été groupées par thèmes émergents. Les difficultés financières et le manque de traitement préférentiel faisaient obstacle à l’accès aux services et soins de SSR. Les facteurs qui facilitaient l’accès aux services et soins de SSR étaient le soutien prodigué par les aidants et les relations amicales nouées avec les prestataires de santé. Pour lever ces barrières et élargir l’accès, les politiques, services et programmes relatifs à la SSR devraient tenir compte des besoins des femmes malvoyantes. Il convient également d’adopter des mesures pour supprimer les écueils financiers s’opposant à l’utilisation des services et favoriser les relations positives avec les agents de santé, les membres des églises et des communautés.

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grupos focales con 21 mujeres con discapacidad visual, seleccionadas por medio de técnicas de muestreo intencional y de bola de nieve. Se utilizó el análisis temático para crear códigos y los datos fueron agrupados por temáticas emergentes. Las barreras para acceder a los servicios de SSR eran: dificultades financieras y falta de tratamiento preferencial. Los facilitadores que facilitaron el acceso a los servicios de SSR eran: el apoyo brindado por cuidadores y relaciones amigables con prestadores de servicios de salud. Para abordar estos retos y promover acceso, las políticas, servicios y programas relacionados con SSR deben tener en cuenta las necesidades de las mujeres con discapacidad visual; además, se debe adoptar medidas para eliminar los retos financieros para utilizar los servicios y fomentar relaciones positivas con trabajadores de salud y miembros de la iglesia y la comunidad.