Disabled persons in Ghanaian health strategies: reflections on the 2016 adolescent reproductive health policy

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Abstract: The sexual and reproductive health (SRH) needs of persons with disabilities have received minimal attention from the Government of Ghana in the past. This was partly reinforced through reproductive health (RH) policies that did not well recognise disability inclusion and the inaccessibility of services for persons with disabilities. In acknowledgement of national and international RH policies, frameworks and legal instruments highlighting disability inclusion, the 2016 adolescent health policy document recognised the need to give attention to the SRH of adolescents and persons with disabilities. However, there is an absence of analysis of factors affecting adolescents with disabilities. Despite the lack of disability-specific indicators, and absence of data on adolescents with disabilities, interventions were developed which are poorly understood. This commentary argues that since we do not know the exact nature of SRH needs of adolescents with disabilities, the policy is unlikely to be successful in addressing existing inequities in access, quality of services and outcomes for adolescents with disabilities in Ghana. Recommendations are made for future improvements.

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Introduction

After the 1994 International Conference on Population and Development (ICPD), Ghana increased its efforts to significantly advance its reproductive healthcare system through the development of policies and strategies on adolescents and young adults. This culminated in the Adolescent Reproductive Health Policy 2000, the Ghana Health Service Reproductive Health Strategic Plan 2007–2011, the Ghana National HIV/AIDS and STI Policy and the Ghana Adolescent Health Service Policy and Strategy 2016–2020, among others. Improvements in the policy and legal environment in Ghana also reflected guidelines set out in international frameworks and agreements. The 2016 adolescent health policy recognises the Global Strategy for Women’s, Children’s and Adolescents’ Health (2016–2030) and affirms the commitment made in the Global Accelerated Action for the Health of Adolescents. The adolescent health policy further notes the call made in the Sustainable Development Goals 3.7 and 5.6, which required States to make sexual and reproductive health (SRH) services accessible and to integrate RH care into national strategies and programmes. Reproductive rights enshrined in the Programme of Action of the ICPD and the Beijing Platform for Action and related documents are also acknowledged.

In terms of the legal terrain, the Directive Principles of State Policy (35 3) of the 1992 Constitution also enjoins the State to “promote just and reasonable access by all citizens to public facilities and services in accordance with law.” Although the Ghana Disability Act does not specifically refer to SRH and rights of persons with disabilities, Article 7 of the Act on access to public services requires persons providing services to the public to ensure that “necessary facilities” are in place to make their services available and accessible to persons with disabilities. Internationally, the Convention on the Rights of Persons with Disabilities, Article 25 requires States to guarantee for persons with disabilities, equal access to health services, including SRH services and population-based public health programmes, and to make health services accessible and gender-sensitive.

Regardless of these compelling national and international frameworks, a careful examination...
of RH policies and strategies in Ghana reveals that the SRH needs of persons with disabilities are inadequately integrated. Rather, disability is casually mentioned in certain portions of the policies, making disability look as if it were added as an afterthought, and an attempt to make the document appear all-encompassing. Before the 2016 adolescent health policy was issued, disability was subsumed within terms like minorities, vulnerable people or persons with compounded vulnerabilities and special groups. This meant that a proper analysis of the needs of persons with disabilities and the necessary interventions were not targeted or comprehensive. For instance, the Ghana National HIV/AIDS & STI Policy only mentions persons with disabilities from the social protection aspect, obviously citing from the Ghana Social Protection Strategy, 2007. The HIV/AIDS and STI needs of persons with disabilities were not integrated. Instead, ministries, departments and agencies responsible for youth, the aged, women, children, the poor and destitute, including the mentally and physically challenged, were urged to develop similar policies for their constituents.

The problem highlighted above is that everybody is bundled up as “vulnerable”, without considering what, specifically, constitutes this “vulnerability”. With the 2007-2011 Reproductive Health Strategic Plan and HIV/AIDS and STI Policy, among other documents, failing to describe and specify particular vulnerabilities, it was easier for the architects of the policies to leave out strategies to address the “vulnerabilities” in question. People with disabilities were seldom mentioned, and when they were, there was scant analysis of the circumstances that contribute to their vulnerability. I believe that if adequate analyses of “vulnerability” are done, obstructing factors can be identified, and adequate measures proposed to do away with, or alleviate, vulnerabilities. It is therefore imperative to provide empirical evidence and analysis of the needs of all target groups in policies and implementation guidelines to enhance the quality and comprehensiveness of services.

The Ghana adolescent reproductive health policy and strategy

The 2016 adolescent health policy analysed the current state of Ghanaian adolescent reproductive health, reviewed ongoing adolescent programmes, spelt out interventions and captured outcomes, targets and programme delivery approaches. The full involvement and participation of adolescents and young people were ensured in its development. It further committed to disability inclusion to make SRH information and services accessible for adolescents with disabilities. The policy recognised the National Council for Persons with Disabilities as a stakeholder with roles and responsibilities. The Guiding Principles and Statements in the policy discusses disability and vulnerability responsiveness. This policy represents a major shift from how disability was treated in previous health-related frameworks, with inclusion of disability components in key areas.

Despite these gains in disability inclusion, the policy fails to account for the overwhelming need to analyse factors which impede adolescents with disabilities’ access to SRH care and services. The aim of the adolescent health policy is to provide a systematic approach to understand and prioritise adolescent health needs and to plan, monitor and evaluate adolescent health programmes. Yet, the document does not engender understanding of the health needs of adolescents with disabilities. For instance, an analysis of knowledge and use of contraceptives in the policy reports higher usage among adolescents and young girls without disabilities, but no mention is made of the situation in relation to adolescents and young girls with disabilities. Pertinent regional and international references are available, which could have been used; a study from Senegal, for example, affirms that young people with disabilities had low knowledge on the use of contraception and on SRH in general. Similarly, the policy noted that the majority of Ghanaians do not have access to RH counselling, contraceptives and safe abortion services and in areas where these RH services do exist, young peoples’ access is limited by distance to services, provider bias, unsuitable opening hours, legal restrictions and negative labeling. The policy did not indicate the extent to which the negative attitudes and distance to services impact the health-seeking behaviours of adolescents and young people with disabilities, yet there are many studies confirming these problems. In 2014, a study in Uganda showed that persons with physical disabilities also had to deal with provider bias, long distances, queues in health facilities, cost, adverse physical environment and the notion that persons with disabilities were asexual. The World Health Organization (WHO) states that
persons with disabilities are twice as likely to find skills of health workers insufficient to meet their needs, three times more likely to be refused care, and four times more liable to experience bad treatment.

The policy also noted that health services targeting adolescents were disjointed and of low quality, with inequality in access and usage, and poor incorporation of the health concerns of adolescent girls in particular, into programmes. There was silence, however, on the health concerns of adolescent girls with disabilities, despite the existence of relevant information. UNFPA guidance notes on SRH service provision for persons with disabilities indicate that, “…in fact, persons with disabilities may actually have greater needs for SRH education and care than persons without disabilities due to their increased vulnerability to abuse.” The WHO Factsheet on Health and Disability reports that the health needs of persons with disabilities are largely unmet and argues that more persons with disabilities look for health care than those without disabilities. A study in the Philippines reported that girls and women with disabilities seeking SRH services face discrimination and negative attitudes at the hands of some health workers. An exposition on the SRH experiences of visually impaired women in Ghana reveals how pregnant women and girls with disabilities were faulted and perceived as undeserving of motherhood, irrespective of whether they were married, or had experienced unwanted pregnancies.

Another example of the neglect of disability-specific data is in the area of adolescent nutrition. The policy shows that 47.7% of females in urban and rural communities aged 15-19 years had anemia, with lower levels among more educated women. The analysis indicated how the nutritional deficiency was likely to result in impairment, but did not refer to its importance in persons with disabilities. UNICEF and UNFPA reports have established poverty to be linked to disability, as well as disability to poverty, which in tandem, increases people’s inability to meet dietary requirements, resulting in malnutrition. Evidence from WHO shows that persons with disabilities generally have a poor diet. The adolescent health policy has failed to draw these important interrelationships out, with the risk of contributing to the inequity and inequality faced by adolescents with disabilities.

Numerous other instances can be cited where disability inclusion is lacking. In the section of the policy titled “disability and vulnerability responsiveness”, there is an indication that “special attention” will be given to adolescent and youth health education and services, to enable the specific needs of persons with disabilities and vulnerable groups to be met. However, a picture of the gaps stemming from their “peculiar needs” is not provided, despite mention of special attention. Although disability is mentioned once in the strategic objectives section and in the adolescent health service delivery “standards and desired outcomes”, no mention of disability is found in the section on the 21 key targets which illustrate the outcomes and benchmarks of the policy. The targets could not capture disability-specific outcomes since no analysis of baseline information on adolescents with disabilities was featured in the preceding components, except to give statistics on persons with disabilities in Ghana. This absence of disability-related indicators in the policy renders disability invisible and further pushes the SRH needs of adolescents with disabilities to the periphery when documenting, measuring and evaluating outcomes. These instances highlight the lack of statistics on adolescents with disabilities, as well as on disability, as a variable in Ghana’s Demographic Health Surveys. The policy draws data largely from the 2014 Demographic and Health Survey which hardly disaggregates data by disability, thus falling short of international commitments and requirements. This lack of attention jars with the emphasis in the Global Accelerated Action for the Health of Adolescents on the need for data disaggregation. A thorough disaggregation of information on adolescents, with and without disabilities, would seem to be in order.

Other relevant policy documents may be considered for future improvements. The needs of adolescents with disabilities are acknowledged at the outset in the South African adolescent health strategy, with a situation analysis recognising the neglect of the SRH needs of adolescents with disabilities in South Africa. The document integrates discussions of adolescents with disabilities in other sections, making it hard for stakeholders to forget the needs of adolescents with disabilities. In addition, the WHO/UNFPA Guidance notes on SRH provision for persons with disabilities, and the Disability Special Interest Group Report on improving SRH services for persons with disabilities in Australia, all offer acceptable standards for developing SRH services and programmes
principled on human rights and inclusion for persons with disabilities, with the Disability Special Interest Group Report\textsuperscript{27} in particular recommending the involvement of people in decisions which affect them.

**Conclusions and recommendations**

Until very recently, the specific SRH needs of adolescents with disabilities were casually dealt with in Ghanaian reproductive health policies. The 2016 adolescent health policy tried to change the status quo by including disability. Yet this inclusion was attempted without exhibiting a clear understanding of the specific SRH needs of adolescents with disabilities, and revealed a considerable lack of data on adolescents with disabilities.

In this era of “leave no one behind”\textsuperscript{28} the government, Ministry of Health and relevant agencies should endeavour to adhere to principles of evidence-based programming, and ensure disaggregation of data and targets to eliminate, or reduce significantly, the inequities present within our health sector and policy landscape.

To remedy these inequities and make adolescent SRH policies adequately reflect the needs of all adolescents and to improve inclusivity, future action should take cognisance of the following aspects. Disaggregated information on disability should be prioritised in the Demographic and Health Survey and statistics on adolescents with disabilities captured in the Ghana Statistical Service’s surveys. The specific SRH needs of adolescents with disabilities should be examined and gaps in existing interventions for persons with disabilities presented. With improvements in data availability, the next adolescent health policy can include disability-specific indicators, allowing enhancement of accountability. Adolescents with disabilities should be involved and empowered to participate in the design or review of future adolescent health policy and programmes concerning them.

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**References**

1. United Nations Population Fund. International Conference on Population and Development; 1994.
2. Republic of Ghana. Adolescent reproductive health policy: national population council. Accra: National Population Council; 2000.
3. Ghana Health Service. Reproductive health strategic plan. 2007–2011. Accra: Ghana Health Service; 2007.
4. Ghana AIDS Commission. National HIV and AIDS, STI policy. Accra: Ghana AIDS Commission; 2013.
5. Adolescent Health Service Policy and Strategy (2016–2020). Ghana Health Service: 2016.
6. Global Strategy for Women’s, Children’s and Adolescents’ Health (2016-2030). New York: Every Woman Every Child; 2015.
7. World Health Organization. Global accelerated action for the health of adolescents (AA-HAI): guidance to support country implementation. Geneva: WHO Press; 2017;(p8).
8. United Nations. Sustainable development goals. New York: United Nations General Assembly; 2015. Available from: http://www.un.org/sustainabledevelopment/sustainable-development-goals/.
9. United Nations Population Fund. Programme of Action; 2004.
10. Beijing Platform for Action. Available from: http://www.un.org/womenwatch/daw/beijing/platform/
11. The Constitution of the Republic of Ghana. Accra; 1992.
12. Republic of Ghana. Persons with disability Act: Act 715. Accra: Parliament of the Republic of Ghana; 2006.
13. United Nations General Assembly. The convention on the rights of persons with disabilities. New York (NY): United Nations General Assembly; 2007.
14. Government of Ghana. The national social protection strategy: ministry of manpower, youth and employment. Accra: Ministry of Manpower, Youth and Employment; 2007.
15. Burke E, Kébé F, Flink I, et al. A qualitative study to explore the barriers and enablers for young people with disabilities to access sexual and reproductive health services in Senegal. Reprod Health Matters. 2017;25(50):43–54. Available from: https://www.doi.org/10.1080/09688080.2017
16. Ahumuza SE, Matovu JKB, Ddamulira JB, et al. Challenges in accessing sexual and reproductive health services by people with physical disabilities in Kampala, Uganda. Reprod Health; 2004;11(59):59–67.
17. World Health Organization. Disability and Health Fact sheet. [2018 January]. [Cited 2018 March 28; research: about one screen]. Available from: http://www.who.int/mediacentre/factsheets/fs352/en/
18. Promoting sexual and reproductive health for persons with disabilities: WHO/UNFPA guidance note. Geneva: 2009; (Sec2:5).

19. Lee K, Devine A, Marco J, et al. Sexual and reproductive health services for women with disability: a qualitative study with service providers in the Philippines. BMC Women’s Health: 2015;15(87):1–11.

20. Abdul Karimu A. Exploring the sexual and reproductive health issues of visually impaired women in Ghana. Reprod Health Matters. 2017;25(50):128–133.

21. United Nations Children’s Fund. Children and young people with disabilities: fact sheet. New York (NY): United Nations Children’s Fund; 2013.

22. Ghana Statistical Service. 2010 population and housing census: summary report of final results. Accra: Ghana Statistical Service; 2012.

23. Government of Ghana. Ghana-Demographic and health survey. Accra: Government of Ghana; 2014. Available from: http://www.microdata.worldbank.org/index.php/catalog/2373

24. Department for International Development. Disability Framework: 2014. Available from: https://www.gov.uk/government/publications/dfid-disability-framework-2014.

25. United Nations 72nd General Assembly. Sexual and reproductive health and rights of girls and young women with disabilities- note by the secretary-general. New York (NY): United Nations 72nd General Assembly; 2017. Available from: http://www.ap.ohchr.org/documents/dpage_e.aspx?si=A/72/133

26. National Department of Social Development. National adolescent sexual and reproductive health and rights framework strategy, 2014–2019. Pretoria: National Department of Social Development; 2015.

27. SH&FPA Special Interest Group on Disability. Improving sexual and reproductive health for people with disability. Australia: SH & FPA Special Interest Group on Disability; 2013. Available from: https://www.shinesa.org.au/media/product/2015/04/ImprovingSexualandReproductiveHealthforPeoplewithDisability.pdf.

28. Resolution A.70/L.1. Transforming our world: the 2030 agenda for sustainable development. New York: United Nations General Assembly; 2015.

Résumé
Dans le passé, le Gouvernement ghanéen n’a accordé qu’une attention minime aux besoins de santé sexuelle et reproductive (SSR) des personnes handicapées. Cette situation était partiellement renforcée par des politiques de santé reproductive qui ne prenaient guère en considération le handicap et l’inaccessibilité des services pour les personnes handicapées. S’inspirant des politiques nationales et internationales de santé reproductive, des cadres et des instruments juridiques insistant sur l’inclusion des personnes handicapées, la politique de santé de l’adolescent de 2016 a reconnu qu’il était nécessaire de prêter attention à la SSR des adolescents et des personnes handicapées. Néanmoins, on observe une absence d’analyse des facteurs touchant les adolescents handicapés. En dépit du manque d’indicateurs spécifiques au handicap et de données sur les adolescents handicapés, des interventions ont été mises au point qui sont mal comprises. Ce commentaire affirme que, puisque nous ignorons la nature exacte des besoins de SSR des adolescents handicapés, il y a peu de chances que la politique réussisse à corriger les inégalités existantes dans l’accès, la qualité des services et les résultats en faveur des adolescents handicapés au Ghana. Des recommandations sont présentées pour des améliorations futures.

Resumen
Las necesidades de salud sexual y reproductiva (SSR) de las personas con discapacidad han recibido atención mínima del gobierno de Ghana en el pasado. Esto fue reafirmado en parte por políticas de salud reproductiva (SR) que no reconocieron bien la inclusión de personas con discapacidad y la inaccesibilidad de los servicios para esas personas. En reconocimiento de las políticas, marcos e instrumentos jurídicos nacionales e internacionales referentes a la SR que destacan la inclusión de las personas con discapacidad, el documento de la política de 2016 relativa a la salud de adolescentes reconoció la necesidad de prestar atención a la SSR de adolescentes y personas con discapacidad. Sin embargo, aún no se han analizado los factores que afectan a adolescentes con discapacidad. A pesar de la falta de indicadores relacionados específicamente con discapacidades, así como de la falta de datos sobre adolescentes con discapacidad, se elaboraron intervenciones que no han sido bien comprendidas. Este comentario argumenta que dado que no sabemos la naturaleza exacta de las necesidades de SSR de adolescentes con discapacidad, es poco probable que la política logre abordar las inequidades relacionadas con el acceso, la calidad de los servicios y los resultados para adolescentes con discapacidad en Ghana. Se hacen recomendaciones para futuras mejoras.