Accessing Healthcare in Ghana: Challenges Encountered and Strategies Adopted by Persons with Disabilities in Accra

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ABSTRACT

Purpose: *Access to quality and timely healthcare is essential to the health and wellbeing of all individuals. Unfortunately, the more vulnerable populations, such as persons with disabilities, encounter a number of barriers in accessing healthcare services. This study focusses on barriers that persons with disabilities face in accessing healthcare in the Accra metropolis, and the strategies they adopt when they are ill.*

Method: *A phenomenological approach was employed to achieve a deeper and holistic understanding of the challenges encountered when accessing healthcare. Purposive sampling technique was used to recruit 21 persons with disabilities, between 18 and 64 years of age, from the organisations of persons with disabilities in Accra.*

Results: *The study revealed that physical, financial, communication, transportation, and attitudinal barriers, as well as healthcare professionals' lack of knowledge about disability issues, limited access of persons with disabilities to healthcare. The majority of persons with disabilities preferred to stay at home and self-medicate or depend on herbal medicine, rather than seek help from healthcare professionals.*

Conclusion: *Healthcare for all is a right that every human being is entitled to, irrespective of disability. The removal of barriers restricting access to healthcare for persons with disabilities is a necessity to achieve Goal 3 of the Sustainable Development Goals (SDG) Agenda 2030.*

Key words: *access to healthcare, disability, Ghana, challenges to healthcare.*

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INTRODUCTION

Access to quality and timely healthcare is essential to the health and wellbeing of all individuals (Beatty et al, 2003) without exception. Equality concerning healthcare requires that all individuals have access to quality healthcare (Eide et al, 2015). However, there is evidence of existing disparities in the provision of healthcare services, relating to socio-economic status, age, gender, disability, education and ethnicity (Yee, 2011), which could contribute to differences in health outcomes and reduce overall quality of healthcare for the more vulnerable populations (Krahn et al, 2015).

Furthermore, people in developing countries tend to have less access to healthcare than those in developed countries (Peters et al, 2008). Access to healthcare in Africa can be viewed from several angles including geographical location (Jacobs et al, 2012), accessibility and affordability (Fraizer & Kleinstein, 2009; Jacobs et al, 2011), and availability and acceptability of healthcare services (O'Donnell, 2007; Jacobs et al, 2012). Persons with disabilities encounter greater disparities in accessing healthcare than those without disabilities due to the diverse barriers which impede their access to healthcare (Mcdoom et al, 2014). This study adds to the literature in Ghana on barriers that persons with disabilities face in accessing healthcare in the Accra metropolis and reveals the strategies they employ when they are ill.

Challenges to Accessing Healthcare for Persons with Disabilities

The high cost of healthcare is a major barrier to accessing health services. While it has a negative impact for everyone, Mccoll et al (2010) found that persons with disabilities were three times more likely than those without disabilities to report unmet needs due to cost; their study was conducted in Canada, which is known to have universal health insurance. Similarly, persons with disabilities who had health insurance in the United States of America had challenges paying for health services (Drainoni et al, 2006). Access to health services was more challenging for those who did not have health insurance (Sommers, 2006). In Africa, the situation could be worse due to the absence of universal insurance coverage for the populace. A population-based household survey which was carried out in Sudan, Namibia, Malawi, and South Africa, undoubtedly identified cost as one of the main hindrances to healthcare for persons with disabilities in these countries (Eide et al, 2015).

High cost and the non-availability of accessible transport are barriers to healthcare for persons with disabilities. Transportation barriers were reported in South Africa (Schierenbeck et al, 2013; Eide et al, 2015; Vergunst et al, 2015; Hussey et al, 2017), Namibia (Rooy et al, 2012; Eide et al, 2015), Sudan and Malawi (Eide et al, 2015) and Ghana (Naami, 2019).Inaccessible transportation was also identified as a challenge in the West, e.g., in the United States of America (Church & Marston, 2003; Erin, 2011) and the United Kingdom (Sakellariou & Rotarou, 2017).

Persons with disabilities, who overcome transportation barriers to access health facilities, encounter other challenges such as architectural barriers which are evident in both the developed and developing countries. Architectural barriers relate to the absence of elevators and ramps as well as inaccessible ramps (Aldred & Woodcock, 2008; Tijm et al, 2011; Inclusion Ghana, 2013; Badu et al, 2016; Naami, 2019). The lack and inaccessibility of health equipment impact on access to health services for persons with disabilities (Kroll et al, 2006; Badu et al, 2016).

Attitudinal barriers also hinder access to healthcare for persons with disabilities. Attitudinal barriers relate to unfair treatment of persons with disabilities by health professionals (Scheer et al, 2003; Maart & Jelsma, 2014), disrespect for persons with disabilities (Amadhila, 2012), which manifests in conduct such as yelling at and ignoring them (Drainoni et al, 2006), as well as negative behaviour while interacting with persons with disabilities (Vergunst et al, 2015).

Communication barriers, especially relating to ignorance of Sign Language interpretation, have also been reported in the literature as challenges for persons with disabilities. Poor Sign Language interpretation prevents effective communication with persons with hearing disabilities, making it difficult for the latter to express their health needs to health professionals (Mprah, 2013; Hussey et al, 2017). Communication barriers complicate health-seeking behaviours, especially for persons with hearing disabilities (Brown & MacArthur, 2006).

Strategies that Persons with Disabilities Employ when they are Ill
The challenges in accessing health services influence health-seeking behaviours of persons with disabilities. They have developed various strategies to deal with their healthcare needs. Some of them resort to self-medication when they are ill (Palmer et al, 2011; Amadhila, 2012; Imoro, 2015).Others, especially those in rural areas in developing countries, seek the services of unqualified practitioners whenever they are ill (Hosain et al, 2005), while many others, especially in Africa,

consult traditional healers and herbalists, or use herbs and herbal medicines when they fall ill (Amadhila, 2012; Mulumba et al, 2014; Imoro, 2015).

Objective

Although the United Nations Sustainable Development Goal 3 seeks to promote quality healthy lives and overall wellbeing for everyone, access to healthcare services remains a major challenge for persons with disabilities. It is imperative to identify and eliminate the barriers that hinder access to quality health services for persons with disabilities, yet this area is least studied in Ghana. A few studies focus mainly on subsections of persons with disabilities (Inclusion Ghana, 2013; Mprah, 2013; Ganle et al, 2016) or on aspects of the challenges they encounter (Imoro, 2015; Badu et al, 2016). The literature is also geographically sparse. This study, therefore, sought to determine the barriers that persons with physical disabilities face in accessing healthcare in the Accra metropolis, and the strategies they employ when they are ill.

METHOD

Theoretical Framework

The Social Model of Disability (SMD) formed the theoretical basis for the study. The model was proposed by advocates of the Union of the Physically Impaired Against Segregation (UPIAS) in 1976 and was given academic integrity through the works of scholars such as Oliver (1990, 1997), Finkelstein (1980) and Barnes (1992). The SMD acknowledges that persons with disabilities could have functional limitations posed by their impairment but postulates that the environment is more limiting (Union of the Physically Impaired Against Segregation - UPIAS, 1976). Examples of challenges are societal values and culture (Geffen, 2013), inadequate access to healthcare, unemployment, transportation barriers and inaccessible buildings (Barnes & Mercer, 2005).The SMD also emphasises institutional barriers which include inadequate policies, programmes and the exemption of persons with disabilities from their implementation (Scullion, 2010).

The model lays emphasis on the inclusion of persons with disabilities in mainstream society by identifying and eliminating barriers which hinder their inclusion (Shakespeare & Watson, 2002). The Social Model of Disability was useful in facilitating the researchers' understanding of the barriers that persons with disabilities in the Accra metropolis encounter in accessing healthcare. The theory

also helped in the analysis of data, and in shaping appropriate recommendations for policy and practice decisions that could address the barriers persons with physical disabilities face in accessing healthcare.

Study Design

The study employed a qualitative research design, specifically, a phenomenological approach to help the researcher achieve a deeper and holistic understanding of the challenges persons with disabilities experience in accessing healthcare and how they interpret it(Lester, 1999).

Study Sample

Purposive sampling technique was used to recruit 21 persons with physical disabilities – 7 each with visual, hearing and mobility disabilities respectively. They were between 18 and 64 years of age. All the study participants had accessed healthcare at health facilities in the Accra metropolis. They were all members of organisations of persons with disabilities.

To recruit participants, the researchers contacted leaders of the organisations, namely, Ghana Blind Union, Ghana National Association for the Deaf, and Ghana Society for the Physically Disabled, in their capacities as gatekeepers for persons with visual, hearing and mobility disabilities respectively. With the information obtained, members were contacted via phone calls and text messages. The purpose of the study was explained to them, and those who volunteered to participate were recruited. Their verbal or signed consent was taken before the interviews.

Data Collection

Data was collected through in-depth interviews with the participants, at agreed locations and times. The interviews, lasting approximately between 40 and 60 minutes, were audio-recorded with permission. Although the interview guide was designed in the English language, interviews were conducted in English, Twi and Ga which were the languages that the study participants understood. Sign Language interpretation services from Ghana Association of Sign Language Interpreters were provided to those with hearing disabilities.

Data Analysis

Data was analysed using Braun and Clarke's (2006) six steps for thematic analysis of qualitative data. The recorded interviews were transcribed verbatim from the

audiotapes into text. Interviews recorded in the local dialect were transcribed into English. The researchers familiarised themselves with the transcribed data, which aided in coding, identifying and organising patterns into categories, themes, subthemes and their relationships. The researchers used peer debriefing and member checking to ensure the credibility and trustworthiness of the study (Rolfe, 2016). After the preliminary analysis by the lead researcher, two other researchers reviewed the procedures and the themes. The participants with hearing impairment reviewed their scripts for accuracy. Feedback from all of these measures was incorporated into the final work.

Ethics

The study observed all ethical requirements of the University of Ghana.

RESULTS

Evidence from the study indicated that physical, financial, communication, transportation, and attitudinal barriers, as well as healthcare professionals' lack of knowledge about disability, were issues limiting access to healthcare for persons with disabilities.

Physical Barriers

The themes that emerged under this category were: inaccessible entrances of hospitals/clinics and individual rooms inside these facilities; the internal arrangement of consulting rooms, admission wards and Out-Patient Departments (OPDs); and, the absence or lack of access to furniture and hospital equipment.

Access to Entrances of Hospitals/Clinics and Rooms within the Facilities

The study found that entrances to hospitals/clinics and consulting rooms, laboratories, Out-Patient Departments (OPDs), pharmacies, records departments and the general hospital environment were not accessible, especially for persons with mobility disabilities. Major access challenges were stairways, unusable ramps, heavy and narrow doors, and high doorknobs. While most hospitals did not have ramps, the available ramps were not disability-friendly as they were rough, steep or narrow, which hindered access to health facilities.

"Though there are few ramps at 37 Military Hospital, they are very high and rough. There is no ramp at the entrance of the laboratory rooms, so I have to use the stairs

and it is very difficult. When I was pregnant, the issue of ramp and laboratory test was very difficult for me. I usually pleaded with the people to assist me" (Participant 20, female, uses crutches).

Many participants with mobility disabilities, especially those using wheelchairs, reported that the entrances to consulting rooms were narrow, making entry difficult.

"In the doctor's office, I usually use my wheelchair, but the problem is with the entrance to the doctor's office. It is narrow. I have difficulty going in with my wheelchair. Whenever I want to talk about this issue, the majority of the doctors disagree with me. They make it look like you should keep quiet and not complain about their office" (Participant 3, male, wheelchair-user).

The records and pharmacy departments were not accessible, especially for those using wheelchairs, due to narrow doors and high counters. The narrow doors obstructed their entry, while the height of the counters, where participants received their folders and medicines, limited communication with the staff of these departments. Participants claimed they could not effectively communicate with the staff because they could not see them.

"The entrance of the records department is narrow and the counter where we take our folders is not accessible. You have to raise your neck and stretch before you can see the one behind the counter and talk to him or her. When they don't see you, then they begin to scream, 'Where are you? Where are you?' They have to do something about the counter because it is a barrier" (Participant 3, male, wheelchair-user).

Inaccessible infrastructure at hospitals hampered the privacy of the participants while consulting with doctors and using laboratories and pharmacies. The clients were forced to receive healthcare services outside the designated facilities.

"The hospital I go to has stairs in front of its doors which I am unable to climb, so I always use the back door. Even with the back door, I cannot go in with my wheelchair, so I have to stand outside for the doctor to come and attend to me. I do not have my privacy because whatever I have to tell him, I need to say it in the open. I am not happy about this" (Participant 4, female, wheelchair-user).

"I am unable to go to the pharmacy because the entrance is narrow. I always have to stand outside for the pharmacist to come and attend to me there. I feel uncomfortable about this arrangement. I really want to go in there,

but I am unable to do so because my wheelchair cannot pass through the entrance" (Participant 10, male, wheelchair-user).

Access inside Doctors' Offices, Admission Wards, OPDs and Pharmacies

The study revealed that the internal arrangement of consulting rooms, Out-Patient Departments (OPDs), admission wards and pharmacies were inaccessible due to limited turn-around space and slippery floors. Participants with mobility issues said that the consulting rooms were crowded with chairs and examination tables which restricted their movements.

> "The arrangement of chairs in the doctor's office and OPD restricts my movement. I have to sit close to the doctor but, because the arrangement is bad in the office, I am unable to do so. At times when they see you enter the office is when they start rearranging things to enable you to use your wheelchair" (Participant 3, male, wheelchair-user).

Inadequate turn-around space in admission wards sometimes compelled wheelchair-users to park their chairs outside the wards and depend on the mercy of others to help access the washroom when needed.

> *"The admission ward at the hospital I visit is not spacious enough. I remember when I was on admission some time ago I couldn't park my wheelchair in the ward because the place was not spacious enough so it was parked outside. I had to call someone to bring my wheelchair to me when I wanted to go out. If I do not get anyone, I cannot go out"* (Participant 4, female, wheelchair-user).

Lack of and Limited Access to Furniture and Hospital Equipment

The participants, especially those with visual and mobility disabilities, lamented that most of the hospital furniture and equipment such as beds, laboratory chairs, examination tables and chairs, and beds in the admission and labour wards were very high, making them difficult to climb onto. Some of them said they had slept on the floor during admission. The situation was worse for pregnant women with mobility disabilities who struggled for access to the beds while in labour.

> *"I sometimes have to hold the bed before I can climb. The beds are not accessible at all. With the labour ward, where I delivered the first time, the bed was high. Just imagine a woman who is in labour being asked to climb a bed and you are not lifted*

up by someone, but you have to get on the bed yourself. So, when I tried and I was able to climb the bed, my leg hit a bucket filled with waste substances. If the bed was accessible, I don't think my leg would have hit the bucket" (Participant 4, female, wheelchair-user).

Those with visual disabilities stated that the chairs in consulting rooms were unstable and made them feel uncomfortable.

"Some time ago I almost fell because of the chair in the doctor's office. It wasn't stable. It was this kind of chair that turns around. Some of the chairs make me feel uncomfortable" (Participant 19, female with visual disability).

Inaccessible equipment such as scans, weighing scales and height measuring scales were also identified as impediments for persons with mobility disabilities. Wheelchair-users stated that they did not know their weight and height because the scales were not accessible.

"Persons with mobility disability are unable to check their weight. This is because we don't have that machine in Ghana. I have visited lots of hospitals in the Accra metropolis, so I know what I am talking about. No scale in hospitals in Ghana can check our weight. I also don't know my height because the machine used in checking is not accessible at all, and this is a very big issue" (Participant 3, male, wheelchair-user).

Financial Barriers

The majority of the study participants pointed out that they had difficulty paying hospital bills and buying prescription drugs. The National Health Insurance Scheme (NHIS), which is supposed to help reduce their healthcare burden, did not cover all hospital expenses.

"I have the health insurance, but it does not cover everything. I remember the last time I went to the hospital it didn't cover anything. I used my own money to pay for my hospital expenses. Sometimes I do not have enough money, so I had to use my money meant for food to buy the drug. The medicines are very expensive and at times I ended up paying for some of the medicines and leaving others" (Participant 19, female with visual disability).

While some of the participants refrained from seeking healthcare due to financial constraints, others depended on friends, family and the District Assembly Common Fund to pay their healthcare expenses.

> *"Sometimes I use my own pocket money to pay for my medical expenses. I must say that about ninety percent of my medical expenses are paid by my friends. They have been very helpful"* (Participant 11, male with visual disability).

> *"I have national health insurance that usually I use to pay. As for the other services that the health insurance does not cover, I apply for the common fund and pay with it"* (Participant 18, male with hearing disability).

However, a few participants who were gainfully employed acknowledged that they had no problem paying their hospital bills.

> *"I pay for my hospital bills myself. I am a trader so when I fall sick, I do sell some of my products and I get money to pay for my bills"* (Participant 1, female with hearing disability).

> *"I pay my own hospital expenses without anybody's assistance. I do not have any challenge in paying for my hospital bills because I am working"* (Participant 5, male with visual disability).

Communication Barriers

Communication barriers were experienced only by those with hearing disabilities. These individuals lamented their difficulty in communicating their health needs to healthcare professionals due to lack of Sign Language interpreters. Consequently, they believed their healthcare needs were not adequately addressed.

> *"I remember there was a time I went there alone and when I dropped my card, they were calling me and I didn't even hear, they came to me and I did not understand because I did not go with my sign language interpreter. They just gave me the paper and said they had finished; I should go home. Because I did not understand, I left. My health problem was not solved. But with the interpreter, he will interpret for me and I will understand everything. When I use an interpreter, the understanding comes clear"* (Participant 1, female with hearing disability).

Health professionals, in their bid to understand the healthcare needs of clients with hearing disabilities, communicated through writing and by making gestures. However, not all hearing-impaired people were able to read English. In consequence, participants with hearing disabilities were at risk of receiving wrong diagnoses and medications, which could complicate their conditions.

"The health professionals write information on paper for me, but sometimes I do not understand some of the words. They do not even have basic sign language skills and sign language interpreters. This has always been our complaint, but they do not mind us. A hearing person will talk and write on paper, but you will not even understand" (Participant 2, female with hearing disability).

Transportation Barriers

Three main barriers to transportation were revealed in this study: high cost, inaccessible vehicles, lack of destination signs and attitudes of bus drivers. The high cost of transportation was a challenge to all categories of study participants. The study further revealed that participants with visual disabilities were worse off because they also had to pay transport fares for their guides.

"Whenever I go to the hospital, I go with a guide who provides me with assistance. Going with him means I have to also pay his transportation fare, which is an extra cost. It is not easy. I always have to ensure that I have his fare in addition to mine, before leaving the house" (Participant 11, male with visual disability).

With regard to inaccessible buses and minibuses (*trotros*), participants with mobility disabilities claimed that they did not have any option but to travel in them. However, the participants who used wheelchairs said they were carried or had to crawl into the buses, making themselves dirty and/or sustaining injuries during their trips.

"If you have realised, a wheelchair-user will always have his clothes becoming dirty whenever boarding the car because where you place your shoes when climbing the vehicle is where we usually sit to climb" (Participant 3, male, wheelchair-user).

Lack of destination signs posed a challenge for the participants with hearing disabilities. They sometimes ended up at wrong destinations due to the absence of these signs and because the bus conductors did not signal that they had arrived at their destinations.

"One day I was going to a hospital at Circle, and because of my condition, I could not hear the mate shout 'Circle! Circle! Circle!' I ended up going to a different destination because I was unable to locate the right vehicle. If there had been a destination sign on the vehicle or the mate has used his hand to do the circle sign, I would have understood" (Participant 1, female with hearing disability).

Moreover, attitudes of some drivers and their mates made transportation problems worse for study participants. Some wheelchair-using participants recounted that there were drivers who would not stop to pick them up.

"When some drivers see me by the roadside, they intentionally increase their speed because they know I will stop them. The drivers do not want to pick me even if I tell them I am going to the hospital. This is because I am a wheelchair-user" (Participant 3, male, wheelchair-user).

Attitudinal Barriers

This study found that, by and large, healthcare professionals (doctors, nurses and laboratory technicians) exhibited negative attitudes towards persons with disabilities. Participants considered these healthcare professionals rude and disrespectful because they laughed at them, provoked them, and often made sarcastic remarks.

"My doctor at a private hospital I used to visit was a politician and wasn't always at post because he was campaigning for elections, so I was referred to another doctor. I went to the new doctor one day and told him I feel dizzy. He asked how I, a blind person, know I feel dizzy? I wasn't happy at all. I wasn't happy with the way the doctor spoke to me. Since then I haven't been to that hospital. I go to Adabraka Polyclinic whenever I am sick" (Participant 7, male with visual disability).

Women with disabilities reported that they had been ridiculed by healthcare professionals when they were pregnant.

"If you are a deaf person and you get pregnant, the nurses will provoke, ridicule and tease you when you go to the hospital. This is not good. It happens in all the hospitals; I cannot single out any hospital. The behaviour they put up towards women is very bad" (Participant 1, female with hearing disability).

Inadequate Knowledge among Healthcare Professionals on Disability Issues

Participants bemoaned the lack of knowledge about disability issues among healthcare professionals. They felt this resulted in negative behaviour towards them and impacted the services they received.

"I am not sure they are knowledgeable about disability issues. To me, I will say they are not knowledgeable because if they were, they would know how to treat a person with physical disability. You know persons with physical disability do things

differently from those without disabilities. They are not experienced in disability issues. If they were, they would do everything in accordance with our needs " (Participant 4, female, wheelchair-user).

Strategies Employed by Persons with Physical Disability when they were Ill

The participants resorted to self-medication, visiting pharmacies and exercising faith when they fell ill. Although they reported that they visited hospitals, hospital visits seemed to be the last resort. Some stayed home without taking medicine and went to hospital only when their conditions became intolerable, while others took first aid when they were ill.

> *"When I am sick, because I do not like taking medicines, I keep it to myself until maybe it becomes unbearable for me before I seek medical help at the hospital. Mostly, I go to the hospital whenever I realise that I am very sick"* (Participant 19, female with visual disability).

Due to the high cost of healthcare, self-medication was a strategy adopted by some participants. They prescribed their own medicines; generally medicines they might have taken earlier or medicines which people close to them had prescribed for them. Others sought treatment from pharmacies due to proximity and cost.

> *"If I do not go to the hospital when I am sick, then the pharmacy shop is the next option for me to get treatment. The pharmacy is in this area. I do not board a vehicle. I walk to the pharmacy whenever I am sick to buy medicine to heal my sickness"* (Participant 11, male with visual disability).

Some participants resorted to using herbal medicines when they were ill. They either prepared their own medicines or bought them from pharmacies. However, the herbal medicines, both the self-made variety and the purchased ones, were abused. Herbal medicines from pharmacies were mainly misused by persons with visual disability because they could not read the inscriptions on the medicines.

> *"Sometimes I do not know the dosage I am to take unless I get someone to read for me. Other times, I have to use a cup to measure the quantity of medicine I am to take, because of my condition I don't know if I am overdoing it or under doing it if I don't have sight assistance. Again, if there is a note attached to the medicine, I can't read"* (Participant 13, female with visual disability).

DISCUSSION

This study explored access to healthcare for persons with disabilities in the Accra metropolis. Study outcomes indicated that persons with disabilities encountered several barriers in accessing healthcare. These included physical, financial, communication, transportation, and attitudinal barriers, as well as healthcare professionals' lack of knowledge about disability issues.

Study findings indicated that entrances to hospitals/clinics, consulting rooms, laboratories, OPDs, and pharmacies, as well as washrooms, were not accessible to persons with mobility disabilities and some persons with visual disabilities. This finding supports the study by Badu et al (2016) in the Kumasi metropolis which revealed that persons with disabilities were challenged by inaccessible entrances when accessing healthcare. However, they were not explicit about which groups of persons with disabilities experienced this challenge.

Major access challenges regarding entrances to health facilities related to stairways, ramps that were rough, steep or narrow, heavy and narrow doors, and high doorknobs. Absence of usable ramps validates other studies (Amadhila, 2012). The study found that inaccessible infrastructure at hospitals led to loss of privacy, especially for persons with mobility disabilities, in accessing healthcare services at various levels, including consulting with doctors and using laboratories and pharmacies. This occurred because persons with mobility disabilities were made to receive healthcare services outside the designated areas, for want of accessibility.

In addition to inaccessible entrances to hospital facilities, the study found that the interiors of consulting rooms, Out-Patient Departments (OPDs), admission wards, pharmacies and laboratories were not accessible. The interior arrangement resulted in limited turn-around space because the rooms were crowded with chairs, examination tables, beds and other equipment. Slippery floors, together with the other physical barriers, restricted the movement of participants with mobility and visual disabilities. Inadequate turn-around space at the Out-Patient Departments (OPDs) also restricted the movement of persons who used wheelchairs. Those who used crutches cited their unique experience of shifting from one seat to another while waiting in queues to see doctors, as a challenge to accessing healthcare.

Findings also indicated that most of the hospital furniture and equipment, such as beds in admission and labour wards, laboratory chairs as well as

examination tables and chairs, were difficult to use by persons with visual and mobility disabilities because they were very high. This situation compelled some wheelchair-users to sleep on the floor while they were awaiting admission. The situation was worse for pregnant women with mobility disabilities; they struggled to use scan machines and access beds while in labour.

Hospital equipment such as scans, as well as weighing and height measuring scales, were not accessible to individuals with mobility disabilities (Kroll et al, 2006; Badu et al, 2016). They admitted that they did not know their own weight and height, which could complicate their health situation.

It is important to note that the financial barrier was a key challenge to accessing healthcare for persons with physical disabilities in the Accra metropolis. The majority of study participants pointed out that they had difficulty paying hospital bills and buying prescription drugs (Drainoni et al, 2006; Mccoll et al, 2010; Rooy et al, 2012). The National Health Insurance Scheme (NHIS), which is supposed to help reduce their burden of healthcare expenditure, did not cover all hospital expenses. The gap in coverage of the NHIS relates to institutional challenge which confirms the Social Model of Disability (Shakespeare & Watson, 2002).

A further barrier to healthcare for persons with disabilities is communication. The study findings revealed that participants with hearing disabilities had difficulty communicating their health needs to healthcare professionals due to the lack of Sign Language interpreters. Health professionals, in their bid to understand the health needs of these clients, used several modes of communication, including writing and gestures. However, not all hearing-impaired people were educated to read English. This finding validates the study by Scheer et al (2003), which reported that persons with disabilities experience inadequate communication with health providers which affects diagnoses. Thus, participants with hearing disabilities risked receiving wrong diagnoses and medications from healthcare professionals and this could complicate their conditions. This finding supports studies which reported that the lack of Sign Language interpreters at health facilities hinders persons with hearing disabilities from receiving adequate healthcare (Mprah, 2013; Hussey et al, 2017).

Transportation barriers to accessing healthcare for persons with disabilities were also identified in this study. The three main transportation barriers were: high cost, inaccessible vehicles and lack of destination signs. The study found that the high cost of transportation was a challenge to all categories of study participants

and hindered access to healthcare. It was further revealed that participants with visual disabilities were worse off because they paid transport fares for their guides. Compounding the problem of high cost of transportation was the fact that buses and minibuses (trotros) were not accessible for persons with mobility disability. While some crawled into inaccessible vehicles and got their clothes dirty, others were helped like children onto the buses. All these barriers affected their ability to access healthcare.

Persons with physical disabilities could possibly have used taxi services which were more accessible, but they could not afford to pay taxi fares. This finding validates studies such as Naami (2014; 2019) and Tijm et al (2011). In conformity with this finding, the Social Model emphasises that transportation barriers, such as inaccessible public vehicles, restrict the movement of persons with disabilities (Barnes & Mercer, 2005). The findings of the current study also revealed that lack of destination signs posed challenges for the participants with hearing disabilities. They sometimes ended up at wrong destinations due to the absence of these signs and due to the bus conductors' failure to signal to them when they arrived at their destination.

Regarding attitudinal barriers, this study like others (Scheer et al, 2003; Amadhila, 2012; Vergunst et al, 2015) reports that the attitudes of doctors, nurses, and laboratory technicians towards persons with disabilities were largely negative. Participants described the attitudes as rude and disrespectful because health professionals ridiculed and provoked them, and often made sarcastic remarks about them. These findings are in tandem with the assumptions of the Social Model of Disability which posits that persons with disabilities encounter negative attitudes which undermine their status in society (Barnes & Mercer, 2005).

Additionally, the study findings revealed that negative attitudes demonstrated by health professionals towards study participants resulted from the health professionals' inadequate knowledge about disability issues and the needs of persons with disabilities (Inclusion Ghana, 2013; Ganle et al, 2016). All these barriers negatively impact on the quality of health and overall wellbeing of persons with disabilities due to their unmet healthcare needs.

Due to the numerous challenges they experienced when accessing healthcare, participants employed various coping strategies when they were ill, including hospital and pharmacy visits, self-medication, and exercising faith. Hospital visits seemed to be the last resort. While some stayed home without taking any

medicine and went to hospital only when their conditions became intolerable, others took first aid when they were ill.

Visiting the pharmacy was another strategy they adopted, confirming a study by Palmer et al (2011) which found that persons with disabilities in Vietnam resorted to pharmacy services when they were ill rather than visiting the health facilities. Healthcare from pharmacies was preferred because it was cheaper compared to hospital services, and the pharmacies were nearer. Self-medication was practised by some participants due to the high cost of healthcare. Participants prescribed medicines for themselves, usually medicines they might have taken previously or those which people close to them had prescribed (Amadhila, 2012; Imoro, 2015).

Using herbal medication was another strategy they favoured. Some of them prepared their own medicines while others bought them from pharmacies. However, herbal medicines, both the self-made and purchased varieties, were sometimes misused. Misuse of self-made herbal medicines was due to lack of knowledge about the dosage (Amadhila, 2012; Mulumba et al, 2014). Herbal medicines from pharmacies were generally improperly used by those with visual disabilities because they could not read the inscriptions on the packaging.

Finally, when persons with disabilities were ill, they exercised their faith by praying to God for healing.

CONCLUSION and RECOMMENDATIONS

Findings from this study cannot be generalised to persons with disabilities in the Accra metropolis and Ghana as a whole, due to the sampling technique and the sample size used. However, it is evident from this study that persons with physical disabilities experience myriad challenges in accessing healthcare in the Accra metropolis. The situation compels the majority to stay home and do nothing, self-medicate, or depend on herbal medicine, which they tend to abuse, rather than seek healthcare from professionals. Healthcare for all is a human right which must be enjoyed by everyone irrespective of disability. The need for the removal of barriers restricting access to healthcare for persons with disabilities is a necessity to achieve Goal 3 of SDG Agenda 2030.

It is recommended therefore that the National Health Insurance Policy be amended to cover all general and specialist medical care, rehabilitation services and assistive devices as well as all other unique health issues relating to persons with disabilities as enshrined in Section 31 of the Persons with Disability Act 715.

This measure could eliminate the financial barriers persons with disabilities face in accessing healthcare. Furthermore, the Ministry of Health, in collaboration with the Ghana Health Service and Hospital Management Teams, should ensure that healthcare facilities, equipment and furniture, as well as the arrangement inside the individual rooms such as consulting rooms, OPDs and laboratories have enough turn-around space for persons with disabilities, especially for wheelchair-users.

It is also suggested that the Government, through the Ministry of Health and Ghana Health Service, should collaborate with Organisations of persons with disabilities and Non-Governmental Organisations to conduct training workshops on disability issues for health professionals. In addition, disability issues could be introduced into the curricula for training health professionals, also laid out in Act 715.These measures would improve healthcare professionals' knowledge about disability issues and ways to effectively provide healthcare to persons with disabilities.

Since the study findings suggest that persons with hearing disabilities risk receiving wrong diagnoses and treatment, the need for basic Sign Language training for healthcare professionals cannot be over emphasised. This can also be included in their curricula. The government could create a pool of Sign Language interpreters at a central location, for their services to be utilised by any health facility when required. Moreover, a Disability Desk can be set up at health facilities, to serve as the first point of contact for persons with disabilities who visit hospitals. The Disability Desk Officer will help coordinate and facilitate access and fast-track services for these clients. Finally, practitioners should advocate for barrier-free healthcare delivery for persons with disabilities.

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