

ORIGINAL RESEARCH

Perceptions about Barriers to Sexual and Reproductive Health Information and Services among Deaf People in Ghana

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ABSTRACT

Purpose: *This study aimed to provide insights into factors that influence the acquisition, accessibility, and utilisation of Sexual and Reproductive Health (SRH) information and services by deaf people who communicate using Ghanaian Sign Language (GSL).*

Method: *The study explored deaf people's perceptions about barriers to SRH information and services in Ghana. There were 26 participants in 3 focus groups: 10 executives of Ghana National Association of the Deaf (GNAD), 7 deaf adult males and 9 deaf adult females. A key informant, who had experience in working with deaf people, was also interviewed. Review of documents and observations helped to clarify data gathered from the focus groups.*

Results: *Study findings indicated that when accessing SRH information and services in Ghana, deaf people encounter numerous barriers such as problems with communication, ignorance about deafness, negative attitudes, and services that are not customised to their needs.*

Conclusion: *If it is to succeed, any SRH programme for the deaf community must make the eradication of communication barriers a priority, since communication is fundamental to all challenges that deaf people encounter.*

Key words: *attitudes, communication, deaf, Ghana, sexual health services, reproductive health services*

INTRODUCTION

Although the Sexual and Reproductive Health (SRH) concerns of people with disabilities are similar to those of people without disabilities, the former often face

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numerous barriers when accessing information and services due to ignorance, negative attitudes, and lack of services tailored to accommodate their unique needs (Groce, 2004; Wilson & Monaghan, 2006; World Health Organisation, 2009). Also, as people with disabilities are rarely included in SRH prevention and outreach programmes, SRH information is often not provided in accessible formats (Wilson & Monaghan, 2006) such as Braille, large print, simple language, pictures, and sign languages, thereby depriving access to those with visual, hearing, and intellectual disabilities (WHO, 2009). Low literacy levels among people with disabilities compound the issue of access. For example, many people with disabilities in developing countries have limited formal education and access to SRH education in schools, and thus lack adequate health literacy (Groce, 2004; WHO, 2009). In addition, social and cultural barriers limit their chances to interact with peers, which could be an important opportunity for informal learning about reproduction and sexuality (WHO, 2009).

In particular, adolescents with disabilities face severe challenges because it is often difficult for parents, educators, and counsellors to discuss SRH issues with them, or else they are perceived to be sexually inactive (Job, 2004; Prilleltensky, 2004). Consequently, many of these young people are not familiar with basic vocabularies about their bodies, cannot describe what is happening to them and are therefore vulnerable to SRH problems and sexual exploitation (Groce et al, 2007; WHO, 2009). Barriers may not necessarily be directly related to impairment, but rather reflect the lack of legal and institutional support, and poor understanding of the SRH concerns of people with disabilities (WHO, 2009). Thus, while it is estimated that people with disabilities are three times more likely to be abused physically and sexually, they often have little or no access to police and legal counsel (WHO, 2009). Access to medical interventions, including psychological and prophylactic care, is also limited because of barriers to obtaining health information and services.

Data on the SRH status of deaf people suggest that they are more likely to face difficulties in accessing common sources of information than their hearing counterparts (Fedorowicz, 2006; Heyederick, 2006; Roberts, 2006; Wilson & Monaghan, 2006; Groce et al, 2007). Deaf people are less likely to access media such as television and radio (Roberts, 2006). They also encounter communication barriers in the healthcare system because healthcare providers typically cannot communicate with deaf people (Mottram, 1999). Healthcare providers often underestimate the difficulties of speech reading and overestimate deaf people's ability to understand written notes (Margellos-Anast et al, 2005).

There is a lack of data pertaining to the SRH experiences of deaf people in Ghana because national SRH studies, such as the Ghana Demographic and Health Survey (GDHS), do not collect data on people with disabilities. Though a few studies have been done among deaf people in Ghana (Tsiboe-Darko, 2008; Poku, 2009), they do not provide directly relevant and comprehensive SRH data about this community. For example, Tsiboe-Darko's study (2008) focussed mainly on HIV/AIDS which is just one component of SRH, while Poku's study (2009) focussed only on describing knowledge, attitudes, and sexual behaviour, without exploring the factors that hinder access to SRH information and services. Thus, there is little information which is representative of the SRH experiences of the deaf population in Ghana.

Since more data is needed to understand the complexity of factors that influence their SRH behaviour, this study explored deaf people's perceptions about challenges they encounter when accessing information and services on SRH issues. By identifying factors that affect the acquisition, accessibility, and utilisation of SRH information and services by deaf people in Ghana, the study aims to make the data available for policy and programmatic interventions on their behalf.

METHOD

Study Design

The study was a participatory SRH needs assessment that focussed only on deaf people who were fluent in the Ghanaian Sign Language (GSL). A qualitative study was conducted, utilising focus groups to explore participants' perceptions about barriers they encountered at SRH centres. This method was employed instead of a survey because the participants with low literacy levels would not have been able to read and understand the survey items. Indeed, many studies have documented the low English reading skills among deaf people and how this affects their responses in studies involving surveys (Pollard, 2002; Margellos-Anast et al, 2005). Thus the use of focus groups made it possible to overcome the potential language barrier. Also, the sensitive and multifaceted nature of SRH issues called for an approach that would allow an in-depth exploration of the topic, so as to understand the complexity of factors underlying participants' concerns. Review of documents, observations and discussions with one SRH worker helped to clarify data gathered from the focus groups.

Population and Sample

Twenty-six participants (between 22 and 56 years of age) were selected for 3 focus groups. They consisted of 10 executives (all males) of the Ghana National Association of the Deaf (GNAD), 9 adult females and 7 adult males. There was only 1 female executive member but she was out of the country at the time of the study. Except for the SRH worker, all the participants were deaf or hard of hearing, and were fluent in the GSL. Lack of formal education was an exclusion criterion since formal education is required to use the GSL. Working with a non-GSL group would have presented a serious communication barrier.

While the female and male participants were recruited from 2 deaf churches and 1 deaf centre in Accra, which is the national capital and located in the Southern part of Ghana, the executives came from each of the 10 administrative regions in the country. GNAD has branches in all regions. Thus, the executives represented the perspectives of members from their respective regions. All the male and female focus group participants were selected from Accra, mainly for logistical reasons. Although this was a limitation as it did not allow for a diverse representation of views from people with different backgrounds, to some extent, participation by the executives compensated for this. Also, 4 of the 10 male participants, and 3 of the 9 female participants were from the Northern part of the country, and had migrated to the South at the time of the study, in search of better jobs. As such, their views could represent perspectives of those in the North. The North-South “divide” of Ghana is very significant because it reflects important differences in culture and socio-economic development. The Northern sector is generally poor and characterised by poorly developed infrastructure and harsh climatic conditions (Berry, 1995; National Population Council, 2000). Based on advice from GNAD, one health worker was chosen from a health centre in Accra. The health worker was familiar with the challenges of working with deaf people.

Sampling Strategy

The purposive sampling procedure was used to select participants for this study. Only those who had adequate knowledge about SRH issues affecting the deaf community were recruited. Apart from the 10 current GNAD executives, 11 of the participants were past executive members while the remaining 5 were serving committee members in the deaf churches. Thus, those selected were considered opinion leaders in the deaf community. By minimising inputs from respondents

who lacked any perspective on the concerns of the community, the utility of the data was maximised.

Apart from the executives, all focus group participants were recruited from 2 deaf churches and a deaf centre. These locations were selected in order to increase the likelihood of identifying deaf people who had formal education and knowledge of the GSL. Recruitment was done through announcements that included information about the study and eligibility requirements. Informed consent was obtained from all participants before recruitment.

Written scripts of the recruitment announcements were developed in English but were communicated to participants via the GSL at introductory meetings. Prospective focus group participants were contacted through text messages and emails, and meetings for the males and the females were arranged at two different locations to discuss the focus group procedures, their remuneration, and issues concerning privacy and confidentiality. Seven of the 12 males and 9 of the 15 females who were contacted agreed to participate. All the 10 GNAD executives agreed to participate in the study. The key informant was recruited from one of the SRH centres, after obtaining permission from the SRH unit head.

Data Collection - Focus group Procedures

Three separate focus group sessions were conducted: 2 single-sex focus groups and 1 for the executives of GNAD. A focus group guide was developed, consisting of open-ended questions to elicit participants' views of barriers to SRH services and information. The guide was tested on 2 groups (5 males and 5 females) before a final guide was developed. The major issues discussed were sources of information, experiences at SRH centres and ways to eliminate barriers that deaf people encounter when accessing information and services on SRH issues. With participants' permission, video tapes were used to record proceedings from the focus groups.

Two research assistants - 1 male and the other female - conducted the focus group sessions. The male research assistant was in charge of the focus groups for the males and the executives, while the female focus group was conducted by the female research assistant. The GSL was used in all the focus groups as the researcher and the research assistants are all native users of sign language. The men's focus group session was held first, followed by the women's group and then the executives'

focus group. Both single-sex focus group meetings were held on church premises, while the one for the executives was held at the GNAD Head office.

To facilitate equal participation, ground rules were communicated to the participants at the outset. Group members were asked to respect other participants' confidentiality and privacy, wait for their turn to sign or speak, and to respect the right of everyone to freely express his or her views. Every participant was given an opportunity to answer each question.

Before each focus group meeting, forms were given out requesting basic demographic information from participants: gender, age, ethnicity, how long they had stayed in their respective communities, and their ratings of accessibility of SRH information and services. This was followed by a review of the ground rules, and then self-introduction by each participant.

During each focus group session, the research assistants led the discussions while the researcher summarised and noted down important points that were made for each of the questions. Notes were used to back up the video recordings. The researcher kept track of the time and assisted the research assistant when probes were needed for clarification or when the discussions went off-topic. Participants stood up when answering questions so that they could be seen by others and be videotaped.

In order to make signing easier for the facilitators, the interview guide for the male focus group was put on a laptop screen. In the case of the other 2 focus groups, the interview guides were written on flip charts that were hung in front of the participants (due to the frequent power cuts in some locations, and for convenience of use, the facilitators switched from laptops to flip charts). These visual aids facilitated signing and also made it possible for participants to read the questions and to correct the facilitators when necessary. After each focus group session, the research assistant and researcher met to evaluate the discussions and plan how to make improvements at the next focus group meeting.

Analysis of focus group data

The data from the 3 focus groups were analysed separately. The videotapes were first converted to DVDs using Adobe premiere video software, and then transcribed to text format.

To ensure accurate transcription, 2 deaf adults who were fluent in both English and GSL were selected to work with the 2 research assistants. Each deaf adult was paired with one of the research assistants and each pair (the research assistant and deaf adult) viewed the tapes several times and then translated it verbatim from GSL grammar into English. The scripts translated by the research assistants were then edited by the researcher to ensure that there were no errors or omissions in the translation. Two participants from each focus group were invited to discuss and validate the final scripts. After validation, the scripts were read through to identify themes relevant to the research objectives. Supporting quotes from the transcripts were identified and linked to the respective themes. The themes formed the subsections for the focus group data. No computer software was used in the data analyses.

Ethical Issues

The study was approved by the University of Illinois at Chicago's (UIC) Institutional Review Board (IRB). No Institutional Review Board exists in Ghana but permission was sought from GNAD. The GNAD acted as an advisory body, ensuring that both researchers and participants complied with the research ethics. Using the GSL, informed consent was obtained from all participants before recruitment. The informed consent process included giving information about the expected duration of focus group sessions, how much they would be paid, and confirming that participation was completely voluntary and that the decision not to participate would not adversely affect their relationship with the investigator or GNAD. In addition, they were assured that they were not obliged to answer all questions, had the right to withdraw from the study at any time, and that their names would not be identified in the data. Focus group volunteers were told that the discussions would be videotaped.

RESULTS

The findings indicated that deaf people in Ghana encountered myriad barriers when accessing SRH information and services. Seven interrelated barriers – communication, ignorance about deafness, attitudes towards deaf people, illiteracy among deaf people, privacy and confidentiality at SRH centres, limited time for consultation, and interpretation skills of sign language interpreters – were identified by participants.

Barriers associated with Communication

Communication barriers were described in terms of non-use of deaf people's preferred means of communication, for example, the absence of sign language interpreters at SRH centres. Several focus group participants expressed frustration at their inability to communicate with health professionals mainly due to inadequate sign language interpretation services. According to them, the absence of sign language interpreters made it difficult for health workers to explain information to deaf people. The following quotes illustrate deaf people's difficulties when communicating with health workers and how this affected the quality of information they received:

"I think one important issue is the problem with inadequate information on sexual issues because of communication problems with sexual health workers. Most of the available information is not friendly, difficult to understand and not meaningful to deaf people because the centres that provide these services do not have interpreters" (Female participant).

"Most of the information obtained is on HIV/ AIDS, STIs and health. However, the problem is that most doctors and health workers cannot communicate with people who are deaf to meet their health needs. Also because information is not in sign language, it is difficult for people who are deaf to benefit. I remember I had to take my son to the centre to act as my interpreter. That is the only way I can benefit from information provided from these centres since there are no sign language interpreters at these centres" (Male participant).

Some participants described how the difficulties in communicating with health professionals sometimes caused them discomfort and were an impediment to effective consultation as health workers were unable to understand their health problems. This situation may be worse for deaf women, as indicated by the following quotes:

"Health professionals and staff at these centres cannot talk to deaf women and in most cases they can't even ask you questions and understand the health of deaf people. Without sign language interpreters, workers at [SRH] centres find it difficult to deal with deaf people as they do with the hearing people" (Female participant).

"Anytime I visited the health centre it was difficult to communicate with health professionals as there were no interpreters. Sometimes health workers make guesses as they do not understand deaf people. I believe deaf people are sometimes given the

wrong medicine. This can happen to deaf women and those who cannot read and write” (Male participant).

“Sometimes deaf women feel uncomfortable when the information is given with no detailed explanation. This requires the services of sign language interpreters. For example, there are [SRH] organisations in my area but staff there merely administer papers for people with hearing loss with no further explanation. Anytime I visit there, I felt uncomfortable because if there is no sign language interpreter, these services become bore” (Executive participant).

From the above quotes, it is clear that communication is a major barrier that appears to be hindering access to quality SRH information and services for the deaf community in Ghana. However, claims that wrong medications were sometimes administered to deaf people could not be confirmed. So far no cases have been reported of deaf people having been given wrong medication due to communication barriers. Nonetheless, the lack of evidence does not necessarily mean this has not occurred. Even if the claim is mere speculation, it suggests a perceived degree of doubt or insecurity among the deaf about services they receive from health workers.

Barriers associated with Attitudes

An issue which seems to have further compounded communication barriers is the attitude of health staff towards deaf people. Some participants believed that staff at the SRH centres made matters worse for deaf people. A male participant claimed that *“the staff don’t care and do not give the deaf attention even though their deaf clients had difficulty communicating with them”*. Similar claims were made by two other male participants who alleged that the staff at the SRH centres did not have time to explain SRH information to them during their respective visits, and that the attitude of the staff made things very hard for deaf people who visited the centres. The following quotes illustrate participants’ sentiments:

“I don’t visit these centres often. I know many deaf people who also don’t go there due to lack of interpreter services...yes, the attitude of the workers too. That is very important because their behaviour makes deaf people feel uncomfortable. I mostly visit there [SRH centre] yearly, especially when they are having big programmes and there are interpreters. I am not alone because other deaf people complain the same way” (Male participant).

“In my area, I once visited the family planning hospital but staff at these centres didn’t have time to explain things relating to birth control to deaf people. Their

behaviour makes me feel not happy and uncomfortable. In fact, the workers at the centre make things very hard for deaf people” (Female participant).

Barriers associated with Ignorance

Ignorance on the part of health professionals about the needs of deaf people and the need to create awareness on issues affecting people with disabilities in general, were major concerns for some participants. There was a general perception that many of the challenges they faced stemmed from *inadequate knowledge about deaf people and, in particular, their communication needs*. Health professionals’ ignorance about the socio-cultural conditions of deafness was a factor which hindered effective interaction, and thereby created barriers for deaf people at the SRH centres. For example, a female participant observed that:

“Some health professionals and staff at these centres do not understand deaf people. They don’t know anything about deaf culture. Also, most of them still think that deaf people are people who are illiterate and cannot read and write, so even if the deaf person wants the health worker to write, they often refused to write for them.”

Although deaf people generally claim a unique linguistic-cultural identity, many people are unaware or lack understanding of their cultural values. This often leads to distrust, thus hindering effective interaction between deaf people and those who can hear.

Barriers associated with Illiteracy

Participants discussed the low literacy rate among deaf people and how it hindered access to information on SRH issues. Several participants agreed that illiteracy prevents access to commonly used print materials such as newspapers, magazines, leaflets, brochures, posters and billboards. A female participant commented on the low literacy among deaf people, and speculated that deaf women with little formal education would find it difficult to understand information on SRH from sources other than the GSL. The following quotes highlight participants’ perceptions about the effect of illiteracy on access to information:

“Many deaf have no good education and find it hard to read and understand health workers. They cannot also read from doctors and other health people. This is especially for deaf women and deaf people in the villages and rural areas. Also, low education makes it difficult for deaf people to understand television news and posters.

Sometimes we get confused with the information we get if there are no interpreters to translate the information into GSL” (Female participant).

“Some deaf women are illiterate and others have low level of education and as such they find it difficult to understand. Government should make education free of charge to people who are deaf so as to promote literacy and make it easier for deaf people to make good decisions in matters relating to safe sex and reproductive health” (Male participant).

Literacy is crucial to understanding health information such as instructions on prescriptions, medical education brochures and doctor’s directions, and to negotiate complex healthcare procedures. The low literacy level among deaf people can have dire consequences for them in this regard.

Barriers associated with Privacy and Confidentiality

Privacy was another issue that generated a great deal of discussion in the focus group. Lack of privacy at health centres, according to some participants, may force some deaf people to withhold information about their health. Participants thought that the presence of a family member or an interpreter, though useful, violated their privacy. A male participant observed that sometimes he felt “comfortable” going to the hospital alone “because sometimes interpreters or family members may not keep what they see secret”. Another male participant described how the lack of privacy due to the presence of an interpreter or a family member could compel a person to withhold vital information from health workers. A female participant also commented that the fear of breach of privacy may prevent deaf people from visiting SRH centres altogether.

Barriers associated with Limited Time during Consultations

Another important issue that emerged during the group discussions was the limited time available for consultations with health workers. Some participants observed that doctors did not have enough time to explain information to them, and wrote in a language that made reading and understanding difficult for even those deaf people who had formal education. This is expressed in the following quote:

“Information obtained from SRH professionals is never satisfactory because health workers and doctors do not have time to communicate effectively with deaf people. Even with an educated deaf person, doctors do not have sufficient time to write everything on paper for them. Doctors may also not have time to write in a language

that deaf people will understand even if they [deaf people] can read and understand"
(Male participant).

Communicating with a deaf person could be frustrating and time-consuming for many hearing people, especially when no interpreter is available. Thus, if there is inadequate time for consultation (which is often the case in the healthcare setting) it can result in many deaf clients leaving the consultation room without knowing much about their illness and how to use the prescribed medicines.

Barriers associated with Skills of Interpreters

The lack of trust in sign language interpreters and the need to upgrade the quality of interpretation services was also important to some of the participants:

"Sometimes you can't trust or believe the information obtained because interpreters may confuse the question or sign language given by the deaf person. Even if one uses interpreter, information will still be inadequate because interpreter may omit most of the things said. Most interpreters can't be trusted because of omissions" (Executive participant).

Though it is not easy to verify this assertion, it cannot be disregarded because there are no professional interpreters in Ghana and many of those available have low levels of education.

DISCUSSION

The study investigated deaf people's perceptions of barriers to accessing SRH information and services, and identified a wide range of impediments. Although the barriers relate primarily to communication, of equal concern are issues such as privacy and confidentiality at SRH centres, illiteracy among deaf people, ignorance of their needs, negative attitudes towards them, doubts about interpreters' competence, and limited time for consultation.

Even though health professionals are the most accurate and reliable sources of information, by virtue of their training and knowledge, study findings indicated that there were serious communication barriers between deaf people and health professionals. This seemed to have made deaf people mistrustful of health professionals, and particularly suspicious about the quality and reliability of information and services (including medication) they received from them. The problem is compounded by a healthcare system that does not take into account

the unique needs of the deaf population. In Ghana, procedures are complex at the health centres; for example, one has to go through lengthy registration processes to consult a doctor, to go for a laboratory test, and to get medication (Baidoo, 2009).

This study found that health professionals were unable to communicate effectively with their deaf clients. The finding is in accord with other studies, which also revealed the negative impact of communication barriers on quality of healthcare (Mottram, 1999; Margellos-Anast et al, 2005). According to Schiavo (2007), the accessibility and usability of information for decision-making depend on myriad factors. Notable among them is the degree to which effective communication occurs between people, for instance, between a provider and a client. The use of complex jargon or technical terms, common in health-related information, can lead to difficulties in comprehension and can create anxiety among many people (Schiavo, 2007). Schiavo (2007) further observed that for health information to be accepted, understood, and utilised by those for whom it is intended, service providers must be familiar with the unique needs of that community. Deaf people have unique communication and linguistic needs and preferences, but this study found a widespread lack of understanding about these needs among health professionals.

It is hard to ascertain the accuracy of some of the claims made by participants, in particular the references to the quality of interpretation services and the prescription of wrong medication for deaf people. While no definitive data exist, these claims cannot be entirely ignored for reasons relating to the nature of the GSL, the lack of sign language interpreters, and the level of educational attainment and interpretation skills of many interpreters. Professional interpreters are rare in Ghana; many of the interpreters are volunteers and have low educational qualifications. In addition, since the GSL is not standardised and does not cover several medical terms, it is difficult for interpreters to provide accurate translations of SRH messages. Under these conditions, deaf people would find it daunting to negotiate the healthcare system and would be at a disadvantage to understand and follow instructions. Hence it is not surprising that they should feel doubtful about the quality of information and services they receive.

The focus of this study was on deaf people with some formal education and the ability to communicate in the GSL. There is however the need to conduct a study on the large number of deaf people who do not communicate in the GSL, in order to understand their SRH information and service-seeking behaviour.

Implications

Findings of the study have implications for the provision of accessible SRH information and services for deaf people in Ghana. Since communication barriers were the major hindrance in accessing SRH information and services, any successful SRH programme for the deaf community must first address these barriers. Possible solutions could include having the GNAD appeal to all television stations to adapt their programmes with sign language interpretation or to provide subtitles. The GSL could be given more airtime and coverage on national television stations and, ideally, it could be accorded equal status as other local languages. However, a simple recommendation to provide sign language interpretation services is unlikely to resolve all access issues. Efforts should be made to include measures that will eradicate doubts and create confidence in the healthcare system.

Consequently, all SRH education outreach programmes for the deaf community should be done in a collaborative manner, so that GNAD can provide technical assistance and help supply sign language interpreters. Also, appealing SRH educational programmes could use visual communication formats such as pictures, videos with sign language or subtitles, and activity-based learning (e.g. drama) to facilitate understanding of the messages. The study found that negative attitudes towards deaf people and ignorance about the socio-cultural conditions of deafness were other factors hindering effective interaction between deaf people and health professionals. There is a need for programmes to teach health professionals how to communicate directly with their deaf clients. One possibility would be to designate some SRH centres as “specialised” centres capable of serving deaf people. Healthcare providers at these centres could be given training in sign language and their skills enhanced through frequent interaction with the deaf community.

Working collaboratively with the deaf community has the potential to increase awareness of their cultural values, reduce negative perceptions and make health professionals more sensitive and supportive. The involvement of deaf people in SRH programmes will raise awareness about resources within the deaf community which could be used to develop programmes relevant to them.

The GNAD should give greater priority to SRH issues and make SRH an integral component of its advocacy programmes. It should lobby for the inclusion of deaf people in national surveys, especially those on SRH issues, in order to highlight their needs to policy makers. Since discrimination and social exclusion are major obstacles to achieving quality of life for people with disabilities (Ministry of Employment and Social Welfare, 2000), concerted efforts must be directed towards

the reduction of discrimination and prejudice against deaf people. The GNAD should therefore collaborate with Ghana Federation of the Disabled (GFD) to push for the implementation of provisions in the Ghana Disability Policy that address discrimination against people with disabilities. The elimination of negative perceptions, prejudice and discrimination against deaf people will ensure that they are given equitable attention in national policies and programmes.

CONCLUSION

The study explored deaf people's perceptions about barriers to accessing SRH information and services. The aim was to provide insights which could be integrated into future action plans and policies. The study found that access to SRH information and services was limited by a number of factors, the most notable one being communication. Hence, any future action plans should make the elimination of communication barriers a priority. The study also underscores the importance of understanding the unique needs of different groups when designing policies and programmes. It highlights the importance of avoiding 'one-size-fits-all' policies, as solutions to addressing the concerns of one group in a community do not necessarily apply to other subgroups. The SRH information needs of the deaf community in Ghana go beyond merely improving accessibility; without improving comprehension, this measure alone may be inadequate.

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