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Improving Access of the Physically Disabled to Health Services in Tamale Metropolis, Ghana

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Abstract
The study examined the factors that determine the physically disabled access to health Services in Tamale, Ghana. The study focused on the physically disabled persons who have crippling conditions and are aged 15-60 years. A sample size of 165 is used and the study design is cross sectional. The physically disabled were selected from three institutions, Ghana Society of the physically disabled, Tamale Rehabilitation centre and the six sub-districts demarcations of Tamale Metropolis. The data collection techniques were interviews, structured questionnaire and the use of secondary information. A conceptual framework is drawn indicating the independent variable and the dependent variables, the study revealed that, employment, belief systems, education, nature of health facilities, income, service cost and transport cost are the main determinants of the disabled person's access to health care in Tamale. The disability Bill (Act715) was passed in Ghana in 2006 but it has not yet been implemented, the result revealed that, disabled persons in Tamale rely on family members and benevolent individuals for support when accessing health care. There is no significant difference in the mode of accessing health care between able- persons and the physically disabled, differences exist only in relations to both enabling and restrictive factors. Policy initiatives to assist address the disparities in accessing healthcare have been made.
Keywords: Physically disabled, Access to health, Enabling factors, Restrictive factors and Disability bill.

INTRODUCTION

The physically challenged is a term that is often used to describe three (3) types of disabled persons, the hearing impaired, the visually impaired and the physically disabled. This study focused on the physically disabled persons who have crippling conditions.

Disability is not rare, but because of the little attention given to disabled persons we have rough estimates of disabled persons throughout the world. It is estimated that disabled people constitute 10% of a country's population, WHO(2009),Coleridge,(1993).The World Bank director, Wolfensohn(2002) reports that 10-20% of the world's population were disabled, this percentage he observed, is expected to grow because of poor health care and nutrition early in life, growing elderly populations and violence civil conflicts. The World Health Organization (WHO) in its news letter Disability and Rehabilitation (April, 2013) states that one (1) billion people in the world have some form of disability and 50% of disabled persons cannot afford health care. The report also states that, most of the estimated one billion people with disabilities around the world lack access to appropriate medical care and rehabilitation services, especially those living in low and middle income countries.

In Ghana, the (GSPD) Ghana Society for the Physically Disabled was formed in 1980, it is a branch of Ghana Federation of the disabled (GFD).Persons with physical disabilities in Tamale are registered with the (GSPD) and the Tamale Rehabilitation centre(TRC) respectively. It has been estimated that there are (2.4) million disabled persons in Ghana and this number is expected to increase by the year 2020 (GSPD 2004) The management of Ghana Federation of the Disabled (GFD) still pursues the implementation of the disability Bill (Act715) which was passed in 2006.The Bill seeks amongst other things the following, disabled persons rights to family life and social activities, Access to public and health service empowerment of persons with disability, establishment of employment centres, granting of an annual tax rebate of (0.5) percent companies and individuals who employ people with disabilities.

The physically disabled in Tamale are made up of adult men and women, adolescent and children, these persons are aided in their movement by any of the following appliances, wheel chair, crutches, tricycle and walkers, however, only a few registered disabled persons with the Tamale Rehabilitation centre and the GSPD are privileged to own these mobility appliances, some of the disabled persons found within the Metropolis are seen on the streets crawling whiles others are confined by relatives.

The GSPD has a total member of (259) two hundred and fifty nine registered physically disabled persons in the Tamale Metropolis out of this number one hundred and forty four (144) disabled Persons are men whilst one hundred and fifteen (115) are women (GSPD, 2004).

Another centre in the Tamale metropolis that deals with physically disabled people is the Tamale Rehabilitation centre. It is under the care of the government. The school operate a formal school system for disabled persons between the ages of (15-45) years the number of physically disabled persons currently stand at twenty one (21) learning Technical and Vocational Skills. Out of this number eleven (11) are men and Ten (10)

are women. Majority of physically disabled people remain scattered in the communities of Tamale metropolis, this category of disabled persons are not registered, some of the reasons include, lack of education, value and belief systems, confinement by relatives and poor information flow, Tamale GSPD outreach programme report, (2002).

The disabled persons are exposed to common diseases that are found in the Metropolis,but currently, the only means and assistance by way of treatment is through family benevolence, institutional or community based treatment and the National health insurance scheme.Debrah (2013) the President of the Ghana federation of the Disabled on the 2013 year's National Disability Day states that, the difficulties faced by the physically disabled when accessing health services is caused by lack of awareness of the disability Act which was passed in Ghana in 2006.Debrah notes that, despite the passage of the disability Act 715 which covers the right of persons with disability to family life, social activities, promotes education, health care and employment, persons living with disability continue to be marginalized in all spheres of social endeavours.

In Tamale, Policy makers have tried over the years to educate people about disability, emphasising that it is never a curse whilst encouraging disabled persons that their state is never inability. Non Governmental Organisations have also tried to rehabilitate some of the disabled persons, providing them with tools and equipping them with employable skills, and providing some of them with health care services but as soon as such NGO,S leave Tamale the disabled persons are left on their own. Debrah (2013) states that lack of awareness of the Disability Act (715) has hindered the smooth implementation of the Act and that the only way the Act can be successfully implemented is for the Government to merge other UN disability regulations to the Act in order to make its implementation effective.

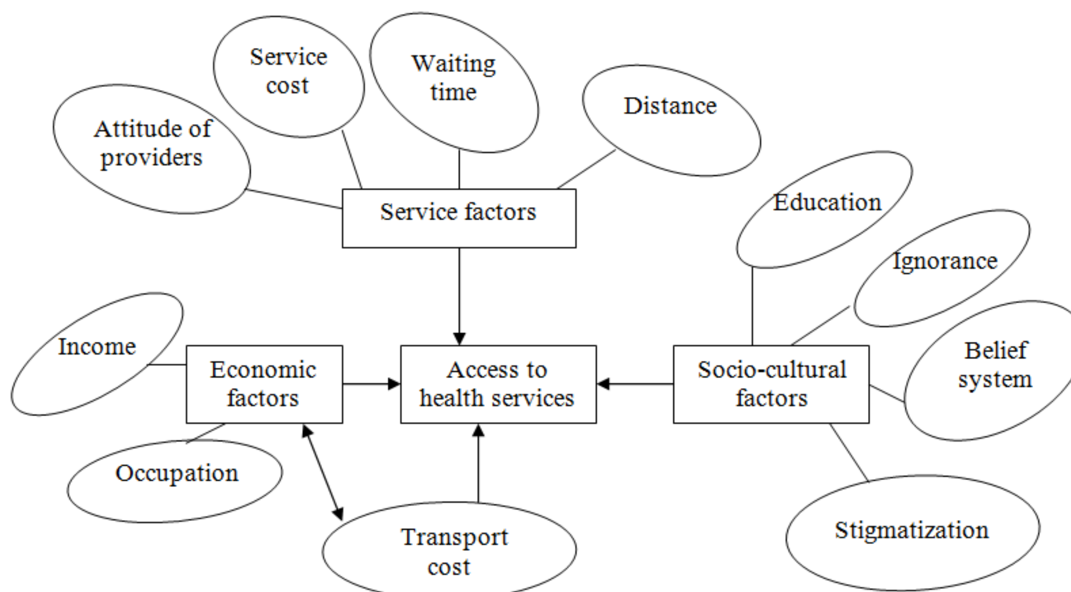
Despite all these efforts, disabled persons in Tamale are still viewed largely under traditional sentiments where disability is seen as punishment or the result of ancestral anger whilst the enlightened persons see disability as abnormality.

The physically disabled persons in Tamale are hindered by physical or non physical barriers when accessing healthcare services. The physical barriers include, designed roads without space for disabled persons, narrow door openings of vehicles and hospital wards, distance, stepped thresholds and storey buildings of health facilities without lift services. The non physical barriers are the attitude of health care providers, relatives, peers and other patients, the rest are service cost, waiting times and transport costs.

The plight of the physically disabled is further compounded by the fact that in Tamale, majority of them are denied access to education, occupation, accommodation, mobility device and property. There is also the popular belief that disabled people are a curse to the family. It is common to see many of them begging on the streets during the day and sleeping outside and in corridors at night. Currently, there is no government policy on service cost refund with regards to the disabled persons and they compete on equal levels with the able people for health services. Those who manage to visit the health facility are either stigmatized or given prescription they cannot afford. In addition, physically disabled persons in Tamale are often restricted by transportation and service cost and hence stay at home in times of illness, the condition of the disabled persons is often used against them to keep them away from going to school, finding work and being visible in their own neighbourhood. Coleridge(1993) reports that Relatives of the physically disabled in developing countries sometimes confine them and rely so much on herbal medicine because of cost of transportation and medical care. In Ghana, the introduction and passage into law of the National Health Insurance Scheme in 2003 to replaced the cash and carry system is expected to reduce the financial burden on the disabled persons, but the payment of premium annually has affected the physically disabled persons access to health services. The disabled person is not covered by the exemption policy which caters for only children and the aged.

CONCEPTUAL FRAMEWORK

Figure 1: A conceptual framework showing Socio cultural, Economic and Service factors that determine access to health services for the physically disabled.



The conceptual framework consists of variables which are dependent and independent that relate to the factors influencing access to health care services for the physically disabled. The dependent variable is “Access to health service” and the independent variables are explained below.

Socio-cultural factors - Consist of variables like education, ignorance, stigmatization and belief systems that exist within households and the communities.

Service factors - Relate to conditions prevailing at the health facility, these are attitude of providers, service cost, waiting times, insurance and distance.

Economic factors – Relate to income, occupation and transport cost that determine the physically disabled person’s ability to access health services.

These variables are categorized into two major factors 1) Enabling factors and 2) Restrictive factors. Buor (2004) in his study about utilization of health services in Ghana identified enabling factors as income, insurance, employment and transport whilst education, distance, service cost and health status act as restrictive factors.

CONCEPTS ON DISABILITY

SOCIO- CULTURAL FACTORS

People with disability have been active in fighting for their rights since the 19th century. The first International Day of People with Disability was celebrated in 1981. (MDAA)2005 (Multi-cultural Disability Advocacy Association). The celebration focused on the achievements and short falls of disabled persons activities and provides participants with a practical framework to make things happen in their work place and their communities, so that, people with disability can have access to the same opportunities like able- people do.

The physically disabled persons in the developing world are sometimes over protected by relatives; this attitude does not give them freewill to approach and explain their health needs to health providers. Coleridge (1993) writes that education, belief systems, ignorance and stigmatization are among the socio- cultural factors that hamper the disabled persons in their attempt to access health services and public places. Coleridge concludes that, both non-disabled and disabled people are part of the business of stigma- attachment and stereotyping, for disabled people, breaking the stereotype means being proud of their identity and creating role models that do not perpetuate the syndrome of the “helpless victim”.

Physically disabled on crutches, wheel chair, tricycle and those who crawl are given little room to participate in certain activities as compared to able persons. Activities like education, economic ventures and social relations in the developing world are restricted to able persons; these restrictions among others affect the disabled person’s ability to attend hospital for health services. These restrictions, such as education, distance, service cost, transport cost, ignorance, and stigmatization are in line with the findings of Buor (2004). Glenn et al, (1999) who assert that a physically disabled young adult experience more severe social difficulties than did an able-bodied comparison group.

Individual and community actions are influenced by social institutions and norms such as religion, culture, politics and economics. Such influences have implications for health and must be understood and used

by health educators or providers as points for influencing health behaviour in a positive direction, these institutions, do not give much room for the physically disabled people to benefit from health education and healthcare services.Buor (2004) states that education shows a direct positive relationship with the use of health services.Parents foster dependence by refusing to allow their physically challenged adolescents and adults to continue their education, obtain mobility appliance, drivers licences and discouraging opposite sex relationship and peer group membership, such parents are often afraid that the disabled person will be hurt, thus, the physically disabled is expected to remain at home under parental care and treatment in times of sickness.

A family is greatly affected by disability of a family member; the impact is dependent on a number of factors, these include the type and severity of the disability as well as the mechanisms and strategies that have been adopted by the disabled individual and family members in times of sickness. Chan and Heck (2000) asserts that, the effects of disability and its impact on relationships between the disabled and different family members are interdependent; therefore disability has an extensive impact on the family system.

The society in which a disabled person reside has an impact; there are social attitudes and rules towards disability that affect the individual who is mobility challenged. Coleridge (1993) reports that in some society's disease or disability is considered an illness that is nurtured at home. Participation of disabled persons in society is not a generally accepted norm. In this type of society, the person with mobility difficulty is not only physically challenged but also has to overcome social attitudes in order to participate fully in the community and be able to access health care.

Families and the society have no proper education on the right attitude to adopt in handling a disabled person. The ultimate resort to the 'cure or care' principle is very common in societies of the World. Parents go to the Rehabilitation centres with the hope that their disabled children will be cured. But in terms of physical rehabilitation techniques like conductive education, physically disabled persons cannot be cured. Schwartz (1999) writes that most disability literature speaks of integration as the ideal situation, when in fact participation might reflect more accurately in what disabled people aspire to achieve.

Poverty and Disability

There is a close relationship between poverty and disability. Coleridge(1993) writes that, in the world today, common happenings like malnutrition, mothers weakened by frequent children, inadequate immunisation programmes, accidents in over-crowded homes, all contribute to an incidence of disability among poor people. He concludes that, disability creates poverty by increasing isolation and economic strain, not just for the individual but for the family: there is little doubt that, disabled people are among the poorest in poor countries.
However, it is important to stress two vital points that contradict much received wisdom on the prevalence of disability. Scott (1990) reports that impairment is not only a function of poverty, and is not restricted to poor people. An important factor is cultural behaviour, such as early marriage in India, female circumcision in Africa, or marriage between blood relatives in the Middle East. Wars, which since 1945 have taken place chiefly in the South, have maimed hundreds of thousands, mainly civilians, irrespective of class. Disability affects all strata of society. Coleridge (1993) contends that, more technical development does not mean less impairment. Statistics on disability are extremely unreliable but, while the incidence of impairment may be high in developing countries, there is strong evidence to suggest that improved health care in industrialised countries leads to increased prevalence of impairment, simple because those with severe impairment survive longer, and people live long enough to acquire the impairments of old age. Thus, disability is also an important development issue in industrialised countries.

SERVICE FACTORS

Public policies concerning disability and the social welfare system can be major enablers or barriers for the disabled population. Policies also provide direction for acceptable social attitudes, individual groups, organizations and businesses.

In Ghana, the Parliament has passed the disability bill Act715 since 2006, but it is very difficult to implement the bill because of the infrastructural challenges confronting, Public places like hospitals schools and other institutions. On the International Day for the disabled persons December 3rd 2013 the Ghanaian Parliament resolve to demand that service barriers and public places are made accessible to the physically disabled persons pending the implementation of the disability bill.

Awareness and enabling policies for the disabled population exist in many industrialised countries. Chan and Heck (2000) writes that The Americans with Disability Act (ADA) in the united states (28) the Canadian charter of Rights and Freedom (29) and the Ontario Human Rights code (30) (Canada) are some examples of policies that set guidelines and standards for what is expected of Society regarding disability.

A World Health Organization (2013) News Letter reports that the 66th world Health Assembly has adopted a resolution calling for better health care for people with disabilities. Member states are encouraged to ensure that all mainstream health services are inclusive of people with disabilities, provide more support to informal care givers and ensure that people with disabilities have access to services that help them acquire or

restore their skills.

In developing countries, development policies are formulated by governments and international agencies directives. Both however, tend to give disability a low priority in the overall development planning. The disability “industry” is driven largely by attitudes that are more charitable than developmental.

Ruddy and Jill(2003) writing on service challenges disabled persons faced states that, the underlying factors that bring about poor service to the disabled include, assumptions by governments and health providers that rehabilitation is complicated and expensive, providing trained professionals. Aids and equipment are presumed to be too expensive to be budgeted for in normal primary health care programmes. There is also the assumption that disabled people are taken care of in institutions and disability is not a priority.

Assumptions by able- people and health care providers greatly influence the attitude of health care providers with the implication that unless a person is normal he or she does not qualify for the same chances as everybody else. Freeman et al (1997) explain that perceptions and stigmatization are negative connotations exhibited by health providers which illicit poor services for the physically disabled.

Disabled people in developing countries, if they have been exposed to any service at all, have experienced only a medical or institutional model of rehabilitation which treats them as “passive” without giving them equal opportunities like able people to discuss freely their health status. Ruddy and Jill (2003) underscores this point in their study and reports that Client – provider interaction is very important for quality health care delivery, and good face to face communication between clients and providers forms a cornerstone of good quality service. In developing countries as soon as a disabled on crutches, or wheel chair crawls to the hospital he or she is presumed by providers to be looking for free medical care, which often result in poor reception and prescription of poor quality of drugs which they think the disabled person can afford. In Ghana, the (GFD) has made strenuous attempts to change people’s perceptions about disabled persons, the association in 2001 presented a disability bill to the Goverment which was passed into an Act in 2006.This move brought some hope to the physically disabled but the Act has not been implemented to improve upon social and physical services the disabled persons require.

The physically disabled in Ghana face a lot of challenges. These barriers are categorised into physical and non physical.

The physical barriers include:

- Stepped thresholds
- Narrow door openings
- Lifts to storey buildings with no provision for the physically disabled
- Narrow seats in transport
- Tall hospital buildings
- Inappropriate location of health centres

The non-physical barriers include

- Transport owner’s policy that requires disabled person who occupies two seats to pay twice the price.
- Pharmacies instructions to staff to refuse large orders from disables
- Negative attitude of medical staff for fear that the disabled cannot pay for medicine supplied.
- Policy of health administrators that require long waiting times at the hospital
- Health providers attitude which turn away the disabled people from health can services. (The wheel disabled newsletter 2004)

These categorisation of barriers are in line with Disabled Access Auditors Act (1995) where they have put barriers confronting the physically disabled into physical and non physical barriers.

Some of the physical barriers may be overcome by carrying out simple modifications Brooks (1996) explained that such changes should be incorporated as part of normal plan maintenance with examples being new door handles, clearer signs, contrasting colours finishes. Other barriers may require more significant structural alterations example is widening doorways, and providing ramps.

Service providers are more likely to be able to comply with their duties if they.

- Audit physical and non physical barriers to access
- Make adjustments
- Provide training to staff which is relevant to these adjustments
- Draw the attention of disabled people
- Let disabled people know how to request for assistance
- Regularly review the effectiveness of adjustments and act on the findings

May (1992) identifies structural environmental factors and states that they are less dependent on nature and therefore can be modified by the community through policy development. The author concluded that Political and economic factors have a major impact on structural factors that affect individuals who are mobility challenged. Enabling policies for the disabled and a favourable economy can result in removal of a significant number of structural barriers in the community. Policies such as the one that require all health facilities and

buildings to be made accessible for the physically disabled are examples of removing structural barriers.

Physical environment has been identified as one of the determinants of the health status of the individual and of population health. Martin (1994) contends that Physical environment incorporates hospitals, housing work place and community, including road design and prolonging the timing of traffic light changes are some examples of making positive changes to the physical environment to enhance mobility and health for the physically disabled. Martin (1994).

Using appropriate mobility device as prescribed by health care professionals does not automatically result in increased activities and participation in health issues.

According to the (1997) revision of WHO international classification of impairment disability and handicap (JCIDH) impairment activity and participation are the new classifications for the consequences of and the impact on the lives of individuals with health conditions.

In Ghana, the physically disabled is confronted by environmental factors which can be considered at the Micro level which takes into account an individual's home and social environment. They can also be considered at the Macro level which pertains to the structural and physical environments. These barriers are captured in the disability bill Act (715), which requires the provision of an enabling and friendly environment for persons with disabilities to live and operate within the society.

At the Micro or individual level the environment must be adapted for the physically disabled using mobility devices, if a wheelchair or tricycle is used than barriers such as stairs, narrow door widths, step thresholds at health facilities and public places have to be modified to allow for the use of a mobility device. Modification of the micro environment applies to the person's home, work, school, church, roads and other buildings frequented by the individual.

The Macro level includes environmental factors at the regional and national levels.

The Climate, geographic and structural factors also influence the mobility of the physically disabled access to health care. The disability Bill advocates that structural environmental factors are less dependent on nature and therefore can be modified by the community through policy development, Part (5) of the disability act talks about health care and facilities and calls on the Ministry of Health when formulating health policies to provide for subsidised general and specialised medical care and rehabilitative operation treatment for those with severe disabilities.

ECONOMIC FACTORS

In almost all societies of the world, major obstacles continue to hamper the development of persons who are physically disabled. These obstacles prevent them from exercising their rights and freedom, and make it difficult for them to participate fully in economic activities or generate income for themselves to meet transport cost and service cost to access quality health services.

At the societal level, the amount of funding available to ensure that the community and environment are accessible could be either an enabler or a barrier to individuals with mobility difficulties.

Income replacement is a relevant economic policy that can improve and maintain the disabled persons status. Some countries have guaranteed income for those who are unable to work.The Multi cultural Disability Advocacy Association, (MDAA) (2005) reports that Canada has a social safety net; individuals who are unemployed or unable to be employed are entitled to a basic living income with health care benefits. Countries without these basic living incomes for disabled persons impose economic hardship on individuals with mobility difficulties who are unable to continue with their usual employment.

Income is a factor that affects proper utilisation of health services, Ensor and Cham-Bich San (1996), Delanyo et al (1990) contended that poverty is a predominant factor in utilisation. The results implied that, with, poverty which is more endemic in deprived rural areas access to quality health care will continue to be poor, disabled persons who are unable to work for some time or work at all, will have their income significantly affected, thus a physically disabled person is often in a financially compromised situation due to possible reduction in income and the increased cost associated with disability.

Maintaining activity and mobility is another challenged to physically disabled persons. Chan and Heck (2000) carried out a longitudinal study and established that 42.7% of individuals with multiple sclerosis (MS) were able to continue with full time work, while 49.2% received external support to maintain their financial standard.

Income and its associated social status have been proved to be determinants of individuals and population health and well being, Chan and Heck (2000) found out that, poor quality of life was associated with unemployment and mobility limitation on stairs was strongly related to interference by multiple sclerosis in social activities.

The Multicultural Disability Advocacy Association (MDAA) News letter (2005) states that 700,000 Australians are on the Disability Support Pension receiving up to $470 a fortnight, to qualify for the pension they

must prove to a medical practitioner that, they cannot work more than 30 hours a week.

In Ghana, the physically disabled is discriminated against by most employers, even though some disabled persons have managed to acquire the needed skills and certificates to work the disabled persons are still sidelined. The disability Bill has advocated among other request that, companies that employ persons with disabilities should be granted a tax rebate of five percent (5%).The leadership of persons with disabilities are also pushing for five (5%) employment quota for the physically challenged in public companies in Ghana.

METHODOLOGY

Sampling method

The study covers physically disabled adults with age 15 to 60 years and selected from three institutions, Tamale Rehabilitation centre, Ghana society of the physically disabled and Six sub -districts of the Tamale Metropolis demarcation of health facilities by Ghana Health Services.

A simple random sampling and systematic sampling techniques were used for the selection of physically disabled persons. The study design is cross sectional and the methods used for the study were qualitative and quantitative. The data collection techniques were interviews and written questionnaire. 20 healthcare providers were interviewed.

A sample size of 165 was used and derived using the model formulated by William, G.Cochran (1977)

$$n = \frac{N}{1 + N(\alpha)^2}$$

Where

n = Sample size

N = Total population of physically disabled Persons in Tamale Metropolis. (280)

α = The level of significance (0.05)

1 = Absolute or constant figure

Using 95% confidence interval

(a) Independent variables

Independent variables considered for the study with their operational definitions, indicators and scales of measurement.

Variable	Operational Definition And Indicator	Scale of Measurement
1, Education	a)The completed level of schooling attained b) Level of formal education	Ordinal
2, Belief systems	a)Ideals and values cherished by a group of people b)Response to questions	Nominal
3,Stigmatization	a) To treat a particular type of behaviour as wrong or embarrassing. b) Response to questions	Nominal
4, Ignorance	a) Lack of knowledge about the existence of something in need b)Response to questions asked	Ordinal
5,Waiting times	a)Time spent waiting for a doctor from the time of arrival at a health facility to the time a patient is called to a doctors consultation room b) Response to questions	Interval
6,Distance Distance(con,t)	a) Total distance in kilometres covered by any means of transport from home to a health facility. b)Distance from house to facility	Interval Interval
7,Service cost	a)The cost of consultation, laboratory and drugs b)Cost charge on services	Interval
8,Attitude of providers	a) Affective behaviour of Medical staff towards clients. b) Clients response to questions.	Ordinal
9,Income	a) Amount of money earned monthly and income by household. b) Amount of money earned monthly by Husband and wife.	Interval
10,Occupation	a) Engagement in an income generating activity, whether in the formal or informal sector b)Employment status	Nominal
11,Transport cost	a) The cost of transport paid for travelling to the health facility and back. b) Cost charge on transport.	Interval

Source: Authors Compilation from data analysis

(b) Dependent Variable and its operational definition

(1) Access to Health services – The right or opportunity to acquire health care. The ability to reach, enter or use a facility.

RESULTS

Table 2.

Background Characteristics of Respondents (Physically Disabled)

Age	Male	Female	Total	Percentage
15 – 25	22	27	49	30%
26 –35	32	10	42	25%
36 – 45	25	23	48	29%
46 – 55	6	7	13	8%
56 – above	10	3	13	8%
Total	**95**	**70**	**165**	**100 %**

Source: Field data 2005

Table 3.

Profile of Sampled Health Care Providers for interview

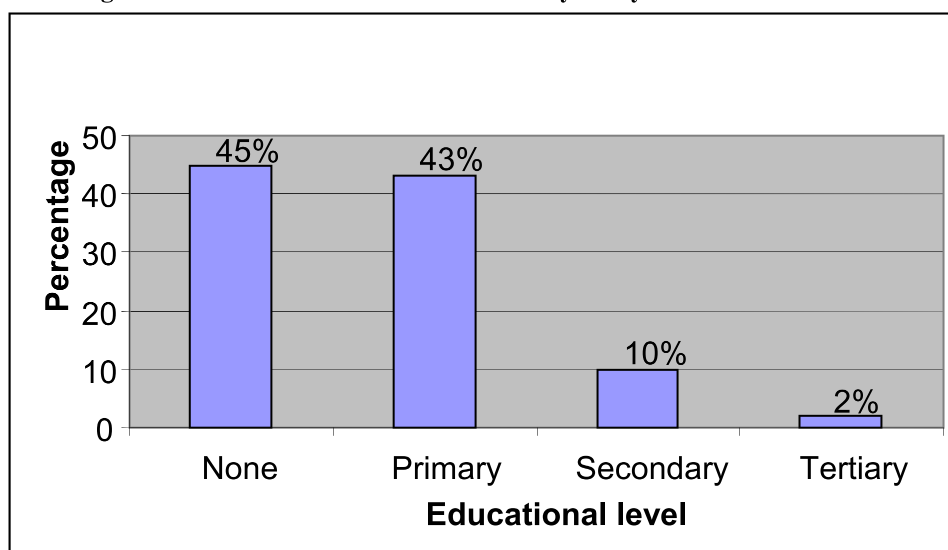
Age	Male	Female	Occupation	Rank	Total	Percentage
16-25	3	2	Nurse	SN	5	25 %
26-35	3	5	Nurse	SRN	8	40%
36 – 45	3	1	Doctor	SMO	4	20%
46 – 55	-	3	Midwife	SMW	3	15%
56 above	-	-	-	-	-	-
Total	**9**	**11**	-	-	**20**	**100%**

Source: Field Data, 2005

SN= Student Nurse. SRN= State Registered Nurse. SMO= Senior Medical Officer. SMW= Senior Midwife.

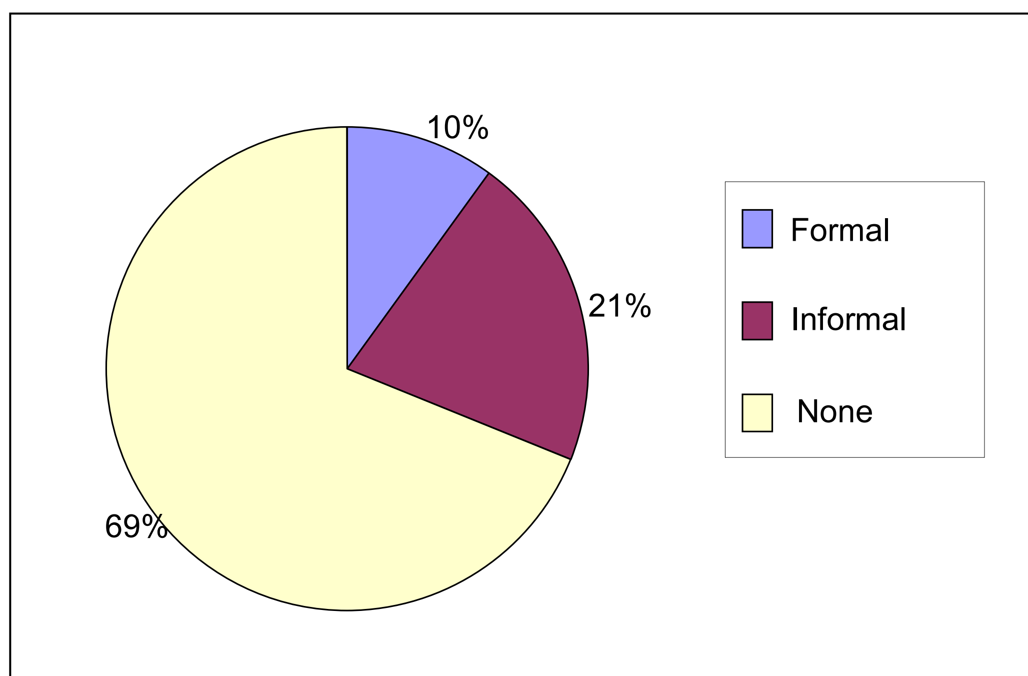
Figure 2

Percentage distribution of educational level of Physically disabled Persons.



Source: Field data, 2005

Figure 3
Employment status of physically disabled persons



Source: Field data, 2005

Table 4
Distribution of Physically disabled persons by the kind of medical care sought.

Response	Frequency	Percentage
a. Traditional medicine	130	79%
b. Orthodox	28	17%
c. Both	7	4%
Total	**165**	**100%**

Source: Field data, 2005

Table 5
Physically disabled persons response on community members attitude towards them

Response	Frequency	Percentage
a. Satisfactory	59	36%
b. V. Satisfactory	6	3%
c. Not Satisfactory	18	11%
d. Poor	82	50%
Total	**165**	**100%**

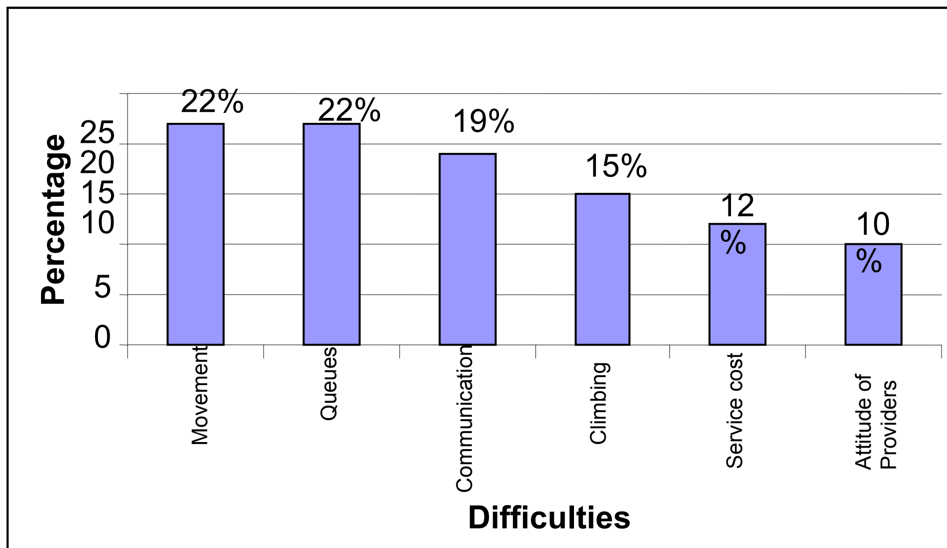
Source: Field data 2005.

Table 6
Physically disabled persons response on difficulties in accessing health service at health facilities

Response	Frequency	Percentage
Yes, there is a difficulty	116	70%
No, there is no difficulty	49	30%
Total	165	100%

Source: Field data 2005.

Figure 4
Difficulties experienced by the physically disabled in accessing health care.



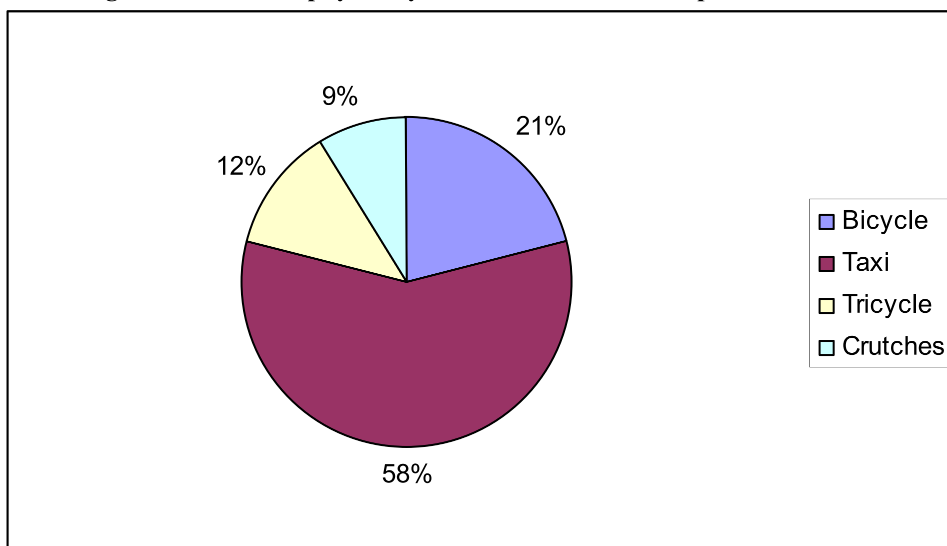
Source: Field data 2005.

Table 8
Number of hours spent at the health facility by the physically disabled

Response	Frequency	Percentage
30min – 1 hour	28	17%
1.30min - 2 hours	56	34%
2.30min – 3 hours	59	36%
3.30 min – 4 hours	18	11%
4.30min – 5 hours	4	2%
Total	**165**	**100%**

Source: Field data 2005

Figure 4
Percentage distribution of physically disabled means of transport



Source: Field data 2005

Table10
Suggestion by the physically disabled on how to improve their access to health care

Response	Frequency	Percentage
a. free medical care	75	46%
b. Separate unit at the hospital	52	31%
c. Ambulance service	28	17%
d. Special ID cards	9	6%
Total	**165**	**100**

Source: Field data 2005

CHAPTER FIVE
DISCUSSIONS

Differences exist between physically disabled persons and the able- persons in Tamale Metropolis when it comes to utilization of health services, this is greatly influenced by restrictive factors and enabling factors.

(a)Restrictive factors

Education

Disabled persons in the Tamale Metropolis have low levels of formal education. Those with primary education are more than those with secondary and tertiary level of education. Primary Education formed (43%) and a minute figure of (2%) with Tertiary level of education. Disabled persons who attained the tertiary level of education benefited from scholarships granted by Non-Governmental organizations.

This phenomenon has serious consequences for the physically disabled person's access to health services. The consequences include ignorance about the use of drugs, refusal to attend hospital as a result of previous experiences of difficulties at health facilities, and communication gap. Health care providers interviewed acknowledged the fact that differences exist between educated and uneducated physically disabled persons, some of these difficulties are; default on reviews, follow ups and drug administration. These findings are consistent with the conclusions reached by Buor (2004) that, education is one of the key factors that has direct positive relationship with the use of health care. Buor categorised education as a predisposing factor and concluded that education has a considerable impact on health service utilization.

Attitude of community members

The attitude of community members in Tamale towards the physically disabled is poor. Results from the study revealed that the people see disability as a curse or punishment from God. fifty percent (50%) of disabled persons feel neglected in their communities, such stigma attached to disability affect the support required by the disabled when they are ill. The physically disabled go through psychological trauma when they are neglected. Refusing to accept their plight leads to premature deaths, way side begging and accidents. Healthcare providers confirmed that they do experience abandoned disabled cases in Tamale. Such disabled individuals are often assisted by religious bodies or referred to the social welfare unit. Chan and Heck (2000) expressed similar views in their findings that, in some cultural groups a female with physical disability would be dependent on the male member of the family to take her outside of the home and make decisions for her. Should the male member choose not to, she cannot go outside to a health facility even if she has an appropriate mobility device.

Difficulties faced at the health facility

The kind of difficulties the Disabled persons encounter at the hospital are; mobility within the hospital, queues, Communication barriers, climbing, service cost and Attitude of health providers, among these restrictive factors, the research revealed two major problems faced by disabled at the hospital, these are movement within the facility and queues respectively.

This trend has serious implications on access to health service. In the first instance, the physically disabled cannot endure the long queues at the health centres. Those who manage to go to the facility are further challenged by structural barriers and communication gap where interpreters are harsh on them. The interviewed health care providers (55%) are of the view that, there was no facility or any modality put in place to facilitate easy movement for physically disabled at the health centres, they suggested that a separate unit for disabled persons will reduce the queues, mobility difficulties and the communication problems at the health facility.

These findings are in line with the Disability Discrimination act (1995) of the United Kingdom which highlights on physical and non physical barriers faced by the physically disabled, with emphasis on health facilities, employment, education and public transport and required service providers to make reasonable adjustment for disabled persons.

Attitude of Health Care Providers.

The attitude of service providers towards the disabled in Tamale is satisfactory, this constitute a percentage of (54%) according to the findings. This result is an indicative factor that the health providers are more sympathetic towards the physically disabled. There is no any policy guideline on the special treatment required by the physically disabled, health care providers therefore use their own discretion to give quick attention to the

physically disabled. The findings revealed that disabled clients who were dissatisfied with the service providers' behaviour relied on perception about other clients experiences.

Client – provider relationship is an important feature in health care delivery, it encourages disabled clients to visit health facilities, reduces the sensation they go through, and clear the stigma attached to disabled persons. These results confirms Hag Lund (1996) report that studies revealed that communication to patients who are to undergo endoscopies studies, the actual experience reduce their distress which is more effective than descriptions usually given by nurses and physicians. For the physically disabled, according to them, the major problem is the nature of the health facility and able- client's behaviour and not health providers' attitude.

(c) Enabling Factors

Employment

Physically disabled persons representing 69 percent are not working in the Tamale Metropolis. A few are engaged in the informal sector doing petty trading and designing of shoes. Lack of occupation greatly affects the income status as well as utilisation of health services.

Occupation and income have great effect on disabled access to health service, disabled persons inability to meet the transport cost to hospital, service cost and purchase of drugs are important determinants to the visits they make regularly to the hospital. The research revealed the various means by which the physically disabled persons often pay their medical bills. Payment by friends, benevolent people and parents constitutes a large proportion of how the disabled persons pay for service cost and drugs. The physically disabled in Tamale have no control over their demand for health care. They are regarded a burden on the family or friends.

These findings are in line with Ensor and Pham- Bich-San (1996) and Delanyo et al (1990) who showed in various studies that, with poverty more endemic with deprived people like the physically disabled and the poor, utilisation rates will more likely be lower with the low income than with the higher income, they described this phenomenon as a "social class" and concludes that 'lower income less health'.

Income levels

The income levels of the physically disabled persons is generally low, this emanate from the fact that most employers refuse to engage disabled persons services, factors such as discrimination traditional beliefs and parental neglect all militate against the physically disabled persons in their attempt to generate income to access good health care.

The research revealed the kind of treatment the respondents seek when they are ill. A large number representing 79% seek traditional medicine and with this attitude, the tendency for complications in medication is likely to increase. This revelation is consistent with Buor,s conclusions that the enabling factor of income exhibits a higher positive coefficient with utilization among the less privileged and the rural poor. Buor (2004) adds that, with low income opportunities in the rural areas, and with low assessment of the value of modern medicine, as compared with traditional medicine, it is the higher income earners who would have a little more to spend on areas other than the basic necessities of food, clothing and shelter.

Transport used by disabled persons

The means of transport widely used by the physically disabled in Tamale to the health centers is Taxi, The research revealed that 58% of the physically disabled use Taxis and 21% are carried on bicycles to the hospital. Majority of them are not able to purchase tricycles because of the cost. This means that physically disabled who cannot meet the transport cost will have to stay at home instead of going to the hospital for treatment.

Transport cost is a major enabling factor of access to health services, the physically disabled that have no access to any means of transport can resort to self medication.

These findings are in line with Schwartz (1999) report that handicap people in the society depend so much on those around them and could be confined for fear of ridicule and poverty, especially in times of illness.

POLICY IMPLICATIONS

The Ghana National Health Insurance Scheme(GNHIS) which was passed into law in 2003 is a policy established by the Government of Ghana with a goal to provide equitable service and financial coverage for basic health care services to Ghanaians , currently, the free concept cover only children and the aged, the Government must include the physically disabled in the exemption brackets under the scheme to encourage parents to send their physically disabled persons to hospital regularly in times of illness. The research revealed that transport cost and service cost are major restrictive factors to the disabled person's visits to the health centre. Parents confine them and resort to self medication.

The disability bill Act 715 was passed into law by the parliament of Ghana in 2006, but it has not yet been implemented, the study established a general concern and support for the government to speedy up the implementation of the disability bill to improve physically disabled persons access to public places, employment and health care.

There should be an educational program on the need for the physically disabled person to concentrate on the utilization of orthodox medicine which is more reliable than the Traditional medicine they currently rely

on. The education they require should aim at equipping them with knowledge and skills so that they can work to earn some income and overcome stigmatization in order to be on their own. Policy makers' opinion leaders and Nongovernmental organizations have a role to play in ensuring equity in healthcare Utilization.The idea of Government intervention in this direction is consistent with the Multicultural disability advocacy association (MDAA) report (2005) on the measures adopted by the Australian Government to improve the lives of disabled persons. 700 thousand Australians are on the disability support pension receiving up to $470.The qualification is that one should prove to medical professionals that you cannot work for more than 15 hours a week, the Government intervene to reduce the number of working hours which was originally 30 hours a week.

Transport and distance problem must be considered seriously by the Government, Ambulances, vans and buses that are disability friendly must be procured and put at vantage points to carry the physically disabled persons to hospitals frequently. Health facilities must be accessible and health clinics should be built in communities of Tamale to reduce the distance the physically disabled persons will have to cover to a health centre. These measures to deal with the problem of distance are supported by Buor (2004) in his study of access to health in Ahafo- Ano district of the Ashanti region of Ghana, he advocated for the establishment of more primary health care centres within easy reach of the rural settlements, he recommended that such public health care centres must be manned by medical assistance or professional clinical and public health nurses. The PHC must be established within 5.2 kilometres radii in order to make access to health less cumbersome.

The problem of longer waiting times and daily struggle with able-bodied patients in the hospital can be tackled effectively by the Government if separate unit blocks are build in the hospitals for the physically disabled persons. Hospital administrators should also adopt the protocol system to ensure quick health service delivery in order to reduce waiting times for the physically disabled persons.

Improvement in architectural design and structural changes at the health centres by the Government and stakeholders in the communities will assist the physically disabled persons have access to healthcare. Currently, majority of the buildings in the Tamale Metropolis are not disability friendly. Rigorous building Policy directions on modification of existing structures are required to bring about structural changes. Wheelchairs and tricycles are commonly used in Tamale, barriers such as stairs, narrow door widths and narrow turning angles must be modified by policy makers to allow for the use of a mobility device. At the regional level all pavements and roads should be modified. Modernisation of the Tamale Metropolis must be accompanied by provision of lift services to all tall buildings to facilitate access by the physically disabled persons.

CONCLUSION

The focus of this study has been on determinants of health services and how to improve the physically disabled person's access to health services in Tamale Metropolis, Ghana.

The study sought to find out whether the physically disabled person is confronted by barriers such as service factors, socio- cultural factors and economic factors when accessing health care. The dependent and independent variables which emerged from the study are categorized into enabling factors and restrictive factors. Income, employment, transport cost and service cost were the enabling factors whilst education, distance, stigmatization, attitude of health providers and nature of health facility constituted the restrictive factors. The major conclusion is that, physically disabled persons in Tamale find it difficult to access health services because of their condition and barriers which have been created as a result of discrimination and lack of policy direction.

There is a direct relationship between service cost and utilization of health services but the research revealed that sixty nine (69%) of the physically disabled persons are unemployed as a result of discrimination and stigmatization. Disabled persons are unable to pay the cost of health services and resort to self medication. The health insurance scheme which is operational in Ghana attracts a premium for clients between the age of 14years – 69years and there is no special exemptions for the physically disabled.

The health of a population like that of the physically disabled persons who constitute 10% of Ghana's population encompasses more than health care or health services. It includes, the broader determinants of health, such as income and social status, social support net works, education, employment and working conditions, social environments, personal practices and coping skills, belief systems and health services. The effective measure a developing country can adopt is to gradually move away from the "Rehabilitation model" and rather adopt an "Awareness and Integration model".

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