



Barriers faced by service providers in meeting the sexual and reproductive health needs of deaf persons in Ibadan metropolis: A qualitative study

Oyedunni S. Arulogun^{*1}, Musibau A. Titiloye¹ and Adeyimika Desmenu¹

¹Department of Health Promotion and Education, Faculty of Public Health, University of Ibadan, Ibadan, Nigeria

*Corresponding Author Email: omoyisola2002@yahoo.com, Telephone: 234-8035794630 (Mobile)

ABSTRACT

Deaf persons have unique cultural and linguistic issues that affect healthcare experiences. The study aimed at exploring the level of preparedness of providers of reproductive health care services to meet the need of deaf clients. The methodology consisted of 11 individual in-depth interviews spread over health facilities in close proximity to institutions for the deaf in Ibadan with service providers. Only private health facilities reportedly provided services to deaf clients and none of the health care providers interviewed had ever been trained on service provision for the deaf. Communication was the key barrier identified for the provision of services to deaf clients. Healthcare providers must be trained to become more effective communicators with deaf patients and to use qualified interpreters to assure access of deaf people to healthcare.

Keywords: Deafness, health service provider, constraints, sexual and reproductive health.

INTRODUCTION

Over 5% of the world's population (360 million people) has disabling hearing and the majority of these people live in low- and middle-income countries (WHO, 2013). Furthermore, about 10 percent of the world's population, 650 million people, live with a disability, and their sexual and reproductive health has been neglected (UNFPA, 2012). Globally, traditional cultures used to and still view disability with contempt; condoning a culture of exclusion as well as instilling feelings of self blame and worthlessness in people living with disabilities (Arno et al, 1992).

In the context of sex and sexuality, these myths and superstitions perpetrated the idea that people living with disabilities (PLWDs) are incapable of initiating sexual and marital relations similar to those of non-disabled people and are thereby likely to be excluded intentionally or unintentionally from normal sexual lives which are an integral part of human reproduction and pleasure. This misconception of regarding PLWDs as asexual or less sexual is reminiscent of the idea that they do not have sexual desires and feelings. Moreover, it is a violation of sexual and reproductive health rights of people with disabilities and it exposes them to sexual violence and

inadequate sexual and reproductive health care (Russinga, 2012).

Deaf and hard of hearing (D&HH) individuals often have to cope with extraordinary communication barriers when working with their health care providers receive health care services that are inadequate, inappropriate to their needs and unethical due to the interplay of numerous complex individual, interpersonal and systemic factors and have a poorer self-reported health status than the general population (Harmer, 1999).

The major issue for all D&HH patients is communication with the hearing world. As the non-English-speaking minority at greatest risk for physician-patient miscommunication, deaf people particularly have problems with common English words; some educated deaf persons do not understand the words "nausea" and "allergic" and "constipation" (Helen and Philip, 2005). D&HH persons have poorer health care knowledge, including an inferior understanding about current preventive medicine interventions, compared with hearing persons (McEwen and Anton-Culver, 1988; Tamaskar et al, 2000). When seeing D&HH persons, physicians must

speak simply, use certified interpreters as indicated, and verify that patients understand all recommendations.

An example of such a miscommunication between a physician and his deaf patient was reported by Helen and Philip (2005) when no interpreter was present and English was used. The physician wrote, "*You may need surgery.*" The patient understood this to mean, "*You need surgery in May.*" In American Sign Language (ASL), the English sentence, "*You may need surgery*" would be signed, "*You maybe need surgery.*" In ASL, the English sentence "*You need surgery in May*" could be interpreted as "*You (in) May need surgery.*"

Research has therefore shown the need to improve health care services for all D&HH groups and that the health care communication needs of D&HH people have been and continue to be neglected. D&HH persons report lower subjective health care status and have inferior knowledge regarding HIV/AIDS and preventive medicine. Deaf persons visit physicians less frequently. Deaf participants expressed the belief that physicians and nurses seemed unprepared to accommodate their communication needs, and physicians reported "significantly greater difficulties communicating with (deaf) patients" (Helen and Philip, 2005).

It is therefore essential to explore the constraints faced by health care service providers in meeting the sexual and reproductive health (SRH) needs of D&HH people in our settings so as to proffer a culturally and socially acceptable solution to identified issues. The objective of this study was to identify barriers faced by health care service providers in meeting the SRH needs of deaf clients and mechanisms employed to overcome these service provision barriers.

MATERIAL AND METHODS

Study design

The study was a qualitative one based within the phenomenological paradigm. A qualitative study method was chosen because of its usefulness in exploration of people's knowledge views and experiences. The other advantage of qualitative methods is that they can be participatory, democratic and empowering (Kitzinger, 1994). To ensure that similar topics were covered during the interview as well as allowing participants to express their views and experiences, the semi-structured in-depth interview was used. These interviews were used to collect information from health care providers regarding their experiences with regard to providing healthcare services to deaf persons.

Study setting

The study was conducted in health facilities in close

proximity to institutions for the deaf in Ibadan. Ibadan is home to one of the earliest establishments for the deaf as well as reproductive health services. These population clusters are around elementary and secondary schools as well as in vocational and residential settings.

Sampling

The participants for this study were recruited by purposive sampling. As part of a larger study, the health care providers were purposively sampled based on their specific knowledge of health care services in the area and proximity to the deaf population in the study area. As at the time of the study, there were no known health care providers that focus mainly on deaf clients. As a result, the proximity of the health care providers to the deaf institutions was assumed to serve as an avenue for the deaf to access the services. Therefore the main service provider in Ibadan which is the University College Hospital Ibadan was purposively selected. Others were identified by asking the deaf persons to mention where they go to access sexual and reproductive health services when the need arises. There are 11 health institutions (all privately owned) around the various educational and vocational centres as at the time of the study and all the facilities were sampled. In each of the private facility, the one service provider at the facilities was interviewed. For the main provider, the head of the facility was interviewed.

Data collection methods

Training on qualitative research was conducted for the four research assistants who were involved in the data collection. An in-depth semi-structured interview guide which was designed in English through review of literature was pretested among persons of similar characteristics in another area of Ibadan. In-depth interviews were conducted with health care providers who are directly involved in the provision of sexual and reproductive health related services from the identified health institutions. Issues in the guide included types of services rendered generally and type rendered for deaf persons, level of preparedness to provide service to the deaf, constraints to service delivery, policy issues relating to service delivery to the deaf and training needs. In most instances the interviews took place at the participants' offices at times convenient for them after advance booking. A brief explanation of the aim of the study and confidentiality related issues kicked off the interview. At the end of the interview, debriefing was carried out and some quotations were read back to the participants especially on some important points. Each interview lasted about one hour. During each of the interview, data were recorded by taking hand written notes and audio-recording the interviews.

Data analysis

A concurrent data collection and analysis strategy was used to enable researchers to go back and refine questions and make more inquiry into emerging issues. After the field study, the written and recorded materials were transcribed. The transcripts were validated by a blinded transcriber who did a second transcription of the interviews. The actual analysis began with reading through the transcribed interviews and listening to the audio records in order to get a good grasp of all the data. The key ideas and emerging themes were identified and themes from different groups were pooled together and integrated into common themes. This was then followed by generation of concepts that were used to organize the presentation of the findings.

Ethical Considerations

This study followed the ethical principles guiding the use of human respondents in research. Approval for the study was obtained from the University of Ibadan/ University College Hospital (UI/UCH) Health Research Ethics Committee (Ref No UI/EC/08/0019). The nature, purpose and process of the study were explained to the participants after which informed consent was obtained. Participants were assured of confidentiality, privacy and anonymity of information provided. Necessary steps such as keeping transcripts and data sources in a secure place were taken to ensure confidentiality. Participants were continuously reminded of their right to withdraw from the study at any time and were reassured that refusing to participate in or withdrawing from the study would not disadvantage them in any way. They were informed that they will not necessarily benefit directly from the project but that the data will be used to try and contribute to universal and equitable access to healthcare.

RESULTS

Demographic characteristics

All the health care providers who participated in the in-depth interview were females by default. The ages of the participants ranged from 42 to 59 years with a median of 48 years. Respondents were made up of community health practitioners, a deputy coordinator of a fertility unit, a community birth assistant, a voluntary health worker, a midwife and seven senior nursing officers. The median duration of years of work in the current workplace was 10 years with a range of 4 to 20 years.

Types of facility and services rendered

Data were collected from two types of health care

facilities i.e. government owned and privately owned facilities. The government owned facilities visited were categorized into tertiary and primary health care. In order to get an insight into the operations of the facilities where the health care providers work, participants were asked to state types of services rendered. Services listed varied by type of facility and were relatively generalized at all the facilities except at the University College Hospital that is focused strictly on reproductive health services. For the main service provider (University College Hospital), services listed were:

reproductive health and family planning services such as counseling, provision of commodities, community outreach and training of all cadres of health workers on family planning and reproductive health as well as research activities.

For the primary health care and private facilities, services rendered were:

taking care of pregnant women, treatment of accident victims, immunization to only pregnant women and not babies, treatment of minor ailments like malaria and diarrhea, family planning services such as injection, insertion, copper T and pills and referral services for laboratory test.

In relation to types of infrastructure available, only two of the participants said they had separate rooms for rendering services to young people so that

the adults and other people will not hear what they are saying.

At the main service providing centre, the participant said that;

there are many rooms but we don't have a particular one for youth. We have different rooms that we tag counseling rooms that we can make use of. We hold our patients in high esteem especially the youth, the adolescents and the teenagers; we ensure privacy and respect the right of the clients.

Clientele of health facilities

When asked about their clientele, this differed from facility to facility. Responses to this were:

we care for young persons, mothers, elderly and housewives, eighteen years and above attend the facility and there is no limit to educational qualification adults and influential people do come to our clinic and most of them are educated.

The participants from the facility with the closest proximity to the oldest school for the deaf said *more elderly people and deaf access our services.*

The participants who had rendered services to deaf persons were further probed to share their experiences on the characteristics of those they saw, the reason why they accessed the facility, communication process and the dynamics of their interaction. The participants reported that deaf persons come to their facilities seeking treatment for ailments like malaria, diarrhea and

and for delivery. The deaf persons treated were adults of both sexes. In relation to communication processes, the service provider said they communicate

by writing, you know by describing, most of them can write, when they come, I am with an exercise book, they will write their problem, I will ask them, I will welcome them how are you? What is your problem?

Describing their experiences with deaf clients one of the participants said;

you know at times if you don't have patience to listen to them they get angry easily. In fact they get angry very very easily, so I have to be patient with them, take a lot of time with them, be very patient with them and listen to them, answer their questions, but you need to exercise a lot of patience when dealing with them.

Another provider said;

most of the services I render for those that normally come here are malaria treatment and dysmenorrhea at times. When they want to start their menses, we counsel them, just give them paracetamol and buscopan, then we advice them not to go and just hide themselves. Some would say I've stayed inside because of abdominal pain.

Another provider reiterated that;
being deaf does not affect their sexual and reproductive life. I've had like four of them coming for ANC and they've had their babies safe and sound no problem.

Narrating what happens at the antenatal clinic (ANC), a participant said;

when we have a deaf patient like that during ANC, somebody will stay with them and translate, explain to them whatever we are saying; there will be somebody that will be writing for them. We will just write for them so they will understand what is going on.

The participant who reportedly had not cared for deaf clients before opined that;

it's a little bit difficult for the deaf to access sexual and reproductive health services compared with their hearing counterparts because they cannot speak, if they do not have anyone to speak on their behalf, it will be difficult for them to come to the hospital, their source of information about SRH services is in the school. It is quiet difficult to relate with those deaf girls when they come for treatment except if they come with someone who understands them and can explain better.

Perception on the sexual and reproductive health needs of deaf persons

The participants were of the opinion that the sexual and reproductive health needs of deaf persons are not

different from those of their hearing counterparts. In addition, participants disagreed on whether being deaf makes the person more or less prone to abuse.

According to the participants;

the sexual and reproductive health needs of deaf girls are the same with their hearing counterparts, whether they speak or not, they have the same anatomical and physiological needs and all that but their growth rate may not be the same.

The deaf girls are not self empowered because of their language barrier.

The deaf girls are more prone to abuse and are being maltreated because of their deafness. They are more vulnerable because they cannot speak, they can't shout and they can't hear. There should be a means of particular package for them concerning reproductive health issue.

Their being deaf does not affect their SRH in any way. Their vulnerability does not lead to any kind of bullying or sexual violence, this happens more among their counterpart. This is because the deaf cannot hear anything that go on around them, so they are always defensive and alert moreover there has never be any reported cases of sexually transmitted infections among the deaf

Level of preparedness to render SRH services to deaf persons

The study aimed to establish what the participants' level of preparedness for providing service to deaf clients. All the participants reported that they had not received any training on how to relate with deaf clients when they come in contact with one. This they said was the main constraint to their rendering service to persons who have a hearing disability.

For effective service delivery, the greatest need identified which cut across participants was ability to communicate with the deaf without an interpreter. This they said would ensure confidentiality and privacy of information disclosed by the clients which would otherwise not be possible in the presence of an interpreter or a family member. All the participants therefore want to receive training on the use of sign language which would improve communication between them and deaf persons when they come around to seek medical help. In their words

if the Government can provide things that the health facilities need so as to take care of the deaf girls and they also need money too.

if only we can be trained in their sign language to communicate with them easily and our facility is well equipped.

Also, none of the participants was aware of any law, policy or regulations concerning accessing of health

services by the deaf. They opined that there should be specific laws addressing the need of the deaf persons in accessing health care. The law should contain the basic provisions that each facility is supposed to have such as sign language interpreters and other special services as found in the developed world.

DISCUSSION

This study was designed to determine constraints that health care providers face in rendering sexual and reproductive health services to deaf persons. Such information is important in designing appropriate interventions for the scaling up the utilization of health care services among deaf persons using trained health workers as the spring board. For the health care providers to render high quality services to deaf persons, it is important to know whether they view themselves as being professionally prepared to render service to deaf persons. It is against this background that the study set out to identify the constraints to sexual and reproductive health service delivery for deaf persons. The participants in this study identified communication as the major constraint to service delivery. The finding is supported by previous studies where it was documented that lack of sign language interpreters and resulting communication problem had a negative impact on the health of deaf persons (Reynolds, 2007). Also other studies (Bachman et al., 2006; lezzoni, O'Day, Killeen and Harker, 2004) have also highlighted communication barrier as a constraint experienced by service providers in health care setting which could affect both access and quality of health services. Communication in health care settings between deaf persons and their health care providers in Ibadan therefore falls below par as elsewhere (lezzoni et al. 2004) and may be one of the main reasons why deaf people use health care services differently from the general population (Steinberg et al., 2006).

The participants in this study who had provided service to the deaf relied solely on writing as the means of communication between them and their client as similarly documented by Arulogun et al (2013), lezzoni et al (2004) and Steinberg et al (2006). While this approach may be helpful commendable, it is not without problems. One of the biggest problems in writing is the limited vocabulary among deaf people whose primary language is sign language and who use spoken and even written language infrequently. In order for writing to be an effective form of communication, providers need to tailor the vocabulary and improve quality of handwriting (Steinberg et al., 2006).

None of the participants had received any training on providing care for persons with a hearing loss, a finding that has been reported by other studies. To overcome this, Levin (2006) and Arulogun et al (2013) recommended that interpreters should be more widely

and readily available and health providers should be trained in working with interpreters during consultations. This recommendation was also echoed by deaf participants in the Steinberg et al. (2006) study who also suggested that interpreters should be used on a more regular basis and that providers learn some basic sign language. For this to be implemented, health care professionals need to be taught the subtleties of working with patients with hearing loss and to recognise the different communication preferences that are associated with differing degrees of hearing loss during their training. This would improve quality of service and reduce mutual frustration (Barnett, 2002).

To create a more deaf sensitive environment, deaf people persons recommended that providers be educated about the medical needs, assistance needs and communication needs of the deaf (Kroll et al., 2006; Yousafzai et al., 2005) as well as being educated about the socio-cultural aspects of being Deaf (lezzoni et al., 2004).

Limitations of the study

Purposive selection of health care providers who took part in the interviews may have introduced some selection bias. Views presented may therefore not be representative of all health care providers. Also, the sample was small and represented only one jurisdiction; hence it may not represent health care providers in other jurisdictions even in the same country. However, one of the strengths of the study was the category of participants interviewed. These were people in the health facilities with close proximity to deaf institutions who could be reached for health care service even in emergencies.

CONCLUSION

This study highlights problems faced by health care providers in providing service to deaf persons. The main barrier experienced by the participants was communication, a problem not specific to the health care environment but also experienced within society at large. This plays an integral part in how the participants render health care services. The responsibility for this problem should not be the health system's alone, as the educational system also shares in this responsibility and has a role to play in revising the training curriculum of different cadres of health providers to include service provision for the disabled especially the deaf.

There is therefore a need for a paradigm shift in national standards related to language access to health care. There should be support for provision of interpreters and involvement of policy outlining required use of professional interpreters.

ACKNOWLEDGEMENTS

This research received financial support from UNDP/UNFPA/WHO/WORLD BANK Special programme of research, development and research training in human reproduction Grant ID A65459. We are grateful to all the respondents for consenting to participate in the study.

REFERENCES

- Arnos K, Isreal J, Devlin L, Wilson M (1992). Genetic counseling for the deaf. *Otolaryngol Clin North Am.* 25 (5), 953 -972.
- Arulogun OS, Titiloye MA, Afolabi NB, Oyewole EO, Nwaorgu OGB (2013). Experiences of Girls with Hearing Impairment in Accessing Reproductive Health Care Services in Ibadan, Nigeria. *Afr J Reprod Health.* 17(1): 85-93.
- Asch A (1998). Distracted by disability. The difference of disability in the medical setting. *Camb Q Healthc Ethic.* 7 (1): 77-87.
- Bachman SS, Vedrani M, Drainoni M, Tobias C, Maisels L (2006). Provider perceptions of their capacity to offer accessible health care for people with disabilities. *J Disabil Policy Stud.* 17(3), 130-136.
- Barnett S, Franks P (2002). Health care utilization and adults who are deaf: Relationship with age at onset of deafness. *Health Serv Res.* 37(1), 105-120.
- Harmer L (1999). Health care delivery and deaf people: practice, problem and recommendation for change. *J Deaf Stud Deaf Educ.* 4 (2):73-110.
- Helen EA, Philip Z (2005). Health care interactions with deaf culture. *J. Am. Board Fam. Med.* 18 1(3):218-222. doi.10.31222
- lezzoni LI, O'Day BL, Killeen M, Harker H (2004). Communicating about health care: Observations from persons who are deaf or hard of hearing. *Ann Intern Med.* 140(5), 356-362.
- Kitzinger J (1994). The methodology of focus groups: the importance of interactions between research participants. *Sociol. Health Ill.* 16:103-21 .
- Kitzinger J (2005). Introducing focus groups. *BMJ* 311:299-302.
- Kritzinger J (2011). Exploring the barriers and facilitators to health care services and health care information for deaf people in Worcester Stellenbosch University <http://scholar.sun.ac.za> December 2011
- Kroll T, Jones GC, Kehn M, Neri MT (2006). Barriers and strategies affecting the utilization of primary preventive services for people with physical disabilities: A qualitative inquiry. *Health Soc Care Community.* 14(4), 284-293.
- Levin ME (2006). Language as a barrier to care for Xhosa-speaking patients at a South African paediatric teaching hospital. *S Afr Med J.* 96: 1076-1079.
- Meador HE, Zazove P (2005). Health Care Interactions with Deaf Culture. *J Am Board Fam Med.* 18 (3): 218-222
- McEwen E, Anton-Culver H (1988). The medical communication of deaf patients. *J Fam Pract.* 26: 289-91.
- Reynolds SA (2007). Deaf Peoples Understanding of Health and Health Care Systems. Dissertation submitted to University of Bristol in requirements for the degree of Master of Philosophy
- Russinga O (2012). Perception of deaf youth and their vulnerability to sexual and reproductive health problems in Masvingo district, Zimbabwe. *Afr J Reprod Health.* 16(2):271-82.
- Steinberg AG, Barnett S, Meador HE, Wiggins EA, Zazove P (2006). Health care system accessibility: Experiences and perceptions of deaf people. *J Gen Intern Med.* 21(3), 260-266
- Tamaskar P, Stern C, Gorenflo DW, Meador H, Zazove P (2000). Preventive attitudes and beliefs of deaf and hard of hearing individuals. *Arch Fam Med.* 9: 518-522.
- UNFPA (2013). Women's watch focus on ability, celebrate diversity: Highlights of the Asian and Pacific decades and disabled persons 1993-2002. social policy paper No.13.
- WHO (2013). Deafness and Hearing loss: Key facts updated 2013.
- Yousafzai A K, Edwards K, D'Allesandro C, Lindström L (2005). HIV/AIDS information and services: The situation experienced by adolescents with disabilities in Rwanda and Uganda. *Disabil Rehabil.* 27: 1357-1363.

How to cite this article: Arulogun OS, Titiloye MA and Desmenu A (2013). Barriers faced by service providers in meeting the sexual and reproductive health needs of deaf persons in Ibadan metropolis: A qualitative study. *J. Med. Med. Sci.* 4(11):433-438