UNIVERSITY OF EDUCATION, WINNEBA

ACCESS TO REHABILITATION SERVICES FOR PERSONS WITH PHYSICAL DISABILITIES: THE CASE OF THE SALVAVTION ARMY REHABILITATION AND ORTHOPEDIC TRAINING CENTER, AGONA-DUAKWA, CENTRAL REGION, GHANA.

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MAY, 2017.

ACCESS TO REHABILITATION SERVICES FOR PERSONS WITH PHYSICAL DISABILITIES: THE CASE OF THE SALVAVTION ARMY REHABILITATION AND ORTHOPEDIC TRAINING CENTER, AGONA-DUAKWA, CENTRAL REGION, GHANA.

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MAY, 2017

DECLARATION

STUDENT’S DECLARATION

I, Anita Yaaya Avoke declare that this research work – Access to rehabilitation services for persons with physical disabilities, the case of the Salvation Army Rehabilitation and Orthopedic Training Center, Agona-Duakwa is the result of my own efforts with the exception of references made to other people’s work and in published articles, which have been dully cited and acknowledged. I declare that this work does not exist in part or whole elsewhere.

Candidate’s name: Anita Yaaya Avoke

Signature: …………………..................… Date: ……………………………………

SUPERVISOR’S DECLARATION

I hereby declare that, the preparation and presentation of this project work was supervised in accordance with the guidelines for supervision of project work laid down by the University of Education, Winneba.

Supervisor’s name: Dr. Yaw Nyadu Offei (PhD)

Signature: …………………......................... Date: ………………………………...

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DEDICATION

To my dear parents, Prof and Dr. Mrs. Avoke, who taught me that in life, the most valuable asset you can give your child is education. To all persons with disability who still find it a struggle to use everyday facilities.

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ABBREVIATIONS

W.H.O	World health organization
P.W.D	Persons with disability
C.B.R	Community – based rehabilitation
S.U	Service users
P.P.D	Person with Physical Disability
S.P-	Service Providers

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ABSTRACT

This was a qualitative study focused on access to rehabilitation services for persons with physical disabilities at the Salvation Army Rehabilitation and Orthopedic Training Center at Agona-Duakwa in the Central Region of Ghana. Data was collected and analyzed thematically with the use of document scrutiny which enabled for data triangulation during the analysis process. Results indicated that persons with physical disabilities had three main types of access to the Center which are, physical, service and personnel access which made their rehabilitation sessions meaningful. Also persons with physical disabilities felt their aptitudes and interest were determining factors in the rehabilitation process. The results revealed interestingly that persons with disabilities felt their service providers should take the lead in decisions that concern their rehabilitation process as such they had very little to say on how services they received could be improved. Prominent among their challenges was finance, as most of the persons were now involved in vocational training for independent living. The study recommends that the management of the Salvation Army Rehabilitation and Orthopedic Training Center need to organize regular in-service training for all their staff involved in the provision of rehabilitation services to persons with disabilities. The training should include new strategies for service provision, collaboration and strategies for fund raising. This would in the long run improve service delivery, address the issue of funds and foster stronger relationships between the Center and other organizations. The Center with the help of the Ministry of Health should employ more staff to address the issue of long waiting times and the issue of staff-patient-ratio. This will enable the service providers render better services and improve on the overall quality of the service delivery process.

CHAPTER ONE

INTRODUCTION

1.0 Background to the study

In recent years, there has generally been an overwhelming demand on healthcare and rehabilitation services for persons with disabilities the world over. The situation seems to be worse in developing countries even though they seem to have the highest number of persons with disabilities. Most of these developing countries do not have the requisite resources and adequate facilities to meet the growing demand of their populace who are in need of rehabilitation services. This has led to an increase in the number of persons with disability seeking rehabilitation services, and an even greater number who do not have access to these rehabilitation services. Accessing healthcare services is a universal human right covered under international instruments like the Convention on the Rights of Persons with Disabilities (CRPD) which states in its 25th article that every person with disability is entitled to the enjoyment of the optimal achievable standard of health without discrimination on the grounds of their disability (United Nations, 2006). Rehabilitation services form part of these crucial healthcare services. The world report on disability estimated that 5.8% of people with disability are unable to access healthcare when the need arises as compared to 3.9% of their non-disabled counterparts. Furthermore, the rate of access for low and middle income countries increased to 6.4% as against 3.9% in developed countries (World Health Organization, 2011).

An analysis of the 2010 housing and population census of Ghana by the Ghana Statistical Services, indicated that some 737,743 persons have some form of disability which translates to 3.0% of the total population with 52.5% of these being female and 47.5% male (Ghana Statistical

Service, 2012). The report further indicated that Region wise, the Central Region accounts for 3.4% of persons with disability placing it fourth out of the ten regions in Ghana. Even though the census conducted by the Ghana statistical service in 2010 covered percentages region wise, there was no further breakdown of these percentages district wise thereby making it quite impossible to know the exact number of people living with disability within a particular district and to also ascertain the number of people who have access to rehabilitation services and those who do not have access to the services per district. The United Nations, 2011 estimates that less than 5% of people living with disabilities in Ghana have access to formal rehabilitation services which they state is as a result of limited services, ignorance and negative traditional practices and beliefs of the people. Notwithstanding, the United Nations findings, there exists limited information on access to rehabilitation services for persons with disability in some developing countries and Ghana in particular.

The World Health Organizations report of 2010 estimated that over 600 million disabled people worldwide, most of these live in developing countries like Ghana. With the high demand on rehabilitation services across developing countries, rehabilitation is now viewed as a process in which people with disabilities and their advocates make decisions about what services they need to enhance participation. It is therefore important that professionals who provide rehabilitation services have the responsibility to provide relevant information to people with disabilities so they can make informed decisions regarding what is appropriate for them (C.B.R. Joint Position Paper, 2004). In order for persons with disabilities to participate in rehabilitation, the rehabilitation services need to be readily available to them in their communities, and in contexts where these rehabilitation services are inadequate or are not readily available, the life of persons with disability could be negatively affected (WHO, 2006).

The world health organization in its attempt to define disability, explained it as an intricate process encompassing bodily functions, health, environment, movement restrictions and limitations in social involvement of an individual (WHO, 2010). In 2011, WHO estimated that 15% of the population globally presents with disabilities, and those with physical disabilities being the most prevalent. The increase in number of people with disabilities globally, according to WHO, is attributed to the population growth, ageing, and emergence of chronic diseases as well as medical advances that preserve life (WHO, 2005). They further stated that these trends create overwhelming demands for health and rehabilitation services which are very far from being met particularly in low-income countries.

The government of Ghana in endorsing the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) passed the Persons with Disability Act 2006 (Act 715) to support services for its populace with disability. In its 15th clause, the Persons with Disability Act 2006 states that the Ministry of Health should ensure as far as attainable, that every person with disability be rehabilitated within the communities in which they live to ensure and foster better and proper reintegration. Ten years after passing the Act, the situation of access to buildings and resources for persons with disabilities still remain an issue. In an attempt of ensuring and upholding the responsibilities enshrined in the Act and in accordance with the World Health Organization's 1964 constitution of ensuring every person has the highest attainable standard of health, the community based rehabilitation approach was employed to bridge the gap between policy and practice. As part of the approach, key components highlighted include health promotion, health prevention, assistive devices, medical care and rehabilitation.

The World Health Organization defined rehabilitation as "a set of measures that assist individuals, who experience or are likely to experience disability, achieve and maintain optimum functioning in their environments"(WHO, 2011,p.3). The World Health Organization further explained rehabilitation as demanding the coming together of different sectors with their varied approaches in conjunction with other relevant professionals within the medical setting or a community setting to help address the rehabilitative needs of persons with disability. The rehabilitation components is aimed at enabling persons with disability (PWD) reach and maintain their maximum sensory, physical, psychological, intellectual as well as social functional levels (United Nations, 2007).

Eva and Wee (2010) were of the opinion that rehabilitation services can reduce the impact of disability on the individual as it contributes to their sense of independence and ultimately promotes their participation in society. Persons with disabilities can better participate and live in their communities if they have access to rehabilitation services and access to the physical environment through the use of assistive technology and devices. Although rehabilitation services can be said to improve the quality of life and improve the social participation of persons with disabilities, it is estimated that amongst the 16% of people living with disabilities in Africa, only 2% have access to rehabilitation services (UN, 2007). Access has therefore, become a global issue when persons with disabilities are concerned and more importantly those with physical disabilities in terms of rehabilitation.

Persons with physical disabilities account for the second highest category of disabilities in Ghana according to the Ghana National Disability Policy (NDP) document (2000). Even with the findings of the report from the Ghana National Disability Policy on persons with physical disabilities, many still are unable to access the much needed rehabilitative services. And with only 2% of persons with disabilities having access to rehabilitation services out of the total global population, it is not surprising that currently in Ghana where the Persons with Disability Act has been passed, Badu (2014), stated that the percentage of people who had received and continue to receive rehabilitation services is unknown. Accessing rehabilitation services enhances equal opportunities for individuals with disability as outlined in the United Nations Standard Rules for Equal Opportunities (UN, 1993).

Due to the insufficient information from the 2010 census, it is difficult to know the number of people who live with disabilities and have access to rehabilitation services within the Agona-East District where the Salvation Army Rehabilitation and Orthopedic Training Centre is located.

1.1 Statement of the problem

Having access to rehabilitation services is crucial in enhancing equal opportunities for persons with disabilities. A report by the United Nations (2007) estimates that amongst the 16% of people living in Africa with disabilities, only 2% have access to rehabilitation services. An earlier interaction during a practical attachment visit in 2012, to the Salvation Army rehabilitation and orthopedic center, in Agona-Duakwa revealed that some of the clients did not know how to access rehabilitation services at the center. Four years down the line, the situation seems not to have changed considerably. This research is motivated by the imperative to establish the nature of service user's access to rehabilitation services on offer at the center.

Again, it was not clear if services devised at the rehabilitation center meet the needs of the service user's. The joint position paper on Disability and Rehabilitation (2004) indicate that rehabilitation services must be tailored to meet the individual needs of service users since no two disabled persons have the same rehabilitative needs. This appears not to be the case at the Center.

More so, interactions with some service providers at the center revealed that there were some inherent challenges that hinder rehabilitation service delivery at the center. Abusalem, Myers and

Aljeesh (2012) opine that Nurses provide the largest proportion of healthcare services to patients in all healthcare sectors and are therefore well suited to identify challenges within the healthcare delivery process.

Furthermore, it could not be ascertained what ideas and suggestions service providers have about improving on service delivery at the Center. With the assertion that each stakeholder in the rehabilitation process brings skills, knowledge, resources and networks and as well advocate for improved accessibility and inclusion of people with disabilities (WHO - CBR guidelines, 2010), it is therefore, important to establish ways of improving the service delivery process from their perspective.

1.2 Purpose of the study

The purpose of the study was to find out access persons with physical disabilities have to the rehabilitation services at the Salvation Army Rehabilitation and Orthopedic Center, Agona-Duakwa, in the Central Region of Ghana.

1.3 Objectives of the study

The specific objectives of the study were to find out:

- How persons with physical disabilities have access to rehabilitation services at the Salvation Army Rehabilitation and Orthopedic Training Center.
- How services planned at the Salvation Army Rehabilitation and Orthopedic Training Center meet the rehabilitation needs of the user's.

- What inherent challenges affect service delivery at the Salvation Army Rehabilitation and Orthopedic Training Center for persons with physical disabilities.
- Ways ensured to improve rehabilitation services at the Salvation Army Rehabilitation and Orthopedic Training Center for persons with physical disabilities.

1.4 Research questions

The following research questions were raised to guide the study:

1. To what extent do persons with physical disabilities have access to rehabilitation services at the Salvation Army Rehabilitation and Orthopedic Training Center?
2. How do services planned at the Salvation Army Rehabilitation and Orthopedic Training Centre meet the rehabilitation needs of the rehabilitees?
3. What inherent challenges face service delivery at the Salvation Army Rehabilitation and Orthopedic Training Centre?
4. What ways are ensured to improve on rehabilitation services at the Salvation Army Rehabilitation and Orthopedic Training Center?

1.5 Significance of the study

The results of this study would help in finding out the extent to which persons with physical disabilities have access to rehabilitation services at the Salvation Army Rehabilitation and Orthopedic Training Center. This would enable the management of the Center find means of ensuring that rehabilitation services are ensured for all service users. In addition, the results of the study would help in finding out how services devised at the Center meet the needs of service users. This would also enable the management of the Center evaluate their services in order to improve on them to meet the needs of their service users.

The results of the study would also help in finding out any inherent challenges the Center face in service delivery for persons with physical disabilities. This would enable management of the Center find means of addressing any inherent challenges. Furthermore, the results of the study would help in revealing ways that are ensured to improve on rehabilitation services at the Center. This would enable the management of the Center find ways of improving on the rehabilitation services for its service users. Finally, results of the study would add to the existing literature for any researcher interested in similar studies.

1.6 Delimitation

The scope of the study covered only the Salvation Army rehabilitation and orthopedic Training Centre in the Central Region of Ghana. The study was delimited specifically to those with physical disabilities at the Centre, the services providers and the parents of persons with physical disabilities. Their responses would therefore not be a representation of persons with physical disability in other Rehabilitation Centers across the country.

The service providers were selected based on the fact that they are the main support that provide the rehabilitation services to the rehabilitees at the Centre.

1.7 Limitation

There was a general difficulty in getting literature that was centered around access mostly in the African context and more specifically Ghana. The poverty of literature resulted in the use of largely Western literature. This notwithstanding, the literature drawn upon was relevant to the study.

1.8 Operational definition of terms

The terms used in the study have been operationally defined.

Access: This refers to the ability of an individual to have information that would be relevant to their needs and decision making. It includes the ability to use a building without any hindrances in terms of structural design and the availability of service providers to the individual.

Rehabilitation services: These are required services or interventions provided to persons with disability in order to help address their needs.

Persons with disability (PWD): The term persons with disability here would be used to cover all individuals who have mobility limitations or any bodily dysfunctions that inhibit their daily movement or activities.

Rehabilitation: The term rehabilitation means to re train an individual who has lost their ability to perform daily functions due to an impairment or a disability.

Physical disabilities: This covers all groups of people who have difficulty relating to movement. They include those with musculoskeletal, neurological and sensory impairments.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter presents the literature reviewed for the study. The literature reviewed covered the following strands:

- The theoretical frame work
- The conceptual framework
- Rehabilitation services for persons with disabilities
- Meeting the needs of persons with disabilities
- Challenges to rehabilitation service delivery
- Improving rehabilitation services

2.1 Theoretical frame works of the study

In this study, theoretical frameworks were necessary as a basis of guiding the discussion on access to rehabilitation services for persons with physical disability. The study is underpinned by three theoretical frameworks namely; the expectancy theory by Victor Vroom, the Andersen's behavioral model of healthcare utilization and the medical model of disability by Oliver. These theories are discussed in more details below.

Victor Vroom's expectancy theory

Victor Vroom is the proponent of the expectancy theory. The theory which is also known as the expectancy theory of motivation was formulated in 1964 in the study of organizational behavior. The theory assumes that behavior results from conscious choices among alternatives whose purpose is to maximize pleasure and to minimize pain. Vroom (1964), proposes that an individual will decide to behave or act in a certain way because they are motivated to select specific behavior over other behaviors due to what they expect the results of the selected behavior will be. In essence, the motivation of the behavior selection is determined by the desirability of the outcome. The expectancy theory is about the mental processes regarding choice or choosing. Vroom states that effort, performance and motivation are all linked to an individual's motivation. He uses three variables in accounting for this thus; expectancy, instrumentality and valence. He explains expectancy as the belief that increased effort will lead to increased performance, instrumentality he says is the belief that when an activity is performed well, a desired outcome will be achieved and valence is the importance one places on the desired outcome of the said activity. These three elements are important behind choosing a specific behavior over another.

The second theory driving the study is the Andersen's behavioral model of healthcare utilization.

The Andersen's behavioral model of healthcare utilization

The Andersen's behavioral model of health care utilization which has been mainly used for explaining health care utilization patterns by the general population was developed in the 1960's. It is a conceptual model that demonstrates the factors that lead to the use of health services. According to the model, health service usage (including inpatient care, physician visits and dental care) is determined by three dynamics: predisposing factors, enabling factors and need for the services. According to Andersen (1960), predisposing factors can be characteristics such as age, race and health beliefs. For instance if an individual believes health services are an effective treatment for an ailment, that individual is more likely to seek care. The enabling factors according to the model could be family support, access to the health center and access to health insurance.

The needs include both the perceived and the actual need for the said healthcare service and they could include restricted activity and activities of daily living.

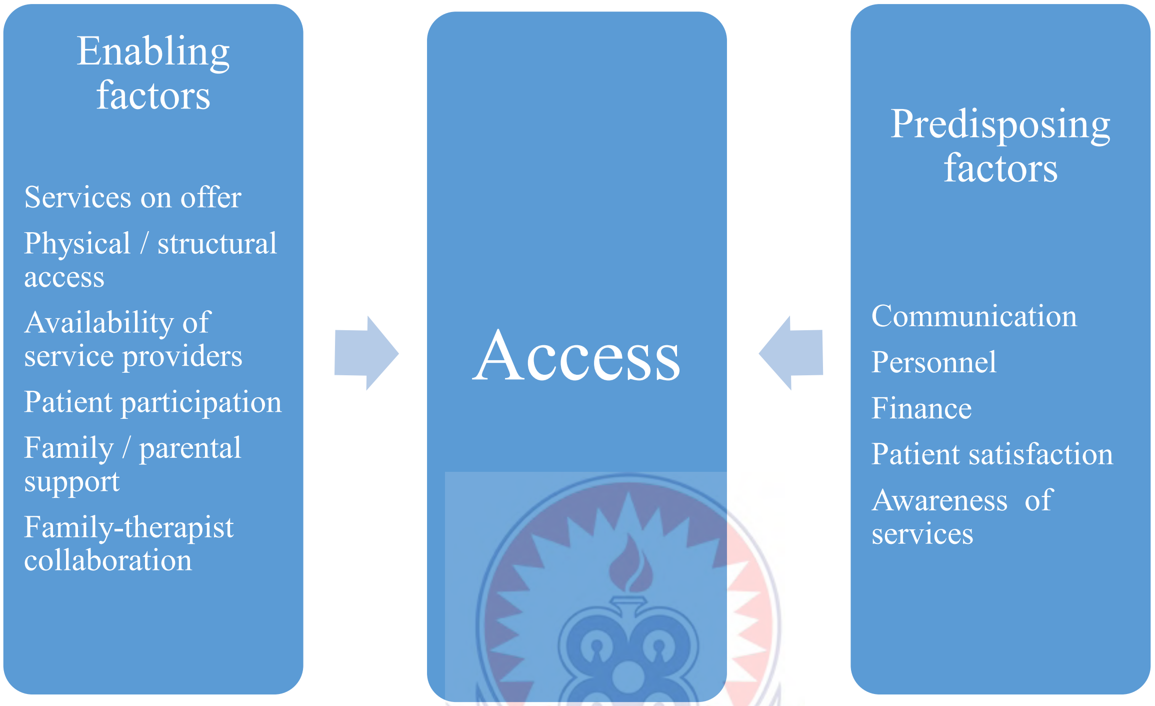
A major motivation for the development of the model was to offer measures of access. Andersen discusses four concepts within access that can be viewed through the conceptual framework. Potential access is the presence of enabling resources, allowing the individual to seek care if needed. Realized access is the actual use of care, shown as the outcome of interest in the earlier models. The Andersen framework also makes a distinction between equitable and inequitable access. Equitable access is driven by demographic characteristics and need whereas inequitable access is a result of social structure, health beliefs, and enabling resources.

The third theory driving the study is the medical model of disability.

Medical model of rehabilitation

The medical model of disability is mostly seen as an individualistic, personal tragedy model informed by medical science (Oliver, 1996; Taylor, 2004). This model is mostly characterized by the belief that the disability is inherent in the individual and medicine would be able to cure, treat or rehabilitate the individual with the disability. As a result professional approaches, services and program measures were aimed at returning the disabled individual to “normal” to compete with the able bodied individuals. According to Finkelstein (2004), as far back as the 1980’s, there were suggestions made that the medical model rendered persons with disability dependent thereby encouraging a helper and helped form of relationship between persons with disability and their non-disabled peers. These suggestions outlined by Finkelstein give hint of the charity discourse as embedded within the medical model of disability through the helper and helped relationship. Anleu (1999), contends that the model though dependent on medical interventions and technologies, and devoid of therapeutic effects can help the disabled individual conform to everyday social activities thereby leading to social inclusion of that person. The medical model of disability has dominated for a very long time the disability discourse in Ghana (Avoke, 2004) and has directed professional practice and disability service delivery. A critical flaw identified within the medical model is that it promotes dependency of persons with disability and fails also to take to account the social and ecological factors that effectively promote or hinder the independence of persons with disability (Smart, 2001).

Figure 1: Conceptual framework for access to rehabilitation services for Persons with physical disability.



Source : Author's construct 2016

Figure 1.1 illustrates the relationship between persons with disability and the various enabling and predisposing factors that determine access for them. It explains the relationship between the various factors and how they interact to enable persons with disability have access to rehabilitation services. The arrows on the diagram show how the various enabling and predisposing factors interact to promote access for persons with physical disability when addressed properly. In the inner box is the ultimate aim of persons with physical disability 'access'. The arrows all lead from the various boxes containing enabling or predisposing factors to the ultimate outcome when conditions are suitable. From the diagram, the independent variable factors which serve as enablers to their access include; availability of services, services on offer, physical/structural access to the facility, availability service providers, patient participation, family / parental support and family therapist collaborations. In an attempt to attain full access to services by persons with physical disabilities, there were predisposing factors or factors that hinder the process and they include, communication, personnel, finance, patient satisfaction with services and awareness of services. An important idea behind the conceptual framework is that it can be used in determining the factors that promote or hinder access to general healthcare services for persons with other categories of disability in general and not just those with physical disability.

2.2 Rehabilitation services for persons with disabilities

The United Nations (2007), explains rehabilitation as an idea that is designed to help persons with disability through the usage of services maintain their best physical, sensory, intellectual and emotional states and in order to be useful members of society. The World Health Organization (WHO, 2011) also defined rehabilitation as “a set of measures that assist individuals, who experience or are likely to experience disability, to achieve and maintain optimum functioning in their environments”. (p.3) The World Health Organization further explained rehabilitation as involving the coming together of different sectors with their varied approaches in collaboration with other relevant professionals within the medical setting or a community setting to help address the rehabilitative needs of persons with disability. Within the community, these rehabilitation programs are known as community based rehabilitation services. Eva and Wee (2010) are of the opinion that rehabilitation can address the impact of disability on the individual as it contributes to their sense of independence and ultimately promotes their participation in society.

Awareness about rehabilitation services

With the growing population and increasing demand for rehabilitation services, not all persons with disability are aware of rehabilitation centers and the services they have to offer. A report by the National Sample Survey Organization (NSSO, 2003) on persons with disability found that very few people with disability are aware of, and benefit from rehabilitation services in India. This growing trend of unmet rehabilitation needs has led to limited participation, restrictions in activities, increased reliance and a fall in the health of persons with disability (Elrod & DeJong, 2008). Effective awareness creation about rehabilitation services and its benefits should be seen as a national issue as persons with disability form a substantial percentage of every nation's population. Prominent among the factors that have been noted to affect the use of health care services among persons with disability, is awareness: awareness about the services and where to get these services and the socioeconomic status of the family (Ensor & Cooper, 2004).

In a study by Srivastava, Khan, Pandey, Pillai and Bhavsar (2014) on awareness and utilization of rehabilitation services among the physically disabled people of rural population of a district of Uttar Pradesh in India, findings indicated the prevalence of physical disability as 19.46 per 1000. The study also revealed that 64.71% of disabled people were unaware of the availability of rehabilitation services, according to the authors, the main reason why people did not avail themselves for rehabilitation services was a lack of awareness. Further findings from the study indicated that among the number of persons with disability who were receiving healthcare services, 65.85% discontinued the treatment and 19.51% had no treatment at all. The authors concluded that there was a lack of awareness and utilization regarding the availability of rehabilitation services in the country. My own study also seeks to establish issues around awareness at a rehabilitation Center in the Central Region.

Accessibility to services on offer

An important determinant of healthcare barriers for persons with disability is accessibility. Sowney and Barr (2004) remark that accessibility is the easy availability of services not only in terms of time and distance but also in terms of healthcare or service providers attitude towards users of those services. In the discussion on access, it is important to know that access is not only limited to the time spent to reach a health center to use their services but also includes physical access, service access (access to the services) and personnel access (access to service providers). For persons with disability to adequately utilize rehabilitation services, these services must be available and easily accessible to them. Although rehabilitation services can be said to improve the quality of life and the social participation of persons with disabilities, it is estimated that amongst the 16% of people living in Africa with disabilities, only 2% have access to rehabilitation services, (UN, 2007). To better promote participation in rehabilitation activities for persons with disabilities, the rehabilitation services must be readily available to them in their communities, in contexts where these rehabilitation services are inadequate or are not readily available, the life of persons with disability could be negatively affected (WHO, 2006). The community-based rehabilitation program is often said to be the bridge between persons with disability and their unmet rehabilitation needs. An essential aim of community-based rehabilitation is empowerment of persons with disabilities, their families and the communities in which they live. In order to achieve this aim, there is the need for services to be accessible and involve the disabled individual and their families in the rehabilitation process (WHO, 2011). An important aspect of the rights of individuals with disability is active participation as stated in the United Nation’s Convention on the Rights of Persons with disability (UN, 2006). This document further states that access to rehabilitation services is key in achieving the desired participation for persons with disability.

Among adults with physical disabilities, participation in rehabilitation activities is an important predictor of life satisfaction however these rehabilitation services should not be imposed on the individual with disability without their consent and participation thus rehabilitation is now viewed as a process in which people with disabilities or their advocates make decisions about what services they need to enhance their participation.

Professionals who provide rehabilitation services have the responsibility to provide relevant information to people with disabilities on where and how to get the services so they can make informed decisions regarding what is appropriate for them. (CBR Joint position paper, 2004). According to the Samuel Wellington Botwey Foundation, a disability focused non-governmental Organisation of Ghana (SWEB, 2014), out of the estimated population of 1,312,500 youth and children with both visible and invisible disabilities in Ghana, less than 5% have access to formally organized rehabilitation services. The few specialized rehabilitation services according to SWEB, are located mainly in towns and cities and are poorly resourced. They further remarked that Community-Based Rehabilitation (CBR) programmes are very limited in Ghana and that the availability of rehabilitation services tends to be concentrated geographically in the higher socioeconomic and metropolitan areas. With the estimation by the WHO (2010) that only 2% of people with disability have access to basic health and rehabilitative services out of the 16% of the total number within Africa, it is not surprising that the SWEB foundation estimated the number who have access to be less than 5% in Ghana, equally, statistics from the Ghana Statistical Services places the disability population at 3% within Ghana (Ghana Statistical Service, 2012).

Kahonde, Mlenzana and Rhoda (2010) conducted a study on persons with physical disabilities' experiences of rehabilitation services at Community Health Centers (CHCs) in Cape Town, South Africa. The study employed in-depth qualitative interviews as a method of enquiry.

Ten persons with physical disabilities who had received rehabilitation services at CHCs were involved in the study. Thematic analysis was used to analyze the data. Findings from the study revealed that clients experienced problems with accessing transport and obtaining information from the service providers. Experiences regarding clients' involvement in the rehabilitation was varied. All clients involved in the study reported positive experiences regarding their interaction with service providers and family involvement. The current study is in line with that of Kahonde et al. as it also seeks to know how persons with physical disability have access to rehabilitation services. It would be interesting to see if clients in the current study would raise similar issues in relation to their rehabilitation process.

Counselling services

Counselling according to Taylor and Buku (2006), is a relationship between two people mainly a professional who is a skilled and experienced and an individual who make be looking for help in understanding themselves, improving decision making, change in behavior or acquiring specific skills for problem solving. In the counselling process, there is no boss and subordinate attitude between the one given the counselling service and the recipient of the services, it is a relationship which is based on an equal basis where opportunities and appropriate environments are created for personal, social, educational as well as vocational growth of the individuals in the process. Gadagbui (2012), remarks that when counselling an individual, a counsellor must not give that individual a sense of false hope but rather out of the results of the diagnostic test conducted, the counsellor should be factual. In being factual, the author noted that, it will be important to bear in mind that an individual's recovery time or period depends on the skills of the counsellor, support of the parent and the overall cooperation from the client. There are various forms of counselling and these are done to achieve certain aims and objectives, but they are all geared towards helping the individual make a decision which would be best for them. Most counselling sessions take place in schools and family settings and in cases where it has to do with a person with disability, the counselling session can take place usually in the rehabilitation center and this form of counselling is known as the rehabilitative counselling.

Rehabilitative counselling

Rehabilitative counselling according to Gadagbui (2012), is concerned with restoring an individual to his or her former capabilities most often in the social, emotional, vocational or physical capacity. It is also a process of providing assistive services to individuals with disability for instance individuals with cerebral palsy, orthopedic disabilities and individuals with hearing impairment. Rehabilitative counselling helps individuals to overcome insufficiencies in any aspect of their lives. When an individual is born with a disability, it becomes a family affair to look after that child and most often, parents are not prepared mentally to assume the position as a mother or father of a child with disability, it therefore becomes very important for the parents to receive some form of counselling from a professional to help them both emotionally and psychologically. The counselling process results in a renewed sense of hope and encouragement in families dealing with their children with disability. Not all counselling sessions are conducted by a professional counsellor, there are instances where people offer advice and consolation in the form of counselling to help an individual who may be dealing with a traumatic event in his or her life.

Physiotherapy services

The goal of any rehabilitation service provision is for the person with disability to regain optimal use of a body part whose function ability has been lost due to an accident or impairment and the functional independence should lead to the attainment of as normal a life as possible. The world confederation for physical therapy (WCPT Policy statement, 2012) explains physiotherapy (physical therapy) as the provision of services to people and populations to help develop, maintain and restore maximum movement and function ability throughout their life span and includes service provisions in conditions where movement and function is threatened by the process of ageing, disease or as a result of an injury. According to the WHO and ICF (2012) movement should be the main aim of physiotherapy, and this is achieved through physical exercises in order to have the most out of the body functions and structures. Physiotherapy plays a pivotal role is the quest for the attainment of functional independence desired by persons with disability and more specifically those with physical disability. Almost all individuals with mobility impairment's and this includes, but are not limited to those with physical disability and cerebral palsy go through some form of physiotherapy service usually for an extended period of time (Damiano, 2009). According to Anttila, Autti-Rämö, Souranta, Mäkelä and Malmivaara (2008), the principal goals of physiotherapy are the enhancement of motor ability, maximizing potentials of the individual with disability to participate in activities of daily living as well as the improvement in the quality of life of the individuals and their family. The role of the physiotherapist in the rehabilitation team is to collaborate with other professionals like the orthotics, the counsellor, the occupational therapist in addressing the rehabilitation needs of persons with physical disability through the teaching of handling skills to the persons themselves and in cases where the children are too young, to their parents in order to facilitate better and easy transition of the individuals into their activities of daily living (Kauser, 2014). The role of physiotherapy in the rehabilitation process dates back a long time, early researchers like Levitt and Goldschmied (1990) assert that rehabilitation personnel's like physiotherapist are not only expected to treat people through exercises but to serve as advisors to the other rehabilitation team members, it would be interesting to establish if same is the pattern at Salvation Army Orthopedic and Rehabilitation Center.

Physical access / structural access

Roads and the outdoor environment, particularly those leading to the health center and its general environment play key roles in determing physical access to any building for persons with physical disability. Physical access is an area of concern for persons with disability but most importantly for those with physical disability since most of these people use mobility devices like canes, wheel chairs and clutches. A study by the African Child Policy Forum which sort to assess healthcare facilities in South Africa, revealed that out of the total number of healthcare service facilities, only one quarter could be accessed by wheelchair users and only a third of the facilities had specially designed or modified facilities like rest rooms for persons with disabilities (ACPF, 2011). Uslu (2008) observes that the needs of persons with disability are as important as the needs of those without, and it is therefore important to include their physical accessibility needs in the planning and designing of buildings. Physical accessibility according to Yarfi (2011) requires making public places open to every individual regardless of their special needs in order to give an equal opportunity to everyone to use those facilities. The United Nations (2011) in its report, also estimated less than 5% of people with disabilities in Ghana as having access to formal rehabilitation. This they noted was as a result of service limitations, ignorance, negative traditional beliefs and practices. The assertion by the UN, is in line with the accessibility audit data from some districts in Ghana, namely Ajumako-Enyan-Essiam, Sekondi-Takoradi, New Juabeng, Ho, Wa, Ashaiman and East Gonja which found that 76.6% of medical centres do not have policies that specifically covered access to medical facilities for people with disabilities. The report further suggested that 57.4% of health facilities do not have accessible structures and environments for wheelchair users (Institute for Democratic Governance, 2011).

In a cross sectional study by Badu, Agyei-Baffour and Opoku (2015) on access barriers to healthcare among people with disabilities in the Kumasi Metropolis of Ghana, 255 respondents were involved in the study and questionnaires were used as the method of enquiry. The study covered three disability groups namely: the deaf, the blind and the physically disabled. Findings from their study indicated that females were the group more likely to experience physical barriers to healthcare and less likely to experience communication barriers. The authors observe that the findings are suggestive of the fact that females have higher demands for health care as found consistently in most literature in health service research. These authors comment further that the findings may also imply females with disabilities are not treated well as compared to their male counterparts at health facilities and as such may experience negative attitudes from health facility staff. Further findings from their research suggest that old age was a factor accounting for some of the access difficulties persons with disability face at the various health facilities. They explained that the age of the disabled person coupled with their disability could make them naturally weak and they are therefore more likely to face physical barriers to structures and equipment at the health facility. This study also confirmed that physically disabled persons generally face more physical barriers than hearing impaired persons. My own study is not exploring the variables of age and gender. It is also further set apart from the study of Badu et.al., by the varying methods of inquiry. While they utilized questionnaires to harvest their data, I am driven by the use of interviews.

Communication

In the healthcare delivery process, provider-patient communication plays a vital role in patient-centered care. (Azizam & Shamsuddin, 2014). Communication according to Schuster (2000) cited in Azima and Shamsuddin, (2014), is the "use of words and behaviors to construct, send and interpret messages. It is a process by which one individual may affect another through written, verbal and non-verbal means" (p.5). When a message is sent, received and understood by a recipient, then communication is said to be effective. Due to the importance of communication, Wallace (2001), is of the opinion that it can be considered the primary medium of care delivery. Thompson (2012), notes that communication is not just about offering information but also making sure that the information provided is understood. Courtney (2010), defines effective communication as a two-way process of sending the right message and it being correctly received and understood by the person on the over side. Hugman (2009), is also of the opinion that effective communication in healthcare means that the healthcare provider makes sure the information he is giving concerning the disease, drug and treatment is well understood by the patient as per the patients' needs and abilities. Building on the statement Smith, Hedrick, Earhart, Galloway, and Arndt, (2010) remark that within the clinical setting, language used by the healthcare providers regularly is of their disciplines thereby making it difficult for patients to properly understand what their healthcare providers may be trying to communicate. Koch-Weser, DeJong and Rudd (2009), explained further by stating that the vocabulary associated with medicine are complex and patients often times face a difficulty in understanding these vocabularies or even in certain instances, misinterpret what the vocabularies may mean. Azima and Shamsuddin (2014), opine that communication in the healthcare setting is not limited to sharing information regarding problems, treatments and possible causes of diseases but looks also at the emotional needs of the patient.

These authors further noted that patients who know and can feel that their healthcare providers are concerned about their health and wellbeing tend to be more satisfied with their healthcare sessions. Within the healthcare setting, Arford (2005), notes that providing the best patient care possible must begin with clear and appropriate communication without which true collaboration among professionals is impossible. Patient participation in communication within the healthcare delivery process is important so as to lower the one way channel of communication. (Ruan & Lambert, 2008).

A study conducted by Cooper, Roter, Johnson, Ford, Steelnwachs and Powe (2003), revealed that busy schedules and high number of patients limit the duration and the quality of communication between patients and their physicians. They noted in addition, empathy and kindness as important factors that were often lacking in the patient-physician communication session and in turn results in a major break in communication. It is further reported by the authors that patient's emphasis on communication, conduct and listening will result in a higher level of satisfaction among patients as they are found more willing to adhere and continue treatment. They maintain also that poor communication skills on the part of the healthcare providers will result in unsatisfied patients which would in turn affect the quality of the treatment and their willingness to conforming to therapy. Herrera-Kiengelher, Villamil-Álvarez, Pelcastre-Villafuerte, Cano-Valle, López-Cervantes (2009), also noted that limited social skills on the part of physicians was a factor affecting communication between the patient and physician.

A descriptive survey research by Anoosheh, Zarkhah, Faghihzadeh and Vaismoradi (2009), on nurse–patient communication barriers in Iranian nursing was carried out in three randomly selected educational hospitals in a large urban city in Iran, with a sample which consisted of 61 patients and 75 nurses, employed questionnaire as its method of enquiry. Results from the study indicated similarities and differences between the two groups of respondents. According to the participant nurses in the study, heavy workloads, hard nursing tasks and lack of welfare facilities for nurses' were the main barriers to communication between them and their patients. The patient participants also stated unfamiliarity of nurses with dialect, having contagious diseases and differences in sex between nurses and patients as their main barriers to communication. Findings from the study further indicated the shared communication barriers between these two groups were age difference, social class difference and contagious diseases. The current study is however set apart from this study as it would employ a case study design and use interviews as its method of enquiry, it would be interesting to see if communication would be one of the factors that affects access to rehabilitation services at the Salvation Army Rehabilitation and Orthopedic Training Center.

Due to the raising importance of communication within the healthcare sector, Cooper, Roter, Johnson, Ford, Steelnwachs and Powe (2003) noted further that effective. Sheldon, Barrett and Ellington (2009) also suggest that effective communication between the nurse and patient enhances the understanding of the patient in relation to their diagnosis, treatment and decisions about future treatment thereby enhancing good patient care planning, education, discharge planning and timely patient outcomes. Healthcare providers have as a duty of care to provide clear information to patients and it is the right of the patient to understand the information in order to be empowered and make the right or informed decision concerning their health. (Lambert, Glacken & McCarron, 2013). Patients being worried about the aftermath of their treatment or a condition which may require hospitalization according to O'Hagan, Manias, Elder, Pill, Woodward-Kron, McNamara, Webb and McColl (2014) is an indication that patients do not fully understand the information's their healthcare providers communicate to them.

2.3 Meeting the needs of persons with disability

Patient participation

Patient participation is a core component of the healthcare delivery process and has become an important concept in rehabilitation and the general healthcare delivery process. It is defined as "the involvement in a life situation" (p.xvi) by the International Classification of Functioning Disability and Health (ICF, 2002) and the communal perception on human functioning. Sahlsten, Larsson, Sjöström, and Plos (2008), also explained patient participation as a relationship between the service provider and the service user where there the former relinquishes some of his authority and control, shares any information and knowledge as they both engage in an activity. Although the idea of patient participation in healthcare and treatment is not a new one, it has only currently become an important governmental necessity in many countries and healthcare systems the world over (Thompson, 2007). With the growing benefits and improvements in health outcomes that mark patient participation, patients are how being considered as partners in the healthcare delivery process, and are being encouraged to actively participate in treatments and decisions concerning their health in order to help improve service provisions for them (Farrell, 2004). The Joint Position Paper on Disability and Rehabilitation (2004), indicates that among adults with physical disabilities, participation is an important predictor of life satisfaction but also advises that the services in the rehabilitation process should not be forced on the individual with disability without their approval and involvement. An important aspect of the rights of individuals with disability is active participation as stated in the United Nation's Convention on the Rights of Persons with disability (UN, 2006). The article indicates that access to rehabilitation services is key in achieving the desired participation for persons with disability. In the planning and decision making process, rehabilitation centers and units are now encouraging active patient participation basing it on the theory that the individual's participation is fundamental to the effectiveness of the rehabilitation process. (Kennedy and Hamilton, 1999). Sabate (2003), is also of the view that patients who actively participate in their own care tend to follow treatments more vigorously thereby reporting better outcomes and satisfaction in relation to their care. Cahill (1996), saw patient participation as a kind of collaboration between the service provider and the patient where both patient and service provider have equal control over the rehabilitation process. Regarding participating, Cahill is of the view that the patient has to participate in the decisions about rehabilitation planning, including goals and means; share information with the professionals; and feel that he or she has some control over the situation. The author views patient participation, involvement and partnership in an order of importance with the term patient involvement at the lowest level and partnership at the highest.

Lindberg, Kreuter, Taft and Person (2013), conducted a study of patient participation in care and rehabilitation from the perspective of patients with spinal cord injury and reported that participation is a critical component of successful spinal cord injury rehabilitation and must be facilitated, promoted and tailored to each patient by the staff. They also stated that in order to facilitate participation in planning and decision-making, it was necessary for staff to recognize the individual's expectations of capabilities for and or special obstacles to his or her care and rehabilitation. Lindberg et. al., opined also that participation in rehabilitation must be tailored to each participant's unique preferences, capacities and needs; staff should recognize that the extent and ways patients may want to participate may vary during the course of the rehabilitation process.

The present study is set apart from that of Lindberg et. al., my focus is on access to rehabilitation services for the physically disabled. It would however be interesting to see if the patients in the current study would hold similar views to those sampled by Lindberg et. al.,

Dijkers (2010), argued satisfaction to belong to two continuums thus the objective and subjective. He describes the objective perspective as things which concern behaviors that can be monitored as for example the number of hours spent at a facility or even the number of hours one engages in an activity within a week. For the subjective perspective, Dijkers explains it as an assessment of the individual involved in the activity and the restrictions experienced by the individual. These two perspectives according to the author account for the changing levels of participation in the rehabilitation process and problems associated with participation. Eldth, Ekman and Ehnfors (2006), also viewed participation from the viewpoint of the patient and indicated that it served as an important opportunity to interact with the service provider and a way of acquiring enough and appropriate information about treatments and medical conditions. Perenboom and Chorus (2003), comment that participation of individuals is within certain parameters which they determine themselves; therefore, the idea of participation is directly linked to the idea of independence.

In a study by Nordin, Fjellman-Wiklund and Gard (2014), in which interviews were used as a method of enquiry with a sample of 17 patients aged 23-59 who had completed multimodal pain rehabilitation, data were analyzed using qualitative content analysis. Findings from the study revealed that some patients felt healthcare professional's reluctance to involve patients in decisions on medication or in development of training programs, restrained patient participation. Further findings indicated that patients' perceptions of healthcare professionals keeping a physical distance were also experienced as limiting patient participation. The study also found service users fell disrespected, neglected and occasionally dismissed in their encounter with health professionals. Such encounters were experienced by patients as restraining patient participation and developing negative thoughts and emotions. The authors concluded that patients experienced restrains in patient participation when they did not obtain appropriate medical help from the healthcare professional. It would be interesting to see if any of the above experiences would reflect in the current study.

Patient satisfaction

Patient satisfaction has become an issue of importance in healthcare. It has been regarded as being an important indicator in determing the quality of healthcare received by a patient. Client satisfaction with care is an important sign of perceived quality of care capable of influencing greatly on patient health outcomes (Alazri & Neal, 2003). These authors note also that perceptions of satisfaction with care and healthcare services received is also often a determinant of eventual obedience to medical procedures and health outcome. Afzal, Rizvi, Azad, Rajput, Khan and Tariq (2014), posit that patient satisfaction is an indicator of the quality of care being provided as well as an indicator of flaws in the healthcare delivery process. They further state that patient satisfaction can be an important tool in improving the quality of services, as it can be used as a tool in the growing push toward accountability among health care providers. Aiello, Garman and Morris (2000), opined that patient satisfaction is what the patient thinks of care received compared with what is expected. Patient satisfaction as a sign of good service received is particularly important within the rehabilitation process, as success in this field is dependent to a large extent upon patients' perceptions, motivation and personal preferences (Kramer, 1997). Benbassat, Pilpel and Tidhar (1998), also comment that active participation in rehabilitation by the patient has a direct influence on the patients' satisfaction with their healthcare service. According to Crowe, Gage, Hampson, Hart, Kimber, Storey and Thomas (2002), the meaning of "satisfaction" has not been well established. These authors stated that "something that satisfies will adequately fulfill expectations, needs or desires, and, by giving what is required, leaves no room for complaint" (p.1). They were also of the view that "a feeling of satisfaction with a service does not imply superior service, but rather an adequate or acceptable standard was achieved thus satisfaction can be measured only against individuals' expectations, needs or desires" (p.1). In determing what the exact meaning of the word satisfaction is, one should not lose sight of the fact that it is a relative idea thus what may make one person satisfied (meets their expectations) may not be the same for another person. (Crow et al, 2002).

In corroborating the view of Crow et. al., (2002), Owens and Batchelor (1996) in a study revealed that in comparing elderly patients versus younger ones, the elderly patients seem more likely to express satisfaction with healthcare services. This they say is as a result of the fact that elderly patients tend to have lower expectations of the healthcare process or services. When satisfaction occurs on the part of a consumer or patient towards a service or product, Dispensa (1997), observed that consumers or patients would communicate desirable information about the said product or service to family or friends with a view of encouraging their patronage of the said product or service. Dispensa commented further that if a consumer is dissatisfied with a product or service, instead of communicating the desirable information of the said service or product they would rather communicate undesirable information, this time with the sole purpose of discouraging the patronage of their family and friends from the said service or product. Consumers according to Ofosu-Kwarteng (2012), can and do pass judgment through their expression of satisfaction or dissatisfaction of a product or service or an aspect of the care process and its outcomes. Powers and Bendall-Lyon (2003), are of the opinion that when seeking healthcare, patients have both cure expectations and care expectations that ultimately set the standard by which they measure their satisfaction with the healthcare encounter.

A descriptive study of patient satisfaction with advanced practice nurses by Brayant and Graham (2002), found that affective support, health information received, decisional control, and technical competence all positively influenced overall patient satisfaction with care. It would however be interesting if some of the factors found in their study reflects in the current one. Power and Bendall-Lyon (2003), are of the opinion that experiences that fall within an acceptable range relative to the patient's standards will result in satisfaction. They note also that patient satisfaction or dissatisfaction becomes a driving force that ultimately shapes their attitudes and behavior. These authors further remarked that satisfaction should be viewed from two perspectives thus attribute satisfaction and interpersonal satisfaction. According to the authors, attribute satisfaction is the patient’s assessment of the noticeable elements associated with a specific healthcare service. These noticeable elements may include the physical environment as well as the physical facilities where these services occur. During the healthcare session, Powers and Bendall-Lyon note that clients are exposed to an array of elements such as the modernity of equipment and the general cleanliness of the facility. In their view these are processed cognitively and they in turn shape their levels of satisfaction. They commented further that interpersonal satisfaction is the client’s assessment of the unnoticeable elements that are related to the interaction between the service provider and the client during the healthcare delivery and they include access and communication, the availability of the physician and other staff of the facility. It would be of great interest to see if findings from my study would corroborate what Powers and Bendall-Lyon noted.

2.4 Challenges to rehabilitation

Finance

In most developing countries, persons with disabilities tend to have lower incomes, complex health conditions and inadequate access to healthcare. The World Health Organisation posits that 52% of persons with disabilities worldwide lack access to healthcare due to their inability to afford it, as compared to 32.8% of the population without disability (World Health Organization, 2011). This situation is more worrying as the number of people living with disability increases due to population growth, ageing, emergence of chronic diseases and medical advances that preserve and prolong life (W.H.O, 2005). Even though the Disability Act 2006 of Ghana in its section 31 mandates the formation of policies to provide free general and specialized medical care, rehabilitative operation treatment and appropriate assistive devices for Persons with Disabilities, provisions being made for persons with disabilities in Ghana is still inadequate (Mensah, Williams, Atta-Ankomah & Mjomba, 2008). Preker and Carrin (2004) posits that vulnerable groups including persons with disability are unable to generate enough income towards attainment of healthcare services, this they attribute to the fact that most disabled individuals and vulnerable groups are unemployed thereby making it difficult for them to save up enough money to attend to their various health care needs. In addition, to their inability to attain healthcare due to unemployment, the World Health Organization (WHO, 2013) indicates that physical proximity is another major reason why vulnerable groups and persons with disabilities are unable to obtain healthcare services in developing countries. The proximity from the dwelling places of persons with disabilities to healthcare centers coupled with travel times tend to create barriers to healthcare accessibility. Apoya and Marriot (2011) asserted that out of the total population of Ghana, one-fourth of the populace live over 60 kilometers away from the nearest health facility there by making it even more difficult for persons with disability to attain healthcare services since most of them live far away in the slums of the communities and are unable to afford the transportation costs to these health facilities. In view of this, persons with disability are at an even higher risk of developing health-related conditions (Muderedzi & Igstad, 2011). Fitzgerald (2007) and WHO (2011) suggest that persons with disability are most likely to lead unhealthy lives and may most likely suffer from malnutrition and various types of diseases as a consequence of unemployment and lower income. This phenomenon accounts for the higher patronage of traditional healers on the part of persons with disability (Brocklehurst & Costello, 2003).

In a cross-sectional study involving semi-structured questionnaires and a sample of 255 respondents covering 5 clusters of communities in the Kumasi Metropolis by Badu, Opoku, Appiah and Agyei-Okyere (2015) on financial access to healthcare among persons with disability in the Kumasi Metropolis Ghana, found that among the respondents, the average monthly expenditure on healthcare was GH₵ 21.46 (USD 6.0) which constituted 9.8% of their income. There were more male than female participants involved in the study and nearly one-third of them had no formal education and 28.6% of them were unemployed. The study found factors such as age, gender, disability type, education, employment and whether or not they were living with family members as having a significant bearing on the average monthly expenditure on healthcare. Further findings reveled cost of transportation, travel distance to facilities and the regular sources of payment for healthcare all had significant relationship with access to healthcare. The current study however is set apart from that of Badu et al, as it does not seek to research on the financial access of healthcare among persons with disability but rather to look at access to rehabilitation services for persons with physical disability with finance being a component of the accessibility process for those with physical disability. It would non-the less be interesting to see how their findings play out in the current study.

<u>Staff</u>

The ever important role the health workforce plays in the progress of the healthcare sector has been progressively acknowledged with a lot more attention being given to training, planning, scope of practice, staff retention and human resource management. (Joint learning initiative, 2004; W.H.O, 2006). In developing countries like Nigeria, well trained and motivated workers are not usually guaranteed in the health sector and the situation is even worse in rural areas (Awofeso, 2010). With more pressure on healthcare services, there is a higher demand for more healthcare workers as equitable distribution of healthcare workers is necessary for improvement in access to health care, as well of the quality of services rendered (Obembe, Osungbade, Olumide, Ibrahim & Fawole, 2014). The Canadian Nursing Advisory Committee (2002) acknowledges Nurses as the main group of health-care professionals thus the quality of service provision is dependent largely on the sufficient supply of these personnel.

In-service training

Institutions charged with providing healthcare services have a duty of ensuring that care provided by them and their staff is of the maximum quality (Booyens, 2004). The quality of the services they render can be greatly improved if the workforce is knowledgeable about modern developments in their various fields of specialization through in-service training (Erasmus, Loedolff & Nel, 2009). Muller (2004) defines in-service training a process of informal training where healthcare professionals have opportunities to improve and upgrade their specialized skills, knowledge and learn new attitudes that are beneficial to the demands of their profession. Over the years in-service training has become one of the many avenues through which health professionals get equipped with modern trends to render better services to their clients (Muchinsky, Kriek & Schreuder, 2003). The importance of in-service training in any organization cannot be underscored, Booyens (2004) and Erasmus et al., (2009) opine that skills and knowledge of healthcare professionals are directly linked to the quality of healthcare they render to their patients thus organizations or healthcare institutions that invest in in-service training either by organizing or participating in them have better service outcomes as a result of improvement in skills and ability of their workers. In order for healthcare professionals to maintain a high standard of healthcare provision, healthcare professionals need to periodically undergo in-service training.

2.5 Improving rehabilitation services

Under improving rehabilitation services, the following issues would be discussed:

- Family involvement
- Family-therapist collaboration

Family involvement / Parental support

According to Foster, Armstrong, Buckley, Sherry, Young, Foliaki, James-Hohaia, Theadom and McPherson (2012), the term family broadly includes all those who influence recovery of an individual with disability, they may be family members, friends and significant others who may take on the caregiving or support role to the disabled individual. These authors explained further that aside the individual with disability, family can be considered one of the most important members of the rehabilitation team. They further state that the family provides information concerning the client and in some cases take decisions with or on behalf of the client. Kreutzer, Stejskal, Ketchum, Marwitz, Taylor and Menzel (2009), also opine that actively involving the family in the rehabilitation process can have an effect on the degree of recovery in the individual. The all too important role of the family in rehabilitation cannot be underestimated.

The family is the immediate form of socialization for the individual and in most cases the person with disabilities rate of recovery hinges more on the encouragement the family members give than the services the individual receives. A rehabilitation services that has the basis of achieving optimum outcomes for its patients should therefore give precedence to supporting the family members of the patient and find ways that would allow them to engage as much as possible in the rehabilitation process. (Foster et. al., 2012).

A structured interview survey on physical therapists perception of family involvement in the rehabilitation process by Ryan, Wade, Nice, Shenefelt, and Shepard (1996) using a convenience sample of 40 physical therapists from 35 rehabilitation facilities in Eastern United States of America (E.U.S.A), found all participants reporting that they encouraged family participation in the therapy sessions which included observation of the treatment session, training exercises, demonstrations and even written information on home exercise programs and also organized home visits to work with the family in their natural environment. Further findings from the research indicated four major factors which could either facilitate or hamper family involvement. These factors according to Rayon et. al., (1996) include issues that were related to the family, the patient, the therapist and the healthcare organization. In their view Physical therapists identified family members' flexibility and availability, cognitive skills, relationship with the patient, financial status and their emotional state as barriers or facilitators to their involvement in the rehabilitation process. Commenting further they remarked that a potential barrier identified by the family according to the findings was the experience and confidence of the physical therapists. Commenting further, Rayon et al., suggested, more experienced physiotherapists, are more likely to involve the family in their everyday therapy sessions. By addressing issues that pertain to the care of the patient through conflict resolution and effectively addressing disparities and priorities that may arise between the family and the rehabilitation professionals, the families views regarding the importance of the rehabilitation process can be changed thereby encouraging more or active involvement in the whole process. (Kreutzer, Stejskal, Ketchum, Marwitz, Taylor & Menzel, 2009). Another study conducted by Galvin, Cusack and Strokes (2008), investigated the views of 75 people with stroke and 100 friends /family of these individuals in Ireland. The study employed a questionnaire to identify current rate of family involvement and to ascertain whether or not these family / friends would be willing to engage in training to learn how to carry out physiotherapy exercises when the person was discharged. Seventy nine (79%) percent of the individuals with acute stroke reported that their family members had not been invited to be involved in their physiotherapy sessions and 87% expressed an interest in the involvement and training of their family and friends in carrying out physiotherapy exercises. Those individuals, who did not wish their family members be involved, reported reasons including; the opinion that it was not an appropriate role for their family /friend, not feeling confident in their relatives' abilities to undertake rehabilitation activities and perceiving that family members could express unrealistic expectations during rehabilitation and put pressure on them. The authors indicated that the potential barriers to family involvement comprised concerns such as the appropriateness of the involvement of their family member/friend, confidence in family/friend abilities and concerns about potential conflict in the relationship due to differences between the expectations of the person with stroke and their family members/friends' expectations of the rehabilitation process. It would be interesting to see how patients in the current study would view the involvement of family members in their rehabilitation process.

Galvin, Cusack and Strokes (2009), in a separate study explored the views of 10 expert physiotherapists on the role of the family using a qualitative focus group methodology. The physiotherapists reported the carryover of treatment as a benefit of family involvement in the rehabilitation process. They identified also level of interest and motivation, education and availability as factors that could influence family involvement. The physiotherapists however did not identify any service barriers to family involvement. Findings from the study indicated that majority of the participants in the study perceived family involvement to be beneficial in the rehabilitation process. Levack, Dean, Siegert and McPherson (2009), are also of the view that decision making processes such as goal planning that involves the family can make the family more interested in engaging in the rehabilitation process as through their involvement, they help identify outcome expectations for the patient and transfer skills and knowledge gained from the hospital to the home.

Family- professional collaboration

Involving the family as a partner in the rehabilitation process of persons with disabilities is an ideal in this twenty first century where more healthcare providers are moving towards family and client centered care. The term partnership however can be defined and used in different ways, partnership maybe used ultimately to mean professionals recognizing family members as contributors who provide information about the patient and their condition in a mutual relationship with professionals or it may be viewed also as a relationship where two or more people (family and professionals) with the same goals agree to work together to attain a specific target. (Frank & Smith, 2000). Within the health sector, family-professional collaborations are an essential aspect of the health care delivery process and are developed on mutual respect, sharing of information, trust, shared decision making, open communication and processes that involve family needs, beliefs and preferences pertaining to treatment and interventions. (Keen, 2007). Families according to Cioffi (2006), are the most central and enduring part of any person's life. In many societies, illness is a family affair and family members are expected to play important roles in the care-giving process. (Chang & Harden, 2002). Ahmann and Dokken (2012), opine that developing and increasing skills in professional partnerships with family members are therefore essential in helping address some of the challenges that come along with the care-giving process.

Despite the important role of the family in an individual's life, family collaborations with care givers do not always happen in practice as service providers most often only speak of the collaboration but do not practice it. (Levack, Siegert, Dean, & McPherson, 2009). It is generally assumed that collaborations between the caregiver and the family are beneficial and as such should be encouraged. On the contrary, Hinojosa, Sproat, Mankhewit and Anderson (2002), remark that therapists spend less time focusing on the child's needs as more time is spent on review of home instructions and teaching position handling techniques to the parents as part of the collaboration process. In a qualitative interview study based on 98 professionals, Hodges, Hernandez and Nesman (2003), propose five developmental stages of collaboration;

1. Individual action (independent action on behalf of children and families, no specific collaborative activities)
2. One-to-one (several service delivery agencies are involved with the child/family, core groups may develop)
3. New service development (stronger child centered approach to providing services and introduction of formal collaborative structure)
4. Professional collaboration (well-developed professional collaborations among child-serving partners)
5. True collaboration (families fully involved in service delivery). True collaboration incorporates "qualities of role clarity for family and service providers, interdependence and

shared responsibility among collaborating partners, vision-driven solutions and focus on the whole child" (p.297).

In a survey and focus group study by Teggart and Linden (2006), which investigated service users and careers views of children and adolescent mental health services in Northern Ireland, 68 participants were sampled. It was found that both service users (child or adolescent) and caregivers (parents) expressed a willingness to work collaboratively with healthcare providers. Participants from the study were also found to be interested in "developing care and treatment plans and sharing information; models of treatment and service provision should be developed along lines that would enhance such collaboration" (p.40). It would be interesting to see if findings from my study reflect those of the above mentioned study. Bamm and Rosenbaum (2008), indicated that rehabilitation professionals have sort to develop collaborative relationships mainly by providing families with knowledge concerning therapies and skills.

2.6 Summary of literature review and notable gaps in the literature

The literature even though has been able to expound the various factors that account for access to rehabilitation services, it is noted that the concept of "access" differs depending on who and where the services may be offered. To some, access my mean being able to use the physical structures that at present and to others, it is not limited to the physical structures alone but includes the entire process of communication right through to the availability of service providers and individuality of services on offer.

A notable issue emerging from the literature is the importance of patient participation and satisfaction in the access process. It is also clear from the literature that notwithstanding the importance physical structures play in the access process for Persons with disability, there are still a number of health facilities that are not disability friendly.

The literature revealed that there wasn’t enough research done on rehabilitation within the Ghanaian context as a result, the literature used was mainly from Western and East African Countries. Nonetheless, according to the literature, access to rehabilitation services promotes the independence of persons with disability.

Even though some attempts have been made by Ghana to provide the necessary rehabilitation services to Persons with disability, there is still a large population of Persons with disability who do not have access to these services as a result of a lack of awareness about them and their inability to access physical structures.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents the methodology for the study. The following areas were covered: the research approach, research design, population, the sample size, sampling techniques and instrumentation, validity, reliability, procedure for data collection and data analysis.

3.1 Methodology

This study employed a qualitative method of enquiry. The choice of a qualitative approach is based on its appropriateness and also on the fact that in qualitative inquiry the intent is not to generalize to a population, but to develop an in-depth exploration of a central idea (Creswell, 2005). Creswell notes further that the use of the qualitative approach in educational research allows the researcher rely on the emic views of participants; to ask questions generally and collect data in the form of text from the participants. Creswell's opinion is that qualitative research is a useful tool in understanding in depth a central idea through asking of specific questions in an attempt to unearth and collect detailed information from participants (Creswell, 2003). Since this study seeks to explore the access to rehabilitation services which centers mostly on the emic views of the participants, with an attempt at thematic analysis of the data collected, it justifies the use of the qualitative research design.

The choice of a qualitative approach was also based on its ability to bring me closer to the reality of the phenomenon through an interaction with the respondents thereby leading to an in-depth oral depiction of the said phenomenon (Sarantakos, 1998). This study, like most qualitative studies is generally descriptive. In this study, I was to build a picture of the ecology through the gaze of the participants, a strong justification for the use of the qualitative methodology in this research.

Furthermore, the flexibility of the qualitative methodology was critical in building a picture of the entire ecology from the viewpoint of the respondents. The seeming flexible nature of most qualitative designs does not make them substandard in comparison to the quantitative methods as every type of empirical research has an implied if not obvious design (Yin, 1994).

Although qualitative studies are not easily generalized, Maxwell (1998) suggests that the value of a qualitative study may depend on its lack of generality in the sense of being representative of a larger population. According to the author such a trend may provide an account of a setting or population that is illuminating as an ideal or extreme type case. I do not intend to generalize the findings from this study but to reveal it as an ideal or extreme type peculiar to the Salvation Army rehabilitation and orthopedic training Center alone, which is in accordance with Maxwell's value of a qualitative study, and Avoke (2004), has also commented similarly.

3.2 Research design

A research design is a strategic framework for action that serves as a bridge between the set research questions and the execution of the research itself (Durheim, 2002). This research adopted a case study design. The case study design is a strategy for conducting research which involves a realistic investigation of a particular modern-day occurrence within its real setting using multiple sources of evidence (Robson, 2002; Yin, 1984). Robson contends further that the case study is not a flawed experimental design but an essentially different research strategy with its own design. This research intends to use interviews and document scrutiny as a method of data collection and consistent within the qualitative paradigm and other naturalistic enquiries therefore well justified for this study.

The case study design is appropriate within the qualitative paradigm. It is therefore well-chosen and appropriate for a study of this nature which sought the views of a typical population within the context of access to rehabilitation services in a defined ecology s as the Salvation Army Rehabilitation and Orthopedic Center.

3.3 Population

The population for the study includes all service providers at the center, persons with physical disability and the family members of the persons with disability. The estimated population for this study is 50. This population is made up of twenty (20) service providers, twenty (20) persons with physical disability and ten (10) parents of persons with physical disability.

3.4 Sample size

The sample size for this study was fifteen (15) respondents. This consist of five (5) physically disabled persons, five (5) family members of persons with physical disabilities and five (5) service providers at the Rehabilitation Center.

According to Krathwohl (1993) a sample is a group or subset of the larger group (population) and it is intended for it to represent the population. A carefully selected sample can provide data representative of the population from which it is drawn. Holloway and Wheeler (2002) assert that "sample size does not influence the importance or quality of the study and that there are no guidelines in determining sample size in qualitative research" (p.128). These authors state that qualitative researchers do not normally know the number of people in the research beforehand; the sample may change in size and type during research. Due to the design of the research and the fact that case studies lend themselves to small numbers in order to better explore and study in detail a phenomenon, the sample size was justified. In this study however, the numbers did not change.

3.5 Sampling technique

The purposive sampling technique was used to select all participants for the study. Creswell (2003) stated that in purposeful sampling, "researchers intentionally select individuals and sites to learn or to understand the central Phenomenon" (p.194). Maxwell (1998) also explained that the purposive sampling allows for the researcher to deliberately select a particular setting, persons or events based on the importance of the information they can provide which would not be gained elsewhere. Cohen, Manion and Morrison (2003) were also of the view that the purposive sampling technique allows the researcher to handpick the cases that are to be included in the sample on the basis of their judgment and typicality. Guided by the admonishment of Creswell, (2003), Maxwell (1998), and Cohen et. al., (2003), I handpicked all the fifteen (15) respondents in the study based on the typicality of their views. These individuals were made up of persons with physical disability who were still receiving services from the center, using an assistive device and were either schooling or in a vocation of some sort. The service providers were those who were directly involved in providing services to the individuals with physical disability and these included a physiotherapist, rehabilitation officer, nurse, psychologist and an orthotist. The parents of persons with physical disability were parents of children with physical disability who were receiving rehabilitation services at the center but were not using any assistive device yet.

3.6 Instrumentation

<u>Interview</u>

A semi-structured interview guide was used to collect data. The interview consisted of three separate focus group discussions. The groups that were involved in the study were persons with physical disability, service providers and parents of children with physical disability. The interview as a method of data collection allowed an open-ended exploration of the topics in the research as well as stimulate responses that would be understood in the unique words of the respondents (Gall, Borg & Gall, 1996). The semi-structured nature of the interview allowed participants to freely express themselves and enabled me to ask questions that would not elicit just a yes or a no answer.

Interview questions for the service providers were not given to them ahead of the interview date even though they requested for it. This was done in order to preserve the information that would be collected making it more "natural". There were also questions for the individuals with physical disabilities and parents of persons with disability. Robson comments that semi structured interviews allow the interviewer to set questions ahead of the interview but is free to modify those questions based on what the researcher deems appropriate or relevant (Robson, 1993). With the suggestion by Robson (1993), I developed an interview guide ahead of the interview to guide the discussions. The guide contained semi-structured questions based on the objectives of the research topic. The semi-structured nature of the questions allowed the researcher to probe further for a more detailed information gathering. Prompts were used to aid further exploration during questioning and also tease out more interesting responses which I did not predict before the interview.

In general, the use of the semi-structured interview guide allowed the respondents to 'express and contextualize their true feelings rather than pigeon-hold into boxes with no or little opportunity for contextual explanations' (Kitchin, 2000, p.43). Participants in all focus groups were encouraged to freely express their opinions and be honest about their responses. The interview sessions were tape recorded with permission from participants and written notes were taken as a way of compensating for any malfunction or difficulty that may present from the tape recorder. Robson (2003), comments that the tape recorder helps the moderator remember details collected during the interview and allows for easy interpretation of the data. After each session the tape recorder was played back to the participants to ensure what they said has been recorded. This also served as a way of ensuring respondent validation of the recorded material.

Focus group interview

As stated already, a focus group interviews were utilized. Focus group interviews according to Creswell (2003) are noted mostly for their potential to provide interaction among the people being interviewed (interviewees), collecting extensive data and the participation by all individuals being interviewed in the group. Creswell (2003), was of the opinion that focus group interviews were disadvantaged when it comes to responses because some few individuals may dominate the whole conversation in turn bringing about responses that may not necessarily reflect the general concurrence of the group. Stewart and Shamdasani (1990), opine that 'focus group research may be one of the few research tools available for obtaining data from children or from individuals who may not be particularly literate' (p.509). With the assumption that not all participants are particularly literate, the focus group approach was very relevant to the study.

In order to avoid a scenario were an individual takes over the entire interview discussion, I acted as the moderator during the interview sessions and adopted a conversational approach which allowed even the shy and reserved members within the group the opportunity to talk. The role of the moderator is supported by Fern (2001), who opines that an effective moderator keeps the discussion focused but at the same time does not discourage the sharing of ideas and gets all members in the group to participate while making sure that no individual or group of people dominate the discussion. The focus group discussions which took place in a room at the Center, free from noise and interference from other users was made up of 3 groups with five participants per group. In each of the four groups, the interview guide was the blue print in directing the course of the interview. Since the purpose of the interview was explained prior to the interview, there was no need for further explanation at the beginning of each session. The interviews lasted between 30-40 minutes and everyone was encouraged to participate.

Document analysis

Documents form an important aspect of qualitative data analysis (Creswell, 2003; Avoke, 2003). Document analysis is particularly used in qualitative case studies or studies which are rich in producing descriptions of a single phenomenon, event, organization or program (Stake, 1995; Yin, 1994). The process of analyzing document as a data collection tool involves the skimming (superficial reading), reading (thorough examination) and interpretation of the information's available in the documents (Bowen, 2009). Corbin and Strauss (2008) contend that like other investigative approaches, document analysis involves data being looked at and understood in order to deduce meaning, gain understanding and develop practical knowledge. Policy documents for Persons with disability from the Salvation Army rehabilitation and orthopedic center, the Persons with Disability Act (Act 715) of the Republic of Ghana, as well as the United Nations Convention on the Rights of Persons with Disability were examined and relevant information's obtained were used to help in the data analysis process. The usage of document in qualitative research allows for the triangulation of data. As in this research, they were critical in triangulating data from the focus group interviews. Merriam (1988), argues that 'documents of all types can help the researcher uncover meaning, develop understanding and discover insights relevant to his research problem' (p.118).

3.7 Procedure for data collection

Negotiating through the gate keepers

A letter was written by the Head, Department of Special Education, University of Education, Winneba to the Head of the Salvation Army rehabilitation and orthopedic center in Agona Duakwa to introduce the researcher. With the letter, a visit was made to the center to seek permission to conduct the research. As with most qualitative studies, negotiating your access with the gatekeepers was necessary. A discussion was held on the 5th of October, 2016 with the Head of the Center to explain the details of the research and agree on a suitable date and time for the researcher to go and collect the needed data. The date, time and place for the focus group discussions were agreed upon with the head of the center and the head of the rehabilitation unit thus October 17th, 2016 through to 3rd November, 2016 at exactly 9:00 am each day at the center, schedules were confirmed a day before the start of the interview date. Permission was sought also from the staff of the Center since they were also directly involved in the study. This was necessary because assent from the Head did not guarantee consent from the participants. The venue which was the center was selected in order to facilitate the easy access of respondents for the interview. Participants were given light refreshments at the end of the interview discussion.

Period of data collection

The first interview which was with the service providers of the Center took place between the 17th and18th of October, 2016. Focus group interviews for the persons with physical disability took place between the 24th and 27th of October and that for the parents of persons with physical disability took place on the 20th of October, 2016. Document analysis was between the 31st of October, and the 3rd of November, 2016. The data collection period covered a period of three weeks, and was guided by the time lines outlined above.

3.9 Reliability

Piloting

In order to determine the reliability of the interview items, a pilot study was carried out. The semi-structured interview guide was pre-tested at the Mephiboseth on the 23rd of September 2016**.** The aim of the pilot study was to ascertain how feasible the instruments were and where necessary, delete irrelevant statements from the interview guide. Conducting a pilot study according to Cohen, Manion and Morrison (2003), helps in establishing the reliability, validity and practicability of the instruments and helps:

- Check clarity of questions
- Gain feedback on how valid the test items may be
- Remove vagueness in the questions
- Ensure that the required data collected would answer the research questions
- To check and address the coding or system of classification for the analysis of collected data

The sample involved in the pilot study was eight (8). This was made up of three (3) service providers, two (2) parents and three (3) physically disabled users of the facility. The facility was chosen since respondents there had similar characteristics of the intended respondents for the study but were not part of the study. All eight (8) respondents were purposively sampled for the study due to the depth of knowledge they had that was of interest to the researcher. The interviews were tape recorded with permission from the respondents. Respondents were assured of confidential treatment of the data which encouraged them to be open in answering the various questions asked. The interviews lasted an average of 20 minutes. The feedback received from the respondents helped the researcher correct some items in the interview guide. It was also realized that some interview questions were ambiguous, thereby making it difficult for respondents to know exactly what the researcher was asking. Results of the pilot study also indicated that there were some problems associated with the understanding of specific words used in the interview guide. These views were collected and studied by the researcher and her supervisor at the University of Education, Winneba. Items in the interview guide were revised and questions were made more focused and sharp while certain phrases used were edited and these served as a guide in finalizing the questions in the interview guide. All corrections were affected before the final collection of the data.

3.10 Validity

Validity is very important within any research that aims to ensure that people's opinions and experiences are properly represented (Macmillan & Schumacher, 2001; Rodgers, 1999). In qualitative research, validity is ensured through trustworthiness and authenticity of the collected data. To ensure this, tapes were played back to respondents to make sure that what was going to be analyzed were the correct responses from the respondents. Creswell (1994), opines that trustworthiness and authenticity are an important viable stance in interview data. To establish the face validity of the interview guide, it was given to my supervisor and some lecturers at the Department of Special Education as well as fellow colleagues for their inputs and comments.

Suggestions made on the quality of interview items were effected before they were used to collect data.

3.11 Reflexivity

Reflexivity in qualitative research is an essential concept as it poses a potential threat to how accurate our research outcome is. It is the determinant of the social power relationship pattern between the interviewer and interviewee (Kvale, 2002). As a qualitative researcher, the act of reflection allows for a thorough consideration on how opinions of the interviewee about the interviewer on things like age, gender or socioeconomic status could prevent the interviewee from giving accurate information during the interview process. In order to curb this phenomenon, I took part in one of their general meetings and developed a relationship with some clients and on days of the interview, I walked to the Center with my interviewees so that they would not feel uneasy with my presence. This enabled me to get the most accurate picture of situations at the Center and added more credibility to the qualitative work.

3.12 Procedures for data collection

Qualitative data analysis according to Marshall and Rossman (1989), is 'a search for general statements about relationships among categories of data' (p.112). Maxwell (1998), also states that coding is the main categorizing strategy when it comes to qualitative research.

Analysis of data from interviews

The process of data analysis for the focus group data began with carefully reading the transcripts and notes from the interview. Themes and similar ideas were looked for and grouped. Miles and Huberman (1994), are of the opinion that focus group interviews could be analyzed by reducing data through thematic grouping and the collating of interview data into predetermined themes.

Response from the respondents were coded into specific categories for better analysis. Stewart and Shamdasani (1990), described the coding process as the translation of responses to questions asked and respondent information given into specific categories for analysis. The coding process allowed the researcher to organize large amounts of text, and at the same time discover patterns that would have been difficult to detect just by listening to a tape recording or merely reading a transcript (Goldenoff, 2004; Cohen, Manion & Morrison, 2003). The aim of analyzing the interview data was to look for trends and patterns that reappear throughout the focus group discussions. In analyzing the contents of the transcripts, the researcher considered the strength of comments from the respondents as well as the consistency of those comments and how specific their responses to follow up probes were. The interview data obtained from the focus group discussions were analyzed using the qualitative content analysis procedure (Babbie & Mouton, 2002). Once a thorough transcription of comments from respondents was made, data was categorized and grouped under appropriate themes. The content of each theme was examined in order to discover its meaning and its specific implication in relation to the research question (Stewart & Shamdasani, 1990). Conclusions were drawn from the developing patterns and possible themes. Possible explanations were also given to the data, evidence was shown to back up those possible explanations and considerations made in relation to the possibility of repetition in other sets of data.

Analysis of documents

The investigative procedure of document analysis involved finding, choosing, evaluating and combining the data contained in the policy documents of the Salvation Army Rehabilitation and Orthopedic Center. This was done through scanning of the relevant documents, data excerpts, quotations and where necessary, entire passages were organized into major themes, categories and reviewed through content analysis (Labuschagne, 2003). Predefined codes developed for the interview data were applied to the contents of the documents. In order to establish that the content of the documents being analyzed fits the conceptual framework of the study, the researcher selected policy documents and yearly reports of the center in order to establish authenticity, credibility, accuracy and representativeness of the selected documents (Bowen, 2009).

3.13 Ethical considerations

There was the need for ethical considerations during the process of this research. The purpose of the ethical consideration in research according to Kimmel (1996), is to safeguard the rights and the welfare of the research participants (respondents). Due to the qualitative nature of this research, I was mindful of the ethical values of the respondents as the study involved an interactive collection of data and exchange with respondents (McMillan & Schumacher, 2001). These authors remarked that ethical guidelines include informed consent seeking, confidentiality, anonymity and privacy among others. All respondents were informed that no participants name was going to be used in anyway in the final write up, codes were used to represent each respondent instead. Participants and the institution were promised access to copies of the findings from the study.

CHAPTER FOUR

DATA ANALYSIS AND DISCUSSION OF FINDINGS

4.0 Introduction

This chapter presents data analysis and discussions of findings. The findings are presented in accordance with the themes posed to guide the study. All data gathered were analyzed in order to uncover relationships, discover patterns and substantiate findings and develop meaningful research (Babbie, 2001).

In all, four questions were raised to guide the study. In the analysis of the results, the various themes were restated. Verbatim expressions from respondents were quoted in the discussions.

Analysis of data from the interviews

The process of analyzing the focus group interview data in the present study began with the researcher carefully reading the transcripts from the interview and the field notes made while gathering data. Items or similar ideas were looked for and grouped under a theme. Comments or information given by respondents were coded into meaningful categories (Cohen, Manion & Morrison, 2003).

Results

4.1 Theme one

Extent of access for persons with physical disabilities to rehabilitation services

Access was conceptualized namely as awareness, physical access and how readily accessible the personnel were to individuals with physical disabilities.

Awareness

From the analysis of the interview data awareness about the existence of the center and its services on offer was very critical to the use of the center, making awareness an important nexus to access. From the evidence, the center went to great length to create awareness and knowledge about the Center.

Such viewpoints were supported by one member of focus group of Service Providers who commented:

> *'With awareness creation, normally we go out and embark on sensitization. Normally we do go to schools, churches and the communities and again we have volunteers, we have a group of volunteers who are also doing the work.* (S.P, focus group 1)

This view point was corroborated by Persons with Physical disability within their focus group. The remarks from the group was generally encapsulated by one individuals comment as follows:

> *'Ok, the center does outreach programmes for persons with disability so through that I got to know and I came'* (P.W.D, focus group 2).

Promoting awareness was carried out in a number of ways namely; strategy and word of mouth. These are discussed below.

Strategies

In ensuring awareness, a variety of strategies were often adopted. The viewpoint of Persons with physical disability was corroborated by the service providers who remarked:

> *'… There were few occasions where we have been on the air waves to create awareness about the center and what we do'.* (S.P, focus group 1)

Another mode of creating awareness was involving people who visited the Center. Often these individuals became a point of contact.

> *'When clients also come, we tell them this is what we do here so when they also see other people in similar conditions they tell them and they also try to come around'* (S.P, focus group 1)

It was also the case that the use of the churches was quite prevalent as a platform for creating awareness

> *'We also do announcement, awareness in our churches and our various core officers, we call them pastors and when they identify persons with disability in their community, they also refer them to the center'* (S.P, focus group 1)

Other strategies deployed in creating awareness included:

Word of mouth

Awareness creation about the center also took the form of 'word of mouth' as some service users were introduced to the center by parents who also had children with disability and in some cases, workers at other centers that provide services to persons with disability. When asked how they heard about the center, parents of children with physical disability commented:

> *'For me, a sister of mine brought her child here. It happened that her child also had a child with disability so she told me about the center and the services it provides are good so I should also bring my child here'* (P, focus group 3)

> *'I was introduced to the center by someone who works here'* (P, focus group 3)

> '*It was our physiotherapist at Nsawam, who directed us to come to the center here'* (P, focus group 3).

The responses suggest that awareness creation involved a joint effort by the service providers and service users.

Another sub theme that emerged was impediment to physical access. Consequently, to ensure access, ramps were provided and this is discussed below.

Ramps

In order to facilitate access, ramps were positioned at various parts of the center. In the view of some members of the focus group for service providers, the creation of these ramps was to facilitate physical access:

> *'So far as you see it for yourself, from down to this place, we try to make it simple for wheel chair users to be able to use this center and when you look at the polyclinic it-self we have a place where there are ramps and steps for them to be able to get to the clinic so it is accessible to the wheel chair users and all types of disabilities'* (S.P, focus group 1)

They commented further:

> *'There are ramps every-where for those using wheel chairs so I will say the environment is accessible'* (S.P, focus group 1)

A viewpoint also supported by parents in the focus group:

> *'Even sometimes if my child doesn't want to push himself up in the wheel chair, I push him up and because the place is not all straight and there are some things that make it easy for wheelchairs to pass, we have no problem'* (P, focus group 3)

Another parent within the focus group remarked:

> *'My child uses the wheelchair and because of the ramps the center has provided, it is very easy for me to push his wheelchair up here to the consulting room or the other rooms where we get some of our services'* (P, focus group 3)

Clearly, mobility was critical in guarantying access to the facilities on offer at the center. It was thus important that these had been provided within the ecology to facilitate movement and to be able to access the broad range of facilities within the Center. Persons with physical disability relayed during their focus group discussions:

> '*I personally have been using crutches since I was a child so I am used to using it anywhere I feel like going, so the environment here is not a problem for me at all*'(P.W.D, focus group 2)
>
> '*I am able to get around easily even though I use crutches*' (P.W.D, focus group 2).

Interestingly however, there were some individuals who were of the view that even though the ramps facilitated access, some parts were too steep, resulting in the fear of falling over. In the view of one individual:

> *'Even though the ramps are there, there are parts that are steep so am afraid I will fall if I try to get up on my own'* (P.W.D, focus group 2)

It would seem that the nature and severity of the disability played a role in how efficiently some of the Persons with physical disability negotiated round the ramps, a factor critical to ensuring access for all.

Indeed the United Nations Convention on the Rights of Persons with Disabilities, obliges:

> *'Governments to take measures to provide persons with disabilities the needed access to communication, the physical environment and transportation as well as any other facilities and services that are open to those without disabilities in rural and urban areas'* (Article 9, clause 1, CRPD, 2008).

These provisions by the United Nations Convention are to ensure that the needs of persons with disability are taken into consideration when decisions are made concerning service provisions for the general public.

From this study there was awareness creation about the Salvation Army rehabilitation and orthopedic Center and its services. The awareness creation by the Center utilized several mediums in order to maximize effect. There were instances where service users were used as contacts, and service providers embarked on sensitization within the community. This was a way of encouraging and educating more persons with disability on the availability and use of the services on offer at the Center. In the Community Based Rehabilitation's Joint position paper (2004), professionals who provide rehabilitation services have a duty of providing information to people with disabilities on where and how to get the services so they in turn make informed decisions regarding what is appropriate for them. Interestingly, a study conducted by Srivastava, Khan, Pandey, Pillai and Bhavsar (2014) on awareness and utilization of rehabilitation services among the physically disabled people of rural population of a district of Uttar Pradesh in India. The study adopted the disability criteria of national sample survey and the multistage sampling technique. It found that 64.71% of disabled people were unaware of the availability of rehabilitation services. The authors concluded that there was a lack of awareness and utilization regarding the availability of rehabilitation services in that country. Findings from my own study is at variance with the India study, as I found evidence of significant awareness creation. The India study also deployed statistical and survey data while my study is set apart because it was underpinned by a naturalistic inquiry.

The United Nations Convention on the Rights of Persons with Disability (CRPD, 2008) indulges its state parties to ensure that Persons with disability have equal access to the physical environment and other facilities open to or provided to the public. It would therefore seem that awareness about rehabilitation services is inadequate if persons with disability are unable to use those services. Uslu (2008) comments that the needs of persons with disability are as important as the needs of those without, and it is therefore important to include their physical accessibility needs in the planning and designing of buildings. As in the medical model of disability, it is generally assumed that the problems of Persons with disability are inherent, and not in the institutional barriers. Consistent with that conceptualization, for those who could not access the ramps, nothing was put in place as an alternative.

Another emerging sub-theme was accessibility.

Accessibility

Accessibility to service providers by Persons with physical disability was critical in defining the pattern of interaction within the staff of the Center. The staff were always available to support and listen to the clients. In the focus group discussions for service providers they relayed:

> ‘*Our clients have the chance to talk to us anytime they need to because most of the time we are here except on Sundays so anytime they need to get in contact we are here. Most of the time too, we give our numbers out so anything they would like to ask or discuss they have the chance to call any stuff member*’ (S.P, focus group 1)
>
> *‘We are always available because that is the work that we are doing, we always expect them to come and when-ever they come, we also receive them. For the availability I would say that is one touch, even if they are not coming, we will go to them’* (S.P, focus group 1).

These remarks demonstrated the willingness of the staff to support the clients, which was also acknowledged by the parents of children with physical disability:

> ‘*They told us they are here because of us and our children so any time we have anything when they are not busy we just go and talk with them’* (P, focus group 3)

> *'Even if you decide that you want to talk about your child's rehabilitation every day you come in, I they will listen and have that discussion with you because like my sister said they said they are here because of us so they always make time for us'* (P, focus group 3)

In the focus group, of Persons with physical disability, they commented:

> '*They are always available, if you need their help and you come to the center, they are always available to help you. They always get the time for us*.'

From the evidence above, there were no barriers to interaction with the staff. The service providers were critical in facilitating interaction and such was critical for a healthy social interaction and good psychological wellbeing, all of which are helpful in the rehabilitation process. Persons with disability need to be able to discuss issues pertaining to their treatment with their service providers, and they in turn need to be available to listen. Service users at times do not just communicate problems pertaining to the rehabilitation process to their service provider but also communicate issues that are of concern. This view is supported by Azizam and Shamsuddin (2014), who opine that communication in the healthcare setting is not limited to sharing information regarding problems, treatments and possible causes of diseases but looks also at the emotional needs of the patient. These authors further noted that patients who know and can feel that their healthcare providers are concerned about their health and wellbeing tend to be more satisfied with their healthcare sessions, as was the case in this study.

There were indications that service providers encouraged service users to call on them any time they felt they needed to discuss any issue of concern. Clearly, this was an effective way of engaging the clients. On the whole the service provider and service user relationships were generally cordial. Barrett and Ellington (2009) suggest that effective communication between the nurse and patient enhances the understanding of the patient in relation to their diagnosis, treatment and decisions about future treatment thereby enhancing good patient care planning, education, discharge planning and timely patient outcomes. Interestingly, even though Cooper, Roter, Johnson, Ford, Steelnwachs and Powe (2003) argued that busy schedules and high number of patients limit the duration and the quality of communication between patients and their physicians, findings from my study did not indicate that at the Salvation Army rehabilitation and orthopedic Center as interactions with service providers was not affected by busy schedules. There was evidence suggesting that clients had access to the Salvation Army Rehabilitation and Orthopedic Center through service providers which in turn encouraged their general usage of the services on offer at the Center.

This finding is consistent with the Andersen's theory of healthcare utilization which indicates that enabling factors like access to the health center influences the individuals' use of the healthcare service. This enabling factor was at play at the Salvation Army Rehabilitation and Orthopedic Center as Persons with disability and their family members had access to the Center through the service providers which enabled their usage of the services on offer.

Summary of findings

In synopsis, at the Salvation Army Rehabilitation and Orthopedic Center, there was evidence of significant awareness creation about the Center, the awareness creation imbibed strategies like word of mouth and using clients as contacts. There were however impediments to the physical environment which affected the overall access to the facility. None the less, service providers were easily accessible to users of the Center which enabled better understanding of the rehabilitation process by the users.

4.2 Theme two

Meeting the needs of persons with physical disabilities.

Services aimed at addressing the needs of persons with physical disability at the Salvation Army Rehabilitation and Orthopedic Center were designed with their needs and interests in mind. Services were designed based on individual uniqueness, vocational interests and their independent living after service provision. These are discussed further below.

Uniqueness

Analysis of the data revealed that most of the services on offer at the Center were tailor-made to the needs of the person with physical disability. From focus group interactions with service providers they commented:

> '*Everyone that comes to the center has a special condition they come with so we give them services that would help improve the kind of condition, so you would see that even if there are two children with the same type of condition, their exercises would be different'* (S.P, focus group 1)

This viewpoint was substantiated by parents of children with physical disabilities who remarked:

> '*... before coming here, most of the time, once your child and another child have a similar condition, they make them both do the same kind of exercises but here, my child has his own set of exercises he does and as we go along they change them'* (P. focus group 3)

They commented further that:

> '*The exercises here are not the same for everyone even though we all have children with disability, my child's exercises are different from this woman's child's own because the two of them do not need the same things'* (P, focus group 3)

They were also of the view that:

> *'… exercises they take my child through are just for my child's needs that's why the service provider told me the other time that my child is different from all the other children here so his exercises too should be different' (P, focus group 3)*

From the evidence above, it was the case that the entire service provision at the Center was underpinned by the uniqueness of the individual. This differentiation of services to the required needs of each individual was relevant in the sense that the package put in place to support each individual addressed a specific need. As already indicated, document analysis was also one of the methods of enquiry and this was critical in triangulation aspects of the data glimmed from parents and service providers.

A scrutiny of the Salvation Army Policy, Protocols, Procedures and Practice Manual revealed that one of the cardinal principles of the rehabilitation center was the uniqueness of the individual. The document reveals:

> '*The Salvation Army believes in the uniqueness of each individual*'

(Salvation Army Policy, Protocols, Procedures and Practice Manual, 2014)

Service provisions tailored to the needs of persons with disability impacts the overall wellbeing of the individual, thereby leading to service satisfaction. Dispensa (1997) comments about the importance of service satisfaction to clients as an important factor to the continuous use of those services and states the opposite as the case when service satisfaction is not achieved. In the view of Kramer (1997), satisfaction with service provision is an important determinant in the rehabilitation process as success in rehabilitation relies to a large extent on the patient's views, motivations as well as personal inclinations. Powers and Bendall-Lyon (2003) are also of the opinion that the fulfilment of both the cure and care expectations by the healthcare encounter is the ultimate measure of how satisfied the patient is with the service. In their view, patient satisfaction or dissatisfaction becomes a driving force that ultimately shapes their attitudes and behavior.

Clearly this is consistent with Vroom's expectancy theory of 1964 which emphasis that an individual's choice concerning an activity is influenced by an anticipated outcome which in effect is driven by motivation and the unique individual needs of that person. With growing recognition that every person with disability is an individual with specific needs, service provisions are tailored to meet their unique needs.

Another sub-theme that emerged was related to the vocational interest of Persons with disability.

Vocational interest

It was evident from the analysis that service provision took into consideration the vocational needs of the service users. Their aptitude and interest was thus a determining factor in the rehabilitation process. From interactions with Persons with physical disability it was clear to me that this point was often reoccurring. In the focus group for Persons with physical disability, some remarked:

> *'they asked me what I want them to do for me and I decided that since people always wear shoes, I would go into shoe making so I choose that and that has really helped me a lot'* (P.W.D, focus group 2)

Another viewpoint was also that:

> *'ok, it's the same for me, when I completed junior high school, they asked me if I would go to school or learn a trade and I decided that maybe the school may not be friendly for me so I decided to choose sowing'* (P.W.D, focus group 2)

These comments which encapsulates the general discourse within the group supports the viewpoint that vocational interests of the individuals was critical in the rehabilitation process. Farrell (2004), argues that patient participation in the decisions concerning their healthcare process brings a lot of benefits and improvements in the healthcare process and helps improve service provisions for them. Kennedy and Hamilton (1999) comment that during the planning and decision making process, rehabilitation centers and units have taken a more positive position of encouraging active patient participation. A position the authors say is as a result of the believe that the individual's participation is fundamental to the effectiveness of the rehabilitation process. In their opinion, Jabeen, Kazmi, Rehman, Gul and Qureshi (2016), believe the vocational interest of Persons with physical disability are often overlooked, their capabilities underestimated and their needs given a lesser priority.

Lindberg, Kreuter, Taft and Person (2013) commenting on patient participation in care and rehabilitation from the perspective of patients with spinal cord injury, revealed patient participation as a critical component of the rehabilitation process as such must be facilitated, promoted and tailored to each individual by the staff. Further findings from the above study indicated that in order to facilitate participation in planning and decision-making, it was necessary for service providers to recognize the individual expectations and capabilities of the client. Findings from my study finds consistency with that of Lindberg et al., as both revealed the importance of participation by patients in the decision making process. This finding is influenced in part with Vroom's 1964 expectancy theory of motivation which states that motivation to do a selected activity is determined by the desirability of the results of that activity, in essence, service provider's enquiry concerning the interest of the service users is aimed at encouraging their participation and help improve services they are provided with.

Independent living of persons with disability was clearly of interest when services were planned.

Independent Living

Independent living of Persons with disability was encouraged at the Center. It was one of the Center's philosophies that persons with physical disability be supported to be independent and that was important to the way the services were packaged. In the focus group discussions, service providers commented:

> *'The services we give here are towards independent living so the services are very important to the clients'* (S.P, focus group 1)

This viewpoint was consistent with the points espoused by the parents within the focus group who noted:

> *'They have been taking the child through various exercises that I know will surely help them to be independent someday'* (P, focus group 3)

The views of persons with disability was no different. They commented:

> *'I was small and started using the services here and now am more independent.* (P.W.D, focus group 2).

There was no doubt the services provided by the Salvation Army Rehabilitation and Orthopedic Training Center were central to the lives of persons with disability. Independent living of persons with disability is a core component in the rehabilitation process of persons with disability and as such most rehabilitation services are geared towards their independent living. The United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2008) indicates that independence of persons with disabilities is essential and can only be achieved when persons with disability have access to the wide range of opportunities and resources so that they can make meaningful decisions and choices that concern their life. Without the maximum opportunities through service provisions, the desired independence cannot be achieved. The desire for independent living on the part of persons with disability conforms to Andersen's 1960 behavioral model of healthcare utilization which suggests that factors like the perceived need for the health service, as for instance the desire to perform activities of daily living and to be able to lead independent lives all account for the reasons why Persons with physical disability utilize the services at the Salvation Army Rehabilitation and Orthopedic Training Center.

Summary of findings

Evidence from the findings suggest that service provision at the Salvation Army Rehabilitation and Orthopedic Training Center took into consideration the uniqueness of every individual as service provisions were tailored to the specific needs of individuals. It was also the case that the vocational interest of the Persons with disability was at the core of the service provision with emphasis on vocations that would enhance their independent living.

4.3 Theme three

Challenges to service delivery for persons with physical disabilities at the Salvation Army rehabilitation and orthopedic Training Centre.

In-service training

One of the emerging sub themes in respect of inherent challenges related to in-service training.

From the focus group interactions service providers remarked:

> *'With the in-service training it's not as regular as we would have thought it should be'* (S.P, focus group 1)

They remarked further:

> *'I have been here for five years and since I came, there has been no in-service training. I don't know whether they used to do it and have stopped but since I came, I have not gone on any'* (S.P, focus group 1)

Analysis of the data revealed that in-service training was irregular or non-existent in some areas from the view of the respondents. Even though there was some evidence pointing to the fact that the institution was not organizing in-service training for its staff, it emerged however, that some departments had taken it upon themselves to organize their own in-service training on the departmental level:

> '*There are various departments as far as the center is concerned, so for my department, we have been having a lot of in-service training. We have it every four months, because most of the people I work with were trained by me and sometimes we also have visiting technicians who come from other centers to give us in-service training'* (S.P, focus group 1).

The non-existence of institutionally organized in-service training, meant that some departments took the initiative to organize it at their departmental level. In-service training is crucial in maintaining an overall quality in the provision of services and brings service providers up to date with procedures and trends in their various fields. In the opinion of Erasmus, Loedolff and Nel (2009), the quality of services rendered can be greatly improved if the workforce is knowledgeable about modern developments in their various fields of specialization through in-service training, as such the importance of in-service training in any organization cannot be underestimated. Muchinsky, Kriek and Schreuder (2003) relate that in-service training has become one of the many avenues through which health professionals get equipped with modern trends to render better services to their clients. Booyens (2004) comments that skills and knowledge of healthcare professionals are directly linked to the quality of healthcare they render to their patients thus organizations or healthcare institutions that invest in in-service training either by organizing or participating in them have better service outcomes. In the view of Cole (2002), there are some factors that affect the amount and quality of training and development activities and they include; external environmental changes, the amount of internal change, the availability of suitable skills within the existing work-force and the extent to which management see training as a motivating factor within the work environment. The Health Workforce Advocacy Initiative (2010) advised that the health workforce should plan strategies to strengthen in-service training mechanisms so that health workers can be sufficiently educated and taught skills to provide high quality care to enable health workers in urban as well as rural areas be abreast with the latest skills in the healthcare delivery process. Clearly the desire for in-service training on the part of the service providers is reflected in Vroom's 1964 expectancy theory of motivation which indicates that three key elements play an important role in the choices made by people. One of these elements is expectancy which he explained as the belief that increased effort will lead to increased performance. In principle, service providers believe that if in-service training is given the needed attention, they will be able to learn new skills and provide the best services to their users.

Another sub-theme was staff-patient-ratio.

Staff-patient-ratio

The ratio between staff and patients in the healthcare sector has become an issue of concern as some health centers are outnumbered by the large number of patients. The comments from the service providers encapsulates an interesting view point.

'*We are managing with what we have'* (S.P, focus group 1)

These words give a perspective of the challenges of managing Persons with disability at the Center for Service providers arising out of staff-patient-ratio. In the focus group with the staff, they commented:

> *'...during the peak periods we need some extra hands to help'* (S.P, focus group 1)

Interestingly, the Persons with physical disability seem to be aware of the inadequacy of the staff available to support them:

> *'The people who bring their children here are now many and it's the same number of workers, that use to attend to us when we were not so many that still attend to us now that we are many'* (P.W.D, focus group 2)

They were also aware of the growing number over the years of Persons with disability without a corresponding increase in staffing positions:

> *'The people have become many over the years so if they have more workers helping them it would be good'* (P.W.D, focus group 2).

This realization on the part of the Parents and Persons with disability that Center needs more staff to handle the increase in the population of service users was supported by the Persons with disability Act (715) of Ghana which states:

> *'A rehabilitation center shall be provided with the staff and other facilities that are necessary for the performance of its function'* (Section 14, clause 1.2.2, Person with disability Act, 2006).

The need for adequate healthcare providers to cater for the needs of persons with disability has been spelt out in the Persons with Disability Act, Act 715, but there is evidence suggesting that more service providers are needed as some Centers are barely managing with the huge numbers of persons with disability. Obembe, Osungbade, Olumide, Ibrahim and Fawole (2014), comment on the growing pressure on healthcare services, and the need for more healthcare workers as their equitable distribution is necessary for improvement to health care access, as well as service quality.

As a consequence of the low staff-patient-ratio, patients were spending longer waiting times at the Salvation Army Rehabilitation and Orthopedic Training Center.

Long waiting time

The poor staff-patient-ratio had created a situation where parents had to spend longer hours waiting.

From the focus group interactions for parents, they remarked:

> *'…you have to wait for some time before you are attended to depending on the number of people you come to meet, spending long hours than what we normally would'* (P, focus group 3)

They also commented:

> *'There are times when you come in, you would have to wait for long because the people who bring their children here are now many'* (P, focus group 3)

The remarks from the parents suggest that the time spent at the center is dependent on the number of service users at the Center at a particular time.

The remarks of the parents are validated by the service providers during focus group discussions when they related that:

> *'Depending on the number of people at the center at a particular time, if the number is huge, you would expect to be in the queue for a longer time'* (S.P, focus group 1)

They commented further:

> *'Sometimes the center becomes so busy so you realize that clients end up spending longer than they normally would'* (S.P, focus group 1)

From the evidence here, it came out that the low patient-staff-ratio led to a situation where clients had to wait for long hours, which was often frustrating and delayed access to the rehabilitation services.

Sastry, Long, de Sa, Salie, Topp, Sanghvi, and Niekerk (2015) comment that long waiting times in sub-Saharan Africa are often symptomatic of low staff-to-patient ratios that are connected to health worker's inability to spent adequate time attending to the needs of each patient.

Another emerging issue was funding and this is discussed below

Funds

Another critical sub-theme related to funding. In the focus group interviews, service providers commented:

> *'We still need more financial assistance to be able to cater for the less privileged, we need more funds to be able to help'* (S.P, focus group 1).

They also related that:

> *'If we were able to be part of the national health insurance scheme it would help loosen the financial burden of the center'* (S.P, focus group 1).
>
> *'Most of our clients, their financial and economic level is erh, you know it's down there, they find it difficult because most of them are single parents, so we pick their bills'* (S.P, focus group 1)

The need for more funds for the center was clearly evident during the focus group interview with persons with physical disability too:

> *'Right now things are hard, initially, the center took up all the expenses'* (P.W.D, focus group 2).

The entire discourse from all the analysis of data showed that funds was an issue. Funds were needed to run the Center. As a charity organization, money is an imperative to sustainable quality service provision. The lack of funds was therefore a potential threat to the services on offer. Of course, even though pivotal to the work of the Salvation Army Rehabilitation and Orthopedic Center, was its support and charity work, there was also the potential that the Center was encouraging the dependency level of care. A model associated with the charity discourse, which is located within the broad domain of the medical model of disability. This charity discourse encourages the dependency of Persons with disability on persons or systems that would rather view them as people who are in constant need of help, incapable of fending for themselves.

Such dependency is inconsistent with objective 1, outlined by the vocational training Centers policy of the Salvation Army Rehabilitation and Orthopedic Center which seeks:

> *'To equip trainees with employable skills to make them economically independent'* (P, P, P, P Manual, 2014).

This objective is aimed at the economic independence of all users of the facility through the teaching of employable skills which would be of great help to them after the services they receive at the Center.

It must be argued that some of the interventions were, however social interventions for example paying for those whose parents could not support them. In the opinion of Preker and Carrin (2004) vulnerable groups including persons with disability are unable to generate enough income towards attainment of healthcare services, this they attribute to the fact that most disabled individuals and vulnerable groups are unemployed, thereby making it difficult for them to save up enough money to attend to their various health care needs. Clearly, this is consistent with the medical model of disability which argues that there is a helper and helped kind of relationship promoted when persons with disability begin to see themselves as constantly in need of help.

The services rendered by the Salvation Army Rehabilitation and Orthopedic Training Center are geared towards economic independence on the part of the persons with disability, but before that is achieved, the persons with disability would have grown comfortable with the charity by the facility and the skills they acquire may not be put to use.

'The Salvation Army is there for us'. These simple phrases sum up the dependency on the Center by persons with physical disability. In the focus group interview, they remarked:

> *'The Salvation Army is there for us so when you come and they realize your parents don't have the money they foot the whole bill'* (P.W.D, focus group 2)

There is evidence to suggest that persons with disability seem to have rather become more dependent on the center even though it is the intent of the Center to rather make them more self-reliant.

There was also issues of users relinquishing opinions and participation to the service providers who were thought to be experts by the parents and Persons with disability. This position contradicted the well-rehearsed dictum in disability studies of nothing about us without us.

Nothing about us without us

The general understanding among the non-disabled population is that Persons with disability would want to be a part of any decision making that concerned them directly. Interestingly though, I found out during my study it was not always the case.

'The workers here are the specialists, they know what is good for the child'

The above sentence sums up the position of parents of children with physical disability when it comes to service provisions for their children. In the focus group interview, one parent specifically commented:

> *'The workers here are the specialists and they know what is good for the child and I think they are doing the best'* (P, focus group 3)

Interestingly, this was the general trend among all the parents within the focus group.

Ironically, documentary evidence from the Salvation Army's Manual outlines as part of its Rehabilitation service objective:

> *'To involve parents and families in the rehabilitation of children with disabilities so that they can understand the needs and potentials of their children better'* (P, P, P, P Manual, 2013)

It would seem that the service providers have become authorities over the lives of the Persons with disability and their parents and were dictating the direction of events without the opinion of the clients. As with the medical model of care, the way Persons with disability are constructed dictates service provisions put in place for them. It is expected that those with disability do not have an opinion and are unable to self-advocate for themselves. Their difficulties are thought to be consequences of their own personal tragedy. Any consideration is therefore thought of as being a favor. This particular notion is influenced by the medical model of disability where the service providers have all power to make decisions concerning the rehabilitation process, and service users are viewed as incapable of decision making, consequently all rights to decision making is surrendered to the former.

Farrell (2004) is of the opinion that with the growing benefits and improvements in health outcomes that mark patient participation, patients should be considered as partners in the healthcare delivery process and are be encouraged to actively participate in treatments and decisions concerning their health in order to help improve service provisions for them. In his view, Thompson (2007) indicates that the idea of patient participation in healthcare and treatment is not a new one, but has only currently become an important governmental necessity in many countries and healthcare systems the world over. Interestingly the service users at the Salvation Army rehabilitation and orthopedic Center have surrendered all their rights to the service providers in a helper and helped sort of relationship instead of taking on the role of partners in the rehabilitation process (Farrell, 2004).

Major decisions concerning their children's rehabilitation process is left at the discretion of the service provider who are assumed to be the specialists. Kennedy and Hamilton (1999) are of the view that rehabilitation centers and units are now encouraging active patient participation on the understanding that the individual's participation is fundamental to the effectiveness of the rehabilitation process. Yet this was not the trend at the Salvation Army Rehabilitation and Orthopedic Training Center.

Summary of findings

Analysis of the data brought out a number of issues as inherent challenges to service provision at the Salvation Army Rehabilitation and Orthopedic Training Center. Among these issues was funding, patient-staff-ratio, long waiting time, in-service training and the surrendering of authority by the clients to service providers. All these challenges affect the service delivery process as well as the quality of service delivery at the Center.

4.4 Theme four

Improving services on offer at the Salvation Army rehabilitation and Orthopedic Training Center.

Among the list of how services could be improved, emerged the following: collaboration, donor support and staff. These would be discussed below.

Collaboration

Service providers during the focus group interview when asked how service provision could be improved, commented:

> *'… We need more collaboration with the district assembly, religious bodies, GES, and the persons with disability themselves'* (S.P, focus group 1)

They also said:

> *'We need to collaborate more with the chiefs and people in the community that the center is located in'* (S.P, focus group 1)

From the analysis, the issue of collaboration came out strong as one of the means of strengthening and improving the services on offer at the Center. The greatest strength to the success of service delivery relies on the multi-sectorial approach of collaboration it is therefore imperative to the success of every organization. As in this study, it did appear that some of the major stakeholders were not deeply involved in the activities of the Rehabilitation Center.

It was also the view of the parents with children with physical disability that, parent service provider relationships needed to be strengthened. In their view:

> *'What we are saying is that they should discuss with us and get to know the kind of exercise we take the children through at home so that they can help us to improve upon them and help our children'* (P, focus group 3)

The parents were concerned that the discussion with service providers was inadequate when it came to seeking their views. Murray, Kwabata and Valentine (2001) are of the opinion that service users' views are a direct measurement of how their needs are being met and attended to and are related to their expectations regarding the services they receive in the health care delivery process.

Keen (2007), also argues persuasively that family-professional collaborations are an essential aspect of the health care delivery process and are developed on mutual respect, sharing of information, trust, shared decision making, open communication and processes that involve family needs, beliefs and preferences pertaining to treatment and interventions. A survey and focus group study conducted by Teggart and Linden (2006) found that both service users (child or adolescent) and caregivers (parents) expressed a willingness to work collaboratively with healthcare providers. My study only established that parents were willing to work with service providers but they felt they were being left out of the process in some instances.

Interestingly, the persons with disability had very little to say concerning how services they receive could be improved. This demonstrates the typical helper and helped relationship underpinned by the medical model of disability. The medical model places persons with disability at a constant need of help from the healthcare provider as a result Persons with disability even though could contribute to their own rehabilitation process, take the back role seat and depend on the advice service providers give them.

Donor support

Donor support was also a strong emerging sub-theme necessary to improve the services at the Center. The request for support from N.G.Os was strong:

> *'NGOs, should come to our aid'* (P.W.D, focus group 2)
>
> *'NGOs and those big big companies too should help'* (S.P, focus group 1)

They also commented:

> *'Donors should support us with wheel chairs and clutches, so if there are people out there like donors who can help, they should help'* (P.W.D, focus group 2)

Even though there were some provisions in place, there was clear evidence that the provisions were inadequate.

> *'Now the number of persons with disability is increasing so we need enough support to be able to help'* (S.P, focus group 1)

Even though it was not clear the kind of support they were talking about, it was suggestive of the need for some level of intervention within the broad range of service provision on offer at the Center.

Staff

Staff was also an area of need in the quest to improve service provision at the Center. From the focus group discussions with parents, they remarked:

> *'You would have to wait for long because the people who bring their children here are now many and it's the same number of workers'* (P, focus group 3)

This comment was indicative that the center had service users waiting for longer because the staff number was inadequate.

The viewpoint was also supported by comments during focus group discussions with persons with disability who remarked:

> *'If they have more workers helping them it would be good'* (P.W.D, focus group 2).

It was quite evident from both comments that staff numbers was a factor that affected service delivery at the center.

Needlam, Buerhaus, Mattke, Stewart and Zelevinsky (2002) comment that staffing is strongly linked to important patient out-comes, such as in hospital mortality and adverse events, as a result staff numbers affect the ultimate health care experience. Ideally, staffing (i.e., number per patient and types of providers) is based on the need to ensure that there are healthcare providers with the right skills, education, and experience to best fit patient needs (Sharma, Hastings, Suter & Bloom, 2016). Kane, Shamliyan, Mueller, Duval and Wilt (2007), were also of the view that better nurse-patient-ratios have an effect on patient mortality and other adverse events in the hospital setting.

Clearly, these findings agree with Andersen's behavioral model of healthcare utilization (1960), which indicates that access to the healthcare Center, thus service providers form part of the enabling factors that help an individual get access to healthcare services. In effect, persons with disability at the Salvation Army Rehabilitation and Orthopedic Center, with the right number of service providers would enjoy better healthcare access and in effect reflect on their overall utilization of the Center.

Summary of findings

In summary, analysis of the data revealed a number of ways service provisions at the Salvation Army Rehabilitation and Orthopedic Training Center could be improved. Among these were collaboration between the Center and stakeholders, more support from donors and more staff to bridge the patient-staff-ratio and adequately cater for the needs of all who use the Center and its services.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0 Introduction

This chapter presents the summary of the findings, conclusions and recommendations for the study.

Summary

The purpose of the study was to determine access to rehabilitation services for Persons with Physical Disability at the Salvation Army Rehabilitation and Orthopedic Training Center.

The study sought to specifically find out:

- The nature of access persons with disability have at the Salvation Army Rehabilitation and Orthopedic Training Center to rehabilitation services.
- How the services devised at the Salvation Army Rehabilitation and Orthopedic Training Center meets the rehabilitation needs of the persons with physical disability.

- The inherent challenges that face service delivery at the Salvation Army Rehabilitation and Orthopedic Training Center.
- How services on offer at the Salvation Army Rehabilitation and Orthopedic Training Center can be improved.

Four research questions were raised from the objectives to guide the study. In addition, three theories were also used to guide the study namely the Expectancy theory of motivation by Victor Vroom (1964), the Anderson behavioral model of healthcare utilization (1960) and the medical model of disability (1996). The qualitative approach using a case study research design was used to determine access to rehabilitation services for persons with physical disability at the Center. Fifteen people were involved in the study with focus group interview as its method of data collection. The fifteen consisted of five persons with physical disability, five service providers and five parents of children with physical disability.

Interview data were analyzed using themes that emerged from the responses and relevant information from documents were also used to help triangulate the data.

5.1 Summary of major findings

Summary of the major findings were done based on themes and sub-themes that emerged out of the analyzed data.

Access

In determing the nature of access to the Center, themes of awareness, physical access and service provider accessibility were highlighted. The findings were that the Center created awareness about its services to the general public and most persons with disability were used as contact persons in the awareness creation process by the Center.

It was also noted that the center had made significant strides in improving physical access to the environment of the Center by erecting ramps at vantage points. It is important to also point out that while the ramps were generally an improvement, there were some negative aspects to them. The findings revealed some parts were too steep.

Service providers were also easily accessible to service users as the study discovered that service users had the personal contact numbers of service providers and were able to call them anytime they needed to.

Meeting needs

In meeting the needs of Persons with Physical Disability, two major things emerged: uniqueness and employment. All service users saw themselves as unique individuals with unique needs deserving of specified service provisions tailored to meet their needs. The service providers understood this uniqueness and treated each service user as an individual through the services they provided to them.

There was also the case that service provision was aimed at equipping the service users with employable skills so that they could get a vocation at the end of their service provision. Service users were also involved with the decision on the kind of vocation they were trained in.

There was also the fact that services provided at the Center were geared towards the independent living of the Persons with disability and as a result, service users were encouraged to participate in the decisions concerning their rehabilitation process.

Challenges to Rehabilitation

The study revealed that lack of in-service training was a major concern of the service providers at the Center. For example, service providers called for more and frequent in-service training as this was virtually nonexistent in their view.

Findings also revealed that the staff-patient ratio at the Center was inadequate resulting in longer waiting times by service users in receiving much needed rehabilitative care. Parents noted for instance that the number of service users have increased but it's still the same number of service providers to attend to their needs.

Further findings from the study revealed funding was a major problem the Center was battling with. For instance, service providers and service users both suggested that more non-governmental organizations should come to their aid to help address the funding needs of the Center.

The study also revealed among others that service users had relinquish their decision making rights to the service providers. For instance the service users noted that they did not interfere in the rehabilitation process because the service providers were the experts and they knew what was right for them.

Improving service provision

The study revealed that collaboration was a major determinant when it comes to service improvement at the Center. Service providers acknowledged that there was the need for more collaborations with stakeholders and service users and a stronger service provider relationship in order to improve the services they provide at the Center.

Findings revealed that found that donor support was needed in order to address the needs of service users that use the Center. For instance, service users appealed to NGOs to donate to the Center wheelchairs to aid in service provision.

Furthermore, the study found that more staff was needed to help improve the service delivery process by halving the waiting time of service users and reducing the workload on the service providers.

5.2 Conclusion

The study concluded that access to rehabilitation services for persons with disabilities went beyond physical access to the environment at the Center, it included service provider accessibility, how their needs are meet through the services rendered, challenges service users face and how to improve the service delivery process.

It was also found that there was a lot of awareness creation about the rehabilitation services and the Salvation Army rehabilitation and orthopedic center.

The findings revealed that access for persons with physical disability was not determined by their experiences alone but also by the experiences of the service providers at the Center. The service providers did what they thought was improving and promoting access to the Center and service users felt satisfied with the services they received.

The three theories that guided the study thus the Medical model of disability by Oliver, Vroom's expectancy theory and the Andersen's behavioral model of healthcare utilization all played pivotal roles in the analysis of the data. The models all worked together to explain access to rehabilitation services for Persons with physical disability at the Salvation Army Rehabilitation and Orthopedic Center.

On the whole it was found that there was considerable access to the rehabilitation services at the Center for the persons with physical disability.

5.3 Recommendations

Based on the findings of the study, it was recommended that:

- Regular in-service training should be organized for all persons involved in the provision of rehabilitation services at the Salvation Army Rehabilitation and orthopedic Center. The training should involve new strategies of service provision, collaboration and strategies of fund raising. This would in the long run improve service delivery, address the issue of funds and foster stronger relationships between the Center and other organizations.
- The Center with the help of the Ministry of Health employ more staff to address the issue of service provision and long waiting times at the Center by service users. This will enable the service providers render better services and improve the overall quality of the service delivery process.
- The Center finds more innovative ways of getting NGOs involved in funding the activities of the Center. This would help boost the capital base of the Center and more persons with disability would then be catered for.
- Service providers strengthen the relationship between them and the service users. Since the service users are the direct beneficiaries of the services, their inputs would help improve the service provision at the Center.

- Service providers should involve service users in the decisions concerning the rehabilitation process. This would enable the users feel they have an equal stake in the decisions that concern them.

5.4 Suggestions for further research

Further research is needed to examine additional factors that determine the access process for persons with physical disability in Ghana. Based on the present study, it is suggested that future research should focus on access for other categories of disability but this time with emphasis on general healthcare service usage. Further research could also be carried out to find the impact of in-service training on rehabilitation service provision for Persons with disability.

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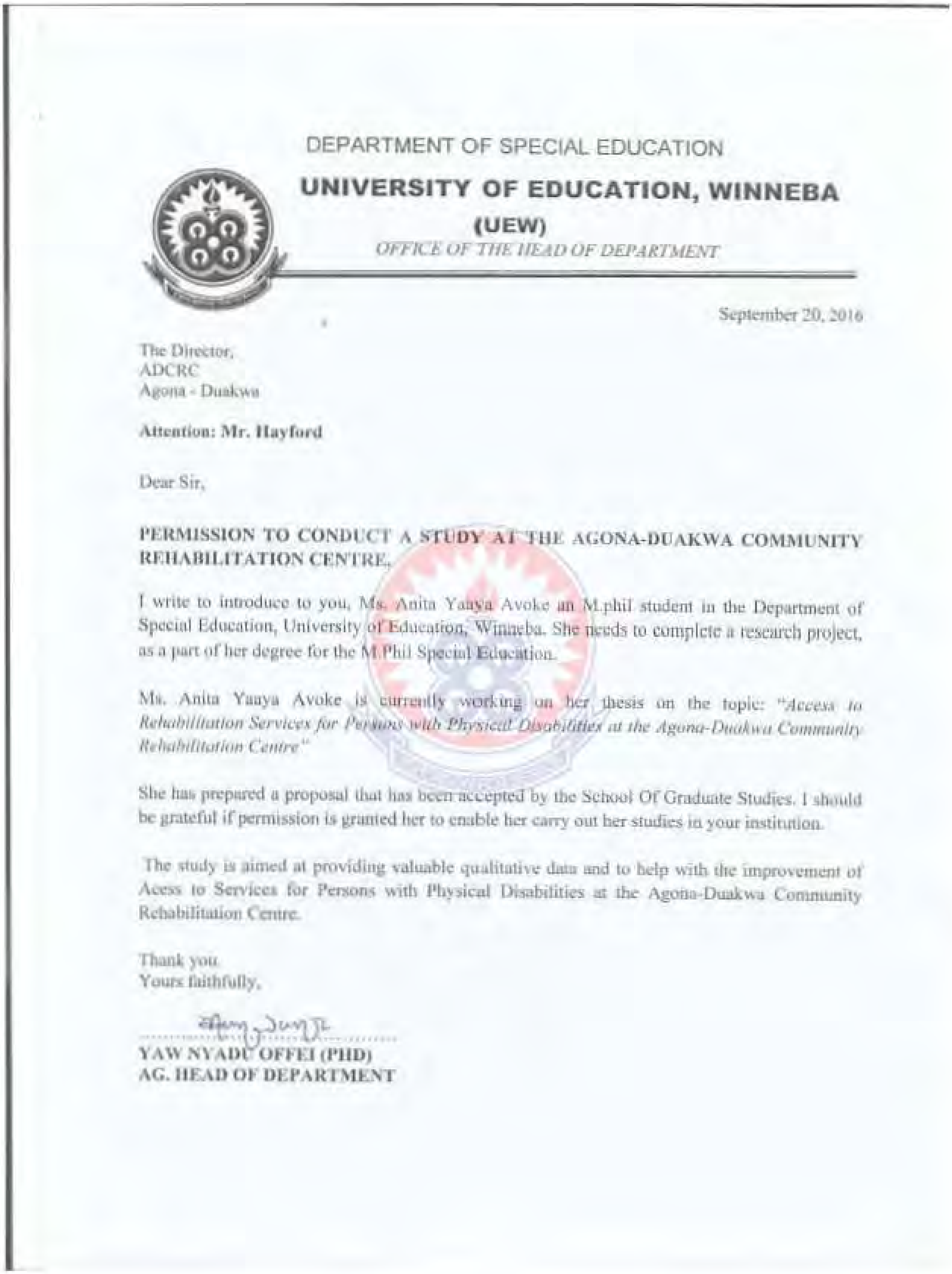


DEPARTMENT OF SPECIAL EDUCATION
UNIVERSITY OF EDUCATION, WINNEBA
(UEW)
OFFICE OF THE HEAD OF DEPARTMENT

September 20, 2016

The Director,
ADCRC
Agona - Duakwa

Attention: Mr. Hayford

Dear Sir,

PERMISSION TO CONDUCT A STUDY AT THE AGONA-DUAKWA COMMUNITY REHABILITATION CENTRE.

I write to introduce to you, Ms. Anita Yaaya Avoke an M.phil student in the Department of Special Education, University of Education, Winneba. She needs to complete a research project, as a part of her degree for the M.Phil Special Education.

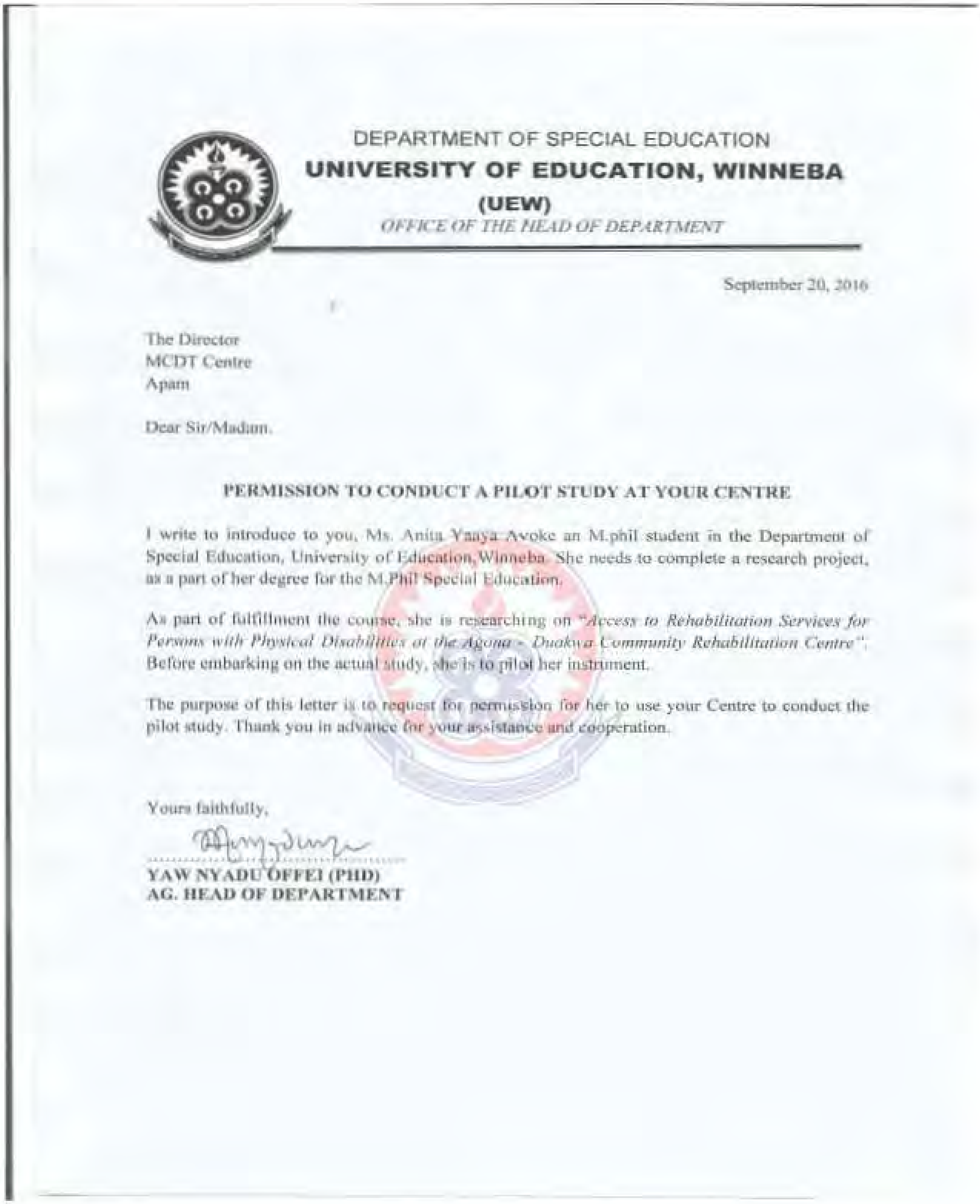
Ms. Anita Yaaya Avoke is currently working on her thesis on the topic: *"Access to Rehabilitation Services for Persons with Physical Disabilities at the Agona-Duakwa Community Rehabilitation Centre"*

She has prepared a proposal that has been accepted by the School Of Graduate Studies. I should be grateful if permission is granted her to enable her carry out her studies in your institution.

The study is aimed at providing valuable qualitative data and to help with the improvement of Acess to Services for Persons with Physical Disabilities at the Agona-Duakwa Community Rehabilitation Centre.

Thank you.
Yours faithfully,

…………………………………………
YAW NYADU OFFEI (PHD)
AG. HEAD OF DEPARTMENT



DEPARTMENT OF SPECIAL EDUCATION
UNIVERSITY OF EDUCATION, WINNEBA
(UEW)
OFFICE OF THE HEAD OF DEPARTMENT

September 20, 2016

The Director
MCDT Centre
Apam

Dear Sir/Madam.

PERMISSION TO CONDUCT A PILOT STUDY AT YOUR CENTRE

I write to introduce to you, Ms. Anita Yaaya Avoke an M.phil student in the Department of Special Education, University of Education, Winneba. She needs to complete a research project, as a part of her degree for the M.Phil Special Education.

As part of fulfillment the course, she is researching on "*Access to Rehabilitation Services for Persons with Physical Disabilities at the Agona - Duakwa Community Rehabilitation Centre*". Before embarking on the actual study, she is to pilot her instrument.

The purpose of this letter is to request for permission for her to use your Centre to conduct the pilot study. Thank you in advance for your assistance and cooperation.

Yours faithfully,

YAW NYADU OFFEI (PHD)
AG. HEAD OF DEPARTMENT

APPENDIX B

Interview guide for persons with physical disability at the Salvation Army Rehabilitation and Orthopedic Training Center. (Focus group discussions)

Research question 1 Access

Physical access

How were you introduced to the Center?

Probes: family member, service provider, friend, teacher, announcements, internet

How are you able to get around at the center?

Probes: ramps, design of buildings

Service on offer

Think about how services are provided at the center, what are your impressions so far?

Probes: long / short waiting times, availability of services

Availability of support and service providers

How available are the service providers to you?

Probes: easily contact them, not enough time for you, always busy

How often are you able to discuss with service providers about the rehabilitation process?

Probes: when they are less busy, anytime at all

Research question 2 meeting needs

Relevance of services

- How would you say the services are helping improve your condition?
  Probes: physically, emotionally, occupationally and socially
- Would you recommend the center and its services to a friend with physical disability as well?
  Probes: encourage/discourage

- What do your family members say about the kind of services you are given at the center?
  Probes: do their opinion matter

Research question 3 challenges to service delivery (rehabilitation services)

- What difficulties do you face as service users?
  Probes: personnel, finance, attitudes of providers, community perceptions

Research question 4 improving service delivery

- What do you think can help improve the services you receive at the center?
  Probes: collaborations, training, equipment, personnel, parental support, policies

APPENDIX C

Interview guide for service providers at the Salvation Army Rehabilitation and Orthopedic Training Center. (Focus group discussions)

Research question 1 Access

Physical access

How do you create awareness about the Center?

Probes: family members, announcements, internet, word of mouth

How appropriate is the environment to the clients?

Probes: ramps, design of buildings,

Service access

What are your impressions about the services you render?

Probes: long / short waiting times, availability of services

Personnel access

How available are you as service providers to the clients?

Probes: easy to contact, not enough, always busy

How often are you available to discuss with service users about their rehabilitation process?

Probes: when am are less busy, anytime at all

Research question 2 meeting needs

Relevance of services

- How are services tailored to meet individual needs of clients?
  Probes: general services, laid down exercises for everyone

- What would you say the center is doing to improve the conditions of clients?
  Probes: encourage/discourage, individualized services

- How beneficial are services to clients?

Probes: improvement physically, emotionally, socially

Research question 3 challenges to service delivery (rehabilitation services)

- What problems do you face in the service delivery process as service providers?
  Probes: personnel, finance, attitudes of providers, community perceptions

Research question 4 improving service delivery

- In your view as service providers, what do you think can help improve the services you render at the center?
  Probes: collaborations, more training, better equipment, personnel

APPENDIX D

Interview guide for parents of persons with disability at the Salvation Army Rehabilitation and Orthopedic Training Center. (Focus group discussions)

Research question 1 Access

Physical access

How were you introduced to the Center?

Probes: family members, announcements, internet, teacher, service provider, friend

How appropriate is the environment to your ward?

Probes: ramps, design of buildings, automatic doors, accessible washrooms

Service access

What are your impressions about the services your ward receives?

Probes: long / short waiting times, availability of services

Personnel access

How available are you as service providers to you?

Probes: easy to contact, not enough, always busy

How often are you available to discuss with service providers about your child's rehabilitation process?

Probes: when they are less busy, anytime at all, never, when they want to

Research question 2 meeting needs

Relevance of services

- How applicable are the services to your ward?
  Probes: general services, laid down exercises for everyone
- What would you say the center has done to help your ward?
  Probes: encourage/discourage, individualized services
- How beneficial are services to you?
  Probes: improvement physically, emotionally, socially

Research question 3 challenges to service delivery (rehabilitation services)

- What problems do you face as a parent of a child with disability?
  Probes: personnel, finance, attitudes of providers, community perceptions

Research question 4 improving service delivery

- In your view as a parent, what do you think can help improve the services you receive at the center?
  Probes: collaborations, more training, better equipment, personnel