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DEAF PEOPLE'S SATISFACTION WITH HEALTH CARE SERVICES IN THE WA MUNICIPALITY, GHANA

PROSPER TENGEPARE

MASTER OF PHILOSOPHY

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DEAF PEOPLE'S SATISFACTION WITH HEALTH CARE SERVICES IN THE WA MUNICIPALITY, GHANA

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DECLARATION

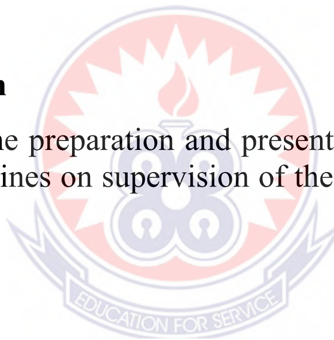
Candidate's Declaration

I, **Prosper Tengepare**, declare that this thesis, with the exception of quotations and references contained in published works which have all been identified and duly acknowledged, is entirely my own original work, and it has not been submitted, either in part or whole, for another degree elsewhere.

Candidate's Signature……………………...

Date………/………/2022

Supervisors' Declaration



We hereby declare that the preparation and presentation of the thesis was supervised in accordance with guidelines on supervision of thesis laid down by the University of Education, Winneba.

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Date……/……/2022

Name: Dr. Samuel Kwasi Amoako-Gyimah

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DEDICATION

This work is dedicated to my late parents, my lovely wife and children, and my siblings.

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My heartfelt thanks go to my supervisors; Prof. Yaw Nyadu Offei and Dr. Samuel Kwasi Amoako-Gyimah for their patience in guiding me to carry out this research work successfully. I also thank all lecturers in the Department of Special Education; UEW, especially those who taught me various courses during the course work.

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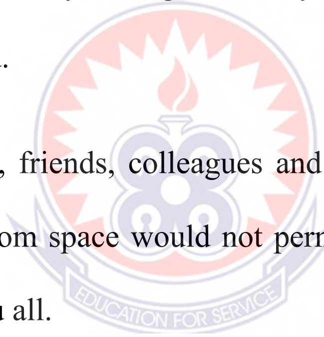
To Mr. Francis Xavier Tengepare, who was always available to proofread every chapter of this work before they were given to my supervisors for their expert advice, I say God richly bless you.



Finally, to all my family, friends, colleagues and loved ones who supported me in various ways, but for whom space would not permit their names to be mentioned, I say a big thank you to you all.

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GLOSSARY

FGD	Focus Group Discussion
GHS	Ghana Health Service
GNAD	Ghana National Association of the Deaf
GSL	Ghanaian Sign Language
HOD	Head of Department
MOH	Ministry of Health
NHIA	National Health Insurance Authority
NHIS	National Health Insurance Scheme
OPD	Out-Patients Department
P	Participant
SDGs	Sustainable Development Goals
SERVQUAL	Service Quality
UEW	University of Education, Winneba
UK	United Kingdom
UN	United Nations
WHO	World Health Organisation

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ABSTRACT

This study explored deaf people's satisfaction with healthcare services in the Wa Municipality. The study employed Phenomenological design. Twelve participants, comprising seven males and five females were purposively sampled. Data were obtained through interviews and analysed thematically. The results show that deaf people in Wa Municipality have positive and negative experiences with healthcare access. Some healthcare staff are respectful, caring, and empathetic. However, due to communication difficulties, deaf people endure negative experiences such as discrimination, stigmatization, poor staff attitude, and delay in health facilities. Factors that contribute to satisfaction among deaf people include communication, reduced waiting time, and equity in treatment. The study concluded that deaf people are not satisfied with healthcare services in the Wa Municipality. The study then recommended that management of health facilities within Wa Municipality should strengthen their monitoring mechanism to identify and sanction staff with negative attitudes towards deaf people. Again, the study recommended that management of health facilities should organize in-service trainings for staff on areas of communication and interpersonal relations. Finally, training to communicate using Ghanaian Sign Language should be given to health staff as part of their training.

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Satisfaction with healthcare embodies a set of attitudes and perceptions of patients towards healthcare services (Odonkor et al., 2019). It concerns the degree to which an individual regards healthcare as useful, effective, and beneficial (Odonkor et al., 2019). Odonkor et al. (2019) add that satisfaction or dissatisfaction is the judgment of patients about their needs and expectations as against the services provided them by the healthcare provider. The Ghana Health Service (GHS, 2010) states that satisfaction with healthcare is the level of contentment that patients experience having used the services of a facility. The Ghana Health Service further adds that patient care is the primary function of every hospital and serves as one of the yardsticks for measuring the effectiveness of a hospital, where effectiveness is related to the provision of quality care that maximizes satisfaction.

In Ghana, one strategy to enhance patients' care is the Patient's Charter of the Ghana Health Service which is person-centred and provides the patient with the responsibility to provide adequate information for their diagnosis and treatment. Thus, making sure the dignity of each patient is catered for. Hence, it is desirable and proper that the views of patients should be sought on their experiences and expectations of healthcare (Ramez, 2012). To ensure satisfaction, hospitals must be sensitive to patients' socio-cultural and religious backgrounds as well as satisfying the needs and expectations of patients with disabilities (Essiam, 2013). Patient satisfaction should be the central focus of every healthcare institution. To this end, there is the need for

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health institutions to offer clients services that ensure maximum value and satisfaction. It is therefore the responsibility of hospitals' staff to create a conducive environment including effective communication that will make the patients comfortable while receiving care (Franx et al., 2012). Effective and efficient communication is crucial for optimal delivery of healthcare (Vermeir et al., 2015).

As noted by Andrade (2010), communication between patients and their healthcare providers is essential but can always be hindered when the patient is deaf, thereby creating hesitation in accessing healthcare. In that case, the health status of deaf people population is affected. Barnett (2012) also observed that, although medical education is to prepare health professionals for the common issues they will face in practice, medical/health training schools do not adequately teach the communication skills necessary to work with clients with hearing loss. The Barnett further noted that the key to a successful communication with people with hearing loss is the ability to adapt to the needs of their situation to allow them to express themselves correctly.

Global reports from the World Health Organization indicate that persons with disabilities have more unmet healthcare needs and receiving fewer routine and preventive healthcare services than the general population (WHO, 2013). Barnett (2013) reported that people with deafness face significant challenges in communicating their health needs to healthcare professionals. For instance, in a study of deaf women's experiences and satisfaction with prenatal care, O'Hearn (2016) found that Deaf women were less satisfied than hearing women with physician communication and less satisfied with overall care. O'Hearn (2016) also noted that poor communication between clinicians and patients leads to low patient satisfaction and treatment adherence rates, thereby, contributing to poorer healthcare outcomes.

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Similarly, in a study on satisfaction with healthcare among people with hearing impairment, Barnett (2013) observed that deaf people demonstrated some level of dissatisfaction with the quality of healthcare they received. Also, Farias and Cunha (2017) reported high level of dissatisfaction among deaf people with the healthcare system quality in relation to communication and non-availability of informative and educational materials. This report was confirmed in a separate study where Rezende et al., 2020) noted that though healthcare services were highly sought for by the Deaf, most of the population was dissatisfied with the medical care. Appiah et al. (2018), examining communication experiences of speech and hearing-impaired clients in accessing healthcare in the Volta Region of Ghana reported that due to communication difficulties, Deaf patients experienced disparity, discriminations, neglect, and delays in receiving healthcare from providers. This is contrary to the proposition of international and local legal documents such as the United Nations Convention on the Rights of Persons with Disabilities (2006), goal three of the United Nations Sustainable Development Goals (SDGs) (2015), the Persons with Disabilities law of Ghana (2006), Act 715 and the 1992 Republican Constitution of Ghana. These legislations forbid discrimination in all its forms against all categories of people.

The evidence available in Ghana about healthcare delivery and patient satisfaction reveal that patient satisfaction with healthcare delivery is dependent on; human relations of nurses and physicians towards patients, and ability of health staffs to explain issues for patients' full understanding (Ofosu-Kwarteng, 2012). From the management point of view, (Dansky & Milles, 2007) expressed the importance of patients' satisfaction with healthcare in the following ways: "first, satisfied patients are more likely to maintain a consistent relationship with a specific provider. Second, by identifying sources of patients' satisfaction, an organization can address system

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weaknesses, thus improving its risk management. Third, satisfied patients are more likely to follow specific medical regimens and treatment plans. Finally, patients' satisfaction measurement adds to important information on system performance, and therefore, contributes to the organization's total performance index. Consequently, patient satisfaction with healthcare delivery has been emphasized variously by stakeholders in the healthcare sector (Adu-Adjei, 2015).

Unfortunately, several studies across the globe have reported the negative attitudes of healthcare professionals towards persons with disabilities (Badu et al., 2016; Devkota et al., 2017; Khan et al., 2016; Masuku, 2020; and Shakespeare & Kleine, 2013). Individuals who are deaf, therefore, also experience these negative attitudes from healthcare professionals (Orrie & Motsohi, 2018).

In the Wa Municipality for instance, there are many deaf people who access healthcare services from health facilities within the Municipality like all other persons in society. Communication is the means through which humans interact with one another and the hospital setting is not an exception. As someone who live in Wa and access healthcare services in the Municipality, I have observed that deaf people encounter challenges when they visit health facilities within the Municipality. These difficulties are largely due to the communication gap that exists between them (deaf people) and healthcare staff because of the absence of sign language interpreters in the health facilities. As a result of this language barrier, some healthcare professionals tend to subject deaf clients to unfriendly treatments such as discrimination, neglect, and avoidance. This observation was reaffirmed by "Song Maali" FM (a local Community Radio station in the Wa Municipality) on 20th March, 2021 during a radio discussion session where a woman recounted the predicaments of her deaf son when he visited the Municipal hospital. She lamented that the son was left unattended to

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simply because he went to the hospital without any hearing person or sign language interpreter.

Due to the unfriendly attitudes of some healthcare workers, coupled with language barrier, a lot of deaf people in the Wa Municipality are resorting to the pharmacy stores and herbal treatment centres as the preferred places of call when they fall sick. The effect of this trend is enormous. It has the potential of exposing deaf people to health complications, which eventually may lead to loss of lives. For instance, in an informal conversation with some deaf people in Wa, it came out that a deaf woman was found dead at a herbal treatment centre in a suburb community of Wa where she was undergoing herbal treatment regimen.

1.2. Statement of the Problem

Research shows that about 55.5% of deaf people in Brazil have stopped going to the doctor, or reporting any problems, relating to pains, discomfort or anguish, for fear that healthcare providers would not understand them (Augusto & Pereira, 2020). Other available evidence in the United States suggest that deaf people continue to experience fear, mistrust and frustration in healthcare settings related to many factors including difficulty in communicating with the healthcare providers which has the potential to result in incorrect diagnosis and improper treatment (Chang et al., 2012; Hark et al., 2004).

Though deaf people continue to seek healthcare services, most of this population are dissatisfied with the medical care due to delays and frustration (Drainoni et al., 2006; Rezende et al., 2020). The factors influencing patients' satisfaction with healthcare are multifaceted. Some of the factors that affect patients' satisfaction with healthcare include communication skills of staff, provision of appropriate health related

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information in language that the patient understands, ability of the care provider to answer patient's questions, ability to provide patients with an opportunity to ask questions and competence of the care provider in diagnosing and treating the health problem (Act, If, Rose & Unless, 2016).

Some evidence suggest that inefficient communication has several potentially negative consequences for all involved in the healthcare process (Vermeir et al., 2015). Reports indicate that faulty communication has been implicated in many medical errors and adverse events for patients (Sutcliffe et al., 2004). Poor communication can lead to various negative outcomes including patient dissatisfaction, discontinuity of care, compromise of patient safety, inefficient use of valuable resources both in unnecessary investigations and physician work time as well as economic consequences (Vermeir et al., 2015). As an essential element and quality characteristic of healthcare, effective and efficient communication should be ensured by providers to facilitate better information exchange with their patients. However, this can be a challenge in the best of circumstances especially during healthcare delivery for deaf people and may lead to dissatisfaction with healthcare (Vermeir et al., 2015).

A study conducted in Ghana by Appiah et al., (2018) on the communication experiences of deaf people and people with speech impairment revealed that, due to communication difficulties, deaf people experience disparity, discriminations, neglect, and delays in receiving healthcare from providers in the Hohoe Municipality of the Volta Region. In his speech at the opening of a three-day training workshop for selected health workers from 12 hospitals in the Accra Metropolitan Assembly and the Ashiaman Municipality in the Greater Accra Region, the Executive Director of

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Ghana National Association of Deaf (GNAD), Juventus Duorinaah, remarked that many deaf people in Ghana do not seek healthcare due to stigmatization and lack of communication between them and health workers (Gyesi, 2018, December 4).

In the case of the Wa Municipality, deaf people are reluctant to visit hospitals when they fall sick. Many of them prefer buying drugs from the pharmacy stores or opting for herbal treatment rather than seeking orthodox treatment in the hospitals. Similar behaviours have been reported across the globe by researchers (Alister et al., 2019; Chang et al., 2012; and Rezende et al., 2020). From this trend of behaviour among deaf people in the Wa Municipality, it appears they are not satisfied with the services offered to them by the various hospitals in the Wa Municipality.

In the prevailing circumstances, especially now with Covid-19 pandemic, if people continue to experience dissatisfaction with healthcare services, this could have dire consequences for utilization of essential healthcare services. However, at present, there seems to be scarcity of documented evidence that examined deaf people's satisfaction with healthcare services in the Upper West Region. Therefore, this study sought to explore deaf people's satisfaction with healthcare in the Wa Municipality with focus on their concerns regarding satisfaction with healthcare services, the factors contributing to their satisfaction with healthcare, constraints in accessing healthcare and potential strategies to help improve access and satisfaction with healthcare among deaf people in the Wa Municipality.

1.3. Purpose of the Study

The purpose of the study was to explore deaf people's satisfaction with healthcare services in the Wa Municipality.

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1.4. Research Objectives

1. To explore the concerns of deaf people regarding their satisfaction with healthcare services in the Wa Municipality.
2. To examine factors that contribute to satisfaction with healthcare services among deaf people in the Wa Municipality.
3. To explore the constraints of deaf people with access to healthcare in the Wa Municipality.
4. To identify strategies which can help improve deaf people's satisfaction with healthcare services in the Wa Municipality.

1.5. Research Questions

1. What are the concerns of deaf people regarding satisfaction with healthcare services in the Wa Municipality?
2. What factors contribute to satisfaction with healthcare services among deaf people in the Wa Municipality?
3. What are the constraints of deaf people with access to healthcare in the Wa Municipality?
4. What strategies can help improve deaf people's satisfaction with healthcare services in the Wa Municipality?

1.6. Significance of the Study

This study explored the concerns of deaf people regarding their satisfaction with healthcare services within the Wa Municipality. This will serve as feedback to managers of health facilities within the Wa Municipality as the findings will indicate areas in which the service providers have weaknesses and the need to improve on those areas. It also examined factors contributing to satisfaction with healthcare

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services among deaf people in the Wa Municipality. Knowledge of this information will guide managers of health facilities in the Wa Municipality to put measures in place, for instance, organizing refresher programmes for healthcare staff that will equip them with the necessary competences to eliminate factors that do not promote satisfaction among the deaf. The study findings also unearthed the constraints in accessing healthcare and possible strategies to help improve access and satisfaction with healthcare among deaf patients in the Wa Municipality. When these strategies are implemented, it will help improve the healthcare systems in the municipality. Finally, findings of the study will add knowledge to the existing literature on patients' satisfaction with healthcare services in the Wa Municipality.

1.7. Delimitation

This study was delimited to Wa Municipality of the Upper West Region with concentration on deaf people's satisfaction with healthcare services.

1.8. Operational Definition of Terms

Nursing Care – Services provided to clients at the health facility by healthcare staff for the satisfaction of clients' needs.

Satisfaction with healthcare – A person's subjective evaluation of their cognitive and emotional reaction as a result of interaction between care providers and their expectations and perceptions regarding health service delivery.

1.9. Organization of the Study

This study is organized into five chapters. Chapter one introduces the entire study, beginning with a general background to the study. It covers the statement of problem, research objectives, and research questions. This chapter also discusses significance

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of the study, delimitation, operational definition of terms and chapter organization of the study.

The second chapter of the study focuses on the discussion of the theory relevant to patients' satisfaction with healthcare. An eclectic review of relevant conceptual and empirical literature is also carried out in this chapter. The empirical literature review is based on the objectives of the study to ensure the study is grounded on empirical evidence in the literature so that cogent findings and conclusions are drawn based on the stands of existing literature.

In Chapter three, the researcher discusses the research methodology of the study. Again, this chapter explains the philosophical underpinning and justifies the research paradigm under which the methods for the study are selected. It also covers sources of data, population, sample size, sampling technique and the instrumentation. In addition, data collection procedure, trustworthiness, and ethical considerations are also discussed in this chapter.

In chapter four, findings are presented together with the discussions to enable readers follow the connection between the objectives of the study and research questions, the literature review, and the responses from participants.

Chapter five of the study summarizes and concludes the entire study. The necessary recommendations are made to inform practice, policy action and direction to ensure satisfaction with healthcare services among deaf people in the Wa Municipality.

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CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter is composed of three parts with specific focus on theoretical, conceptual, and empirical literature review relating to patient satisfaction with healthcare services. The first part presents a review of the theory underpinning this study. Specifically, the theoretical review looks at the consonance theory of patient satisfaction proposed by Bernardo (2017).

The second part of this chapter presents conceptual literature on various concepts under patient satisfaction. The areas covered include overview of the concept of deafness, overview of patient satisfaction with healthcare, and overview of the concept of quality healthcare.

The third part of this chapter delved into review of empirical literature related to the key concepts of the study. Specifically, the major themes of the empirical literature review include deaf people's experiences with access to healthcare services, factors contributing to satisfaction with healthcare services, constraints to satisfaction with healthcare services and potential strategies to improve satisfaction with healthcare services. The empirical review served to help identify knowledge gaps in the literature, that formed the basis for the study objectives.

The theoretical, conceptual, and empirical literature served to provide input, constituting the basis for discussion of the study results to draw meaningful conclusions from the study and guide the recommendations that are made to inform

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practice and policy to help contribute towards improving satisfaction with healthcare services, particularly, among deaf people.

2.1 Theoretical Literature

2.1.1 Consonance Theory of Patient Satisfaction

The consonance theory of patient satisfaction which was proposed by Bernardo (2017) is a theory that was deductively derived through critical review of existing literature on patient satisfaction with nursing care. The theory holds that patient satisfaction is the outcome of the consonance between patients' expectations of care and actual care received from the care provider which eventually influences the patients' health-related outcomes and the institution's quality of care. This theory recognizes the active role of the patient and the care provider, as well as their harmonious interaction to achieve their shared goal, which is, patient satisfaction. Therefore, this theory provides a pragmatic way of understanding and achieving satisfaction with healthcare as it relates to nursing care and healthcare delivery. The components of the theory are patient's care expectation, individualized nursing care, patient satisfaction, institutional quality of care, and health-related outcomes.

For easy and better understanding of the theory, Bernardo (2017) elaborated the components of the model as presented below:

2.1.2 Patient's Care Expectation

This is the patient's personal standard of nursing care (technical care, interaction or support care, and information care) which are based on the patient's healthcare needs, perception of ideal care, and previous care experience. The care provider identifies individual patient's healthcare needs and their expectations of care to provide individualized nursing care. To achieve patient's satisfaction consistently, data about

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what the patient prefers should be obtained before care is delivered, not at the end of a care encounter, to bridge the gap between patient's perceptions of quality of care and those of the nurses. Assessing patient's preferences should be a major component of the nursing assessment.

2.1.3 Individualized Nursing Care

Individualized Nursing Care refers to what nurses provide based on their assessment of patient's needs and preference. Individualised nursing care is designed in consonance to the needs and preferences of a particular patient at a particular time recognizing the context in which the care is provided. Such care requires the health professional to take account of patient's beliefs, values, hopes, needs, and desires and their differing states of health and demographic status (Suhonen et al., 2012). Suhonen et al. (2012) defined the perception of individualized care from the patient's perspective as the provision of support for individuality during specific nursing interventions and care delivery generally. Individualized nursing care increases patient satisfaction and promotes positive patient outcomes.

2.1.4 Patient Satisfaction

Patient satisfaction is the outcome of the consonance between the patient's expectation of care and actual care received from the nurse; as well as a precursor of patient's health-related outcomes and the institution's quality of care. Patient satisfaction is viewed as both a dependent variable of quality of care, as well as a predictor of subsequent health related behaviour. It represents a complex mixture of perceived need, expectations of care, and the experience of care (Wilkin et al. cited in Bernardo, 2017). Patient satisfaction is mainly determined by the patients' expectations regarding the nursing care they should receive and their perception of delivered

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nursing care. Thus, the patient, who experiences the quality of nursing service and care provided better than expected, reports higher level of satisfaction with his hospitalization, and dissatisfaction arises when patients' expectations are not fulfilled. Moreover, since patient satisfaction is an indicator of institutions' quality of care, it is then necessary to evaluate patient satisfaction to determine the quality of nursing care practices and the hospital quality of care in general. When the patient has a positive experience with the nursing care, this will be positive for the nurse and the entire health organization as well.

2.1.5 Institutional Quality of Care

It refers to the efficiency of services and systems of a healthcare institution. It is composed of variety of services such as nursing care, medical care, etc. Institutional quality of care is represented by the actual nursing care the patient received and is determined by patient satisfaction. Patient satisfaction with nursing care is the most important predictor of patient’s overall satisfaction with their hospital care. Quality of healthcare usually is defined by healthcare providers from a technical perspective; however, recent literature has emphasized the importance of the patient's perspective in assessing quality of healthcare. Moreover, other researchers reported that the patient’s perspective is increasingly being viewed as the meaningful indicator of health services quality and may represent the most important perspective (Tejero, 2012). Patients' opinions about the care they receive are highly influenced by their experiences during hospitalization. Their opinions about the nursing care they receive have been found to be an important outcome indicator for quality nursing care. Furthermore, the assessments of quality of healthcare represent a complex mixture of needs, expectations of care and the experience of care. A satisfied patient is loyal to his healthcare provider, will use the services of the given healthcare facility if a need

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arises in the future, and will recommend the facility to other customers (Dansky & Milles, 2007). An unsatisfied patient prematurely ends treatment and looks for help elsewhere. The healthcare facility then must bear costs linked with the loss of an unsatisfied patient and with obtaining new patients (Bernardo 2017).

2.1.6 Health-related Outcomes:

This component refers to positive and negative behaviours that the patient obtained from the nurse-patient interaction influenced by their satisfaction with the actual experience of individualized nursing care. Health-related outcomes are influenced by patient's satisfaction and the actual experience of individualized nursing care that is in consonance to his/her expectations of care. Patients who are satisfied with nursing care are important for the hospital as they will more likely comply with instruction and advice of health professionals and will most likely obtain better treatment results. Whereas an unsatisfied patient does not cooperate during the care and treatment process.

2.1.7 Summary of the Theory

In summary, the harmonious relationship between the patient and the nurse provides an avenue for both to achieve their shared goal – patient satisfaction. The goal of the nurse is the patient's well-being, and this is realized through the interaction between them, an experience transpiring in whatever cultural context or healthcare setting in the world. The bonding between nurse and patient directly affects patient satisfaction, thus pointing to the importance of the nurse–patient relationship in bringing about outcomes of care. Nurse–patient bonding should be fostered and strengthened in every nurse– patient interaction to enhance patient satisfaction (Tejero, 2012).

From the foregoing, it is important to put the current study in context of the consonance theory of patient satisfaction, in that, deaf people assess their satisfaction

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with healthcare services in the Wa Municipality in line with their expectations of care vis-a-vis the actual care received from the health facilities.

2.2. Conceptual Literature

2.2.1 The concept of Healthcare

Healthcare is the state of improvement of health through the prevention, diagnosis, treatment, amelioration, or cure of disease, illness, injury, and other physical and mental impairments in people (WHO, 2010). This definition of healthcare is adopted by practitioners in medicine, chiropractic, dentistry, nursing, pharmacy, allied health, and other care providers who deliver healthcare service (Adu-Adjei, 2015). They refer to health as the work done in providing primary care, secondary care and tertiary care, as well as in public health. Furthermore, healthcare is conventionally regarded as an important determinant in promoting the general health and wellbeing of people around the world (WHO, 2010).

2.2.2 Overview of the Concept of Quality Healthcare

In ordinary language, quality is how good something is. It may either be a service or a product. A person's judgement about a service or product depends on what they expect of it or from it. Although different words are used to explain quality, the intent is to describe the extent to which a product or service satisfies a person or a group utilizing it, i.e., how much satisfaction the person gets from the service or product (Adindu, 2010). Quality is also understood as the totality of features and characteristics of a product or services that bear on its ability to satisfy stated or implied needs (Kotler et al., 2002).

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Quality healthcare delivery has a significant influence on the patient's overall perception and satisfaction. It offers a fulfilling environment where the patient is more likely to continue utilizing services provided by the provider (Atinga et al., 2011). In his study, Haywood (1988) identified three main components of service quality, which he termed the 3 "Ps" of service quality (Physical facilities on processes and procedures, Personal behaviour on the part of serving staff(s), and Professional judgment on the part of serving staff(s) (Gunawardane, 2011).

When we say quality of care, it means healthcare activities that people in the medical, nursing, laboratory fields etc. perform daily to benefit their patients without causing harm to them (Offei et al., 2004). Quality of Care demands that healthcare professionals pay attention to the needs of patients and clients. They must also use methods that have been tested to be safe, affordable and can reduce deaths, illness, and disability. Furthermore, healthcare providers are expected to practice according to set standards as laid down by clinical guidelines and protocols (Offei et al., 2004).

Quality of Care entails that health workers do the right things at the right time, see to patients promptly, make the right diagnosis and give the right treatment. With quality of care, service providers keep on improving on their standard of services till excellence is attained.

The quality of healthcare is said to have three domains: patient safety, clinical effectiveness, and patient experience (compassion, dignity, and respect) (Black et al., 2014). Unlike the quality of other manufactured goods, the quality of healthcare services is very elusive. Even though there are several definitions on the quality of healthcare service, it is still complicated and an indistinct concept. Adindu (2010), stated that the quality of healthcare is a multidimensional concept which reflects a

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judgment about whether services provided for patients were appropriate and whether the relationship between doctor and patient was proper.

The World Health Organization (2010) noted that the quality in health services should reflect the following: *safety* (avoiding injuries to people for whom the care is intended), *effective* (providing evidence-based healthcare services to those who need them), *people-centred* (providing care that responds to individual preferences, needs and values) and *timely* (reducing waiting times and sometimes harmful delays) (Upadhyai et al., 2019). Service quality is further defined as the difference between clients' expectation for service performance prior to the service encounter and their perception of the service received. Clients' expectations serve as a foundation for evaluating service quality because, quality is high when performance exceeds expectation and quality is low when performance does not meet their expectation (Asubonteng et al. cited in Mugambi & Kiruthu (2015).

In service quality literature, expectation is viewed as desires or wants of consumer i.e., what they feel a service provider should offer rather than would offer (Parasuraman, Zeithaml, & Berry, 2008). Atinga et al., (2011) opined that most studies on patient satisfaction with quality of healthcare often emphasize areas such as communication, provider courtesy, support/care, environment of the facility and waiting time as important tools in measuring quality healthcare.

Mugambi and Kiruthu (2015) pointed out that, by defining service quality, service providers will be able to deliver services with higher quality level, which ultimately, will result in increased customer satisfaction.

2.2.3 Components of Quality Healthcare

Quality healthcare service has several components. Health practitioners need to understand these in order to improve quality of care. Touching on the parts of quality

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health services, Offei et al. (2004) identified eight components of quality healthcare in line with World Health Organization (WHO) standard as: access, technical competence, equity, and effectiveness. The rest are efficiency, continuity, safety, and amenities.

Access to Service

Access refers to the ability of the individual to obtain health services. Access is affected by some factors of which some are:

Distance: where health facility is situated far away, or it is difficult to get transport to the facility, access to quality health care becomes a problem.

Financial: where people cannot pay for the services provided.

Culture, beliefs, and values: The services provided may not be in line with the culture, beliefs and values of some people.

Technical Competence

Technical competence as an indicator of quality assurance means that practitioners should have adequate knowledge and skills to carry out their functions so as to provide quality service. This is achieved through effective training and retraining of the healthcare staff. Practice should also be guided by laid down standards and guidelines e.g., Standard Treatment Guideline.

Equity

Quality services should be provided to all people who need them, be they poor, children, adults, old people, pregnant women, disabled etc. Quality services should be available in all parts of the country, in villages, towns and cities.

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Effectiveness

Talking of effectiveness, it concerns the type of care that produces positive change in the patient's health or quality of life. Health professionals must therefore use treatments that are known to be effective.

Efficiency

Efficiency is the provision of high-quality care at the lowest possible cost. Health professionals are expected to make the best use of resources and avoid waste of the scarce resources.

Continuity

Continuity means that the client gets the full range of health services he/she needs, and that when the case is beyond him/her, the client is referred to the right level for further care. Continuity may also be achieved by the patient seeing the same primary healthcare worker or by keeping accurate health records so that another staff can have adequate information to follow up the patient.

Safety

Safety means that when providing health services, practitioners must endeavour to reduce to the barest minimum injuries, infections, harmful side effects and other dangers to clients and to staff. In providing quality care, they should not put the patient's life at risk. For instance, they should not give unsafe blood to patients and thereby infect them with HIV/AIDS.

Amenities

They are features that can be provided by management of health facilities to make life comfortable and pleasant for clients. They contribute to clients' satisfaction and make clients willing to use the services. For example, provision comfortable seats,

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television sets, music, educational materials, educative video films, etc. at the OPD and wards.

2.2.4 Overview of the Concept of Patient Satisfaction with Healthcare

Kotler and Armstrong (2014) posited that satisfaction is a state of happiness or disappointment that comes from the comparison of a perceived performance of a product relative to its expectations. The authors added that satisfaction is an action, which is, meeting a genuine desire, demand, and expectation. Generally, patient satisfaction is defined as the patient's view of services received and the results of the treatment (Kleinman, 2012). Satisfaction is seen as an emotional response and can only be understood when one recognizes the emotional state of the client (Zineldin, 2006, Burns & Neisner, 2006).

The available literature suggests that the first attempt to measure patient satisfaction in the healthcare industry was initiated by Hulka, Zyzanski, Cassel, and Thompson (1970). The aim of this initiative was to develop "Satisfaction with Physician and Primary Care Scale". Ware and Snyder (1975), followed with their "Patient Satisfaction Questionnaire", targeted at assisting with the planning, administration, and evaluation of health service delivery programmes. In the late 1970s, Larsen et al. developed the "Client Satisfaction Questionnaire" (1979) with eight-item scale for assessing general patient satisfaction with healthcare services. This scale was superseded by their "Patient Satisfaction Scale" (Gill & White, 2009). Eventually, Parasuraman et al., (1985), conceptualized service quality in relation to patient satisfaction using a disconfirmation model that compared patients' expectations and perceptions (Yousapronpaiboon & Johnson, 2013). Advancing the discussion, Garvin (1988) built on this model by using a more enhanced approach by defining quality

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along eight dimensions; (i.e., performance, features, reliability, conformability, durability, serviceability, aesthetics, and perceived quality) to measure patient satisfaction with service quality.

Anderson (1995) measured the quality of services provided by a public university clinic using a 15-item instrument to represent the five dimensions of Service Quality (SERVQUAL). Findings of his study revealed that, all the five dimensions measured negatively, with assurance being the worse measured. Other studies have been conducted in different countries on perceived service quality in the hospital sector. For instance, Boshoff and Gray (2004) adopted this model for a study on customer satisfaction and loyalty among patients in the private healthcare industry in South Africa and found that SERVQUAL dimensions such as nursing staff empathy, assurance, and tangibles, impacted positively on patients' loyalty.

In a similar study, Cohen (1996) reported that consumers of healthcare services mostly ranked communication and interpersonal aspects of the healthcare encounters as the highest. A survey on inpatients and outpatients who visited primary healthcare centres, community healthcare centres, district hospitals and female district hospitals in the state of Uttar Pradesh in India identified the following dimensions of service quality; medicine availability, medical information, staff and doctor behaviour and hospital infrastructure (Rao et al., 2006). Patients' perception of service quality was found to be slightly above average. On the part of outpatients, doctor behaviour was the major determinant of patient satisfaction.

Additionally, a study of patients' attendance at the outpatient's department (OPD) of government allopathic health facilities of Lucknow District of India, Kumari et al. (2009) reported that, even though overall satisfaction with the patients was

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satisfactory, patients identified shortfalls in certain areas such as long OPD hours, non-availability of drinking water, absence of clean toilets and poor doctor–patient communication. Meanwhile, Sodani & Kalpa. (2014) also measured the satisfaction with patients visiting the outpatient department (OPDs) of a district hospital, a civil hospital, a community health centre, and primary health centre of eight selected districts of Madhya Pradesh, India and observed an increase in the satisfaction levels of patients with the behaviour of doctors and staff at lower-level facilities compared to higher-level facilities.

Also, in their study, Nwankwo et al. (2010) found that public hospitals were largely providing unsatisfactory services to their patients with regards to doctor's responsiveness, length of getting an appointment time, access to core treatment and hours of operation. Further, reporting on the important indicators for measuring service quality among patients in Turkish hospitals, it was confirmed that tangibility, reliability, courtesy, and empathy were significant for clients' satisfaction, while responsiveness and assurance were not (Zaim et al., 2010). Examining the service quality in hospitals of Kerman University of Medical Sciences, Nekoei-Moghadam and Amiresmaili (2011) found that the largest discrepancies between patients' expectations and perception were in the tangibles dimension followed by responsiveness, reliability, assurance, and empathy in that order.

In their separate studies, Alrubaiee and Alkaa'ida (2011) and Ramez (2012) found that patient perception of healthcare quality had a significant positive relationship with patient satisfaction. Patient satisfaction is influenced by the interaction between two factors: patient expectations and experience of the real services. If the performance falls short of expectations, there is dissatisfaction, but if it matches the expectations, then there is satisfaction (Salihu & Metin, 2017). Shinde and Kapurkar

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(2014) noted that by understanding the essence of patients' satisfaction and determining its existence level, healthcare services can be made relevant and readily available to the requirement of people and patients.

Contributing to the discourse on satisfaction, Kotler and Armstrong (2014) opined that satisfaction is the feelings of pleasure or disappointment which a person expresses because of comparing a product's outcome in relation to his or her expectation. In the situation where expected performance is more than perceived performance, then, clients become dissatisfied. On the contrary, if perceived performance outweighs expectation, the client turns to be satisfied. Furthermore, patient satisfaction is viewed as a cognitive evaluation of the service that is emotionally affected, thus, an individual subjective perception (Crow et al., 2002; Urden, 2002). In short, Gill and White (2009) observed that patient satisfaction is considered part of quality healthcare outcome which includes the clinical results, economic measures, and health related quality of life.

2.2.5 Overview of the Concept of Deafness

History has it that deaf people in the United States have been marginalized and discriminated against internationally and locally (Tye-Murray 2009). This largely stems from the fact that deafness is an invisible disability as such it is often side-lined, ignored, unrecognised or even forgotten by the hearing community (Purcell 2014; Tye-Murray 2009). The concept of "deafness" is viewed differently by different people. The term "deaf" may be labelled with lower case "d" or upper case "D" depending on the orientation of the individual. Powers (1997) noted that hearing parents, professionals serving deaf people and medical proponents view deafness as a pathology which requires rehabilitation, and thus, use the lower case "d". On the other

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hand, Powers (1997) observed that adult deaf and advocates of Deaf Culture see deafness as a social and linguistic difference and therefore use the upper case “D” in their reference to them. This group is thought to belong to a cultural community of individuals who are deaf and do not necessarily need rehabilitation. They have a separate culture and communicate through Sign Language. Deaf Ghanaians who are members of deaf people Cultural Community, therefore, use the Ghanaian Sign Language (Oppong, 2006).

The term Deaf is thus used to refer to an individual whose hearing loss is such that he/she cannot use hearing to understand speech or for the normal purposes of life (Offei & Acheampong, 2018; Avoke, 2004). Even though a deaf person may have residual hearing, he/she uses vision as the primary medium for learning and communication (Heward, 2003). Hallahan et al. (2009) also stated that deafness refers to hearing loss in which hearing is not sufficient for the individual to comprehend auditory information, with or without hearing aid.

According to the World Health Organization (2019) standard, deafness is a loss of more than 40 decibels (dB) in the better ear for those over the age of 15 years and a loss of 30 dB in the better ear for those between the age of 0 and 14 years. Deafness is caused by congenital diseases acquired at birth or infections much later in life and other causes such as exposure to loud noise, accident, ageing, or malformation of the inner ear (Breu et al., 2018). In terms of categorization and degree, people who are considered deaf are those in the categories of severe and profound hearing loss (50 to 70 dB HL) and (71dB HL and above) respectively (Northern & Downs, 2002).

The World Health Organization’s 2011 global report on disability shows that deaf people population is estimated to be about 5% of the world’s population, with

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approximately one-third of them being over 65 years (WHO, 2011). With regards to Ghana, Joshua (2013) reported that deaf people population was more than 260,000 people. In society, deaf people community is mostly neglected, as such, they tend to learn from their older associates. The consequent of deafness leads to decreased capability to communicate, delay in language development, economic and educational backwardness, social isolation, and stigmatization and hence affects health (Singh, 2015).

2.2.6. Deaf People and Healthcare Access/Utilization

Access to healthcare services refers to one's ability to receive needed treatment. Three components of accessibility put deaf people at significant disadvantage: knowledge, financing, and communication barriers. These restrictions can lead to exclusion of deaf patients out of health services or may lead these individuals to avoid or delay seeking for healthcare services (Mitsi et al., 2014).

Communication problems have the potential to lead to misdiagnoses, unnecessary movements and contribute to the deterioration of the health of deaf people, because of misunderstanding of medical instructions or even dispersion of infectious diseases due to incomprehension of the precautionary methods. Olusanya et al. (2014) opined that hearing impairment has negative consequences on the emotional well-being and societal participation of deaf people. Mahfooth and Abushaira (2014) also noted that the cultural belief regarding deafness influences how people with difficulty hearing participate in society.

In a survey of deaf adults about their experiences of consulting in primary healthcare, Reeves and Kokoruwe (2005) reported that majority of their study participants said they had not understood the diagnosis and medical guidelines given by the doctors

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and that they had received the wrong dosage of medication. Access to quality healthcare is a major need for all categories of people. Nearly every member of society has a need to use healthcare at one time or another.

Furthermore, timely and effective access to healthcare is crucial, not only to immediate and long-term well-being, but to the risk of severe morbidity or even death. In the light of these, Reeves and Kokoruwe (2005) noted that if there are barriers obstructing access, it can have far reaching consequences in the healthcare sector than in any other area of public life.

Largely, several factors interfere with access to healthcare. Key among these is the quality of communication between the patient and the healthcare professional (Reeves & Kokoruwe, 2005). Unambiguous and full communication is essential for successful diagnosis, treatment, compliance, and aftercare. If the patient is unable to fully convey the history of their condition, their symptoms, and other factors such as drug allergies to the practitioner, the ability of the latter to make a full diagnosis and prescribe appropriate treatment can be seriously compromised. On the other hand, if communication from the practitioner to the patient is restricted, the patient may not be able to: confirm that they have been understood or comprehended the diagnosis or understand how to comply with the recommended treatment.

2.2.7. Service Quality Dimensions in Healthcare

When talking of quality in medical care, Gill (1993) noted that there is difference in opinions. Medical quality is a combination of various elements such as correct diagnosis, appropriate intervention, and effective treatment. It also includes other elements such as good communication, patients' satisfaction, and consideration for the patients' preferences (Gill, 1993). It is therefore not sufficient to consider only the

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technical competence of those providing care, but also care must be provided more effectively, efficiently, and humanely. As noted by Opuni et al., (2014), two questions come to mind when we consider professional quality: (1) Does the service meet professionally assessed needs of its clients? (2) Does the service correctly select and carry out the techniques and procedures which professionals believe meet the needs of the clients?

Brown et al. (1998) described nine quality dimensions of health service delivery as: effectiveness, efficiency, technical competence, interpersonal relations, and access to service. The others are safety, physical aspect of healthcare, choice, and continuity. These dimensions are further explained below.

Effectiveness

The degree to which desired results (outcomes) of care are achieved through appropriate diagnosis and treatment.

Efficiency

The ratio of the outputs of services to the associated costs of producing those services (taking into consideration both materials and time resources).

Technical Competence

The degree to which tasks carried out by health workers and facilities meet expectations of technical quality (according to clinical guidelines).

Interpersonal Relations

The level of respect, courtesy, responsiveness, empathy, effective listening, and communication exhibited between clinic personnel and clients.

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Access to Service

The degree to which healthcare services are unrestricted by geographic, economic, social, organizational, or linguistic barriers.

Safety

The level of trust, confidentiality and privacy in the service and the degree to which the risks of injury, infections or other harmful side effects are minimized.

Physical Aspects

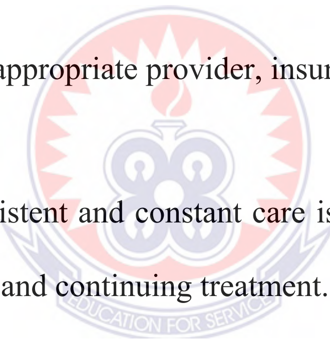
The physical appearance of the facility and the level of cleanliness, comfort, and amenities offered.

Choice

It is the client's choice of appropriate provider, insurance plan, or treatment.

Continuity

The degree to which consistent and constant care is provided, including the value of visiting the same provider and continuing treatment.



2.3. Empirical Literature

2.3.1. Patients' Experiences with Access to Healthcare Services

Knowledge of patients' experience with access to healthcare services is crucial for ensuring improvement in systems and maximizing satisfaction. By assessing patients' experiences with their access to healthcare delivery, healthcare services can be made relevant and readily available to the expectation of the public and patients (Al-Abri & Al-Balusi, 2014).

Studies across the globe have revealed different experiences with access to healthcare services among various groups of people. In their study of satisfaction among deaf

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people with the healthcare system quality in Brazil, Farias, and Cunha (2017) noted that greater percentage of the participants (86.7%) were very dissatisfied with the communication of the healthcare professionals, 80% reported lack of informative and educational materials to clients, while 53.3% were dissatisfied with the time it took them to access doctors and test results. However, their study did not look at possible strategies to improve satisfaction with healthcare among deaf people.

Also, Khamis and Njau (2014) investigated patients' level of satisfaction on quality of healthcare at Mwananyamala hospital in Dares Salaam, Tanzania and reported general dissatisfaction with the quality of care. In that study, a cross-sectional study design was used where pre-tested SERVQUAL questionnaire was administered to 422 study subjects to collect data and one-sample t-test was employed to identify patients' level of satisfaction and principal component analysis to identify key items that measure quality of care. After analysing the data, patients' level of satisfaction mean-gap score (-2.88 ± 3.1) was identified, indicating overall dissatisfaction with the quality of care. The level of dissatisfaction in the five service dimensions were as follows: assurance (−0.47), reliability (−0.49), tangible (−0.52), empathy (−0.55), and responsiveness (−0.72).

On the contrary, Adamu and Oche (2014) found that 65% of the participants in their study of patients at the Outpatient Clinic of a Tertiary Hospital in Nigeria expressed satisfaction with the neatness of the clinic environment. With regards to communication between physicians and patients, 65% of the participants expressed satisfaction with explanations offered by the physicians concerning their diagnosis and treatment. In all, 54% of the participants expressed satisfaction with the overall services of the clinic. It is asserted that the more a patient understands his/her illness

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during consultation, the more the likelihood of the patient being satisfied with the consultation (Keitz et al., 2007).

The assessment of patients' experiences is largely based on the healthcare services patients receive at the hospital. Satisfaction or dissatisfaction may therefore be expressed due to several factors, including waiting time before receiving attention, communication, nature of equipment, staffs' attitudes, proximity to hospital, cost of treatment, impression about the hospital environment, and professionalism of nurses/doctors handling them. For instance, Islam et al. (2015) conducted a study on patients' satisfaction in Bangladesh with focus on maternal and neonatal health, family planning services and diabetes and found that providers' attitude towards the patients and reduced waiting time influenced patients' satisfaction significantly in the rural public health facilities.

In a related study, Kyle et al. (2013), revealed that, harsh attitudes were meted out to deaf patients by certain healthcare providers in the United Kingdom. For instance, it was reported that more deaf clients frequently languished in waiting areas not knowing that their names have been called. In another study, Laur (2018), also observed that deaf people in the United Kingdom (UK) struggle at medical settings to have equal access to healthcare services daily. The report added that some deaf patients feel trapped and are treated like second-class citizens. Aldana et al. (2001) reported that only 45% of women who received services at the maternal and/or family planning units were satisfied with privacy arrangements during consultation.

Similarly, Adhikarylford et al. (2018) reported that factors such as convenient opening hours, opportunity to ask related questions to the providers, cleanliness of the facility, and privacy settings had significant association with patients' satisfaction. It

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was particularly observed that being satisfied with facility cleanliness 95% and privacy setting 95% were the strongest predictors of patients' satisfaction in the Rajshahi and Sylhet divisions of Bangladesh. Women are also known to be more dissatisfied with public healthcare services in Bangladesh than men (Adhikary et al., 2018).

In their investigation of the association between age and satisfaction, Iddrisu et al., (2019) observed that majority (76.5%) of those who were dissatisfied with healthcare services they received were aged less than 30 years. Vadhana (2012) noted that older clients often assign more scores to service providers as they (aged) have been going through the social services all their lives. Often, the aged are less judgmental and are more likely to be satisfied with the healthcare system than the young (Demir & Celik, 2002).

In their study, Batbaatar et al. (2016) and Crow et al. (2002) found that healthcare providers' interpersonal communication skills and behaviour towards the patients were directly linked with patients' satisfaction. In Pakistan, Hussain et al. (2019) asserted that among the several factors that influenced patients' satisfaction in southern Punjab hospitals, pharmacy services, laboratory services, doctor–patient communication, and physical facilities of the hospitals were found to be major determinants. The study found that hospitals with less qualified pharmacy staffs provided insufficient information to clients which in turn led to deficient interaction between the dispenser and the patient. With regards to laboratories services, the study reported unhygienic environments, late and fake results, uncompetitive staff, and a significant communication gap, which ultimately resulted in dissatisfaction.

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In the Ghanaian context, Ampofo (2015) investigated patients' satisfaction with the quality of healthcare services provided by selected health facilities within Cape Coast Metropolis and reported that only 4.2% of the participants were very satisfied with healthcare services provided them. A vast majority of them 91.4% were fairly satisfied while the remaining 4.4% were not satisfied at all. Findings of the study however showed no significant associations between socio-demographic variables (i.e., gender, age, marital status, educational level, and occupation of patients) and the satisfaction levels of the participants accessing healthcare at the selected health facilities in the Cape Coast Metropolis. Ampofo (2015) further found that patients' satisfaction was positively influenced by family income, treatment cost, waiting time, information disclosure and environmental cleanliness. It should be noted, however, that this study was basically conducted among the hearing people without including deaf participants.

Like the findings of Ampofo (2015), Nketiah–Amponsah and Hiemenz (2009) also reported waiting time as a significant predictor of healthcare satisfaction in three selected Districts of Ghana (i.e., Lawra, Dangme West and Ejisu-Juaben). In addition to waiting time, Nketiah–Amponsah and Hiemenz (2009) observed distance and socio-demographic characteristics such as level of education and gender of client as being significant determinants of patients' satisfaction.

Iddrisu et al. (2019) also carried out a study on patients' satisfaction with healthcare services in the Tamale Teaching Hospital and reported that patients' satisfaction was influenced by good communication (66.5%), good attitude of staff, availability of nurses, and knowledge of their diagnosis prior to interventions. About 27.5% of patients however expressed frustration over long waiting time to access their folders at the Outpatient Department (OPD). Peprah (2014) reported that at the Sunyani

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Regional Hospital of the then Brong Ahafo Region of Ghana, patients' satisfaction with healthcare services was found to be influenced by attitude of health professionals, prompt service delivery, ability of health professionals to disseminate information to patients, availability of up-to-date equipment, the hospital's ability to render 24-hour service, and cleanliness of the hospital.

2.3.2. Factors Contributing to Satisfaction with Healthcare Services

World Health Organization (2010) noted that whereas reliability, durability, high performance, and packaging are used to distinguish one tangible product from another, in the service sector, however, packaging embodies how client is treated right from the initial entry at the facility. The way a patient is welcomed, registered, and treated or referred goes a long way in determining whether the patient will continue to patronize a particular facility (Amankwah & Ohene-Adu, 2011). Also, the process involved in delivering the service plays a significant role as far as patient satisfaction is concerned. When the process of delivering the service is prolonged, it influences the patient's turnaround time. For instance, long queue(s) at the OPD before a patient can retrieve their folder or see the doctor for consultation can irritate them.

In a study of factors affecting patient satisfaction and healthcare quality, a comprehensive conceptual model to understand and measure variables affecting patient satisfaction-based on healthcare quality was built. The model explained that patient satisfaction is a multi-dimensional healthcare construct affected by many variables (Naidu, 2016). The model showed that healthcare quality affects patient satisfaction, which in turn influences positive patient behaviours such as loyalty (Naidu, 2016). The study observed that patient satisfaction and healthcare service

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quality, though difficult to measure, can be operationalized using a multi-disciplinary approach that combines patient inputs as well as expert judgement (Naidu, 2016).

In a systematic review of factors that affect patient satisfaction with nurse-led-triage, factors such as nurses' ability to provide patient-centred care, communication skills, nurses' caring abilities, concern for the patient and competence in diagnosing and treating the health problem were found to be associated with patient satisfaction (Abdul et al., 2015). In the same systematic review, other factors such as availability and visibility of nurses, provision of appropriate health related information in a jargon-free language, nurses' ability to answer questions, and an ability to provide patients with an opportunity to ask questions were found to be associated with patient satisfaction (Abdul et. al., 2015).

In other studies, the impact of communication style on patient satisfaction with healthcare services was assessed during routine follow-up visits among patients. Among the factors considered in the study, employment status (0.12, 95% CI -0.0094-0.25, $p = 0.069$) and physical health score (effect size = 0.0058, 95% CI 0.00051-0.0011, $p = 0.032$) of the patient had the greatest impact on patient satisfaction (Mougalian, 2019; Trant et al., 2019). Communication and information exchange between patients and healthcare providers was found to influence patient satisfaction with healthcare. Two-way communication is seen as one of the most important characteristics of good quality care as well as being necessary for the development of good staff relationship. Eriksson and Svedlund (2007) report that sometimes patients are misunderstood or not taken seriously because of one way communication and that the communication they receive may be delivered in a technical language that is hard to understand. Lack of information provided to the patient about disease, its causes,

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perspectives, and way of treatment can be a source of dissatisfaction (Bankauskaite & Saarelma, 2003).

An exploratory study was also conducted for quality management in the healthcare sector to examine the factors affecting patient satisfaction. The results of the study revealed that factors which affect patient satisfaction are affordability and convenience, fulfilment of clinical requirements, nursing and staff care, general behaviour of doctors, registration and administrative procedures, infrastructure and amenities, professional behaviour of doctors and facilities at reception and outpatient department area (Kamra, 2016). It has also been found that health insurance and various categories of participant demographics, namely gender, residence, education and occupation are significantly different statistically ($p<0.05$) with respect to the identified factors (Kamra et al., 2016). In a related study, Zun et al. (2018) reported that in Malaysia, patient satisfaction was influenced by patients' past experiences, lifestyle, individual values, and level of knowledge. Lengthy waiting time, employee attitude and work process were other factors identified.

Generally, patient satisfaction is a useful measure for providing a quality benchmark for healthcare services (Mohiuddin, 2020). Hence, the concern about the quality of healthcare services has led to a loss of confidence in some healthcare providers, low use of public health facilities and increased outflows of patients from one health facility to another. For example, the concern for quality healthcare caused an increased outflow of patients from health facilities in Bangladesh to hospitals abroad (Mohiuddin, 2020).

An assessment of patient satisfaction with healthcare services from the Bangladesh perspective revealed that the key obstacles to access to health services are insufficient

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infrastructure and poor quality of existing facilities, lack of medical equipment, scarcity of doctors due to high patient load, long distance to the facilities and long waiting times until facilities have been reached, very short appointment hours, lack of empathy of health professionals, callous and casual attitude, aggressive pursuit of monetary gains, poor levels of competence and, occasionally, disregard for the suffering that patients endure (Mohiuddin, 2020). Failures of this kind can likely impact patient satisfaction with healthcare services. Thus, strategies to limit or prevent such failures within health institutions can play a powerful role in shaping patients' negative attitudes and dissatisfaction with healthcare service providers and healthcare itself.

In their review of existing literature to identify the determinants of patient's satisfaction with healthcare system in Pakistan, Naseer et al. (2012) identified educational attainment as having a significant impact on satisfaction. Their review of the available studies in Pakistan showed that higher level of education is associated with lower level of patient satisfaction as educated patients are more likely to have good understanding of disease and they expect a better communication from healthcare providers.

Patient's expectation(s) with the healthcare providers and healthcare system is yet another factor that plays fundamental role in the concept of patient satisfaction. The patient compares his/her own experience of the healthcare with expectations and this assessment of patient expectations about healthcare services helps healthcare providers to measure their satisfaction (Greenberg et al., 2006). Greenberg et al., (2006) further noted that, as an evaluative and measurement tool of quality assurance, expectations make the concept of satisfaction more complex. Naseer et al., (2012)

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conducted a review of available literature on patient satisfaction in Pakistan and reported three categories of patient expectations. These are summarized below:

Background Expectations

These are explicit expectations resulting from accumulated learning of treatment and consultation processes.

Interaction Expectations

This refers to patient expectations regarding the exchange of information between them and healthcare providers

Action Expectation

This expectation borders on the action that doctor will take, examples of action expectation include prescribing, referral, or advice from a doctor.

Different patients hold different expectations based upon their knowledge and prior experience and are likely to change with accumulating experiences. Patients with lesser expectations usually have higher satisfaction rates Naseer et al., (2012).

Some other documented evidence present patient satisfaction with healthcare delivery systems giving insight through exploratory research, and support for the strategic use of hospital secondary support functions as an initial strategy for marketing healthcare, increasing patient volume, and expanding patient satisfaction. The evidence revealed that patient perceptions are significantly influenced by hospital support functions (Makarem et al., 2017). Also, the perceptions of patients determine hospital reputation, influence future patient demands, and are integral to the understanding of patients as consumers of healthcare systems rather than consumers of medical procedures (Makarem et al., 2017).

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Chawani (2009) carried out a meta synthesis of available literature of primary qualitative research findings on patient satisfaction with nursing care of adult patients in hospitals across the world. Her study also reported that several factors contribute to patient satisfaction with nursing care including socio-demographic background of the patient, expectations of nursing care, organizational and physical environment, communication and information, participation and involvement, interpersonal relationships, medical and technical skills of health professionals (Chawani, 2009).

2.3.3. Constraints in Accessing Healthcare Services

The United Nations Convention on the rights of persons with disabilities identifies access to healthcare without barriers as a clearly defined right of persons with disabilities. With regards to the deaf, communication has been identified as a major hindrance in accessing healthcare, thus affecting their overall satisfaction with healthcare. Talking about communication, the perceptions of deaf people about the communication process with health professionals was assessed in the state of Rio de Janeiro in Brazil (Santos & Portes, 2019). The study was a cross-sectional observational study and data was collected through the administration of a questionnaire with quantitative and qualitative questions to 121 deaf adults. The data was analysed descriptively through frequency tables and by inferential statistics and logistic regression. The results of the study revealed that the lack of interpreters and the lack of use of the Brazilian Sign Language by professionals were perceived as the main communication barriers for deaf patients during healthcare (Santos & Portes, 2019). In turn, the presence of companions who are listeners (73%) and the use of mime/gestures (68%) were among the strategies most used by the deaf. The majority of deaf people reported insecurity in consultations, and those who best understood their diagnosis and treatment were the bilingual deaf ($p = 0.0347$) and deaf people

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who used oral communication (p = 0.0056) (Santos & Portes, 2019). The study concluded that communication with the professionals was facilitated when deaf people had a companion or when they used mimics and gestures (Santos & Portes, 2019). Sign language was neglected, despite the fact that the provision of care to deaf people by professionals trained to use this language is guaranteed in the legislation (Santos & Portes, 2019). Hence, communication problems exist in the interaction between healthcare workers and deaf patients (Oudesluys-murphy, 2011).

Among the deaf people, problem arises in terms of communication with the hearing population due to linguistic and cultural barriers (Oudesluys-murphy, 2011). For instance, deaf patients may be less assertive or show inappropriate assertiveness when visiting a doctor. One qualitative study explored the communication experience of deaf patients regarding their in-hospital stay. The results of the study revealed that deaf people experience communication difficulties during their in-hospital stay. The study found four major themes regarding the experiences of deaf people during access to healthcare which included: (a) experiencing a common vulnerability: the need for reciprocal understanding and sensitivity, (b) being outside the comfort zone: feeling discriminated against once again, (c) perceiving a lack of consonance between care and needs and (d) developing a sense of progressively disempowerment (Sirch et al., 2017). The study observed that the experiences of deaf people during their in-hospital stay may be critical, suggesting that deaf people are exposed to protracted communication and interaction with healthcare providers and an environment that is not prepared and designed for them as vulnerable patients (Sirch et al., 2017). Two levels of strategies were identified and recommended to be implemented and developed to increase the quality of communication with deaf people during

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hospitalization, both at the hospital/health system level and at the healthcare professional/clinical level (Sirch et al., 2017).

A similar study assessed deaf women experiences and perceptions of healthcare system access. The study results showed negative experiences and avoidance or non-use of health services among the deaf, largely due to the lack of a common language with healthcare providers (Steinberg et al., 2002). The evidence also showed that insensitive behaviours on the part of the care providers were also reported (Steinberg et al., 2002). However, positive experiences and increased access to health information were reported with practitioners who used qualified interpreters (Steinberg et al., 2002). Providers who demonstrated minimal signing skills, a willingness to use paper and pen, and sensitivity to improving communication were appreciated by deaf people(Steinberg et al., 2002). The study noted that deaf people have unique cultural and linguistic issues that affect healthcare experiences. The study recommended that strategies for improved access to health information may be achieved with specialized resource materials, improved prevention and targeted intervention, and self-advocacy skills development. Healthcare providers must be trained to become more effective communicators with deaf patients and to use qualified interpreters to assure access to healthcare for deaf people(Steinberg et al., 2002).

Available evidence show that recurring patterns of communication difficulties occur within the relationship between care providers and patients and these relationships appear to be associated with the occurrence of medical mishaps (Sutcliffe, Lewton, & Rosenthal 2004). Thus, poor communication between the care provider and deaf patients may result in the occurrence of everyday medical mishaps (Sutcliffe et al., 2004).

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Generally, it is clear that deaf people are deprived of some of their rights to healthcare because their first language, the Brazilian Sign Language (LIBRAS), is neglected (Santos & Portes, 2019). The present evidence point to the non-use of sign language by health professionals and the absence of interpreters in health units as the main communication barriers faced by deaf subjects (Santos & Portes, 2019). The communication barriers discouraged deaf people to seek healthcare, influences the perception that deaf people develop of health care, and make them more dependent on mediators that facilitate the communication with health professionals. Although this seems favourable in some situations, in certain moments, the presence of a third party may generate uncertainties, fear, embarrassment, besides hindering the independence and autonomy of deaf people(Santos & Portes, 2019). Regarding the direct interaction between deaf people and health professionals, it is evident that the knowledge and use of Brazilian Sign Language (LIBRAS) guaranteed the respect for the privacy of deaf people and their overall satisfaction with healthcare (Santos & Portes, 2019). Therefore, it is essential to invest in the qualification of health professionals and on their awareness in choosing communication strategies, taking into account deaf people's needs, respecting their particularities, and the perception that the subjects hold a singular cultural identity (Santos & Portes, 2019).

In another related study, Orrie and Motsohi (2018) investigated the challenges experienced by healthcare workers in managing patients with hearing impairment at a primary healthcare setting in South Africa. The study employed the qualitative, descriptive case study design. It was reported that, among other challenges faced by healthcare workers in dealing with deaf patients, difficulties in communication and preconception on the part of both healthcare workers and deaf patients were identified. Other international studies have shown that people with hearing problems

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are unsatisfied by their communication with the health professionals, are less satisfied by the health services they receive, do not receive sufficient messages related to the preventive healthcare and have a deficiency in knowledge of health matters comparing to the hearing people (Mitsi et al., 2014).

Furthermore, in talking about constraints to healthcare access and satisfaction, Abraham et al. (2018) intimates that though access to healthcare is very crucial to all people, persons with disability usually face many barriers including inadequate equipment and skills of healthcare providers, negative experiences with healthcare personnel, and direct exclusion.

Talking about the constraints of persons with disabilities with access to healthcare and satisfaction, Mensah et al. (2008) asserted that just as physical structures and equipment are inaccessible, there are no provisions for sign language in most health facilities in Ghana to respond to the needs of Deaf patients. This, they noted, is likely to result in misinterpretation of sign language by doctors with no knowledge in signing.

2.3.4 Strategies to Improve Satisfaction with Healthcare Services

In every human endeavour, there is the need for improvement. Stakeholders in the health service sector are equally encouraged to put in measures that will facilitate improvement in patients' satisfaction. This may be achieved differently by different institutions/facilities. In Pakistan, for instance, to enhance patients' satisfaction with healthcare services, Hussain et al. (2019) recommended the creation of transparent health sector policies, provision of increased funding for physical infrastructure, and the involvement of all stakeholders in decision making. They further suggested that hospitals' records should be digitized to decrease congestions and delays.

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In their study, Adhikary et al. (2018) noted that the satisfaction with patients with healthcare services can be improved by focusing on improving facility cleanliness, privacy settings and providers' interpersonal skills.

In another study, Velonaki et al. (2015) reported that deaf access to healthcare with satisfaction can be improved through modifying the knowledge, attitudes, and behaviours of healthcare professionals. Khamis and Njau (2014) also recommended that to increase patients' level of satisfaction with healthcare services in Tanzania, hospitals management should focus on; improvement on communication skills among OPD staff in showing compassion, politeness, and active listening. They should also ensure availability of essential drugs and improvement on clinicians' prescription skills.

Contributing to the discussion, Iddrisu et al. (2019) suggested that patients' satisfaction with healthcare services can be enhanced when waiting time at the OPD is reasonably reduced by creating more folder collection points and functioning consulting rooms in the facility. Similarly, Ampofo (2015) also noted that improvements in waiting time, favourable staffs' attitude, respect for patients and their rights, hospital environment and information disclosure were necessary measures to improve patients' satisfaction with healthcare services in the Cape Coast Metropolis.

In a systematic review conducted to examine interventions to improve hospital patient satisfaction with healthcare providers, the study recommended that more rigorous research is needed to identify effective and generalizable interventions to improve patient satisfaction (Falzon et al., 2018). The study also noted that given the importance of patient satisfaction as well as patient outcomes, safety, and cost in

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high-value healthcare, there is an urgent need for properly designed interventions to evaluate novel and sustainable methods to improve patient satisfaction, that have a demonstrable impact on important clinical outcomes, and that can be spread across different regions and hospital contexts (Falzon et al., 2018). Thus, the need for more studies to identify strategies to improve patient satisfaction with healthcare.

Improvement in the professional-technical skills and competence of the care provider has also been identified as a strategy to improve satisfaction among patients. Andaleeb (2017) argued that a basic expectation among hospital patients is assurance that they will be attended to by skilled and competent staff that will treat them professionally and efficiently. Besides, the better the level of assurance provided by the hospital staff, the higher the levels of patient satisfaction will be with the services.

Johansson et al. (2012) also noted that patients expect nurses to have a command of specific knowledge about each patient and their treatment. Lindwall et al. (2013) pointed out that encounters with staff that is proficient and knowledgeable enhance patient satisfaction with nursing care. Jennings et al. (2015) intimated that, patients feel their body is in safe hands if nurses are competent and skilful; and competence gives them a sense that the staff knows what they are doing. In a study done by Kools et al. (2012) patients expressed fear of the staffs' unfamiliarity with their treatment protocols.

Similarly, as a suggestion towards improving the quality of their services to deaf patients, Orrie and Motsohi (2018) recommended that sign language interpreters should be made available at health facilities. It was further recommended that all healthcare workers should receive training in sign language to facilitate their communication with deaf patients. Finally, management of health facilities were

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encouraged to put special labels on the folders of deaf patients for easy identification and prompt treatment.

2.4 Summary of the Literature

Generally, the evidence presented in the scientific literature shows that patient satisfaction is a multi-dimensional healthcare construct affected by many variables. The evidence further shows that patient satisfaction is an important subject to medical (health) care providers, the patients themselves and other third-party stakeholders in the medical care industry. The literature again revealed that patient satisfaction is a key determinant of quality of care and an important outcome measure. Some of the studies found that patients' demographic characteristics such as age, gender, occupation, and educational level affected their satisfaction level whereas other studies found no association between socio -demographic characteristics and patient satisfaction.

Some of the studies reviewed also showed that patients' satisfaction level was influenced by their income (enabling factors) whereas others found no association. Most of the studies showed an association between patients' experience and their satisfaction level. Key among the determinants of patient satisfaction in the literature review was factors such as communication, courtesy, empathy, efficiency, accessibility, and cleanliness.

For healthcare providers, ensuring that patients are satisfied is a continuous effort. Thus, the discourse on the concept of patient satisfaction with healthcare is not exhaustive and needs further investigation. Hence, knowing the true state of patient satisfaction continuous to be a critical issue for healthcare providers. To achieve this,

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the healthcare providers and researchers need to embark on research to examine the experiences of patients and discover ways of serving them better (Ofili, 2014).

To date, deciding the right instrument and methodology to effectively measure the satisfaction level of patients remains a major challenge for healthcare providers/researchers (Ofili, 2014). Also, there is lack of data for generalizable interventions to improve satisfaction with healthcare (Abdul et al., 2015; Falzon et al., 2018; Kamra et al., 2016; Naidu, 2016). The knowledge gap that has been identified in the literature search is that, with regards to deaf peoples' satisfaction with healthcare, the literature search has not found any study conducted on the area of deaf people's satisfaction with healthcare services in Ghana. The studies that are conducted in Ghana are largely on access barriers and communication experiences of deaf people within health facilities Ghana.

In view of the forgoing, to help address the knowledge gap in the literature, this study attempts to explore the satisfaction of deaf people with access to healthcare services, focusing on their concerns regarding healthcare access, factors influencing satisfaction with healthcare services, constraints to satisfaction with healthcare services and potential strategies to improve satisfaction with healthcare services among deaf people in the Wa Municipality of the Upper West Region of Ghana. The knowledge of satisfaction with healthcare among deaf people generated through this study in the perspective of deaf people, the factors that are responsible for their satisfaction and the strategies to improve patient satisfaction can be adopted by healthcare providers to improve healthcare service quality and increase patient satisfaction with healthcare services.

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CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter discusses the philosophical underpinning, research approach, research design, the study setting, the population, the sample size and sampling technique, the instrument for the data collection, pre-test, data collection procedure, trustworthiness, and ethical considerations.

3.1. Philosophical Underpinning

This study is underpinned by the constructivist worldview. The constructivist believes that knowledge is constructed through communication and interaction; as such, knowledge is not "out there" but within the perceptions and interpretations of the individual (Vanderstoep & Johnston, 2009). Guided by this, the researcher holds the belief that deaf people develop subjective meanings of their experiences with access to healthcare services in the Wa Municipality, and these subjective interpretations will be better understood through the qualitative approach.

3.2 Research Approach

The researcher adopted the qualitative research approach to carry out this study. This approach is appropriate for this study as it ensured an in-depth understanding of deaf people's concerns with access to healthcare services within the Wa Municipality. Participants recounted their lived experiences in their attempt to seek healthcare services and how those experiences contributed to their overall satisfaction with the healthcare services in the Wa Municipality. The approach made it possible for the researcher to explore the concerns of deaf people regarding their satisfaction with

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healthcare services, examine the factors contributing to satisfaction with healthcare, explore the constraints to satisfaction and identify the possible strategies to improve satisfaction with healthcare services among deaf people within the Wa Municipality of the Upper West Region.

Johnson and Larry (2014) noted that with the qualitative research approach, the researcher tries to understand how particular people in particular contexts make meaning and interpret their lived experiences. This approach, Johnson and Larry added, concerns itself with participants' perspectives on their lived experiences and in their somewhat distinctive experiences rather than attempting to describe experience that cuts across all people, universally. The qualitative research focuses on the meanings of experiences by exploring how people define, describe, and make sense of these experiences.

3.3 Research Design

The study employed the phenomenological study design. Phenomenological research is a design of inquiry which describes the lived experiences of individuals about a phenomenon as described by participants and to understand how their personal meanings are constructed from their lived experiences (Creswell & Creswell, 2018). The choice of this design for the study is therefore appropriate as the researcher administered interviews to collect data. Besides, it afforded the researcher the opportunity to explore the concerns of deaf people regarding their satisfaction with healthcare services as well as examine factors that contribute to satisfaction among deaf people in the Wa Municipality. With this design, the researcher was able to explore the constraints to satisfaction and, also identified some possible strategies to

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improve satisfaction with healthcare services among deaf people within the Wa Municipality.

Giorgi (2009) noted that the phenomenological research design has strong philosophical underpinnings and usually involves conducting interviews.

3.4. Setting

Wa Municipality is one of the eleven administrative Districts/Municipalities that make up the Upper West Region (UWR) of Ghana. The Wa Municipality shares administrative boundaries with Nadowli-Kaleo District to the north, Wa East District to the east and to the west and the south Wa- West District. It lies within latitudes 1º40'N to 2º45'N and longitudes 9º32'W to 10º20'W. It has a land area of approximately 579.86 square kilometres, which is about 6.4% of the Region's total land area (Ghana Statistical Service, 2014). According to the 2010 Population and Housing Census District Analytical report, 2.6 percent (2,788) out of the total population of Wa Municipality (107,214) were with various forms of disabilities. Out of the 2,788 persons with disabilities, hearing impairment accounted for 9.8 percent (273 people) (Ghana Statistical Service, 2014). With regards to healthcare system, the Wa Municipality has 48 health facilities, comprising hospitals, polyclinics, health centres, clinics, maternity homes and Community-based Health Planning and Service (CHPS compounds) (Ofosu, 2017). A map of the study area is presented in Figure 3.1 below:

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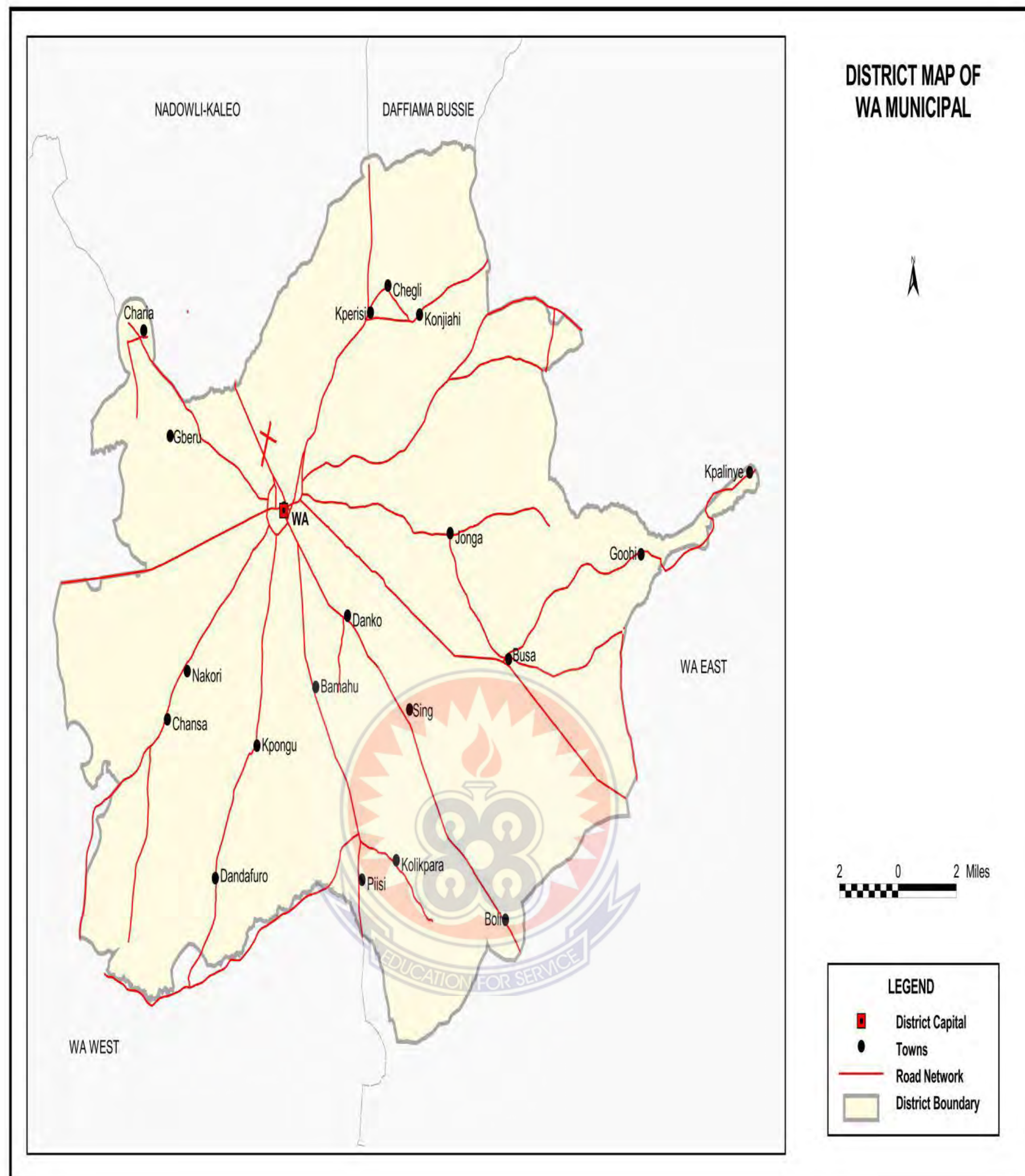
Figure 3.1: Wa Municipal Map



Source: Ghana Statistical Service (2014).

3.5 Study Population

The target population of this study comprised 12 adult deaf people who are registered members of the Wa Municipal branch of the Ghana National Association of deaf people (GNAD).

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Population is a group of elements or cases, (i.e., whether individuals, objects, or events) that conform to specific criteria which a researcher can identify and study (McMillan & Schumacher, 2014).

3.5.1 Inclusion Criteria

For inclusion in this study, participants had to be:

1. Deaf individual in the Wa Municipality.
2. Able to give informed consent
3. A person who accesses healthcare services in the Wa Municipality

3.6 Sample Size:

For this study, the sample size was 12 deaf people. Sample size refers to the number of participants or observations that are included in a study. Among the scientific community, there seems to be lack of consensus about determining the sample size for a qualitative study. However, Bentley et al. (2014) noted that there is general understanding that in qualitative studies, irrespective of the study design, one can typically begin with approximately 5 interviews, increasing the sample size until saturation is reached. Where data saturation is the stage in data collection when gathering fresh data no longer sparks new insights or reveals new properties (Stormy & Faulkner, 2017). Guest et al. (2006) have observed that using a sample of 6 interviews and more may be sufficient to enable a researcher to develop meaningful themes and useful interpretations.

Drawing insights from the available literature, the researcher concluded that a sample size of twelve (12) participants were sufficient to reach data saturation and draw meaningful themes.

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3.7 Sampling Technique

Purposeful sampling technique was used to recruit cases, primarily total population sampling. Total population sampling is a type of purposive sampling technique that involves examining the entire population that have a particular set of characteristics that are of interest to the researcher. This sampling technique is appropriate for this study because, not only did it afford the researcher the opportunity to collect data from a sample with low margin of errors, but also, at twelve interviews, data saturation was reached. Adult deaf people who access healthcare services in the health facilities within the Wa Municipality as either inpatients or outpatients had experienced the quality of services rendered by the facilities. They were therefore well positioned to espouse their concerns on the quality of the services they received and how that influenced their overall satisfaction. Creswell (2012) noted that total population sampling technique is beneficial because it paves the way for researchers to see information from the various extremes of population groups as everyone is considered a target participant for the study being conducted. Besides, the information gathered in this type of sampling has a low margin of errors, and it can produce results that are available in real-time.

3.8 Research Instrument

Research instrument refers to the tool(s) that is/are used to gather, measure, and analyse data for a particular study. In this study, data were collected using semi-structured interview guide.

3.8.1 Semi-Structured Interview Guide

Semi-structured interview guide was used to collect data from participants. The interview questions were developed by the researcher and were deductive in nature.

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The interview guide was designed in two sections (i.e., Section "A" and Section "B"). Section A elicited information about basic socio-demographic characteristics of participants such as age, level of education, employment status, religious affiliation, frequency of visit, and the most recent visit to the facility. Section B required participants to respond to various statements/questions which were categorized under headings according to the study objectives.

For objective 1 which is on deaf people's concerns about their satisfaction with healthcare, the variables measured included staff attitude, responsiveness, communication, nature of equipment, cost of treatment, and skills of health staff. To obtain data for this objective, two major questions were posed, and probes were used to guide participants to provide responses appropriately. In the case of objective 2; factors contributing to satisfaction, four questions were used to elicit information from the participants. The variables that the objective sought to measure included cleanliness of facilities' environment, waiting time, and availability of seats. For objective 3, i.e., constraints to access and satisfaction, two major statements were posed for participants to react to. Finally, objective 4 which was about the strategies to improve access and satisfaction with healthcare, participants were presented with three questions.

The in-depth interview afforded the researcher the opportunity to seek answers to the research questions on Deaf people's concerns with access to healthcare services, factors influencing satisfaction, constraints to satisfaction and potential strategies to improve satisfaction with healthcare services. The selected instrument is a useful tool in conducting qualitative studies, as noted by (Neuman, 2011). Besides, the instrument was chosen because it enabled participants to freely express themselves at length and offered the researcher the opportunity to use probes to obtain response

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clarity and/or additional information. This advantage of the instrument is attested to by Johnson and Larry (2014).

3.9. Validation of Instrument

The interview guide was peer reviewed by two colleagues who are knowledgeable in research work. The peer reviewers suggested that the statements should be open ended rather than closed ended. They also suggested that the number of questions/statements in the guide should be reduced. The suggestions from the peer reviewers were incorporated into the instrument and later presented to the supervisors for their expert comments. A final interview guide was then produced, which was used to collect the data.

3.10 Pre-testing of Instrument

To ensure that the research tool generated appropriate findings, a pre-test was conducted. Yin (2016) explains that pre-testing is an initial, preliminary study conducted to ascertain the feasibility of a data collection tool to improve the research design and refine aspects of the final study. A pre-test was conducted in Jirapa Municipal of the Upper West Region with a sample size of two deaf people. The pre-test yielded no modifications to the interview questions; therefore, it was deemed to be feasible and did not warrant any refinement.

3.11. Ensuring Trustworthiness

Trustworthiness is the process of enhancing the quality (validity and reliability) of a qualitative study. At the heart of qualitative research is the issue of trustworthiness (Lincoln & Guba 2015). Lincoln and Guba (2015) therefore identified the trustworthy criteria of qualitative study as, credibility, dependability, transferability, and

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confirmability. Cognizant of its importance, the researcher put in various measures that ensured the trustworthiness of this study.

3.11.1 Credibility

To ensure credibility of the data collected, the researcher did peer review on the interview guide. The instrument was given to two other peers who are knowledgeable in research work to critique. The suggestions from the peer reviewers such as reducing the number of questions, and constructing open ended questions were incorporated into the instrument and later presented to the supervisors for their expert comments. A final semi-structured interview guide was then produced, which was used to collect the data. During the focus group interview session, credibility measures were again taken. The researcher established rapport with participants before the data collection started. The purpose of the study was explained to participants, and they were also assured anonymity of their responses. All interviews were videorecorded after the researcher had sought the permission of participants. The videorecorded interviews were carefully transcribed and reviewed by two sign language interpreters (i.e., interpreter triangulation) at separate appointments. These interpreters are professionals in deaf education and are also being engaged by deaf people community in the Wa Municipality for interpreting during official functions. Where there were conflict(s) in interpretation of concepts, they were reconciled, and a final transcript written for analysis. This was done to minimise the possibility of compromising the integrity of the data collected. Credibility was further enhanced using audit trail by ensuring that all the video recordings of the focus group discussions are safely kept. The use of audit trail in ensuring credibility is supported by Daytner (2006).

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Credibility is the "fit" between participants' views and the researcher's representation of them. It refers to the degree to which the research represents the actual meanings of the research participants, or the "truth value" (Lincoln & Guba, 2015). Merriam (2009) also observed, that among other methods, qualitative researchers can enhance credibility of their studies through adequate engagement during data collection, triangulation, and peer debriefing. These strategies were brought to bear in the present study.

3.11.2 Dependability

In this study, the researcher ensured dependability by first, giving a detailed report on all the processes within the study. For instance, the researcher presented a comprehensive description of the research design and implementation, the methodology and methods (i.e., details of data collection, research approach, the design, population, tools for data collection, etc). Besides, dependability was further ensured through data archiving (creating an audit trail). The researcher kept complete and accurate records of all interviews. The coding process and data analysis process are also clearly described.

Dependability relates to the consistency and reliability of the research findings and the degree to which research procedures are documented, such that someone outside the research can follow, audit, and critique the research process (Polit et al., 2006; Streubert, 2007).

3.11.3 Transferability

Tobin and Begley (2004) stated that transferability of a qualitative study findings refers to the generalizability of the inquiry. Lincoln and Guba (2015) also opined that transferability, a type of external validity, denotes the degree to which the

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phenomenon or findings described in one study are applicable or useful to theory, practice, and future research. It concerns the extent to which findings of a particular study may or may not be relevant to other contexts. In other words, transferability concerns relate to the extent to which the results of a particular research programme can be extrapolated, with confidence, to a wider population (Shenton, 2004). The researcher ensured this by providing a detailed description of the study area and study participants. The inclusion and exclusion criteria were also clearly stated. Finally, the researcher provided a description of the setting where data was collected as well as the seating arrangement during data collection.

3.11.4 Confirmability

Confirmability relates to the objectivity of the study results (Guba, 1992). Moon et al. (2016) highlight that to achieve confirmability, researchers must demonstrate that the results are clearly linked to the conclusions in a way that can be followed and, as a process, replicated. To address any bias or subjectivity in collecting, handling, and analysing data obtained in this study, the researcher applied reflexivity and bracketing. This was achieved by making use of a peer reviewer who assisted in reflecting on the interpretations and analysis of the data. Peer reviewing, according to Flick (2009), entails having regular meetings with peers who are not part of the research study to identify the researcher's blind spots, information, and results, which may have been missed by the researcher, and aspects of trustworthiness, which may not have been upheld accidentally.

Confirmability was further ensured during the data analysis and interpretation where direct quotes from participants which related to the various inferences and interpretations are captured in the analysis. Finally, the researcher kept an audit trail

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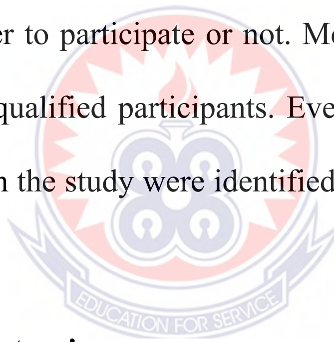
of all the data that were collected, the coding process, and the analysis process that was followed.

3.12. Procedure for Data Collection

Prior to the commencement of the data collection, the researcher wrote a letter to the leadership of the Wa Municipal branch of the Ghana National Association of deaf people (GNAD) asking for permission to conduct the study among its members. This request was duly granted by the leadership (see Appendix C). With the support of the President of the Association, deaf people who met the inclusion criteria were recruited. The President informed members about the research and the criteria for participation through the association's social media page (WhatsApp), and they were left free to decide whether to participate or not. Members on the platform facilitated the recruitment of other qualified participants. Eventually 12 members who met the criteria for participation in the study were identified and a date and time was fixed for the data collection.



3.12.1. Conducting the Interview

The data were collected through focus group discussion. During the interview, discussants were made to sit in a semi-circular fashion with the moderator (researcher) and sign language interpreter in the middle. Since the study was conducted amid the COVID –19 pandemic, participants were made to observe social distance in their seating. Participants took turns to respond individually to the moderator's questions and were also encouraged to speak and interact with one another. The purpose of this group interaction was to encourage participants to explore and clarify individual and shared perspectives. All participants were given equal opportunity to contribute to the discussion.

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The setting for the interview was the Wa Municipal Resource Centre for Persons with Disabilities. Data were collected on 3rd December, 2021. The interview commenced after the rationale of the study was explained to participants and they reaffirmed their preparedness to participate in the study. Participants were assured that their responses would be confidential. The interview was conducted in English and Ghanaian Sign Language (GSL) by the researcher with the help of two assistants who were trained on the specific roles they needed to play in the data collection process. The first assistant who was a trained sign language interpreter, interpreted the instructions and questions/statements that were presented by the interviewer (researcher). The interpreter also verbally interpreted the answers/responses from the participants. The researcher sought the permission of participants to videorecord the discussion session. The duty of the second assistant was thus, to videorecord the interview that was administered using a digital camara. The discussion session lasted about 90-100 minutes. After the interview, the researcher thanked participants for accepting to take part in the study. He also gave them some cash amount for water and transportation (T& T) back to their homes.

3.13. Data Analysis

The video-recorded interviews were transcribed into English language, i.e., translating the Ghanaian Sign Language (GSL) into English words. I reviewed the video-recorded interviews together with two peer reviewers who are Ghanaian Sign Language interpreters. During the review with the different sign language interpreters, the audio sound of the initial interpreter was tuned-off to prevent them from listening to whatever that was vocalized by the initial interpreter during the interview session. The purpose of this crosschecking was to ensure fidelity of the transcriptions. Cognizant of the fact that it is ungrammatical to translate GSL word by word or

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sentence by sentence, as its structure is entirely different from English language, the researcher captured the whole meaning of each participant's expression(s). The researcher then read through the transcripts repeatedly to become familiar with the data.

From each transcript, significant phrases or sentences that pertained directly to the various variables were identified and coded with unique colours. Five different colours were used for the coding. For instance, phrases or sentences that indicated positive experiences by participants were coded with green colour. Sentences pointing to negative experiences were given red colour code. All phrases/sentences suggesting factors that contribute to satisfaction with healthcare were coded with yellow colour. Pink colour was used to code statements pointing out constraints to satisfaction while blue colour represented suggestions on strategies to improve access and satisfaction.

Meanings were then formulated from the significant statements and phrases. The formulated meanings were clustered into themes allowing for the emergence of themes common to all the participants' transcripts. To ensure that the themes are useful and accurate representation of the data, the researcher revisited the data set and compared the themes with it. After the researcher was certain with the themes, they were then named and defined in ways that were easily understandable by the researcher. Finally, an inductive analysis of the data was carried out and the results were then presented in text in the form of narrative report.

3.14. Ethical Consideration

Ethical considerations are the procedures that are followed to protect the rights of the institution where a study is being conducted and the participants to ensure scientific integrity. Bhandari (2021) noted that ethical considerations in research are a set of

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principles that guide a researcher's conduct and practices which aim at protecting the rights of research participants, enhancing research validity, and maintaining scientific integrity. Some ethical considerations that were ensured in this research include voluntary participation, informed consent, anonymity, and confidentiality. These considerations are in line with the proposition of Bhandari (2021).

3.14.1. Voluntary Participation

Voluntary participation means that all research participants are free to choose to participate without any pressure or coercion. Any subject can withdraw from, or leave, the study at any point without feeling an obligation to continue. The researcher made it clear to participants that there are no negative consequences or repercussions to their refusal to participate in the study or respond to any question or statement posed from the interview guide.

3.14.2. Informed Consent

Informed consent refers to a situation in which all potential participants receive and understand all the information they need to decide whether they want to participate in the study (Bhandari, 2021). This ethical principle was ensured by the researcher. Participants were informed about the purpose of the study, i.e., they were made to understand that the study was purely for academic purposes. Aside from telling them verbally, the purpose was also well stated at the introductory part of the interview guide.

3.14.3. Anonymity and Confidentiality

Anonymity means that the researcher does not know who the participants are and cannot link any individual participant to their data. Confidentiality, on the other

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hand means that the researcher knows who the participants are but removes all identifying information from the report (Bhandari, 2021). To ensure anonymity and confidentiality, the researcher did not collect data on personal identifiers such as names and phone numbers. Participants were treated with dignity during the interview session.

3.15. Summary of the Chapter

In this chapter, the researcher looked at the methods and procedures used in gathering data to answer the research questions. The various headings discussed in this chapter include the philosophical underpinning, description of the study setting, i.e., touching on the geographical location of the area, number of health facilities, and the population of the area. The research approach, research design and study population have also been discussed. The researcher went on to explain the sampling technique that was used to recruit participants as well as how the sample size was determined.

For data collection, semi-structured interview guide was used to hold focus group discussion for a total of twelve participants. Trustworthiness criteria such as credibility, dependability, transferability, and confirmability have also been looked at. To analyse the data collected, thematic data analysis was employed. Presentation on the chapter concluded by touching on issues of ethical considerations.

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CHAPTER FOUR

PRESENTATION OF RESULTS AND DISCUSSION

4.0 Introduction

This chapter presents the analysis performed on the data collected from the participants in the study. Four research objectives were set. The thematic areas of the chapter presentation involve socio-demographic characteristics of study subjects, experiences/concerns of deaf people regarding satisfaction with healthcare, factors contributing to deaf people's satisfaction with healthcare, constraints of deaf people with access to healthcare and strategies to improve access and satisfaction with healthcare among deaf people.

4.1 Socio-demographic Characteristics

Data on the socio-demographic characteristics of the participants were collected to help have a fair understanding of the background of the participants in the study. The characteristics examined included sex, age, level of education, religious affiliation, marital status, and socio-economic status.

Total population sampling was used to purposively sample 12 participants for the study as shown in table 4.1a. 7 were male participants, and the females were 5. The socio-demographic characteristics indicate that 3 of the participants had either completed tertiary institutions or were still in tertiary institutions, 2 were Senior High School graduates while 2 others had JSS/JHS education. Also, 1 participant had Middle School education, 3 completed Technical/Vocational institutions while only 1 had no formal education at all.

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For religious affiliation, the demographic results indicate that 7 participants were Muslims, while 5 were Christians. With regards to employment, 3 of the participants were government employees, 4 were private sector employees, 2 were self-employed, while the remaining 3 were unemployed. All 12 participants were aged between 26 and 45 years, with the average age being 35 years (SD = 5.0). Majority of the participants (8) were married, while 4 were not married. The tables below give a summary of the socio-demographic characteristics of the participants:

Table 4.1a: Socio-demographic Characteristics of Participants

Demographic Variable	Categories	Frequency
Gender	Male	7
	Female	5
Educational Level	No formal education	1
	Middle School	1
	Technical/Vocational	3
	JSS/JHS	2
	SSS/SHS	2
	Tertiary	3
Employment Status	Government employee	3
	Private Sector employee	4
	Self-employed	2
	Unemployed	3
Religious denomination	Christians	5
	Muslims	7
Marital status	Married	8
	Never married	4

Source: Researcher's construct 2021

Table 4.1b: Age of Participants

Number	Mean	Standard Deviation	Minimum	Maximum
12	35.00	5.0	26	45

Source: Researcher's construct 2021

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4.2 RQ1: What are the Concerns of Deaf People Regarding their Satisfaction with Healthcare in the Wa Municipality?

The concerns of deaf people about their satisfaction with healthcare services is very crucial. From the results, two major themes emerged under the concerns of deaf people concerning their access to and satisfaction with healthcare services in the Wa Municipality. That is; positive concerns/experiences and negative concerns/ experiences. Under each major theme, sub-themes emerged.

4.2.1. Positive Experiences with Access to Healthcare

Positive experience is anything that makes a person feel well treated and contented with the services that they receive from a service provider. From the interviews, two sub-themes have been identified in line with the positive experiences by deaf people:

4.2.1.1. Being Respected as a Deaf Patient in the Hospital

From the interviews, it became evident that some of the health personnel in the Wa Municipality treat deaf clients with respect. Some healthcare providers are aware that deaf patients' experiences of the healthcare process are different from the hearing patients due to the communication barrier that exists between them. As a result, they try to be nice in their dealings with them (deaf patients). For instance, one participant out of 3 participants who said some healthcare staff are respectful touted the respect of a nurse as captured below:

> *Some of the nurses are respectful, but others are not. There was a day I went to the hospital and met one elderly nurse. She was full of respect and very kind towards the patients. She particularly attended to me first when she saw that I was deaf. The woman is fit to be a nurse.* [P1]

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A second participant supported this view by saying,

> *The last time I went to the hospital, and they were delaying in attending to me, I made them aware that I am deaf. Upon realizing that, they apologized for the delays and attended to me.* [P2]

Another participant said,

> *If the doctor or nurse does not know that there is a deaf person among the patients, it is better you alert them. When I do that, they attend to me before attending to the hearing.* [P3]

Other participants recounted their experience of positive interactions with a medical staff in the following words:

> *There used to be one doctor at the regional hospital who was so nice. Anytime I went to hospital and met that doctor I was always happy. Though he didn't understand sign language, he was always very humble enough to use his own signs just to make sure we understood each other. But now he has been transferred.* [P4]
>
> Another participant said, *If the doctor or nurse does not know that I am deaf or there is a deaf person in the queue, it's better for deaf people to alert them when I do that, they call me before even attending to other people.* [P5]
>
> *Some have bad attitudes, but others are very good. They help me and I'm happy. The nurses, they come and make sure that everything is fine, and they explain everything to me very well. But some, they just get there and say, "we finished, please go home" Some explain nicely, but some are bad ... they're very different people.* [P6]

4.2.1.2. Feeling of Empathy by Some Healthcare Staff

Empathy entails identifying with or understanding the thoughts, feelings, or emotional state of another person. Often, such tiny moments extended to a patient in the hospital setting can instantly boost his/her mood and go a long way to relief the pressure being experienced by the patient due to the sickness. Empathy can bring healthcare workers

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closer to their clients and put a nice and warm memory in their minds when they think about the healthcare encounter.

From the interviews, another sub-theme that emerged under positive experience was the feeling of empathy. Participants indicated that some healthcare staff are empathetic towards them in the health facilities. For instance, a participant said:

> *I remember one time I went to the Regional Hospital laboratory for some test. The place was very busy because it was a Monday. They delayed attending to me. At a point I could not control my anger, rather than to express it. Seeing me in that angry mood, one nurse came to me and asked why. After I explained in writing, he replied in the following words "Sorry, I can imagine how you feel in this situation, I will let them attend to you." [P7]*

Another participant said:

> *There are some of the nurses when they realize that you are a deaf person, they try to attend to you before the hearing clients. However, others do not really care.* [P8]

4.2.2 Negative Experiences with Access to Healthcare

Even though some instances of positive experiences were expressed by participants, several others indicated that their experiences with access to healthcare within the study area were negative. Negative experiences are feelings that have the tendency of making a person feel dissatisfied or unhappy with the services they receive. Five sub-themes were identified in line with the major theme of negative experiences are summarized below:

4.2.2.1 Difficulty in Communicating during Access to Healthcare

It is known that communication plays a vital role in all human interactions. Communication can take various forms, i.e., verbal/spoken, written, gestural, etc. Mitsi, et al. (2014) noted that with regards to the methods of communication, deaf

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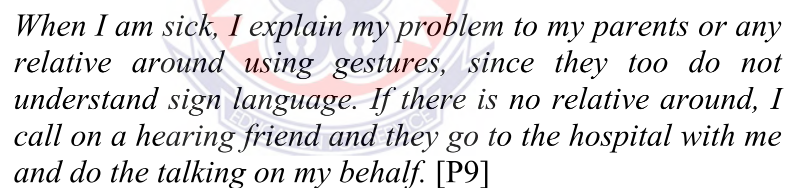
people use various methods, including sign language, lip reading, written and the spoken language. From the focus group discussions, it was clear that the deaf, in accessing and utilizing healthcare services in the Wa Municipality, employ various strategies to communicate with healthcare providers. No matter the form it takes, the primary function of communication is to ensure mutual understanding between/among the parties involved in the communication process. Apparently, participants reported that they had four communication experiences during access to healthcare services in the Wa Municipality: including communication through friends/family members, using gestures, communication through writing and communication using sign language interpreter.

Majority of the participants attested to using this mode of communication whenever they visit the health facilities for healthcare services.

> *When I am sick, I explain my problem to my parents or any relative around using gestures, since they too do not understand sign language. If there is no relative around, I call on a hearing friend and they go to the hospital with me and do the talking on my behalf.* [P9]



Another participant said:

> *When I am sick, I tell my husband by gestures. Sometimes he buys drugs from the pharmacy. If I take the drug and get better, I do not go to the hospital but if it continues, he escorts me to the hospital and explains my complaint to the doctor.* [P10]

> *If you are sick and go to the hospital alone, they do not mind you. The other time my father was not around, and I was not feeling well so I decided to go to the Municipal hospital. I was there and they were attending to the hearing clients leaving me. Later I saw a known person and asked him to call my father who then came and assisted me. It is really a serious problem. We are suffering.* [P11]

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This concern was seriously supported by several other participants.

From the utterances above, it is quite clear that deaf people in the Wa Municipality face communication problems at the health facilities, thereby resorting to family members and friends to relay their complaints to nurses/doctors. However, while relatives/friend's assistance is crucial in the communication experience of deaf people in accessing and utilizing healthcare services, it has the potential of self-medication, which could compromise the health of the deaf. As indicated by participant 10, the client does not go to hospital for diagnosis of her sickness but depends on what medicine the husband provides.

Again, though a significant mode of communicating with service providers in terms of accessing and utilization experience, the challenge here is that proper diagnoses and treatment of what deaf people suffer from depends on the ability of friends or relatives to vividly describe the problem to the understanding of the healthcare providers. As noted by Elliott et al. (2015), lack of effective communication between a deaf patient and a healthcare provider leads to miscommunication, misunderstanding, misdiagnoses, and poor outcomes.

Besides, deaf people are denied privacy if they will always have to see the doctor through the assistance of a relative or friend. For instance, a participant lamented that:

> *It is not convenient going to the hospital with friends or family members on all matters. There are some problems we may not want other people to know but because we are deaf, we do not have that privacy. I really wished the nurses and doctors would agree to learn sign language so that we can communicate with them directly.* [P12]

Communicating using gestures was identified as one of the dominant modes of communication in accessing and utilizing healthcare services among deaf people in

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the Wa Municipality. This is sometimes complemented by other modes of communication such as writing to enhance clarity.

> *I use two strategies to communicate with the doctor. Most of the times I use gestures, but because I can also read and write, I sometimes write to the doctor, and he/she writes back to me.* [P1]

Another participant said:

> *As for me because I cannot read and write, it is either I use gestures, or I go with someone to help me.* [P9]

Another common communication experience by deaf people in accessing and utilization of healthcare services in the Wa Municipality is communicating through writing. This communication mode as explained by participants, involves writing down one's complaint on a piece of paper for the health service provider to read. He or she in turn does the diagnosis and writes down the feedback for the patient to read. Treatment involved is communicated through the same medium. For instance, a participant recounted:

> *Anytime I am sick and go to the hospital, I always communicate with the nurses/doctors through writing. But it is difficult because I am not always able to tell them all my problems in writing. Another problem is that some of the words they write I do not understand. Sometimes too, there are some of the words I do not know their spelling.* [P6]

Other participants strongly supported this concern by saying:

> *If the doctor questions me by speaking, I tell him I am a deaf, so I want to write, then he gives me a paper to write, and the discussion is done through writing without any problem.* [P12]

> *If the doctor speaks and I do not hear, he asks if I can write which I agree to, so we communicate by writing.* [P8]

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I use writing in communicating but when I do not know how to write a particular word, I use gestures to express it. [P3]

From the above utterances, it will be realized that the major requirement of this mode of communication is that the deaf patient must be prolific in the English language to ensure effective consultation session. The implications of this communication mode as evident from the focus groups discussion are that deaf people are often not able to ask questions even if they want to. Writing communication also posed a challenge where deaf people do not understand some of the words written by the providers or cannot express themselves well in writing which interferes with understanding and eventually, the diagnoses and treatment. This is especially so, where deaf people visit the facilities on their own without relatives accompanying them, where they are not able to read and write and where there are often no sign language interpreters.

When the researcher probed further to understand what their preferred mode of communication was, given the situation, all participants indicated that since the healthcare staff cannot sign, the better alternative was communicating through a sign language interpreter. However, from the comments that followed, it was very clear that in terms of experience, this is the one they rarely experienced. This is because there are no sign language interpreters in health facilities in the Wa Municipality, especially the government health facilities.

It is not easy to have interpreters. Maybe the interpreter is far, and I am sick, I cannot have access to the interpreter. [P1]

Telling the doctor our problem through writing is not easy. Sometimes what the doctor writes is not clear and some of the words you will not understand. If there is sign language interpreter to tell the doctor our problem, we will be happy [P2].

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4.2.2.2 Being Avoided by Healthcare Providers

From the discussions, it came out that deaf patients in the Wa Municipality have the feeling that they are being avoided by some healthcare staff at the health facilities. This behaviour is demonstrated through the facial expressions and body language of health workers. This may be attributed to the perceived communication difficulties that staff go through when they encounter a deaf client. A participant shared her experience in the following words:

> *One time I was sick and went to the old hospital. Three nurses were siting talking. The moment they saw me approaching the OPD, two of them who knew I am Deaf picked their phones and started moving away leaving the other one. It appears she did not know I am Deaf, so I got closer and greeted. The moment I greeted her, and she noticed I was deaf, her face changed. Straight away, she pointed at a chair indicating that I should sit. I sat there for a long time while she was there manipulating her phone. Meanwhile, my leg was hurting me seriously. After some time, the two who moved away came back and the three of them exchanged some few words and started laughing. Later, they invited me and took my vitals. As I attempted getting up to go and see the doctor, I nearly stumbled but none of them helped me, rather they were laughing again. I was then wondering; were they laughing because I am Deaf? Or were they laughing because I could not walk?* [P2]

Another participant affirmed this concern by recounting her own experience as follows:

> *I remember one day I went to the Municipal hospital and met one nurse. Let me even say a small girl. She looked so young but full of pride. She did not react towards me with respect at all. But most of the times her attention was always on her phone. [P4]*

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4.2.2.3 Being Discriminated Against

Participants lamented that deaf people are being discriminated against when they visit the hospital. Participants said the service providers prefer attending to the hearing clients as against the deaf. Some of them cited instances where healthcare staffs demonstrated this behaviour towards them. The blind and other disability groups are also perceived to be better handled at the facilities. For instance, some of them said:

> *When there is a queue, the nurses upon knowing we are deaf, they attend to the other hearing clients whom we even went before. They attend to us last. They also treat the blind and the physically disabled nicely. It is difficult. We really need interpreters at the hospital.* [P11]

> *This is very true, but it is not only here. Even in Accra it ever happened to me. I was sick and went to the hospital. But when they realized I was deaf, they asked me to sit aside while the hearing people were going in to see the doctor.* [P7]

Other participants supported this by saying:

> *As for me, if they continue with that their discriminatory attitude, I will never be satisfied with their services.* [P8]

> *We deserve fair treatment, the same as hearing people. Because when hearing people communicate, they do not have to write. So why should we write?* [P4]

4.2.2.4 Delay in Accessing Services.

Another negative experience which was very prominent among the focus group discussants was delay in accessing healthcare services among deaf patients. Deaf people reported that they usually waste a lot of time at the health facilities before they can be attended to. This perceived delay in accessing healthcare services can have far reaching implications on the healthcare seeking behaviours of deaf patients. First, it has the potential of discouraging deaf people from going to the hospital when they are

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sick. Secondly, it can lead to self-medication, and thirdly, they may resort to unorthodox ways of treating themselves. In terms of productivity, the delays experienced by deaf patients at health facilities lead to loss of productive hours and reduction in productivity. The quotes below present a better picture of the concerns of the participants.

> *One day I visited the Municipal hospital. When I arrived at the OPD there was already a queue, so I also joined. Later the records officer came out and took our OPD cards to go and remove our folders. She was inside calling the names and people were going for their folders. Because I cannot hear, she called my name, but I did not know, and I was still sitting. People who came after me took their folders and went to see the doctor and I was there.* [P1]

This concern by the participant was buttressed by other participants in the following words:

> *This time it is even worse. The time they were using the hard-copy folders it was better. With that system one could tell whom one was following. With the current online system, the records officer sends your information direct to the doctor in the consulting room. The doctor then calls the names from the consulting room for patients to enter. As a deaf person, once you don't know the person you are next to, they always call your name without you knowing. This makes you waste time unnecessarily.* [P2]

> *I have realized that anytime I go to the hospital with an interpreter or someone to help me communicate with the nurses/doctors, they attend to me faster than when I go alone.* [P3]

> *When I am in a queue and it's my turn and the doctor realize that I cannot hear, he writes to me but because I cannot write back, he asks me to sit aside and attends to the hearing clients.* [P4]

> *Yes, I also had similar experience at the regional hospital. They attend to clients who can hear and neglecting us (deaf). I had an experience where a nurse told me to sit as the last client just because I cannot speak. It is a serious problem.* [P6]

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> *I am a tailor. When people come with their things, I tell them when to come back for them. Now, if you are sick and you go to spend the whole day in the hospital, will you be able to meet the date you fixed for your customers? You will end up disappointing your customers and lose them. That's why I prefer going to buy my own drugs. Unless the condition is so serious, I don't go the hospital.* [P7]

4.2.2.5 Feeling Dissatisfied with Healthcare Services

Participants expressed dissatisfaction with the services that they received from health facilities in the municipality. For instance, when asked about their general satisfaction with the healthcare services in the municipality, only two of the participants said they were satisfied with the services. One of them expressed her contentment in the following words:

> *If they write for me and I understand and I also write and they understand, that is okay for me* [P4].

The other participant also said:

> *As for me because I work in the School for the Deaf, anytime I want to visit the hospital I go with a sign language interpreter, so I don't face communication problem. When they give me the medicine and I go and take it, I get well, so I am satisfied.* [P8]

However, majority of the participants expressed dissatisfaction with the services they received. This, they said was largely due to the language barrier, staff attitude and the long waiting time that they had to endure. This was how some participants expressed their frustrations:

> *How can we be satisfied when we leave our work and go to spend the whole day in the hospital*? [P3]
> *……if they continue with that discrimination, I will never be satisfied.* [P1]

> *If you go to the health facility without sign language interpreter, they (health professional) will never understand … I feel very discouraged about that and*

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> *discouraged to go and seek for healthcare service in the hospital. The last time I wasn't feeling well, I decided to go straight to the drug store and bought my drugs.* [P7]

> *Remember some health issues are confidential. Deaf people also deserve privacy like the hearing people… the health worker or the doctor or nurse should learn sign language because it will be easier to communicate with a deaf person one-on-one, never a third person, because with an escort or interpreter, there's a third person. You never know what the person will go out and later say to the hearing of others* [P9].

4.3 RQ 2: What are the Factors Contributing to Deaf People's Satisfaction with Access to Healthcare Services in the Wa Municipality?

Satisfaction with healthcare access is influenced by various factors. From the interviews, three themes were identified in line factors which could potentially contribute to deaf people's satisfaction with healthcare services in the Wa Municipality.

4.3.1 Ability to Communicate with Healthcare Providers

Majority of participants indicated ability to effectively communicate with healthcare providers as the most important determiner of satisfaction. This is understandably so because human interaction is facilitated by a common communication code, the absence of which has the potential to generate problems. The feeling that health staff may not understand their problem make deaf patients hesitant in visiting health facilities when they are sick. Even when there is assistance from a relative or friend, it is still troubling to know that the assistant might not be relaying the right information or may not be able to describe the sickness very well to the doctor since they themselves do not understand the sign language very well. Inability to communicate effectively may lead to wrong diagnosis and treatment. The following are verbatim expressions by some participants:

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> *There was a time I had problem with my menses and decided to visit the hospital with a female hearing friend for check-up. I suspect the doctor did not understand when my friend told him my problem. So, he prescribed some medicine for me which I went and took but the problem continued. Later, I decided to go back to see the doctor again, but this time round, I went with a sign language interpreter and now my problem is solved.* [P9]

Reiterating the risks associated with miscommunication and misdiagnoses, one participant recounted her experience as follows:

> *I have a problem, one experience. My close friend, he could read and write small. He was very sick and went to the hospital but communicated to the doctor through writing, but the doctor did not really understand what my friend wrote and prescribed a wrong drug, later my friend died. It happened because the doctor did not really understand, we really need an interpreter.* [P5]

When the researcher sought to understand whether participants are given the opportunity to ask questions about tests and other assessments that are carried out on them, this is what some participants had to say:

> *No as for me I don't ask them any questions.* [P1]

Another participant said:

> *The doctor is always busy writing things. We don't ask questions.* [P2]

One other department of the hospital where communication is critical is the pharmacy. The researcher then inquired to know whether pharmacy staff always educate participants on how to take the medicines that they are served, as well as the possible side effects. Majority of the participants reported that the pharmacy staff always tell them how many times they should take the medicine. For instance, one of the participants said:

> *Yes, they always tell us to take it morning, afternoon and evening or morning and evening. They also tell us to eat before we take the drugs. So as for me I think that is good.* [P8]

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However, male participant said though they are always told the number of times they should take the drugs, the pharmacy staff do not educate them on the possible side effects associated with taking the drugs.

> *Yes, it's true they always tell us to take it morning, afternoon, or evening, but I don't think that is enough. They don't tell us what will happen to us when we take the medicine.* [P4]

4.3.2 Reduced Waiting Time when Accessing Healthcare Services

From the conversation, it was revealed that a shorter waiting time before accessing healthcare services is preferable to the deaf. Most of the participants stressed that a reduction in the time they spend at the hospital before they can see the doctor, access laboratory services, or get medicine at the pharmacy will be more satisfactory for them. Majority of deaf people in the Wa Municipality are engaged in the private sector, and whose income depends on what they do on daily basis. Longer waiting time at the hospitals will therefore affect their economic activities. For instance, some participants said:

> *As a self-employed person, what you do on daily basis determines what you eat. So, if I go and spend the whole day in the hospital what will I eat when I go home. If they make special arrangement for us deaf people to reduce our waiting time at the OPD it will help us.*
> *How can you go to hospital before someone but because you cannot speak you will just be made to be sitting down while others are being attended to? Do they think we are goats or what?* [P7].

About 8 participants supported the suggestion that special arrangements should be made for deaf people to reduce their waiting time at the OPD.

4.3.3 Equity in Treatment:

Participants noted that for them to be satisfied with the services of the healthcare providers in the Municipality, healthcare staff will need to ensure equitable treatment

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for all clients. By this, they meant that, measures should be put in place such that deaf patients can easily be identified and promptly attended to. The quotations below represent the views of participants.

> *If they create a separate sitting place at the OPD for deaf patients alone it will be good. When you go and sit there and anyone sees you, they will know you are deaf rather sitting with the hearing patients where nobody may identify you as a deaf patient.* [P12]

> *There should be two different queues one for hearing and other for the deaf. When one deaf is attended to, one hearing should also be attended to in that order.* [P9]

4.4 RQ3: What are the Constraints of Deaf People with Access to Healthcare Services in the WA Municipality?

4.4.1 Lack of a Common Mode of Communication

The absence of a common communication code between healthcare staff and deaf patients was identified as the major constraint to satisfaction with healthcare access. This challenge featured dominantly among all the participants. It was evident that though clients sometimes wish to ask further questions for clarification, they are not able to do so because health service providers do not understand sign language. It was revealed that deaf patients prefer communicating through sign language/sign language interpreters since written communication sometimes poses a challenge and affects access and utilization. For instance, a participant said:

> *I always communicate with the nurses/doctors through writing. But it is difficult because I am not always able to tell them all my problems in writing. Another problem is that some of the words they write I don't understand.* [P6]

> *It is very true. Even there are some of the words I cannot spell, so sometimes I end up spelling the word wrongly or I write a different word which does not describe my condition.* [P11]

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4.4.2 Stigmatization of Deaf Clients

Stigmatization was one of the major barriers to satisfaction. Deaf people complained of experiencing neglect when they visit the health facilities, and this reduces their enthusiasm to call on the same facilities when the need arises again. They explained that some of the nurses do not want to have anything to do with them just because they cannot hear or speak. Some participants lamented their predicaments in the following words:

> *They attend to clients who can hear and neglecting us (deaf). Some of the nurses don't want to have anything to do with the deaf.* [P1]

This was strongly supported by other participants who said:

> *Yes, when they see that you are Deaf, they ask you to wait while they will be attending to the hearing people.* [P2]
>
> *………..the moment they saw me approaching the OPD, two of them who knew me started moving away leaving the other one.* [P3]

This allegation of stigmatization against deaf patients in the Wa Municipality is an indictment on the healthcare system in the municipality. Like all other human beings, deaf people equally have the right to access healthcare services without discrimination because of their impairment.

4.4.3 Negative Attitudes of Some Health Staff towards Deaf Clients

This was also identified as one of the constraints to satisfaction with healthcare services. Deaf people reported that some healthcare providers hate seeing them (deaf) appear in the hospital. According to the deaf, the moment the staff notice you are a deaf coming, their mood and facial expressions will change. The following statements explain this further.

> *One time I was sick and went to the old hospital. Three nurses were siting talking. The moment they saw me approaching the OPD, two of them who knew I am deaf*

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> *picked their phones and started moving away leaving the other one. It appears she didn't know I am deaf, so I got closer and greeted. The moment I greeted her, and she noticed I was deaf, her face changed.* [P5]
>
> *When there is a queue, the nurses upon knowing you are deaf, they attend to the other hearing clients that came after me. They attend to me last. It is a problem.*
> *The private health facilities are better. Even those that do not have sign language interpreters, the nurses and doctors have patience to listen to you compared to the government hospitals.* [P10]

From the interviews, it became clear that healthcare providers are more comfortable when there is someone to assist deaf people, otherwise most providers tend to delay in rendering services to them (deaf patients). It was also evident that most of the service providers become unfriendly towards deaf patients when they visit the facilities without any escort. This attitude of some health staffs can discourage deaf people from seeking treatment in the hospital. Some participants said:

> *Sometimes when we are called, we don't hear, and we are being given direction to go to the next office, the nurse just points to the direction, and we get confused. Therefore, I prefer to get to the drug store instead of the hospital* [P9].
>
> *They [healthcare professionals] have a very bad attitude, some of them will never help you, you just wait there for the whole day and you end up going home _ any assistance… they become very difficult when they see that you're a deaf person and they don't know how to help you* [P7].

4.4.4 High cost of Treatment

THE Participants lamented that though the services of the private health facilities in the municipality were better, the cost was unbearable for most deaf patients. Explaining why they said services at the private health facilities were better, one of the male participants said the nurses and doctors at the private health facilities are more patient, respectful and tolerant. Besides, some of them also employ the services of sign language interpreters. This was what one of the participants said:

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> *The private health facilities are better, but their services are also costly because some of them are not accepting the national health insurance cards. SDA hospital and Homeland clinic for instance have sign language interpreters so me I always prefer going there despite the cost.* [P1]

4.5. RQ4: What Strategies can Improve Deaf People's Satisfaction with Healthcare in WA Municipality?

To improve satisfaction with healthcare services among deaf people in the Wa Municipality, four themes were identified after analysing the various responses by participants:

4.5.1. Healthcare Staff Should Learn Sign Language

As a way of improving satisfaction with healthcare services among deaf people in the municipality, a participant suggested the learning of sign language by healthcare staff. This view as expressed by the participant is captured in the following words:

> *As for me I think the solution will be for government to make it mandatory for all doctors and nurses to learn sign language before they are considered qualified to be employed.* [P11]

This view was largely supported by most of the discussants

> *Yes! If they learn sign language that will be better for us.* [P9]

> *That's true. They shouldn't only learn English in school, they should also sign language because it is not only the hearing people that need their services, deaf people also fall sick.* [P7]

4.5.2. Special Arrangement for Deaf Patients.

Participants suggested that hospital managements should make special provision to cater for the health needs of persons with disabilities. For instance, a participant suggested that a section of the OPD should be designated for persons with disabilities. According to the participant, if such special arrangement is in place, anytime a person

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with disabilities visits the hospital and sits there, they can easily be noticed and treated accordingly.

> *Apart from healthcare staffs learning sign language, hospital management can also create a section within the OPD for persons with disabilities. Why is it that they have separate place for psychiatric patients, and they cannot do the same for persons with disabilities?* [P3]

As an alternative to the above, another participant suggested that at the OPD, some seats should be labelled for persons with disabilities. Captured below are the participant's own words:

> *They can make two seating arrangements. One side for the hearing people and another for deaf people and other persons with disabilities, so that if one hearing person enters the consulting room and comes out, one person with disability will also enter in that order.* [P6]

Another participant thinks that a better alternative to ensure that deaf people are easily identified and promptly attended to at the health facility will be for management to ensure that folders meant for deaf people are given unique labels.

> *For me, I will suggest that our folders should be given special labels/marks for easy identification.* [P5]

4.5.3 Ensuring Availability of Medicine

The National Health Insurance Scheme was introduced by government to replace the cash and carry system of healthcare. A patient who has a functional health insurance card, ideally, does not expect to make out of pocket payment for their medicine and other services when they visit the health facilities. In recent times, however, it is common for hospitals to demand cash payments from patients with the excuse that the drug is not covered by health insurance, or they write it for the patient to go and buy from the drug store. This practice is worrying to deaf patients. Considering the long ques that patients must endure at the OPD, laboratory, and pharmacy, it becomes a waste of time if they struggle this way for the whole day only to be told the drug the

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doctor has prescribed is not in stock. This situation can lead to self-diagnoses and self-medication among patients, especially deaf patients. As a suggestion to improve satisfaction with healthcare among deaf in the municipality, participants said government should ensure that hospitals are stocked with enough medicine.

> *Government should ensure that all the necessary medicines are available at the health facilities. Sometimes you will go and waste the whole day at the hospital only to be told later that your medicine is not there so go and buy.* [P2]
>
> *The medicines are not there. Sometimes you will get to the pharmacy, and they will write common paracetamol for you to go and buy. What is the use if the health insurance card? Government should provide the medicines.* [P4]

4.5.4 Ensure Improved Staff Professionalism and Interpersonal Skills

Professionalism entails the competences and skills that are required of a professional in a particular field of work. Participants doubted the professional competences of some of the nurses at the health facilities. They explained that by observing the way some of the nurses perform their duties, one would conclude that they do not have the requisite confidence and skills needed for the job. For instance, participants cited instances where some of the nurses in the wards are unable to set lines for intravenous (IV) drugs. The following utterance is the way a participant narrated her ordeal at the Municipal hospital.

> *They should ensure that the nurses are properly trained. A lot of the young nurses do not know anything and yet they are so proud. As you can see, I developed this sore in my wrist because an inexperienced nurse tried to pass a line in that hand. With that experience, I have stopped going to the Municipal hospital. I always visit Homeland clinic or SDA Hospital.* [P7]
>
> *Some of them don't know anything.* Besides, most of the young nurses are very lazy. They don't like work. [P2]

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4.6 Discussion of Major Findings

4.6.1 Deaf People's Concerns Regarding Satisfaction with Healthcare Services in the Wa Municipality

This question sought to explore the concerns of deaf people regarding their satisfaction with healthcare services. The investigation revealed that deaf people in the Wa Municipality have mixed experiences as far as access to healthcare services is concerned. Some of their experiences are viewed as positive experiences whereas others are considered as negative experiences. Few participants reported that some health staff are respectful, caring, tolerant and empathetic towards deaf patients. They are ready to attend to them (deaf patients) first upon realizing that they are deaf. This finding conforms to the Consonance Theory of Bernardo (2017) which proposes that patients become satisfied with the services they receive if prior expectation is in consonance with the actual care received.

However, majority of the participants reported negative experiences at the health facilities. As a result of language barrier between healthcare staff and deaf patients, clients go through negative experiences such as difficulty in communication, discrimination, avoidance, stigmatization, and delay in accessing healthcare services. These experiences are similar to the ones reported by Appiah et al. (2018) in their study of the communication experiences of speech and hearing-impaired clients in accessing healthcare in Hohoe Municipality of the Volta Region of Ghana. On the contrary, findings of this study slightly defer from those of Appiah et al (2018), in that, unlike the present study, their study did not report positive experiences with access to healthcare services. This difference may be attributed to difference in context. Meanwhile, in another breath, this finding agrees with the Consonance theory because, where actual care received does not match with expectations, the patient is seen dissatisfied. Deaf people's expectation is to have effective communication with

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the healthcare staff. They also expect shorter waiting time, equity in treatment between them and the hearing clients, as well as meeting staff who are warm and welcoming. As these expectations are not met, certainly, there is bound to dissatisfaction.

In their attempt to access healthcare services in the Wa Municipality, deaf people are confronted with communication challenges, largely because, providers lack knowledge in sign language, which is the main mode of communication among deaf people. As a result, majority of deaf people reported the use of family and friends, gestures, and writing as the medium of communicating with service providers. There were very few instances where deaf patients communicated with service providers through sign language interpreters. These findings are consistent with the findings of Orrie and Motsohi (2018) who investigated the challenges experienced by healthcare workers in managing patients with hearing impairment at a primary healthcare setting in South Africa.

From the report, majority of deaf people in the Wa Municipality are dissatisfied with communication, waiting time and staff attitude. This is in concurrence with the findings of Farias and Cunha (2017) who investigated the satisfaction of deaf people with the healthcare system quality in Brazil and reported that greater percentage of the participants were very dissatisfied with the communication of healthcare professionals, lack of informative and educational materials to clients and the time it took them to access doctors and test results. This finding is further consistent with that of Mitsi et al. (2014) who also found in their study that deaf patients in Greece are unsatisfied by their communication with the health professionals, are less satisfied by the health services they receive, do not receive sufficient messages related to the

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preventive healthcare and have a deficiency in knowledge of health matters comparing to the hearing people.

Again, this study found that deaf people are dissatisfied with the professional competence and skills of some nurses in the municipality. This finding is also like the findings of Abdul, et al., (2015) who, in their review of factors that affect patient satisfaction with nurse-led -triage and reported that nurses' competence in diagnosing and treating the health problems of patients was associated with patient satisfaction. The results of this study are however inconsistent with the findings of Adamu and Oche (2014) who observed that majority of participants in their study of patients at the Outpatient Clinic of a Tertiary Hospital in Nigeria expressed satisfaction with the communication between physicians and patients, their diagnosis and treatment. This variation in finding may be due to differences in the characteristics of their study subjects.

Though some healthcare providers tried to support when they realize the client is a deaf, most of them delay attending to them (deaf clients) since there was nobody to assist them in understanding the complaint(s) of deaf clients. In such instances, the providers find it more convenient to use relatives/ friends' assistance and writing as a way of communication. Meanwhile, this is yet another problem. Some deaf clients experience difficulties in expressing themselves through writing, while the presence of relatives/friends also compromises the privacy of deaf people. This finding confirms the finding of Musuku, Moroe, and Van der Merwe (2021) who conducted a study on the experiences of women who are deaf or hard of hearing in accessing healthcare services in Johannesburg and reported that due to communication barrier, deaf women experienced compromised quality of care and infringement on their right to confidentiality.

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4.6.2 Factors Contributing to Satisfaction with Healthcare Services among Deaf People in the Wa Municipality

This objective explored the factors that contribute to the satisfaction of deaf people with access to healthcare. With regards to communication, the findings indicated that deaf people who were able to establish effective communication with healthcare providers, either through writing or with the help of a third party, (i.e., sign language interpreter or family member) were more satisfied than those who could not communicate effectively with the service providers. Personal attributes of healthcare workers such as respect, tolerance, concern, and empathy were also found to positively influence deaf patients' satisfaction in the Wa Municipality. Other factors that have been found to be associated with satisfaction include reduced waiting time, equity in treatment, cost, and professional competence of service providers. Also, level of education was identified to have positive influence on satisfaction. Therefore, it was established that, deaf patients who had education up to tertiary level were better able to communicate with service providers through writing than those with lower levels of education.

These findings are found to be consistent with the findings of Iddrisu et al. (2019) who carried out a study on patients' satisfaction with healthcare services in the Tamale Teaching Hospital and reported that patients' satisfaction was influenced by good communication, good attitude of staff and nurse availability. However, the findings are inconsistent with the finding of Naseer et al. (2012) who, in a review of existing literature to find out the determinants of patient's satisfaction with healthcare system in Pakistan, reported that higher level of education is associated with lower level of patient satisfaction among the Pakistani people.

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In their studies, Cohen (1996) and Chawani (2009) also found that customers of healthcare services ranked communication and interpersonal aspects of the healthcare encounters as the highest determiner of satisfaction and loyalty. In that respect, the findings of this study are akin to those of Cohen (1996) and Chawani (2009). The findings are also in sync with those of Peprah (2014) who reported that, at the Sunyani Regional Hospital of the then Brong Ahafo Region of Ghana, patients' satisfaction with healthcare services was found to be influenced by attitude of health professionals, prompt service delivery, and ability of health professionals to disseminate information to patients.

Additionally, this study's findings are congruent with those reported by Abdul et al. (2015), Kamra, Singh, and De (2016), Zun, Ibrahim and Hamid (2018), Nketiah–Amponsah and Hiemenz (2009), who, in their separate studies found waiting time and treatment cost to influence patients' satisfaction. Nketiah–Amponsah and Hiemenz (2009) particularly reported waiting time as a significant predictor of healthcare satisfaction in three selected districts of Ghana, i.e., Lawra in the Upper region, Dangme West in the Greater Accra, and Ejisu-Juaben in the Ashanti region.

Conversely, socio-demographic characteristics of participants such as socio-economic status, age, sex, marital status, and religion were found to have no positive influence on deaf patients' satisfaction. These findings are like those of Ampofo (2015) who also found in his study of patient satisfaction with the quality of healthcare services provided by selected health facilities within Cape Coast Metropolis that socio-demographic characteristics of participants did not have significant influence on their satisfaction with healthcare. Similarly, this study revealed that variables such as environment, infrastructure, amenities, and equipment did not positively relate with satisfaction.

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The findings of the current study however contradict those of Mougalian (2019), Odonkor et al. (2019), Iddrisu, et al (2019), Adhikary et al. (2018), Kamra, Singh, and De (2016), Abdul et al. (2015), and Vadhana (2012) who reported socio-economic status, age, sex, marital status and religion as having positive influence on satisfaction. The results further contradict the findings of Peprah (2014) and Ampofo (2015) who found availability of up-to-date equipment and cleanliness of hospital environment as contributors to patients' satisfaction in Sunyani and Cape Coast hospitals respectively. These differences in findings could be due to lifestyle, individual values/standards, and level of knowledge of the subjects involved in the various studies.

From the findings, it is also apparent that the private health facilities in the Wa Municipality provide more satisfactory healthcare services to deaf people than the government health facilities. This finding is comparable with the findings of Nwankwo, et al. (2010) who carried out a study on service quality and patient satisfaction with access to public and private healthcare delivery in London and reported that public hospitals were largely providing unsatisfactory services to their patients with regards to doctor's responsiveness, length of getting an appointment time, access to core treatment and hours of operation as opposed to the private hospitals.

4.6.3 Constraints of Deaf People with Access to Healthcare Services

The purpose of this objective was to identify the constraints of deaf patients with access to healthcare in the Wa Municipality. After a thorough analysis of the responses by the study participants, it was revealed that the major constraint with access to healthcare services among deaf patients in the Wa Municipality was communication difficulties. All participants bemoaned the absence of sign language

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interpreters in health facilities and the inability of service providers to use sign language as a serious hindrance to their access with healthcare services and consequently, negatively influenced their satisfaction with the quality of services they received. Though clients resorted to the use of other alternative modes of communication, such as gestures, writing and use of family members or escorts, these were proven to be ineffective means of communicating their complaints to health workers. The presence of family members or friends/escorts in consulting rooms were particularly thought of as an invasion of their privacy. This finding confirms the findings of Santos and Portes (2019) who researched into the perceptions of deaf people about the communication process with health professionals in Brazil and reported the lack of interpreters and the lack of use of the Brazilian Sign Language by professionals as the main communication barriers for deaf patients during healthcare access. Santos' studies also revealed the use of escorts and gestures as alternative strategies that were used by deaf people in Brazil to communicate with healthcare providers.

Also, the study further revealed stigmatization, discrimination, poor attitudes of some staff and high cost of treatment as other constraints to access and satisfaction with healthcare. These findings are similar to those found by Mohiuddin (2020) when he studied patient satisfaction with healthcare services from the Bangladesh perspective. In his study, the researcher found lack of empathy on the part of health professionals, callous and casual attitude of staff, poor levels of competence and, occasionally, disregard for the suffering that patients endured as some of the obstacles to access to health services. The report on poor staff attitude towards patients was also reported by Kyle et al. (2013) in their study which revealed that, harsh attitudes were meted out to deaf patients by certain healthcare providers in the UK. It was specifically observed

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that more deaf clients frequently languished in waiting areas not knowing their names have been called. This finding is like the findings of this current study.

Some findings of the current study however disagreed with the those of Mohiuddin (2020) who noted insufficient infrastructure, poor quality of existing facilities and lack of medical equipment as constraints to healthcare access and satisfaction. This may be due to difference in context and personal values and standards of study participants.

In the same vein, the findings on stigmatization, discrimination and delays as revealed by this study are in consonance with the ones reported by Appiah et al. (2018). Like the present study, their study also found that due to communication difficulties, deaf patients in Hohoe municipality experienced disparity, discriminations, neglect, and delays in receiving healthcare services from providers.

4.6.4. Strategies to Improve Deaf People's Satisfaction with Healthcare Services in the Wa Municipality

The intent of this objective was to identify strategies which can improve Deaf people's access and satisfaction with healthcare in the Wa Municipality. Data from participants revealed that, to improve deaf patients' access and satisfaction with healthcare services in the municipality, management of health facilities must consider employing sign language interpreters in the various health facilities in the municipality. It was also suggested that healthcare workers should endeavour to learn sign language as part of their training.

This suggestion as reported in this study is like the findings of Orrie and Motsohi (2018) who reported that to improve the quality of services to deaf patients in South Africa, sign language interpreters should be made available at health facilities while

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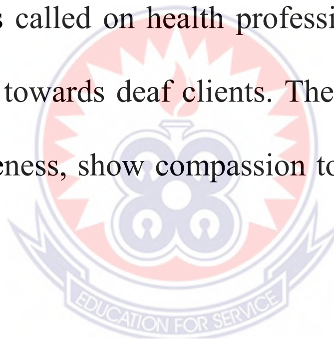
also ensuring that all healthcare workers receive training in sign language to facilitate their communication with deaf patients.

Participants also suggested that, to improve access and satisfaction among deaf people, hospital managements should institute special arrangements such as designating a section of the OPD for persons with disabilities, putting special labels on the folders of deaf patients for easy identification and reducing waiting time at the OPD. Other suggested strategies included ensuring availability of medicine and improved staff professionalism and interpersonal skills. This study's findings are found to be consistent with the findings of Iddrisu, et al (2019). These findings are also congruous with the findings of Velonaki et al. (2015) and Khamis and Njau (2014) where participants called on health professionals to modify their knowledge, attitudes, and behaviours towards deaf clients. They also encouraged health workers to improve on their politeness, show compassion towards clients, and practice active listening.



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CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.0. Introduction

This chapter presents the summary, conclusion, contribution to knowledge and recommendations. This study was undertaken to first, explore the concerns of deaf people regarding their satisfaction with healthcare in the Wa Municipality. Second, to examine the factors that contribute to deaf people's satisfaction with access to healthcare. Third, to identify the constraints of deaf patients with access to healthcare, and lastly, to identify the strategies which can improve deaf people's access and satisfaction with healthcare in the Wa Municipality. Views from multiple theories were synthesized to broaden the outlook of the study. Qualitative approach was used where focus group discussion was used to collect data. Data collected were analysed thematically.

From the results, profile of the participants shows that there are more males compared to the female participants in the study. The ages of participants range from 26 to 45 years with the average age being 35 years. Three participants had education up to tertiary level compared with 5 who have education below the tertiary level. Three participants completed Technical/Vocational institutions, while 1 participant had no formal education.

With regards to employment, three participants are government employees, four are employed in the private sector, two are self-employed while three are unemployed. In terms of religion, five are Christians and seven are Muslims. The major findings of the study are therefore presented as follows:

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5.1. Summary of Major Findings

Research question 1: What are the Concerns of Deaf People Regarding Satisfaction with Healthcare in the WA Municipality?

From the research findings, deaf people in the Wa Municipality have both positive and negative concerns about their satisfaction with healthcare services. The positive concerns include feeling of respect, tolerance, care, and empathy. Deaf people also have some negative concerns about their satisfaction with healthcare services such as communication difficulties, feeling of avoidance, discrimination, stigmatization, disparity, poor staff attitude and delays in accessing services.

Research question 2: What are the Factors Contributing to Satisfaction with Healthcare Services among Deaf People in the Wa Municipality?

Under research question 2, the following findings were made:

1. The factors that contribute to deaf people's satisfaction with healthcare services are related to the institutional factors such as ability of staff to communicate with deaf clients, reduced waiting time, good staff attitude and equity in treatment.
2. Hospitals' environment and nature of equipment do not contribute to satisfaction with healthcare among the deaf.
3. Socio-demographic characteristics such as age, gender, socio-economic status, and religion do not contribute to satisfaction among deaf people in the Wa Municipality.

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Research question 3: What are the Constraints of Deaf People with Access to Healthcare in the WA Municipality?

The results show that the constraints of deaf people in accessing healthcare services are lack of common communication mode with healthcare providers, stigmatization, poor attitude of some staff, long waiting time and high cost of treatment.

Research question 4: What Strategies Can Help Improve Satisfaction with Healthcare Access among Deaf People in the WA Municipality?

Findings reveal four strategies which can help improve satisfaction with healthcare services among deaf people in the Wa Municipality. These include:

1. Effective communication between healthcare staff and deaf people.
2. Ensuring equity in treatment
3. Ensuring availability of medicine
4. Improved staff professionalism.

5.2. Conclusion

Based on the findings, it is concluded that deaf people in the Wa Municipality are not satisfied with the quality of healthcare services they receive. Also, socio-demographic characteristics such as age, sex, level of education, socio-economic status, and religion do not contribute to deaf people's satisfaction with healthcare in the Wa Municipality. Irrespective of their background characteristics, the factors which contribute to satisfaction among deaf people are related to the institutional care structures such as waiting time, communication, staff attitude, staff professionalism, and nature of facility's environment.

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5.3 Recommendations

Based on the conclusion, the following recommendations have been made.

Recommendation for Research Question 1:

I recommend that management of health facilities within the Wa Municipality should strengthen their internal monitoring mechanism to identify and sanction staff who put up negative behaviours which have the potential to cause dissatisfaction among deaf people.

Recommendation for Research Question 2:

The study also recommends that management of health facilities in the Wa Municipality should organize in-service trainings for their staff in areas of communication, interpersonal relations, etc to eliminate the factors that breed negative experiences among deaf people.

Recommendations for Research Question 3:

I. Management of health facilities in the Wa Municipality should liaise with government to employ sign language interpreters at the various hospitals to facilitate communication between deaf people and healthcare providers.

II. Effective training on how to communicate using Ghanaian Sign Language should be given to health staff as part of their training.

III. Government should employ more staff to reduce the waiting time of clients

Recommendations for Research Question 4:

I. Management should ensure equity in treatment between deaf people and the hearing populace

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II. Management should ensure improved staff professionalism through refresher trainings.

5.4 Limitation

The researcher encountered difficulty in scheduling appointments due to the widespread nature of participants. Also, due to resource constraints, only deaf in the Wa Municipality were involved in the study. A study of this kind should have been extended to include all Districts and Municipalities in the region for a wholistic understanding of the situation about deaf people's satisfaction with healthcare in the region.

5.5. Suggestions for Future Research

A study to estimate the average waiting time for each unit and department of the hospitals should be done to help improve the services rendered by hospitals in the Wa Municipality.

Also, Studies into deaf people's satisfaction with healthcare services using comparative study of both public and private health facilities should be conducted to understand which of the two are doing better in terms of offering services to deaf people.

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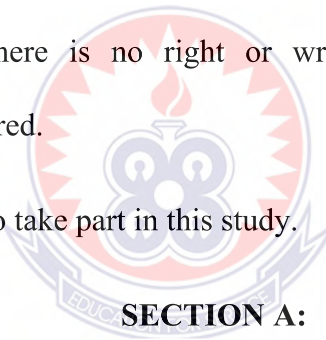
APPENDIX A

INTERVIEW GUIDE ON DEAF PEOPLE'S SATISFACTION WITH HEALTHCARE SERVICES IN THE WA MUNICIPALITY

My name is Prosper Tengepare, a student at University of Education, Winneba. I am conducting a study on the topic- "Deaf people's satisfaction with healthcare services in the Wa Municipality", as part of requirements for the award of Master of Philosophy degree in Special Education.

I would be very grateful if you could spend a few minutes to respond to these questions about the services you receive from the health facilities within the Wa Municipality. This is purely an academic exercise and information provided will be treated confidentially. There is no right or wrong response. Your honesty in responding is highly required.

Thank you for accepting to take part in this study.



SECTION A:

Background characteristics of participant

4. What is your age?
5. What is your highest level of formal education?
6. What work do you do?
7. What is your religious status?
8. How often do you visit the health facilities within the Wa Municipality?
9. When was the last time you visited any health facility within the municipality?

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SECTION B

Concerns with access to healthcare in the Wa Municipality

1. Tell me about your general experiences with access to healthcare at health facilities in the Wa Municipality……………………………………………
2. What did you think about the health facility environment the last time you visited the hospital/health centre?..

Probe the following:

- ✓ Availability of modern-looking hospital equipment
- ✓ Availability of adequate seats for clients
- ✓ Waiting time before been attended to
- ✓ Attitude of health staff
- ✓ Professionalism and competence of health staff
- ✓ Skilfulness of staff in the performance of their duties
- ✓ Helpfulness of health staff (responsiveness)
- ✓ Respect for patient dignity
- ✓ Respect for patient rights
- ✓ Ability of staff to understand patient specific needs
- ✓ Provision of special attention for Deaf patients
- ✓ Information on what was wrong/health condition
- ✓ Education on tests you had to undergo.
- ✓ Educate you on how to take your medications and the possible side effects?
- ✓ Opportunity to ask questions relating to your health/treatment
- ✓ Affordability of fees that are charged for services
- ✓ Departments that were visited within the health facility

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- ✓ Departments whose services were better. **Probe**
    - What specific things did they do that made their services better?
- ✓ Departments whose services were poor. **Probe**
    - What specific things did they do that made their services poor?

Factors contributing to deaf people's satisfaction with healthcare in the Wa Municipality

1. Tell me all that you felt about the services that were provided to you the last time you visited the hospital/health centre……………………………………………

    Probe:

    - ✓ Which day was it that you visited the health facility?
    - ✓ What time of the day did you visit the facility?
    - ✓ What was your complaint?
    - ✓ Tell me all that made you feel satisfied with the services that you received
    - ✓ Tell me all that made you not satisfied or less satisfied with the services that you received
2. Tell me what you would do just in case next time you or your friend is ill. **Probe**
    - Intention to visit the facility again
    - Intention to recommend the facility to a friend or family member
3. What do you think about the overall healthcare quality of the health facility you visited the last time? …………………………………………………………………
4. Describe to me your overall satisfaction with the healthcare that you received the last time you visited a health facility…………………………………………

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Constraints with access to healthcare in the Wa Municipality

1. Tell me what your major constraints were when you visited a health facility the last time. **Probe**

- ✓ Are there others that you have not mentioned?

2. Tell me the units/departments where you experienced the most challenge/challenges. **Probe**

   1. Are there others that you have not mentioned?

Strategies to improve access and satisfaction with healthcare in the Wa Municipality

4. What measures do you think should be put in place to enhance access to healthcare for the Deaf? ……………………………………………………………
5. How will each of the measures that you mentioned help to improve access to healthcare for the Deaf?...
6. Overall, tell me how you think deaf peopleshould be handled in order to improve their access and satisfaction with healthcare when they visit the health facility ……………………...…..

END OF INTERVIEW

THANK YOU FOR YOUR TIME

University of Education,Winneba http://ir.uew.edu.gh

APPENDIX B

LETTER FROM RESEARCHER ASKING FOR PERMISSION TO COLLECT DATA

Yao-Yiri M/A Junior High School
Post Office Box 14
Jirapa, U/W/R
28th October, 2021.

The President
Ghana National Association of the Deaf (GNAD)
C/O Resource Centre for Persons with Disabilities
P. O. Box 109
Wa Municipal
Upper West Region

Dear Sir/Madam,

REQUEST FOR PERMISSION TO COLLECT DATA:

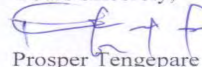
My name is **Prosper Tengepare**, a final year MPhil student at the Department of Special Education, University of Education, Winneba. I am conducting a study titled- **"Deaf individuals' satisfaction with healthcare services in Wa Municipality, Ghana"**, as part of requirements for the award of Master of Philosophy degree in Special Education. The study is purely an academic exercise and information provided by your members will be treated confidentially and only used for the purpose for which it is collected.

By this letter, I wish to ask for permission from your office to carry out this study among your membership in the Wa Municipality.

I count on your kind cooperation.

Thank you.

Yours sincerely,



Prosper Tengepare
(0241125777 / 0207351173)

University of Education,Winneba http://ir.uew.edu.gh

APPENDIX C

PERMISSION LETTER FROM GNAD; WA MUNICIPAL BRANCH

RESOURCE CENTRE FOR PWDS
P.O.BOX 109
WA, UPPER WEST REGION
8TH NOVEMBER, 2021.

MR. TENGEPARE PROSPER
YAO-YIRI M/A JUNIOR HIGH SCHOOL
POST OFFICE BOX 14
JIRAPA, U/W/R

Dear Sir,

RE: REQUEST FOR PERMISSION TO COLLECT DATA

I write in response to your request in a letter dated 28th October, 2021 and received on 4th November, 2021.

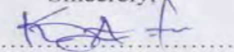
You wish to collect data among our membership for your research work titled **"Deaf individuals' satisfaction with healthcare services in Wa Municipality, Ghana"**, as part of requirements for the award of Master of Philosophy degree in Special Education.

I'm glade to inform you that you have been granted permission to collect data among our members for your study.

You are, however, to ensure the security of our members as the COVID – 19 pandemic disease is still spreading.

I count on your maximum cooperation.

Sincerely,



Kazia Abudu
(Secretary)
For: President