COMMUNICATION BETWEEN DEAF WOMEN & HEALTH WORKERS IN REPRODUCTIVE HEALTHCARE: A CASE OF ADAMOROBE IN THE EASTERN REGION.

BY

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DECLARATION/SIGNATURE PAGE

I hereby declare that this research is a result of my/our own original research and that no part of it has been presented for another degree in this university or any other higher education institute. I further declare that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.

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CERTIFICATION BY SUPERVISOR

This Dissertation/Thesis has been prepared and presented under my supervision according to the guidelines for supervision and formatting of Dissertation/Thesis laid down by the University of

Media, Arts and Communication, UniMAC.

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DEDICATION

This work is dedicated to my husband and children.

ACKNOWLEDGEMENT

I would like to acknowledge my friends and family for their unwavering support throughout this journey.

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AdaSL	Adamorobe Sign Language
C4D	Communication for Development
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CRPD	Convention on the Rights of Persons with Disabilities
GHS	Ghana Health Service
GSL	Ghanaian Sign Language
ICPD	International Conference on Population and Development
LMICs	Low- and Middle-Income Countries
NHIS	National Health Insurance Scheme
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
UniMAC	University of Media, Arts and Communication
UN	United Nations
UNFPA	United Nations Population Fund
WHO	World Health Organisation

ABSTRACT

The study focuses on the communication between deaf women and healthcare providers in Adamorobe, a community in the Eastern Region of Ghana, which has one of the highest occurrences of hereditary deafness. The study adopts a qualitative case study approach, informed by the interpretivist philosophy, and relies on the transactional model of communication, as formulated by Barnlund, and Foucault's theory of power/knowledge to examine communication practices and power relationships in the clinical encounter. Semi-structured interviews with fifteen deaf women and five healthcare providers in the Adamorobe health facility were used to collect data with the assistance of trained sign language interpreters. The use of thematic analysis was done to reveal patterns in the experiences of the participants. The results show that communication is mostly improvised and mediated. It relies on writing, gestures, and family members because there are no professional sign language interpreters, and the healthcare providers have poor sign language skills. The practices are damaging to informed consent, privacy and the reproductive autonomy of deaf women. The research also found that communication barriers are some of the factors that lead to delayed care, health facility avoidance, low reproductive health knowledge, and the tendency to rely on others to make health-related decisions. Deaf women recognised the necessity for healthcare workers to be able to use sign language, interpreter assistance, and visual and technological means of communication. It is found that the communication barriers are not only technical, but are institutional and socio-economic inequalities that are embedded in the practices of institutions. The recommendation is to have effective, inclusive communication systems between deaf women and health practitioners as stakeholders in the reproductive healthcare system of Ghana.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

Communication lies at the core of every human interaction process as it is the main source whereby people establish, exchange and define meaning (McQuail, 2010). It is a complicated social and psychological process which involves the use of verbal language, non-verbal signals, written signs, visual manifestations and other forms of interaction that are found in a culture. Communication helps people to negotiate relationships, express and receive emotions, overcome uncertainty, coordinate activities, and create their sense of the world. It is thus not the act of communicating but a process of interaction that is influenced by the circumstances, power dynamics, and cultural standards as well as personal abilities. It is this multidimensional nature that renders communication fundamental to human society and indispensable in environments that require comprehension and collaboration, e.g., education, government, and healthcare (Shannon & Weaver, 1949).

Communication does not just involve the transmission of messages. It is effective when it is clear, precise and interpreted mutually so that the intended meaning of the sender gets to the receiver (Melkote and Steeves, 2015). Effective communication in the workplace, particularly in the field of healthcare, entails being attentive and empathetic, as well as being able to modify messages to fit the needs and abilities of a wide range of audiences. It is the basis of trust, resulting in informed decisions and positive interpersonal interaction (Melkote and Steeves, 2015).

In a health setting, communication takes on a greater significance since it is directly related to diagnosis, treatment, patient satisfaction, and health outcomes (Corcoran, 2013). The patient-provider relationship depends on the accuracy and clarity of communication, as this will be

what determines the patient's ability to follow advice, give informed consent or feel valued within their care.

In healthcare settings, communication is rarely symmetrical: healthcare providers typically hold institutional authority, specialised knowledge, and control over time and language, producing inherent power imbalances (Roter & Hall, 2006; Foucault, 1977). For deaf individuals who rely on visual-gestural languages such as Ghanaian Sign Language (GSL), these imbalances are intensified because most health systems are designed around spoken language and auditory norms (Barnett et al., 2011; Kusters, 2015).

Informed consent, treatment adherence, patient satisfaction, and health outcomes depend on the effective communication between providers and patients (Corcoran, 2013; Kaplan et al., 2010). The failure of communication has especially serious implications in the reproductive health sector, where contraception, pregnancy, childbirth, and sexual health choices are sensitive and time-restricted and rights issues (WHO, 2022). As women, disabled people, and those unable to communicate, deaf women are particularly vulnerable to isolation, forced treatments, and slow treatment (Mprah, 2013; Seidu et al., 2021).

This paper centres on reproductive (as opposed to general) health communication due to three reasons. To begin with, reproductive health services entail sensitive life-altering choices that demand a lot of mutual understanding and informed consent. Coerced sterilisation or denial of safe abortion practices are some of the types of violations that can be triggered by miscommunication and occur in deaf women around the world and in sub-Saharan Africa (WHO, 2022; Ahumuza et al., 2014; Mprah et al., 2023). Second, such services are provided in Ghana in many instances by special maternal and child health units or community outreach programmes, which seldom incorporate disability-sensitive communication guidelines (Mprah et al., 2023). Thirdly, international and country-specific data indicate that deaf women

experience disproportionately high rates of contraceptive misinformation, late antenatal presentation, and coercive sterilisations; the factors that are directly connected to the exclusion of communication (Badu et al., 2018; Nketsia et al., 2022). According to recent research, the comprehensive knowledge of contraception (only 12-18% vs. 40-50% among hearing counterparts) and the prevalence of unwanted pregnancies and late prenatal care are much higher among deaf Ghanaian women (Nketsia et al., 2022; Mprah, 2013).

Women have a significant influence on the socio-economic and health development of society, especially by being mothers, caregivers, and influencers of the health community (UNFPA, 2018). They are, however, sidelined in some way or other, especially in reproductive health. According to the World Health Organisation (2022), women with disabilities are three times more likely not to be provided with reproductive health services than non-disabled women are. It is possible that deaf women will not receive health education, consultations, and other services because of the lack of access to sign language interpreters, ineffective visual aids, and insufficient training of the providers (Barnett et al. 2011). Therefore, they do not have the chance to make conscientious choices regarding their reproductive health, hence undercuts the autonomy and human rights of women.

1.1.1 Communication in the Health Setting

The health seeker-provider communication is generally recognised as a major determinant of quality healthcare provision. Clinical situation communication provides an opportunity to share the symptoms, concerns, diagnoses and treatment plans and provides the basis of understandability and collaborative decision-making (Street et al., 2009). research indicates that patient-provider communication has a direct impact on treatment compliance, patient satisfaction with care, further care, and patient outcomes (Kaplan et al., 2010). Respectful, comprehensible and empowering communication might make the patient feel confident in

accepting medical advice, sharing confidential information and contributing to the management of his or her personal health. Conversely, efficient communication can lead to misinterpretation of medical instructions, less use of services, and incompetent therapeutic relationships.

Language, education, social status, and cultural expectations are some of the factors that determine communication issues in most healthcare systems (Shamsi *et al.*, 2020). Health providers are known to use technical language or a one-way communication style that restricts the chances of patients asking questions or seeking clarifications (Roter & Hall, 2006). Moreover, time limitations, shortage of staff, and the lack of proper training in patient-centred communication can limit meaningful communication. Such barriers affect people who are already marginalised in the health system disproportionately.

The communication barriers in health care are even stronger in the case of female patients with disability. The available literature on disability and reproductive health suggests that women with disabilities tend to note that they are misunderstood, ignored, or even invisible to healthcare providers, unless they are provided with training on inclusive communication skills (Shakespeare, 2018; Groce & Trani, 2009). Studies show that paternalistic or dismissive attitude towards women with disabilities is a significant issue in health consultations in sub-Saharan Africa, and such attitudes do not allow women with disabilities to communicate their symptoms, questions, and make informed choices regarding reproductive health (Ahumuza et al., 2014; Kumi-Kyereme, Seidu & Darteh, 2020). These barriers are increased when cognitive restrictions are assumed by the providers or when translating the communication using family members; therefore, impairing privacy, autonomy and confidentiality.

In Ghana, access to quality reproductive health services is a national priority, but it is not being implemented for persons with disabilities (Seidu et al. 2021). According to Nyst (2007)

communities such as Adamorobe, known for its hereditary deaf population, the use of sign language are central to any discussion (Kusters, 2015). Such communities are associated with intersectional discrimination where deaf women are confronted with the events of inequality between the genders and exclusion due to disabilities, especially in access to communication (Barnett et al., 2011; Mprah, 2013). The ineffective communication may result in misinterpretation of medical advice, poorly-informed consent and non-follow-up care. On the other hand, clear communication is quite significant in enhancing the overall healthcare experience, and this is one of the properties of clarity, access, empathy and feedback opportunities. It enhances relationships between patients and providers, patient satisfaction, as well as adherence to medical recommendations and development of trust levels needed to make informed and collaborative choices in the course of clinical practice (Corcoran, 2013). In reproductive health, communication is the key to whether or not women have the correct information about family planning, safe pregnancy and maternal care. For deaf women, the lack of access to forms of communication translates directly to exclusion from these life-saving services. Thus, the question of communication is not simply a question of technicalities but one of dignity and empowerment.

This study is therefore important because it discusses the communication dynamics that could influence the reproductive health rights of deaf women in the context of Ghana. By analysing how communication practices in the health system in Adamorobe may hinder or support access to reproductive healthcare, the study aims to add to the national and international efforts to achieve inclusive healthcare. The insights generated will also contribute to the development of the practical framework to overcome communication gaps so that no woman, regardless of her hearing ability, is left behind in exercising her reproductive rights.

1.1.2 Reproductive Health and Ghana's deaf population

The World Health Organisation has defined reproductive health as full, physical, mental and social well-being and not simply non-disease or non-infirmity in everything that has to do with the reproductive system and the functioning and processes thereof (Badu *et al.*, 2018; Abekah-Nkrumah and Abor, 2016). Reproductive health would mean that individuals can enjoy a good and healthy sex life and that they can conceive, and have the freedom to choose whether, when and how many times to have sex and/or conceive.

The global development and population health are based on such a fundamental principle as reproductive health and rights, aimed at obtaining the highest level of sexual and reproductive health and having informed choice without discrimination and coercion (United Nations, 1994; WHO, 2022). Rights-based approach focuses on the availability, accessibility, acceptability and quality of care and associates reproductive health with autonomy, dignity as well and agency instead of merely service delivery (Cook et al., 2003; Sen et al., 2002). These international ambitions are echoed in the Sustainable Development Goals (SDGs) and (Goal 3 and Goal 5) that aim at universal access to reproductive healthcare and gender equality (Dovlo et al., 2024). Nevertheless, there are some gaps that remain in its implementation, especially between the low and middle-income countries (Abekah-Nkrumah and Abor, 2016; Ha et al., 2023). It is estimated that there are 470,737 people living in Ghana with a certain degree of hearing loss, and that there are more than 211,000 people with deafness and are hard of hearing, and their primary communication tools are sign language (Ghana Statistical Service, 2021). Studies of the deaf community in Ghana demonstrate that most deaf people do not know how to use contraceptives and safe abortions, and policymakers have not effectively tackled structural and informational barriers, as they prevent deaf people from receiving reproductive health education (Nketsia et al., 2022; Mprah et al., 2023).

On all matters related to the reproductive system and functions of deaf women, reproductive health can be described as an abnormality of full physical, mental and social well-being (United

Nations, 1994). The reproductive system helps one conceive, give birth, and have sexual and maternal health. Reproductive healthcare, in turn, refers to the availability of safe family planning, maternal healthcare, and reproductive rights, which would help people make informed decisions (WHO, 2022). The particular aspect of deaf women that is examined in the present study is access to reproductive health services and the communication barriers.

Deaf women are also one of the most marginalised groups in the world and in Ghana due to the multilayered challenge of discrimination; firstly, discrimination because of their gender, secondly their disability and also their inability to participate in communication (Barnett et al., 2011). They indeed play significant roles in society in terms of being mothers, caregivers, as well as contributors to social development; however, they may lack health education and services due to poor interpretation of sign language and lack of accessibility. This omission goes against the Sustainable Development Goals and, more so, Goal 3 (Good Health and Well-being) and Goal 5 (Gender Equality), which require universal access to reproductive healthcare, in addition to empowering every woman.

An interesting case of the present study is the situation in Adamorobe, in the Eastern Region of Ghana. This unique cultural and linguistic environment is an excellent opportunity to study how deaf women can experience, negotiate, and have access to reproductive care.

1.1.3 Adamorobe: A Unique Context

Adamorobe is a farming community located in a bowl-shaped valley at the foot of the Akuapem hills in Ghana's Eastern region. It is known for its high rate of hereditary deafness and its indigenous sign language, Adamorobe sign language (AdaSL). The community has a much higher incidence of deafness than the rest of Ghana. This stands at roughly 2% of the population compared to 0.4% in the continent of Africa as a whole (The language shop, n.d). *Graphic*

online (n.d) reports that the most up-to-date records had identified 50 hearing impaired, mostly with speech impairment, out of the 1,800 indigenes in the village as of 2019.

That figure is double the global average, according to the World Health Organisation (WHO) projection, which estimates that five out of every 1,000 children worldwide are either born with hearing loss or acquire it soon after birth. Deaf women in this special community face several challenges, one of them being communication about their reproductive health, despite national knowledge that the community has a high incidence of deafness. The characteristics of this community create a unique environment to study how local linguistic resources interact with (or are ignored by) formal health systems.

This study will fill the gap between the policy rhetoric and actual lives of the deaf women in the Ghanaian community through the lens of communication accessibility as one of the keys to providing reproductive health services. It may be useful to inform the policies and practices in order to transform commitments into actionable results by offering contextual evidence of barriers to communication and inclusion opportunities. The rest of this chapter establishes the problem, research questions and objectives, justification of the study and establishes the scope and structure of the chapter.

1.2 Problem Statement

Reproductive healthcare in Ghana remains a very unequal space, especially when it comes to women with disabilities. Although the Government has adopted the Sustainable Development Goals (SDG 3 and SDG 5) and the Persons with Disability Act, 2006 (Act 715), numerous women with hearing impairments are out of reproductive health services (Seidu et al., 2021). Research indicates that female deaf women encounter increased barriers that are intertwined because of gender, disability, and communication problems (Barnett et al., 2011; Mprah, 2013). National policies on inclusion focus largely on inclusion, although, in rural and semi-urban

communities like Adamorobe, where sign language is commonly used, it is hardly supported in health institutions (Kusters, 2015).

Effective health provider-patient communication is very important in reproductive health as it helps in making informed decisions, safe care, and patient satisfaction of patients (Corcoran, 2013). Nevertheless, health workers and deaf women frequently do not communicate effectively or not at all because of the absence of trained interpreters and a sufficiently developed use of visual aids and insufficient cultural and linguistic competence among providers (Nketsia et al., 2022). This makes deaf women often rely on family members to decode sensitive health information, which interferes with their privacy, confidentiality, and autonomy in decision-making regarding their reproductive health.

Even though the inclusion of disability in Ghana's health sector is acknowledged by scholars (Seidu et al., 2021), current studies on the topic have concentrated on physical accessibility, but not communicative accessibility (Badu et al., 2018; Seidu et al., 2024). A community with a special linguistic heritage and a high rate of hereditary deafness, Adamorobe, is an invaluable but poorly studied site to examine these dynamics.

Although increasing academic interest is being shown in disability inclusion in the Ghanaian health sector, the available literature is still inadequate in terms of breadth and depth of analysis with regard to communication as a factor in the reproductive healthcare access by deaf women. Most of the existing literature has focused on physical access, the use of services and, in general, policy inclusivity, but has little focus on communicative accessibility in the daily clinical experience (Badu et al., 2018; Seidu et al., 2021). Research that considers disability and reproductive health in Ghana has the tendency to take persons with disabilities as one person, and hence impairment-related obstacles such as exclusion of sign language, mediated consultations, and informed consent failure are obscured. Beyond this, where deafness has been

recognised, studies have mainly concentrated on the absence of knowledge or service-seeking behaviours, instead of looking at the nature of communication and how it is practised, managed, and negotiated in the context of reproductive health consultation, and the role of such practices in defining autonomy, privacy and choice.

Critically, there is a notable absence of empirically grounded, communication-oriented studies that examine reproductive health experiences of deaf women, and provide a significant lack of studies that conjecture the meaning-making process and power dynamics. To be more precise, no literature in Ghana has imposed the communication theory (e.g., transactional models or the power/knowledge approach) to question the interaction process between institutional practices, linguistic norms, and clinical authority to marginalise deaf women in reproductive healthcare contexts. This difference is particularly acute in special deaf communities like Adamorobe, where there is an indigenous sign language, but which is almost unknown in formal health systems. In turn, not much evidence has been published to guide policy and practice on how reproductive healthcare communication may be reorganised to become inclusive, rights-focused, and sensitive to the lived experiences of deaf women. The proposed study will thus fill this gap by studying the communication patterns of deaf women and the health care providers within Adamorobe, particularly the ways in which the communicative practices affect the access, autonomy, and reproductive health outcomes.

1.3 Research Objectives

The main objective is to explore communication dynamics between deaf women and healthcare providers in reproductive health services in Adamorobe in the Eastern region of Ghana.

Specific objectives are:

i. To explore the nature and dynamics of communication between deaf women and healthcare providers during reproductive health consultations in Adamorobe.
ii. To identify challenges and facilitating factors that shape deaf women's access to reproductive health services.
iii. To document deaf women's perspectives on how communication with healthcare providers and other stakeholders can be improved.

1.4 Research Questions

i. How is communication enacted and experienced between deaf women and healthcare providers in Adamorobe during reproductive health consultations, and how do power dynamics shape these interactions?
ii. What challenges and facilitating factors influence communication effectiveness, between deaf women seeking reproductive healthcare and healthcare providers?
iii. How do deaf women perceive their communication with healthcare providers and relevant stakeholders, and what improvements do they suggest?

1.5 Significance of the Study

The research is a novel contribution to the interdisciplinary research areas of health communication, development communication, and disability and reproductive health research, especially the research on communication accessibility and power in clinical interactions. Although prior literature on reproductive health outcomes and disability inclusion in Ghana and sub-Saharan Africa has been based on either biomedical, policy, or service-utilisation approaches, this research contributes to knowledge development since the authors have anticipated that a central analytical category review is communication. Through the analysis of the reproductive health communication practices enacted, mediated, and negotiated between

deaf women and healthcare providers, the study provides an empirical contribution to a field which has received little attention on communicative processes in dictating reproductive autonomy and health equity.

The research also contributes to theory because it utilises Barnlund's transactional model of communication and Foucault's power/knowledge model to the reproductive health experiences of deaf women, the application of which is under-represented in the world literature and the Ghana literature. This theoretical integration contributes to the current body of communication literature by showing how an institutional power, a normative linguistic practice, and the lack of shared communicative resources interfere with a process of mutual sense-making and reestablishes power imbalances in the clinical practice. By so doing, the paper will go beyond the description of the barriers to give an understanding of the role of communication practices as an area within which reproductive rights are either facilitated or limited in daily healthcare interactions.

The research is also empirically novel because it presents context-specific findings about Adamorobe, a linguistically distinct deaf group with an indigenous sign language that has experienced a fair amount of ethnographic research but has seldom been researched through a health-communication lens. The study contributes to a significant gap in the literature of impairment-specific reproductive health communication in low- to middle-income settings by describing the lived experiences of deaf women and healthcare providers in this context.

Outside its academic value, the study provides analytically based information, which can guide the health communication practice, professional training and policy making within the Ghana Health Service and other related institutions. Nevertheless, its major impact is the promotion of academic knowledge regarding the intersection of communication, power, and disability in the provision of reproductive healthcare. The fact that the study supports the re-theorisation of

reproductive health access as a communicative and rights-based process by placing deaf women at the centre as communicative agents and not service-receivers, enhances current debates in the field of health and development communication scholarship.

1.6 Scope of the Study

The contextual and analytical confines of this study are necessary to help conduct a thorough study of communication practices within a particular reproductive healthcare context. The study is geographically confined to the rural community of Adamorobe in the Eastern Region of Ghana, which is typified by a high incidence of hereditary deafness as well as having an indigenous sign language. Such a choice of place is not accidental but explained by its socio-linguistic peculiarities, which make it possible to concentrate on the interaction processes between deaf women and medical workers.

Substantively, the research is solely based on communication in reproductive health interactions, such as family planning, antenatal care, and similar women's health consultations. It fails to analyse larger health services, overall disability experiences and population-level reproductive health outcomes. It looks at the way communication is performed, mediated, and experienced in clinical interactions, and it does not emphasise biomedical indicators and epidemiological measures.

The population confined to be part of the study will be restricted to deaf women within the reproductive age of Adamorobe and people providing reproductive health services at the local health facility. Primary participants are not included when it comes to other stakeholders, like policymakers or non-governmental organisations. The study is methodologically a qualitative case study design, which is based on interviews and focus group discussions to observe lived experiences and practices of interaction. Therefore, the results are not to be statistically

generalisable. It is a deliberately limited scope, thus to permit depth, rigour and theoretical contribution as opposed to breadth or representativeness.

1.7 Organisation of the Study

This paper is divided into five chapters. In Chapter One, the study is introduced, where the background, problem statement, research questions, objectives, significance, scope, and chapter arrangements are presented. Chapter Two examines existing literature on reproductive health and rights, disability, and development communication, with a particular interest in experiences of deaf women, and what gaps there are in available research. Chapter Three presents the research method that includes the research design, study area, population, sampling methods, data collection procedures and data analysis procedures, including the ethical aspects of the research. The fourth chapter gives and summary of the research findings according to the study objectives and presents the discussion of existing literature. Chapter Five concludes by summarising the major findings, specifying conclusions, and providing policy, practice and future research recommendations as a way to enhance accessibility to reproductive health services and rights of deaf women in Ghana.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL WORKSHOP

2.1 Introduction

In this chapter, the study critically assesses literature in the area of reproductive health and rights, disability, and communication, giving some special attention to the experience of deaf women in Ghana. The review relies on the global, regional, and national research in its discussion of disability and reproductive health, in addition to evaluating how the population has been treated or ignored by the development communication frameworks. This chapter not only reports past work; instead, the chapter will engage critically with literature to draw up contradictions, silences, and gaps, specifically concerning reproductive rights discourse in its provisions to women with hearing impairments. The aim is to give a conceptual and empirical framework within which the research was done, and also identify the gaps in any attention given by scholars in the various fields. This prepares the ground to have an in-depth study of the obstacles deaf women encounter.

2.2 Conceptualising Reproductive Health and Rights

The topic of reproductive health and rights has received massive research attention in the literature on global health and development, and most of the coverage has been under broader human rights and gender equity structures (Ha et al., 2023; Ganle et al., 2021; Abekah-Nkrumah and Abor, 2016). An internationally agreed definition of reproductive health emerged in the International Conference on Population and Development (ICPD) that was held in 1994. The Conference defined reproductive health as a state of full physical, mental and social well-being and not just the absence of disease or infirmity, but all issues concerning the reproductive system, its functions and processes (Ganle et al., 2021; United Nations, 1994). This definition is not only clinical, but also deals with the right to make informed decisions, using health

services and receiving proper information. Nonetheless, despite its popular likelihood, the implementation of this conceptualisation in real life, especially in low-income environments and within the marginalised communities, is highly inconsistent (Abekah-Nkrumah & Abor, 2016).

Most of the literature grounds reproductive health in the framework of rights, by referring to scholars like Cook, Dickens and Fathalla (2003) who claim that reproductive rights are not just about access to services but issues of dignity, autonomy, and agency of individuals. Nonetheless, literature tends to overlook the way these rights are realised by individuals living with disabilities, especially ones with sensory deficiencies like deafness. This trend is reflected in the persistent assumption within reproductive health discourse that women constitute a homogeneous group. Such an assumption obscures internal differences and contributes to the marginalisation of disabled women, whose specific reproductive health needs are seldom foregrounded in policy design or service delivery and are only addressed sporadically in practice (Ha et al., 2023; UNFPA, 2018).

Further, the reproductive health literature narrowly concentrates on the biological and behavioural aspects of the utilisation of such services. It ignores the communicative environments where such services are provided (Kinaro et al., 2018). It is important that interpersonal and mediated communication play a major part in realising and protecting reproductive rights (Kinaro et al., 2018). However, since, as Zuurmond et al. (2019) note, the provision of just any services does not mean that they are then accessible to deaf users, a lack of communication accessibility (e.g. sign language interpretation, visual aids) can render such services inaccessible on a de facto basis. This observation implies that reproductive health rights, which are conceptually inclusive, fit in the context of many countries as being exclusive. This critique is also reinforced by a literature review on development and health communication. Although the communication for the development (C4D) industry promotes

inclusive and participatory messages, there is no substantial representation that deaf people are actively involved in the design and implementation of health-related projects (Klu et al., 2022). This reaffirms the notion that the process of providing reproductive health services to deaf women cannot be measured solely in terms of the availability of those services, but also in terms of accessibility of the communication process (Kinaro et al., 2018).

When comparing the literature on reproductive health with the one on disability and communication, one can see a gaping void to be filled. To a large extent, the reproductive health literature takes women as a rather homogeneous group, by making an implicit assumption that all women share reproductive experiences and have equal access to services (Ha *et al.*, 2023). It is this framing that is more likely to obscure the unique nature of exclusion against women with disabilities, as the nature of their reproductive health is not only influenced by gender but also by structural, social and communicative factors. As postulated by Shakespeare (2018), the predominance of the biomedical model of health research puts the primary emphasis on the biological functioning as well as on clinical outcomes, whereas the social, cultural, and communicative context of providing care is relegated to the periphery. This means that the daily obstacles that disabled women have to face, including the inaccessibility of communication, stigma, and power dynamics during clinical interactions, are a poorly analysed problem that undermines the ability of reproductive rights discourse to work on inequality of lived experience and not just principle (Kumi-Kyereme, Seidu and Darteh, 2020; Ha *et al.*, 2023).

2.3 Rights-Based Approaches to Reproductive Health

The rights-based approach to reproductive health expands on the definition of health as something more than a service; it is, however, an entitlement and is within the framework of the international human rights law. This practice entails associating reproductive health with

the basics that relate to equality, autonomy, non-discrimination, and informed consent. According to some scholars like Cook and Ngwena (2007), the issue of reproductive health as a human right is subject to legal and moral conditions of access, availability, acceptability and quality of services. Although such a perspective has been reinforced in the majority of debates devoted to health science in the world, the literature base suggests that there is a discrepancy between the ideal standards of rights and their actual realisation, including the lives of underrepresented groups, including deaf women (Kumi-Kyereme et al., 2020).

The reproductive health rights are contextualised to the global conventions, e.g., Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), and Convention on the Rights of Persons with Disabilities (CRPD), in one of the most dominant lines of literature. The same scholars, such as Cook, Dickens and Fathalla (2003), directly relate reproductive health to the requirements of international law in CEDAW, bearing in mind the duties of the state to ensure freedom of women, informed consent and non-discriminatory access to such services. Equally, Sen, George and Ostlin (2002) and Gruskin, Ferguson and Tarantola (2008) take reproductive health as a human rights problem that is based on international conventions, such as CRPD, which states that persons with disabilities should equally access sexual and reproductive healthcare. Through these tools, the states are bound to offer easy access to health information or services to everyone, including women with disabilities. As an illustration, Article 25 of the CRPD demands that states give persons with disabilities access to the same range and quality of health care as others, including sexual and reproductive health. Nevertheless, as explained by Sen, George and Ostlin (2002), the realisation of these rights into a graceful and inclusive national system has been slow, as well as unevenly distributed, mainly in sub-Saharan Africa.

The researchers (Gruskin, Ferguson, and Tarantola 2008) state that the rights-based approaches tend to presuppose a playing field, which neglects the way social inequalities like inequality

that is caused by disability, gender, communication, etc., define the capacity to assert rights. This criticism is especially pertinent in the Ghanaian situation, as the health strategies of the nation speak a language of rights, yet fail to entrench systems that can enhance access to those people with communication disabilities. In another example, although the Ghana National Health Policy (2020) brings up the inclination to leave no one behind, research indicates that there is an unawareness of clarity on the guarantees of reproductive rights in deaf women, especially where there are no sign language interpreters and integrated educational programs (Nketsia et al., 2022).

Furthermore, a rights-based approach to the issue tends to be normatively idealistic, being empirically almost undeveloped. The existing literature has a tendency to praise the universality of reproductive rights, but hardly puts the universality in practice to the test (Mprah, 2013; Barnett et al., 2011; Nketsia et al., 2022). Examples here can include deaf women being aware, in theory, about their reproductive rights but not able to act on them due to structural and social barriers. The literature has little to say on this contradiction. The disability rights-based frameworks and the communication tools used are often symbolic rather than functional; as the research study by Ahumuza et al. (2014) in Uganda notes, the healthcare workers have not been trained in either disability rights or in the tools of communication. This study, albeit not focused on Ghana, is in tune with the anecdotal evidence in Ghana, and the results indicate a major gap in the policy analysis as well as academic research.

Another problematic area in the literature is its tendency to overutilize legal documents and advocacy reports, with little critical reflection on how deaf women experience reproductive rights in their day-to-day reality (Cook et al., 2003; UNFPA, 2018; WHO, 2022). For example, there is also a lack of research in Ghana and West Africa on how deaf women negotiate reproductive decision-making, access to consent-based care, and privacy during clinical experiences, which are central promises within rights-based approaches. A lack of disability-

specific research with empirical foundations implies that the rights-based discourse is too abstract concerning the real-world experience of reproductive health in deaf women (Mprah, 2013).

In conclusion, even though the rights-based approach has transformed the discourse of global reproductive health, it is noticeable in the literature that a gap exists in the implementation of the same on disabled people, especially deaf women in low-income countries such as Ghana (Mprah, 2013). There are legal and normative frameworks, but implementations and conceptual articulations of them are under-theorised and under-researched. There is a need to engage more critically and empirically to review how the rights, which are characterised by negotiation, denial, or exercise of those rights by deaf women, exist in the healthcare system of Ghana. The fact that there is a gap (between reproductive rights in concept and reality) is indicative of the gap that needs to be filled by research.

2.4 The Intersection of Disability and Reproductive Health

Disability and reproductive health are complex and rather neglected aspects in health and development discourse (Avoke, 2010). The gap becomes even more evident when discussing the experiences of women with sensory disabilities, i.e. deaf and other women whose reproductive health needs are subject not only to gender and disability but also to the fixed communication barrier and socio-cultural exclusion.

In the study on disability and health, systemic marginalisation is a recurring theme, and the obstacles include physical inaccessibility to healthcare facilities and discriminatory attitudes among the people attending to the healthcare practice (Hunt et al., 2021). Nonetheless, most of these studies explore disability as a uniform entity, and they fail to examine the variations in the manifested experiences of disabilities (Mprah et al., 2022). This is a very serious lack of care since the needs and concerns of a deaf woman will vary a lot from the needs and challenges

of a woman with a physical or visual disability in terms of accessing reproductive health information and services (Seidu et al., 2024). As an example, physical access may be the biggest challenge to women with mobility challenges, but deaf women face different challenges: barriers based on communication, privacy, and informed consent, topics that are not well covered in existing sources.

More so, on one hand, global data on disability rights literature are becoming more and more inclusive of the reproductive autonomy rights of women with disabilities (WHO, 2009; UNFPA, 2018), but on the other hand, what the literature lacks is interrogating how health systems are implementing that autonomy in low and middle-income countries. The topic is especially crucial in Ghana, where little empirical data exists in terms of how reproductive agency is denied or as experienced by deaf women.

In addition, studies of intersectional interdependencies between gender, disability, and socio-economic status as the compounding factors of reproductive health inequities are mostly absent in the Ghanaian literature. As the number of studies regarding gender differences in reproductive health increases (Darteh et al., 2016), the further complication of disability, namely hearing impairment, has not been thoroughly investigated. This gap is particularly worrying considering that deaf women are likely to be doubly marginalised: both by a mainstream women's health services model that is not disability-friendly, and also in terms of disability advocacy, where reproductive health is seldom seen as a relevant issue.

Moreover, the literature regarding ways in which gender, disability, and socio-economic status interact to compound inequities in reproductive health is largely unrepresented in the Ghanaian literature. Although gender differences in reproductive health have been studied more (Darteh et al., 2016), the issue of disability, especially hearing impairment, has not been thoroughly examined by scholars. More importantly, the communicative aspect of this intersection is usually ignored. The extant literature scarcely looks at the additional marginalising effect of

inaccessible communication, absence of sign-language support, and provider-based interactions to deaf women in reproductive health care (Mprah, 2013; Barnett et al., 2011). Consequently, deaf women are marginalised twice: one, due to the mainstream reproductive health models that presuppose spoken communication, and two, due to the disability advocacy framework, in which the communication about reproductive health receives little priority (Nketsia et al., 2022; Seidu et al., 2024).

The few studies that consider the connection are descriptive and not critical. For example, Nketsia et al. (2022) report on the overall difficulties that persons with disabilities in Ghana face when trying to access healthcare, although this does not reveal much about how the same experiences can be manifest in certain circumstances relating to reproductive health. On the same note, although international studies (e.g., UNFPA, 2018) recommend sharing inclusive sexual and reproductive health education, peer-reviewed research to determine its effectiveness in deaf people in Ghana or its efficacy is rare.

The nexus between disability and reproductive health has not received a lot of theoretical and research attention, especially among deaf women in Ghana (Seidu et al., 2024). The existing literature is too generalised on the one hand and lacks any meaningful and intersectional approaches to reproductive health on the other. Indicatively, Osei-Kwakye and Tettey (2020) explain the barriers to healthcare among persons with disabilities in Ghana; however, they do not break down the results by impairment type or put specific emphasis on the communication of reproductive health. Equally, the article by Seidu et al. (2021) reviews the policy inclusiveness on people with disabilities in Ghana, but mostly highlights the gaps in policy formulation as opposed to the daily communication practice of Ghanaian deaf women in reproductive health. The attention to disability is usually very brief, even in papers that focus on reproductive health, or is discussed as an incidental variable, such as population-level reproductive health research that does not analyse communication accessibility as a barrier to

deaf women participating in utilisation (Abekah-Nkrumah and Abor, 2016; Azaare et al., 2024). This methodological deficit compromises the design of purposeful policies and programmes that would meet the unique reproductive health requirements of deaf women. It is thus both topical and needed to develop targeted research that places the subject of reproductive health of deaf women in larger contexts of socio-cultural, institutional and communicative factors.

2.4.1 Women and Health Communication Barriers

Healthcare access is an imperative area in which communication plays a crucial role; in particular, there is a far-reaching reliance on dialogue within the scope of reproductive health, where involved parties base decisions upon the sort of knowledge, consent, and trust between patient and provider (Melkote & Steeves, 2015; Corcoran, 2013). To women, especially those representing the constituent groups of the marginalised persons or individuals, the health communication barrier is very much an obstacle to the actualisation of reproductive rights (Klu et al., 2022). The available research expresses the view that women experience difficulties with accessing health information systems, especially on the basis of language, literacy levels, socio-cultural practices and imbalances of power between the patient and medical workers (Sarker et al., 2007; Keleher, 2007). When, however, these challenges meet with that of disability in the form of deafness or inability to hear properly, the communication gap emerges even more defined and exclusive (Corcoran, 2013).

When referring to health communications, deaf women are exposed to one of the biggest health disparities (Barnett et al., 2011). This gap, according to Barnett et al. (2011), is not merely practical but strictly structural in contexts where the use of sign language interpreters in healthcare institutions is limited, as in the case of Ghana. According to Seidu et al. (2021), health facilities (especially in Ghana) do not have more than a handful of trained staff or

guidelines to ensure that persons with communication disability can be accommodated, and the deaf women have to depend on relatives or untrained intermediaries, which undermines both privacy and autonomy. This violates concepts of informed consent and erodes confidence in the healthcare system, which leads to low uptake of reproductive health services.

Importantly, the literature such as Seidu et al. (2021) and Badu et al. (2018), indicates that there is no sign of institutional prioritisation of inclusive communication. Mass campaigns on family planning, antenatal care and cervical cancer screening are examples of health communication interventions in Ghana that involve a one-size-fits-all approach that is mostly in the English language or in the predominant local languages and distributed over the radio or television (Kumi-Kyereme et al., 2020; Klu et al., 2022). Such strategies lock out the deaf who use visual communication and an alternative style of interaction. The WHO (2022) states that this is not an incidental omission, but, moreover, a manifestation of the failure to consider the issue of disability in the field of public health communication planning and resource distribution.

More so, scarcity of disability accommodative content, including sign language health video content, illustrated reproductive health guides, or sign language educators in the community, indicates a wider knowledge production gap (Avoke, 2010). Most of the literature on health communication in Ghana does not give too much consideration to the experiences of disabled women, and when it is mentioned in such literature, its mention is always distorted in a manner that expresses charity or vulnerability, as opposed to rights and inclusion.

In a nutshell, the literature indicates clearly that communication barriers are a key, yet poorly explored, issue in the access to reproductive health by women. Adding to those barriers experienced by deaf women is the overall neglect within the system and the absence of relevant policy measures. Lack of inclusive communication practices in health delivery places in Ghana is an existing gap that is worth investigating.

2.4.2 Social and Cultural Perceptions of Deafness in Africa

Reproductive health experiences of deaf women are largely based on the societal and cultural attitudes toward deafness in Africa (Avoke, 2010). Although disability rights models on the international level consider inclusion and autonomy of people with disabilities, cultural settings in most African communities tend to perceive not only deafness as a difference but also as a disability or even a curse (Kusters, 2017; Ndekezi et al., 2025). Such framing bears far-reaching consequences, both in terms of the social status of the deaf and their treatment in the families, at the community and health-care levels (Ndekezi et al., 2025). The literature shows that stigma, cultural misconceptions, and systematic ableism unite and marginalise deaf women, who especially have to suffer because of genuine misconceptions about reproduction.

Several studies show that in some African societies, deafness is often interpreted through cultural beliefs that frame it as superstition, spiritual punishment, or ancestral retribution (Murugan & Manimekalai, 2019; Oppong & Oti-Boadi, 2013). These beliefs influence not only how deaf individuals are perceived by the wider community but also how families respond to deafness. As a result, some deaf children are hidden from public view, excluded from formal education, and denied participation in decisions related to healthcare and everyday life. Being on the crossroads of gender and disability, deaf women are doubly stigmatised (Murugan & Manimekalai, 2019). According to Groce and Trani (2009), women in most African settings are regarded as asexual and unwise to bear children, just like disabled women. By making them invisible as reproductive subjects, this perception deprives them of social status as individuals who may claim their rights to be included in sexual health programmes and among policy beneficiaries.

Avoke (2010) cites the fact that even the societal response to disability still remains as being charitable or welfare-based, rather than as a right. This belief continues the paternalistic approach and is jeopardising the independence of the deaf people, especially women. In addition, opinions concerning women with disabilities not being allowed to marry or produce

children are not rare within some of the regions of Ghana, further excluding them from the reproductive health services (Osei-Kwakye & Tettey, 2020). These normative beliefs are hardly questioned by reproductive health textbooks or in social discussions, which means that it is a silence that perpetuates structural discrimination.

The main weakness of the existing literature is the absence of an empirical study on how cultural conceptions of deafness can be put into practice in healthcare organisations. Although some studies have recorded stigma and negative social beliefs about disability among the community, a number have not explored how negative social beliefs influence provider behaviour, communication styles, and decision-making during reproductive health consultation with deaf women (Avoke, 2010; Osei-Kwakye and Tettey, 2020; Mprah, 2013).

Finally, it should be mentioned that the social and cultural notions of deafness in Africa remain far from harmless: these perceptions truly influence the environment within which deaf women affect their reproductive well-being. Although the literature has started pointing to the existence of stigma and misbeliefs, it has failed to establish the integration of these aspects in health systems and practices of service delivery. This lack is especially crucial when it comes to this case of Ghana, where empirical data concerning how cultural perception of deafness meets the area of reproductive health is scarce and is under-theorised.

2.5 Development Communication and Reproductive Health

It has been identified earlier that development communication can be a strategic instrument in achieving the goals of public health, which includes reproductive healthIncreasingly, development communication draws on participatory communication and behaviour change traditions to inform and support interventions that aim to guide, influence, and enable individuals and communities to make informed decisions (Waisbord, 2020). Communication,

particularly in the context of reproductive health, is crucial in creating awareness, influencing attitudes, as well as in informed decision-making.

The majority of the works on reproductive health communication in Ghana focus on mass media campaigns, peer education, and outreach in the community (Kumi-Kyereme et al., 2020; Darteh et al., 2016). The interventions have emphasised promoting contraceptive use, maternal health services, as well as HIV prevention. The prevailing line of employment has been the Social and Behaviour Change Communication (SBCC) framework that attempts to explain individual knowledge and attitude by sending a series of messages in a structured manner. But as some experts claim, most SBCC practices are top-down and message-oriented, which reduces adaptability to the specific informational and communicational requirements of discriminated populations (Servaes, 2008; Melkote & Steeves, 2015).

The dominant languages (English, Akan, Ewe, etc.) health communication programmes in Ghana are always based on oral or written messages, and they are hardly adjusted to communicate with the deaf (Seidu et al., 2021). This handicap is especially worrisome because deaf people physically need visual communication. In literature, it was found that even in participatory communication programs, like community durbars or health outreach programs, deaf people are seldom involved in coordination or implementation (Klu et al., 2022). This destroys the participatory spirit that is the centre of development communication and extends to support the status quo of health disparities.

In addition, the literature indicates that government-led development communication planning in Ghana has not systematically integrated disability-inclusive strategies. As an example, UNFPA (2018) recommends using disability-sensitive messages and accessible materials, such as sign language and visual assistance. Nonetheless, very little is apparent through the operationalisation of such recommendations in Ghana. It has been observed that development communication programmes simply use standard messaging strategies which amount to

paraterns of one size fit-all and do not appreciate the diversity of communication. Indeed, reproductive health campaigns in Ghana do not take into consideration the heterogeneity of its target population, as Badu et al. (2015) and Nketsia et al. (2022) posit, leading to incomplete reach and low intensity of impact.

2.5.1 Communication Strategies Targeting Marginalised Groups

Development communication depends largely on the ability to integrate the needs and the voices of the marginalised groups to effectively address health disparities. Scholars hold the opinion that health communication interventions are more effective when they are inclusive, participatory, and within groups who are normally not involved in the mainstream communication processes (Melkote and Steeves, 2015; Servaes, 2008). In turn, various tools have been designed to reach marginalised populations (such as rural inhabitants, people in poverty, and people with disabilities) with the help of health communication on a global level, including community-based communication, participatory methodology, and alternative and accessible communication forms (Waisbord, 2020; WHO, 2022). Nonetheless, a close review of the literature shows that although inclusive rhetoric in health and development communication has increased, practical communication initiatives have fallen short of effectively reaching and empowering vulnerable groups such as deaf women. This gap is particularly evident in contexts like Ghana, where persistent structural barriers continue to limit meaningful inclusion in reproductive health communication and service delivery (Badu et al., 2015; Seidu et al., 2021; Nketsia et al., 2022; WHO, 2022).

On a global scale, a participatory and community-based model of communication has been advocated as being more concerned with the actual situations that affect the marginalised communities (Melkote & Steeves, 2015; Servaes, 2008). These frameworks promote community-based activities, community ownership and culturally acceptable mechanisms. In reproductive health, these methods have elicited instrumental value by promoting

communication and de-stigmatisation, particularly in groups that have low literacy. As an example, the use of community theatre, storytelling, and radio talk shows has been utilised in different African nations to create awareness on the issue of family planning and maternal health (Sood et al., 2004). But, even though those models can mitigate linguistic and cultural gaps, they often underestimate the needs of people living with disability regarding their senses and communication options, especially those who are deaf and use sign language.

The attempts to involve persons with disabilities in the response to interventions have been irregular and not well institutionalised. According to the UNFPA (2018) report on inclusive reproductive health programming, accessible forms of communication presented by visual communication tools, captioned videos, and the availability of trained sign language interpreters are advocated. However, there remains a significant gap between global recommendations and their implementation at the national level. In Ghana, the health communication ecosystem does not include the disability-related training of healthcare employees; there is no financing assigned specifically to inclusive communication resources, and sign language is not recognised as part of reproductive health education (Badu et al., 2015). The major weakness of the literature on the topic lies in its tendency to summarise marginalised populations into one, non-differentiated category and not disaggregate their unique communication needs (Abekah-Nkrumah and Abor, 2016; Kumi-Kyereme et al., 2020). Reproductive health communication studies in Ghana usually include all rural women, adolescents, persons with disabilities, and the poor in the same group and consider general communication barriers instead of the specific communication difficulties related to impairment (Abekah-Nkrumah and Abor, 2016; Kumi-Kyereme et al., 2020; Klu et al., 2022). In such a general framing, the deaf women are barely discussed as a separate group that has special needs of visual and sign-language communication. Thus, the literature does not say much about how deaf women can read, recreate, refuse, or bargain with a reproductive health

message to action (Mprah, 2013; Nketsia et al., 2022). Further, communication development research in Ghana also does not exhibit much of co-creation or participative message development with persons with disabilities, although it is central to the theory of participatory communication (Servaes, 2008; Melkote and Steeves, 2015).

2.6 Theoretical Foundations of Communication in Health Encounters

(a) Barnlund's (1970, 2008) Transactional Model of Communication, which views communication as a dynamic, simultaneous process in which both parties are senders and receivers, influenced by personal, cultural, and environmental factors, and shaped by feedback loops. In the context of deaf–hearing clinical encounters, "environmental noise" includes the absence of qualified interpreters, providers' limited sign-language competence, and institutional time constraints. Barnlund's (2008) transactional model posits that communication is a simultaneous, dynamic process in which all parties are senders and receivers, continuously influencing one another through verbal, non-verbal, and environmental cues. Meaning is co-constructed and shaped by prior experiences, cultural frames, and "noise" (both literal and metaphorical). In healthcare, this noise includes institutional time constraints, lack of sign-language competence, and the dominance of spoken-language norms.

(b) Foucault's (1977) concept of power/knowledge, which helps explain how medical knowledge is constructed as "truth" within hearing-centred institutions, marginalising alternative (visual-gestural) ways of knowing and reinforcing the subordination of deaf patients. Together, these frameworks allow the study to move beyond a deficit-oriented "barriers" approach and examine how meaning is co-constructed (or blocked), how power operates in everyday clinical interactions, and what strategies might foster more equitable communication. Foucault's (1977) power/knowledge framework complements this by illuminating how medical discourse constructs "truth" about bodies and reproduction, often

silencing non-hearing ways of knowing and reinforcing the authority of the hearing provider. Together, these theories provide analytical tools to examine not only what is said (or signed) in reproductive health consultations, but how power circulates, how meaning is negotiated (or blocked), and how deaf women resist or re-appropriate agency within these interactions (Roter & Hall, 2006; Street et al., 2009).

2.7 Gap(s) in the Literature

A critical review of the existing literature shows that there are limited research studies targeting the reproductive health of deaf women in Ghana, and where found, few are empirical in nature. Although there is a lot of work on reproductive health and the growing awareness of disability rights regarding health service delivery, such disciplines are often approached in isolation, with limited integration across fields. Research on the topic of disability in Ghana is often rather general in its approach to persons with disabilities, hardly focusing on the way that a particular form of impairment affects the ability to access information, communications, and reproductive choices. Likewise, the literature in the realms of health communication and development usually focuses more on the use of mass media strategies and participatory methods, but never evaluates how inclusive deaf populations find these strategies and methods.

While reproductive health and disability are both well-researched fields in Ghana, almost no studies apply a communication theory lens (transactional or power/knowledge) to the reproductive health encounters of deaf women. Existing work remains largely descriptive, rarely examining how meaning is co-constructed, how power circulates through communication practices, or how deaf women themselves propose transformative solutions. The unique socio-linguistic context of Adamorobe, with its high prevalence of hereditary deafness and indigenous sign language, has been ethnographically documented (Kusters, 2015)

but never studied from a health-communication perspective. This study fills these critical theoretical, empirical, and contextual gaps.

In addition to this, although the dominant global ideal is to have reproductive health that is disability-friendly, empirical data to support its actualisation in the existing health system in Ghana are scarce. More importantly, no studies have exhaustively explored the issue of deafness, gender and reproductive rights through the prism of development communication. Such a lack is an indication of a marked academic deficiency, as well as a policy evaluation. It is this gap that must be filled so that reproductive health strategies are not just equity-minded but actually efficient in reaching all the women in both practice and effect, most especially those who are deaf.

2.8 Chapter Summary

The chapter presented literature reviews on reproductive health, disability, health communication, and development communication, mostly focusing on the experiences of deaf women. The review demonstrates that although reproductive health and disability are popularly addressed, the communicative aspects influencing the accessibility of deaf women to care are not well studied. Current research focuses on biomedical outcomes and rights-based rhetoric, which tends to ignore the practice of everyday communication and power dynamics in healthcare encounters. Another finding in the chapter was gaps in the Ghanaian literature, especially a lack of empirical studies, which have a communication orientation within deaf communities like Adamorobe. These gaps provide the rationale for the qualitative, context-sensitive research to investigate the dynamics of communication in reproductive healthcare.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter presents the methods used to collect and analyze data for the study. It describes the research methodology and design, the population and sampling methods, data collection and analysis methods, and the ethical principles that were used in the research. The chapter discusses the methodological decisions that were made to ensure that the data produced are adequate, valid, and can be used to answer the research questions. It also brings out the actions that can be made to maintain ethical behaviours, especially in cases where a marginalised group is involved. The chapter opens with the philosophy guiding the study, then the approach and design of the study.

3.2 Research Philosophy

The research is based on the interpretivist philosophy of research that focuses on the investigation of subjective senses, lived experiences, and constructed realities. Interpretivism is a theory that presupposes that human experiences cannot be completely explained in terms of objective measurement but through interpretation that exists within the context of their sociocultural background (Saunders, Lewis & Thornhill, 2019). Since the proposed study aims to comprehend communication between deaf women and healthcare professionals, which is a process of perceptions, influences of power, language, and cultural expectations, interpretivism offers the most appropriate perspective.

It also recognises the significance of the researcher getting immersed in the story of the participants to bring out meanings to their stories, which would not be achieved without doing so (Creswell & Poth, 2018). Interpretivism thus fits within the qualitative method and endorses the goal of coming up with context-specific findings concerning accessibility to

communication. The researcher took the time to listen, observe and interpret narratives and signed expressions of participants, considering context, emotion, and non-verbal reactions in this research. This first-hand experience allowed the opportunity to value the experience of communication barriers and negotiating them during reproductive health interactions in daily life.

3.3 Research Approach

The study takes the form of qualitative research, which was suitable due to the complex and context-specific nature of communication between deaf women and their providers during reproductive health care. Because communication barriers are not just technical problems but instead lie within social interaction, cultural environments and power relations, a qualitative research design allowed the researcher to represent these complexities and not simplify them to quantifiable terms.

The research attempts to establish the manner in which communication takes place between deaf women and healthcare professionals, the challenges that are associated with these interactions, and the way such issues affect the experiences of reproductive health. The qualitative method also enables the researcher to bring in the aspects of emotions, perception, language, and context- all of which are the focus of the communication and disability studies (Silverman, 2013). It also helps in the flexibility of digging deeper into the meaning of the participants, especially considering the linguistic context unique to Adamorobe, where the local sign language as well as the informal communication strategies are at play.

3.4 Research Design

This research employed a case study research design, which made it possible to explore a particular community, Adamorobe, in detail and its own communication setting. A case study

design is suitable for analysing modern phenomena in real life, particularly when there is no clear-cut boundary between the phenomenon and its context (Yin, 2018). In the given study, there is no means of separating the deaf woman and healthcare provider communication practices from the cultural, linguistic, and social setting of Adamorobe; hence, the case study approach is suitable.

Adamorobe is a unique environment characterised by hereditary deafness, and Adamorobe Sign Language (AdaSL) serves as a means of communication, influencing the norms of communication and interaction within the community. A case study design gave the researcher an opportunity to describe these contextual dynamics in detail and learn how they influenced reproductive healthcare communication. This conforms to the viewpoint brought forward by Merriam and Tisdell (2016) that case studies are appropriate in investigating intricate social processes that have many parties and understandings.

The design helped gather the rich and layered narratives of deaf women, the healthcare providers, and other concerned parties, making the study create context-specific but analytically transferable information on the relevant deaf communities in Ghana.

3.5 Population

The sample used in this research included the actors who were directly involved in the communication sessions in the context of reproductive healthcare in the Adamorobe community. This consisted of deaf women of child-bearing age (15-49 years) who either have wanted reproductive health services and healthcare providers who provided maternal, sexual, and reproductive healthcare in the Adamorobe health centre. Inclusion of the two groups indicates the interest of the study in interpersonal communication in the process of healthcare interaction and how the interaction influences access to reproductive services.

Also covered by the broader population of interest are the stakeholders in the community, like the community leaders, the public health officers or the sign language interpreters (where applicable) who may affect practices of communication, or health-seeking behaviour. Even though the research used empirical evidence of Adamorobe alone, the given population represented the social framework of the community regarding reproductive healthcare communication. This enabled a holistic undertaking of how communication enables or limits access to reproductive health by deaf women.

3.6 Sampling

3.6.1 Sample Size

Qualitative studies prioritise the intensive over the extensive and, therefore, enable a smaller but richer information sample (Patton, 2015). The research study thus used a sample size of 20 participants, who included 15 deaf women of reproductive age and 5 healthcare providers who dealt with them. This breadth can be explained by qualitative principles that propose that deep and significant themes can be developed using quite small samples, especially in targeted case studies (Guest, Bunce & Johnson, 2006; Mason, 2010).

3.6.2 Sampling Technique

The research followed purposive sampling, as it allowed the researcher to select the participants carefully and choose those individuals who had first-hand experience in the phenomenon under study. Qualitative studies that intend to capture in-depth information about a subject require the use of purposive sampling since the sample is the most informed about the topic (Etikan, Musa & Alkassim, 2016). The purposive selection of deaf women of reproductive age and

healthcare providers was appropriate because their direct experiences are central to understanding communication processes during reproductive healthcare encounters.

Also, snowball sampling is implemented to determine deaf women who might otherwise be inaccessible. This strategy takes advantage of community referrals to access participants that would not be accessed otherwise because they fit the criteria (Noy, 2008). The purposive and snowball approach will allow the researcher to come up with a sample that is relevant and also diverse enough to represent the communication realities in Adamorobe.

3.7 Data Collection Approach

Semi-structured interviews and focused group discussion was used to gather data for this study because they enabled participants to relate their own experiences on communication in their own words and at the same time offer enough flexibility to probe and seek clarification. Semi-structured interviews were specifically appropriate to investigate the field of interpersonal communication between deaf women and healthcare providers because this approach allowed the scholar to record the description of the interactions, challenges, and perceptions (Kvale and Brinkmann, 2015). The deaf women who were interviewed used a mix of spoken language, gestures, and Adamorobe Sign Language (AdaSL) depending on the preferences of the participants. A sign language interpreter who had been trained in AdaSL was used where there was a need to facilitate communication by ensuring confidentiality.

Health workers, particularly nurses were also interviewed to get their views about communication during the reproductive health consultation. The interviews took place within 30 to 60 minutes and were done in places which would provide privacy and comfort to the participants. All the interviews were recorded either by audio or video with the consent of the interviewees and were supplemented by field notes, where non-verbal communication and

situational observation were documented. Through this method, the quality of data was very rich and portrayed both communicative practices as well as the wider sociocultural setting of Adamorobe.

In addition to individual interviews, focus group discussions were conducted with deaf women to capture shared experiences, collective meanings, and community-level dynamics surrounding reproductive health communication. This is particularly useful in focus groups to study social norms, shared issues, and interactive sense-making processes that do not always happen within one-to-one interviews (Krueger and Casey, 2015; Morgan, 1997). The group discussions enabled the group to stay solitary to reflect and respond to the experiences of each other, whereby areas of congruency, divergence, and reinforcement would emerge naturally. This approach was especially suitable since Adamorobe is a community, and the ways of communicating are similar among deaf women.

The researcher guided focus group sessions with the assistance of interpreters and adopted the protocols of focus group sessions, such as clear ground rules, facilitation to balance participation and sensitivity to the power situation in the group. The sessions were held in the community areas that are not unfamiliar and difficult to access in order to encourage comfort and candid conversation.

3.8 Ethical Consideration

The concept of ethics was used to shape all the processes of the research to promote the safety, dignity, and rights of the participants. The participants received all the information regarding the purpose of the study, its procedures, and the right to withdraw without repercussions at any point. The University of Media, Arts and Communication (UniMAC) provided ethical approval of the study before data collection. The concerned health facility in Adamorobe was also

consulted and given permission. Due to the vulnerability of deaf women, further consent was obtained from family members who expressed full support. The process of informed consent was not only provided to each participant, but also, when needed, the participant was provided with informed consent by relatives or guardians to make sure that the interested parties were fully informed and that their interests were not compromised. From the angle of the nurses, the head nurse was informed and consent sought about a week ahead of the scheduled interview day. Sign language, visual and obvious gestures were used to explain the information sheets and consent forms. Video recording was also explicitly consented to, and signed expressions as well as non-verbal expressions were to be captured. Participants were made aware of their right to drop out of the research process at any point with no repercussions, and confidentiality and dignity were highly respected during the research process.

All transcripts and reports were made anonymous, and all names, locations and other distinguishing information were anonymised to maintain confidentiality. Given the fragility of deaf women and the sensitivity of the reproductive health problems, special attention was paid to the privacy of the interview and to preventing the presence of family members and unauthorised interpreters. All the data were kept securely in password-protected folders that were only accessible by the researcher. These ethical considerations helped in the fact that the study respected, maintained autonomy, and brought justice to all respondents.

3.9 Data Analysis Approach

The research used the thematic analysis of the qualitative data gathered during interviews, drawing on the approach outlined by Braun and Clarke (2006), which provides a systematic framework for identifying, analysing, and reporting patterns of meaning within qualitative data. Thematic analysis is an adaptable technique of defining, tabulating and inferencing designs of

significance within qualitative data (Braun and Clarke, 2006). It fitted the study particularly well as it enabled the researcher to examine how the process and issues of communication were characterised by deaf women and healthcare providers, and how it influenced access to reproductive healthcare.

The analysis was based on the six-phase framework of Braun and Clarke. Initially, transcribing of all audio and video records was done verbatim, and the researcher familiarised herself with the data by reading it several times. At the second stage, preliminary codes were created through evaluating substantial statements, descriptions of communications, and repetitive problems. The coding was inductive, which emerged through the narratives of the participants, and deductive, which is based on the literature on disability and healthcare communication.

The third stage involved sorting out the codes into possible themes through determining larger trends concerning communication experiences, communication barriers, coping, and systemic problems. The fourth phase involved a review of these themes and subsequently refining them to make them coherent and consistent with the coded extracts and the dataset overall. The fifth stage was about defining and naming themes, which captured the spirit of the experiences of participants.

Synthesising the themes into a coherent narrative that answered the research questions and brought out the contextual dynamics of Adamorobe was the last stage. The peer debriefing and reflexive journaling contributed to the validity of the analysis (Nowell et al., 2017). This methodology helped the study to create a wealth of information regarding the effects of communication that was used to create reproductive health experiences among deaf women.

3.10 Limitations and Mitigation

Small sample limits generalizability, but this was mitigated by thick description and analytical transferability to similar high-deafness communities. Secondly, the researcher lacked

knowledge of sign language, and this could have affected data interpretation. To cope with this, the services of trained sign language interpreters were used, and reflexive practices were also used during the process of conducting research. Lastly, self-reports can result in a recall bias, but probing and triangulation between the stories of participants served to increase the credibility.

3.11 Chapter Summary

In this chapter, the methodology used in the study of communication between deaf women and medical practitioners in the reproductive healthcare facilities in Adamorobe has been described. The study was directed by an interpretivist qualitative orientation; thus, it adopted a single case study design so that the topic of lived experiences could be studied in depth and with a context-sensitive design. The deaf women and healthcare providers whose experiences were directly related to the research objectives were recruited through purposive sampling. Semi-structured interviews were used to produce data, and accessibility, as well as ethical participation was supported by the use of sign language interpreters and visual communication means.

The data analysis, ethical considerations and strategies used to achieve trustworthiness, such as credibility, dependability and confidentiality, were also described in the chapter. Special consideration of the ethical issues of studying a marginalised group was noted and the approvals were received by the appropriate institutions and the community. In general, the methodological decisions corresponded with the aims of the study and were targeted at the reflection of the specifics of communication and power relations, as well as access to reproductive healthcare encounters. The following chapter gives the empirical findings of this methodological process and analyses them.

CHAPTER FOUR

PRESENTATION OF FINDINGS AND ANALYSIS

4.1 Introduction

This chapter provides and discusses the results of the qualitative data gathered in Adamorobe from deaf women and healthcare providers. The analysis is structured under major themes that came out based on the participants' recounting of communication experiences in reproductive healthcare encounters. Based on the lived experiences of deaf women and the insights of the healthcare professionals, the chapter emphasises the importance of communication practices, power relations, and institutional constraints on access to reproductive health services. The findings are analysed in direct relation to the study's research questions and interpreted using relevant communication and power frameworks. Participant accounts are used to illustrate recurring patterns and to ensure that the analysis remains grounded in empirical evidence. Specifically, the analysis addresses the following research questions: (i) How do communication processes between deaf women and healthcare providers unfold during reproductive health consultations in Adamorobe? (ii) What challenges and facilitating factors shape deaf women's access to reproductive health services, and what are the implications for autonomy and health outcomes? (iii) How do deaf women perceive ways of improving communication with healthcare providers and other relevant stakeholders in reproductive healthcare delivery?

4.2 Participant Characteristics

Table 1 Participants' Characteristics

Participant	Role	Key Characteristics	Communication Background
Participant 1	Deaf woman	Adult woman; acquired deafness in early childhood	Uses both indigenous Adamorobe sign language and Ghanaian Sign Language

Participant 2	Deaf woman	26 years; married; no children; SHS completed; unemployed	Acquired deafness two years prior; school-based sign language and Adamorobe sign
Participant 3	Deaf woman	31 years; married but separated; two children; petty trader	Born deaf; attended school for the deaf (incomplete); Ghanaian Sign Language
Participant 4	Deaf woman	16 years; single; no children; school dropout	Acquired deafness; limited reproductive health knowledge
Participant 5	Deaf woman	28 years; single; one child; roadside seller	Acquired deafness after childhood; relies on family for communication
Participant 6	Deaf woman	31 years; single; no children; petty trader	Born deaf; attended school for the deaf
Participant 7	Deaf woman	33 years; one child; farmer	Deaf; uses local sign language
Participant 8	Deaf woman	51 years; three children; single; farmer	Deaf; relies on community and family mediation
Participant 9	Deaf woman	60 years; three children; unemployed	Deaf; minimal formal education
Participant 10	Deaf woman	65 years; six children; farmer	Deaf; extensive reproductive history
Participant 11	Deaf woman	60+ years; four children (one deceased)	Deaf; limited access to formal healthcare
Participant 12	Deaf woman	Adult woman; demographic details not specified	Deaf; uses sign language
Participant 13	Deaf woman	Adult woman; No children	Deaf; uses sign language
Participant 14	Deaf woman	Adult woman, 40 years; 4 children	Deaf; uses sign language
Participant 15	Deaf woman	Adult woman; 1 Child, unmarried	Deaf; uses sign language
Participant 16	Nurse	Registered Public Health Nurse; 11–12 years' experience	No sign language training; relies on writing and gestures
Participant 17	Nurse	Senior Enrolled Nurse	Uses writing and accompanying persons for communication
Participant 18	Nurse	Senior Staff Midwife	No interpreter access; uses improvised communication
Participant 19	Nurse	Senior Staff Midwife	Relies on family members and flipcharts

Participant 20	Nurse	Principal Community Health Nurse	No formal sign language training; relies on writing,

Source: Field Data, 2025

As indicated in the table, the research involved twenty subjects, fifteen deaf women of the Adamorobe community and five health practitioners of the community health facility. The deaf women were at different stages of reproductive life and had varying experiences, as there was a variation in age, marital status, parity, education and livelihood. The communication skills varied between congenital and acquired deafness, with the majority of respondents using native Adamorobe Sign Language, Ghanaian Sign Language, or a mixture of both. The medical professionals were highly qualified; however, they did not have official training in sign language. Depending on writing, gestures, flipcharts, and the presence of family members, which were significant determinants of the healthcare communication and outcomes.

4.3 Nature and Dynamics of Communication During Reproductive Health Consultations

4.3.1 Theme 1 Question 1: Communication Conducted Through Writing, Gestures, and Ad-Hoc Signing

Across interviews and focus group discussions, participants described reproductive health consultations as being conducted through a combination of writing, gestures, and improvised or mixed signing systems. These modes were not fixed but were chosen as a result of the presence of certain persons, available resources at a particular time, and the perceived reading/writing skills of the participants. Communication was thus negotiated and situational in practice as opposed to being standardised.

Most deaf women stated that in most instances, the nurses approached them by writing on paper, and they responded similarly. This has been termed as viable to others but restrictive to others. One of the participants said:

> *When I visit the hospital, the nurse tends to write something on paper. Write back, in case you can write. However, not all of us were early achievers at school, and thus the language is hard, and you cannot articulate yourself well"* (Participant 3).

During the focus group discussions, this was reiterated by some of the women, where it was said that writing required a lot of literacy and understanding of medical terms.

The use of the gestures was also common, especially where the writing was slow or illegible. The participants explained that they have to point at body parts, imitate pain, and make facial expressions to communicate the symptoms. One of the participants reported:

> *We use our hands and bodies most of the time to indicate the location of pain. You point, you play it, and wish the nurse to know what you want to say*" (Participant 7).

FGDs implied that gestures were not utilised independently, but used together with writing. In most cases, the participants tried to form a better meaning.

Besides, ad-hoc signing was also mentioned a lot. This involved the use of Adamorobe Sign Language, school-based sign language, and home signs, and at other times, all in the same interaction. One participant described it as such:

> *I have the signs which I learned at school, and also the ones which are called Adamorobe signs. There are times when the nurse has very little idea what I am communicating, sometimes nothing at all. When I realise that they are lost, I substitute*

the signs or introduce gestures that have no sign language meaning but can help the nurse understand me (Participant 2).

It was found during group discussions that this combination of the sign systems was the norm, especially amongst women who had been deafened in the later years of their lives. There is also acceptance of these combined techniques by nurses. One nurse said:

We write for those who can write. When they are signing, we attempt to follow and decipher, and occasionally we will resort to pictures or even gestures explaining what we want to say (Participant 16).

Generally, this data demonstrates that the reproductive health consultation communication was defined by improvised and flexible actions determined by immediate circumstances, skills of participants and mutual efforts to find common ground through the exchange of efforts.

4.3.2 Objective 1 Theme 2: Mediated Communication Through Family and Community Members

The data showed that the reproductive health consultation of deaf women is often indirectly provided by hearing relatives or community leaders when there is no face-to-face communication and professional interpreters. This kind of mediated communication has become a habitual coping process, which does not just influence the way information is shared, but also the person who is the controller of the interaction in a healthcare environment.

Most deaf women also said that they did not visit health facilities regularly. They would rather rely on the mothers, siblings, partners, or other hearing family members to read on their behalf. One participant explained:

> *"Most times when we go to the hospital, our hearing family comes with us. They are the ones who explain our problems to the nurses and then explain what the nurses say back to us"* (Participant 2).

Another participant stated:

> *I always go with my mother. She is the one who does all the explaining for me at the hospital because I cannot communicate well with the nurses myself"* (Participant 5).

These stories indicate that relatives act as informal interpreters by default.

Although a portion of the interviewees mentioned that they trusted their family members, this was not comforting. One deaf woman explained:

> "*We believe our family will not tell our secrets, so we trust them. But sometimes there are things you don't want to say in front of them, especially women's issues"* (Participant 6).

Another participant reflected more critically, noting:

> *"The person who comes with you is the one who controls everything at the hospital. They decide what to say and what not to say"* (Participant 9).

This shows how mediated communication can take the power out of deaf women and restrain their agency in consultations.

This trend was verified by healthcare practitioners in their own view. One nurse explained:

> *"When deaf women come, they usually come with someone who can hear, so we speak to that person instead*" (Participant 16).

Another nurse added:

> *"If they don't come with anyone, it becomes very difficult because there is no interpreter provided by the hospital"* (Participant 18).

These responses suggest that mediated communication is institutionally normalised rather than treated as a temporary solution.

Mediated communication also raised concerns about accuracy and privacy. Participants linked reliance on family members to misunderstandings and incomplete information. One deaf woman stated:

> *"Sometimes the person explaining does not say everything the nurse says, or they change it, and that can affect your health"* (Participant 7).

This concern was echoed by another participant who noted:

> *"Because of this problem, we get a lot of wrong treatment, and it affects us badly"* (Participant 11).

On the whole, the mediated communication and support provided by a family and community mitigates an important gap that would exist in the case of an institutional support deficit. Nevertheless, it also strengthens the dependency, decreases confidentiality, and diminishes the independence of deaf women in their reproductive healthcare experiences. This set-up, instead of empowering deaf women, tends to put the decision-making in the hands of other people, which redefines the consultation process in a manner that marginalises the voices of the deaf women.

4.3.3 Theme 3 Objective 1 Unequal Participation and Control Within Clinical Interactions

The data collected as a result of individual interviews and focus group discussions show that the involvement in the reproductive health consultations was unequal, and the communication and decision-making processes were often transferred to the deaf women. Respondents repeatedly referred to situations in which other people would dominate the process of what was being said, the way it was being said, and the ultimate decision made, as family members, people who are going with them, or health practitioners.

A number of deaf women said that when they went to the health facilities with people who could hear, they tended to be the primary ones to communicate. One of the respondents remarked;

> *When you walk with someone who can hear, nurses would address that individual more than you. The individual is telling it all, and you are sitting there. Although you might want to say something, it is hard to join in the conversation*" (Participant 5).

This trend was strengthened by the focus group discussions, where the participants observed that with the introduction of a hearing intermediary, the interaction shifted.

The dominance of the consultation was also associated with initiating and maintaining the communication. Participants expressed the opinion that interaction between nurses and deaf people was less time-consuming or more commanding after the nurses learned that the patient was deaf. One of the women put it down to this:

> *Sometimes, when they notice you are deaf, they will simply make up their minds already. They do not ask numerous questions due to the difficulty of communication, and, thus, they move on*" (Participant 9).

FGDs had the same experience with women reporting that they were talked about, but not talked with.

Respondents also explained instances when they could not disagree or seek to understand information. One of the participants mentioned:

> *When you do not comprehend something, it is difficult to repeat the question. You think that you are annoying them, and therefore, you remain silent and consenting* (Participant 1).

During group discussions, a few women talked about nodding or going along with the conversation in ways that they were not really certain about in order to stop the conversation.

These descriptions coincided with the statements by the nurses, although they were expressed in service-delivery terms. One of the nurses said:

> *Sometimes the person who accompanies them assists us a lot, as it becomes quicker in this way. We depend on such an individual to explain and even to follow orders back home"* (Participant 18).

Although this made it easier to work, it also focused communicative power beyond the deaf woman herself. In general, the information reveals that the unequal participation characterised the clinical interactions, with participation of the deaf women often being constrained by the dynamics of communication, strain of time, and dependence on others, and thus the lack of control over the development of the consultations.

4.4 Challenges and Facilitating Factors Shaping Access, Autonomy, and Health Outcomes

4.4.1 Objective 2 Theme 1: Communication Barriers, Delays, and Avoidance of Health Facilities

The results further indicate that the inaccessibility of reproductive health services by deaf women leads to delays, lack of concern, as well as failure to access health facilities altogether. The participants were always attributing long waiting times, inattention by the health providers, and discouraging experiences to poor communication, hence making them less willing to seek care.

Some of the deaf women reported that they were ignored or forced to wait longer after healthcare staff realised that they were deaf. One participant explained:

> *"When I enter and greet, and they know I am deaf, they don't even pay attention to me. They just ignore me, and it makes me feel very bad*" (Participant 6).

Another participant recounted a similar experience:

> *"I sat at the hospital for a long time, and they saw me signing with my hands, but they did not attend to me. They attended to others first, and it was only when I complained that they called me"* (Participant 9).

The experiences indicate that the communication challenge is seen by staff as a nuisance that results in service provision delay.

Mockery and scorn also deterred the use of facilities. One deaf woman stated:

> *"When we start to sign, some of the nurses laugh at us and throw their hands. We feel disappointed and ashamed"* (Participant 7).

Another participant added:

> *"What discourages us the most is the mocking. After that, you don't feel like going to the hospital again*" (Participant 11).

These interactions not only destroy the dignity but also pose emotive barriers that discourage subsequent health-seeking behaviour. Consequently, a few respondents said that they did not go to hospitals at all unless it was a serious case. One participant explained:

> *"I don't go to the hospital often. I would rather treat myself at home with herbs than go and be treated badly"* (Participant 8).

Another participant described giving birth without adequate professional care, stating:

> *"I didn't go for antenatal care. My mother took care of me, and I went to the clinic only once because I couldn't afford it"* (Participant 5).

These narrations show how communication obstacles are directly transferred into postponed or skipped care. Notably, those who participated reported that they were treated differently in the presence of someone or not. One of the women stated:

> *When I arrive with my child, they treat me well; however, when I arrive without my child, there is an issue* (Participant 3).

This illustrates that access is dependent on mediated communication, but not institutional inclusion. Altogether, communication barriers not only limit access but also drive deaf women out of formal healthcare, and the consequences of this drastic measure on reproductive health outcomes and autonomy are severe.

4.4.2 Objective 2 Theme 2: Power Relations and Loss of Reproductive Autonomy

The results indicate that the reproductive autonomy of deaf women is often conditionalized and limited by the unequal distribution of power both at home and in the healthcare facilities. Gender norms, economic dependence, and clinical authority are factors that collide with communication barriers that decrease women's ability to ask questions, negotiate choices, and

provide informed consent. Because of this, the decisions that have to do with reproduction are frequently perceived as being done to them and not with them.

On the household level, participants reiterated several times that men were their main decision-makers, particularly since men have a tendency to control money used on transport, consultation fees or medication. This economic dependency makes reproductive decisions negotiations of permission as opposed to agency. One respondent said:

> *In my family, the man makes most of the decisions related to pregnancy and family planning as he is the breadwinner. You cannot insist, should he say you ought not to do it. I must follow what he pleases even when I wish to ask some questions* (Participant 7).

Autonomy was also undermined within healthcare settings where the use of a relative or members of the community was used to get the interpretation. When the interaction is mediated, the deaf woman has no full control of what is revealed, what is highlighted and what is omitted, particularly on sensitive issues. One of the participants said:

> *When I accompany someone, he or she determines the discussion inside the hospital. They clarify to me, they make sense to the nurse, and at times, they fail to narrate all that I would desire to say. I even believe that I do not even speak, but I see them talking* (Participant 9).

Some women explained how the absence of mutual understanding with nurses enhances the dominance of the providers. In the absence of a common language, participants did not feel free to argue with decisions, ask questions, and consider alternatives. This creates a scenario whereby compliance is the least risky or the easiest route. One woman said:

> *When the nurses do not get my signature, they make a swift decision as to what they think is right. They do not describe the treatment in a manner that I can comprehend, and I am unable to ask follow-up questions. Finally, I simply accept, although I may not know it* (Participant 5).

The lack of autonomy was also limited by social norms regarding childbirth and family size, such as the pressure to keep bearing children until a desired ratio of children is reached. This strengthens a cultural rationale in which reproductive decision-making is not individual. One participant said:

> *The child's gender is important in the family. In case you have girls only or boys only, they will put pressure on you until you have a balance. Even when you feel exhausted or scared, they will say to you, Keep on trying and do not give up* (Participant 10).

Lastly, the results indicate that low contraceptive knowledge, associated with obstacles in communication and a lack of health education opportunities, complicates the process by which deaf women can confidently make reproductive decisions. Misinformation and fear also lower the level of agency, due to the fact that the decisions are made under uncertainty. One of the participants remarked:

> *We are not very aware of family planning since no one explains it to us effectively. Others tell you that it will prevent you from giving birth in future, and that is the reason you are afraid of it. Due to the communication issue, you are unable to go and enquire of the nurse at will, and hence you are left confused* (Participant 6).

All in all, the evidence suggests that reproductive autonomy loss is created by stratified power relations in the form of domestic economy, gender ideals, mediated communication, and provider control. Communication barriers are not only the cause of misunderstanding but also

become a further source of dependence and silence, which will restrict the involvement of deaf women in the full process of reproductive decision-making.

4.4.3 Objective 2 Theme 3: Limited Reproductive Health Knowledge and Misinformation

The results show that the access of deaf women to reproductive health services in Adamorobe is highly conditioned by the lack of knowledge and prevalence of misinformation in relation to reproductive health and family planning. This information gap is not just a personal shortcoming, but structural by nature; it is a result of the inaccessibility of health information, the low level of education, and the lack of focused outreach service to deaf women. This has led to most reproductive choices being made in fear, rumour, and partial information instead of proper medical advice.

Numerous respondents stated that they had little or no knowledge regarding the simple reproductive health ideas, like the way a pregnancy works, the choice of contraception, or prenatal care. Participants who were younger in age especially narrated that they had been totally exposed to no reproductive health education, either in school or in the community. A participant said:

> *I know nothing about pregnancy and family planning simply because nobody has ever explained it to me as I can understand. At school, nobody taught us, and in the hospital, I will not be able to ask questions due to the sign language issue"* (Participant 4).

One of the recurrent problems was a fear of contraceptive methods, and it was tightly connected with the misinformation process in families and peer groups. Participants also reported hearing negative stories of family planning methods that would make them infertile, sick or cause long-

term damage. Such fears were not disproven because of the lack of options to check this information by means of the available contact with health workers. One of the women said:

> *I heard about the insertion and injections, but I am very afraid. They say they will make you sick or you will spoil your womb. I am afraid of trying anything because none of the nurses have clarified it to me* (Participant 6).

The results further indicate that poor knowledge of reproductive health is a factor leading to late or non-use of formal health services. Some women acted on home remedies, traditional medicine, or consulting older members of the family rather than consulting medical practitioners, especially during pregnancy. One respondent wrote:

> *In a situation where I got pregnant, I did not attend the antenatal care since I was not aware of what they do in the antenatal care. My mother assisted me at home, and I visited the clinic only once, as I did not have money, and communication there was also problematic"* (Participant 5).

This misinformation was also supported by the lack of outreach programmes targeted at deaf women. The participants observed that health education programs are largely done by oral communication, radio shows, or at a community meeting, where the deaf women have been left out. This makes them rely on second-hand information. One of the participants elaborated:

> *We do not get health education. They communicate via radio, meetings, but we are not able to hear. No one comes and explains things to us through signs, and we therefore rely on what people say to us even when they are wrong* (Participant 8).

Lastly, nurses admitted that they do not have enough time, training, or visual or sign materials to offer sufficient reproductive health education to deaf clients. One nurse posed:

> *We attempt to educate on family planning but it is not easy without the use of sign language. In case the client is bad at writing, you cannot explain everything properly, thus the education is sometimes not complete* (Participant 18).

In general, the results indicate that inadequate reproductive health knowledge and misinformation are not unique issues but the result of systemic communication discrimination. Such gaps compromise informed decision-making, strengthen the fear of modern contraception, and lead to poor reproductive health outcomes amongst deaf women in Adamorobe.

4.5 Deaf Women's Perspectives on Improving Communication and Service Delivery

4.5.1 Objective 3 Theme 1: Demand for Sign Language Skills and Interpreter Support

One of the prevailing issues identified based on the data is that deaf women have a high level of competence in sign language, as a crucial factor in the demand among healthcare providers and the presence of professional sign language interpreters in health facilities. Interviewees expressed to me that they always viewed communication not as an additional convenience but as an essential part of safe, respectful, and autonomous reproductive care. The lack of a common language was continuously referred to as the source of misunderstanding, fear, misdiagnosis, and lack of confidence in the health system.

Various deaf women were frustrated that nurses resorted to almost all writing or gestures, even when they knew that not all deaf patients could read. Writing was cited as poor at elucidating sensitive reproductive health issues, symptoms or procedures. One interviewee said:

> *When we go to the hospital, they only give us paper and pen, yet some of us did not attend school very far. The words are difficult even when they are written, and you*

> *cannot question them. Provided they were able to sign or have someone sign on behalf of us, we would know better and not be afraid* (Participant 5).

This points out the way that informal communication practices are inadequate to respond to the complexity of reproductive health consultations.

Respondents were very much in support of basic training of sign language to the nurses. Instead of thinking that they should have complete fluency, deaf women prioritised functional communication, enabling them to greet, explain, and ask simple questions. One woman said:

> *We are not saying that each nurse must be a professional signer, but he/she must know some. When they are able to welcome us, inquire about the wrong, and clarify minor things, it would make us feel respected and open to communication* (Participant 7).

This is an expression of the need to communicate through a relational mode of communication as opposed to an ideal linguistic precision.

The need to have professional interpreters was also high, especially where there were encounters related to reproductive health, such as pregnancy, family planning or medical procedures. Interpreters were considered to be fundamental and important to privacy, accuracy, and autonomy. One respondent said:

> *In case there is a trained interpreter in the hospital, I will be able to talk freely. I do not want my sister or mother to know about all the things about my body. The nurse will be able to hear me well with the help of an interpreter, and I will be aware of what they are doing to me"* (Participant 3).

Herein lies the correlation between interpretation services and informed consent.

Nonetheless, cost and interpreter availability were also identified as structural limitations by participants. Nonetheless, they claimed that the responsibility of communicating support should be an institution instead of a personal burden. In general, the results indicate that deaf women consider the skill of sign language and the support of the interpreter as the basis of dignity, safety, and fair access to reproductive healthcare.

4.5.2 Objective 3 Theme 2: Use of Visual, Alternative, and Technology-Based Communication Tools

Other than the skills in sign language and the support of interpreters, deaf women also pointed out the significance of visual, alternative, and technology-based communication tools to enhance reproductive healthcare interactions. Individuals identified that face-to-face signing or writing is not enough, especially in the busy health facilities where time is limited, and staff are still inadequate. The use of visual aids and low-cost, easy technologies was thus positioned as a viable, low-cost solution that would make the process of understanding and anxiety considerably lower.

Some of the actresses recommended the implementation of posters, charts, pictures, and cards that describe reproductive health services, symptoms and procedures. Visual materials were considered particularly helpful to clarify the family planning techniques, the process of childbirth and medication regimes. One respondent said:

> *When there are pictures on the wall, which display family planning procedures or stages of pregnancy, I can point to what I need or what I am experiencing. We can even communicate better, although the nurse may not be able to sign* (Participant 6).

This demonstrates the importance of visual messaging in the necessity of overcoming differences where linguistic alignment does not exist. There were also suggestions of short

educational videos in sign language or subtitles, which may be shown in health facilities. These tools were felt to be empowering since they enable the deaf women to convey information without the use of intermediaries.

> *If there are videos in the sign language about pregnancy or family planning, I can watch and get to understand before meeting the nurse, as one woman said. It will make me aware of what questions to ask so that I am not sitting there with a confused look on my face* (Participant 2).

This is an expression of preparation and knowledge in strengthening agency in consultations. There were also technology-based applications like mobile phones, message apps and basic translation or glossary apps that had been discussed. Phones had already been used by some nurses to type messages or display images, and were helpful but inconsistent for participants. One of the participants reported:

> *Sometimes the nurse types something or demonstrates pictures on her phone, and it is much more effective than writing on paper. But it depends on the nurse. It will be improved in case it is incorporated into the system* (Participant 9).

This implies that the informal practices may be formalised into regular procedures.

In general, deaf women did not consider the use of visual and technology-based tools as an alternative to human communication but rather as a supportive tool that allows them to understand, have privacy and confidence. Such tools were perceived to be especially useful to decrease the need to rely on family members, enhance the level of health literacy, and make the healthcare setting more inclusive and respectful.

4.5.3 Objective 3 Theme 3: Broader Structural and Socio-Economic Enablers of Communication

Along with immediate communication skills and tools, deaf women emphasised more overarching structural and socio-economic factors that determine the capacity to communicate efficiently and receive reproductive health care. Participants have consistently associated communication issues with poverty, unemployment, education, and institutional neglect, claiming that significant changes are needed outside the consultation room.

One of the issues that was brought up was economic vulnerability. Most of the deaf women described how their low-income levels influence their access not only to the health facilities but also to communication support, including an interpreter or transportation to better-equipped facilities. One participant said:

> *When you are poor, you cannot visit the hospital frequently. Even when you feel like bringing somebody who can sign well, you are not able to pay them. You keep house and take care of your sickness on your own"* (Participant 8).

Economic limitations thereby enhance the communication exclusion and health hazards.

Another important facilitator of communication was also found to be education. Respondents who had less or no formal schooling indicated that they found written communication or listening to medical explanations more difficult. One woman said:

> *They write things to us, and there are women who did not attend school. I cannot make sense of it when they are spelling big English words and feel embarrassed to repeat myself once more"* (Participant 4).

This exposes the role of assumptions on literacy in adding to the communication barriers among deaf women.

Another issue that became of great concern was institutional commitment. The participants noted that health facilities had not been prioritising disability-inclusive planning, as Adamorobe was known to have a deaf population. One interviewee said:

> *This is a community with deaf people, yet the hospital is not ready to receive us. They seem to forget that we are here, yet they are aware of our existence* (Participant 1).

This is an indication of systematic negligence and not personal negligence.

Another reason why the participants attributed employment and social inclusion to the confidence in communication is that. The women who had been actively economically or were networked by communities to do so indicated that they were more willing to interact with health providers. The woman said:

> *When working and being independent, it makes a woman more confident to visit the hospital and express yourself. You are afraid to speak when you are always relying on people* (Participant 7).

Indirect empowerment of the economy was thus perceived to be enhancing communicative agency.

In general, the results indicate that the communication needs of deaf women can be enhanced through structural spending on education, workforce, institutional responsibility, and disability-responsive policy. Unless these more general socio-economic enablers are discussed, the communication interventions may be left to be fragmented and ineffective.

4.6 Discussion of Findings

The data reveal that communication in the reproductive health consultation in Adamorobe is performed in an improvised and situational manner, which involves writing, gestures, ad-hoc signings, and mediated interaction through hearing relatives. Such practices indicate that there are no common linguistic materials between deaf women and health workers, which leads to broken and uneven communication. Instead of being dialogic and being constructed mutually, interactions are provider-initiated and provider-controlled.

In the view of the transactional model of communication by Barnlund, any efficient communication involves interactive feedback, making sense together, and interdependence. The results indicate that the presence or absence of these transactional aspects is weak or not present in most of the consultations made with deaf women. Communication can be very linear, and there is a flow of information in only one way, and there is little possibility to clarify or negotiate. It is reflective of previous research, which reports that deaf-hearing clinical interactions tend to collapse to one-way communication in the event of unattainability of sign language proficiency (Barnett et al., 2011; Kusters, 2015).

These relationships are also conditioned by power relations. As Foucault suggests in his power/knowledge theory, the healthcare professionals have a status of institutional power, which is supported by control of medical knowledge, the time of consultation, and communicative rules. Instead, deaf women are identified as passive recipients of the care, especially in cases where communication restricts the possibility of questioning, interrupting, and/or challenging clinical decisions. This has been revealed by showing that power is exercised in multiple ways, not necessarily through overt decision-making processes, but also through the less explicit communicative behaviours, including other people initiating the discussion, who controls the pace of discussion, and whose interpretation holds precedence.

This agrees with the literature that recognises communication as a prominent location where medical power is practised and maintained (Roter and Hall, 2006; Street et al., 2009).

Also, the data identified several obstacles that hinder the effectiveness of communication, most of which are not personal but structural. The barriers to communication also have a direct contribution to delayed care, health facility avoidance, and lack of involvement in reproductive health services. Deaf women emphasised being ignored, ridiculed or deprioritised in the clinical settings, and this discouraged future health-seeking behaviour. These results are consistent with the past studies that indicate that the unfavourable attitudes of the providers and unavailable communication conditions lead to the decline in service uptake rates among women with disabilities (Mprah, 2013; Seidu et al., 2021).

Mediation through family members was also a facilitating and limiting element. Although the involvement of relatives makes access possible when there are no institutional tools to support communication, the intervention usually shifts the power further away from deaf women, which influences the privacy, accuracy, and autonomy. Such a dual role can be seen as a reflection of the literature that suggests that reliance on informal interpreters could enhance access to services in the short-term but decrease informed consent and confidentiality in the long-term (Badu et al., 2018; Barnett et al., 2011).

Communication effectiveness is also determined by socio-economic factors. Lack of education and poverty, and unemployment mean that deaf women will have limited chances to participate in the consultations on an equal footing or address other sources of information. These areas of intersection combine with the barriers to communication to create compounded disadvantage, which confirms previous research on the intersection of disability, gender, and socio-economic inequality of access to reproductive health (Ha et al., 2023; Nketsia et al., 2022). The facilitating factors, to the extent that they existed, were mostly informal and

sporadic, as they pointed to the lack of institutional backing in terms of the availability of communication.

Deaf women's perspectives highlight a clear understanding of how communication affects their dignity, safety, and reproductive autonomy. Participants expressed concrete and viable recommendations, such as competence of healthcare providers in sign language, presence of interpreters, and use of visual and technology-oriented communication devices. These recommendations are an indication of a willingness not to be accommodated but to be involved in healthcare engagements in a meaningful manner.

In development communication terms, these opinions speak to the principles of participatory communication that focus on inclusion, dialogue, and the co-creation of meaning (Servaes, 2008; Melkote and Steeves, 2015). The recommendations given by deaf women oppose top-down and one-size-fits-all health communication strategies and emphasise the need to tailor communication systems to the lived realities of users. They also focus on visual materials and technology, which are recommended by the international community as disability-inclusive health communication (UNFPA, 2018; WHO, 2022).

Notably, the respondents associated the enhancement of communication with the expansion of the general framework, education, employment and institutional responsibility. This implies that communication is not perceived as a peculiar technical problem but rather an extended ecosystem of inclusion and exclusion. These results support criticisms in the literature that suggest the need to shift the focus of symbolic inclusion to operationalisation of disability-responsive communication in health systems (Seidu et al., 2021; Mprah et al., 2023).

4.7 Conclusion

The chapter discussed and analysed data from deaf women and health service providers in Adamorobe. It was identified that reproductive health communication is mostly improvised, mediated, and determined by unequal power relations, which leads to limited participation, delayed care and reproductive autonomy among deaf women. It was demonstrated that those communication barriers interacted with the socio-economic situation and the institutional practice to affect the health-seeking behaviour and the outcome. The view of deaf women highlighted the importance of availing communication to dignity, trust, and making informed decisions. The second chapter is based on these findings by synthesising the main arguments, endorsing general conclusions and offering policy, practice and research recommendations to enhance inclusive reproductive healthcare communication in Ghana.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This final chapter presents a synthesis of the main findings of the research, draws conclusions on the basis of the research questions and offers practical recommendations. The chapter is a reflection on communication practices between deaf women and medical professionals in a way to influence access to reproductive healthcare services, impact autonomy, and determine health outcomes in Adamorobe. It also provides policy, practice, and future research areas, which focus on advancing inclusive reproductive care provision to deaf women in Ghana.

5.2 Summary of Findings

The researchers concluded that deaf women's communication with healthcare providers in Adamorobe is mainly improvised, disjointed, and sporadic. Clinical interactions lack formal sign language communication, and health workers have to depend on writing, sign language, and ad hoc approaches. Such strategies are not very effective, especially for low-literacy women. Communication is thus provider-dominated and nurse-initiated, and restricts feedback and mutual understanding. This leads to short consultations that are one-way, lacking in understanding and causing confusion as well as emotional distress. Lack of professional interpreters essentially compromises mutual meaning-making in the reproductive health consultation.

The research established that barriers to communication are a direct cause of delayed care, evading health facilities and or diminished reproductive autonomy among the deaf women. Respondents complained of long waiting times, negligence, ridicule, and dismissive behaviour by certain health care practitioners. The relation of power in the homes and the hospitals also limited the capacity of the women to make independent reproductive choices, especially when

the communication and financial resources were in possession of the men or relatives of the individuals. There was also a lack of reproductive knowledge and misinformation on a large scale regarding family planning methods, mostly as a result of unavailable health education. All these difficulties led to the high probability of unintended pregnancies, home births, and the use of unsafe options.

Deaf women offered definite and feasible ideas on how to enhance reproductive healthcare communication. The most important of these were learning the basic sign language by medical professionals, hiring trained interpreters and the use of visual and technology-based tools of communication like pictures, charts, videos, and mobile applications. Another key point that was raised by the participants concerns the significance of wider structural enablers, such as education, employment, and institutional devotion to disability inclusion. In general, deaf women defined access to communication as a right and a requirement for dignity, safety, and informed choice.

5.3 Conclusion

This paper finds that a lack of good communication is a structural and endemic problem to fair reproductive healthcare of the deaf women in Adamorobe. These results indicate that communication issues are not single technical issues dealing with a language difference only, but are interwoven in institutional practices, power relations, and larger socio-economic disparities that inform the healthcare delivery. Spoken language and auditory norms as a systemic characteristic of the health systems effectively isolate the deaf women and restrict their possibility to partake in a meaningful consultation process, comprehend medical messages and make informed choices in their reproductive-health decisions.

The lack of sign language competency among the healthcare providers and the insistence on professional interpreter support were found to shift the reproductive health consultation into

exclusionary encounters. Communication in these contexts is unidirectional and controlled by providers, and it compromises feedback, understanding and trust. Deaf women tend to feel forced to depend on their relatives or community representatives, something that interferes with the notion of privacy, confidentiality, and autonomy. These circumstances elevate the chances of misdiagnosis, delayed healthcare, avoidance of healthcare institutions, and informed consent, and they have a direct impact on reproductive health outcomes.

These communication barriers are also found to meet at gendered power relations and economic vulnerability, as found in the study. Financial dependence, control of men in the decision-making process and lack of access to correct information about reproductive health often influence the reproductive choices of deaf women. Consequently, reproductive health is not only a medical concern but also a place where inequality, marginalisation, and silence are replicated in the daily clinical encounters.

To solve these issues, one needs to move beyond policy rhetoric and symbolic inclusion to effective, enforceable and disability responsive communication systems. Such systems have to acknowledge the role of deaf women as rights-holders, and not merely caretakers. Reproductive healthcare needs to be made inclusive, ethical, and relevant to the needs of deaf women in Ghana by institutional commitment to sign language training, the provision of interpreters, the availability of accessible communication materials, and structural empowerment.

5.4 Recommendations

The results indicate that improvised and situational practices are significant in reproductive healthcare communication in Adamorobe. Health facilities that cater to deaf populations should

be aware of communication diversity and strategise on its conscious presence when undertaking normal service delivery. Instead of an informal arrangement, the healthcare organisations would have to establish internal nursing standards regarding the way in which the deaf clients would be approached during consultations, including providing them with ample time to engage in communication and facilitating various forms of expression, like writing, gestures, and pictorial explanation.

Another finding of the research is that consultation communication is often mediated through family members, which, although providing access, tends to restrict the direct involvement and the agency of the decisions made by deaf women in regards to their own health. Healthcare providers should, in turn, be made to emphasise direct communication with deaf women during consultation, despite the presence of others with them. This is feasible by simple orientation and in-service training that would sensitise the providers about the inclusion practice of interaction and the need to deal with deaf women as the main decision-makers in their reproductive health.

The other important discovery is associated with the gaps in the knowledge of reproductive health and uncertainty in deaf women, which can be attributed to their inability to access clear and understandable information. Educational resources in health care ought to be modified to incorporate visual presentation, simplified written texts and demonstrations that are easy to use by the deaf community. The community-based outreach through the common forms of communication can also be used to address the information gap outside the clinical settings.

5.4.1 Recommendations for future studies

The next line of research can be longitudinal and comparative in nature in the study of the effects of communication interventions on the reproductive health of deaf women in the long term. Research might also consider the voices of male partners, community leaders, and

policymakers to have a better conception of the whole socio-cultural interactions that determine reproductive choice-making. Moreover, the study needs to be continued to measure the effectiveness of the technology-based communication tools and participatory models of co-creation that would engage deaf women in developing health communication plans.

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APPENDIX

APPENDIX A: INTERVIEW GUIDE FOR DEAF WOMEN

Introduction

It is my pleasure to invite you to take part in this research about reproductive health and rights of deaf women in Ghana. This interview is aimed at knowing about your experiences and your views. No right or wrong answers, and we would like to know your opinions. I want to hear your true story and your ideas. Everything we will talk about is private. No one in the community or hospital will see it. You can stop any time. Do you agree to talk with me today?

Section A – Background

1. Can you tell me a little about yourself? (Age, occupation, education, marital status, etc)
2. Were you born deaf or did you become deaf later?
3. What sign language do you use most? (AdaSL, Ghanaian Sign Language or both?

Section B – Nature and Dynamics of Communication (Objective 1)

4. When you go to the clinic for family planning, pregnancy check-up, or women's health, how do you and the nurse/midwife talk together?

→ Who starts talking? Who signs or speaks more?

→ Do you feel the nurse really understands what you sign?

→ Do you really understand everything the nurse wants to tell you?

1. In your own words, what happens step-by-step when you sit with the nurse?

→ Do you get a chance to ask questions?
→ Does the nurse wait for your answer or rush?
→ Do you feel you and the nurse make the decision together, or does the nurse decide alone?

2. Has a professional sign-language interpreter ever been there with you at the clinic?

→ If yes: How did it change the conversation?
→ If no: How do you manage without one?

3. Sometimes family members or friends help interpret. Has this happened to you for reproductive health topics?

→ How did you feel about your private information being shared with them?

Section C – Power, Meaning-Making and Consequences (Objective 2)

8. During the visit, who controls the conversation most - you or the nurse/midwife? How do you know?

→ For example: Who chooses the topic? Who decides when it ends?

1. Have you ever felt the nurse thinks you cannot understand because you are deaf? Give an example if yes.
2. Has a nurse ever given you a contraceptive method or treatment without you fully understanding or agreeing?

→ How did that make you feel? What did you do?

3. After you leave the clinic, do you usually feel:

a) clear about what to do next, or

b) confused or worried?

Why?

Section D – Deaf Women's Ideas for Improvement (Objective 3)

12. If you could change how nurses talk with deaf women, what would you change first?

1. What would help you feel equal and respected during the visit?
   → More interpreters? Pictures? Videos in sign language? Nurses learning basic AdaSL?
2. If you could sit with the Minister of Health or the head of the clinic and sign to them directly, what would you say?
3. Is there anything else you want to tell me about your experiences or ideas?

Closing

Thank you very much. Your story is very important. We will use it to help make services better for deaf women.

APPENDIX B: INTERVIEW GUIDE FOR HEALTHCARE PROVIDERS (Conducted in spoken English)

Introduction

Thank you for agreeing to talk with me. This research is about communication between healthcare providers and deaf women during reproductive health consultations in Adamorobe. Your honest views will help improve services.

Section A – Background

1. What is your role, and how long have you worked at Adamorobe Health Centre?
2. Roughly how many deaf patients do you see per month for reproductive health?

Section B – Communication Dynamics (Objective 1)

3. Walk me through a typical reproductive health consultation with a deaf woman - step by step.

→ How do you usually communicate? (Is it through writing, gestures or family members?)

→ How do you know the patient has understood you?

→ How do you know you have understood her?

1. In your view, who controls the flow and content of the conversation most? Is it you or the patient?
2. Have you ever had a professional sign-language interpreter present?

→ If yes: How did it affect the consultation?

→ If no: What strategies do you use instead?

Section C – Power Relations and Consequences (Objective 2)

6. Do you ever feel uncertain about whether a deaf woman has given true informed consent for a method or procedure? Give an example.

1. Have you ever felt that time pressure or lack of communication tools forced you to make decisions for the patient rather than with her?
2. From your experience, what are the most common misunderstandings that happen with deaf patients around contraception, pregnancy, or delivery?

Section D – Ideas for Improvement (Objective 3)

9. What training or resources would help you communicate better with deaf women?

1. Would you support having a trained sign language interpreter based at the health centre? Why or why not?
2. What one change do you think would make the biggest difference for deaf women's reproductive health care here?
3. Anything else you would like to add?

Appendix C: Consent Form for Deaf Participants

Participant Information and Consent.

You are encouraged to participate in a research study that investigates how deaf women interact with health practitioners in taking reproductive healthcare services in Adamorobe. However, some information presented below is imperative to read before you make your decision on whether to participate or not. The information has been discussed to you by use of sign language and or visual aids to understand it clearly.

Purpose of the Study

This study aims at learning about your experiences when you talk to nurses or health workers about reproductive health issues, e.g. pregnancy, family planning, and maternal care. The research will also aim at understanding what are the difficulties that you are experiencing and how communication can be enhanced.

Participation

Your involvement is voluntary. In case you accept to participate, you shall be requested to be involved in an interview or discussion group. You have the right to refuse to answer any question that you are not comfortable with, and you have the right to drop out of the study at any time without any penalty or loss of benefits.

Communication Support

Interviews will be held either through Adamorobe Sign Language (AdaSL), Ghanaian Sign Language, hand signals or any other visual technique that you prefer. Sign language interpreters will be employed where the need arises to facilitate proper communication.

Recording

To ensure the researcher captures your words and even your non-verbal expressions correctly, the interview can be audio-/video-recorded with your permission. The recordings will be utilised solely in the research.

Confidentiality

Everything that you tell will be held in confidence. No report, thesis, or publication will be written with your name on it. Rather, you will be assigned an ID number. All the details identifying participants will be eliminated from the transcripts. All data will be kept safe and only accessed by the researcher.

Risks and Benefits

No physical risks are known to be involved in taking part in this study. Certain questions can be related to sensitive issues; however, you can terminate or avoid any question. Although you might not gain any direct personal gain, your effort will contribute to enhancing knowledge and further planning of inclusive reproductive healthcare for deaf women.

Ethical Approval

The University of Media, Arts and Communication (UniMAC) has given ethical consent to this study. Authorities in the pertinent health facility and the community have also been sought to allow.