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SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN GHANA FOR PERSONS WITH DISABILITIES

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ABBREVIATIONS

CRPD	-	Convention on the Rights of Persons with Disabilities
DHS	-	Demography and Health Survey
ICPD	-	International Conference on Population and Development
MDGs	-	Millennium Development Goals
NGOs	-	Non-Governmental Organizations
OPWDs	-	Organizations of Persons with Disabilities
OVC	-	Orphans and Vulnerable Children
PHC	-	Primary Health Care
PLHIVs	-	Persons Living with HIVs
PWDs	-	Persons with Disabilities
SRH	-	Sexual and Reproductive Health
STDs	-	Sexually Transmitted Diseases
STIs	-	Sexually Transmitted Infections
WHA	-	World Health Assembly

ABSTRACT

Persons with Disabilities have the same Sexual and Reproductive Health needs as other people, yet they often face barriers to information and services. The ignorance and attitudes of society and individuals, including policy makers and health-care providers, raise most of these barriers, not the disabilities themselves. In fact, policies and existing services usually can be adapted easily to accommodate Persons with Disabilities. Increasing awareness is the first step. Beyond that, much can be accomplished through resourcefulness and involving Persons with Disabilities in programme design and monitoring.

An analysis of the references to Persons with Disabilities in the various policies, research and reports on Sexual and Reproductive Health will provide valuable information about the extent and ways in which disability and Persons with Disabilities are included in programmes and policies.

1.1 INTRODUCTION

In Ghana, three percent (3%) of the population of 24.7 million people has a disability (Ghana Statistical Service [GSS, 2013]). Persons with Disabilities (PWDs) have the same Sexual and Reproductive Health (SRH) needs as other people (World Health Organization & United Nations Fund Population Agency [WHO & UNFPA, 2009]). Yet they often face barriers to information and services. Furthermore, they have often been denied the right to establish relationships and to decide whether, when, and with whom to have a family. Many have been subjected to forced sterilizations, forced abortions, or forced marriages (UNFPA, 2007). They are more also likely to become infected with HIV and other Sexually Transmitted Infections (STIs) (Groce, 2003).

According to UNFPA and WHO (2009), the challenges to SRH faced by PWDs are not necessarily part of having a disability, but instead it often reflects lack of social attention, legal protection, understanding and support. PWDs often cannot obtain even the most basic information about SRH. Thus they remain ignorant of basic facts about themselves, their bodies, and their rights to define what they do and do not want.

Furthermore, SRH services are often inaccessible to PWDs, including physical barriers, the lack of disability-related clinical services, and stigma and discrimination. In many situations WHO and UNFPA (2009) affirm that barriers to health services include: lack of physical access, including transportation and/or proximity to clinics, lack of information and communication materials (e.g. materials in Braille, large print, simple language and pictures, lack of sign language interpreters), health-care providers' negative attitudes and lack of knowledge and skills about PWDs.

In addition to the above identified challenges, in Ghana, the general perception and treatment of PWDs is influenced by religious and cultural norms. Slikker (2009), in her study on perception of disability, stated that Ghanaians perceive disability as the result of a curse, punishment for sins committed by PWDs or their family members or the result of witchcraft, magic, or sorcery. Prior to this study by Slikker, Quayson (2007) pointed out that this perception has led to a general negative attributes about disability among Ghanaians of which PWDs are shunned and stigmatized.

In recent times, Organizations of Persons with Disabilities (OPWDs) and other Non-Governmental Organizations (NGOs) who have interest on disability issues have become more active in their advocacy roles and activities and continue to create awareness about situations of PWDs in Ghana, with the enactments of disability policies, laws and conventions since 2006 (Mprah, Anarfi & Sekyere, 2014).

Slikker (2009) has also noted that PWDs and their organizations engage in lobbying for changes in policies, and their focus has been on the most basic issues such as education and employment. Thus, SRH seemed not a priority despite the fact that it is a public health problem for PWDs and the country as a whole.

2.1 SEXUAL AND REPRODUCTIVE HEALTH ISSUES

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The proposition of reproductive health is that people are able to have a satisfying and safe sex life and that they have the ability to reproduce and the freedom to decide whether, when and how often to do so. The country therefore approves of the principle that Reproductive Health care is an arrangement of preventive, curative and promotional services to improve on the health and wellbeing of the population particularly, mothers, children and adolescents (National Population Council, [NPC, 2011]).

Reproductive health is thus defined as '*a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes...*' (ICPD Program of Action, para.7.2).

The Government of Ghana has long recognized that improving SRH is key to the nation's development and the goals are therefore designed to improve health and quality of life of all Ghanaians. Reproductive health is recognized as a human right and a global development priority as articulated in the Millennium Development Goals (MDGs) and other international policies (Ghana Health Service [GHS], United States Agency International Development [USAID] & Quality Health Partners [QHP], 2007).

In 1994, the Cairo International Conference on Population and Development (ICPD) marked a turning point for reproductive health and for the first time, reproductive rights were internationally recognized by Governments, as contained in the international human rights documents. The conference adopted and endorsed a wide range of SRH principles (Shalev, 2000) which specifically, recognizes the connection between human rights underlying social, political, cultural, and legal determinants of SRH (Roseman, Reichenbach & Firestone, 2007).

With respect to the SRH needs of PWDs, the ICPD Program of Action calls for measures to create awareness about disability issues and urges governments to improve access to education, training, and rehabilitation services for PWDs. Additionally, it calls on governments to eradicate all forms of discrimination encountered by PWDs so that they could exercise their sexual and reproductive rights (UNPFA, 1995).

Ten (10) years later, in 2004, the World Health Assembly (WHA) adopted the first *Global Strategy on Reproductive Health*. This was a renewed commitment to the principles underlying the ICPD.

In addition, the WHA urged for joint and accelerated action to achieve the MDGs. The strategy targeted five priority aspects of SRH: improving antenatal, delivery, post-partum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating STIs, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health (GHS, USAID, QHP, 2007).

The importance of the 2004 *Global Strategy* was reaffirmed at the 2005 Millennium Summit, where Heads of State and Governments expressed their commitment to '*achieving universal*

*access to reproductive health by 2015*¹, as set out at the ICPD, and integrating this goal in strategies to attain the internationally agreed development goals, including the Millennium Development Goals (MDGs).

The *Convention on the Rights of Persons with Disabilities* (CRPD) recognizes the rights of PWDs to free and informed consent and personal autonomy and dignity, and advocates for the promulgation of ethical standards to prevent discrimination and abuses in public and private healthcare systems (CRPD, 2008).

The CRPD in article 25 (a), focuses on health, which states that:

“States Parties shall: Provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons, including in the area of sexual and reproductive health and population-based public health programmes”(CRPD, 2008).

This means the Government should recognize that PWDs have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability (WHO & UNFPA, 2009).

Over the years, Ghana has demonstrated its commitment to the advancement of population programmes by formulating its first *Population Policy* in 1969. The Policy was revised in 1994 to incorporate emerging issues such as population and the environment, concerns about the aged, children, the youth, PWDs and HIV/AIDS. In the same year, the ICPD held in Cairo marked the watershed for Reproductive Health after which the shift from Maternal and Child Health and Family Planning to the broader Reproductive Health came into effect (Odoi-Agyarko, 2003).

Furthermore, Odoi-Agyarko (2003), indicated that as an outcome of the conference, Ghana endorsed the ICPD and adopted the ICPD definition of reproductive health which has the following components: safe motherhood, family planning, prevention and management of unsafe abortion and post abortion care, prevention and management of reproductive tract infections including STI and HIV/AIDS, prevention and management of infertility, prevention and management of cancers of female and male reproductive system, responding to concerns about menopause, discouragement of harmful traditional practices, gender based violence and reproductive health care, sexual health and information, education and communication. Thus, Ghana moved from Maternal and Child Health/Family Planning (MCH/FP) to the broader coverage of services of Reproductive Health.

After ICPD, a review of documents on family planning situational analysis, household surveys, and Demographic and Health Survey (DHS) revealed a great variation in service delivery practices and different interpretations about service policies and standards. In 1996, the *Reproductive Health Service Policy and Standards* was developed and the second edition was developed in August 2003 to include other issues such as sexual health, gender based violence and male sexual dysfunctions.

Other reproductive health policies/guidelines that have been developed and produced include: *National HIV/AIDS and STI Policy, Adolescent Reproductive Health Policy, Policy and Strategies for Improving the Health of Children Under-Five in Ghana, Maternal Health/Death Audit Guidelines, and Ghana HIV/AIDS Strategic Framework.*

The *Criminal Code, 1960, Act 29* contains sections that affect the implementation of reproductive health. The Code was amended in 1994 to include the offence of female circumcision. The Code also contains a section on abortion which is illegal in Ghana but is permitted under circumstances such as rape and incest.

Other reproductive health programmes that have been given attention of late include adolescent health, cervical screening and mother-to child transmission of HIV/AIDS, infertility, menopause /andropause, and gender-based violence.

To achieve these objectives of reproductive health, the programme relies on the principles of Primary Health Care (PHC), including outreach and community based activities, health education, promotion of appropriate technology and collaboration.

The past three (3) decades have seen increased interest in SRH issues because risks associated with SRH are among the major causes of morbidity and mortality, especially in developing countries such as Ghana (Glacier, Gülmezoglu, Schmid, Moreno & Van, 2007). It has been noted that the Government and other stakeholders are increasing their efforts to address the consequences of poor SRH on individuals, families, and society at large.

3.1 EXISTING POLICIES AND GUIDELINES

Ghana has adopted policies and strategies which protect and promote the growth and development of people in the country, along with in-depth public education on the policies. Some of the policies include:

3.1.1 National Population Policy (Revised Edition, 1994)

This policy was developed twenty five (25) years after the *1969 Population Policy* was promulgated and was adopted to improve the quality of life of the population. The rationale was that:

- Ghana's population growth rate still remained unacceptably high
- The population factor was a serious impediment to the country's economy, sustainable development and eradication of poverty
- Emergence of new concerns such as HIV/AIDS, population and the environment, children, the aged, the youth, and PWDs

3.1.2 National Reproductive Health Service Policy and Standards

The document which was first produced in 1996 and revised in 2003 indicates government's pledge to the health and well-being of women, children and adolescents.

The policy covers the following areas:

- Safe Motherhood Services
- Family planning
- Prevention and Management of Unsafe Abortion and Post-Abortion Care
- Prevention and Management of Fertility and Harmful Practices

The strategies include:

- Integration of family life education (FLE) into school curriculum and out-of-school programmes
- Create awareness of the problem of gender-based violence and its implications for reproductive health
- Provide aid to victims of gender based violence by linking them to organizations that addresses these issues

Reproductive health is very crucial when dealing with health issues among women. This is because most women do not have control over their health especially when it comes to regulating fertility and using contraceptives, this has implications for development planning. By adopting the policy the government seeks to improve the health and well-being of the population (NPC, 2011).

This Policy took into account the current national goals and priorities of the Ministry of Health/Ghana Health Service within the framework of the National Population Policy and recommendations made at International Conferences such as the ICPD.

3.1.3 National Reproductive Health Service Protocols (1998)

The protocols specify logical and chronological phases of the technical gestures necessary to deliver the service. The protocols cover all the components of reproductive health.

3.1.4 National HIV/AIDS and STI Policy (Revised Edition, 2013)

This policy was developed and adopted by the Government of Ghana in 2004 and has been revised taken into account recent developments in the national and global response. The revised document is guided by the dictates of the 1992 Fourth Republican Constitution and other government policies, international conventions and protocols, including the MDGs.

The document provides useful information on the status of the epidemic, its consequences and interventions necessary to adequately respond to the epidemic and the policies and organizational structures that have been put in place to address the epidemic comprehensively.

The rationale of the National HIV/AIDS, STI Policy is to provide guidance to other HIV-related policies, interventions and programme design and implementation in Ghana.

The overall goal of the policy on prevention is to halt and reverse the spread of HIV infection in the general population and in key and vulnerable populations and also seeks to promote the elimination of mother-child transmission.

One of the objectives is alleviate the social, cultural and economic effects of HIV/AIDS at individual, household and community levels by reducing HIV-related stigma and discrimination through the provision of information, basic needs and legal and community safety nets for Persons Living with HIV (PLHIVs), Orphans and Vulnerable Children (OVC) and key and vulnerable population.

3.1.5 Adolescent Reproductive Health Policy

The Policy seeks to strengthen adolescent reproductive health services in Ghana with the adoption of a multi-sectoral approach, involving appropriate institutions of government, private/civil society organizations and individuals to achieve the objective of adolescent health programmes.

The Policy also seeks to invest in young people as a measure to assist in reducing the contribution of teenage pregnancies to overall fertility of the country, prevent STI, including HIV/AIDS, among young adults and create a conducive and healthy environment for young people to learn about their own sexuality and that of the opposite sex.

The development of the policy is to promote the rights of adolescents to SRH information and services in an atmosphere of friendliness.

The Policy aims:

- At adolescents - which include other categories as street youth and street-involved adolescents/youth, mentally disturbed, physically challenged, teenage parents, adolescent couples, young people living with HIV/AIDS, marginalized groups and females in ritual servitude (e.g. Trokosi).
- All categories of people who influence the attitudes and behaviour of or provide services to adolescents.

The Policy among other things seeks to:

- Strengthen linkages among Government Ministries, Departments and Agencies as well as NGOs involved in the formulation and implementation of SRH programmes for adolescents and young people.
- Inculcate in the youth the idea of responsible sexual behaviour, the small family size norm, pursuit of career, values of responsible adulthood and mutual respect for people of the opposite sex.
- Provide adolescents and young people with skills that will make it possible for them to be involved in the formulation, implementation and monitoring of programmes designed to meet their needs.

3.1.6 Gender and Children's Policy (2005)

In order to promote equality, equity and empower women in Ghana, this policy was adopted. Women bare the largest poverty burden, suffer from preventable diseases relating to complication due to pregnancy and malnutrition.

The policy seeks among other things to:

- Promote the health and welfare of women and children
- Mainstream gender and children's concerns

The objectives stated in the policy are:

- The promotion of children's development and survival
- Address issues of existing gender inequalities through policy review, legal reforms and enforcement of existing gender legislation
- Enable women to have equal access to and control over economically significant resources and benefits
- Provide a national framework from which policies are developed

The policy objectives thus ensure that women and children benefit from all development programmes and plans aimed at enhancing their health and welfare.

3.1.7 Policy and Strategies for Improving the Health of Children Under-Five

In terms of morbidity and mortality, the under-fives are a particularly vulnerable age group and contribute to more than half of deaths in all age groups in Ghana. Although programmes targeted at this age group exist and are on-going, the desired impact has not been achieved. There was therefore the need to develop and implement a more comprehensive and integrated approach to child health including policy formulation and development of protocols.

The priority interventions to improve child health are:

- Neonatal health care
- Prevention and control of growth and nutritional problems
- Prevention and control of infectious diseases and injuries
- Clinical care of the sick and injured child
- Health related interventions

Other guidelines and policies that have been produced for children under five include:

- Breastfeeding Promotion Regulation
- National Breastfeeding Policy
- School Health Education Policy
- Vitamin A Supplementation Guidelines in Ghana

All these policies enhance the health status of the populace since it is the basic rights of all people to decide freely and responsibly their reproductive goals and must be given information to do so.

Since the ICPD, and following the Programme of Action's Agenda, however, very little seems to have been realized even though Ghana has developed several policies and strategies in line with international policies. More importantly, the concerns of PWDs have not been addressed adequately because of cultural, attitudinal, and institutional barriers (WHO, 2010). PWDs share many of the same SRH concerns as persons without disabilities, but they often face serious barriers to information and services due to ignorance, negative attitudes, and lack of services tailored to accommodate their unique needs (WHO, 2010; Wilson & Monaghan, 2006; Groce, 2004). They are rarely included in SRH prevention and outreach programs, and SRH information is often not provided in accessible formats or tailored to cater for their needs (WHO, 2010; Wilson & Monaghan, 2006). For instance, the lack of information in accessible forms such as Braille, large print, simple language, pictures, and sign languages, deprive access to those with visual, hearing, and intellectual disabilities (WHO, 2010). Low literacy levels among PWDs compound the issue, especially in developing countries such as Ghana, where many are without access to SRH education in schools or lack adequate health literacy school programs (WHO, 2010; Wilson & Monaghan, 2006).

4.1 METHODOLOGY

4.1.1 Sampling of documents

Nine (9) documents were reviewed to assess the extent to which PWDs are targeted as beneficiaries, how SRH needs of PWDs have been addressed, identification of gaps that exist in the policies and legislations which advocacy can be based. These included national policy documents, strategies and research reports. The documents reviewed are:

- The National Reproductive Health Service Policy and Standards [22,25]
- The Adolescents Reproductive Health Policy [26]
- The National Population Policy (revised edition, 1994) [24]
- The National HIV/AIDS and STI Policy [7,14,15]
- The Criminal Code (on Abortion)[28]
- The National Survey of Adolescents [29]
- The National Reproductive Health Service Protocols [
- The Ghana Population Stabilization Report [22]
- The Ghana Demographic and Health Survey (2008) [23]

These documents were obtained from the Ghana Library Board, other institutions/agencies and the Internet. The basis for selecting the documents were their relevance to the subject and target group and their sources. The researcher focused on government documents based on the belief that government policies and programs, including those on health, must not be discriminatory; as such, it is expected that SRH policies and research by government should include the concerns of PWDs.

The aim of the desk review is to identify, collect, compile and synthesize the policies that are available on SRH in Ghana and assess the inclusion of disability in the policy documents. The researcher utilized relational analysis, a component of content analysis which seeks to identify and explore the relationships and meaning among concepts in a text (Busch, Paul_DeMaret, Flynn, Kellum, Meyers, Saunders, White & Palmquist, 2012).

The researcher reviewed each document separately for policy or statements relevant to disability to determine whether each addressed the concerns of PWDs. The researcher first read through each document thoroughly to identify concepts that are used to describe disability; the presence of these concepts in a document suggests that attention has been given to disability while absence means no attention has been given to disability. Relevant sections of each document that have something on disability were marked.

The next stage involved examining the meaning and relationships of these concepts with other concepts; that is, how disability has been dealt with in the documents.

The final stage involved classifying the relevant ideas into issues. Four (4) issues were identified:

- Reference to disability
- No reference to disability
- Reference to disability is derogatory
- Reference to disability is ambiguous

5.1 FINDINGS

Based on the themes, the following are the findings:

5.1.1 Reference to disability issues

The *National Population Policy* (revised edition) makes provisions for appropriate actions to ensure the full integration of the aged, children, youth, and PWDs into society (NPC, 1994).

The *Adolescent Reproductive Health Policy* categorizes the primary beneficiaries as special groups. It states:

'The special group category may be either in- or out-of-school youth. However, for programme purposes they have been identified as a separate group due to their special needs. They can be categorized in diverse ways such as married or unmarried, sexually active or inactive or reside in rural or urban areas. Other categorizations include those involved in commercial sex; street youth and street-involved adolescents/youth, mentally disturbed, physically challenged, teenage parents, adolescent couples, young people living with HIV/AIDS, marginalized groups and females in ritual servitude (e.g. Trokosi)' (NPC, 2000:10).

The *National Reproductive Health Policy and Standards* focuses mainly on birth control for “mentally disabled” women. The policy states that decisions regarding family planning for the “mentally disabled” should be made by the next of kin.

The *Criminal Code and the National Reproductive Health Policy and Standards* have specific portions of these documents that are of interest for PWDs, and they include sections that focuses on the reproductive functions of PWDs and the termination of fetuses that are considered “abnormal.”

5.1.2 No reference to disability issues

The following documents make efforts to examine factors that could predispose people to risky SRH behavior as well as strategies to target groups at high risk.

The *Ghana Demography Health Survey* provides a broad understanding of the demographic characteristics and health status of the general population in Ghana, examines the relationships between SRH and a set of variables. These variables include age, marital status, education, place of residence, ethnicity, and sex (Odoi-Agyarko, 2003).

The *National Survey of Adolescents* provides a comprehensive information on adolescents' risk-taking and health-seeking behavior in regards to Sexually Transmitted Diseases (STDs) and unintended pregnancies. The report identifies groups at high risk of STDs, who were often excluded from adolescents' SRH studies in Ghana to be street children, young girls living in traditional shrines known as the Trokosi system, and HIV/AIDS orphans (Awusabo-Asare, Abane & Kumi-Kyereme, 2004).

The *National HIV/AIDS and STI Policy* targets mother-to child transmission and key populations and vulnerable persons. Other intervention strategies outlined in the policy include HIV Testing and Counselling and the target populations are pregnant women, key populations, patients in the emergency rooms of hospitals, in-patients, adolescents attending adolescent-friendly services, client accessing STI services, patients with Tuberculosis, individuals who have experienced potential occupational or sexual exposure and any other identifiable groups likely to have a high prevalence of HIV (Ghana AIDS Commission [GAC, 2013]).

The National Population Policy make provisions in the policy to eliminate discrimination against PWDs, but there is nothing specific regarding access to SRH information and services for PWDs (NPC, 1994).

5.1.3 Reference to disability is derogatory

The Criminal Code has provisions that have significance for PWDs in several respects, but the way it represents disability is derogatory. There are specific portions of these documents that have interest for PWDs, and they include sections that focus on the reproductive functions of PWDs and the termination of fetuses that are considered “abnormal.”

It states: ‘where the pregnancy is the result of rape, defilement of a female idiot or incest and the abortion or miscarriage is requested by the victim or her next of kin or the person in loco parentis, if she lacks the capacity to make such request’ (Section 58, 2a). ...‘where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health and such woman consents to it or if she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis’ (Section 58, 2b).

5.1.4 Reference to disability is (ambiguous) categorized

The *Adolescent Reproductive Health Policy* identifies commercial sex workers, street children, teenage parents, adolescent couples, young people living with HIV and AIDS, marginalized groups, females in shrines, and people labeled as “mentally disturbed” and “physically challenged,” as “special groups” who need attention.

The *National Population Policy* makes provisions for appropriate actions to ensure the full integration of the aged, children, youth, and PWDs into society. In this policy, whereas women and adolescents are treated separately in the policy, PWDs and the aged are treated as one group and the same strategies prescribed for both, although they do not have the same set of concerns and needs.

The *National HIV/AIDS and STI Policy* intervention strategies target ‘key populations and vulnerable people’, and also categorizes PWDs as vulnerable

6.1 DISCUSSIONS

6.1.1 Reference to disability issues

The *National Population Policy* (revised edition) makes provisions for appropriate actions to ensure the full integration of the aged, children, youth, and PWDs into society. This is as a result of emergence of new concerns on the above vulnerable group. This policy is a commitment to the principle that a well-managed population resource is a fundamental requirement for sustainable development.

The *Adolescent Reproductive Health Policy* specifically categorizes special groups to include “mentally disturbed” and “physically challenged,” who need attention. Their needs, demands and the strategies for meeting these needs could be different for each of the groups though.

The *National Reproductive Health Policy and Standards* states that decisions regarding family planning for the “mentally disabled” should be made by the next of kin. This policy focuses on birth control for “mentally disabled” women.

The *Criminal Code* has provisions on abortion that have some significance for PWDs. Although abortion is illegal and a criminal offence in Ghana, the criminal code provides exemptions for women with developmental disabilities, referred to as “female idiots” and those situations “where there is substantial risk that if child were born it may suffer from or later develop a serious physical abnormality or disease”.

6.1.2 No reference to disability issues

The *Ghana Demography Health Survey* examines the relationships between SRH and a set of variables on the demographic characteristics and health status of the population in Ghana. The aim is to understand how these variables influence SRH behavior and so doing, identifies groups at risk for appropriate policy and programmatic interventions.

The *National Survey of Adolescents* also provides information on adolescents’ risk-taking and health-seeking behavior in regards to STDs and unintended pregnancies.

The *National Population Policy* makes provisions in the policy to eliminate discrimination against PWDs, but there was nothing specific regarding access to SRH information and services for PWDs.

Similarly, the *National HIV/AIDS and STI Policy* did not make reference to PWDs.

Therefore, it is impossible to determine the extent of inclusion of PWDs in the two (2) studies on SRH status.

All the above documents do not have information or data on PWDs as findings show, but it cannot be concluded that PWDs were not included in these studies.

6.1.3 Derogatory and perceptions on disability

The Criminal Code provides exemptions for women with developmental disabilities, referred to as “female idiots”, which is a derogatory name for this type of disability. This portrays negative impression or perception about disability.

It refers that ‘where the continuance of the pregnancy would involve risk to the life of the pregnant woman or injury to her physical or mental health and such woman consents to it or if she lacks the capacity to give such consent it is given on her behalf by her next of kin or the person in loco parentis’ (Section 58, 2b).

First, permitting the reproductive rights of women with disabilities to be controlled by others is discriminatory and infringe on the reproductive rights of PWDs, especially women with (developmental) disabilities. These provisions assume that such individuals do not have the capacity to make informed decisions and as a result someone else should make the decision for them, which is a clear violation of their right to self-determination.

Second, granted that there are some women with mental disabilities who cannot make such decisions, differentiating between those who can make such decisions and those who cannot will be hard. In fact, the decision is left at the discretion of professionals, many of whom lack positive attitude toward disability.

6.1.3.1 Ambiguity

There are also ambiguities that would permit varying interpretation of the provisions, thus creating problems in their applications. For instance, the abortion law under the *Criminal Code* is not clear on what constitutes “serious physical abnormality” or how to define a “female idiot.” Such ambiguities provide a great deal of discretion to medical personnel to determine the legality of abortion. And since disability is negatively perceived in Ghana (Kassah, 2008; Quayson, 2007) medical personnel are likely to counsel parents and next of kin based on their own prejudices and stereotypes about disability.

In the same vein, the *Reproductive Health Policy and Standards* does not provide a clear definition of “mentally disabled,” allowing too much elasticity in the application provisions in the policy. Similarly, the *National HIV/AIDS and STI Policy* intervention strategies target ‘key populations and vulnerable people’, which does not also provide the definition of ‘key populations nor vulnerable people’.

Such flexibility has the tendency to infringe on the rights of women with various cognitive disabilities who may have the capacity of independently making SRH decisions. In fact, depriving any person, irrespective of cognitive acuity, of access to SRH information and services is a violation of his or her right to health.

6.1.3.2 Categorization/specialized groups

The *Reproductive Health Policy and Standards* treats the concerns of those labeled “mentally disabled” not differently from the concerns of women generally. It assumes the two groups have the same SRH concerns and needs. Studies suggest that women with cognitive disabilities need more assistance to access SRH information and pregnancy services than other women (Bergen, 2010). Moreover, by focusing on women with mental illness, the policy ignores people with other forms of disabilities, and seems to be primarily more concerned with the reproductive functions of PWDs, rather than their overall SRH concerns.

Similarly, the *National Population Policy* makes provisions for appropriate actions to ensure the full integration of the aged, children, youth, and PWDs into society. Though women and adolescents are treated separately in the policy, PWDs and the aged are treated as one group and the same strategies prescribed for both, although they do not have the same set of concerns and needs.

7.1 IDENTIFIED GAPS

Policies on RH rights make provisions for specific groups whose peculiar needs would make it impossible for them to benefit from policies for the general population. These groups have been categorized as “special” because their concerns are vastly different from other groups, and these groups are likely to be excluded from programs for the general population. For example, the Adolescent Reproductive Health Policy states that:

‘Their needs, demands and the strategies for meeting their needs could be different for each of the groups’. But some of the groups in this category tend to be left out in the design and implementation of programmes and activities on adolescent reproductive health. Therefore, it is necessary to identify them so as to ensure that their needs are considered and taken care of in sexual and reproductive health programming (NPC, 2000:13).

This policy again clearly acknowledges the need to develop special programs to meet the specific needs of these subgroups. However, there is very little in the policy to serve as guidelines for defining the targeted individuals groups. For example, who are the “mentally disturbed” or the “physically challenged” population? It is also not clear if people who are deaf and visually impaired form part of the “physically challenged” population. And even if the “physically challenged” are included, there is nothing in the policy that addresses how the service system should respond to their unique needs, such as communication barriers for the deaf and physical barriers for the blind and physically disabled.

The *National Population Policy* (revised edition) make provisions for appropriate actions to ensure the full integration of PWDs into society. There are also provisions in the policy to eliminate discrimination against PWDs, but no specific mention is made of access to information and services on SRH, though the broader policy of integration of PWDs should, in theory, increase their access to SRH information and services.

Also in the same policy, women and adolescents are treated separately in the policy, PWDs and the aged are treated as one group and the same strategies prescribed for both, although they do not have the same set of concerns and needs.

Undoubtedly, the review shows that PWDs have received little or no attention in SRH policies and research in Ghana. Findings indicated that major studies on SRH issues such as the GDHS and NSA do not have data on PWDs, and thus were not included in these studies. The lack of data on disability makes it difficult to initiate and plan for PWDs.

The paucity or inadequate of data and research on disability issues among others continue to plague the disabled, as well as a wide variance of definitions, standards and methodologies used to identify the conditions of PWDs remains an obstacle to the effective formulation and implementation of disability-inclusive policies and programmes, especially SRH, as well as in the monitoring and evaluation of progress in achieving the MDGs, as a whole.

8.1 POLICY IMPLICATIONS/RECOMMENDATIONS

The study provides some initial perspective on the need to target specific subgroups, which many policies and programs tend to ignore. Some groups, defined by socio-demographic characteristics such as age, gender, or educational attainment are more vulnerable to SRH problems than the general population (GSS, 2004).

A number of studies have examined such risk groups in Ghana: adolescents, street children, and women. However, as indicated in the review, the association between disability and risk for SRH problems has received little attention in Ghana. As a result, little is known about how disability affects one's SRH behavior and the resultant risks. The present review sought to broaden the conception of vulnerability to include a specific group (the disability community) within the larger Ghanaian community.

Furthermore, the review has the potential to make SRH needs of PWDs visible and create awareness about other issues concerning this sub-group and, thus, possibly ignite interests in disability in national policy making and research.

Disability statistics remain underdeveloped. Recently, in 2010, Ghana collected information on disability through census but the official data still remains debatable. To a significant extent, the dearth of socio-economic data on PWDs reflects the social welfare and/or medical approach to disability that still prevails in the country.

9.1 CONCLUSION

Persons with disabilities represent a significant portion of the Ghana's population and are part of every community. The prevention of disability and the care of PWDs as productive citizens is an important aspect of the development of the nation's human resources. Attention to the SRH needs of PWDs is important to ensure the protection and promotion of their human rights, to move forward the international development agenda, and to build a truly inclusive society. Although the full picture of SRH issues for PWDs is not yet clear, it is certain that there are significant unmet needs. Like everyone else, PWDs need information about SRH. In order to do so, they have the right to make reproductive decisions for themselves. They must have the same access as everyone else to programmes, services, and resources that support them in their decisions.

In addition, most people are ignorant about PWDs and on disability issues and should disabuse their minds of superstitions. Science has established that disabilities are as a result of chromosomal and genetic abnormalities or incidence that occurred during or after birth. Therefore people should accept PWDs since they have a lot to offer to society, and desist from calling them derogatory names. The only way Ghana could catch up with development is to assist them and include PWDs in all spheres of the society.

Government Ministries, Departments, Agencies and other partners and stakeholders who work on SRH issues should ensure that the SRH of PWDs is considered and addressed at local, national, regional, and global levels. Legislation, funding structures, policies, and programmes must all be designed to take into account the rights and needs of PWDs. SRH experts and advocates can help create a dialogue with and within the disability community to foster more open discussion of SRH issues.

With the recent entry into force of the CRPD, such efforts could not be timely. Addressing the needs of PWDs present a unique challenge to all Ghanaians. The potential for making a significant difference is enormous. We all stand to gain when everyone, including PWDs, is included.

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