

# UTILISATION OF HEALTH SERVICES BY THE DEAF AND HARD OF HEARING

BY

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UNZA

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**THE UNIVERSITY OF ZAMBIA  
SCHOOL OF MEDICINE  
DEPARTMENT OF POST BASIC NURSING**

**UTILISATION OF HEALTH SERVICES BY THE DEAF  
AND HARD OF HEARING IN KANYAMA  
COMPOUND**

**BY**

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requirement for the award of the Bachelor of Science Degree in  
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## **LIST OF ABBREVIATIONS**

ASLIZ	-	Association of Sign Language Interpreters of Zambia
CSO	-	Central Statistics Office
LUDHMT	-	Lusaka Urban Districts Health Management Team
MCDSS	-	Ministry of Community Development and Social Services
MOH	-	Ministry of Health
VCT	-	Voluntary Counselling and Testing
WHO	-	World Health Organisation
ZAPD	-	Zambia Agency of people with Disabilities

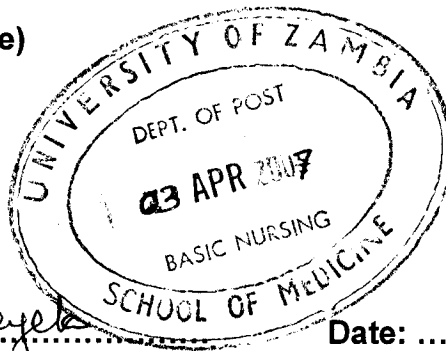
## DECLARATION

I, hereby declare that the work presented in this study for a Bachelor of Science degree in nursing has not been presented either wholly or in part, for any other degree and is not being currently submitted to any other degree.

Signed: ..... *Benny* .....

Date: *3<sup>rd</sup> April 2007* .....

(Candidate)



Approved: ..... *Shaleya* .....

Date: *03/04/2007* .....

(Supervising Lecturer)

## STATEMENT

I, ***Chisupa Eric***, do hereby certify that this study is entirely the result of my own independent investigations. The various sources to which I am indebted are clearly indicated in the text and reference.

Signed: *Eric*

Date: 3<sup>rd</sup> April 2007

## DEDICATION

*To*

*My wife Chisupa Elita whose patience and consideration sustained me through the  
years of my studies*

*To*

*My son Nathan for his understanding while I was busy studying*

*To*

*My parents Mr. Green Chisupa and Mrs. Voilet Chisupa whose love and affection  
inspired this endeavour*

*And*

*To*

*All those who live in the world of silence*

## **ABSTRACT**

The Deaf and hard of hearing is vulnerable group in society. Their form of communication makes it difficult for them to effectively communicate their needs and complaints. Among the disabled group the deaf and hard of hearing are the only ones whose disability is not so obvious (ASLIZ, 2006).

The government of the Republic of Zambia is striving to reach the health related millennium development goals. This involves provision of health services to all the population including the deaf and hard of hearing.

The purpose of the study was to determine the factors influencing Underutilisation of health services by the deaf and hard of hearing in Kanyama Compound.

Literature review was from various scholars globally, regional and national literature on the disabled. The literature focused on factors which influence the marginalisation of the deaf and hard of hearing.

A non experimental descriptive study design was used. Sample selection was done using non probability sampling method. The type of non probability sampling method chosen for the study is the judgemental sampling method. The respondents were selected judgementally by the researcher so long as they had the characteristics of interest to the researcher.

A total of 60 respondents took parting the study. 50 were deaf and hard of hearing who live in Kanyama compound and 10 were health workers who work at Kanyama Clinic.

The data from health workers was collected by the use of a semi structured questionnaire. The questionnaire was self administered since all the respondents had some form of education.

The study revealed that the deaf and hard of hearing do utilise health services. Majority 42(84%) of them sated that they went to the government clinic when they fell sick (table 17). What seems to be the problem is the quality of the service they received. This was seen in that 49(92%) of the respondents who are deaf and hard of hearing were not satisfied with the service they received at the government. The quality of service was connected to the method of communication with the health workers. The client who communicated the complaints to health worker using sign language was satisfied with the service he received (table 19). All the respondents 50(100%) suggested that teaching health workers sign language will greatly improve health services for the deaf and hard of hearing

In view of this finding the recommendation were made to government The government should help train health workers in sign language especially in areas where the numbers of the deaf and hard of hearing are high to ease communication. Another suggestion to government was that the Ministry of Health and the Ministry of Community Development and Social Welfare should coordinate their activities when dealing with the health issues of the deaf and hard of hearing. Information should be disseminated to them in sign language. However these suggestions are long term ones. In the meantime Sign language interpreters' can be trained in counselling skills so that they can assist in counselling the deaf and hard of hearing.

## **CHAPTER ONE**

### **1.0 INTRODUCTION**

#### **1.1 BACKGROUND INFORMATION**

Zambia is a landlocked country situated in the heart of Central Southern Africa. The country covers an area of about 752 612 square kilometers, which is 2.5% of the total area of Africa (CSO, 2003). She shares borders with eight other countries. These are the Democratic Republic of Congo and Tanzania to the north, Malawi and Mozambique to the east, Zimbabwe and Botswana to the south, Namibia to the southwest and Angola to the West.

The country is divided into nine provinces for administrative purposes. These provinces are further divided into 72 districts. The provinces are Lusaka, Southern, Central, Western, North Western, Northern, Luapula, Copperbelt and Eastern Provinces

Following independence in 1964, the new government policy was to diversify the economy and improve on the coverage of provision of health services to its citizens (Ministry of Health, 2001). This prompted the government to make available, health facilities at provincial, district and community levels.

In this regard the government decided to have all categories of persons with disabilities covered under one Act of parliament and their affairs administered under one umbrella organization. It was assumed that persons with disabilities would be more united if their affairs were governed by one Act of parliament. The persons with disabilities were therefore, referred to as 'handicapped' without being categorized as the blind, physically handicapped, the deaf and mentally handicapped (MCDSS, 2000).

However lumping up of all disabilities has disadvantaged the deaf. They cannot access oral presentations because of their inability to communicate effectively verbally (Asliz, 2006).

The number of persons with disabilities in the world is large and growing (Ministry of Community and Social Services, 2000). In 1981, the World Health Organization (WHO) estimated that there were no less than five hundred million persons with disabilities in the world (WHO, 1981). WHO further stated that 60% of the people with disabilities lived in developing countries. It was further stated that persons with disabilities constitute at least ten percent (10%) of a country's population. With the current population of approximately 10 million (CSO, 2000), Zambia has about 1 million persons with disabilities.

In Zambia there are no explicit statistics on the magnitude of disability. This is because there has never been a special survey to establish the number of the disabled in the country (Ministry of Community Development and Social Services, 2000). However, the 2000 census of housing and population report established that the deaf and hard of hearing make up 13% of the total disabled persons in Lusaka province (CSO, 2000). However, the Association of Sign Language Interpreters of Zambia (ASLIZ) put the estimates of the deaf and hard of hearing at about 20% of the disabled population in Lusaka Province (Asliz, 2006).

People with disabilities like any other citizens in Zambia need to receive social services from government. However, the deaf do not fully utilize social services like health services because of communication barriers. Access to health facilities is calculated in terms of distance away from a health facility (Ministry of health, 1991). Based on this criterion, it is estimated that 99% of the urban households in Zambia have access to health services because they live within 5 km of a health facility (WHO, 2005). However there is one particular group of the Zambian population whom proximity to a health facility does not necessarily mean access to the health services. This group is of the deaf and hard of hearing.



## **1.2. Statement of the Problem**

Access to health services is crucial for anyone. The concept of primary health care (PHC), adopted by the government in 1978 is aimed at addressing this crucial aspect of health care delivery. Its main focus was to provide health services as close to the individual as possible (Ministry of Health, 2000).

However, most of the techniques used to disseminate information about health services, cannot be used by the deaf. The common use of radio messages to disseminate information does not benefit the deaf because they cannot hear. Furthermore, when TV is used there is more talking than demonstration or writing on the screen, making it difficult for the deaf to make a complete picture of what is being put across.

In Kanyama, although the community lives within 5 km radius of the government health centre the deaf do not fully utilize its health services. The Out Patient Department (OPD), in Kanyama Clinic which attends to about 15 000 cases per month (LUDHMT, 2006) has no record of a deaf person being attended to despite there being approximately 350 deaf and hard of hearing in Kanyama compound (ASLIZ, 2006). This could mainly be because it is difficult for them to express themselves fully as the majority of health workers do not use sign language, and where sign language interpreters are available there is lack of privacy. Such instances lead to non disclosure of ailments thereby leading to wrong prescription of treatment.

## **1.3. Factors Contributing to the Problem**

Some of the factors attributed to the problem are as follows

### **1.3.1. Social Cultural and Economic factors**

#### **1.3.1.1. Illiteracy**

There are high levels of illiteracy among the deaf and hard of hearing in Zambia due to lack of sustainable education policy for them (Asliz, 2006). Majority of the

deaf only go up to grade 12 because there are inadequate Colleges in the country which offer sign language. The deaf and hard are therefore denied higher education. As a result their understanding of social issues is limited. This lack of understanding includes issues related to health.

#### **1.3.1.2. Unemployment**

There are high levels of unemployment among the deaf due to illiteracy and severe language barrier. This lead or makes then live in abject poverty and consequently they cannot afford to pay for health services.

#### **1.3.3.3. Lack of Information**

Information on pertinent issues like HIV/AIDS, family planning does not exist in sign language.

#### **1.3.1.4. Traditional beliefs and perceptions**

It is considered to be a curse to have a child who is disabled in many Zambian tribes. It is seen as a curse for a serious wrong doing in the family, (MOH, 2000). Therefore the nuclear and extended family members feel embarrassed to live with deaf relatives. They prefer to hide them at home or transfer them to other people who are equally not ready for them.

#### **1.3.1.5. The Deaf's attitude of the hearing**

Due to communication barriers the deaf are distrustful of those around them. As a result they do not trust even health workers who cannot use sign language.

### **1.3.2. Service Related Factors**

#### **1.3.2.1. Health Workers Attitude towards the Deaf**

Because of their communication problems the deaf have problems to fully express themselves giving an impression that they are difficult to work with.

### **1.3.2.2. The Deaf Dissatisfaction of Health Services**

Since the deaf can not verbally communicate what they want, they do not get what they really need from health workers. As a result they feel dissatisfied with most of the care and treatment given to them thus discouraging them to come back next time.

### **1.3.3. Diseases Related Factors**

#### **1.3.3.1. Lack of Privacy**

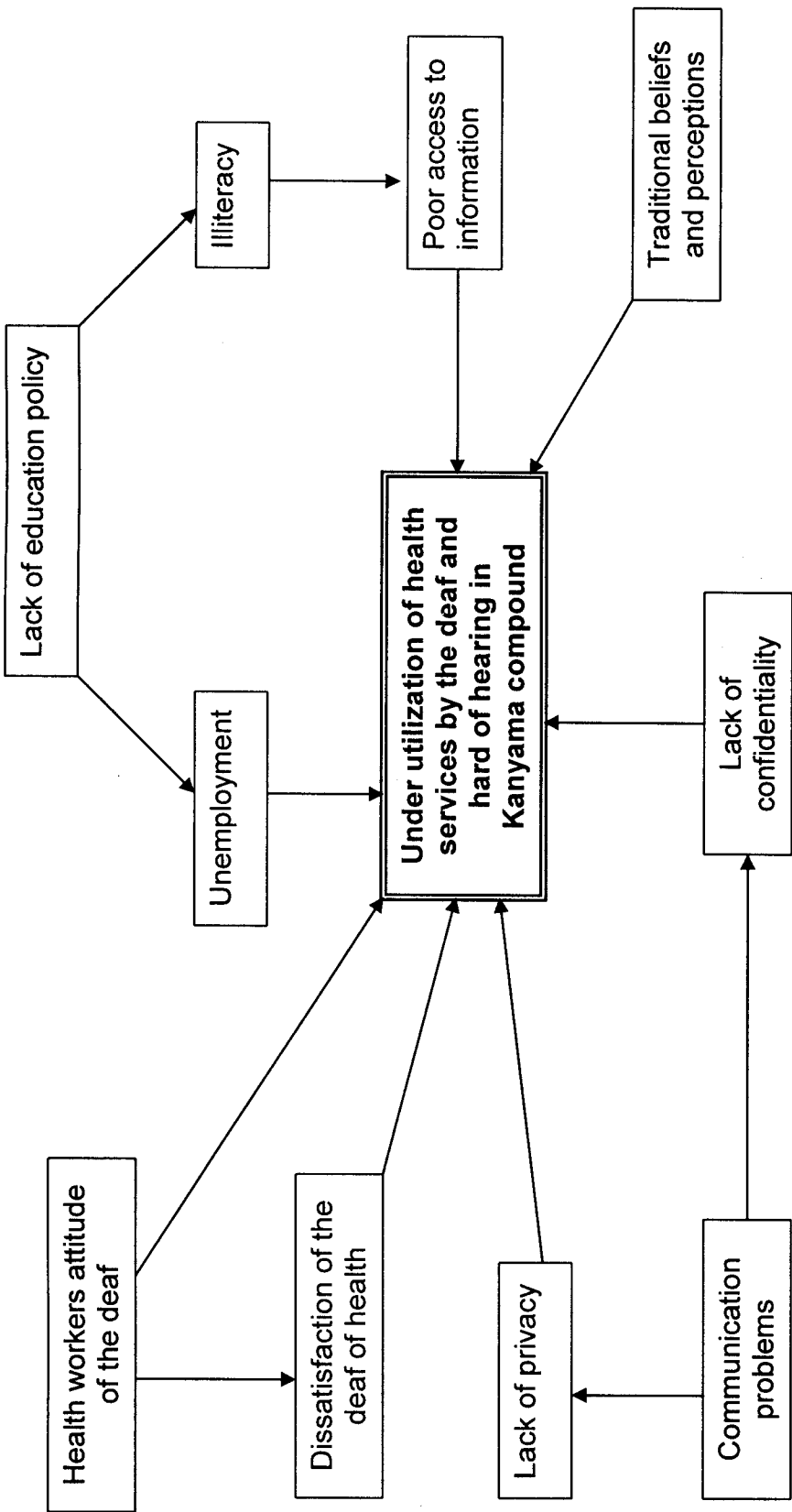
Since most of the diseases are often private, the use of sign language interpreters leads to lack of privacy.

#### **13.3.2. Lack of Confidentially**

This problem arises because most health workers do not know sign language. The presence of sign language interpreters removes confidentiality on sensitive conditions likes VCT.

1.4. Diagram of Problem Analysis

Diagram 1



## **1.5 Justification**

The problem of under utilization of health services by the deaf needs to be addressed if Zambia is to meet the health related United Nation's Millennium Development Goals.

According to the 2000 census (CSO, 2000) the disabled make up 2% of the total population of Lusaka Province. Of the number about 20% are deaf and hard of hearing and about 2% live in Kanyama compound.

According to statistics obtained from Kanyama Clinic (LUDHMT, 2006) no deaf persons have been attended to since January, 2006. Knowing that illness affects anyone (WHO, 1986) irrespective of their ability or disability, this study therefore wishes to explore factors that influence the deaf's under utilization of health services. The results could be used by policy makers, health workers and Non Governmental Organizations to make health facilities user friendly for the deaf and hard of hearing.

## **1.6. Objectives**

### **1.6.1. General Objective**

To determine factors that influence the under utilization of health services by the deaf and hard of hearing in Kanyama compound

### **1.6.2. Specific Objectives**

- a. To assess the perception of the deaf and hard of hearing towards health services.
- b. To determine the attitude of health workers towards the deaf and hard of hearing
- c. To establish the attitude of health workers towards learning sign language.
- d. To determine utilization of health services by the deaf and hard of hearing in Kanyama compound.

## **1.7. Hypothesis**

1.7.1. The more educated the deaf person is the more likely he is to access health services.

1.7.2. The more the number of health workers who know sign language, the more the number of the deaf and hard of hearing who will utilize health services.

## **1.8. Operational Definitions of Terms**

### **Disability**

Refers to a person who is limited in the kind or amount of activities that he or she can do, due to a long term physical, mental or health problem

### **Deaf**

Complete loss of sense of hearing

### **Hard of Hearing**

Partial loss of sense of hearing

### **Under utilization**

Not fully using or accessing

### **Health Services**

Services offered to improve an individual's health. These include preventive and curative services.

## **1.9 Variables and cut off points**

- a. Knowledge of health services
- b. Accessibility of health services
- c. Utilization of health services by the deaf
- d. Perception of health services by the deaf
- e. Attitude of health workers towards sign language

**Table 1 VARIABLES AND CUT OFF POINTS**

	Variable	Grading	Cut off
1	Knowledge	Good Average Poor	7-9 4-6 0-3
2	Accessibility of Health Services	Very Accessible Moderately Accessible Poorly Accessible	7-9 4-6 0-3
3	Utilization of Health Services	Utilized always Utilized sometimes Under Utilized	7-9 4-6 0-3
4	Perception of Health Services by deaf	Very good Good Fair Poor	8-10 7-9 5-8 1-4
5	Attitude of Health Workers learning sign language	Willing May be willing Not willing	7-9 1-6 0

## **CHAPTER TWO**

### **2.0 LITERATURE REVIEW**

#### **2.1 Introduction**

Literature review is a review of available information on the subject under study. This literature review will review literature related to the handicapped and the way they utilize social services of which health is one of.

#### **2.2 Global Perspective**

According to WHO, the persons with functional limitations resulting from physical, intellectual, psychiatric or sensory impairment are referred to as disabled (WHO, 1980). Their number is growing. In 1981 the WHO estimated that there were no less than five hundred million persons with disabilities in the world. It further stated that persons with disabilities constitute at least ten percent (10%) of a country's population.

The United Nations declared 1981 as the international year of disabled persons (WHO, 1981). The most important outcome of this declaration was the formulation of a World Program of Action concerning disabled persons, adopted by the general assembly on 3<sup>rd</sup> December 1982 (WHO, 1982). The plan of action provided a strong impetus for progress in the area of improving living conditions of the disabled. Emphasis was placed on the right of persons with disabilities to have the same opportunities as other citizens and to an equal share in the improvement in living standards resulting from economic and social development.

The period 1983 to 1992, which was declared as the international decade for disabled persons by the United Nations, resulted in increased awareness on the rights of persons with disabilities. Consequently, many associations and organizations of and for persons with disabilities were formed all over the world.



In 1994, the United Nations adopted the standard rules on the equalization of opportunities for persons with disabilities (Ministry of Community Development and Social Services, 2000). The purpose of the standard rules was to encourage the elimination of all forms of discrimination against persons with disabilities so that they can exercise their rights and obligations like others, hence improving their status in society.

These actions set in motion measures aimed at addressing the health needs of the people with disabilities. However, these measures at the global level remained remote because there was little implementation by member governments of the United Nations (WHO, 1984).

### **2.3 Regional Perspective**

Of the estimated 500,000,000 disabled people in the world in 1981, 60% were said to be living in the developing countries (Ministry of Community Development and Social Services).

Reporting on the developing countries situation regarding the disabled, the WHO journal of 1984 stated that the quality of life among disabled people in developing countries is a matter of great concern to the international community. The death rate among disabled children is higher than among non disabled children, malnutrition and infections being the main cause of these deaths (WHO, 1984).

The report continued to relate that disabled adults in developing countries generally have lower income than others. And live more often in poverty. Adult women with a disability are often abandoned by their husbands and deprived of their children (WHO, 1984).

The journal also observed that disabled children have fewer opportunities to attend school. The presence of one child with a visible disability in a family reduces the marriage prospects of the other siblings.

The disabled people are usually excluded from position of leadership in their communities. They are seldom elected or appointed to political office and are left out of planning and decision making. Their lack of representative in community affairs results in neglect of their needs (Ministry of Community Development and Social Services, 2000).

## **2.4 National Perspective**

In Zambia the problems affecting the disabled in general and the deaf in particular have received some attention in the form of legislation. Traditionally though the Zambian Society believes that disability is as a result of some misfortune in the family, brought about by offending ancestors and witchcraft (Ministry of Community Development and Social Services, 2003).

People with disabilities are considered incapable of doing anything on their own and are therefore denied the opportunity to engage in any meaningful activity (Asliz, 2006). Ignorance, neglect, superstition and fear are some of the social factors that have interfered with the prevention of disability and led to the isolation of persons with disabilities and delayed their development (MOH, 2000).

Legislation pertaining to persons with disabilities dates back to the colonial time. In 1961, the blind person's ordinance was enacted under which the Northern Rhodesia Society of the blind was created to provide services to the blind persons. After independence, the Zambian government decided to have all categories of persons with disabilities covered under one Act of parliament and their affair administered under one umbrella organization (MCDSS, 2000). The persons with disabilities were all referred to as handicapped without being categorized as the blind, physically handicapped, the deaf and the mentally handicapped. The handicapped persons Act was then enacted in 1968 to provide for the establishment of the Zambia council for the handicapped. The council was given the responsibility of providing and facilitating access of persons with disabilities to specialized services. The council was also responsible for co-coordinating

programs for persons with disabilities (MCDSS, 2000). This Act proved to be inadequate to effectively deal with disability issues. The Zambia council for the handicapped was also not providing adequate services to persons with disabilities as expected (Asliz, 2006).

Therefore in November 1996, Government enacted the persons will disabilities Act, No. 33, which provided for the establishment of the Zambia Agency for Persons with Disabilities (ZAPD). The Act also provides for the elimination of all forms of discrimination on the grounds of disability.

The majority of persons with disabilities in Zambia are not able to realize their potential for full integration into the mainstream society. As a result, persons with disabilities have little or no access to their fundamental social, political and economic rights (MCDSS, 2003). As shown in table 2 the exclusion experienced by the people with disabilities is as a result of poor education which has perpetuated stereotypical perceptions of people with disabilities as dependent and in need of care.

Table 2 shows education level of the disabled in Zambia according to the 2000 census of housing and population. The proportion of those who have never attended school is highest among the deaf at about 53.1 percent (CSO, 2000). Table 3 also shows that the proportions of completed levels of education decrease with increasing level among the disabled. The highest proportion of those who completed higher education was among the partially sighted followed by the physically handicapped (CSO. 2000).

**Table 2 Percentage Distribution of Disabled Persons 5 yrs and over, by type of Disability and Level of Education  
Lusaka Province 2000**

Type of Disability	Level of Education Completed					
	Total Number	% Total	No Education	Primary	Secondary	A levels
Total	27 742	100.0	27.9	38.9	24.2	6.2
Blind	1 759	100.0	48.5	27.2	17.7	4.8
Partially sighted	7 831	100.0	22.1	35.9	26.4	10.6
Deaf/Dumb	1 898	100.0	53.1	27.7	16.5	1.7
Hard of Hearing	3 162	100.0	35.9	41.8	17.3	3.4
Mentally ill	2 362	100.0	44.5	33.0	19.2	2.0
Ex mental	873	100.0	25.1	49.3	23.3	1.5
Mentally retarded	1 363	100.0	41.7	39.9	16.1	1.2
Physically handicapped	11 966	100.0	27.4	41.3	24.7	4.7
						2.0

**Source:** CSO, 2000 census of population and housing: Lusaka Province

The next Table 3 shows the status of employment among the disabled in Zambia. The deaf in Zambia are either unemployed and if they are employed the common jobs they do are sales men and women

**TABLE 3 Percentage Distribution of the usually Working Disabled by Type of the Disability and Occupation,  
Lusaka Province**

Type of Disability	Occupation									
	Total No.	% Total	Prof & Tech	Admin & Magt	Clerical Work	Sales Worker	Service Worker	Agric	Production transport	CDE
Blind	110	100.0	10.9	0.9	19.1	12.7	7.3	39.1	8.2	1.8
Partially slighted	2951	100.0	22.0	3.6	5.2	17.8	10.4	24.7	15.5	0.8
Deaf/Dumb	164	100.0	4.3	0.0	3.0	17.1	9.8	50.0	15.9	0.0
Hard of hearing	581	100.0	6.9	0.3	4.1	17.0	14.8	37.5	18.9	0.3
Mentally ill	172	100.0	5.8	0.0	1.2	9.9	8.1	55.2	19.8	0.0
Ex mental	231	100.0	3.9	0.0	2.6	48.5	11.3	18.2	15.2	0.4
Mentally R	186	100.0	7.5	0.0	3.2	17.1	12.8	41.2	17.6	0.5
Physical handicapped	2508	100.0	11.2	1.0	4.1	19.0	11.7	31.9	20.7	0.3
Total	6904	100.0	14.8	2.0	4.6	18.9	11.2	30.2	17.7	0.6

**Source:** CSO, 2000 census of population and housing: Lusaka Province

**Conclusion**

The literature review has shown that the social cultural factors like illiteracy, Unemployment and tradition beliefs have contributed to deaf poor economic status. This could have consequently contributed to their failure to utilize social services like health care.

## **CHAPTER THREE**

### **3.0 RESEARCH METHODOLOGY**

#### **3.1 Introduction**

This chapter presents the research methodology that was used in this study. In discussing the research methodology the focus will be on research design, study setting, study population, sample selection, data collection tools, data collection techniques used in the study. The chapter will also discuss the pilot study, validity and reliability, ethical and cultural considerations

#### **3.2 Research Design**

According to Uys and Basson (2000), a research design is the structural framework or blue print of the study and it guides the researchers in the planning and implementation of the study, while optimal control is achieved over factors that could influence the study.

A non experimental descriptive study design (Treece and Treece, 1986) was used to collect data for this study. This type of study design involves systematic collection and presentation of data to give a clear picture of a particular situation (Uys and Basson, 2000).

#### **3.3 Study Setting**

Research setting is the physical location and conditions in which data collection takes place in a study (Pilot and Hungers, 1997). The study was conducted in Kanyama compound.

Kanyama compound is in the Kanyama clinic catchment area which has a population of about 149 827 people (Kanyama Health Center Statistics, 2004). The site was chosen because that is where a good number of the deaf live in Lusaka Province, and it was easily accessible to the researcher.

### **3.4 Study Population**

A study population is “the total group of individuals or things meeting the designated criteria of interest to the researcher” (Dempsey and Dempsey, 2000). In this study the study population included all the people who are deaf and hard of hearing living in Kanyama compound at the time of the study.

### **3.5 Sample Selection**

Sample selection is “a process of selecting a portion of the population to represent the entire population” (Treece and Treece, 1986). In this study the selection of the sample was done using non probability sampling method (Uys and Basson, 2000). The type of non probability sampling method chosen for the study is the judgemental sampling method (Uys and Basson, 2000).

A judgmental sample is obtained according to the discretion of the researcher or someone who is familiar with the relevant characteristics of the population (Treece and Treece, 1986). The deaf and hard of hearing of between 15 to 60 years were chosen. These included both males and females.

### **3.6 Sample Size**

50 females and males who were deaf and hard of hearing living Kanyama and 10 health workers working at Kanyama Clinic were selected.

### **3.7 Data Collection Tool**

A data collection tool is a devise that is used to collect data (Polit and Hungler, 1997). Data was collected between August and September 2006 in Kanyama compound using a structured questionnaire. The questionnaire had both open ended and closed ended questions. Open ended questions were used to elicit reactions and obtain reasons to certain situations. The open ended questions were used to allow the respondents to provide their opinions and attitudes by allowing them to express themselves rather than giving them definite answers (Treece and Treece, 1986). The researcher utilized a sign language interpreter to

elicit information from the respondents.

### **3.8 Data Collection Technique**

Polit and Hungler (1999) define data collection technique as a procedure of collection of data needed to address a research problem.

During the process of using a questionnaire the researcher

1. Introduced himself as well the sign language interpreter to the respondents in order to make the respondents at ease.
2. Explained the purpose of the study in simple terms to enable the respondents to take part in the research fully informed.
3. Ensured confidentiality by assuring the respondents that the information will only be used for research purpose and that names will not be entered any where.
4. Repeated without indicating the answer with the help of the sign language interpreter the questions which the respondents were having difficulties understanding.

### **3.9 Pilot Study**

A pilot study was done in the first weeks of the research process in Matero Township in Lusaka and at Matero main clinic. According to Polit and Hungler, (1997) a pilot study is a small study or trial run, done in preparation for the major study.

The pilot study was conducted to assess the feasibility of the study design and methodology so that necessary adjustment's can be made. The pilot study will constituted of 10% of the sample size which was 5 respondents among the deaf and hard of hearing and 1 health worker.

However after the pilot study no adjustments were made to the data collecting tool.



### **3.10 Validity and Reliability**

Uys and Basson (2000) define validity as 'the degree to which an instrument measures what it is supposed to measure, it constitutes both internal and external validity. External validity is the extent to which the findings of the research can be generalized to a large population or to a different social, economical and political setting (Uys and Basson, 2000). To ensure external validity the sample size comprised of respondents from different social, economic, political and religious backgrounds.

Internal validity refers to interpretation of the findings within the study or data collected (Uys and Basson, 2000). It seeks to find out if the effect on the dependent variable observed was actually due to the action of the independent variable. Therefore the same questions were asked to all research participants.

Reliability according to Uys and Basson, 2000 refers to "the degree of consistency or accuracy with which an instrument measures this attribute it is designed to measure". Reliability was ensured by use of a structured questionnaire.

### **3.11 Ethical and Cultural Consideration**

Research has to be developed and implemented according to the acceptable ethical standards. Polit and Hungler, (1997) defines ethics as a system of moral values that is concerned with the degree to which research procedure adhere to professional, legal and social obligations to the study participants. For me to conduct the study I sought permission from the following.

1. Head of Department from the University of Zambia, School of Medicine  
Department of Post Basic Nursing.
2. The Director Zambia National Association of the Disabled
3. The Director Lusaka District Management Board
4. Nurse in charge of Kanyama Health Centre
5. Individual research participants

## **CHAPTER FOUR**

### **1.0 DATA ANALYSIS AND PRESENTATION OF FINDINGS**

#### **1.1 INTRODUCTION**

This chapter looks at the presentation of the research data. It concentrates on data analysis and presentation of findings. Data presented in this chapter was collected from 50 respondents who are deaf and hard of hearing and 10 respondents who are health workers at the research setting

#### **1.2 DATA ANALYSIS**

Raw data was collected using a questionnaire, edited for accuracy and completeness and was tallied on a data master sheet. Responses were categorized and coded and analyzed manually with the aid of a calculator.

#### **1.3 PRESENTATION OF FINDINGS**

The findings of the study are presented in graphs and frequency tables. Cross tabulation of variables are used in some tables in order to elicit relationships among certain variables. The presentation of data has been divided in to two parts. Part one has presentation of data from the respondents who are deaf and hard of hearing and part two has presentation of data collected from the health workers

**PART 1: RESPONDENTS WHO ARE DEAF AND HARD OF HEARING**  
**SECTION A DEMOGRAPHIC DATA**

**Table 4, Distribution of respondents by age (n=50)**

Age category (Years)	Frequency	Percentage (%)
16-24	43	86
25-29	3	6
30-34	1	2
35-39	3	6
40+	0	0
<b>TOTAL</b>	<b>50</b>	<b>100</b>

Majority of the respondents, 43 (86%) were in the age range 16 – 24years, 3 (6%) were aged between 25 – 29years, another 3 (6%) were aged between 35 - 39 years, while 1 (2%) was aged between 30 – 34 years. None of the respondents 0 (0%) was aged above 40 years.

**Table 5, Respondents' gender (n=50)**

Gender	Frequency	Percentage (%)
Male	19	38
Female	31	62
<b>TOTAL</b>	<b>50</b>	<b>100</b>

The majority of the respondents 31(62%) were female while 19 (38%) were male

**Table 6, Respondents' Marital status (n=50)**

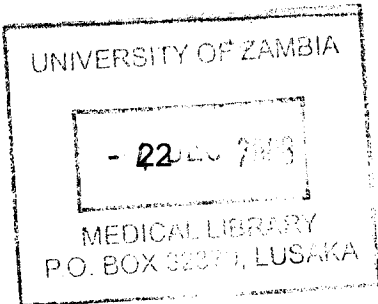
Marital Status	Frequency	Percentage (%)
Single	45	90
Married	4	8
Widowed	1	2
<b>TOTAL</b>	<b>50</b>	<b>100</b>

Most of the respondents 45(90%) were single, 4(8%) were married while 1(2%) was widowed.

**Table 7, Respondent's Level of Education (n=50)**

Level of Education	Frequency	Percentage (%)
Primary	4	8
Secondary	45	90
College	1	2
University	0	0
None	0	0
<b>TOTAL</b>	<b>50</b>	<b>100</b>

All the respondents had some level of education. A large number, 45(90%) of the respondents attained secondary level of education while only 1(2%) attained college level of education 4(8%) had primary education while none 0(0%) had been to university.



**Table 8, Respondents' Employment status (n=50)**

Employment Status	Frequency	Percentage (%)
Formal Employment	5	10
Informal Employment	1	2
Unemployed	44	88
<b>TOTAL</b>	<b>50</b>	<b>100</b>

44(88%) of the respondents were not employed, 5(10%) were in formal employment and 1(2%) was in informal employment.

**Table 9, Respondents' occupation (n=50)**

Occupation	Frequency	Percentage (%)
Marketeer	1	2
Housemaid	1	2
Tailor	1	2
Bricklayer	1	2
Salesman	2	4
None	44	88
<b>TOTAL</b>	<b>50</b>	<b>100</b>

Majority of the respondents 44(88%) have no occupation while 2(4%) were sales persons. 1(2%) was a marketeer, another 1(2%) was a housemaid, another 1(2%) was a tailor while a further 1(2%) was a bricklayer.

**Table 10, Duration of Stay in Kanyama (n=50)**

Duration of stay	Frequency	Percentage (%)
Less than 6 months	4	8
6months-12months	0	0
1year-2years	34	68
Over 2 years	12	24
<b>TOTAL</b>	<b>50</b>	<b>100</b>

The majority of the respondents, 34(68%) had lived in Kanyama compound for a period of 1 to 2 years, while 12(24%) had lived in Kanyama for over 2 years. 4(8%) had lived in Kanyama for a period of less than 6 months while none had lived in Kanyama for a period between 6 months to 12 months

**SECTION B**

**Table 11 Knowledge of Where the Government Clinic is (n=50)**

Location of Government Clinic	Frequency	Percentage (%)
Know where it is	50	100
Does not know where it is	0	0
Not Sure	0	0
<b>Total</b>	<b>50</b>	<b>100</b>

All the respondents, 50(100%) knew where the nearest government clinic was

**Table 12 Distance from Home to Government clinic (n=50)**

Distance	Frequency	Percentage (%)
Less than 30 minutes walk	19	38
Between 30 to 60 minutes walk	27	54
1 to 2 hours walk	4	8
<b>TOTAL</b>	<b>50</b>	<b>100</b>

Most of the respondents 27( 54%) take between 30 to 60 minutes to walk to the government clinic, 19(38%) take less than 30 minutes while 4(8%) take 1 to 2 hours to walk to the government clinic

**Table 13 Free services for the Deaf (n=50)**

Charge	Frequency	Percentage (%)
Knows it is free	3	6
Does not know it is free	47	94
<b>TOTAL</b>	<b>50</b>	<b>100</b>

Majority of the respondents 47(94%) did not know that health services for the deaf and hard of hearing were free while 3(6%) knew that the services were free

**Table 14 HEALTH SERVICES RESPONDENTS WERE FAMILIAR WITH (n=50)**

Service	Frequency	Percentage (%)
Preventive	15	30
Curative	30	60
HIV counseling	1	2
Family Planning and HIV counseling	2	4
Family Planning, Maternity, Antenatal, Post natal and Under 5 clinic	1	2
HIV Counseling and Free ARV	1	2
<b>TOTAL</b>	<b>50</b>	<b>100</b>

Majority of the respondents, 30(60%) are familiar with the curative service at the government clinic, 15(30%) are familiar with Preventive services while 2(4%) are familiar with family planning and HIV Counseling Services. 1(2%) is familiar with HIV Counseling services, another 1(2%) is familiar with the Family Planning, Maternity, Antenatal, Post Natal and Under 5 Services while the other 1(2%) is familiar with the HIV Counseling and the free ARV service



**SECTION C: ACCESSIBILITY AND UTILISATION OF HEALTH SERVICES**

**Table 15 HEALTH SERVICES USED IN THE LAST 6 MONTHS (n=50)**

Service	Frequency	Percentage (%)
Maternity and Antenatal	1	2
Curative and HIV Counseling	1	2
HIV Counseling	2	4
Preventive	15	30
Curative	29	58
Family Planning and HIV Counseling	1	2
Preventive, HIV Counseling and Free ARV	1	2
<b>TOTAL</b>	<b>50</b>	<b>100</b>

Majority of the respondents, 29(58%) have been to a government clinic for Curative services and 15(30%) had been for Preventive services and 2(4%) for HIV Counseling. 1(2%) had utilized the Maternity and Antenatal services another 1(2%) had been for Curative and HIV Counseling services while another 1(2%) had been for Family Planning and HIV Counseling. The remaining 1(2%) had been to a government clinic for Preventive, HIV Counseling and Free ARV

**Table 16, VISITS TO THE CLINIC IN LAST 6 MONTHS (n=50)**

Visits to the Government clinic	Frequency	Percentage (%)
Once in the last 6 months	30	60
Twice in the last 6 months	2	4
More than 2 times in the last 6 months	18	36
None in the last 6 months	0	0
<b>TOTAL</b>	<b>50</b>	<b>100</b>

All the respondents had visited the government clinic in the last 6 months. 30(60%) of the respondents had been to the government clinic once in the last 6 months while 2(4%) had been to the government clinic twice in the last 6 months. 18(36%) had been to a government clinic more than 2 times in the last 6 months and none had never been to the government clinic in the last 6 months

**Table 17, Where they seek Medical Attention (n=50)**

Where they seek medical attention	Frequency	Percentage (%)
Government clinic	42	84
Buy drugs from drug stores	8	16
Consult a traditional healer	0	0
<b>TOTAL</b>	<b>50</b>	<b>100</b>

None of the respondents consulted a traditional healer when they were sick. Majority of them, 42(84%) went to the government clinic when they were sick while 8(16%) bought drugs from drug stores.

**Table 18, Communication with Health Workers (n=50)**

Type of Communication	Frequency	Percentage (%)
Used sign language	1	2
Wrote on a piece of paper	49	98
The health worker guessed the complaint	-	-
<b>Total</b>	<b>50</b>	<b>100</b>

49(98%) of the respondents wrote their complaints on a piece of paper when communicating with the health workers, while 1(2%) used sign language. None made the health worker guess their complaints

**Table 19 Satisfaction of the services received at Government Clinic (n=50)**

Satisfaction	Frequency	Percentage (%)
Satisfied with the services	1	2
Not Satisfied with the services	49	98
<b>TOTAL</b>	<b>50</b>	<b>100</b>

The majority of the respondents, 49(98%) were not satisfied with the service they received at the government clinic and only 1(2%) of the respondents showed satisfaction with the service.

**Table 20 Respondents views on what should be done to help the deaf access health facilities (n=50)**

<b>What should be done</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Teach health workers sign language	50	100
Provide sign language interpreters at clinics	0	0
Does not know	0	0
<b>Total</b>	<b>50</b>	<b>100</b>

All the respondents 50(100%) thought teaching the health workers sign language can help the deaf access health services

**PART 2 RESPONSES FROM HEALTH WORKERS (n=10)**

**Table 21 Health workers Ranks n=10**

<b>Rank of Health workers</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Nurses	3	30
Clinical Officers	7	70
Medical Doctors	0	0
<b>TOTALS</b>	<b>10</b>	<b>100</b>

Majority of the respondents, 7(70%) were clinical officers while 3(30%) were nurses and none 0(0%) of the respondents was a medical doctor

**Table 22 Health workers views of what should be done to ease communication with the deaf n=10**

<b>What should be done</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Teach health workers sign language	10	100
Does not know	0	0
<b>Total</b>	<b>10</b>	<b>100</b>

All the health workers, 10(100%) thought teaching the health workers sign language will help improve services for the deaf and hard of hearing

**Table 23 Health workers willingness to learn sign language n=10**

<b>Willingness to learn Sign Language</b>	<b>Frequency</b>	<b>Percentage (%)</b>
Willing to learn sign language	10	100
Not willing to learn sign language	0	0
<b>Total</b>	<b>10</b>	<b>100</b>

All the health workers, 10(100%) who took part in the research were willing to learn sign language

CROSS TABULATIONS

Table 24 Type of communication with Health workers (table 18) in relation to satisfaction of the service received (table 19) (n=50)

Satisfaction with services	Type of communication used			Total
	Used sign language	Wrote on a piece of paper	The health worker guessed the complaint	
Satisfied	1 (2%)	-	-	1 (2%)
Not satisfied	-	49 (98%)	-	49 (98%)
Total	1 (2%)	49 (98%)	-	50 (100%)

The majority of the respondents, 49(98%) who communicated with the health workers by writing on a piece of paper were not satisfied with the service they received at the government clinic, while the 1(2%) who used sign language was satisfied with the service received.

**Table 25 Type of Communication with the health worker (table 18) In relation to the knowledge that the health services are free for the deaf (table 13) n=50**

Knowledge of the cost of service	Type of communication			Total
	Used sign language	Wrote on a piece of paper	The health worker just guessed	
Aware that the services are free	1 (2%)	2 (4%)	-	3 (6%)
Not aware that the services are free	-	47 (94%)	-	47 (94%)
Total	1 (2%)	49 (98%)	-	50 (100%)

The 1(2%) respondent who used sign language knew that the health services were free and another 2(4%) of those who communicated with the health worker by writing on a piece of paper also knew that the health services were free, 47(94%) of the respondents who communicated by writing on a piece of paper were not aware that the health services are free for the deaf and hard of hearing

**Table 26 Level of education (table 7) in relation to employment (table 8)**  
**n=50**

<b>Level of education</b>	<b>Employment status</b>			<b>Total</b>
	<b>Formally employed</b>	<b>Informal employment</b>	<b>unemployed</b>	
<b>None</b>	-	-	-	-
<b>Primary</b>	-	-	4 (8%)	4 (8%)
<b>Secondary</b>	5 (10%)		40 (80%)	45 (90%)
<b>College</b>	-	1 (2%)	-	1 (2%)
<b>University</b>	-	-	-	-
<b>Total</b>	<b>5 (10%)</b>	<b>1 (2%)</b>	<b>44 (88%)</b>	<b>50 (100%)</b>

5(10%) of the respondents who had a secondary education were in formal employment, while 40(80%) were unemployed; the 1(2%) respondent who had a college education was in informal employment. All the 4(8%) with primary education were not employed



**Table 27 Level of education (table 7) in relation to knowledge that health services are free for the deaf (table 13) n=50**

Level of Education	Knowledge that the health services are free		Total
	Know that the health services are free	Do not know that the health services are free	
None	-	-	-
Primary	-	4 (8%)	4 (8%)
Secondary	2(4%)	43 (86%)	45 (90%)
College	1 (2%)	-	1 (2%)
Total	3 (6%)	47 (94%)	50(100%)

2(4%) respondents with secondary education knew that the health services for the deaf and hard of hearing were free while 43 (86%) did not know that health services for the deaf and hard of hearing are free. The 1(2%) respondent with college education knew that the services were free while all those with primary education 4(8%) did not know and those with primary education 4(8%) also did not know

**Table 28 Level of Education (table 7) in relation to number of visit to a government clinic in the last 6 months (table 16) n=50**

Level of Education	Visits to the government clinic in the last 6 months				Total
	None	Once	Twice	More than twice	
None	-	-	-	-	-
Primary	-	4 (8%)	-	-	4 (8%)
Secondary	-	26 (52%)	2 (4%)	17 (34%)	45 (90%)
College	-	-	-	1 (2%)	1 (2%)
University	-	-	-	-	-
Total	-	30 (60%)	2 (4%)	18 (36%)	50 (100%)

26(52%) of the respondents with secondary education had been to the government clinic once in the last 6 months, 2(4%) had been there twice while 17(34%) had been to the clinic more than twice. The 1(2%) respondent with college education had also been to the clinic more than 2 times while all the 4(8%) with primary education had been to the clinic only once

## **CHAPTER FIVE**

### **5.0 DISCUSSION OF THE FINDINGS**

#### **5.1 INTRODUCTION**

This chapter discusses the findings of the research. Data was collected from the 50 deaf and hard of hearing respondents and 10 health workers it was analyzed and the findings are discussed in this chapter.

The chapter also discusses the characteristics of the sample, recommendations to be made, limitation of the study and the dissemination of the findings.

#### **5.2 CHARACTERISTICS OF THE SAMPLE**

The respondents were in two categories one category was of the respondents who are deaf and hard of hearing and the second category was a category of respondents who are health workers at Kanyama clinic.

The age range for the participants who are deaf and hard of hearing was from 16 years to 39 years. The mean age range and modal age range was 16-24 years. According to the Census of population 2000 (CSO 2000), 50% of the deaf and hard of hearing in Lusaka Province are aged between 16-24 years.

The participants were all coming from Kanyama compound. They had lived in Kanyama for a period ranging from 6 months to over 2 years. There were more female who took part in the study 31(62%) as compared to the males 19(38%) table5. This finding is consistent with the Zambian general population characteristic which indicates that 52% of the general population is female (CSO 2000). The dominant religion among the respondents was Christianity.

The other characteristic worthy noting is the education level. The participants had different education levels. These included; college, secondary education, and

primary education. All the respondents had some level of education (table 7). A large number, 45(90%) of the respondents attained secondary level of education while only 1(2%) attained college level of education 4(8%) had primary education. There was no participant with university education.

44(88%) of the respondents had no occupation despite them having formal education of up to secondary school. Only 6(12%) had an occupation. However, even the six with occupations, the type of occupation they had did not permit them to earn a good salary. They were either, marketers, housemaids, tailors, bricklayers or salesmen. This implies that economically they are dependant on their parents or guardians.

The majority of the health workers who participated in the study, 7(70%) were clinical officers 7(70%) and only 3(30%) were nurses. This is because it is mainly the clinical officers who screen patients in the out patient department. There was no respondent who was a medical doctor because the clinic has no permanent medical doctor.

## **5.3 DISCUSSION OF EACH VARIABLE**

### **5.3.1 Knowledge**

Having knowledge about the services offered by the government is an important step towards utilizing the service. In the study the respondents were asked to tick the service or services they were familiar with. The results showed that all the respondents were familiar with at least one service provided at a government clinic. The service which was well known among the deaf and hard of hearing was the curative service; it was mentioned by 30(60%) respondents.

The second most common service was the preventive service which was known by 15(30%), while 2(4%) are familiar with family planning and HIV counseling services. 1(2%) was familiar with HIV counseling services, another 1(2%) was familiar with the family planning, maternity, antenatal, post natal and under five

services while the other 1(2%) was familiar with the HIV counseling and the free ARV service.

All the deaf and hard of hearing respondents had knowledge as to where the nearest government clinic was (table 11). In fact all the respondents were able to estimate the distance from their home to the nearest government clinic (table 12). But the problem came when they were asked whether they knew that the health services were free for the deaf and hard of hearing at government clinic. Only 3(6%) knew that the services were free for the deaf and hard of hearing (table 13). 47(94%) did not know that the services were free.

This revelation is against the background that all the respondents had visited the government clinic at least once in the last 6 months. 30(60%) of the respondents had been to the government clinic once in the last 6 months while 2(4%) had been to the government clinic twice in the last 6 months. 18(36%) had been to a government clinic more than 2 times in the last 6 months.

It was surprising to note that the deaf and hard of hearing did not know that the services at the government clinic were free and yet they had been to the clinic in the last 6 months. This indicates that the deaf and hard of hearing were charged for the services they were suppose to get free from the government clinic.

**5.3.2 ATTITUDE**

The deaf and hard of hearing's attitude towards services at government clinic was also assessed. The respondents were asked to state where they go when they are sick or what they do when they fell sick. The results (table 17) revealed that the majority, 42(84%) went to the government clinic when sick, while 8(16%) opted to buy drugs from a pharmacy. No one consulted a traditional healer when sick. The study showed that the deaf and hard of hearing had good attitude towards health services.

Despite the deaf and hard of hearing good attitude towards health services some services remained underutilized. Considering that the mean age range of the respondents is 16 – 24, which is the peak of the reproductive age, it shows only 5(10%) used HIV counseling services in the last 6 months. This could be due to fears of possible lack of confidentiality.

All the health workers who took part in the study did not know sign language though they were all willing to learn (table 23). This finding was consistent with the Association of sign language interpreters of Zambia who stated in their position paper that absence of counselors in HIV familiar with sign language is contributing to the deaf and hard of hearing underutilizing this service (ASLIZ, 2006)

The deaf and hard of hearing's attitudes towards health services were also assessed from the way they rated their satisfaction levels. The results showed that only 1(2%) respondent was satisfied with the service received at the government clinic while 49(98%) were not satisfied (table 18). The respondent who was satisfied with the service was the one who used sign language to communicate with the health workers. All the ones who were not satisfied with the service were those who wrote their complaints on a piece of paper to communicate with the workers.

This finding shows that there is a direct link between the type of communication used to communicate with the health worker and satisfaction level (table 24)

### **5.3.3 PRACTICE**

The practice of the deaf and hard of hearing was assessed. Although the majority, 42(84) of the deaf and hard of hearing came to a government clinic when they were sick, their efforts to receive desired care were hampered by poor communication between themselves and the health workers.

It is estimated that 99% of urban population in Lusaka live within 5 Km of a health facility or within 1 hour walk to health facility (WHO, 2005). This is consistent with what the study revealed. Therefore going by this definition almost everyone in urban Lusaka has access to a health facility.

But in case of the deaf and hard of hearing they have access to a building and not the health service because even after reaching the health facility they can not access the health service because of communication barrier. The barrier of communication is stronger than physical barrier (Zambia Daily Mail, 2006) because it is invisible and it exerts occult pressure.

For the sake of the deaf and hard of hearing there is a need to redefine accessibility of health services. The current definition using distance or time taken to reach a health facility is not comprehensive enough.

One of the three respondents who knew that the health services were free for the deaf and hard of hearing was the one who used sign language to communicate with the health worker (table 24) and the only respondent who showed satisfaction with the health services (table 25). The education level of the respondents did improve the practice and knowledge. Furthermore 3(6%) who knew that the health services were free had a secondary level of education and one had college level of education. However it is important to note that the respondents with secondary level of education who knew that the health services were free was negligible 2(4%) as compared to those who did not know, 43(86).

This means that communication still remains the strongest factor in determining satisfaction of health services received by the deaf and hard of hearing. However education did not seem to contribute so much to the utilization of health services. This can be deduced from the fact that all the respondents including those with primary education did utilize health services in the last 6 months (table 15). This disproves the hypothesis that education can help improve utilization of health

services by the deaf and hard of hearing. What seems to be a problem is not the underutilization of health services but the satisfaction of the service received (table 19).

Practice was affected by the lack of health workers who knew sign language. This can be ascertained by the response the respondents gave when they were asked to suggest what should be done to improve health services for the deaf and hard of hearing. All the respondents thought that if health workers were taught sign language that can go a long way in improving health services for the deaf and hard of hearing (table 20). In fact even the health workers thought the same. All the health workers were willing to learn sign so that they can improve the delivery of health services to the deaf and hard of hearing (table 23).

#### **5.4 IMPLICATIONS ON HEALTH CARE SYSTEM**

The study has a number of implications on the health care delivery. The study revealed that the deaf and hard of hearing have knowledge on health services and they utilize health services. But the services they receives did not satisfy them because of communication barrier between themselves and the health workers.

Therefore the health workers in the delivery of health services have to try to learn sign language so that they provide quality health care. There is also need to re look at that the definition of access to health services. The definition of access using distance and time between health facility and the client's home do not favor the deaf and hard of hearing. Because after physically accessing the health facility they are encountered with another barrier between themselves and the service providers. This barrier is communication.

The other implication on the health care delivery system is that there is need for more research to be done to ascertain the health needs for the deaf and hard of hearing.



Administrators in health have to ensure that they adhere to the policies in place as regards the deaf and hard of hearing. It was surprising to note that despite the fact that the deaf and hard of hearing having used the health services in the last 6 months the majority did not know that the services were free. This means that they were made to pay for the service which is suppose to be free.

## **5.5 CONCLUSION**

The study revealed that there is a misconception that the deaf and hard of hearing are underutilizing health service. The study findings showed that the deaf and hard of hearing actually utilize health service but what seem to a problem is the quality of the service they receive. The deaf and hard of hearing are not satisfied by the services they receive at the government clinic.

Poor communication between the deaf and hard of hearing was the major reason the satisfaction levels were affected. The deaf and hard of hearing feel the quality of the service they receive can be improved if the health workers were oriented to sign language. The health showed willingness to learn sign so that they can improve the quality of health care they give to the deaf and hard of hearing clients.

The main object of the study was to determine factors that influence the under utilization of health services by the deaf and hard of hearing in Kanyama compound. However, the study revealed that there was no underutilization instead the quality of the service rendered was poor.

The study also revealed that the attitude of the deaf and hard of hearing towards health services was good. This was seen from the fact that majority of them went to the government clinic when they fell ill and only a small number opted to purchase drugs from the drug stores.

The knowledge of the deaf and hard of hearing towards health services was also good. They all knew where the nearest government clinic was in their vicinity.

Actually they were all able to estimate the distance between where they live and the government clinic in terms of time. They also had knowledge of at least one service offered by the government clinic.

The practice was also good in that in the last 6 months all the respondents who took part in study had utilized the government clinic. All the services offered by the government clinic were all utilized by the deaf and hard of hearing.

## **5.6 RECOMMENDATIONS**

1. The government should help train health workers in sign language especially in areas where the numbers of the deaf and hard of hearing are high to ease communication. In the mean time while government is looking at means of training health workers in sign language, Sign language interpreters can be trained in HIV/AIDS counseling skills so that they can assist in counseling the deaf and hard of hearing
2. The Ministry of Health and the Ministry of Community Development and Social Welfare to coordinate their activities when dealing with the health issues of the deaf and hard of hearing. Information should be disseminated to them in sign language to them
3. The government to fund more research in the study of the health needs of the deaf and hard of hearing.

## **5.7 DISSEMINATION OF FINDINGS**

A bound report of the research will be submitted to the Department of Post Basic Nursing in the School of Medicine to serve as reference to other researches.

Another bound report will be submitted to the library, School of Medicine. The executive summary report will be sent to the stakeholders like Zambia Association of the Disabled, Ministry of Community Development and Social

Welfare and Association of Sign Language Interpreters of Zambia. A bound report will also be sent to my sponsor Ministry of Health and finally a meeting with the health staff in Lusaka Urban District Health Management Board.

## **5.8 LIMITATIONS OF THE STUDY**

**5.8.1** The funds and time allocated to carry out the study was not adequate. This affected sample size, the results in this study can not be generalized.

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**APPENDIX 1**

**QUESTIONNAIRE (TO BE ANSWERED BY THE DEAF)**

**UNIVERSITY OF ZAMBIA  
SCHOOL OF MEDICINE  
DEPARTMENT OF NURSING**

**DATE OF INTERVIEW:**.....

**QUESTIONNAIRE NUMBER:**

**INSTRUCTIONS**

1. Introduce yourself to the respondent
2. Explain the purpose of the study
3. do not write the names of the respondents on the questionnaire
4. Please ensure that all the questions are answered
5. Please tick (Ö ) the appropriate answers using the boxes provided and write the comments in the space provided
6. Assure the respondent that the information given will be treated as confidential
7. Thank the respondent at the end of each interview

**SECTION A:**  
**DEMOGRAPHIC DATA**

FOR OFFICIAL  
USE ONLY

1. How old were you on your last birthday?
  - a) 16- 24 Yrs
  - b) 25-29 Yrs
  - c) 30-34 Yrs
  - d) 35-39 Yrs
  - e) 40+ Yrs
  
2. What is your gender?
  - a) Male
  - b) Female
  
3. What is your marital status?
  - a) Single
  - b) Married
  - c) Divorced
  - d) Widowed
  - e) Separated
  
4. If married how many children do you have? \_\_\_\_\_
  
5. What is your religion?
  - a) Christian
  - b) Buddhist
  - c) Muslim
  - d) Other specify \_\_\_\_\_

6. If Christian what is your Denomination?
- a) Catholic
  - b) United Church of Zambia
  - c) Pentecostal
  - d) Other specify \_\_\_\_\_
7. What is your education level?
- a) Primary
  - b) Secondary
  - c) College
  - d) University
  - e) None
8. Are you in formal employment?
- a) Yes
  - b) No
9. What is your occupation? \_\_\_\_\_
10. If you are not in formal employment what do you do to earn a living? \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
11. How long have you lived in Kanyama Compound?
- a) Less than 6 months
  - b) 6-12 months
  - c) 1-2 years



## **SECTION B: KNOWLEDGE OF HEALTH SERVICES**

12. Do you know where the nearest government clinic is?

- a) Yes
- b) No

13. How long does it take you to walk to the nearest government clinic from your home?

- a) Less than 30 minutes
- b) Between 30 minutes - 60 minutes
- c) Between 1hour - 2hours

14. Are you aware that people who are deaf and hard of hearing are suppose to receive free medical services at all government clinics?

- a) Yes
- b) No

15. Which of the following health services are you familiar with?  
(TICK all that is applicable)

- a) Curative services
- b) Preventive services
- c) Family planning services
- d) Maternity services
- e) Antenatal services
- f) Postnatal services
- g) Under 5 services
- h) HIV Counseling
- i) Free ARV'S

## **SECTION C: ACCESSIBILITY AND UTILISATION OF HEALTH SERVICES**

16. Which of the following health services have you used in the last 6 months?

(TICK all that is applicable)

- a) Curative services
- b) Preventive services
- c) Family planning services
- d) Maternity services
- e) Antenatal services
- f) Postnatal services
- g) Under 5 services
- h) HIV Counseling
- i) Free ARV'S

17. How many times have you been to the government clinic in the last 6 months?

- a) Once
- b) Twice
- c) Numerous times
- d) None

18. When you are sick where do you go to ask for treatment?

- a) Government clinic
- b) Friend
- c) Buy drugs from the chemist
- d) Other specify \_\_\_\_\_

19. If you had gone to a government clinic how did you communicate with the health workers?

- a) Used sign language
- b) Wrote on a piece of paper
- c) The health worker just guessed my complaint
- d) Other specify.....

20. Are you happy with the health services offered by the government clinics?

- a) Yes
- b) No

If No please explain \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

21. What should be done by government to make health services more available to the Deaf?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

22. What should be done by health workers to make health services more accessible to the deaf?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**APPENDIX 2**  
**QUESTIONNAIRE (TO BE ANSWERED BY THE HEALTH WORKERS)**

**UNIVERSITY OF ZAMBIA**  
**SCHOOL OF MEDICINE**  
**DEPARTMENT OF NURSING**

DATE OF INTERVIEW:.....

QUESTIONNAIRE NUMBER:

**INSTRUCTIONS**

- 1. Do not write your name on the questionnaire
- 2. Answer all the questions
- 3. Please tick (Ö ) the appropriate answer using the boxes and write comments in the space provided
- 4. The information given will be treated as confidential

## SECTION A: GENERAL INFORMATION

**FOR  
OFFICIAL  
USE ONLY**

1. How old are you?
  - a) 20-30 years
  - b) 31-40years
  - c) 41-50years
  - d) Over 51years
  
2. State your rank
  - a) Nurse
  - b) Clinical officer
  - c) Doctor
  
3. How long have you been working at Kanyama clinic
  - a) Less than 6 months
  - b) 6-12 months
  - c) Over 1 year
  
4. Have you ever attended to a deaf person or a  
Person hard of hearing
  - a) Yes
  - b) No
  
5. Do you know sign language?
  - a) Yes
  - b) No

6. If you have attended to a deaf person and a person hard of hearing Before, how did you communicate?

- a) Used sign language
- b) Wrote on a piece of paper
- c) Other specify \_\_\_\_\_

## SECTION B: ATTITUDE OF HEALTH WORKERS

7. What should be done to help the deaf and hard of hearing accessible health services

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8. If you were offered a chance to learn sign language would you do it?

- a) Yes
- b) No

9. If yes to question 8 state the reason

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10. If no to question 8 state the reason

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**THANK YOU FOR TAKING PART IN THE STUDY**

### APPENDIX 3 WORK PLAN

<b>Task to be performed</b>	<b>Responsible person</b>	<b>Dates</b>	<b>Time required</b>
Literature Review	Researcher & Supervisor	Continuous	Continuous
Compiling Research Proposal	Researcher	18th April 2006 to 14th August 2006	16 Weeks
Clearance	Researcher	19th June 2006 to 31st July 2006	6 Weeks
Pilot study	Researcher	21st August to 25th August 2006	5 days
Data collection	Researcher	28th August 2006 to 15th September 2006	3 Weeks
Data Analysis	Researcher	18th September 2006 to 13th October 2006	4 Weeks
Report Writing	Researcher	16th October 2006 to 15th December 2006	8 Weeks
Draft Report	Researcher	18th December 2006 to 31st December 2006	2 Weeks
Finalization of Report	Researcher	1st January 2007 to 9th February 2007	5 Weeks
Monitoring & evaluation	Researcher & Supervisor	Continuous	Continuous
Dissemination of Results	Researcher	12th February 2006 to 31 March 2006	7 Weeks



## APPENDIX 5

### Budget

BUDGET CATEGORY	UNIT	UNIT COST (K)	QTY	TOTAL (K)
<b>Stationery</b>				
(a) Duplicating Paper	Ream	25,000.00	4	100,000.00
(b) Pens	Each	1,000.00	4	4,000.00
(c) Pencil	Each	500.00	4	2,000.00
(e) Note books	Each	500.00	4	2,000.00
(f) Tipex	Box	8,000.00	2	16,000.00
(g) Staplers	Each	20,000.00	2	40,000.00
(h) Box of Staples	Box	5,000.00	1	5,000.00
(j) Scientific calculator	Each	60,000.00	1	60,000.00
(k) Flip chart	Each	45,000.00	1	45,000.00
(l) Markers	Each	3,000.00	4	12,000.00
<b>Subtotal</b>				<b>286,000.00</b>
<b>Personnel</b>				
(a) Lunch Allowance (i) Researcher	Days	50,000.00	10	500,000.00
(ii) Research Assistant	Days	50,000.00	10	500,000.00
(b) Transport	Days	30,000.00	10	300,000.00
<b>Subtotal</b>				<b>1,300,000.00</b>
<b>Secretarial Services</b>				
(a) Diskettes	Each	3,000.00	10	30,000.00
(c) Questionnaire typing	Pages	2,000.00	10	20,000.00
(d) Questionnaire photocopying	Pages	200.00	600	120,000.00
(e) Research Report Writing	Pages	3,000.00	100	300,000.00
(f) Research Report photocopying	Pages	300.00	500	150,000.00
(g) Typing and binding Proposal	Each	350,000.00	1	350,000.00
(h) Binding Report	Each	75,000.00	5	375,000.00
<b>Subtotal</b>				<b>1,345,000.00</b>
Hall Hire for dissemination	Each	100,000.00	1	100,000.00
LCD Hire dissemination	Each	150,000.00	1	150,000.00
Refreshments	Each	20,000.00	60	1,200,000.00
<b>Subtotal</b>				<b>1,450,000.00</b>
<b>Total</b>				<b>4,381,000.00</b>
<b>Contingency 10%</b>				<b>438,100.00</b>
<b>GRAND TOTAL</b>				<b>4,819,100.00</b>

## **APPENDIX 6**

### **BUDGET JUSTIFICATION**

#### **1. STATIONERY**

Stationery is required for typing the research proposal, writing the final research report as well as typing and printing the report. The notebooks are needed for record keeping during data collection and analysis. The scientific calculator is required for data analysis. . The stapler and staples are needed to put papers together and to maintain their proper arrangement.

#### **2. SECRETARIAL SERVICES**

There will be need for funds to cater for the typing and photocopying services. Diskettes will be required for data storage. The research bags are needed for carrying the interview schedules. Money is also required for binding the research proposal and report.

#### **3. PERSONNEL**

Funds for transport will be required to move to and from the area of data collection. There will also be need for lunch allowance during the data collection period.

#### **4. CONTINGENCY**

Contingency is the 10% of the total amount of the budget. It is required to cater for any unseen expenses during the research.

#### **5. DISSEMINATION WORKSHOP**

The dissemination workshop will be required to communicate the research



**THE UNIVERSITY OF ZAMBIA  
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Lusaka

15<sup>th</sup> June 2006.

The Director,  
Zambia Agency for people with disabilities,  
Plot 488/7B,  
Leopards Hill Road,  
P. O. Box 50073,  
**LUSAKA**

Dear Sir,

**Re: Mr. Eric Chisupa – Computer Number 23000198.**

The above mentioned and bearer of this letter is a 4<sup>th</sup> year student at the University of Zambia, School of Medicine, Department of Post Basic Nursing. He is currently writing a research proposal entitled 'Factors contributing to the under utilization of health services by the deaf in Kanyama compound. He is required to search for information related to this topic.

The Department will be most grateful if your Organization can give Eric the necessary assistance he may require.

Thanking you in advance for the anticipated support and assistance.

Yours sincerely,

*Concepta N. Kwaleyela*

Concepta N. Kwaleyela (Ms.)

**Lecturer (UNZA) - Research Supervisor**