Lived Experiences of Learners with Hearing Impairment at Musakanya combined School in Mpika District: Focus on Access to Health Services

By

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A Dissertation Submitted to the University of Zambia in Partial Fulfilment of the Requirements for the Award of the Degree of Master of Education in Special Education

University of Zambia

Lusaka

2021

AUTHORS DECLARATION

I, Sichilindi Bevin.M, do hereby solemnly declare that this dissertation represents my own work and that it has never been previously submitted for a degree at the University of Zambia or at any other University.

Signed (Candidate): …………………………………….. Date: ……………………………

Signed (Supervisor): …………………………………….. Date: ……………………………

<h1 align="center">CERTIFICATE OF APPROVAL</h1>

This dissertation of Sichilindi Bevin.M is approved as fulfilling part of the requirements for the award of the degree of a Master of Education in Special Education of the University of Zambia.

Examiner 1

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ABSTRACT

This study focuses on lived experiences of learners with Hearing Impairments (LwHI) when accessing health services in Zambia. From the evidence from the health institution records showed that a significantly low number visit health institution for health issues.

The research objectives that guided this study were to:

i.   explore lived experiences of learners with hearing impairment when accessing health services,

ii. describe the effects of poor health services on academic performance of learners with hearing impairment and

iii. explore supported strategies in use to improve access to health services for learners with hearing impairment or deaf people.

A qualitative methodology driven by Hermeneutics Phenomenology research design was applied. In addition, purposive sampling technique was used to enlist Ten LwHI to participate in this study. Participants volunteered to voice their lived experiences and clusters of themes emerged thereafter. Emergent from the lived experiences of LwHI were the lived experiences of LwHI when accessing health services, poor health services Vs academic performance of LwHI and improving access to health services for LwHI that represent their felt worlds while at Musakanya combined school.

The findings of the study revealed that most of the LwHI health services were unmet due to inaccessibility to better health services caused by poor communication, wrong diagnosis, lack of privacy and confidentiality, discrimination, inadequate medical vocabulary for signs, poor health education, Limited Institutional support staff and Negative attitude.

The study also unearthed that LwHI experienced poor health services which resulted into poor academic performance due to absenteeism, prolonged admission at hospitals and low self-esteem leading to dropping out of school. The study also looked at the strategies to use to improve access to health services for LwHI or deaf people such as sensitization of health workers, involvement of LwHI in decision making, licensed professional interpreters, mandatory sign language training for health workers, use of assistive technology devices, extra time for medical consultation and universal sign language dictionary.

Based on the findings of the current study, the researcher provides eight (8) recommendations among which include: inclusive policy, active involvement, communication, mandatory training of sign language to health workers, assistive technology, employ specialist interpreters, separate counter for hearing impaired and improve on health education.

Key Words: Lived Experiences, Hearing Impairment, Health Services

DEDICATION

I dedicate this work to my father Mr Sichilindi Misheck, my beloved mother, Nangogo Steria who have been a source of inspiration and encouragement throughout my life. Thank you so much for your endless support.

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ABBREVIATION AND ACRONYMS

LwHI …………………….… Learners with Hearing Impairment.

HI …………………..……. Hearing impairments

FGDs ……………………….. Focus Group Discussions

WHO ………………………. World health organization.

UNCRPD …………………... United Nation Convention and Rights for People with Disabilities

VCTs ……………………….… Voluntary Counselling and Testing Services.

DEFINITION OF KEY TERMS

Accessibility- Equal and equitable access for all students within a university environment as it pertained to "the physical and online environment...information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public (United Nations, 2006, Article 9).

CRPD- Convention on Rights for Persons with Disabilities

Deaf- Complete loss of hearing.

Hearing impairment-Refers to impairment in hearing, whether permanent or fluctuating, that adversely affects a child's educational performance (Mahwish: 2012).

Health services - Are services that provide medical treatment, care and information to the public or a particular group (Smith, et al: 2004).

Hermeneutics- The interpretations and meaning LwHI give to their daily lived experiences while pursuing higher education.

Lived Experience - First-hand accounts and impressions of living as a students with hearing impairment while in and out of school.

Special school- A special school is a school catering for students with disabilities that needs special service e.g. learning difficulties, physical disabilities or behavioral problems.

Sign language- is a natural language of the deaf, found all over the world which employs signs made by moving the hands.

Phenomenology - A research approach focusing on people's lived experiences comprising the daily activities, thoughts and impressions of an individual's world within a specific context.

CHAPTER ONE

INTRODUCTION

1.1 Overview

Chapter one introduces the topics of study. It highlights the background of the study, statement of problem, purpose of study, general objective and specific objectives, research questions and the significance of the study. Furthermore this chapter looks at the delimitation of the study, limitations of study and finally the operational definition of key terms used. Thereafter, follows chapter two with literature review and finally look at methodology which will be used to collect data.

1.2 Background to the study.

Barnett et.al (2011) states that the term hearing loss covers all the degree of hearing impairment from slight to deafness. There are three major types of hearing loss namely conductive hearing loss, Sensory neural hearing loss and mixed hearing loss. However, medical and educational definitions of deafness and hearing loss are similar. Deafness and hearing loss are based on audio logical measurement of an individual's ability to hear sound of different levels of pitch and loudness. Specialists compare these measurements with average hearing levels to determine the extent of an individual's hearing loss.

WHO (2011) reports that a person's environment has a huge impact on the experience and extent of disability. Inaccessible environments create disability by creating barriers to participation and inclusion. Examples of the possible negative impact of the environment include a Deaf individual without a sign language interpreter. It is not very well known how many learners born with hearing loss have bad experience in accessing health service. The main problem is how to communicate with health workers such as Doctors, clinical officers, nurses and others. Health workers are always unsuccessful to convey their message to their patient in sign language and this leaves a gap between the children with hearing impaired and the health workers in Zambia. Chiluba & Njapawu, (2019) reported that the problem of hearing impaired learner or deaf people failing to get good medical services has been in existence for a long time and deaf people have been neglected in many ways. Kehl & Gartner (2010) revealed that some learners/people with hearing impairment have died while other have poor health not that they did not know where the hospital is but because they were not attended to properly hence ends up hating the hospital and its services. Hearing impaired would also like their medical services be met but this experience is very rarely to be found in Zambia.

Basic transactions like making a routine appointment proved difficult for many deaf people who found it difficult to book appointments unless they physically visited their doctor's practice. Even more concerning is their inability to book an emergency appointment as they did not know how to do so. Besides that, healthcare professionals do not automatically offer the opportunity to have an interpreter present, so when deaf people attend for appointments, a British Sign Language interpreter was often not present, either because the interpreter had not shown up or the healthcare professional had not booked communications support, preferring to rely on notes. Deaf people also faced difficulties in understanding healthcare correspondence, citing difficulties with the complicated wording of the letter, which often asked for a telephone response. Healthcare professionals need to obtain information and give advice and patients need to ask questions and share their concerns. However, when deaf people attend for consultation, they said they only understand 'some' of the information communicated to them, resulting in a limited understanding of their medical condition.

Hearing impaired persons versus health care studies conducted by world health organization have highlighted that there is a significant lack of knowledge of how hearing impaired individuals suffer inequalities in accessing information within the healthcare service. This is caused by healthcare professionals not possessing adequate knowledge and appreciation of deaf awareness, which has resulted in some serious implications, highlighted in the research and the case studies included in this report (WHO:2011).

The consequences of failed communication between health workers and learners with hearing impairment could lead to wrong diagnosis and prescription of medicine, frustration on both sides; health workers and learners with hearing impairment since they cannot communicate and establish the problem and   if poor health prolongs can even claim lives of HI learners. Despite that, learners with poor health usually miss lessons which highly affect their academic performance since they are always in and out of the hospital. This is because the real cause of illness is wrongly treated and leads to deteriorated life.

World report on disability (2011) states that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. It is important to note that no one should be left behind regardless of the disability where accessibility of health services are concerned and it's a right of every child to access free medical services and care as enshrined in convention on Rights of Persons with Disabilities 2012.

Therefore, this research aims at finding out a gap in lived experiences of learners with hearing impairment when accessing health services at Musakanya special unit in Mpika district. This was done by interviewing hearing impaired learners at Musakanya Special Unit School. The purpose of this research was to explore the lived experiences of learners with hearing impairment when accessing health services at the hospital.

1.3 Statement of the problem

Despite Zambia being a signatory to various policies such as CRPD, disability act 2012 and others with the view of promoting their full participation and accessibility in the society, little has been done in the health sector as a result Hearing Impaired learners are still struggling to access health services on equal basis with non-HI learners because health workers up today lacks sign language skill and also qualified interpreters are not employed to link medical workers with HI learners. However, this research aimed at exploring lived experiences of learners with hearing impairment when accessing health services.

1.4 Purpose of the study

The purpose of study was to explore the lived experiences of learners with hearing impairment when accessing health services.

1.5 Specific Objectives

The study was guided by the following research objectives:

i. To explore lived experiences of learners with hearing impairment when accessing health services.

ii. To describe the effects of poor health services on academic performance of learners with hearing impairment.

iii. To explore supported strategies in use to improve access to health services for learners with hearing impairment or deaf people

1.6 Research questions

The study was guided by the following research questions:

i. What are the lived experiences of learners with hearing impairment when accessing health services?

ii. What are the effects of poor health services on academic performance of learners with hearing impairment?

iii. What supported strategies are in use to improve access to health services for learners with hearing impairment or deaf people?

1.7 Significance of the study

The research would contribute to the body of knowledge and promote more focused and detailed research on lived experiences of learners with hearing impairment when accessing health services. It might also generate information which would be of help to policy makers in formulating health and education policies that will help improve the welfare of children with hearing impairment in Mpika District, Zambia and the world as a whole. It may also assist the relevant authorities in Mpika to realize the importance of paying attention to the challenges hearing impaired children face as they access health services. Finally the study might benefit students and other stakeholders who may wish to further research on the same topic as it would provide information on the lived experiences of learners with hearing impairment when accessing health services in Mpika District.

1.8 Theoretical framework

1.8.1 Social Inclusion Theoretical Model

Disability could better be understood by using a number of theoretical models drawn from different disciplines of social sciences. The theoretical models thus form the basis for social welfare's understanding of disability (Cunningham & Fleming, 2009:2). The theoretical model that will guide the study is the Social Inclusion Model.

Yanagisawa, Et.al (2011) state that according to the social inclusion model, human always have a relationship with society for they are part of the society. Thus human beings by nature have a strong desire to form and maintain social relationships and once excluded from social activities may lead to psychological pain. Social exclusion refers to a form of relational aggression due to damage caused to the social relationships among people. Geniole Et.al (2011) argue that according to social inclusion model psychologists from a broad array of theoretical perspectives concur on the importance of social relationships for human drive. There is much evidence that the quality of a person's social bonds impacts on physical and mental health. However, the opposite happens when they are socially included, they experience pleasure.

Social inclusion was thus developed to challenge the discrimination that the minority groups faced in society. According to Bigby and Frawley (2010) stated that social inclusion means enabling people with disabilities to do those ordinary things, make use of mainstream services such as health services and be fully included in the local community.

Gynnerstedt and Blomberg (2004 cited by Gates, 2007) state that issues of activity, participation and accessibility are important in social inclusion. People should thus be seen not only as actors but subjects and part and parcel of the mainstream society. Understanding disability from such a perspective forms the core of social inclusion. The model of social inclusion entails that people with disabilities should be provided with the much needed support and social services within their own neighbourhoods rather than putting them at the margins of society and providing them with services in special settings.

Gates (2007) posits that, for those with disabilities, for instance, hearing impaired students should have access to goods and services, to education and employment, and to the general community, access to health services is not simply akin to finding the 'right key to the right door.' Instead, the argument is that access is better understood as one of the processes of inclusion. In other words, when those with disabilities are intentionally empowered and included in all spheres of life, not out of charity, but out of the recognition that they have much to contribute to a society, then the question of access becomes a moot point (ibid).

Putnam (2000 cited Gates, 2007) has particularly argued that the key to social inclusion model is to focus on the positive contributions that people with disabilities can make, rather than highlighting the negative. Furthermore, Gates (2007) suggests that the locus of action and responsibility to promote such inclusion falls not on the shoulders of those with disabilities (although their self-advocacy efforts are crucial), or on one ministry but on the shoulders of the entire society. Indeed, all levels of society need to be involved so that access to services for those with disabilities such as hearing impairment can be seen as a human rights' issue, and just as human rights are not relegated to one department for oversight, neither should disability issues be.

Bigby and Frawley (2010) maintain that using the social inclusion model, from a wider perspective social inclusion occurs at two different levels;

- ✓ It occurs when people regardless of their abilities are able to use community facilities without discrimination, and can participate in social organizations such as education, religious groups, and occupy social positions for which they are qualified. Health workers should make health services inclusive to learners with hearing impairment as such will make them healthy and feel accepted in th society.

- ✓ Social inclusion also occurs when people can have both formal and informal social networks with or without disabilities.

Hence achieving social inclusion requires a lot of changes within the social structures e.g hospital buildings have to be accessible, facilities and services such as health, social processes and social networks within society (Bigby and Frawley (2010). People with disabilities are first people, that is, they are not just citizens, but human beings in the first place. They are not only bearers of institutional roles, they are also- and more importantly- identified by their proper names we need to include them in our informal relationships as well as our institutions.

For learners with H.I to experience inclusion, the health workers should accommodate them and be educated in sign language so that their clients could receive and access better health services.

1.8.2 Human Rights Theoretical Model
Inclusion as human right simply means that all rights are guaranteed to everyone, without distinction, exclusion or restriction based on disability or race, sex, language, religion, political or other opinion, national or social origin, property, birth, age, or any other status.

The human rights model locates disability within the human culture, and it holds that all human beings regardless of their disabilities have assured rights that are undeniable (Simui, 2018).
This model builds upon the essence of the Universal Declaration of Human Rights, 1948. This model posits that all human beings are born free and equal in rights and dignity regardless of social, biological or economical standing in society (HRCZ, 2010)).
Inclusion as a human right is enshrined in the CRPD general rules which advocates for:

- ✓ Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons; Non-discrimination.

- ✓ Full and effective participation and inclusion in society.

- ✓ Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity.

- ✓ Equality of opportunity; Accessibility; Equality between men and women; Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

- ✓ The international law tried to recognize and prohibit discrimination of disability through the promotion of equal rights such as the social, economic and political rights.

People with disabilities in Zambia have continued to experience human rights violations despite the country's ratification of the Convention of the Rights of People with Disabilities and subsequent enactment of the Persons with Disability Act in 2012.

Human Rights are fundamental basic human entitlements that are natural. Human rights are universal, inalienable; indivisible; interdependent and interrelated. They are universal because human beings are born with the same entitlement regardless of their wellbeing. Inalienable in the sense that human rights can never be taken away from an individual. Indivisible and interdependent because all rights are equally important and none can be fully enjoyed without others, and interrelated because the fulfillment of one right depends wholly or in part upon the fulfillment of others (Schulze, 2009). Therefore, human lived experiences should be viewed within the context of the universal human rights provisions.

This entails us that access to health services by learners with hearing impairment is a right which should be respected by health workers as they execute their duties. Individuals with H.I should be heard when they go to seek health services at health institutions.

In this study, the Human Rights model of disability was applied to explore and understand the lived experiences of learners with LwHI when accessing health services.

1.8.3 Phenomenology Model

In research, phenomenology approach emerges as a response to the radicalism of what is objectifiable. Phenomenology model is based on the study of life experiences, regarding an event, from the subject's perspective.

Simui (2018) commented that phenomenology focuses on human experience for it explores the individual's lived experiences search of meanings. This approach is oriented to the description and interpretation of the fundamental structures of the lived experience, and to the recognition of the meaning of the pedagogical value of this experience in pedagogy, psychology and sociology according to the experience collected. Its aim is to change the lived experience into a textual expression of its importance, in such a way that the text's effect represents a reviving reflection and a reflexive appropriation of something significant: in which the reader comes to life with strength in its own lived experience (Fuster, 2019).

To sum up, lived experience consists of the daily activities, thoughts and impressions of an individual's domain within a specific context (Creswell, 2007). Lived experiences are experiences, exactly as they appear to us (Carel, 2011, 2013). Since we cannot leave our bodies in our perception

of the world, things, as they appear to us, are subjective (Merleau-Ponty, 1962). The way things appear to us are therefore not necessarily the way things are objectively. Phenomenology offers more than a simple account of daily activities and perceptions. It digs deeper into the meaningful combination of emotions, thoughts, culture and bodily experiences of an individual (Carel, 2011 and Creswell, 2007). The hermeneutic phenomenology of research is conducted through collection of experiences and analysis of their meanings (activities). In this sense, according to Van Manen (2007), the methods are description of personal experiences, conversational interview, and close observation. Experiential material is gathered from the descriptions of the daily living experiences of a group of learners with hearing impairment. These descriptions are collected through conversational interviews and/or writing of protocols in the form of anecdotes and accounts of experiences (Van Manen, 1985).

According to Husserl (1998) in Simui (2019), it is a paradigm that tries to explain the nature of the things, the essence and the veracity of the phenomena. The emphasis is to understand the complexity of the lived experiences of Learners with hearing impairment. This understanding is in turn aimed at raising awareness and finding the meanings surrounding the phenomenon. In order to conduct a research under this approach, it is indispensable to know the conception and principles of phenomenology, as well as the method to approach a field of study and the mechanisms for the search of meanings. Knowing the experiences through stories and anecdotes is fundamental because it allows us to understand the nature of the context dynamics and even change it.

Therefore, a phenomenological account of the lived experiences of students with visual impairment would project their hopes, joys, but also of their fears, hardships and anger. In short, lived experience relates to the taken for-granted world, our perceptions of it and the experiences we have in it (Husserl, 1970).

In order to make sense of the lived experiences of LwHI, the hermeneutics phenomenological model as argued by van Manen (1997) is applied along the four quadrants as follows:

i) Lived with a visual impairment (Body - Corporeality).

ii) Lived with a visual impairment for more than a year in school (Time - Temporality).

iii) Lived with the visual impairment in the target school (Space - Spatiality).

iv) Lived with a visual impairment while studying with others in a school (Relations - Relationality).

1.9 Limitations of study

The study was conducted at one special unit that offers education for learners with hearing impairments in Mpika district. Data collection was collected during COVID19 period in term two of 2021 when learners would be highly engaged in learning at school in order to catch up with the lost time. Apart from that, some learners would not be free to participate in the study for fear of contracting COVID19 virus during FGDs and interviews.

The other constraint would be inadequate literature on HI from the Zambian context. Despite this limitation, it was hoped that this study served as a preliminary point and broadly establish the direction of future research into the lived experiences learners when accessing health services.

However, the findings of study would be generalized with caution to areas which may not have similar characteristics within rural district of Muchinga Province.

1.10 Delimitation of the study

The study would focus only on students with hearing impairment in Muchinga Province, Mpika District at Musakanya combined school catering for learners with hearing impairments. The school is located North of Mpika town near Saint John's Catholic Church. However, the homogenous learners will be selected. This being the case, generalization would be necessarily limited to homogenous groups of learners with H.I. This was a qualitative research study utilizing hermeneutics phenomenology approach to examine the lived experiences of learners with hearing impairment.

1.11 Definitions

1.12 Organization of the study

Chapter One presents the background of the study, statement of the problem, purpose of the study, objectives, and research questions, significance of the study, delimitation and limitations of the study, theoretical framework and definitions of terms used in the study.

Chapter Two explores the literature that relates to the nature of this research. This chapter provides a review of relevant literature to the problem under study that is lived experiences of learners with hearing impairment when accessing health services

Chapter Three provides an in-depth look into the research methodology used in the study. This chapter includes: research design; target population; sample size; sampling procedure; research instruments and data collection; data analysis; trustworthiness and ethical considerations.

Chapter Four presents the research findings using research objectives as thematic guides. The results in this chapter are sequentially arranged in one form which is qualitative in nature.

Chapter Five covers the discussion of the findings. The discussion is based on the research objectives to show the research outputs in relation to the problem being investigated.

Chapter Six presents a summary of the findings and conclusions drawn from the results. It also represents the recommendations made based on the findings of the study and proposed future research.

1.13 Summary of the Chapter

The chapter presented an introduction to the study on lived experiences of learners with hearing impairment when accessing health services by outlining the major features. Chapter consist of background to the study, statement of the problem, purpose of the study, objectives of the study, research questions, limitation and delimitation of the study, theoretical framework and definitions of terms.

The chapter which follows focuses on literature review. It provides a general view of the relevant literature to the problem under discussion.

CHAPTER TWO

LITERATURE REVIEW

2.1 Overview

This chapter presents the literature reviewed related to the study from policy documents and different scholars, taking into consideration different views and approaches under the following sub-headings; explore lived experiences of learners with hearing impairment when accessing health services, describe the effects of poor health services on academic performance of learners with hearing impairment and explore supported strategies in use to improve access to health services for learners with hearing impairment or deaf people taking into consideration a particular case of Musakanya combined School in Mpika District.

2.2 Prevalence of people with disability in developed countries

According to the World Health Organization (WHO) a percentage over the 5% of the global population (360 millions of people) are facing hearing problems or are deaf. In 2025 it is calculated that 900 millions of people internationally will be having hearing problems, out of which 90 million will come from somewhere in Europe, while in 100 years, because of the ageing of the European population, it is calculated that 30% of them will be facing hearing problems. International studies have shown that people with hearing problems have poorer health, exhibit different health behaviors, use the health services in a different way comparing to the general population, are unsatisfied by their communication with the health professionals, are less satisfied by the health services they receive, do not receive sufficient messages related to the preventive healthcare and have a deficiency in knowledge of health matters comparing to the hearing people

2.3 Explore lived experiences of learners with hearing impairment when accessing health services.

The World Health Organization's global strategy, 'Health for All by the Year 2000" is based on the principle that health professionals, educators, scientists, politicians, government committees, and others must cooperate to enhance the quality of life for all people (WHO, 1981). Recently, disparate health care of people with disabilities has captured the attention of the international health and development community.

Mitsi (2014) conducted a research on Deaf People Accessibility in Health Services in Greece. The findings of the study were that people with disabilities had less access to health care services and therefore experience unmet health care needs.

Fernanda (2017) conducted an integrative literature review on main difficulties and obstacles faced by the deaf community in health access. The findings of their study found that there was communication barrier, especially the healthcare professionals' unfamiliarity with the Brazilian Sign Language. In addition, there is also the need for a family member or interpreter to be present during the consultation. Furthermore, the lack of perception on the hearing society part, of the deaf community as bilingual and multicultural subjects, was verified.

Similar research conducted in Germany with deaf participants (n = 841) showed that 41% have experience with an interpreter in the medical setting. Most of the respondents reported minimal hassle during reimbursement of costs but 31% reported that they were not informed of their legal rights to a sign language interpreter. Despite having an interpreter, the findings showed that about 59% of deaf participants never had access to an interpreter which affected accessibility to health care.

McKee, (2011) centered his study on provision of interpreters when the deaf visit their General Practitioners in Netherlands. He observed that most people in the Netherlands do not bring an interpreter when they visit their GP and difficulties in finding an interpreter on a short notice were reported as the main reason. Furthermore, they often do not want to hire an interpreter for a short consultation, as they have only limited interpreter hours each year paid by the government of the Netherlands. The findings of his study found that difficulty in accessing an interpreter was a barrier to many LwHI to access health services. In addition, there was need to train many health workers as interpreters to reduce on the government costs.

Richardson (2014) centred his study on health promotion and education. The findings of his study found that the experiences of the deaf severely lacked adequate education about topics such as safety, mental health, alcohol, drugs, and sex education about balanced meals and nutritional treatment of

health issues is again hampered by communication barriers as a result, this places them at unnecessary high risk for frequent development of non-communicable diseases (NCDs). Further, regular physicals and screenings are not performed due to healthcare avoidance there is also limited education available about necessary lifestyle modifications, medications, or additional treatments to manage their disease.

Höcker, Letzel, & Münster, (2012) conducted a research on Deaf access to health services in Germany with deaf participants (n = 841) showed that 41% have experience with an interpreter in the medical setting. The findings of the study found that the Deaf experienced minimal hassle during reimbursement of costs and were not informed of their legal rights to a sign language interpreter.

Fuentes Et.al (2019) conducted a study on Perceived quality of care and satisfaction for deaf people with regard to primary care in a Health Area in the region of Murcia. The findings of the study found that the health care provided to the Deaf must be adapted so that they perceive quality health care leading to increased access and monitoring of deaf people in the health system.

Eide, (2015) conducted a study on Perceived barriers for accessing health services among individuals with disability in four African countries on deaf people face more difficulty accessing health information than hearing people. The findings showed that Deaf sign language users failed to have access to incidentally occurring information about health issues in tramways, or on the radio or TV and there was general lack of health information and education materials provided in sign language. Limited English literacy and a lack of available information in Sign Language reduced access to preventative health care information for deaf people.

BID Services (2015) undertook a survey consultation with 121 participants who were deaf, deaf blind or hard of hearing, living in the County of Durham. The aim of the survey was to understand whether Deaf, Deafblind & Hard of Hearing People in Durham faced inequalities and barriers when accessing healthcare services. The findings were that basic transactions like making a routine appointment proved difficult for many deaf people who found it difficult to book appointments unless they physically visited their doctor's practice. Even more concerning is their inability to book an emergency appointment as they did not know how to do so. Healthcare professionals do not automatically offer the opportunity to have an interpreter present, so when deaf people attend for appointments, a British Sign Language interpreter was often not present, either because the interpreter had not shown up or the healthcare professional had not booked communications support, preferring to rely on notes. The inequalities in health care experienced by deaf clients reflect the difficulties experienced by disabled people in general. They are disadvantaged by structural and procedural

aspects (physical access, funding, transport, communication barriers) of access to health care as well as the attitudes and beliefs of healthcare providers.

Atqia et.al (2016) explored experiences of LwHI in pakistan using cross-sectional design and the convenient sampling technique was utilized. The study focused on problems faced by children with hearing impairment in getting medical services from private clinic and comprised of 70 school children with hearing impairment who were then enrolled in class 7 to 10 of public school in Lahore. The findings suggest that there was need to train health workers such as doctors, nurses etc in sign language to better serve the needs of learners with LwHI which results into improving health workers and LwHI relationship. Furthermore, there was need to employ professional interpreter to stop subjecting individuals with hearing impairment to wrong prescription and medication hence missing to address their illness.

Kuenburg (2016) conducted a study on Health Care Access among Deaf People in Austria. The findings of the study found that the Deaf still experienced communication problems with hampered their accessibility to better health services. The study was too general on the entire Deaf community instead of incorporating LwHI in a specific study.

Mweri (2018) conducted the study on Privacy and confidentiality in health care access for people who are deaf in Kenya. The findings of the study found that the use KSL interpreters a fact may interfere with their privacy and confidentiality. In the absence of qualified interpreters, people resort to writing under the false impression that all people who are deaf can read and write. Then sometimes relatives of the deaf are used as interpreters just because they may have some knowledge of KSL forgetting that they are not interpreters. Furthermore, the study looked at some initiatives that have tried to teach medical practitioners KSL so that they can communicate with people who are deaf directly and argue that though not adequate in terms of the numbers trained so far but this is the way to go.

Mweri (2018) further examined the challenges that people who are deaf in Kenya faced in accessing medical care. First they are more often than not forced to use KSL interpreters a fact that may interfere with their privacy and confidentiality. In the absence of qualified interpreters, people resort to writing under the false impression that all people who are deaf can read and write. Then sometimes relatives of the deaf are used as interpreters just because they may have some knowledge of KSL forgetting that they are not interpreters. The paper also looks at some initiatives that have tried to teach medical practitioners KSL so that they can communicate with people who are deaf directly and argue that though not adequate in terms of the numbers trained so far but this is the way to go.

Orrie and Motsohi (2018) investigated the challenges experienced by healthcare workers in managing patients with hearing impairment at a primary health care setting in South Africa. The study design was a qualitative, descriptive case study. Data were studied and analyzed using the phenomenological method. The findings of the study found that health workers experienced difficulties when attending Deaf people at primary health care. The health workers experienced communication problems because they could not understand sign language and this resulted into wrong medication, avoiding to attend to Deaf people, used unlicensed third person as interpreter which violated the right to privacy and confidentiality. In addition, it was reported that language is an important enabler of the right to health. It allows access to healthcare information, both preventive and curative, and allows for health care to be provided with informed consent from the user. Furthermore, language is essential to developing a therapeutic relationship with a patient, yet the language barrier between deaf patients and hearing healthcare workers is one of the main challenges to access to health care.

Chisupa (2007) conducted a study which aimed at determining the factors influencing underutilization of health services by the deaf and hard of hearing in kanyama compound in Zambia. The study was a non-experimental, used a descriptive study design and the sampling method was judgemental basing on the characteristics interest of the researcher. The sample size was 50 Deaf and hard of hearing in kanyama compound and 10 health workers at kanyama clinic adding up to 60 respondents. Data was collected using semi-structured questionnaires from health workers. The findings of the study found that the deaf received poor quality of services when they fell sick. Further the study revealed that deaf and hard of hearing were not satisfied with the services they received at the government health institution. The quality of services were connected to the method of communication with the health workers. Furthermore, the deaf suggested that teaching health workers sign language would greatly improve health services for the deaf and the hard of hearing.

Chiluba et al. (2019) conducted a study on An Assessment of The Health Literacy among Deaf People in Kapiri Mposhi District of Zambia and it was a qualitative study which used a cross-sectional descriptive study. The sample size for this research was 10 deaf individuals and 5 health care providers summing up to 15 participants. The findings of the study found that Deaf people do not receive full disclosure of their medical situation and the alternatives are not discussed with them because of communication barriers faced. In addition, even when disclosure does occur, many Deaf people may not fully understand the options available to them because of communication difficulties with health care providers. This entails that the Deaf people in Kapiri Mposhi District have their health literacy extremely low.

Despite literature available focused mainly on high-income countries, it is therefore important to bear in mind that many Deaf people, especially in low and middle-income countries, are suffering from much greater health disparities.

In conclusion, the studies both in developed and developing countries showed that the deaf do not benefit from health services full and their rights to be heard is violated while being screened. As a result, the deaf people end up receiving wrong medication which is uncalled for and needs serious attention.

2.3 Effects of poor health services on academic performance of learners with hearing impairment.

National Health Interview Survey (2014) conducted a study on how asthma affects children with disabilities academic performance in United States. The findings of the study found that children with well controlled asthma could live normal, active lives, but the consequences of poorly controlled asthma was Emergency Department visits, hospitalizations, missed school, disrupted sleep, asthma attacks, and frequent use of medications for quick relief. Nationally, children with asthma miss 13.8 million days of school. Studies find that children commonly experience asthma symptoms at night, which disturbs sleep and causes tiredness during the day. Studies have also found a link between uncontrolled asthma and poor school performance in children with severe and persistent asthma and in children from low-income families.

Basch (2010) also in his study observed that Asthma had a negative impact on a child's school readiness and ability to learn once in school by causing missed school days and sleep disturbance that can affect performance in the classroom. The findings showed that there was a link between asthma and school performance.

In similar vein, Taras and Potts-Datema reviewed literature on the effect of asthma on school attendance or academic achievement. Published peer reviewed literature from 1989 to 2004 that included school-aged children (5-18 years) was reviewed. Taras and colleagues found of 66 studies, virtually all showed a relationship between asthma and higher absenteeism rates.

Pourat, & Nicholson (2009) conducted a study on the impact of dental cavities on academic performance of learners with disabilities. The findings of the study found that Children with untreated cavitiies and associated toothaches have trouble sleeping and eating, increased school absences, difficulty paying attention in school, difficulty keeping up with peers academically and completing homework, and lower standardized test scores. Moreover, they are more likely to report feeling

worthless, shy, and unhappy and are less likely to appear friendly. Furthermore, LwHI coupled with dental cavities experiences academic challenges which is linked to poor access of health services.

National Survey of Children's Health (2011/2012) conducted as assessment on prevalence of ACEs and the association with school engagement and grade repetition, controlling for socio-demographic characteristics and health status. The findings of the assessment found that more than one fourth (25.9%) of children involved in the child welfare system had repeated at least one grade. Nationally, the proportion of children who have repeated a grade is less than half as high. Furthermore, children 5 to 17 years old involved in the child welfare system scored significantly lower than the general population in academic performance. Furthermore, there was a correlational between Adverse Childhood Experiences (ACEs) and poor academic achievement, meaning that as the number of ACEs increases, so does the risk of poor academic achievement. Children with two or more ACEs were 2.67 times more likely to repeat a grade, compared to children with no such experiences. Likewise, children who had not experienced an ACE had 2.59 or greater odds of being highly engaged in school, compared to their peers who had two or more ACEs. It has been observed the study focused on various ACEs categories which made the findings too general and not specific to learners with Hearing Impairment.

Chiluba et al. (2019) conducted a study on An Assessment of The Health Literacy among Deaf People in Kapiri Mposhi District of Zambia and it was a qualitative study which used a cross-sectional descriptive study. The findings of the study found that Deaf people do not receive full disclosure of their medical situation and the alternatives are not discussed with them because of communication barriers faced. Furthermore, the study focused on Deaf people which made the findings too general and not specific to students with learners with hearing impairment and their academic performance which has called for further study.

Children with Hearing impairment caused by otitis media with effusion and associated conductive loss during the first 4 years of life have been reported to score lower in math and expressive language between kindergarten and second grade 12 while those with Mild sensor neural hearing loss affects about 5 % of the school-aged population and these children experience difficulty on a series of educational and functional test measures. Poor education performance is also caused by absenteeism due to unending poor health of children with Hearing impairments. At the hospital, children are given wrong medication which prolongs their healing process as the result they are missing a lot of academic work at school which results in poor academic performance.

In conclusion, LwHI in Zambia are still experiencing poor health services leading to perpetual absenteeism from school most of the time which results into poor academic performance. Apart from hearing impairment, some learners could have other comorbid health problems such as asthmatic, HIV/AIDS, Anemic, epileptic, malaria, cerebral palsy, poor vision, physical problems, stroke and many more which affects their academic performance negatively and severely lead to poor health which may end up disadvantaging them in their daily lives. This as a result leads LwHI to drop out of school and become beggars in streets which is bad.

2.4 Explore supported strategies in use to improve access to health services for LwHI or deaf people.

BID Services (2015) conducted a survey on barriers to healthcare services experienced by deaf, deafened & hard of hearing people in Durham. It involved 121 participants who were deaf, deaf blind or hard of hearing and focused on understanding whether Deaf, Deaf-blind & Hard of Hearing People in Durham faced inequalities and barriers when accessing healthcare services. The findings of the study found there are many ways in which our healthcare services could improve inequality and accessibility to healthcare services for deaf, deaf-blind and hard of hearing people. This includes asking deaf patients how they would like to communicate, offering online appointments and text or email contact with the surgery, booking longer appointments, never expecting family members to interpret for a patient, and making deaf awareness training mandatory for all front-line staff.

Harmer (1999) conducted a study on Health care delivery and Deaf people; Practice, problems and recommendations for change published in Journal of Deaf studies and Deaf education. The findings of the study found that approaches to improve access to health care, such as providing powerful and visually accessible communication through the use of sign language, the implementation of important communication technologies, and cultural awareness trainings for health professionals are discussed. Programs that raise health knowledge in Deaf communities and models of primary health care centers for deaf people are also presented. Published documents can empower deaf people to realize their right to enjoy the highest attainable standard of health.

Smeijers & Pfau (2009) researched on Deaf technology and the Deaf were active participants. The findings showed that Deaf people suggested that health workers should set up a screen or other visible method of notifying patients, rather than calling their name, set up a simple system for booking interpreters and train staff to use this system, set up the 'Interpreter Now' online service and

train staff to use the service in preparation for when a face-to-face interpreter is unavailable and never expect family members or unqualified staff to interpret for a patient with a hearing loss.

Cormier et.al (2013) conducted a study on preferred communication mode of DHH people in clinical settings in the United Kingdom, Florida, New Zealand and United States. The findings of the study were that half of the Deaf population preferred to communicate via sign language interpreters, while others preferred to only have a consultation directly with signing health professionals and the least group agreed to accept communication with doctors using speech, as long as they are aware of deaf issues. In Florida, deaf adults showed an overwhelming preference for seeking mental health services from sign-proficient health professionals whereas younger deaf persons were slightly more open to the use of interpreters. For patients with limited English proficiency, the use of professional language interpreters is correlated with improved clinical care, and deaf patients report positive experiences in health care encounters when medically experienced professional sign language interpreters are present. In New Zealand deaf people's access to professional interpreters is associated with access to health services, engagement in leisure activities, gaining more information and living in a healthy environment. Health maintenance organizations in California (United States) have improved efforts to promote and evaluate sign language interpreter services for the Deaf community. Overall in the United States, Dean and Pollard recognize the complex human interaction factors in the translation process, and have successfully implemented innovative concepts regarding sign language interpretation in the medical field.

Barnett (2011) reported that Communication technology is widely used in the developed and developing countries to aid HI learners to access health services. In recent years, deaf people have benefited from the prospects of modern information technology when accessing services. Minicamps and text-phones are now widely used, and the availability of web facilities in various places is not only helpful when accessing health services, but also provide more autonomy for deaf individuals familiar with these techniques. Technology that allows texting communication with regular phones is another recent development. It enables deaf people to make initial contact by telephone (through voiced text messages) and continue any conversation by SMS. Many others for profit technical assistance services are offered to deaf people who can afford it. Nevertheless, in many cases, deaf people report that it is still not possible to use email to reach their GPs for making appointments or asking short questions, as many services are just available via telephone.

World report on disability, (2016) commended Telemedicine as development on board, which recently has provoked broad interest. It can provide wide reaching access to resource centers, offering web communication with signing experts. Several recent studies discuss the application of

telemedicine in different medical fields. Apart from telemedicine, there is the Auslan Medical Sign bank which is another innovative approach to improving health outcomes for deaf people by fostering an "effective, accepted, and shared sign language vocabulary for the discussion of medical and mental health issues by deaf clients and health professionals in interactions mediated by Auslan interpreters".

Swanson (2007) in his study on New mental health services for deaf patients in Canada recommended that Health care providers should facilitate bonds with patients to ensure user access and need to allow extended appointments for hearing impaired patients. The implementation of transcultural methods to narrow the cultural gaps between hearing and non-hearing participants in the health sector is suggested to recognize individual communication limits and to deal effectively with the cultural and linguistic challenges which often occur when people with different backgrounds or perspectives come together, it is vital that health care professionals acquire more education on Deaf culture and on how to communicate with the deaf. Finally community participatory research allows the identification of health priorities of the Deaf community.

In addition, initiating health education among the deaf Studies highlight the value of health education programs specifically targeted at the deaf and health education material for deaf audiences. Video-based intervention is supposed to be an effective educational tool for reaching the Deaf community with cancer. Deaf women benefit from cancer education programs that address their cultural background. Furthermore, through specially targeted intervention strategies, women are much more likely to access and to use health services, as well as to promote health issues within the Deaf community. To promote access to health care DHH youth in France have successfully been provided with internet training workshops. In South Africa, many disability organizations recognize the importance of accessible HIV education, but people with disabilities are nonetheless still largely excluded from HIV prevention education as well as from access to general health care for testing

In Kenya, some deaf-friendly Voluntary HIV Counselling and Testing Services (VCTs) have been successfully established and peer education for transmitting information has been found to be a suitable model for general HIV prevention efforts and promotion of HIV treatment in the Deaf community. A deaf heart health intervention (train-the trainer community health worker approach) in the United States showed a significant increase in self-efficacy regarding modifiable CVD risk factors such as nutrition, psychological well-being/stress management, physical activity/exercise, and responsible health practices. In the United Kingdom, on the other hand, Patel et al. (2011) found that a CVD risk assessment with associated health promotion after a 6-month follow-up did not reduce coronary heart disease risk estimates.

WHO, (2011) reported that it was cardinal to have primary health care centers for deaf people. The wide reaching implementation of good and available primary care is an important public health approach in various countries. Especially in low and middle income countries (LAMIC) efforts have been made to integrate provision of special health care into general community health care services, and a high quality research paper about health and people with disabilities has recently highlighted work toward optimum strategies to integrate their needs into primary health-care systems Below, we present examples of how primary health care centers for deaf people can become useful platforms for access to specialized care.

Woodcock (2007) revealed that in Austria, Health Centers for the Deaf are attached to general hospitals and provide complete access to health care for deaf individuals by competent staffs that are familiar with Deaf culture and able to communicate in sign language and or other modes according to the need of their patients on a one to one. For many deaf people in Austria these Health Centers have become their primary care facility, while others from far away come only for regular preventive health check-ups. These preventative health check-ups have proven to be important tools for individual health education Specific health education programs are also provided for special target groups like deaf people with diabetes.

Regular health education days convey relevant information to the Deaf community as a whole. Mental health care and social work is also offered within the framework of the Health Center for the Deaf, following the concept which is established in Linz, Vienna, Graz, and Salzburg. In Linz, special programs are provided for elderly deaf people and for deaf people with special needs as well as for parents of deaf children. As the services are connected to general hospitals the patients can be easily referred to the complete range of facilities, accompanied by signing staff when necessary. In France, dedicated ambulatory services for primary healthcare of the deaf people are provided that are well accepted and show benefits for the Deaf community

2.5 Knowledge Gap Table

Emerging from the literature reviewed above, research studies on lived experiences of learners with hearing impairment when accessing health services appear to be largely focusing on all Deaf people and hard of hearing and not on children. Furthermore, the bulk of research works on lived experiences of learners with hearing impairment when accessing health services are generated by developed countries while the developing countries are relatively fewer in number. Thus, in Zambia,

there is no specific research on live experiences of learners with hearing impairment when accessing health services to guide policy formulation, implementation and evaluation. With these identified knowledge gaps, the reviewed literature forms a good foundation for the study at hand.

2.6 Chapter summary

In conclusion, the literature discussed above focuses mainly on high-income or developed countries. It is therefore cardinal to bear in mind that many Deaf people, especially learners who are deaf in low and middle-income countries like Zambia, are still suffering from much greater health disparities. According to Richardson Health promotion and education is severely lacking among the children with hearing impairment (Barnett: 2014). This places them at unnecessary high risk for frequent development of non-communicable diseases (NCDs). Further, regular physicals and screenings are not performed due to healthcare avoidance there is also limited education available about necessary lifestyle modifications, medications, or additional treatments to manage their disease. The Deaf population does not receive adequate education about topics such as safety, mental health, alcohol, drugs, and sex education about balanced meals and nutritional treatment of health issues is again hampered by communication barriers in Zambia and the world at large. Erroneous knowledge on subjects such as nutrition and high-risk behaviors is propagated among the Deaf without access to the real sources. It was discovered that lack of knowledge in sign language exhibited by health workers is a major hindrance to proper accessibility of health services by hearing impaired learners hence leading to poor health and increased poor performance academically since they abscond from lessons most the times.

3.1 Overview

This chapter outlines the instruments that was used when undertaking the research and the methodologies, targeted population, ethical considerations, research samples that would be employed during the research period were discussed in details.

3.2 Research design

Louis et.al, (2007) refers research design to be structure of research which holds all the elements of the research project together. The designs of a study define the study type and methods of data collection. A Hermeneutics Phenomenology design was applied to study the lived experiences of LwHI. Phenomenological approach is a theoretical point of view that advocates the study of direct experience taken at face value; and one which sees behavior as determined by the phenomena of experience rather than by external, objective and physically described reality. The design entails the collection and use of data systematically from a given population to describe certain characteristics of the population (Creswell, 2005).

Simui (2019) sited van Manen's four evaluative criteria on lived experiences which consist of:

i) lived space – Spatiality;

ii) lived body – Corporeality;

iii) lived time – Temporality;

iv) lived human relation – Relationality

Simui (2018) noted that four evaluative criteria such as Space, Body, Time and Relations should be in place for lived experience to takes place. Due to limited time available, cross sectional approach was used to conduct a study. This was done through the segmentation of participants purposively selected according to their level of experience within the school from grade 5 to 9 at primary to junior secondary level. This enabled the researcher to have a broader understanding of the lived experiences of LwHI (Body) with varying ages and grades (Time) studying in a company of other learners (Relations) within a common environment (Space).

3.3 Population study

According to Creswell (2005) state that a population consists of a group of elements, which could be individuals, objects or even elements that pertain to what the researchers embarks to generate the results for the research. Best (2009) defines population as an element which is a subject in which measurement is being taken. According to Mugenda and Mugenda (2003) target population is the population to which the researcher wants to generalize the results of a study. It is the unit of study in which the researcher is interested in gathering his or her findings of study. In this study, the target population involved learners with Hearing Impairment as active participants in Mpika District of Muchinga province.

3.4 Sample size

A sample is a small proportion of the selected population for observation and analysis. By observing the characteristics of the sample which is the diverse, representative, accessible and knowledgeable in the study area, findings can be generalized (Kombo and Tromp, 2006). The nature and the sample, and who is included in depend on what the research is trying to deduce (Kothari, 2004). Musakanya unit for the HI will be selected on the basis of having a good number of learners with hearing impairment. According to Neuman (2003), in purposive sampling the researcher is empowered with the right to select cases with a specific purpose in mind, namely to get information on the basis of their informativeness. To this effect, the participants engaged consisted ten (10) LwHI as active participants by gender 5 females and 5 males.

Below is a table summarising profiles of the ten participants whose real names are replaced with pseudonyms for ethical reasons. Equally, participants' descriptors, such as grade, age and sex were purposively included for the purpose of better understanding of the phenomenon at hand as well as possible replication of the study by other researchers.

Table 1. Participants' profiles (names of participants are pseudonyms)

NAME	SEX	AGE	GRADE	DISABILITY
Con	m	12	7	Hearing Impairment
Rudd	m	13	8	Hearing Impairment
Dust	m	15	8	Hearing Impairment

Jan	m	17	9	Hearing Impairment
Zan	m	17	9	Hearing Impairment
Nad	F	16	9	Hearing Impairment
Fei	F	16	9	Hearing Impairment
Nash	F	15	8	Hearing Impairment
Jie	F	17	8	Hearing Impairment
Jui	F	18	9	Hearing Impairment

3.5 Sampling procedure

Purposive sampling procedure was used to select HI learners. Kasonde Ng'andu (2013) refers to sampling technique as a part of the research plan that indicates how cases are to be selected for the study. Saunders, et.al, (2016) recorded that purposive sampling is used in qualitative research especially obtaining data from the participants who have the experience on the subject. Creswell (2014) explains that, "purposeful sampling is when a researcher selects participants or sites or documents that will help in understanding the problem and the research questions".

Researcher used homogenous sampling to choose participants who in their opinion would be thought to be relevant to the research topic (Cohen and Manwri, 2000). The criterion for selection of a school was based on the availability of HI learners in Mpika District while the selection of learners was done at Musakanya combined school regardless of age, sex and social economic status. The research focused on the HI learners from Grade 7-9.

3.4 Research instruments
Amina (2010) defines tools as instruments used to collect new facts or to explore new information. Two instruments will be employed in data collection for the study. These included the Focus Group Discussions and interviews guides. FGDs and interviews would be physically conducted by the researcher.

3.4.1 Focus Group Discussion Guide
Focus group discussions (FGDs) Guide was used with some HI learners at Musakanya combined school in Mpika district. Saunders et al, (2016) reports that Focus Group Discussion focuses on a

particular topic or issues by encouraging discussions among participants and the sharing of perceptions, lived experiences in an open and tolerant environment. Creswell (2012) recommends that focused group is effective when 6 - 12 members are selected for a study and who are homogenous in terms of their social demographic features with a session lasting one to one and half hours with two hours being the maximum time. Schostok (2010) suggest that a group facilitator keeps the discussion on truck by asking a series of open ended questions meant to stimulate discussion and also creates a thoughtful, permissive atmosphere, provides ground rules and sets a tone of discussion in order to obtain lived experience of HI learners when accessing health services.

This approach was cardinal for it allowed the collection of data which reflects the attitudes, values, opinions and experiences of the participants and created an open and free atmosphere to allow participants to give their opinions and views on lived experience of HI learners when accessing health services.

3.4.2 Interviews Guide
Schostok (2010) guides that an interview can be described in terms of individuals directing their intention towards each other with the purpose of opening up the possibility of gaining an insight into the experiences, concerns, interests, beliefs, values and knowledge of the respondents. In this case an interview guide developed for this study was used to collect data from special education teachers and health workers. An interview to be conducted required learners with hearing impairment to respond to issues concerning the lived experience of HI learners when accessing health services and the strategies to be instituted to improve health services to make it accessible to HI learners at Musakanya combined school and later be generalized to all deaf community. An interview guide contained 8-10 questions.

3.5 Data collection methods
During the research, the researcher visited Musakanya combined school at least twice. The first visit was meant to establish co-operation from the Musakanya combined school. After soliciting co-operation, the researcher booked an appointment for carrying out interviews and Focused Group Discussion with the respondent.

The second visit was for actual data collection through Focused Group Discussion and interviews and on average it took 40 – 50 minutes. This was done to avoid having some questions unanswered and misinterpretation of some questions in order to collect clear and valid data.

Data was collected and recorded in note book for each participant using the codes such as FGD1 and interviews for HI Male learners was indicated as (Con, Rudd, Dust, Jan, Adam) while For HI female learners were indicated as (Nad, Fei, Nash, Jie, Jui).

3.7 Data analysis

Data collected from interviews with learners with hearing impairment and the data collected from Focus Group Discussions of HI learners was analyzed using thematic data analysis. Creswell (2014) defines thematic analysis as a method for identifying, analyzing, and reporting patterns (themes) within data. It minimally organizes and describes your data set in details. However, it also often went further than that, and interpreted various aspects of the research topic.

Firstly, data was systematically arranged to answer research questions. This meant that a researcher went back to the Focus Group Discussions and interview guide and differentiated topics or questions that was answered and those that, was simply included in a Focus Group Discussions and interview guide that emerged from the data.

Secondly, the researcher organized ideas and concepts and that was involved at various responses for one particular question and identifying specific word or ideas that kept coming up from participants' responses. In this case a list of different responses and ideas which was arrived at. Ideas, concepts and phrases was found then the researcher organized these themes into codes or categories.

Thirdly, that was the time to build up over-arching themes in the data. Each of the response categories added more than one associated theme that give a deeper meaning of data. Further, different categories collapsed under one main over-arching theme. This allowed the researcher to test emerging findings and as themes and patterns from the data.

The fourth and last stage called for a researcher to make a summary of the findings basing on the themes. The findings were compared with literature and also those were tied to the themes to get a better ideal of the results found. In conclusion, qualitative data was analyzed thematically. This involved coding and categorizing of data to generate themes which were presented descriptively. It should be noted that van Manen's four reflective thematic guide was used as a starting point for analysis of lived experiences as follows:

(i) Lived space – Spatiality; (ii) lived body – Corporeality; (iii) lived time – Temporality; and (iv) lived human relation – Relationality (van Manen, 1997)

When recoding data, the codes was given to the participants for confidentiality purposes. Musakanya combined school was coded MCS, then FGD1 and interviews for HI Male learners were indicated as

(Con, Rudd, Dust, Jan, Adam) while For HI female learners were indicated as (Nad, Fei, Nash, Jie, Jui).

3.8 Trustworthiness

Trustworthiness is when the researcher maintains data by not misrepresenting the views of participants. Maxwell (2005) reports that trustworthiness is demonstrated when participants recognize the report findings as their own experiences. To ensure that there is reliability and trustworthiness in the data collected and compiled, the researcher will employ measures such as the Focus Group Discussions which will be tape-recorded and transcriptions will be made of FGD for referral adequacy. The researcher made efforts of going back to some of the participants, to confirm whether the transcribed data is a truthful version of their experiences.

3.9 Ethical consideration

Ethical Approval was taken from the University of Zambia Research Ethics Committee to conduct the study. Permission was also obtained from the school head teacher at Musakanya combined school in Mpika district. The researcher informed the respondents that participation was voluntary.

A consent form was given to the learners by the researcher if they wanted to participate in the study. The respondent's identity was protected while the purpose of the study was explained to the participants. This was to ensure that participants are given enough information about the study. Therefore, a pseudonym was assigned in place of their actual names, to assure confidentiality and privacy of each participant. The pseudonym given were as follows: (Con, Rudd, Dust, Jan, and Adam) while For HI female learners were indicated as (Nad, Fei, Nash, Jie, Jui).

The researcher obtained consent for recording the discussions with the participants using a tape recorder and the information was kept under password in the recording gadget.

3.9 SUMMARY

The chapter focused on the methodology applied with its related philosophical underpinnings as well as research paradigm. Given the nature of the research topic at hand, the study applied hermeneutic phenomenology approach targeting primarily learners with hearing impairment within a university. What follows next is chapter four, presenting the findings of this study.

4.1 Overview

In this chapter the researcher presents the findings of the study on Lived Experiences of Learners with Hearing Impairment at MCS in Mpika District: Focus on Access to Health Services. As a recap, there were four key research questions addressed that guided this research study. These were:

i)   What are the lived experiences of learners with hearing impairment when accessing health services?

ii)   What are the effects of poor health services on academic performance of learners with hearing impairment?

iii)   What solutions are in use to improve access to health services for learners with hearing impairment or deaf people?

The three research questions above formed the reflection point throughout chapter four and chapter five, as demonstrated by the themes that emerged subsequently.

4.2 Emerged Themes

After the analysis of data collected about LwHI, the following themes emerged namely: (i) Lived experiences of LwHI when accessing health services (ii) Poor health services Vs academic performance of LwHI and (iii) Improve access to health services for LwHI. What follows below is a detailed presentation of findings based on the four themes as guided by the above research questions.

4.3 Lived Experiences of LwHI when Accessing Health Services.

The findings of the study showed that most LwHI have lived experiences when accessing health services. The lived experiences of LwHI occurs in health facilities mostly during registration of patients details; reception where Blood pressure, body temperature and weight is measured; Outpatient department where the physician listen to patients' complaints and diagnose the patients; Medicine is given to a patient. If a patient is very sick, he/she is admitted in the hospital wards. Apart from that, they also experience a lot during health education. This was evident from the statements provided by various participants during the Focus Group Discussions and interviews with the hearing impaired learners. The following were some of the lived experiences that arose from the study.

4.3.1 Poor communication

It's always difficult for Learners with hearing impairments to effectively communicate with health workers daily. During the process medication, *Con* observed that it is a critical period he doesn't like whenever he falls sick. *Con* reflected on how he was treated by health workers at hospital as he wanted to access health services as explained below:

> …. Reached the registry, a nurse communicated to me verbally and I did not understand her *so she refused to attend to me because I could not communicate verbally and she could not communicate with me in sign language which is very frustrating and embarrassing to me (Con, 2021)* .

As for *Nash,* she recounted how she was forced to explain her problem by writing which was not easy. *'I tried to write but still this did not solve anything. I was just given Panadol which I did not even take because I frustrated with services I received.'* *Nash* complained that they told me to write and read in English when I was still learning the alphabet and I felt humiliated.

Dust with his lived experience observed that he was not fairly treated when the nurse told him to register his personal particulars. *'I recall the nurse asking me about my personal particulars so I had to finger spell my particulars such as name, my age and location.'* To my surprise, she just laughed at me and sent me away rudely to go home and come with my parents. He wondered if being deaf is a crime and he complained why they cannot learn sign language like some teachers in school to easy their accessibility in health institution.

Indeed it's not easy for LwHI to access health services easily because sign language is alien to health workers and this results into discrimination which is an abuse of human rights. The lived experiences of Adam were reported that:

> *I went to the hospital and I found the nurses working. When they discovered that I was deaf, they all avoided me called me because no one new to communicate with me in sign language. I felt bad because I was excluded, delayed and discriminated as well as abused. I was told to wait for a doctor who knew a bit of sign language (Adam, 2021).*

Like *Adam*, *Fei* also had her lived experience on access to health services when she was admitted in the hospital. She explained that she was not happy with how health workers and some other patients in the ward treated her just because she was deaf. She reported that:

> *….. mother went to buy food at the market so I remained in the ward sleeping. The nurse and doctors came to check on me so they did not find my mum who could communicate to them. Mmmmmmm, the nurse spoke to me with her nerves up and I was scared (Fei, 2021).*

This was not her first time as *Fei* recalled that she was not given attention the time she went to meet with the doctor at outpatient department for diagnosis. I went in the OPD and I found the doctor who

wrote that '..... *how can you come alone you know that you don't talk! I deal with people who talk'*. She couldn't even give chance to Fei to respond and chased her out of the screening room. She felt bad because her rights to access health services were abused.

4.3.2 Wrong diagnosis

Many LwHI have experienced wrong diagnosis due to poor communication and this has resulted into prolonged poor health. *Jie* experienced wrong diagnosis when she went in OPD for screening alone. It's the right of everyone to access health services but not for the deaf. *Jie* narrated that she went in the screening room alone to meet with a male doctor who had no knowledge about sign language so he did not listen to her complaints. He just diagnosed her by guessing and the drug she was given made her scratched the whole night. The following day in the morning, '*I went back to hospital with my parents who explained how I was feeling that is when it was discovered that I was given a wrong diagnosis.'*

In similar vein, *Jui* also was a victim of wrong diagnosis due to the inability of health workers to find means and ways to communicate with Jui. Below is Jui's statement during her ill health while at the hospital.

> *…… went to hospital sick and suddenly I begun to vomit. I told the nurse that I ate fermented foods in sign language but she couldn't understand. She started doing pregnancy test and gave me medicine to stop vomiting and this worsened my life. It took the help of my mother who came rushing and explained what happened where we went partying. Today as speak I would have been no more (Jui, 2021).*

Rudd also had a similar experience while at the hospital. He was feeling pain in his heart and here is his report. *Sir, its painful sure…. doctor didn't understand my disease well"* and Nad with her lived experience she failed to explain to a doctor how she was feeling because there was communication barrier so she was given wrong medication. '*I could not tell the doctor/nurse about my disease clearly as a result I end up receiving wrong diagnosis and medication.'* *Rudd* and *Nad* asked why the government could not teach health workers their deaf culture to improve our services. Though some of the Deaf could lip-read, health workers don't face them when talking, others over apply make-up while men with beards makes it difficult for the deaf to pick their words.

Jan reported that, '*miscommunication which occurred often between him and the health care providers, led to misunderstanding in diagnostic and therapeutic aspects.'*

4.3.3 Lack of privacy and confidentiality

All the LwHI in the study complained about the issue of privacy and confidentiality for they are linked to trust. Unfortunately, it was very rare for the LwHI to be accorded privacy and confidentiality as was observer by Jie that always she went to hospital she should go with unlicensed interpreter who is a third person. Below is what Jie said:

> I feel bad to involve a third party as my interpreter….. I refuse to tell them if my
> problem is too private especially my parents because I feel shy. Doctors and
> nurses should learn our language for easy communication. I want to be free with
> the doctor but I fear people without code of ethics (Jie, 2021) .

like *Jie, Adam* also commended that, *'…. my privacy and confidentiality should be respected. What I hate is disclosing to my father or mother that I have a problem with my genitals. Adam* further said that he felt worse when they involved someone to interpret whom he knew to be a vuvuzela in the community.

The rest of the respondents such as *Con, Jui, Nad, Rudd, Dust, Jan, Nash*, and *Fei* echoed one voice about their rights to privacy and confidentiality not to be respected because the people involved seemed not to confidential but news reporters. They observed that despite being young we deserve privacy. Con complained that, '*My rights to privacy and confidentiality are not respected by health workers and the so called interpreters.' Jui said that, '*I had a problem on my private parts and a third part who was not a professional interpreter was involved to interpret for the doctor. I felt injured and shy emotionally.

Separately*, Nad, Rudd, Dust and Jan,* reported that, after the whole process of circumcision, they went back to school to report. Each one in different places experienced that *'Before I could even reached home, the news was all over the palace that I'm circumcised and that was a humiliation of its kind.'* They felt that licensed interpreters should be employed or some health workers should be trained in sign language in order to maintain high levels of privacy and confidentiality.

4.3.4 Discrimination

All medical facilities must be accessible to all patients and staff, not just to those with normal hearing. *Fei* commented that, '*failure to provide fair access to such facilities means the person who is Deaf or has hearing impairment is discriminated against and it is illegal to discriminate against people basing on their disability.*' Like *Fei, Nash* also lamented that any act that seem to exclude LwHI as they rush to access health services makes them feel discriminated.

> First time, I was told to go and get my parents on the basis of disability
> but those of my age mates were attended to. Second time, was told to

*wait until all patients were finished then I was attended to. I felt
dehumanized by the act of the nurse in the presence other patients
(Nash, 2021).*

LwHI felt that discrimination can be painful everywhere be it in school, sports events, church, in a home but worse at hospital when you are sick and in need of services being denied. *Rudd* commented that '*failure to provide sign language services to the deaf is discrimination enough*'. Jan had a similar lived experience on discrimination on a fateful day as he narrated below.

*I went to hospital early but to my surprise I was told that I would waste
a lot of time for I depended on sign language to communicate so I had
to wait until all those on the line. If my brother did not come to check
up on me, I would have gone home late because he helped me as my
interpreter (Jan, 2021).*

It would seem that some health workers had negative attitudes towards LwHI as observed by Jan in his submission above. This could be pointing to the need for an inclusive policy to guide practice, as well as sensitization and capacity building among the health workers in the health institutions, if the reported discrimination was to end.

4.3.5 Inadequate medical vocabulary
During the findings to the study it was discovered that medical vocabulary has a lot of lapses in sign language. *Nad* observed that, '*a lot of medical words have no signs to easy the explanation between us the deaf and health workers*'. Further, *Jui* experienced lacking signs to use to explain her heart problem and below is her statement.

*I had a heart problem which was affecting my veins but I had no
signs to explain to the doctor to help him come up with proper
diagnosis. Despite that, I did not back out until I came up with a
solution. I had to draw my heart on a piece of paper then the doctor
understood my problem well (Jui, 2021).*

Just like it is difficult for non-deaf to explain certain things, *Dust* stated that, it was difficult also for the LwHI to explain using signs. *Dust* in his statement said:

*..... interpreters should be there in hospitals to offer help where we fail
to explain properly. Sometimes we fail to explain well in sign language
which becomes very difficult for health workers to guess what we mean
(Dust, 2021).*

Dust felt many LwHI desire to explain their problems to doctors but due to inadequate medical vocabulary they go back their health unmet which he felt should be addressed.

4.3.6 Poor health education

Health education is vital to all people including LwHI. It's good to expose LwHI to diseases, sexual life, general body cleanness and many more other themes. Health literacy is the ability to understand, communicate, process and obtain basic health information, so keep that in mind as your end goal during patient communication. However, Jie complained that they were not always considered as the result there was a gap in their health education. The lived experience of *Jie* reported that:

> *It's very rare for us the deaf people to have appropriate posters in health facilities that portrays sign language for easy interpretation and understanding in our own language (Jie, 2021).*

Con also observed that poor health literacy levels for the LwHI affects them to present themselves fully as stated; '*deaf patients with low literacy skills will finds it more difficult to present their questions and concern to their doctor.*' This entails that those LwHI with high health literacy levels are able to present themselves fully before the doctor.

Furthermore, *Jui* observed in her statement that health education can be helpful if all health workers had basic sign language. *Nash* also said he got help from health education he watched on BBC where health workers taught in sign language and he observed that;

> *... there is need to come up with deliberate policy where sign language training becomes mandatory to all health workers so that they can spread and teach health education effectively to us the deaf community. If health education for us can be improved then even health services can be offered to us with efficiency (nash, 2021).*

4.3.7 Limited Institutional support staff

Institutional staff covers both health services and non-health support offered to LwHI learn effectively. From the on-going discourse, health staff support to LwHI was limited to a few oriented in Special Education matters. In addition, support is directly affected by the attitudes and values staff have towards LwHI as well. Take the experience of Jan as an example below.

> *While at the health facility ... I was directed to go to pharmacy but just to get there I needed someone to direct. This became a difficulty for me to reach dispensary because all I asked didn't seem to show care by even taking me there. It was after getting lost in a hospital that is when a good Samaritan took me there. Had they helped me at first I would have gotten the medicine early (Jan, 2021).*

The experience of *Jan* is similar to most LwHI (deaf patients) because in hospitals health workers worse enough those not trained in health courses it becomes worse. In addition, health facilities do not have support staff to help the deaf with necessary information and directions within health environment.

4.3.8 Negative attitude

There are many incidents where negative attitude were manifested. For instance, *Nash*, reported a number of health workers could not provide support to the LwHI who also happened to have epileptic condition. She painfully recounted how in the process of getting medication in the past she was attacked by seizures.

> *Whenever they saw me they could coming towards they could scatter into*
> *their offices for fear of talking to a deaf and epileptic person. I was treated*
> *by one nurse who never gave not even a smile because of my conditions.*
> *The time I collapsed, I only found the male nurse sitting next to me and the*
> *female nurse I dint even see her. He communicated to me in sign language*
> *though he didn't know much (Nash, 2021).*

Like *Nash*, Equally, Rudd had his lived experiences when health care providers could not provide support him due to suspected negative attitudes.

> *I was going to toilet while at the health facility but the nurses I asked in sign*
> *language looked to be busy even if there were not busy……. in fact I used*
> *very simple signs depicting that I wanted a toilet. Everyone was just*
> *looking at me unconcerned until an old woman who heard me with passion*
> *directed me to the toilets and since then I felt that health workers have an*
> *attitude problem (Rudd, 2021).*

Negative attitudes is attached to most of the lived experiences LwHI faces as they access health services. The presence of negative attitude in health providers limits LwHI access to health services and health education. This clearly shows that for LwHI to access better health services, there is need to inculcate positive attitudes in health workers.

Table 2. Showing emerging themes

Key words	Near themes	Emerging themes
• LwHI lived experiences. • Attending to LwHI without relevant knowledge and skills by health workers. • No privacy and confidentiality for LwHI. • Negative attitude in health providers limits LwHI access to health services • Medical vocabulary has a lot of lapses in sign language. • LwHI have experienced wrong diagnosis • Health workers Creates professional isolation from LwHI • LwHI are delayed to access better health services. • Health workers could not provide	• Inadequate trainings and sensitization about deaf culture. • Inadequate privacy and confidentiality. • Lack of health workers competency in sign language. • Lack of inclusion in health facilities • Inadequate health education for LwHI. • Lack of support from health workers and their administrators. • Poor communication between LwHI and health workers. • Lack of	• Poor communication. • Wrong diagnosis. • Lack of privacy and confidentiality. • Discrimination. • Inadequate medical vocabulary for signs. • Poor health education. • Limited Institutional support staff. • Negative attitude.

support to the LwHI • Most LwHI complain about poor health services offered.	licensed interpreters. • Poor access to health services	

4.4 Poor health services vs. academic performance of LwHI

The participants sited the effects of poor health services on academic performance of learners with hearing impairment. The participants reported that poor academic performance was due to frequent absenteeism due to poor health, lack of remedial work or catch up strategy, lack of hospital teaching, negative attitude from teachers and low self-esteem leading to dropping out of school and other factors.

4.4.1 Absenteeism

It is cardinal to note that absenteeism of LwHI from school due to poor health pays negative impact on their academic performance as observed by Jui. From the findings, *Jui* confessed that, *'we the deaf are not dull but the experiences they go through which do not favor them academically makes them underscore during assessments or exams.'* Most of the times, *Jui* expressed that they absent themselves from school when they sick and they miss a lot of teacher-pupil contact time. Adam whose academic performance was very good was going down due to perpetual poor health said:

> *I miss lessons when I'm sick especially if I'm wrongly diagnosed or I fail to access*
> *health services on time. It's my prayer and wish that my teacher should teach*
> *me when I recover so that I can be balanced academically (Adam, 2021).*

Adam's statement above was re-echoed by many other LwHI in various ways. For example, *Fei* observed that after he fell sick for a long time, he missed a lot of content taught by his teacher. Below is a lived experience of how *Fei* was repeated by his teacher's influence.

> *I was sick for a long time so when I went to school, I found that I had missed a lot*
> *so I was forced to repeat in the same grade because I did not perform well at the*
> *end of academic year (Fei, 2021).*

Nash also observed that when she was in grade five used to suffer from skin problem so she missed for a number of lessons for months. Below is a lived experienced of how Nash academic performance dropped when she was re-admitted in school.

...but when my sickness advanced I stopped for two weeks. The day I
reported I was given an assessment which my friends wrote. I failed
not that I'm dull but my absence from school. It's painful to miss school
and to fail in my life (Nash,2021).

4.4.2 Prolonged admission in hospital/home based.

From the findings, Con revealed that when he was sick he missed a lot at school so he wished his teachers could visit him at the hospital or at home to teach him sometimes. Con's lived experience is reported below.

I was sick for a long time so I missed lesson but I still wanted to learn.
I wanted my teacher to come and teach me at the hospital. Even when
I was discharged, my teacher would have been coming home to teach
me even once in a week but nothing was done so my academic performance
is bad (Con, 2021) .

The lived experience of Jie is different from the previous respondent. Her report was:

I was hospitalized for three months and my teacher was good so he came up with
program so that he could be teaching me in the hospital. When I heard this, I was
very happy but the nurse refused him because the disease I had was contagious.
This affected my performance at school (Jie, 2021).

4.4.3 Low self-esteem leading to dropping out of school

During the interview, the findings showed that LwHI had experienced a lot of challenges when they are sick. This led *Jui* to loss interest in her education and finally dropped out of school because her performance became extremely poor at school. Jui said that:

I missed a lot at school so I developed low self-esteem in education. My academic
performance so low that I dropped out of school……. I was readmitted after I
relocated to another district (Jui, 2021).

Like Jui, Dust reported that he was doing fine before he fell sick. *'…. after recovering from my sickness, I felt empty for I left school 8 months ago so my academic performance became poor.'* He lost courage to learn and he almost stopped school but his class teacher helped him build his self-esteem.

From the findings above, the effects of poor health services on academic performance of learners with hearing impairment was revealed and proved to be doing more harm academically hence calls for fast and better provision as well as access to health services so that LwHI do not miss lessons and their illnesses should be met on time.

Table 3 showing emerging themes

Key words	Near themes	Emerging themes
• Absenteeism of LwHI from school due to poor health pays negative impact on their academic performance. • Missing of lessons due to prolonged admission in hospital or home. • Developed low self-esteem in education. • Academic performance was very good was going down due to perpetual poor health.	• Unmet health services • Lack of teacher competency in catch up strategy. • Lack of remedial work for LwHI. • Inadequate fund to support hospital teaching/ home visitation. • Lack of support from school administrators. • Lack of coordination between teachers and health workers.	• Absenteeism. • Prolonged admission at hospitals. • Low self-esteem leading to dropping out of school.

Table 3

4.5 Strategies to improve access to health services for LwHI.

The participants both girls and boys with hearing impairment were asked to comment on the strategies in use to improve access to health services for learners with hearing impairment or deaf people. They reported that some hospitals had not put in place working programmes to help LwHI to access health services due to poor policy direction and inadequate funds. Some measures put in place include sensitization of health workers how to attend to LwHI, involvement of LwHI in decision making, employing licensed interpreters, call for mandatory Sign language training for health workers, use of Assistive Technology services and provision of extra time for medical consultation as well as advocate for inclusive policy at health facilities so that LwHI can experience full access to health services.
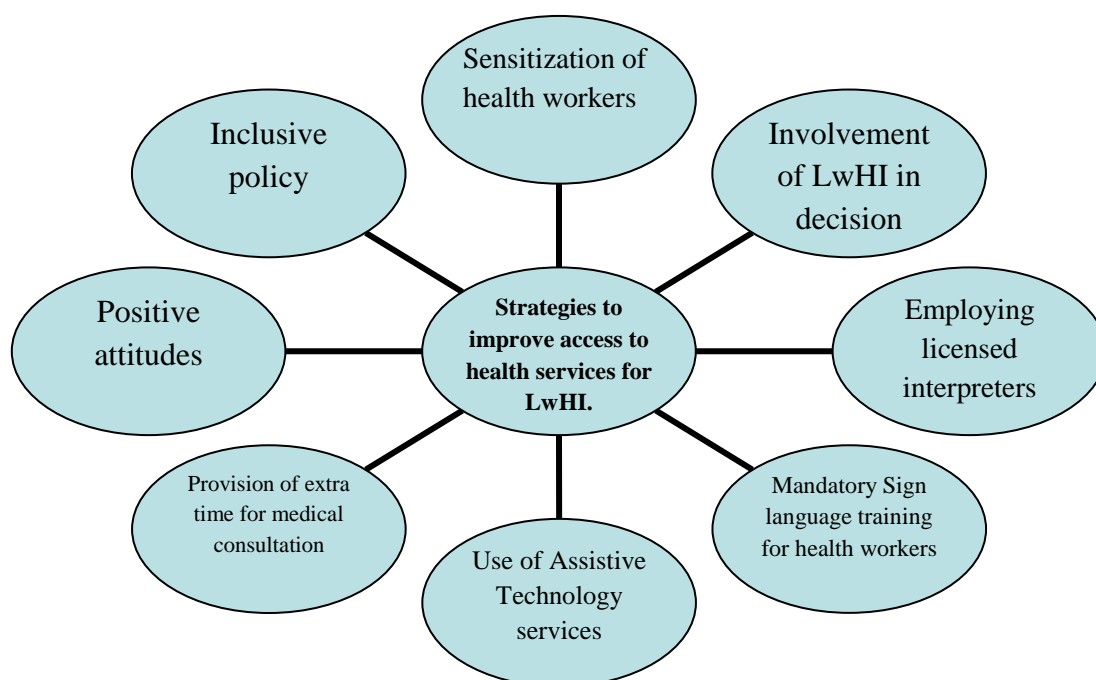
Figure 1: Strategies to improve access to health services for LwHI
Source: Own illustration based on current study

4.5.1Sensitization of health workers how to attend to and treat LwHI
Sensitization of health workers about deaf culture and the rights is key to improving accessibility to better health services for LwHI. Jan observed that most health workers has little knowledge about the deaf culture in general that is why they seem not to care that they hinder deaf right to health care. Jan echoed in his report that:

> *… health workers should receive us with respect like they do with others.*
> *I think if they are sensitized about deaf culture, they can improve and*

better our services (Jan, 2021).

Jan was not the only one who noted the need to sensitize health worker. Equally, *Jie* recounted the need to sensitize health workers after being exposed to hospital environment as stated below.

> *I observed that some health workers are good but they have very little knowledge about us the deaf. I feel health workers should be reminded all the times during briefing about the rights of persons with disabilities and the deaf culture [*human rights model*] (Jie, 2021).*

Nash with her lived experience exposed that health workers should be sensitized about challenges the deaf face especially with communication which is key to all aspects of accessibility to health services. Nash recommended that, *'health workers should strive to know more about us with hearing impairment and our culture for effective deliverance of quality health services.'*

4.5.2 Involvement of LwHI in decision making
Involvement of LwHI in decision making is cardinal to make their voices heard. Rudd observed that the involvement of LwHI would help to let health workers know how the deaf would like to be treated and communicated to once at the health facility. Rudd appreciated how he was treated in when he was at a certain hospital. Below is the conversation between Rudd and health worker.

> *(Doctor) hello, how are you? (Rudd) I'm not ok. (Doctor) How would like to be communicated to? I don't know much signing language. I just know how to greet. He wrote on a piece of paper. (Rudd) I'm comfortable with writing. (Doctor) what is the problem? (Rudd) I'm feeling bad in my heart. I'm feeling an acute pain. (Doctor) Ok I see. You will be fine soon after taking these drugs (Rudd, 2021).*

Rudd wished all health workers were so open and soft to their deaf clients so they could know if such a client is literate or not and which mode of communication would be accommodating to a deaf client.

Like *Rudd*, *Nad* also seconded the issue of involving LwHI on how their health services could be met. Nad advised that she prefer to read the lips and below is what she dais.

> *... if health workers could speak while looking at me, I can lip-read. I find it difficult to lip-read when a doctor or nurse is facing away from me, if a nurse has applied lipstick or a make nurse is having beards. They should maintain their lips clear for easy observation. Its easy for me to also read facial appearances whether happy, sad, bad, good, doubting (Nad, 2021).*

Jie like *Nad*, also felt that the health facilities should provide two screening points for the deaf and non-deaf patients. This would improve efficiency too in the delivery and accessibility of health services to LwHI. She observed that:

> *I feel the hospital should came up with two screening offices for the Deaf and non-deaf so that best services could be offered depending on the disability. It irritated me when I was in the line then the nurse was calling names and I being deaf that was an insult. How could I hear when I don't? Better they came up with two screening rooms for disabilities and non-disability (Jie, 2021).*

It is clear from the above, that solutions to the challenges encountered in the process of accessing health services lies with the excluded persons. If only they can be engaged and consulted in decision-making process, institutions are bound to make a break-through to a multitude of equity challenges they face.

4.5.3 Licensed interpreters

For the outstanding delivery health services to LwHI calls for licensed professional interpreters. Adam commended the issue of licensed interpreter stating that, '*on his personal level, an interpreter plays a key role in the lives of us the deaf persons.*' *Jie* like *Adam*, commended that:

> *an interpreter becomes the liberating voice of the deaf and the linkage to the outside world as he/she enables and facilitates communication, moreover, making the world of the Deaf a little easier and more pleasant. Interpreters in the provision of better health services stands in between LwHI and health workers. Their link is very important to save the lives of LwHI by making doctors to come up with proper diagnosis (Jie, 2021).*

Like *Jie*, many respondents were in support of this strategy but *Dust* added further that it would be more advanced to have health workers learn sign language to scrap off the interpreters so that the needs of the Deaf people are met fully with high levels of trust. *Dust* appreciates the experience he had one time at the health facility as stated below.

> *... while at the health facility, I met a medical doctor who provided my services in sign language and I felt accommodated, accepted and loved because I explained my problems clearly and with trust. I enjoyed not being in company of an interpreter (Dust, 2021).*

Like Jie, Rudd commended the health facilities to uphold and provide *LwHI with licensed professional interpreters who can interpret clearly about their health matters. Rudd echoed that, 'I believe the use of professional language interpreters is correlated with improved clinical care.*

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        ┌─────────────────────────────┐
        │  Interpreter communicates to│
        │  both doctor and deaf patient│
        └──────────────┬──────────────┘
           ┌───────────┴───────────┐
┌──────────────────────┐  ┌──────────────────────┐
│ Doctor speaks to a deaf│  │ Deaf Patient (LwHI) listen to a│
│ patient via an interpreter│  │ doctor via an interpreter│
└──────────────────────┘  └──────────────────────┘
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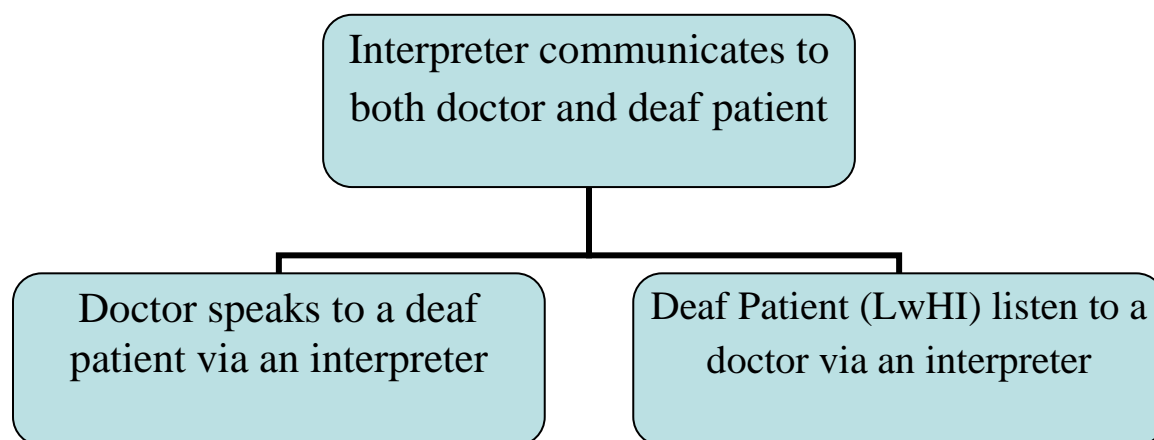
Figure 2: interpreters' role
Source: Own illustration based on current study

Nash was also for the idea that the use of licensed professional interpreter always brings in better services which makes health matters accessible.

> *As a deaf patients I usually expect positive lived experiences in health care encounters when medically experienced professional sign language interpreter is present than unprofessional family member to interpret for me (Nash,2021).*

Con further supported that he would be the happiest if the licensed professional interpreters were employed to help the deaf access better health services. It's everyone's wish so that doctors could understand our true problems.

4.5.4 Sign language Mandatory training of health workers

The findings showed that LwHi would like sign language be mandatory training to all health workers for efficiency, improved services and to uphold inclusive health facilities. Fei stated that though inclusion is enshrined in all ministries with so good statement like leaving no one behind, she still felt that the deaf were still behind in terms of access to health services. Despite some health workers having zeal to learn sign language, *Fei* thought that, '*sign language be made inclusive to all health workers for effective accessibility to health services by the deaf patients*'.

Like Fei, Jan also said, '*I want all health workers to learn my language so that I can explain my problems without a third party. I don't like and trust interpreters.*

In the same vein, Jui stated as follows;

> *Training of health workers in my language (sign language) would make the*
> *deaf community very happy because all sort of communication problems would*
> *be solved and we would receive better health services in all health facilities*
> *(Jui, 2021).*

Jui further said that the health workers should use patient-centred approach to health care and be cognizant with patients' autonomy in order to encourage the healthcare provider to gain an understanding of the disease as well as the patients' experience of the illness.

4.5.5 Use of Assistive Technology services

Assistive technology services which includes installing large screens in health facilities, use of phone and computer as well as laptops for texting, email, whatsup, facebook, video conferencing or zoom meeting are useful tools in communicating with health providers and ends up improving health services commended by Con. Con's statement about the use of technology when acquiring health services is stated, '*Some health facilities have installed screen or other visible method of notifying us deaf patients rather than calling our name'. Jie* made it clear in her statement*, 'health facility should allow us the deaf make future appointment, offer online booking for appointments through whatsup, email or other means.*

> *For us hearing impaired learner, technology such as phones helps us communication*
> *by texting with doctors or nurses about our health problems. It enables us the Deaf*
> *people to make initial contact by telephone through voiced text messages and*
> *continue any conversation by SMS as we access health services (Jie,2021).*

4.5.6 Extra time for medical consultation

During medical consultation and diagnosis, *Nad* observed that LwHI consume a lot of time because it involves Deaf, interpreter and doctor and all should communicate to arrive at a one thing. Due to this, below is what was said.

> *I spend time writing or communicating through an interpreter with*
> *the doctor which I believe is a long process. Sir, I would suggest*
> *that extra time for medical consultation is granted to us the Deaf (Nad, 2021).*

In addition, Dust also narrated that he struggled to explain things in sign language to make a doctor understand. '*I mean and for this I would call for more time to be allocated to deaf in order to access better health services'.*

4.5.7 Positive Attitudes

It's worthy to note that positive attitude appears to influence other lived experiences such as sensitization of health workers how to attend to LwHI, involvement of LwHI in decision making, employing licensed interpreters, call for mandatory Sign language training for health workers, use of Assistive Technology services and provision of extra time for medical consultation as well as advocate for inclusive policy at health facilities. Positive attitudes received by LwHI from health workers and the society is cardinal when accessing health services. On daily basis, LwHI go through a number of experiences just acquire basic health services. An example below of *Jie* lived experience and how she worked with health workers to solve the problem.

> When time for operation came for me on 23th November, 2015, *the operation Team at the hospital told me that they will operate on me next year on 3rd January , 2016 due to the absence of a professional licensed interpreter. Fortunately my teacher came to check on me so he was called and interpreted everything, we had to sign the forms and I was operated on successfully. Health workers showed an attitude of positivity. (Jie,2021).*

For example, *Jui* had also his lived experiences on several occasions when accessing health services at health facilities. She explained that she was with three friends who were deaf but literate unfortunately she wasn't so fluent in writing and below is *Jui's* conversation with the doctor, as she negotiated to be attended to despite going late at the hospital:

> *[Doctor] '...we closed the hospital unless emergencies. How come you are coming this time?' I told him that there is no timetable for sickness. (Jui) 'We bought food on our way home and suddenly we begun feeling stomach pains so instead of going home we have decided to come here' The doctor understood us but he told us individually to write on a paper how each was feeling which I did though with difficulties the doctor read and gave us medicine (Jui,2021).*

It is cardinal to note that health workers positive attitude towards health services increases self-esteem, determination and makes LwHI to access better health services.

Table 4. Showing emerging themes

Key words	Near themes	Emerging themes
• Lived experiences of LwHI. • Access to better health services. • Sensitization of health workers about deaf culture and the rights for LwHI. • LwHI in decision making. • Encourages LwHI to access better health services. • Positive attitude towards health services increases self-esteem, determination. • Extra time for medical consultation is granted to us the Deaf • Interpreter communicates to both doctor and deaf patient • Knowledge is deepen. • Provision of Licensed interpreters. • Improve Health education. • Implementation of inclusive policy at health facilities	• The role of professional licensed interpreter • Significant of communication in sign language • Impact of licensed sign language interpreter on LwHI. • LwHI to focus on ways to communicate with health workers • Gives LwHI sense of trust. • Health workers become effective and efficient in delivery of services to LwHI. • Health workers become experts in communicating with LwHI. • Consultation period for LwHI is extended. • Inclusion is upheld.	• Sensitization of health workers how to attend to LwHI. • Involvement of LwHI in decision making. • Employing licensed interpreters • Call for mandatory Sign language training for health workers. • Use of Assistive Technology services • Provision of extra time for medical consultation. • Advocate for inclusive policy at health facilities • Positive attitude

4.6 Summary of the Chapter

The chapter presented findings of the study regarding lived experiences of learners with hearing impairment when accessing health services: focus on Musakanya combined school in Mpika district. Findings have been presented according to the themes which emerged such as (i) Lived experiences of LwHI when accessing health services (ii) Poor health services vs. academic performance of LwHI and (iii) Improve access to health services for LwHI.

The study revealed that learners with hearing impairments had numerous lived experiences when accessing health services. The findings ranged from poor communication, wrong diagnosis, lack of privacy and confidentiality, discrimination, inadequate medical vocabulary for signs, poor health education, Limited Institutional support staff and Negative attitude. On the other part, the study also looked at poor health services vs. academic performance of LwHI under the following subheadings; absenteeism, prolonged admission at hospitals and low self-esteem leading to dropping out of school. The study also looked at the strategies to use to improve access to health services for LwHI or deaf people such as sensitization of health workers, involvement of LwHI in decision making, licensed professional interpreters, mandatory sign language training for health workers, use of assistive technology devices, extra time for medical consultation and universal sign language dictionary. The next chapter discusses the findings presented in chapter four.

CHAPTER FIVE

DISCUSSION OF FINDINGS

5.1 Overview

In chapter five, the researcher builds on the previous chapter by discussing the findings of the study. The chapter revisits the various themes that emerged in chapter four and weaves other researchers' findings conducted in various settings worldwide. The discussion anchors on the three theoretical models namely (i) Social model; (ii) Human Rights model and (iii) Phenomenological model as earlier presented in chapter two, to elicit meaning from the lived experiences of LwHI. In addition, the chapter discusses the lived experiences of LwHI when accessing health services in three segments namely: (i) Lived experiences of LwHI when accessing health services (ii) Poor health services Vs. academic performance of LwHI and (iii) Improve access to health services for LwHI.

5.2 Lived experiences of LwHI when accessing health services

The first research question of this study focused on lived experiences of learners with hearing impairment when accessing health services. The findings ranged from poor communication, wrong diagnosis, lack of privacy and confidentiality, discrimination, inadequate medical vocabulary for signs, poor health education, Limited Institutional support staff and Negative attitude.

5.2.1 Communication

The results of this study, as with other studies, indicate that communication problems in different forms are the most significant factor affecting access to health care services for our deaf participants. All participants in the study experienced Communication problems which is looked to be a universal problem experienced by LwHI and other deaf people in Zambia, other African countries and the globally.

All of the LwHI cited in the study experienced poor communication in the process of accessing health services. For instance, *Con* cited incidents where he was treated unfairly by health workers at hospital as he wanted to access health services basing on his hearing impairment [*corporeality*]. He sadly recounted how his human right was abused by the nurse who by all means refused to attend to him because he could not communicate verbally and she could not communicate with him in sign language. This state of affairs described above point to lack of human rights [*Human Rights model*] enforcement by the duty bearers.

Equally, *Dust* had moments when health workers treated him unfairly as he was told to register his personal details so he had to finger spell his particulars such as name, my age and location. To his surprise, the nurse just laughed at him and sent him away rudely to go home and come with his parents. *Adam* and *Nash* recounted too how they were mistreated by health workers. They complained that the patient-health workers relationship [*Relationality*] was poor due to their disability [*Corporeality*].

The identified presence of poor communication in this study is common to many settings as noted by Mitsi (2014), Fernanda (2017), BID Services (2015) and Chiluba et al. (2019) in Greece, Brazil, Durham and Zambia respectively. In Greece, students with a Hearing impairment were reported having less access to health care services and therefore experience unmet health care needs (Mitsi, 2014). In Brazil, the study reported that there was communication barrier especially the healthcare professionals' unfamiliarity with the Brazilian Sign Language. In Durham, Deaf, Deafblind & Hard of Hearing People in Durham faced inequalities and barriers when accessing healthcare services due to communication problems. In addition, Chiluba et al. (2019) revealed that Deaf people do not receive full disclosure of their medical situation and the alternatives are not discussed with them because of communication barriers faced. Furthermore, even when disclosure does occur, many Deaf people may not fully understand the options available to them because of communication difficulties with health care providers.

Kuenburg (2016) also noted that the Deaf still experienced communication problems which hampered their accessibility to better health services. Orrie and Motsohi (2018) pointed out that health workers feared to attending to Deaf people at primary health care because they experienced communication problems for they could not understand sign language. Furthermore, language is essential to developing a therapeutic relationship with a patient, yet the language barrier between deaf patients and hearing healthcare workers is one of the main challenges to access to health care. Gaihre et al. (2016) argued that many health workers at health facilities neither understand nor appropriately communicate in sign language, nor are sign language interpreters available to interpret.

5.2.2 Wrong diagnosis and prescription.

Generally, all the lived experiences highlighted such as wrong diagnosis still calls shows the need for sign language for health workers to provide better health services to LwHI at national and institutional levels. Majority of LwHI have experienced wrong diagnosis due to poor communication and this has resulted into prolonged poor health. Look at the case of *Jie* who experienced wrong diagnosis when she went in OPD for screening alone. It's the right of everyone to access health services [*human rights model*] but not for the deaf. The previous day in the morning, she went back

to hospital with her parents who explained how she was feeling and it was discovered that she was given a wrong diagnosis.

In similar vein, *Jui* also was a victim of wrong diagnosis due to the inability of health workers to find means and ways to communicate with *Jui. Rudd and Nad* also had a similar experience of wrong diagnosis while at the hospital. *Jan* too reported that he was exposed to wrong diagnosis due to misunderstanding in diagnostic and therapeutic process.

In developed countries, a number of studies on access to health services by LwHI have established the presence wrong diagnosis and prescription. For example, Atqia et.al (2016) study established that there was need to employ professional interpreter to stop subjecting individuals with hearing impairment to wrong prescription and medication hence missing to address their illness. Mitsi (2014) study conducted revealed that LwHI experienced wrong diagnosis most of the times they accessed health facilities as the result their health care needs were unmet fully.

Other LwHI experienced challenges with Doctor's ability to take patients medical history. Mulumba et al. (2014) revealed that doctors end up making estimations of what patients say and hence gave wrong diagnosis and prescriptions. Also, Mprah (2013), Ganle et al. (2016) and Ledger (2016) reported that health providers do not understand the explanations of health conditions, which has resulted in wrong prescription of medicines. *Jui* experienced correlated with Ganle et al. (2016) where a Deaf learner reported having received just paracetamol for a very complicated situation of her heart problem that a Clinical officer could not understand.

5.2.3 Lack of privacy and confidentiality
The researcher observed that LwHI complained about the issue of privacy and confidentiality for they are linked to trust. Unfortunately, it was very rare for the LwHI to be accorded privacy and confidentiality as was reported by *Adam* that his privacy and confidentiality should be respected and he further pointed out that most third parties involved to interpret fail to uphold confidentiality values. Other participants such as

Fernanda (2017) reported that there was need for a family member with high moral fiber of confidentiality and privacy or interpreter to be present during the consultation. However, Mweri (2018) revealed that the use interpreters; licensed ones or family member/relative is cardinal but may interfere with their privacy and confidentiality. *Con, Jui, Nad, Rudd, Dust, Jan, Nash*, and *Fei* revealed that their rights to privacy and confidentiality were not respected because the people involved seemed not to respect the deaf client privacy and confidentiality but tend to be news

reporters and vuvuzelas. Before they could even reached home, the news should be all over the place which brought humiliation of worst kind.

This is consistent with Nathanson (2011) noted that principles of health ethics such as privacy, confidentiality, patient autonomy and individualization of the person's treatment, is neglected when there is the bias of a third participant in form of a relative of interpreter mediating the information during the medication process. Mostly, LwHI have less trust in the third participant due to lack of confidentiality.

Ledger (2016) also observed that LwHI tend to mistrust the interpreter, who they perceive as giving them wrong information on their health status, or feel uncomfortable with the violation of privacy, particularly when it comes to sensitive information regarding sexual and reproductive health, such as HIV status. Tun et al. (2016) revealed that those LwHI who go to the health centre with the support of an assistant or family member as interpreters, are reported having difficulties to maintain confidentiality.

5.2.4 DISCRIMINATION

The other vital theme that emerged from the findings was discrimination. Participants reported that they experienced quite a number of discrimination in process of accessing health services. All hospitals must be discrimination free and should embrace the spirit of inclusiveness to all patients regardless of disability. LwHI felt that discrimination is painful everywhere be it in school, sports events, church, in a home but worse at hospital when you are sick and in need of services being denied.

It would seem that some health workers had negative attitudes towards LwHI as observed by the above submission. This could be pointing to the need for an inclusive policy to guide practice, as well as sensitization and capacity building among the health workers in the health institutions, if the reported discrimination was to end (HRCZ, 2010).

In line with the above accession, discrimination occurs when you are treated less well or put at a disadvantage for a reason that relates to your disability in one of the situations covered by the Equality Act. *Rudd* and *Jan* comment is tied with Mtonga, (2020) with a views that failure to provide sign language services to the deaf is discrimination enough because any distinction, exclusion or restriction that has the purpose or effect of denying the recognition, enjoyment or exercise by persons with disabilities, on an equal footing, of all human rights and basic freedoms.

5.2.5 Inadequate signs for medical terms

Another theme which emerged was inadequate universal sign for medical terms. During the findings to the study it was discovered that medical vocabulary has a lot of lapses in sign language. For instance, *Dust* felt many LwHI desire to explain their problems to doctors but due to inadequate signs for medical concepts they go back with their health unmet which he felt should be addressed.

Mulonda, M. (2013) reported the same experiences where they noted that LwHI lags behind in reading comprehension, vocabulary, and experiential knowledge for many LwHI negatively affect their knowledge of science concepts. Biology concepts are scientific in nature such as 'antibiotics, drugs, impetigo a disease, neuron, nerves, drugs, heroin, cocaine, chemotrophic, heterotrophic, autotrophic, nutrition, and many others have no signs. Specifically, many students struggle to express themselves using medical (science) concepts because LwHI have not been exposed to the vocabulary of science and about 60% of the words considered important in a science curriculum do not have sign representations as a result there is Under-diagnosis and under-treatment of potentially serious conditions is more common in Deaf people. (Muzata, 2017). This has led to poor treatment of High blood pressure, cardiovascular disease, Diabetes, stroke and others due to lack of detailed knowledge about sign language by health workers and some uneducated deaf.

5.2.6 Lack of health education

All the LwHI recounted how difficult it was when COVID19 broke out and ministry of health had not done enough health literacy for the LwHI. Health education is vital for all people and it's good to expose LwHI to diseases, sexual life, general body cleanness and many more other themes. However, *Jie* complained that they were not always considered for it was very rare for the LwHI to have appropriate posters in health facilities that portrays sign language for easy interpretation and understanding in our own language as the result there was a gap in their health education.

Con also recounted how deaf patients with low literacy skills would finds it more difficult to present their questions and concern to their doctor. Furthermore, *Jui* observed that health education could be helpful if all health workers had basic sign language. *Nash* also recounted how she was help from health education he watched on BBC where health workers taught in sign language and he observed that there was need to come up with deliberate policy where sign language training becomes mandatory to all health workers so that they can spread and teach health education effectively to the deaf community. If health education for the deaf could be improved then even health services could be offered to the deaf with efficiency.

This study's finding on lack of health education is consistent with Richardson (2014) who argued that the experiences of the deaf severely lacked adequate health education about topics such as safety, mental health, alcohol, drugs, and sex education, balanced meals and nutritional treatment of health issues is again hampered by communication barriers as a result, this places them at unnecessary high risk for frequent development of non-communicable diseases (NCDs). It should be noted that Deaf people may be fearing to interact with health care workers who are insensitive or uneducated about the needs of the Deaf community. *Nash*, Richardson (2014) and Chiluba et.al (2019) are for the view that health education and promotion can be effective if health workers were trained in sign language and Deaf culture.

Despite LwHI experiencing direct communication barriers between health workers and patients, UPHLS (2015) reports that there is also indirect communication such as brochures, magazine and prevention or awareness campaigns that are not signed. LwHI are unable to comprehend information embedded in pictures and on flip charts properly without converting it into sing language (Ledger 2016). UPHLS (2015) also reported that prevention messages given on the radio, likewise, are inaccessible for the Deaf people.

5.2.7 Limited institutional support staff

Institutional (spatiality) support staff covers both health services and non-health support offered to LwHI. From the on-going discourse, support from health staff to LwHI was limited and this made the environment alien and undesirable to the deaf children. In addition, support is directly affected by the attitudes and values staff have towards LwHI as well. *Jan* recalled that he was at the health institution (Spatiality) and he was directed to go to pharmacy but just to get there he needed someone to direct him. This became a difficulty for him to reach dispensary because all he asked didn't seem to show care by even taking him there due to communication problem. It was after getting lost in a hospital that is when an old woman took him there (*relationality*). Had they helped him at first he would have gotten the medicine early.

Atqia et.al (2016) explored experiences of LwHI in pakistan where the findings suggest that there was need to train health workers such as doctors, nurses e.t.c. in sign language to better serve the needs of learners with LwHI which results into improving health workers and LwHI relationship. Health Institutions can support its staff through holding seminars, workshops, virtual learning about the deaf culture and their sign language. It was in this light that Chisupa (2007) also argued that teaching health workers sign language would greatly improve health services for the deaf and the hard of hearing.

The experience of *Jan* is similar to most LwHI (deaf patients) because in hospitals health workers worse enough those not trained in health courses it becomes worse. In addition, health facilities do not have support staff to help the deaf with necessary information and directions within health environment.

5.2.8 Negative attitude.

There are many incidents where negative attitude were manifested. For instance, *Nash*, reported a number of health workers could not provide support to the LwHI who also happened to have epileptic condition. She painfully recounted how in the process of getting medication in the past she was attacked by seizures and the nurses scattered into their offices for fear of talking to a deaf and epileptic person, therefore she was treated by one nurse who never gave not even a smile because of her disabilities.

Like *Nash*, Equally, *Rudd* recounted his lived experiences when health care providers could not provide support him due to suspected negative attitudes. He was going to toilet while at the health facility but the nurses he asked in sign language pretended to be busy. It took the help of an old sick woman to take him to the toilets and since then he felt that health workers still had negative attitude towards the disabled.

Negative attitudes is attached to most of the lived experiences LwHI faces as they access health services. Ormsby et al. (2012) reported negative attitudes of health workers experienced by LwHI as a barrier to access health services. The negative attitude of healthcare staff and service providers towards the deaf children and adults have been extensively reported in various studies. Gaihre et al. 2016 and Kritzinger et al. 2014 noted that health care providers seem to be insensitive, whether on purpose or because of a lack of knowledge about the needs of people with disabilities. The presence of negative attitude in health providers limits LwHI access to health services and health education.

Kritzinger et al. (2014) indicated in a study with deaf people that negative attitudes were a result of frustration, because health care staff and deaf people were not able to communicate with each other, and staff did not give deaf people enough time to explain their situation. Other studies mentioned that healthcare providers would ignore patients with disabilities and give priority to other patients, in anticipation of communication problems (Tun et al. 2016). This clearly shows that for LwHI to access better health services, there is need to inculcate positive attitudes in health workers. All in all, health worker's attitude towards disability such as the deaf was found to be negative with poor knowledge and skills about providing services.

Doctors also report discomfort in communicating with deaf patients in comparison to their patients in general, particularly in understanding and maintaining conversation; the deaf patients often became frustrated and these encounters then negatively impact on the patient's trust in their doctors (Andrade et.al, 2010).

5.3 Poor health services vs. academic performance of LwHI

Emerging from the lived experiences of LwHI sited the effects of poor health services on academic performance. Factors included: (i) absenteeism (ii) Prolonged admission in hospital/home based and (iii) Low self-esteem leading to dropping out of school.

5.3.1 Absenteeism

Nearly all LwHI cited incidences where absenteeism was exhibited. It is cardinal to note that absenteeism of LwHI from school due to poor health pays negative impact on their academic performance as observed by *Jui*. For instance, *Jui* cited incidents that the Deaf learners are called dull because of the disability [corporeality]. She painfully complained that the experiences she go through which do not favor her academically makes her underscore during assessments or exams. Most of the times, *Jui* expressed that they absent themselves from school when they sick and they miss a lot of teacher-pupil contact time due to poor health services received compared to the hearing learners. This state of affairs described above point to lack of human rights [Human Rights model] enforcement by the hospital administration and NGOs as advocators for equal access to health services.

Equally, Adam recounted that he missed lessons whenever he was sick especially when he was wrongly diagnosed and prescribed at the hospital [*Spatiality*] or when he failed to access health services on time. It was his wish that his teacher could teach him [*relationality*] whenever he recovered so that he could balance academically.

Fei also cited moments he fell sick for a long time that he missed a lot of content taught by his teacher. Later he was forced to repeat in the same grade because he did not perform well at the end of the academic year. Further, *Nash* had moments when she was in grade five she used to suffer from skin problem so she was avoided and bullied due to her condition [corporeality] by her friends so she stopped going to school for months. The day she reported back at school [*Temporality*] she was assessed and her performance was bad.

The identified presence of effects of poor health services on academic performance in this study is common phenomena in education settings to as noted by National Health Interview Survey (2014); and Pourat, & Nicholson (2009) in USA and other European countries. LwHI having poorly controlled asthma experienced Emergency Department visits, hospitalizations, missed school,

disrupted sleep, asthma attacks, and frequent use of medications for quick relief. Studies have also found a link between uncontrolled asthma and poor school performance in LwHi (disabilities) with severe and persistent asthma and in children from low-income families (NHIS, 2014). Pourat & Nicholson, 2009) argued that LwHI experienced increased school absences, difficulty paying attention in school, difficulty keeping up with peers academically and completing homework, and lower standardized test scores.

5.3.2 Prolonged admission in hospital/home based.

From the findings, *Con* revealed that when he was sick he missed a lot at school so he wished his teachers could visit him at the hospital or at home to teach him sometimes. Equally *Jie* recounted being hospitalized for three months and her teacher came to teacher her [*relationality*] but because she had a contagious disease so her teacher was not allowed.

NHIS, (2014) noted that LwHI experienced Emergency Department visits, hospitalizations and missed school which affects their academic performance in school. The findings of the study found that the deaf received poor quality of services when they fell sick. Due unmet health services, it took time for the deaf children to recover and resume attending their classes and this had a huge impact on their academic performance (Chisupa, 2007). In addition, Chiluba et al. (2019) commended that Deaf people do not receive full disclosure of their medical situation as result fast recovering is far-fetched and the negative impact falls on their academic performance in school.

5.3.3 Low self-esteem leading to dropping out of school

From the findings, LwHI had experienced a lot of problems when they are sick which resulted into low self-esteem leading to dropping out of school. For instance, *Jui* recounted how she lost interest in her education and finally dropped out of school because her performance became extremely poor at school after missing school for a long period and she was just readmitted after the family relocated to another town.

Like *Jui*, *Dust* reported that he was doing fine before he fell sick but just after recovering from his sickness, he felt empty for he left school 8 months ago so this affected his academic performance negatively. He lost courage to learn and he almost stopped school but his class teacher helped him build his self-esteem.

From the findings above, the effects of poor health services on academic performance of learners with hearing impairment was revealed and proved to be doing more harm academically hence calls for fast and better provision as well as access to health services so that LwHI do not miss lessons and their illnesses should be met on time.

For instance, Connecticut's (2017) observed that data for the 2015-2016 school year showed that learners with disabilities under IDEA kept on exhibiting substantially higher chronic absenteeism rates than their peers in general education despite statewide prevention and intervention efforts. The report states that 18% of Connecticut's students with disabilities were chronically absent compared to 9.6 percent overall. However, the Deaf people have lower health conditions than listeners and access health services differently.

5.4 Strategies to improve access to health services for LwHI

The participants both girls and boys with hearing impairment were asked to comment on the strategies in use to improve access to health services for learners with hearing impairment or deaf people. They reported that some hospitals had not put in place working programs to help LwHI to access health services due to poor policy direction and inadequate funds. Some measures put in place include sensitization of health workers how to attend to LwHI, involvement of LwHI in decision making, employing licensed interpreters, call for mandatory Sign language training for health workers, use of Assistive Technology services and provision of extra time for medical consultation as well as advocate for inclusive policy at health facilities so that LwHI can experience full access to health services.

5.4.1 Sensitization of health workers how to attend to and treat LwHI

Sensitization of health workers about deaf culture and the rights is key to improving accessibility to better health services for LwHI. *Jan* observed that most health workers has little knowledge about the deaf culture in general that is why they seem not to care that they hinder deaf right to health care [*Human rights model*]. *Jan* echoed that health workers should receive deaf with respect like they do with others. He thought that once health workers are sensitized about deaf culture, they can improve and better health services.

Equally, Jie commended that some health workers are good but they have very little knowledge about the deaf. He felt that health workers should be reminded all the times during briefing about the rights of persons with disabilities [*Human rights model*] and the deaf culture.
Nash with her lived experience exposed that health workers should be sensitized about challenges the deaf face especially with communication which is key to all aspects of accessibility to health services. Harmer (1999) stressed that cultural awareness trainings about deaf culture and sign language for health professionals is key to improved health services and delivery to the deaf people. Woodcock (2007) suggested that Health Centers for the Deaf should be attached to general hospitals and provide complete access to health care for deaf individuals by competent staffs that are familiar with Deaf culture and able to communicate in sign language and or other modes according to the need of their

patients on a one to one. According to Woodcock (2007), health workers were sensitized thoroughly about the deaf culture and this helped the doctors, nurses and other workers to change and respect the deaf whenever they want to access health services. Health maintenance organizations in California (United States) have improved efforts to promote and evaluate sign language interpreter services for the Deaf community (Cormier et.al, 2013).

Mweri (2018) stressed out that to improve access to health care to people who are deaf, deaf awareness training should be implemented. All health care professionals should be sensitized about deafness, deaf culture and sign language. This will not only make them aware of the communication challenges people who are deaf face in accessing services provided by them but also they will be able to understand that these challenges are mostly communication based and that they are putting people who are deaf at risk. This awareness is a step in addressing the issues of access. There is need in doing this awareness to have clear guides in medical institutions of how staff are expected to handle a person who is deaf. Once the first tier medical professional realizes he/she is dealing with a person who is deaf, there must a clearly laid down procedure that is to be followed that may include taking the patient directly to a medical professional who knows KSL and can handle the situation or a qualified interpreter is sought to provide services.

The Convention on the Rights of Persons with Disabilities strongly supports protection for persons with disabilities in relation to health and rehabilitation. It points out that persons with disabilities have the right to the highest attainable standard of health and that State parties must recognize that right without discrimination on the basis of disability (United Nations, 2014). The state parties in this case are the health workers who should be aware of the right of the deaf as they provide health services to them.

5.4.2 Involvement of LwHI in decision making

The call to involve LwHI in decision making is cardinal to make their voices heard. *Rudd* stressed out that the involvement of LwHI would help to let health workers know how the deaf would like to be treated and communicated to once at the health facility. *Rudd* appreciated how he was treated when he was at a certain hospital. He smiled when he was explaining that he was welcomed very well by the doctor he found and at least the doctor was able to greet him in sign language though he did not much sign language. He communicated with the doctor through writing and he was satisfied and happy with the interaction he had with the doctor [relationality]. *Rudd* strongly wished all health workers were so open and soft to their deaf clients so they could know if such a client is literate or not and which mode of communication would be accommodating to a deaf client.

Like *Rudd*, *Nad* also pointed out that if health workers could speak while looking at the deaf, the deaf could lip-read. He found it difficult to lip-read when a doctor or nurse was facing away from him, if

a nurse has applied lipstick or a male nurse is having beards. They should maintain their lips clear for easy observation. It's easy for him to also read facial appearances whether happy, sad, bad, good and doubting. In addition, *Nad*, also felt that the health facilities should provide two screening points for the deaf and non-deaf patients. This would improve efficiency too in the delivery and accessibility of health services to LwHI. It is clear from the above, that solutions to the challenges encountered in the process of accessing health services lies with the excluded persons. If only they can be engaged and consulted in decision-making process [social inclusive model], institutions are bound to make a break-through to a multitude of equity challenges they face.

Gates, 2007 pointed out that people should not be actors only but subjects and part and parcel of the mainstream society. Understanding disability from such a perspective forms the core of social inclusion. This tells that by involving persons hearing impairments in decision making helping the hospital administration in coming up with inclusive decision. Gynnerstedt (2004) stressed that access is better understood as one of the processes of inclusion. Indeed, all levels of society need to be involved so that access to services for those with disabilities such as hearing impairment can be seen as a human rights' issue, and just as human rights are not relegated to one department for oversight, neither should disability issues be (Gates, 2007).

Bigby and Frawley (2010) noted that health workers should make health services inclusive to learners with hearing impairment as such will make them healthy and feel accepted in the society. Inclusive health services can only be achieved once deaf patients are asked how they would like to be communicated to (BID Services, 2015).

5.4.3 Licensed interpreters
For the outstanding delivery health services to LwHI calls for licensed professional interpreters. *Adam* commended the issue of licensed interpreter due to the key role interpreter played in the lives of the deaf people. *Jie* like *Adam*, commended that an interpreter becomes the liberating voice of the deaf and the linkage to the outside world as he/she enables and facilitates communication by making the world of the Deaf a little easier and more pleasant. Interpreters in the provision of better health services stands in between LwHI and health workers. Their link is very important to save the lives of LwHI by making doctors to come up with proper diagnosis.

Like *Jie*, many respondents were in support of this strategy but *Dust* added further that it would be more advanced to have health workers learn sign language to scrap off the interpreters so that the needs of the Deaf people are met fully with high levels of trust. *Dust* appreciates that the experience he had with a doctor at the health facility (Spatiality) where he felt accommodated, accepted and

loved [inclusive model]   just because he accessed better health services in sign language. He explained his problem clearly with trust.

Like *Jie*, *Rudd* commended the health facilities to uphold and provide *LwHI* with licensed professional interpreters who can interpret clearly about their health matters. Rudd echoed that he believed the use of professional language interpreters is correlated with improved clinical care.

Nash was also for the idea that the use of licensed professional interpreter always brings in better services which makes health matters accessible. The deaf patients usually should expect positive lived experiences in health care encounters when medically experienced professional sign language interpreter is present than unprofessional family member to interpret for the deaf.

Smeijers & Pfau (2009) supported the idea of setting up a simple system for booking interpreters, set up the 'Interpreter Now' for online service incase face-to-face interpreter is unavailable and never expect family members or unqualified staff to interpret for a patient with a hearing loss. Cormier et.al (2013) revealed that most of the deaf people communicate via sign language interpreters. Cormier et.al (2013) was in line with *Con* agreed that he would be the happiest if the licensed professional interpreters were employed to help the deaf access better health services. It's everyone's wish so that doctors could understand our true problems.

For patients with limited English proficiency, the use of professional language interpreters is correlated with improved access to better health services and deaf patients report positive experiences in health care encounters when medically experienced professional sign language interpreters are present (Cormier et.al, 2013). The emphasis here being on a qualified interpreter because they are bound by professional ethics and thus are bound to protect the privacy and confidentiality of the patient (Mweri, 2018). Interpreters should be familiar with medical terminology and medical context in order to effectively interpret in the healthcare setting (The Deaf Health Charity, 2013).

5.4.4 Sign language Mandatory training of health workers

The emerging theme showed that LwHi would like sign language be mandatory training to all health workers for efficiency, improved services and to uphold inclusive health facilities. *Fei* stated that though inclusion is enshrined in all ministries with so good statement like leaving no one behind, she still felt that the deaf were still behind in terms of access to health services. Despite some health workers having zeal to learn sign language, *Fei* thought that, sign language should be made inclusive to all health workers for effective accessibility to health services by the deaf patients [inclusive

model]. *Jan* also claimed that he wanted all health workers to learn his language so that he could explain his problems without a third party as he didn't like and trust interpreters.

In the same vein, *Jui* commended the training of health workers in sign language for it would make the deaf community very happy because all sort of communication problems would be solved and they would receive better health services in all health facilities. She further encouraged health workers to use patient-centred approach [*relationality*] to health care and be cognizant with patients' autonomy in order to encourage the healthcare provider to gain an understanding of the disease as well as the patients' experience of the illness (BID Services, 2015).

In line with the above discussion, the deaf suggested that teaching health workers sign language and making deaf awareness training mandatory for all front-line staff would greatly improve health services for the deaf and the hard of hearing (Chisupa, 2007) and (Smeijers & Pfau, 2009). Barnett (2011) argued that in many cases, deaf people report that it is still not possible to use email to reach their GPs for making appointments or asking short questions, as many services are just available via telephone hence the need for mandatory training of health workers because they are always available to offer better services once trained in handling the deaf as suggested by *Jan* above.

5.4.5 Use of Assistive Technology services
Assistive technology services which includes installing large screens in health facilities, use of phone and computer as well as laptops for texting, email, whatsup, facebook, video conferencing or zoom meeting are useful tools in communicating with health providers and the deaf vice versa and ends up improving health services delivery commended by *Con*. *Jie* made it clear that health facility should allow the deaf make future appointment, offer online booking for appointments through whatsup, email or other means.

Adam equally echoed that the hearing impaired learners should be allowed to use technology such as phones to help them communicate by texting with doctors or nurses about their health problems. He confessed that phones enabled the Deaf people to make initial contact by telephone through voiced text messages as they access health services *(Spatiality).*

In support of *Con* and *Jie* assertions, Smeijers & Pfau (2009) commended that health workers should set up a screen or other visible method of notifying patients, rather than calling their name, set up a simple system for booking interpreters and train staff to use this system, set up the 'Interpreter Now' online service.

Barnett (2011) and World report on disability (2016) recognized that Communication technology is widely used in the developed and developing countries to aid Deaf learners to access health services.

In recent years, deaf people have benefited from the prospects of modern information technology when accessing services. Minicamps and text-phones are now widely used, and the availability of web facilities in various places is not only helpful when accessing health services, but also provide more autonomy for deaf individuals familiar with these techniques (Barnett, 2011). Technology that allows texting communication through whatsup, sms, email, twitter and other Medias with regular phones is another recent development. It enables deaf people to make initial contact by telephone (through voiced text messages) and continue any conversation by SMS. Many others for profit technical assistance services are offered to deaf people who can afford it.

World report on disability, (2016) commended Telemedicine as development on board, which recently has provoked broad interest. It can provide wide reaching access to resource centers, offering web communication with signing experts. Several recent studies discuss the application of telemedicine in different medical fields which helps in up lifting.

5.4.6 Extra time for medical consultation

Communicating with the deaf calls for attention and more time so that better health services could be delivered. During medical consultation and diagnosis, *Nad* observed that LwHI (Deaf) consume a lot of time because it involves Deaf, interpreter and doctor and all should communicate effectively to attend to the needs of a deaf client. *Nad* reported that she spent time writing or communicating through an interpreter with the doctor which she believed was a long process. He commended that the hospital where he went always gave him extra time for medical consultation for being Deaf.

Medical consultation, description and diagnosis calls for extra time due to communication challenges experienced by both parties. Due to limited time allocated to the deaf resulted into the deaf receiving poor quality of services when they fell sick. Healthcare professionals need to obtain information and give advice and patients need to ask questions and share their concerns. However, when deaf people attend for consultation, they said they only understand 'some' of the information communicated to them, resulting in a limited understanding of their medical condition due limited time given to them (Chisupa, 2007). *Dust* recounted how he struggled to explain things in sign language to make a doctor understand. Despite that, *Dust* stressed that he liked the way more time was allocated to him whenever he fell sick and he received good services.

5.4.7 Positive Attitudes

It's worthy to note that positive attitude appears to influence other lived experiences such as sensitization of health workers how to attend to LwHI, involvement of LwHI in decision making,

employing licensed interpreters, call for mandatory Sign language training for health workers, use of Assistive Technology services and provision of extra time for medical consultation as well as advocate for inclusive policy at health facilities. Positive attitudes received by LwHI from health workers and the society is cardinal when accessing health services. On daily basis, LwHI go through a number of experiences just acquire basic health services.

An example below of *Jie* lived experience and how she worked with health workers to solve the problem. When time for operation came for me on 23th November, 2015, the doctors and nurses at the hospital told him that they would operate on him next year on 3rd January, 2016 due to the absence of a professional licensed interpreter. Fortunately his teacher came to check on him so he was called and interpreted everything, they had to sign the forms and he was operated on successfully. Doctors and nurses showed an attitude of positivity.

Equally *Jui* recounted that she was with three friends who were deaf but literate unfortunately she wasn't so fluent in writing and below is *Jui's* conversation with the doctor, as she negotiated to be attended to despite going late at the hospital. It was good the doctor understood them and attended to them and jui and her friends appreciated the doctor [relationality].

It is cardinal to note that health workers positive attitude towards health services increases self-esteem, determination and makes LwHI to access better health services. It's good to Gudlavalleti, et.al, (2014) noted that health workers are able to receive and treat the Deaf patients as report by *Nash*. *Nash* recalled the time she collapsed that she only found the male nurse sitting next to him (relationality). He communicated to him in sign language though he didn't know much but this made him happy and safe.

Health workers have also embraced technology as a tool for communication with the Deaf and this is cardinal and helpful. Media such as whatsup, SMS, online appointment and others are reported to be helpful (Foltz & Shank, 2019). It's important to note that the ministry of health have embarked on deaf awareness training to improve access to health care to people who are deaf. All health care professionals are sensitized about deafness, deaf culture and sign language. This has helped to positively change attitudes of health professional toward the deaf and the deaf patients feel respected and accepted once in contact with health workers at local, district and national level. Orrie and Motsohi (2018) noted that health workers lacked communication skills in sign language but with the deaf awareness program on board, there is a shift in terms of attitudes towards the deaf patients which positive.

5.4.8 Inclusive policy at health facilities

The greatest barriers to inclusion are caused by society, not by particular medical impairments. In this regard, UNESCO applied the Social Model to focus on external factors and not biological factors as championed by the medical model, as cause for marginalization and exclusion (UNESCO, 2017). Negative attitudes manifest through social discrimination, lack of awareness and traditional prejudices. However, with the deaf awareness programs about deaf culture and sign language under the positive influence of UNCRPD, Disabilities Act, 2012 and other policies, health workers have embarked on improving access to health services for learners with hearing impairment or deaf people. For instance, Harmer (1999) stressed that cultural awareness trainings about deaf culture and sign language for health professionals is key to improved health services and delivery to the deaf people.

Inclusive policy at health institutions can only be achieved once heath workers improve the communication skills that is sign language. The Deaf agreed that communicating with health workers using sign language motivate them because they feel to be part of the society practicing inclusive health care. Fei also confirmed that today almost every institution is considering the plight of the deaf when disseminating information. Mostly used mode of communication with the deaf in hospitals is the use of interpreters which is better.

Other developments in the inclusive world is the use of technology for communication. Foltz & Shank (2019) reported that new technology and services are being offered to help Deaf patients make appointments such as having an interpreter call the doctor's office during a video call with the patient. Additionally, some health information is now available online in sign language. Interpreters can also be more easily available at short notice for example in emergency situation through video chat.

5.5 Chapter Summary

This chapter discussed the findings of the study and revealed the lived experiences of LwHI at Musakanya combined school: focus on access to health services in three segments namely: (i) Lived experiences of LwHI when accessing health services (ii) Poor health services Vs. academic performance of LwHI and (iii) Improve access to health services for LwHI. This chapter demonstrated that the objectives of the study were answered. The following chapter will give the conclusions and remarks to the major findings, recommendations and suggested future research.

CHAPTER SIX

CONCLUSION AND RECOMMENDATIONS

6.1 Overview

This chapter gives the conclusion of the study. It highlights the findings of the study, the conclusion drawn from it and a set of recommendations. Suggestions are also made for further areas of research.

6.2 Study Summary

The purpose of this study was to explore the lived experiences of LwHI at musakanya combined school with focus on access to health services. Despite the significant low numbers of students with Hearing impairments that access health services at hospital in comparison to the rest of the community, a review of literature did show the deafening silence on what could be contributing to this phenomenon especially LwHI. Since the study had an added thread of emancipation of LwHI in health institutions, a Hermeneutic Phenomenology approach was chosen to drive the research process. Ten participants volunteered to voice their lived experiences and a cluster of themes emerged thereafter.

Emerging from the lived experiences of LwHI when accessing health services were the three themes namely; (i) Lived experiences of LwHI when accessing health services (ii) Poor health services vs. academic performance of LwHI and (iii) Improve access to health services for LwHI. The silent voices expressed their felt lived experiences while accessing health services. The Lived experiences of LwHI when accessing health services factors included: (i) poor communication (ii) wrong diagnosis (iii) lack of privacy and confidentiality (iv) discrimination (v) inadequate medical vocabulary for signs (vi) poor health education (vii) Limited Institutional support staff and (viii) Negative attitude. On the other part, the study also looked at poor health services vs. academic performance of LwHI under the following subheadings; (i) absenteeism (ii) prolonged admission at hospitals and (iii) low self-esteem leading to dropping out of school. The study also looked at the strategies to use to improve access to health services for LwHI or deaf people such as (i) sensitization of health workers (ii) Involvement of LwHI in decision making (iii) licensed professional interpreters (iv) mandatory sign language training for health workers (v) use of assistive technology devices (vi) extra time for medical consultation and (vii) universal sign language dictionary.

6.3 Conclusion

In conclusion, LwHI are faced with inaccessibility of health services day to day as long as they go to hospital. Due to poor health services, the effects are felt on academic performance of learner with hearing impairments. It is clear that, provision of better health services to the Deaf learners leads to good academic performance. To this end, strategies to improve access to health services lies with the learners with hearing impairment. If only learners with hearing impairment can be engaged and consulted in decision-making process, institutions are bound to make a break-through to multitude of challenges encountered when implementing inclusive health policies. In view of the many explored lived experiences pointed out by the LwHI and the need to improve access to health services in health institutions, I now turn your attention to a set of recommendations for further consideration by various stakeholders.

6.4 Recommendations

Based on the findings of the current study, the researcher provides ten (8) recommendations. Thus, other health institutions be it private or government may do well to engage with and reflect on the recommendations in their quest to implementing inclusive health services. These recommendations are discussed below such as inclusive policy, active involvement, communication, mandatory training of sign language to health workers, assistive technology, employ specialist interpreters, separate counter for hearing impaired and improve on health education. In addition, further research areas for future research are recommended as well.

i.   The health institutions should develop and implement an inclusive policy. It was observed above that policy guides practice of practitioners. However, the UNCRPD, Disability Article 2012 and other policies are only on paper and this a reason the Deaf patients fail to access better health services and find it difficult to participate in health issues. To this effect, government should consider developing an inclusive health policy, which can be domesticated at institutional level as well. The policy could provide a guide and support to LwHI

ii. The health institutions should involve LwHI in decision-making process affecting their access to better health services. All health workers stating from the administration to the front liners are encouraged to actively involve the affected LwHI in decision-making process through consultation. This is consistent with a slogans 'nothing for us without us!' and 'leaving no one behind'.

iii. There is need to make mandatory training of sign language by conducting workshops on Sign language in order to create awareness among the health workers and promote positive attitude towards the deaf learners..

iv. As much as communication barriers was the most significant factor hindering access to health services, the use of sign language by providers and health care staff or the use of interpreters was also one of the most mentioned recommendations to improve health service delivery.

v. There is also need to employ specialist interpreters in health institutions who can understand diverse sign language as it is not universal in nature. In addition, each consultation room should at least have sign language posters indicating basic sign language and through pointing at the poster the provider will then be able to pick up the essence of what the patient's complaint is in case an interpreter is not available. This is of course not an ideal situation but at least there will be some clarity between provider and patient

vi. The installation of assistive technology in health institutions can be utilized to make the deaf persons health care visit much less stressful. They recommend that electronic boards be placed in the waiting areas of clinics, hospitals and doctors' offices and instead of calling the person over the intercom they can simply flash the next person's name on the board so they can see when they are being called. Other assistive technologies are phones, laptops, and computers for SMS, whatsapp, twitter, emails and online booking or appointments.

vii. There is need to provide separate counter for hearing impaired patients to improve their accessibility to health services.

viii. Another recommendation made was to improve on health education such as safety, mental health, alcohol, drugs, diseases, COVID19 and sex education, balanced meals and nutritional treatment.

6.5 Future Research Areas

Further research works are recommended to be conducted on the lived experiences of LwHI when accessing health services using the phenomenology approaches. To liberate LwHI from society bondage, more research should be conducted to uncover their hidden lived experiences. Further research works could be conducted in the following areas:

i. Lived experiences of LwHI when accessing health care services in private health institutions.

ii. A comparative analysis of the lived experiences of LwHI across public/private health institutions.

Since this study was conducted in a single public health institution, findings cannot be generalized to the whole country. This then calls for an expanded study on the LwHI's lived experiences not just in public but also private universities as well.

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APENDICES

Appendix 1: Introductory letter

I am Sichilindi Bevin. M, a postgraduate student conducting a research in the field of special education at the University of Zambia. I am doing a study on lived experiences of learners with hearing impairment when accessing health services in Mpika district. I am humbly requesting you to participate in this research as a respondent. Be informed that your participation is completely voluntary. The information will be used for academic purposes only. The source of the information as well as your responses will be treated with maximum confidentiality.

There are no direct benefits from participating in this study and you will not be compensated for your time. However, your participation may help stakeholders design, development and implement a strategy on lived experiences of learners with hearing impairment when accessing health services in Mpika district.   Further, the study on lived experiences of learners with hearing impairment when accessing health services in Mpika district through your participation will contribute to the literature in inclusive education.

If you have any questions about this research, you may contact Sichilindi Bevin.M by email at bevinsichilindi@gmail.com or phone +260 979696003.

Thank you for your consideration. I will contact you within the next week to see whether you would be interested in participating.

Yours Sincerely,

SICHILINDI BEVIN.M

Appendix 2: Introduction comments

1. Begin with facilitator providing introductory comments:

(i) Welcome and thank everyone for volunteering to participate.

(ii) Introduce yourself.

(iii)Hand out the consent form.

2. Ask participants to ask any questions, and then sign the consent form. Offer a copy of the Consent form (unsigned) to each person. Some will want a copy, others will not but always offer.

3. Give a very brief overview of the project and goals for the focus group discussion or interview.

4. Give participants information about the process, times, breaks, bathrooms, and so forth.

5. Distribute name tags for focus group discussion or community meetings (first names only).

6. Provide basic guidelines for the focus group discussion, review them with participants.

7. Consider posting them for everyone to see. Adapt pertinent guidelines for individual interviews:

- ✓ If you feel uncomfortable during the meeting, you have the right to leave or to pass on any question. There is no consequence for leaving. Being here is voluntary.

- ✓ The meeting is not a counseling session or support group.

- ✓ Keep personal stories "in the room"; do not share the identity of the attendees or what anybody else said outside of the meeting.

- ✓ Everyone's ideas will be respected. Do not comment on or make judgments about what someone else says, and do not offer advice.

- ✓ One person talks at a time.

- ✓ It's okay to take a break if needed or to help yourself to food or drink (if provided).

- ✓ Everyone has the right to talk. The facilitator may ask someone who is talking a lot to step back and give others a chance to talk and may ask a person who isn't talking if he or she has anything to share.

- ✓ Everybody has the right to pass on a question.

- ✓ There are no right or wrong answers.

✓ Does anybody have any questions?

8. Let people know when you are going to ask the last question. This cues participants to share relevant information that may not have come up in answer to your key questions. For example, "Is there anything else you want to share that we haven't talked about yet?"

9. Let participants know the process for feedback after discussion has been transcribed, analysed and written up.

10. Thank all for participating.

Appendix 3: Parental consent for young learners with hearing impairment.

Dear respondent,

This is to give you an understanding of the purpose of this research and procedures that will be followed. Further implications for your participation are explained below. Finally, you are being asked to sign this form to indicate that you have agreed to participate in this exercise. Thank you in advance.

Description

The exercise is an educational research; the researcher is a student at the University of Zambia pursuing Maters of Education in Special Education. This research is a major requirement for the researcher to complete his programme. Therefore, this exercise is purely academic.

Purpose

The study seeks to explore the lived experiences of learners with hearing impairment when accessing health services. The researcher is interested in investigating the impact of poor health services on learners with hearing impairment, the influence of access to health services on academic performance in school and establish the strategies on how to handle lived experiences of learners with hearing impairment when accessing health services.

Consent

Participation in this exercise is voluntary. You are free to decline to participate in this exercise.

Confidentiality

All data collected from this research is treated with utmost confidentiality. Participants are assured that they will remain anonymous and untraceable in this research.

Rights of Respondents

All effort will be taken to ensure that the rights of participants are protected and respected. Participants are assured that they will suffer no harm as a result of participating in this exercise. Participants are free to ask for clarification at any point of the exercise and to inform the researcher if they feel uncomfortable about any procedure in the research.

Declaration of Consent

I have read and fully understood this document. I therefore agree to participate in this exercise.

Signature…………………………………………

Date…………………………………………………

Appendix 4: Focus group discussion guide for learners with hearing impairment or deaf

       persons.

1. What do you do when you are sick?

2. Share with me your experiences in relationship to hospitality you receive at the hospital when you are sick.

3. Tell me about your experiences while at the hospital?

4. What happens if you fail to communicate with doctors and nurses effectively?

5. What do you do if you are wrongly diagnosed by the health personnel?

6. Tell me your experiences when you told to disclose your privacy to a third unlicensed person?

7. How does your absence from school when you are sick affect your academic performance?

8. What are some of the things that need to be done by teachers for you not to miss a lot of lessons in school when you are sick?

9. What are some of the challenges do you experience when accessing health services?

10. What would you like to be done for you get standard health services from hospital?

Thank you for your participation

Appendix 5: Interview schedule for the learners.

1. What is the name of the hospital you like most to go to when you are sick?
2. Why do you like the mentioned hospital?
3. How many times have the teacher/parents escorted you to hospital?
4. Why do you go with your teacher/parents to hospital?
5. What are the lived experiences you go through when accessing health services?
6. What is the impact of poor health services on your academic performance?
7. What does the health workers do when they fail to communicate with Deaf learners in the diagnosis room?
8. How do you feel when a third party is involved in your screening process as an interpreter?
9. What are some of the disadvantages of involving third parties in screening process?
10. What possible solutions do you suggest can be applied to improve access to health services for learners with hearing impairment?

Thank you for your co-operation