University of Malawi

KAMUZU COLLEGE OF NURSING.

A STUDY ON THE DEAF CLIENTS' EXPERIENCE IN ACCESSING HEALTH CARE SERVICES IN LILONGWE URBAN

A RESEARCH DISSERTATION SUBMITTED IN PARTIAL FULFILLMENT OF BACHELOR OF SCIENCE DEGREE IN NURSING

BY

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DECLARATION

I here by declare that this research dissertation is a result of my work. It has not been presented for a degree anywhere.

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DEDICATION

This research dissertaton is dedicated to my beloved parent Mrs Dinna Sabola, my brothers Leonard, Davie, Walter, and Taonga, and my sister Khiri for their tireless effort, inspiration and encouragement for me to be a professional nurse.

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May the almighty God bless you all.

ABBREVIATIONS.

ASL : American Sign Language.

BSL : British Sign Language.

FEDOMA : Federation of Disabled Persons in Malawi.

HBM : Health Belief Model.

MANAD : Malawi National Association for the deaf.

WHO : World Health Organization.

DEFINITIONS OF TERMS.

Client : A person who is either sick or well, who comes to the hospital to seek for health care services

Deafness: This is the partial or complete loss of ability to hear from one or both ears

Hearing impairment: Refers to a complete loss of the ability to hear from one or both ears.

THE DEAF CLIENTS' EXPERIENCE IN ACCESSING HEALTH CARE SERVICES IN LILONGWE URBAN

ABSTRACT

The plight of the deaf patients in accessing the health care services has been a problem especially in the developing countries where proper structures and training of the health personnel on issues of communicating with the deaf patients is still a major challenge. Like any person who is able to hear properly, deaf clients have been experiencing communication problems and isolation by health care workers, as most of them find it difficult to obtain data from patients, as well as giving advice on how to use things like medication. Another concern comes on the issue of lack of privacy as some of the patients need interpreters to express the information to the health personnel. This has led to poor diagnosis being made on the clients leading to wrong prescription of treatment made to those patients.

The purpose of this study was to identify the experiences as well as challenges faced by the deaf clients in accessing health services from the health personnel in Lilongwe Urban.

A qualitative research design was used whereby a sample of 10 participants were selected randomly and interviewed using an interview guide, with the help of the certified sign language interpreter. Data was analyzed using content analysis.

CHAPTER ONE

THE DEAF CLIENTS' EXPERIENCE IN ACCESSING HEALTH CARE SERVICES IN LILONGWE URBAN

1.0 Introduction

Deafness is defined as partial or complete loss of ability to hear from one or both ears (Smeltzer, 2008).The term Deafness is used interchangeably with hearing impairment in some literature. Hearing impairment is referred to as a complete loss of the ability to hear from one or both ears.

There are two types of hearing impairment, in relation to where they occur. According to world Health Organization (WHO), the first type is Conductive hearing impairment, which is the problem in the outer or the middle ear, and that the problem can be medically or surgically treated if there is access to the health services (WHO, 2010). The second type is sensorineural hearing impairment, which usually comes due to problem with the inner ear, and occasionally with the hearing nerve going from there to the brain (Lewis, 2004, p468). This type of hearing problem comes due to hereditary factors or trauma to the middle ear secondary to head injury, infectious diseases such as meningitis, mumps, and chronic ear infections, accumulation of cerumen or foreign bodies blocking the ear canal, and excessive noise, including working with the noisy machinery. This problem is usually permanent and requires rehabilitation. In 2005, the World Health Organization had estimated that there were 278 million people worldwide who had moderate to profound hearing loss in both ears (WHO, 2010). Also, 80% of the deaf and hearing impaired people live in low and middle income countries.

In Africa, there is no exact statistics on the number of deaf persons. In Malawi, very little relevant disability research has been conducted. In 1983, the National Statistical Office survey of the handicapped persons placed the rate of disability in a population of 2.9% (Khaula, 2001). A further survey which was conducted in 1993 indicated that the prevalence of disability was about 2%. Currently, there were no exact statistics in terms of the number of deaf population. However, it is believed that there are many people who are deaf or hard-of-hearing.

Deaf clients face a lot of challenges when accessing health care information from the health professionals (Donaldson, 2007). The commonest problem being faced in Malawi is the barrier to communication between the health worker and the patients. In Malawi, there are some schools where special needs education is provided to people. However, very few health workers have undergone special needs education such as sign language interpretation so as to facilitate the easy communication with the deaf clients. Although this problem has been there for a long time, much research has not targeted this area in Malawi.

Therefore, this had motivated the researcher to conduct a study to find out about the deaf clients' experience as well as challenges faced by these clients in accessing health care services in Lilongwe urban.

1.1 BACKGROUND INFORMATION

As the deaf clients continue to face some challenges in accessing health care services from health providers, very little has been done on how to address these problems.

In 2005, the World Health organization had estimated that there were 278 million people worldwide who have moderate to profound hearing loss in both ears (WHO, 2010). Also, 80% of the deaf and hearing impaired people live in low and middle income countries.

In the United States of America, there is an estimated population of 20 million people who have hearing loss (O' Hearn, 2006). Of this group, 4.8 million people are unable to hear or understand any speech. Communication methods among deaf individuals varied from oral approaches to manual approaches, including the use of American Sign Language (ASL).

In Africa, there is no exact statistics on the number of deaf persons. However, it is believed that there are many people who are deaf or hard-of-hearing.

Although there are an estimated 1 million people, or just 10 % of the population in Malawi with disabilities to date, few studies on the disability sector have been conducted (Khaula, 2002). The only survey which was conducted at national level was in 1983 Survey of Handicapped Persons executed as part of Malawi Labour Force Survey. This survey had covered both urban and rural Malawi. The results indicated that about 3% of the population were at that time living with disabilities. Of these, 93% were in rural areas, and 7% were in urban areas; 54% were males, and 46% were females. The 1983 survey also indicated that the majority of the respondents suffered

from partial loss of sight in one or both eyes (20.5%), followed by those suffering from fits/ epilepsy (18.8%), crippled limbs (18.2%), deafness (13.3%), and mental illness (8.5%). Those having more than one disability represented just 9% (Khaula, 2002)

Based on the 1983 statistics concerning people with disabilities, there has not been any published data concerning the extent of disabilities in Malawi, with no exceptional to deafness. In comparison to other health problems like sight, epilepsy and mental illness, very few services have been considered for the deaf persons despite the enormous challenges faced by this group in daily lives. In the health care services, there are very few specialized services that can be provided to the deaf persons. Public awareness initiatives have been made by Malawi National Association for the Deaf (MANAD) about the importance of having sign language interpreters in the hospital setting so as to facilitate the smooth communication between deaf clients and health care workers (Nyasa Times, 2008)

A study which was conducted in the United States of America on the physicians attitude and beliefs about deaf patients, showed that 43.03% of the doctors had the problems in understanding and maintaining free- flowing conversations, and those patients had more difficulty understanding them, trusted them less, and were less likely to understand their diagnosis and recommended treatment (Ralston, 1996)

Another study which was conducted in Chicago, on knowledge, beliefs and practices of physicians in communicating with deaf patients, revealed that writing was the method used most frequently in communicating with the clients. Although 63% of the doctors expressed that writing or signing was an initial way of communicating with the patients, 22% used sign language interpreters more frequently than other methods in their practice (Ebert, 1995) .

1.2 PROBLEM STATEMENT.

Deaf and hearing impairment is one of the health problems worldwide. It is a big problem especially when the deaf person visits the hospital seeking for health care services. Hearing impairment and deafness are the serious disabilities that can impose a heavy social and economic burden to individuals, families and communities (WHO, 2010).

Also, communication between the clients and health workers can be difficult since there is a gap between health care workers and the deaf patients in terms of data collection and proper diagnosis.

In spite of all the problems, there are no strong measures in the hospital setting that have been put in place to ensure the smooth communication between health care workers and the deaf clients. Many deaf people who come to various hospital departments like the out- patient department, pharmacy, radiological, medical, and surgical departments need to communicate with health workers. Health facilities in Lilongwe City such as Kawale Health Centre, Bwaila Hospital, and Kamuzu Central Hospital do not have professional sign language interpreters. This had motivated the researcher to conduct a study on Deaf Clients' Experiences in Accessing Health Care Services in Lilongwe Urban

1.3 THE SIGNIFICANCE OF THE STUDY

The findings of the study will help to unveil the relationship between health care workers and the deaf clients in terms of communication. It will assist in identifying the current measures that are used to facilitate communication between health care workers and deaf clients.

Furthermore, the study will help to identify challenges that are there in terms of accessibility health care services. The results of this study shall have implications on policy makers, health workers, education, research, and the community at large.

Lastly, the findings of this study will help the government and other non-governmental organizations to come up with ways of assisting this group of clients so that they can benefit from the maximum utilization of health services in all hospital departments. For example, the government and other non-governmental organizations can train nurses, doctors, and other health care workers in sign language communication thereby easing the communication barriers.

1.4 OBJECTIVES

1.4.1 BROAD OBJECTIVE

The main objective of the study was to explore the Deaf Clients' Experience in Accessing Health Care Services in Lilongwe Urban.

1.4.2 SPECIFIC OBJECTIVES.

1. To explore experiences of the deaf clients with health care service providers when seeking for health care services.
2. To investigate the measures that are currently used in communicating with the health care workers.
3. To identify challenges those are encountered by the deaf clients when accessing health care services.

CHAPTER TWO.

2.0 LITERATURE REVIEW

2.1 INTRODUCTION

Literature review refers to all activities involved in identifying and searching for information on the topic or the state of the knowledge in the topic. There are reasons why review of literature is important. For instance literature review helps to determine what has already been done that relates to the topic (Dempsey, 2000, p 61). This is important to avoid the duplication of previous studies, and also helps to develop a framework of the problem that relates it to the completed studies. Literature review also provides ideas about the kinds of the studies that need to be done, provides information regarding the instruments that have been found to be productive and non productive in studying the problem selected, as well as guiding the researcher in discussing the results with of the study in terms of agreement and non agreement with other studies.

This chapter reviews on the deaf clients' experience and satisfaction with health care services with an aim of identifying the gap to be filled. These concepts are reviewed based on the historical, international, African, and Malawian perspectives.

2.2 HISTORICAL PERSPECTIVE

Historically, deaf people have been viewed as inadequate and inferior as compared to hearing people (Scheier, 2009). As such, this negative attitude towards the deaf people has been there for ages. Deaf people have been isolated by the society, and discriminated by various groups of people, with no exception in the health setting. The deaf people have been viewed by the health professionals as aggressive, immature, impulsive, lazy and unintelligent (Meador,2005). In the ancient times, physicians were pouring various potions into peoples' ears and produce loud noises to help them regain their hearing. During the times of Aristostle, there was a belief that thought was contingent to speech. Deaf people were thought to be unable to think because could not hear or speak (Scheier, 2009).

In the 1870s, Alexander Graham Bell promoted oralism, using speech for communication, in deaf Education (Scheier, 2009). During that time, children who were deaf used sign language, and had deaf teachers. In the 1900s, there were no proper records as to how the deaf were taken care of especially in the hospital setting. (Scheier, 2009).

In the 1900s, various centres for the deaf were established in the United States of America and Europe. Also, this was the time when there were the advancements in technology. For example, in 1901, the first electric hearing aid was made (Archives, 2005). In recent years, there has been an official recognition of sign language in some countries. For instance in the United Kingdom in 2003, British Sign Language was recognized as an official language for the deaf.

In health setting, there is little history as regards to when the sign language was used. In May 2001, the World Health Organization introduced the International Classification of Functioning, disability and health, and that the aspect of Communication (hearing and vestibular functions) was also included (WHO, 2001).

2.3 STUDIES DONE IN OTHER COUNTRIES

2.3.1 EXPERIENCES OF THE DEAF PERSONS WHEN SEEKING HEALTH SERVICES

A study which was carried out in great Boston, Massachusetts, and Washington DC on Communicating about health care; Observations from persons who are deaf, revealed that deaf patients experience communication problems that could compromise several dimensions of health care quality, including patient centredness, safety, effectiveness, timeliness, efficiency, and equity (Iezzoni, 2001). Out of 26 deaf and hard-of- hearing persons, the respondents cited risks for medical errors and misdiagnoses, problems during surgery, and anaesthesia, missed and delayed appointments, and less complete and accurate information than the patients receive.

A comparative study which was done by O'Hearn in 2006 on Deaf women's perception and satisfaction with prenatal care showed that deaf women were less satisfied with physicians' communication than the hearing clients, and that they were less satisfied with an overall care. Out of 23 deaf women and 32 hearing women who were recruited in the study, most hearing women had reported that they were getting significantly more information from their doctors

than deaf women. Ninety- one percent of the hearing women reported that they got a lot of information from the doctor, while 61% had endorsed the same. Both groups endorsed being equally informed by their doctors on the use of vitamins, weight gain during pregnancy, and breast feeding habits. The significant differences were noted between the deaf women and the hearing ones o for the overall satisfaction of with prenatal care. Deaf women became less satisfied as the number of appointments with the physician increased.

Also, due to the unavailability of physicians who were conversant with sign language, ninety-five percent of the deaf respondents preferred their doctor to communicate with them by signing or through an interpreter, while only half reported being provided with an interpreter (O'Hearn, 2006). The study further revealed that deaf persons are less likely than their hearing counterparts, to obtain illness prevention information from their physician, television, radio, or books and are more likely to get illness prevention information from the deaf clubs since a lot of clinicians do not know sign language. On the source of prenatal information, 91% of hearing women reported that they got a lot of information from their doctors, while 61% indorsed the same.

2.3.2 THE MEASURES THAT ARE USED IN COMMUNICATING WITH DEAF CLIENTS

In a study which was conducted by Folkins (2005) in California, United States of America, on improving the deaf community's access to prostate and testicular cancer information, revealed that doctors were the best source of information for testicular and prostate cancer, especially when they use the American Sign Language (ASL). There were 102 deaf men who were surveyed before, immediately following, and two months following viewing of a 52 minute prostate and testicular cancer video in ASL. When the men were asked whether they felt that there needed to be more programs on cancer and other health concerns specifically made for the deaf community using sign language, 94.1% (96) responded affirmatively. Before and after the educational intervention, the participants were asked to rate their perception of the Deaf community's access to health information on a one to five scale with one being "very little" access and five being "a lot" of access. The results revealed that most men rated health information access as "very little" or "little" before the video was shown, but perceived access to be higher after viewing the video, a statistically significant shift.

In a study which was done by Griffith (2004), however, came up with the suggestions of improving the relationship like basic training of the staff, including physicians, which should raise the specific needs of the deaf and hard- of –hearing patients; provision of sign language interpreters; as well as clinician asking the clients on preferred methods of communication.

In Europe, a study was done in Scotland on an Exploration of the access to health and social care services by older deaf people (Donaldson, 2007). Out of 18 participants in that research, it revealed that communication support should be a vital pathway to navigate language barriers and create an environment for a participative and informed discussion. Having a communication support of a British Sign Language (BSL) interpreter was reported by all participants to play a major role in determining a positive experience and support a good outcome in accessing and using health and social care services. Participants highlighted the importance of interpreter support as a means of for clear communication in which both parties will be confident that they will understand and have been understood. Participants further said that they faced a significant difficulty with communication support in the hospital setting. The respondents reported feeling uninformed and excluded from dialogues and discussions about their health care.

A report on the mental health needs of deaf and hearing impaired people was done in Queensland, Australia (Briffa, 2001). Out of 135 deaf and hard of hearing people who participated in the study, revealed that health professionals required health education on the issues related to deafness, such as how to communicate effectively with the deaf, and increase their knowledge of the language and culture. The survey further outlined the preference of the deaf people to have mental health professionals such as psychologists and nurses. It was also suggested that referral centres for the deaf should be established where deaf people would feel more comfortable, knowing that their deafness would be understood. The study concluded that deaf community's needs for understanding of mental health problems has been identified, as has the need for interpreters in assisting mental health professionals in all aspects of service profession for deaf clients.

2.3.3 CHALLENGES FACED BY THE DEAF CLIENTS WHEN ACCESSING HEALTH CARE SERVICES.

In Massachusetts, a study was conducted entitled Doctors Must Address the Needs of Deaf Patients (Griffith, 2004). Out of 26 deaf and hard- to –hearing subjects who were recruited in that study, it revealed that they had communication problems. Some of the problems raised by the subjects on poor communication were conflicting views about deafness as physicians have an assumption about deafness that undermine the doctor-patient relationship; different perceptions about what constitutes effective communication as doctors speak too fast and hurry through their checklist; risks of inadequate communication such as poor diagnosis, instructions, and information about medication (Dosage regime and potential side effects); as well as difficulty communicating with the physician during physical examination and procedures, as failure to follow the instructions may necessitate repeating procedures.

In Pittsburg, a study was done by Algier (2004) on the Satisfaction and Barriers to Health care Experienced by the Deaf or Hard of Hearing. In her study, she found out that there was a tendency by the deaf clients of withholding information pertaining to their illness because of fear of embarrassment to the health personnel or to the relatives, as well as avoiding asking questions because they were technically difficult, and parents not being offered interpreters when their hearing children were sick. As such health workers were providing care that was less satisfactory to the clients.

Another research was conducted in Brazil, South America, on the relationship between deaf patients and a doctor (Chaveiro, 2009). The results of the study revealed that deaf patients and physicians face the communication barriers that could compromise the development of the bonds that are required in the health care thereby negatively affecting the diagnosis and treatment. As a result, the deaf patients were not seeking medical help from health care workers more frequently due to mistrust, fear, and frustration Therefore, understanding the issues around the health care for the deaf facilitates a good interaction between patients and physicians, which may reduce discomfort of these clients in the clinical setting.

In Africa, there has been little paperwork of the research on the deaf clients and accessibility to health care services. However, there was a study which was done in Nigeria on the Disabled

Persons and HIV/AIDS prevention; A case study on the deaf and leprosy persons (Enwerenji, 2008). The study revealed that there was no reproductive and health services and HIV prevention programmes among them. There was also lack of government's commitment to fund health programmes as well as rejection, isolation, discrimination, and discouragement of HIV/AIDS prevention programmes in their settlements. Furthermore, there was poor knowledge on the mode of transmission of among clients. Out of 110 participants in Abia, and 117 in Oyo states, 53.6% of the Abia, and 51.3% in Oyo were not interested in voluntary counselling and sex education programmes. This was due to, among other factors, inability of the health workers to use sign language when providing health services.

2.4. STUDIES DONE IN MALAWI

In Malawi, there is no study that was conducted on the deaf clients and accessibility to health care services as well as satisfaction to the services provided.

2.5. SUMMARY OF LITERATURE REVIEW

The literature has shown that much has been talked about the communication problems faced by the deaf clients all over the world in accessing health services. In Malawi, there are either unpublished studies concerning the deaf clients and access to health care services, or that the studies of such kind have not been done at all. Despite the lack of proper statistics in relation to the deaf population, it can be summarized that deaf and hearing impairment still is a health problem in Malawi. The point that there are no official numbers conceming deafness, signifies that there is little national attention to the problem.

CHAPTER THREE.

3.0. CONCEPTUAL FRAMEWORK.

3.1 Introduction

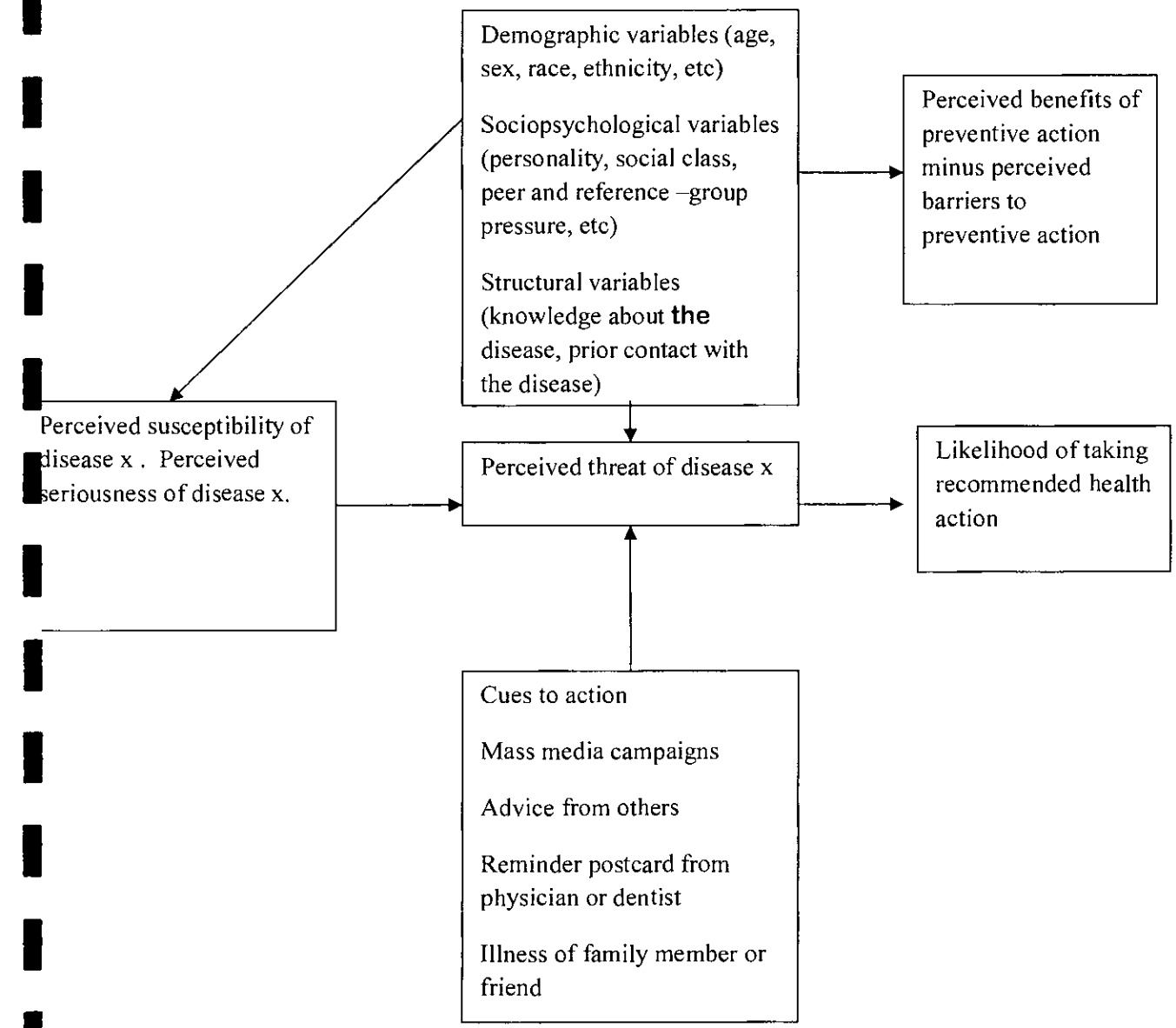
A conceptual framework is a group of related ideas statements or concepts (Kozier, 2004, p36). A model which was used in this study was the Health Belief Model (HBM). This chapter will describe the Health Belief Model and its application in this study.

3.2 The Health Belief Model

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors. This is done by focusing on the attitudes and beliefs of individuals. The HBM was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels working in the U.S. Public Health Services. The HBM was spelled out in terms of four constructs representing the perceived threat and net benefits: perceived *susceptibility,* perceived *severity,* perceived *benefits,* and perceived *barriers.* These concepts were proposed as accounting for people's "readiness to act." An added concept, *cues to action,* would activate that readiness and stimulate overt behavior. A recent addition to the HBM is the concept of *self-efficacy,* or one's confidence in the ability to successfully perform an action. This concept was added by Rosenstock and others in 1988 to help the HBM better fit the challenges of changing habitual unhealthy behaviors, such as being sedentary, smoking, or overeating. The major elements of health belief model are individual's perception, modifying factors, and the likelihood to take action. (Allender,2006, p 290).

FIGURE 1: THE HEALTH BELIEF MODEL

INDIVIDUAL PERCEPTIONS **MODIFYING FACTORS** **LIKELIHOOD OF ACTION**



Source: Kozier, 2004, p 179

INDIVIDUAL'S PERCEPTION

The model explains that individuals perceived susceptibility and perceived seriousness of the health problem, determine threat that will increase the likelihood of the preventive action or participation in in the health intervention that decreases the perceived threat (Clement-Stone et al, 2001). The individuals will not be involved in the health preventive behaviours unless there is an acknowledgement of the perceived susceptibility of the health problem.

MODIFYING FACTORS.

There are modifying factors such as demographic variables which include age, sex, race, and ethnicity; socio-psychological variables such as pressure or influence from peers or other relevant groups; structural variables like knowledge about the target disease and prior contact with it (Kozier, 2004, p179). For deaf clients may have high perceived susceptibility to health problems. However, they can hardly seek any health intervention if there is a barrier of communication between the health care workers and deaf clients is compromised. Cues of action are also modifying factors. They provide suggestions on how to trigger health action. These include public and media information, health education, symptoms of illness of the family member and environmental changes (Kozier, 2004)

LIKELIHOOD OF ACTION

The likelihood of the person to take a recommended action preventive health action depends on the perceived benefits of the action minus perceived barriers to the action. This means that the individual's health action will depend on the benefits of having weighed the problems that a person faces during the course of attempting action. For example, a client may view going to the hospital as a benefit, but a negative attitude of health worker will prevent him to seek for health service.

CONCEPT	DEFINITION	APPLICATION
Perceived susceptibility	This is the deaf person's opinion of chances of getting condition.	Define population(s) at risk, risk levels personalize risk based on a person': features or behavior heighten. Perceived susceptibility if too low.
Perceived severity	Deaf person's opinion of how serious a condition and consequences are	Specify consequences of the risk and th condition.
Perceived benefits	One's belief in the efficacy of the advised action to reduce risk or seriousness of impact	Define action to take; how, where, when clarify the positive effects to be expected.
Perceived barriers	One's opinion of the tangible and psychological costs of the advised action	Provide how to inform, promot awareness reminders.
Self-Efficacy	Confidence in one's ability to take a certain action	Provide training, guidance in performin action.

3.3 APPLICATION OF THE MODEL TO THE STUDY

This model can be applied in a wide variety of health behaviours and subject population. The model will help in finding out the experiences of the deaf clients as they are seeking for the health care services.

Deaf and hearing impaired clients may have the willingness to seek for health services in the hospital setting. However, these people might face a setback in the clinical area as a result of discrimination by health workers due to barriers in communication since much of the hospital staff are not conversant with the use of sign language.

CHAPTER FOUR.

4.0 METHODOLOGY

4.1 Introduction

This chapter aims at describing the research design, sampling and setting, data collection, data analysis, which will be used to find the outcome of the research. The chapter will also look at the pilot study to be done, ethical considerations, budgeting, and finally the limitations of the study.

4.2 Research Design.

The research design was the qualitative study. A Qualitative research is the method in which the investigator identifies the non numerical aspects of the phenomenon under study from the viewpoint in order to interpret the meaning of the totality of the phenomenon (Dempsey, 2001, p 369). Qualitative method was used because there was a need to find out about the experiences of the deaf and hearing impaired persons in seeking health care services, measures that were used to ensure proper health worker- client relation, as well as challenges faced in the course of seeking for health care services.

4.3 Sampling and Setting.

A purposive sampling was used in this study from the population of members of the Malawi National Association for the Deaf (MANAD), Lilongwe Branch. The sample size of 10 subjects was used. Only the deaf people were recruited into the study with the help of two certified sign language interpreters.

4.4 Data collection.

An Interview guide was used in the collection of data, with the use of open ended questions. The data was collected with the help of two certified sign language interpreters from MANAD. An Interview guide was serving as a check list during the time when questions were posed to the deaf subjects, and that each person was interviewed for 25 minutes.

4.5 Instruments of data collection

An Interview guide was used to guide data collection, together with two certified sign language interpreters. The first part of the interview guide contained the demographic data and the second part had questions on the experiences, barriers, and satisfaction with health care services.

4.6 Pilot

The Interview guide was tested at Malawi National Association for the Deaf (MANAD) Secretariat in Blantyre because there was an easy access of the deaf and hearing impaired, and that 3 clients were interviewed. The results from the pilot study were not incorporated in the main study to avoid biasness.

4.7 Ethical Considerations.

Clearance to conduct the study was sought from Kamuzu College of Nursing research and publications committee. The researcher had also looked for clearance to conduct a study from Lilongwe District Health Office, Malawi National Association for the Deaf Secretariat, and Malawi National Association for the Deaf Lilongwe Branch. In order to ensure protection of the human rights, clear explanation was given to participants about the purpose of the research. All participants had a consent form which explained the interventions, benefits of participating on this study, limitations, and activities of the research study. Also, the participants were assured about the good security of data collected, and that numbers were used on the interview guide instead of names. Furthermore, the participants were told about their right to withdraw at anytime from the study, and that no punishment was given for their decision. Those people who had agreed to participate in the study were signing a consent form.

4.8 Data Analysis

Due to the design of the study, content analysis was used to summarize the qualitative data. Content analysis involves the use of coding, categorizing, and summarizing of all written data.

4.9 Limitations

The study was done in partial fulfillment of the Bachelor of Science in Nursing. As such, the researcher had limited amount of time to conduct a wide scale research that was generalizable to the public. On top of that, the research was conducted in Lilongwe urban only, and with a small group of deaf persons. As such, the results cannot be generalized.

4.0 Dissemination of results.

The study findings will be disseminated through a written report that will be placed in the Kamuzu College of Nursing library and through a research seminar.

CHAPTER FIVE.

5.0 PRESENTATION OF FINDINGS

This chapter presents research findings from deaf participants residing in Lilongwe urban. The findings are presented in two parts. Part 1 contains the demographic data which includes sex of the participants, age distribution, denomination, tribe, level of education, marital status, occupation as well as the time when they became deaf. Part 2 includes the qualitative data research findings.

5.1. DEMOGRAPHIC RESULTS.

The results have shown that, from the sample of 10 participants, 6 were males while 4 were females within the age group of 17 to 47 years. Data also shows that 9 participants were Christians from various churches while one participant was a moslem. The results reveals that 9 out of 10 participants were from Chewa tribe while 1participant belonged to the Yao tribe. On the education aspect, data shows that 2 participants had attended primary school education, 6 had attended secondary education, while the other 2 had attended tertiary education. Data further shows that 5 participants were single while the other 5 were married. On the occupation aspect, data reveals that 2 participants were employed, 2 were doing business, 3 were not employed, while the other 3 were students. Finally, data shows that 6 participants became deaf at the age of less than 5 years, 2 participants had become deaf at the age of between 5 and 10 years, 1 participant had become deaf at the age of between 10 and 15 years, while 1 participant had become deaf at the age of above 15 years as presented in table 1 below.

TABLE 1 SHOWING SEX, AGE, RELIGION, TRIBE, LEVEL OF EDUCATION, MARITAL STATUS, AND OCCUPATION OF PARTICIPANTS.

CHARACTERISTIC	NUMBER OF PARTICIPANTS	PERCENTAGE
Sex		
-Males	6	60%
-Females	4	40%
Age range		
-Less than 20 years	2	20%
-Between 20 and 30 years	5	50%
-Between 30 and 40 years	1	10%
-Between 40 and 50 years	2	20%
Religion of the participants		
-Christians	9	90%
-Moslems	1	10%
Tribe of the participants		
-Yao	1	10%
-Chewa	9	90%
Level of education		
-Primary	2	20%
-Secondary	6	60%
-Tertiary	2	20%
Marital status		
-Single	5	50%
-Married	5	50%

CHARACTERISTIC	NUMBER OF PARTICIPANTS	PERCENTAGE
Occupation of the Participants.		
-Employed	2	20%
-Business people	2	20%
-Not employed	3	30%
-Students	3	30%
Age when they became deaf		
-Below 5 years	6	60%
-Between 5 and 10 years	2	20%
-Between 10 and 15 years	1	10%
-15 years and above	1	10%

5.2 DEAF PERSONS' EXPERIENCE IN ACCESSING HEALTH CARE SERVICES.

5.2.1. Frequency of visiting the hospital per year.

The participants were asked to mention how often they visit the health facility per year. One participant stated that he visits the hospital once per year, 3 participants visit the hospital at least twice per year, 1 participant visits the hospital at least three times each year, the other 3 visit the hospital more than three times per year, while the remaining participants said that they rarely go to the hospital as narrated below:

"I frequently go to the hospital mostly with my baby for regular growth monitoring and whenever my baby is sick." Said one of the female participants.

"I rarely go to the hospital because I am discouraged to go there due to the communication breakdown between me and the healthcare personnel." Another participant said.

5.2.2. Last time to visit the hospital.

Participants were asked on the last time they had visited the health facility. The results revealed that 2 participants had visited the hospital in less than a month, the other 2 had visited the hospital in less than two months, two participants had visited the hospital in less than six months, while 4 had visited the hospital more than six months.

5.2.3 The mode of communication between participants and the health care workers.

Participants were also asked to state the mode of communication which was used between them and healthcare workers. Two participants said that they use writing as a mode of communication *"I write my problems to the doctor as a means of expressing my problems. Through that he or she can understand better about my complaints."* Said one participant.

Another participant had a similar idea. *"Writing on a piece of paper is the only way of explaining my health problems to the health personnel."*

The other two participants had included lip reading and use of sign language on top of writing as a method of communication.

"I always read the lip movement of the health personnel so as to get what he or she is saying. After that, I can correspond by expressing some gestures on top of writing my problems." Stated another client.

"Through lip reading, I can partially know what the doctor or a nurse is saying." Said another participant.

Some participants said that they use both writing and gestures in order to communicate with the health personnel, while others stated that they go to the hospital with their guardians who play a part in the interpretation role.

One participant said; *" I always go to the health facility with my mother so that she can explain the problems very well to the doctor, nurse, or any other health care worker."*

5.2.4. Who accompanies the deaf person to the hospital

The participants were also asked to state the one who accompanies them when going to the hospital. The results revealed that half of the participants were accompanied by someone when going to the hospital, while the remaining half, were alone when going to the hospital.

5.2.5. Ability to understand information from health care provider.

The participants were also asked if they were able to understand what the health care worker(s) was telling them during the course of seeking health services. The results revealed that most of the participants were not able to understand what was said by the health care provider for different reasons.

One of the participants said; *"Health workers speak too fast. As such, lip reading to what they are saying becomes difficult."*

Other reasons which were stated by the participants included the inability of the health workers to use sign language or gestures as narrated by one participant;

"Most health care workers only ask us verbally instead of using signs or gestures. This becomes difficult for me to understand and comprehend well."

5.2.6. The availability of health care workers who know sign language.

Participants were asked if the health institutions they visited had any sign language interpreter. The result revealed that most health institutions or hospitals had no sign language interpreters. Only 1 person had gone to the hospital where there was a sign language interpreter.

Participants were further asked on why the hospital did not have any sign language interpreter. Most of the participants had a similar idea. *"Many health workers are not able to use or understand sign language."*

Another participant said; *"The government had not trained either sign language interpreters or health personnel to play a role in sign language interpretation. As such, there are very few sign language interpreters in the hospitals."*

5.2.7. Problems faced by the deaf clients when communicating with health care workers.

Participants were also asked on problems that they face when interacting with health care workers. Most clients had mentioned the inability of using sign language as a major problem.

"Health care workers were not trained on how to use communication skills such as the use of sign language and lip reading especially when interacting with the deaf patient." Said one participant.

"Most health care workers do not understand us and our problems presented because they do not know sign language." Said another participant. *"For example in the pharmacy, where a*

technician can dispense the drugs without giving us clear instructions since much information is presented verbally."

Another participant had also something to add on communication problems. *"Some health care workers consider us as rude because they do not understand our problem. As a result, they sideline us forgetting that we are all human beings who need medical care from them."*

5.2.8. Current measures used for effective communication.

Participants were asked to state the current ways that are used to ensure effective communication between health care workers and deaf clients. The results revealed that half of the participants had used writing as a mode of communication between them and health care providers, 2 participants were going to the hospital with a relative so as to play a role of the interpreter, 1 participant had to use gestures, while the last 2 did not use anything.

5.2.9. Satisfaction with health care services.

On this part, the participants were asked if they were satisfied with the services provided to them based on the communication aspect. The results revealed that some participants were satisfied with care that they had received previously. The reasons for their satisfaction varied according to each participant. One participant said *"Whenever I go to the hospital, I always ensure that I use some signs and write somewhere about my health status so that the doctor can understand about my condition. Through that, doctors can easily assess me and give me a right treatment."*

"The doctors were taking their time to assist me though with some difficulties in communication. On the other hand, they were able to diagnose me and provide the right treatment." Said another participant who was also satisfied with health care he received.

Some participants, however, had stated that they were not satisfied with the care provided to them. The reasons for not being satisfied with care provided to them included problems such as lack of understanding on what the health personnel were saying.

"I was not satisfied with the care provided because what I got from the hospital did not change my condition for the better. All that was because there was a misunderstanding between the two of us." One participant said.

5.2.10. Solutions that can enhance good communication health care workers and deaf clients.

The participants were asked on what can be done to ensure good communication between health care workers and the deaf clients. Most of the participants had a similar idea on what should be done.

One participant said; *"MANAD should include health care workers in the training of sign language interpretation so that communication problems that we face at the hospital can be eased."*

Similarly, another participant said;*"There is a need for the government and other non-governmental organizations in the country to train more health workers in sign language. Health institutions should also consider employing sign language interpreters so as to bridge the gap between health care workers and the deaf clients."*

Other participants were also for the idea that sign language interpreters should be recruited in the hospitals. One participant said; *"We want many sign language interpreters in our hospitals who can assist us in easy communication between us and health workers."*

"Government and other non-governmental organizations must work hand in hand to ensure that many health care workers are trained in sign language interpretation."

CHAPTER SIX

6.0. DISCUSSION OF FINDINGS.

This section presents discussion of findings from the analyzed data. The study findings will be drawn in relation to the Health Belief Model and other available literature.

6.1. DEMOGRAPHIC DATA

The results of this study shows that all participants were adults who had acquired formal education, with many participants reaching as far as secondary school level. Furthermore, the results of data revealed that some participants were either fully employed, conducting small scale businesses, or were still studying in various secondary schools. These findings do not concur with what Meador (2005) noted on deaf participants who were viewed by the health professionals as unintelligent, aggressive, immature, impulsive, and lazy. This is so because some participants were formally employed, others were doing business to earn a living, while some were students which signifies hard working and intelligence. The study also revealed that most of the participants were from Chewa tribe, and that they were Christians from various denominations. There has been no literature in relation to the deaf clients and cultural or religious affiliations when accessing health care services. However, there is a need for a health care worker to be culturally and religiously sensitive when communicating with deaf clients especially on the use of signs so as to avoid embarrassing them

Finally, the study revealed that many participants had become deaf at the age of less than 5 years. This corresponds to what Lewis (2004) had stated on the sensorineural hearing impairment in that it comes due to hereditary factors, and that this problem cannot be reversed by medical or surgical interventions.

6.2. DEAF CLENTS' EXPERIENCE IN ACCESSING HEALTH CARE SERVICES.

6.2.1 Frequency of visiting the hospital per year.

The results of the presented data show that many participants go to the hospital at least once every year for various reasons such as when they are sick. Other participants however stated that they do not go to the hospital because of, among other problems, poor communication between them and health care workers. The findings of this study correspond with the results of the study

by Iezzoni (2001) who had revealed that poor communication between deaf clients and health care workers had caused the problems such as missed and delayed appointments.

Also, the study results can be related to the Health Belief Model in that a deaf client might decide to seek for health services based on the perceived susceptibility to the disease, perceived severity of the disease, perceived benefits of those services. However, the deaf client might be barred from those services on the grounds that there is poor communication with the health care provider.

6.2.2. Communication between participants and the health care workers.

The results of the study have shown that lip reading, writing, and the use of signs were the commonest methods used for communication between the deaf clients and the health care personnel. This is similar to the study results from Steinberg (2004) which revealed that health care workers were using minimal signing skills, paper and pen, in ensuring that deaf women were able to understand the meaning or value of cancer screening, mammography, or Pap smear.

Also, a study which was conducted by Ebert (1995) on knowledge, beliefs and practices of physicians in communicating with deaf patients, revealed that writing was the method most commonly used when interacting with clients. However, there was no literature which had revealed about the use of lip reading as one of the most effective ways of communication between deaf clients and health care workers. The previous studies further did not express the mode of communication between deaf clients who were not educated, and that they had gone to the health facility without an interpreter hence need for further research.

6.2.3. Who accompanies the deaf clients to the hospital.

The results of the study revealed that half of the participants were going to the hospital with relatives with the aim of playing a role in the interpretation, while the other half stated that they were going to the hospital alone. Results of the study by Algier (2004) on the Satisfaction and Barriers to Health care Experienced by the Deaf or Hard of Hearing, revealed that the deaf clients had tendency by the deaf clients of withholding information pertaining to their illness because of fear of embarrassment to the health personnel or to the relatives. As such, the deaf clients had some difficulties in disclosing their problems to the health care provider(s) either because of the absence of the relative who plays a role in the interpretation, or that the

information is too sensitive that the deaf client does not want the guardian (who acts as an interpreter) to hear.

6.2.4. Ability to understand information from health provider.

The study results had revealed that, all the participants minus one, were not understanding fully what the health care workers were communicating to them despite the fact that some participants were good at lip reading and writing. This concurs with the findings of the study by Chaveiro (2009) who revealed that deaf patients and physicians faced the communication barriers that could compromise the development of the bonds that are required in the health care thereby negatively affecting the diagnosis and treatment. All these problem were coming in due to the fact that either the physicians were not able to understand the problems presented by deaf clients, or that the deaf clients were not able to get what the physicians were communicating to them.

Also, according to the study results by O' Hearn (2006), the deaf women were not satisfied with prenatal care services despite having proficiencies in oral communication such as lip reading and speaking. This was due to the point that oral proficiencies among deaf clients did not yield effective communication. The study had concluded that specific efforts were necessary to ensure effective communication with deaf clients who had speech and speech reading proficiencies like the availability of the sign language interpreters.

In the same way, the need to train health care workers in sign language interpretation in our hospital cannot be underestimated as many deaf clients face major problems such as understanding the instructions about the medication regimen.

6.2.5. The availability of health care workers who know sign language.

The results of the study had revealed that many health institutions do not have either health care workers who are conversant with sign language, or do not have specialized sign language interpreters who can assist the deaf clients in communicating with health care workers. There was only one participant who indicated that there was a health facility where a health care worker was conversant with sign language. This concurs with study findings by Griffith (2004) which revealed that most health workers such as physicians were not trained in sign language interpretation. However, the study had further come up with the suggestions of improving the relationship with deaf patients such as the provision of basic training of the staff, including

physicians on sign language interpretation; provision of sign language interpreters; as well as clinician asking the clients on preferred methods of communication. Also, according to the Health Belief Model, a deaf person can decide to take a health action by seeking health care services at the hospital. However, the client can easily be let down if there are no health care workers who can facilitate good communication between him and health care providers. As such, there is a need for the government and other non-governmental organizations to make an effort in training more health care workers in basic sign language interpretation in some health facilities so that they can understand and comprehend positively to the needs of the deaf persons.

6.2.6. Problems faced by the deaf clients when communicating with health care workers.

The results of the study have shown that most of the health care providers are not conversant with sign language or communication skills like lip reading when interacting with the deaf client. As such, it becomes a major problem for the deaf patients to express their problems fully to the health care provider.The study has further revealed that some health care workers have a tendency of shunning away from assisting the deaf clients thereby preventing them from accessing health care services.This concurs with a study which was done by Iezzoni (2001) which revealed that deaf patients experience communication problems when interacting with health care workers. As such, that problem could compromise several dimensions of health care quality, including patient centredness, safety, effectiveness, timeliness, efficiency, and equity. The study had further the cited risks for medical errors and misdiagnoses, problems during surgery, and anaesthesia, missed and delayed appointments, and less complete and accurate information than the patients receive.

Results from this study also concur with the findings of the study by Chaveiro (2009) which revealed that deaf patients and physicians face the communication barriers that could compromise the development of the bonds that are required in the health care thereby negatively affecting the diagnosis and treatment. Therefore, understanding the issues around the health care for the deaf facilitates a good interaction between patients and physicians, which may reduce discomfort of these clients in the clinical setting.

In a similar way, poor communication between health care workers and the deaf clients most health institutions could likely lead to poor history taking, errors in diagnosing the client, as well as poor medical or nursing management of these clients.

6.2.7. Current measures that are used for effective communication.

The study results revealed that half of the participants were using writing as a mode of communication, while some participants were going to the hospital with the guardians or relatives who were playing a role of sign language interpretation. Only one participant had used gestures as means of communication, and the rest did not use anything. All the participants had stated that there were no drawings or pictures that demonstrated various signs like coughing, diarrhea, and fever in the health facilities. The findings of this study concur with the research findings by Ebert (1995), who revealed that writing was the method used most frequently in communicating with the clients. Although the doctors had expressed that writing or signing was an initial way of communicating with the patients, some had used sign language interpreters more frequently than other methods in their practice.

As such, there is a need for most health care workers to continue using writing as a mode of communication with the deaf clients so that there can be smooth relationship. Also, the guardians or sign language interpreters have a bigger role to play in ensuring that there is an easy communication with health care workers especially in situations where the deaf client does not know how to write.

6.2.8. Satisfaction with health care services

Based on the results of the study, some participants were not satisfied with health services provided to them. Upon finding out about the reasons for the dissatisfaction of care provided, participants had cited problems such as lack of understanding by the physicians and other health care providers on the problems presented with the aid of sign language or gestures, which had resulted in the provision of wrong treatment. Others had also stated that the health personnel were talking very fast which had contributed to the inability of clients to make lip- reading.

The results of this study partly concur with the findings of O' Hearn (2006) on Deaf Women's Experience and satisfaction with Prenatal Care, which revealed that deaf women were not satisfied with prenatal care services despite having proficiencies in oral communication such as lip reading and speaking. This was due to the inability of the physicians to use sign language when communicating with the deaf women. The study further revealed that deaf persons were less likely than their hearing counterparts, to obtain illness prevention information from their

physician, television, radio, or books and are more likely to get illness prevention information from the deaf clubs since a lot of clinicians do not know sign language. The study had concluded that specific efforts were necessary to ensure effective communication with deaf clients who had speech and speech reading proficiencies like the availability of the sign language interpreters.

Another study which was conducted by Algier (2004), revealed that there was a tendency by the deaf clients of withholding information pertaining to their illness because of fear of embarrassment to the health personnel or to the relatives, as well as avoiding asking questions because they were technically difficult, and parents not being offered interpreters when their hearing children were sick. As such health workers were providing care that was less satisfactory to the clients. According to the Health Belief Model, the perceived benefit to health care service must outweigh the perceived barrier to the act of seeking health care services. If for instance, the perceived barriers such as embarrassment, lack of understanding, and use of language which is not understood by the deaf clients is greater than health care service provided, then many clients can hardly present their information, thereby leading to less satisfaction to care provided.
As such, there is a need for health workers to realize the importance of the use of gestures, writing, as well as talking at a slower pace for easy lip reading. Apart from that, deaf clients should also be given a task of asking questions in the course of health care provision so that they can ventilate all their feelings thereby reducing the tendency of not disclosing some information.

6.2.9. Solutions that can enhance good communication health care workers and deaf clients.
The results of the study revealed that all the participants wanted the government and other non-governmental organizations to train more health care workers on sign language so that there should be good communication. Others further said that there is a need for the employment of the sign language interpreters in some hospitals so that they can act as mouth piece for the deaf clients when communicating with health care workers.
The findings of this study concur with the results by Griffith (2004) who stated the ways of improving the relationship between health care providers and deaf like basic training of the staff, including physicians, which should raise the specific needs of the deaf and hard- of –hearing patients; provision of sign language interpreters; as well as clinician asking the clients on preferred methods of communication. Also, according to Algier (2004), the results of her study

revealed that most client with hearing problems preferred communicating directly with the care provider (by using sign language) or with the help of the sign language interpreter. The study had concluded that this development is needed for the improvement of confidentiality and explicit medical care to the deaf clients.

There is a great need for the government and other stakeholders to work hand in hand in ensuring that the deaf clients are utilizing healthcare services. This can be in form of training of health personnel in sign language communication as well as training of specialized interpreters so that patients can fill free I expressing their problems to the health care workers.

6.3. CONCLUSION

The study has revealed that deaf clients experience numerous hardships in the course of accessing health care services. Some of these hardships include poor communication between them and healthcare workers which result in wrong diagnosis and wrong prescription, discrimination of the deaf clients due to the inability of the health care workers to interact with the deaf clients using sign language, and the poor medical compliance among others.

A lot of health care workers in Malawi do not understand the language despite the existence of sign language. As such, there is a great need for the government and other non-governmental organizations to come up with strategies of training health care workers in sign language communication, or employing specialized sign language interpreters so that there can be a good interaction between them and the deaf clients in ht e hospital setting.

6.4. RECOMMENDATIONS

Further awareness campaigns by the Malawi National Association for the Deaf in conjunction with the Federation of Disabled persons of Malawi should be made on the importance of having sign language interpreters in our government and other private hospitals so that the deaf clients should no longer face problems when accessing health care services.

6.5. AREAS FOR FURTHER RESEARCH

This study needs to be carried out at a larger scale in order to find out more about the deaf clients' experience in accessing health care service.

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APPENDIX 1

AN INTERVIEW GUIDE.

DEAF CLIENTS' EXPERIENCE IN ACCESSING HEALTH CARE SERVICES IN LILONGWE URBAN.

PART 1; DEMOGRAPHIC DATA

1 Sex

A) Male [ ]

B) Female [ ]

2 How old are you?

A) Less than 20 years [ ]

B) 20 to 30 years [ ]

C) 30 to 40 years [ ]

D) 40 to 50 years [ ]

3. What is your denomination?

A) Roman Catholic [ ]
B)CCAP [ ]
C) Seventh Day Adventist [ ]
D) Pentecostal Churches [ ]
E) Islam [ ]
F) Others (specify) [ ]

4 What is your tribe?

A) Yao [ ]
B) Lomwe [ ]
C) Mang'anja [ ]

D) Chewa [ ]

F) Tumbuka [ ]

G) Tonga [ ]

5 What is your level of education?

A) Primary [ ]

B) Secondary [ ]

C) Tertially [ ]

D) Never been to school [ ]

6 What is your marital status?

A) Married [ ]

B) Divorced [ ]

C) Single [ ]

D) Commuted [ ]

E) Other specify.....

7 What is your occupation?

a) Farmer [ ]

b) Employed [ ]

c) Business man/woman [ ]

d) Not employed [ ]

e) Student [ ]

8 When did you become deaf or hearing impaired?

A) At the age of 5 years and below.

b) At the age of less than 10 years.

c) At the age of less than 15 years.

d)15 years and above.

PART II

DEAF PERSONS' EXPERIENCE IN ACCESSING HEALTH CARE SERVICES.

9. How often do you visit the hospital per year?

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10.When was your last time to receive the health care service at the hospital?

a) less than one month ago.

b) less than two months ago.

c) less than six months ago.

d) More than six months ago

11. What was the mode of communication between you and the health personnel?

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12. Who accompanied you as you were visiting the hospital?

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13. Were you able to understand what was said by the health personnel?

Yes { } No { }

14 If No to question 13, explain.

15. Does the health institution you visited have any sign language interpreter?

Yes { } No { }

16 If No to question 15, why do you think there is no sign language interpreter?

17. What were the problems that you faced when communicating with the Health worker(s) (Doctors, Nurses, Radiology staff, Laboratory technicians) at the health facility?

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18.What are the current measures that are used to ensure the effective Communication between you and health workers?

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19. Were you satisfied with the care that was rendered to you by the health

Care Workers?

Yes { } No { }

20. If yes to question (19), explain.

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21. If No to question (19), explain

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22. What do you think can be done to ensure good communication between the health care workers and the deaf persons?

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APPENDIX II

AN INTERVIEW GUIDE. (CHICHEWA VESION)

CHIPEPALA CHAMAFUNSO:

KAFUKUFUKU WOFUNA KUDZIWA ZOMWE ANTHU OMWE ALI NDI VUTO LAKAMVEDWE AMAKOMANA NAZO PAMENE AKUFUNA CHITHANDIZO CHA ZAUMOYO AKAPITA KUCHAPATALA.

GAWO A: MBIRI YANU

1 Ndinu ndani

A) Mkazi [ ]

B) Mamuna [ ]

2 Kodi muli ndi zaka zingati?

A) Zochepera makumi awiri

B) Makumi awiri mpaka makumi atatu

C) Makumi atatu mpaka makumi anayi

D) Makumi anayi mpaka makumi asanu

3 Ndinu achipembedzo chanji?

A)Katolika [ ]

B)CCAP [ ]

C)Seventh Day Adventist [ ]

D)Pentekositi

E) Chisilamu [ ]

F) Zina tchulani [ ]

4 Kodi ndinu mtundu wanji wa anthu?

A) Yao [ ]
B) Lomwe [ ]
C) Mang'anja [ ]
D) Chewa [ ]
E) Tumbuka [ ]
F) Tonga [ ]
G) Zina, tchulani.....

5 Kodi maphunziro munafika nawo pati?

A) Pulayimale [ ]

B) Secondale [ ]

C) Ukachenjede [ ]

D) Sindidapiteko kusukulu [ ]

6 Kodi muli pabanja?

A) Eya [ ]

B) Lidatha [ ]

C) Sindili pabanja [ ]

D) Ndine wa masiye [ ]

E) Zina, tchulani.....

7 Kodi mumachita chiyani?

A) Ulimi [ ]

B) Ndilipantchito yatikiti [ ]

C) Ndimachita geni [ ]

D) Sindichita chilichonse [ ]

E) Mwana wasukulu. [ ]

8 Kodi vuto losamvari linayamba liti?

A) Ndisanafike zaka zisanu zakubadwa.

B) Ndisanafike zaka khumi zakubadwa

C) Ndisanafike zaka khumi ndi zisanu zakubadwa.

D) Nditapitilira zaka khumi ndi zisanu zakubadwa.

GAWO B: ZOMWE ANTHU AMENE ALI NDI VUTO LA KAMVEDWE AKHALA AKUKOMANA NAZO PA NTHAWI IMENE AKUFUNA CHITHANDIZO CHA ZA UMOYO APITA KU CHIPATALA MU NZINDA WA LILONGWE

9. Kodi ku chipatala mumapitako kangati pachaka kukafuna chithandizo?

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10. Kodi papita nthawi yayitali bwanji chipitileni kuchipatala kokalandira chaithandizo?

A) Sipanathe mwezi umodzi.

B) Sipanathe miyezi iwiri.

C) Sipanathe miyezi isanu ndi umodzi.

D) Patha nthawi yopitilira miyezi isanu ndi umodzi.

11. Kodi mumagwiritsa ntchito njira ziti pofuna kufotokozera mavuto anu kwa ogwira ntchito za umoyo?

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12. Kodi popita kuchipatalako munapita ndi ndani?

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13. Kodi inuyo mumkatha kumva zomwe ogwira ntchito za umoyo'wo amkanena panthawi yomwe mumkalalandira chithandizocho?

Inde { } Ayi { }

14 Ngati yankho lanu liri Ayi, longosolani chifukwa chake.

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15. Nanga pachipatala chomwe mumapitacho pali munthu amene amadziwa kumasulira (kutanthauzira) chilankhulo chogwitsa ntchito zizindikiro

Inde { } Ayi { }

16. Ngati yankho lanu liri Ayi, longosolani chifukwa chake palibe anthuwo.

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17.Kodi ndi mavuto ati amene munakumana nawo pamene mumkafuna kulumikizana ndi ogwira ntchito zachipatara ? (Adotolo, Anamwino, Ojambula mafupa, oyeza magazi, ndi ogawa mankhwala)

Fotokozani.

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18. Kodi pali njira ziti zomwe zikugwiritsidwa ntchito pa nthawi ino pafuna kulumikizana mosavuta pakati pa anthu omwe ali ndi vuto la kamvedwe ndi ogwira ntchito zachipatala?

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19. Nanga inuyo munakhutistidwa ndi chithandizo chomwe munalandira kuchokera kwa a zaumoyo panthawi yomwe munapita kuchipatala?

Inde { } Ayi { }

20 Ngati yankho lanu liri Inde, fotokozani.

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21 Ngati yankho lanu liri Ayi, fotokozani.

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22. Kodi, malingana ndi maganizo anu, mukuona kuti pangachitike chiyani kuti pakhale kulumikizana kosavuta pakati pa anthu omwe ali ndi vuto la kamvedwe ndi ogrira ntchito za chipatala?

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APPENDIX III: CONSENT FORM

Kamuzu College of Nursing,

Private Bag 1,

Lilongwe.

Dear participants,

My name is Edison Wakale Sabola, a student at Kamuzu College of Nursing. In partial fulfillment of the programme for the award of a Bachelor of Science in Nursing, I am expected to conduct a research study. I write to seek your permission to be the participants in my study. My research study title is **Deaf Clients' Experience In Accessing Health Care Services In Lilongwe Urban.**

The aim of the study is to find out about the past experiences of the deaf clients in the course of accessing health care services, as well as the problems faced by them in seeking for health services in the various health institutions in Lilongwe.

Participation in the study is voluntary. No penalty will be imposed for not participating in the study but your participation will greatly help me in my study. You can withdraw from the study at any time and this will not affect the treatment you're receiving. You're also free to ask questions about the study. The research activities will not have any harm on your health.

Data will be collected through an Interview guide. No names will be used but instead ID numbers will be used in the study to provide anonymity. The information obtained will be kept in a locked locker that is out of reach of unauthorized people for confidential purposes.

You are required to sign a consent form if willing to participate in the study.

Looking forward for your favourable response.

Yours Faithfully,

Edison Wakale Sabola

Consent form.

I have understood all the explanations about the study. I hereby give consent to voluntarily participate in the study.

Signature of participant..... Date.....

Signature of researcher..... Date.....

APPENDIX IV

KALATA YOPEMPHA CHILOLEZO

Kamuzu College of Nursing,

Private Bag 1,

Lilongwe.

Wokondedwa Bambo kapena Mayi,

Dzina langa Ndine Edison Wakale Sabola. Ndine mmodzi wa ophunzira ku sukulu ya unamwino ya Kamuzu koleji, ndipo ndili chaka chomaliza pa kolenjiyi. Malingana ndi maphunziro anga ndili oyenera kupanga kafukufuku wondiyenereza kutindidzalandire digiri nyanga. Kafukufuku amene ndikupanga ine ndikufuna kupeza zinthu zomwe anthu omwe ali ndi vuto lakamvedwe amakoma nazo makamaka akapita kuchipatara, kapena pamene akufuna kulandira chitandizo china chilichonse kuchipatala.

Kutenga nawo mbali mukafukufuku ameneyu sikokakamiza.Inu mulindi ufulu wosankha kutenga nawo mbali mu kafukufuku ameneyu kapena ayi. Inu muli odziwitsidwa kuti muli ololedwa kusiya mutavomera kale kutenga mbali opanda chilango chilichonse.Ndipo zimene zidzachitike pakafukufuku ameneyu sidzidzawononga moyo wanu.Komanso ngati muli ndifunso lokhudzana ndikafukufuku ameneyu muli omasuka kudzafunsa.

Mukafukufuku ameneyu chipepala chamafunso chidzidzangwiritsira ntchito.Inu mukavomera kutenga mbali zomwe mudzatiuze zidzakhala zachinsinsi. Chinsinsi chimenechi tidzachisunga posalemba dzina lanu papepala lamafunso ndipo anthu ena sadzalolezedwa kuona nawo zomwe inu mwanena.

Pomaliza ndidzakhala wokondwa ngati mutenga nawo mbali mukafukufukuyu.

Ndine,

Edison Wakale Sabola.

Kupereka chilolezo.

Ndamva zonse zokhuzana ndi kafukufuku ameneyu ndipo ndikuvomera kutenga nawo mbali mopanda kuumilizidwa.

Wotenga mbali..... Tsiku.....

Wopangitsa kafukufuku.....Tsiku.....

APPENDIX V

Kamuzu College of Nursing,

Private Bag 1,

Lilongwe.

21st October, 2010

The Administrator,

MANAD Secretariat,

Private Bag 14,

Blantyre 8.

Dear Sir,

APPLICATION TO CONDUCT A PILOT STUDY AT YOUR INSTITUTION

I am a fourth year student pursuing Bachelor of Science in Nursing at Kamuzu College of Nursing. In partial for fulfillment of the programme for the award of Bachelor of Science in Nursing, I am expected to conduct a research study. Before conducting the actual research study; I am supposed to conduct a pilot study to see the feasibility of the interview guide. I write to ask permission to conduct a pilot study.

The title of the research is **Deaf Clients' Experience in Accessing Health Care Services in Lilongwe Urban**. The aim of the research study is to explore the deaf clients' experiences upon going to the health institution, with much emphasis on communication between them and health care provider, as well as challenges encountered in the course of acquiring health services. A pilot study will be conducted in October, 2010.

Your favourable response will be greatly appreciated.

Yours faithfully,

Edison Wakale Sabola.

APPENDIX VI

Kamuzu College of Nursing,

Private Bag 1,

Lilongwe.

6th July, 2010.

The Chairperson,

Research and Publications Committee,

Kamuzu College of Nursing,

Private Bag 1,

Lilongwe.

Dear Sir,

APPLICATION FOR THE CLEARANCE TO CONDUCT A STUDY

I am Edison Wakale Sabola, a fourth year student pursuing a Bachelor of Science in Nursing at Kamuzu College of Nursing. In partial fulfillment of the degree programme, I am required to conduct a research study. The title of the study is 'Deaf Clients' Experience In Accessing Health Care Services in Lilongwe Urban'.

I therefore, write to apply for the clearance to conduct a study at Malawi National Association for the Deaf Lilongwe Branch. The purpose of the research is find out about the experiences of the deaf clients when seeking for health care service, as well as challenges encountered in the course of accessing health services.

The results of the study may be used by the government and other stake holders in formulating policies and programmes that will problems faced by the deaf clients when accessing health care services in various health institutions.

Lastly, am looking forward for your consideration.

Yours sincerely,

Edison Wakale Sabola.

APPENDIX VII

Kamuzu College of Nursing,

Private Bag 1,

Lilongwe.

The District Health Officer,

Lilongwe DHO,

P.O. Box 1274,

Lilongwe.

Dear Sir,

APPLICATION TO CONDUCT A RESEARCH STUDY IN LILONGWE URBAN.

I am a fourth year student pursuing Bachelor of Science in Nursing at Kamuzu College of Nursing. In partial for fulfillment of the programme for the award of Bachelor of Science in Nursing, I am expected to conduct a research study. The title of the research is **Deaf Clients' Experience in Accessing Health Care Services in Lilongwe Urban**.

I write to apply for a permission to conduct a research study at Malawi National Association for the Deaf Lilongwe Branch. I wish to interview those people who are deaf, through the help of the sign language interpreter, on their experiences upon going to the health institution, challenges encountered in the course of acquiring health services, as well as the ways that can help to improve health services to the deaf clients.

The results of the study may be used by the govemment and other stake holders in formulating policies and programmes that will problems faced by the deaf clients when accessing health care services in various health institutions.

Lastly, am looking forward for your consideration.

Yours faithfully,

Edison Wakale Sabola.

APPENDIX VIII; TIME TABLE FOR THE STUDY

Activity	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV
Choosing a research topic											
Writing a proposal											
Pre-testing											
Data collection											
Data analysis											
Report writing											
Submission of dissertation											
Dissemination of results											

APPENDIX IX; BUDGET FOR THE RESEARCH

ITEM	COST PER ITEM(MK)	TOTAL COST
A4 plain papers ream(2)	K 900.	K1,800
Printing	K2,500	K2,500
Internet	K3,500	K3,500
Ballpoint pens	K500	K500
Pencils	K100	K100
Envelopes	K500	K500
Eraser	K100	K100
Flash disk	K7500	K7,500
Binding	K2500	K2,500
Airtime	K3000	K3,000
Transport data collection	K2500	K2,500
Three Trips to meet the supervisor: Blantyre/Lilongwe	K2,500 each	K7,500
Contingencies	K10,000	K10,000
GRAND TOTAL		K41,400

APPENDIX X

Kamuzu College of Nursing,

Private Bag 1,

Lilongwe.

21st October, 2010

The Administrator,

MANAD Lilongwe Branch,

Lilongwe

Dear Sir,

APPLICATION TO CONDUCT A STUDY AT YOUR INSTITUTION

I am a fourth year student pursuing Bachelor of Science in Nursing at Kamuzu College of Nursing. In partial for fulfillment of the programme for the award of Bachelor of Science in Nursing, I am expected to conduct a research study. I write to ask permission to conduct a study at your institution.

The title of the research is **Deaf Clients' Experience in Accessing Health Care Services in Lilongwe Urban**. The aim of the research study is to explore the deaf clients' experiences upon going to the health institution, with much emphasis on communication between them and health care provider, as well as challenges encountered in the course of acquiring health services. A search study will be conducted in October, 2010.

Your favourable response will be greatly appreciated.

Yours faithfully,

Edison Wakale Sabola.

APPENDIX XI

University of Malawi
KAMUZU COLLEGE OF NURSING

RESEARCH AND PUBLICATIONS COMMITTEE

APPROVAL CERTIFICATE

TITLE: **Study on the deaf client's experience in accessing health care services in Lilongwe Urban**

INVESTIGATOR: **EDSON WAKALE SABOLA**

UNIVERSITY OF M...
KAMUZU COLLEGE OF NURSING
04 -10- 2010
BASIC STUDIES DEPARTMENT
PRIVATE BAG 1, LILONGWE

DEPARTMENT/YEAR OF STUDY: Year 4

REVIEW DATE : 06 SEPTEMBER 2010

DECISION OF THE COMMITTEE: Approved

SIGNATURE: ..... **DATE:** 04/10/10
CHAIRPERSON, RESEARCH AND PULBICATIONS COMMITTEE

cc Supervisor:

DECLARATION OF INVESTIGATOR(S)

I/we fully understand the conditions under which I am/we are authorized to carry out the above mentioned research and I/we guarantee to ensure compliance with these conditions. In case of any departure from the research procedure as approved, I/we will resubmit the proposal to the committee.

DATE 4th OCTOBER 2010 SIGNATURE(S) .....

APPENDIX XII

Ref. No.:
Telephone No.: 265 727017
Telefax No. 265 727817
Telex No :
E-Mail lilongwedho@malawi.net

Please address all communications to:
The District Health Officer

Lilongwe District Health Office
P.O. Box 1274
Lilongwe
Malawi

5th October, 2010

To whom it may concern

RE: PERMISSION TO CONDUCT REASERCH STUDY IN LILONGWE DISTRICT

Permission has been granted to the bearer of this letter,

Edison Wakale Sabola

to conduct a study in Lilongwe District Health Office

The deaf clients' Experience of Acessing Health Care Services in Lilongwe Urban

Any assistance rendered would be appreciated.

Dr. M. Mwale
DISTRICT HEALTH OFFICER

APPENDIX XIII

MALAWI NATIONAL ASSOCIATION OF THE DEAF (MANAD)
Private Bag 14, Maselema, Blantyre 8. Cell: 0888 540206 23/0995 57 87 11: E-mail: Manad.deaf@yahoo.com

18th/10/10

University of Malawi
Kamuzu College of Nursing
Private Bag 1
Lilongwe

Dear Sir

Mr. EDSON W.SABOLA

I hereby confirm that the above named person came and conducted research at this institution on 18/10/10.

It is my hope that the Deaf community is going to benefit a lot from this research.

Looking forward to continuously working with you.

Yours faithfully.

Byson Chimenya
Executive Director

APPENDIX XIV

MALAWI NATIONAL ASSOCIATION OF THE DEAF (MANAD)
Private Bag 14, Maselema, Blantyre 8. Cell: 0888 540206/0995 57 87 11; E-mail: manad.deaf@yahoo.com

8th November 2010

Kamuzu College of Nursing
Private Bag 1
Lilongwe

Dear Mr. Sabola,

PERMISSION TO CONDUCT RESEARCH STUDY AT MANAD LILONGWE CHAPTER

Thank you very much for your interest to conduct research study on Deaf Experience in Accessing Health Service in Lilongwe Urban. We appreciate your kind gesture and fully support your initiative.

We have examined the objects and goals of your proposed study we find the to be in line with the objectives and goals of MANAD especially on access to Health Care Services not only in Lilongwe but in Malawi as whole. So we have no problem in grating you conduct the research study among MANAD members of Lilongwe Chapter.

You are assured of our full cooperation and support.

Yours Faithfully

8/11/10

B.J. Chimenya
Executive Director