NORWEGIAN UNIVERSITY OF SCIENCE AND TECHNOLOGY

DEPARTMENT OF PSYCHOLOGY

Master‘s Thesis in Human Development

BARRIERS TO MAINSTREAM PARTICIPATION OF PERSONS WITH DISABILITIES: A QUALITATIVE STUDY OF PERSONS WITH PHYSICAL DISABILITIES IN TECHIMAN, GHANA

Enock Takyi

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DECLARATION

I**, Enock Takyi**, do hereby declare that except for references to other people's work, which have been duly acknowledged, this work was conducted by me under the supervision of **Professor Sven Hroar Klempe** at the Institute of Psychology, Norwegian University of Science and Technology (NTNU), Trondheim, during the 2012/2013 academic year. This work has neither been submitted in whole nor in part for any degree in this University or elsewhere.

Signed: ………………………………….. …..…………………………….

Enock Takyi **Date**

(Student)

This work has been submitted for examination with my approval.

Signed: **……………………………………….** **…..………………………………**

Supervisor / Advisor **Date**

Sven Hroar Klempe

(**PhD: Professor**)

DEDICATION

To my family and all persons with disabilities in Ghana.

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I am thankful to Yahweh, my Maker and Sustainer, for His unconditional love, grace and mercies extended to me throughout my study.

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Abstract

This study uses data from qualitative interviews and focus group discussions to explore the lived experiences of persons with disabilities in Techiman, Ghana. The study found that persons with disabilities hardly enjoy equal rights and privileges as their able-bodied counterparts in the Ghanaian society. Parsons with disabilities in Ghana are often denied access to education, employment, healthcare, social activities, decision making, and leadership positions. Persons with disabilities are also less likely to be accepted in marriage. Discrimination against persons with disabilities result mainly from negative perceptions about disability, especially the perception that disability is either a sickness or a curse. Participants observed, however, that perceptions about disability, and the corresponding attitudes towards persons with disabilities, are improving recently mainly due to public education. As control measures, participants suggested vigorous public education campaigns aimed at cultural and ideological changes. Participants also suggested structural changes, particularly policies and legislations that would make public places accessible to persons with disabilities, and enhance the opportunities of persons with disabilities to take part in all decisions affecting them.

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LIST OF ABBREVIATIONS

CHRI - Commonwealth Human Rights Initiative

DSW - Department of Social Welfare

GNA - Ghana News Agency

ICF - International Classification of Functioning, Disability and Health

NSD - Norwegian Social Science Data Services

UN - United Nations

WHO - World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Statement of the Problem

The maiden World report on disability published by the World Health Organization in 2011 estimates that more than one billion people in the world have some form of disability (WHO, 2011). Out of this number, approximately 200 million experience considerable difficulties in functioning. The report also revealed that throughout the world, persons with disabilities have poorer health outcomes, lower education achievements, less economic participation and higher rates of poverty than people without disabilities.

Realising the plight of persons with disabilities, the United Nations (UN), in 1975, promulgated the Declaration on the Rights of Disabled Persons which called for equitable treatment of persons with disabilities (Anthony, 2011; UN, 1975). In 1985, the Universal Declaration on Human Rights, which was originally enacted in 1948, was eventually expanded to cover persons with disabilities (Anthony, 2011). Since then, there have been a number of international conventions, policies, and programmes to address disability issues. Notable among them is the UN Convention on the Rights of Persons with Disabilities (UN, 2006). In 1992, the UN proclaimed December 3 as International Day of Persons with Disabilities (Timeanddate.com, 2012). This day is observed annually to re-affirm and draw attention to the rights of persons with disabilities. While these efforts have chalked some successes, the condition of persons with disabilities in some parts of the world leaves much to be desired. This is especially so in the developing world, including Ghana.

An estimated 2.5 million Ghanaians live with disabilities, making them the country's largest minority (CHRI, 2011). However, they also constitute the most impoverished and marginalised group as their situation is characterised by lack of access to public health, education, and other social services that would ideally support and protect them (Ghana Federation of the Disabled, 2012). According to Ghana Federation of the Disabled, persons with disabilities in Ghana can be said to be the poorest among the poor, both economically and socially. Most of them depend entirely on their families throughout their life (Kassah, 1998). A review of available literature suggests that persons with disabilities in Ghana are impoverished not mainly as a result of their impairments, but as a result of societal barriers that impede their full functioning in the society. Such barriers may be physical, social, economic, political or cultural (Anthony, 2011).

In order to guarantee the rights of persons with disabilities in Ghana, the government of Ghana has ratified the numerous international conventions and declarations on the rights of persons with disabilities, and has come out with local laws and policies that address disability issues (Anthony, 2009; Anthony, 2011; Human Rights Watch, 2012). The constitution of Ghana mandates equal opportunities for all Ghanaians, including persons with disabilities, to participate in national development (Government of Ghana, 1992). In 2000, the Government of Ghana developed the National Disability Policy meant to integrate persons with disabilities into the mainstream of the socioeconomic life of the country (Anthony, 2009). The National Disability Policy prepared the ground for a more comprehensive legislation on disability - the Persons with Disability Act, 2006 - which was passed by the parliament of Ghana in 2006 (Government of Ghana, 2006). The act, among other things, seeks to promote equal access to education, health service, information, family life, social activities, public buildings, and employment for persons with disabilities. The baseline of the act is to ensure that persons with disabilities in Ghana are treated as equal citizens with equal rights. In fulfilment of a provision in the Persons with Disability Act, 2006, the National Council on Persons with

Disability was inaugurated in 2009 to propose and evolve policies and strategies to enable persons with disabilities enter and participate in the mainstream of the national development process (Ghana Federation of the Disabled, 2009).

Considering these provisions made by the government, one might expect a major improvement in the lives of persons with disabilities in Ghana. However, the situation of many persons with disabilities in the country is nothing to write home about. The fundamental human rights of persons with disabilities in Ghana are often denied. In view of this, many associations of persons with disabilities and organizations that support persons with disabilities, time and again, make calls to the government to ensure that persons with disabilities enjoy all their fundamental rights as enshrined in the laws of the country (Global Accessibility News, 2012; GNA, 2012; Chronicle, 2011a).

Literature search reveals that research on disability in Ghana is very limited. The available researches on the phenomenon also centre mainly on inclusive education and rehabilitation of persons with disabilities. Researches that look at the lived experiences of persons with disabilities are very scanty. A number of articles mention the negative attitudes of Ghanaians towards persons with disabilities, but the real manifestation of such attitudes in social interactions and their impact on the lives of persons with disabilities are hardly investigated. Besides, available literature on the phenomenon of disability in Ghana that take into consideration the opinions of persons with disabilities and their families are almost nonexistent. Most of the available researches sourced information from teachers, community leaders, donor organisations, students and other stake holders. While I do not challenge the credibility of these literature, I also believe strongly that we can get a better understanding of the situation of persons with disabilities if we look at it from different facets of their lives, including their experiences in their families, school, community, workplace, and so on.

Besides, I am of the conviction that persons with disabilities can tell their stories far better than any other person or group of persons.

Enquiring from persons with disabilities and their families will help provide a more holistic and thorough understanding of the phenomenon. It will throw more light on what persons with disabilities go through, the opportunities available to them in the society, factors that inhibit their meaningful participation in the society, and how they feel about their situation as persons with disabilities. It is for this reason that I set out to conduct this research. While I try as much as possible to be objective, I have to admit that I commenced the study with the perception that there are a number of barriers, aside from educational barriers, that impede the meaningful participation of persons with disabilities in the mainstream Ghanaian society. This perception might have, in some way, influenced my understanding and interpretation of data.

1.2 Objectives of the Study

1.2.1 Main Objective

The main objective of the study is to explore the lived experiences of persons with disabilities in Ghana. The study thus delves into the living conditions of persons with disabilities, the opportunities available to them in their families and in the community at large, the barriers that hinder their meaningfully participation in the society, how they cope with such barriers, and how these affect their general wellbeing and development.

1.2.2 Specific Objectives

The study seeks to achieve the following specific objectives:

1. To examine the current situation of persons with disabilities in Ghana from the perspective of persons with physical disabilities.
2. To explore the challenges faced by persons with disabilities in their daily lives.
3. To investigate the influence of these challenges on their total development.
4. To examine how well existing laws and policies in Ghana address disability issues.

1.3 Relevance of the Study

Persons with disabilities constitute about 10 percent of the Ghanaian population. Their potential contribution to national development, therefore, cannot be overemphasized. There is therefore the need to unearth, and hopefully deal with, the factors that impede their participation in the society to enable them to contribute meaningfully to the socioeconomic development of the nation. The findings of this study will therefore be useful to the government, individuals, international and national organisations, and all interested bodies that aim at integrating persons with disabilities into the mainstream society, in their planning and implementation of interventions. The study is relevant and timely, especially considering the fact that many organisations of persons with disabilities and advocacy groups in Ghana are pressuring the government to ensure that persons with disabilities participate effectively in the mainstream society.

1.4 Research Questions

In order to achieve the aims of the study, the following guiding questions are addressed:

1. What challenges do persons with disabilities in the Ghanaian society face in their daily lives?
2. How do these challenges influence their total wellbeing and development?
3. How do informants view the impact of existing laws and policies on the lives of persons with disabilities in Ghana?

CHAPTER TWO

BACKGROUND TO THE STUDY

2.1 Conceptualizing Disability

Several attempts have been made throughout history to understand and explain disability. The different explanations of disability have led to a number of disability models. Some of the prominent models of disability are discussed below.

2.1.1 The Moral Model of Disability

The moral model of disability views disability as resulting from "being out of harmony with God or the natural order of the universe" (Mackelprang & Salsgiver, 2009, p. 4). In other words, the model views disability as a punishment from God or other spiritual beings. The moral model also sees disability as resulting from evil possession (Clare, 2001; Mackelprang & Salsgiver, 2009). The moral model, therefore, "transforms disability into a sign of moral weakness" (Clare, 2001, p. 360). Hence, persons with disabilities, under this model, are regarded as moral deviants (Mackelprang & Salsgiver, 2009). The moral model of disability, therefore, leads to stigmatization and marginalisation of persons with disabilities and their families.

2.1.2 The Medical Model of Disability

The medical model of disability views disability as a form of innate abnormality that needs to be corrected through medical and scientific means (Anthony, 2011; Coleridge, 1993; Mackelprang & Salsgiver, 2009; Oliver, 1996). The medical model is also called the individual model since it locates the problem of disability within the individual (Anthony, 2011). The medical model places emphasis on cure or rehabilitation. The model requires persons with disabilities to adapt to social and environmental structures around them in an effort to fit within the mainstream society. As a result, persons with disabilities who are not able to adapt are either neglected or kept in special institutions where they can be cared for.

The medical model has come under criticism over the years for its failure to account for the influence of external environmental and social factors on the lives of persons with disabilities (Anthony, 2011; Lindsay, 2003).

2.1.3 The Social Model of Disability

The social model of disability views disability as resulting from societal barriers that prevent persons with impairment from functioning fully in the society. The model thus differentiates between impairment and disability. According to the social model, people are disabled not as a result of their innate characteristics; rather, it is "discriminatory societal attitudes and environmental barriers arising from the inequality and oppression of individuals with impairments" that disable them (Anthony, 2011, p. 1075). In other words persons with disabilities are not able to function effectively because society fails to cater adequately for their needs. The tenets of the social model are well captured by Oliver (2004) in the following definition:

> In the broadest sense, the social model of disability is about nothing more complicated than a clear focus on economic, environmental and cultural barriers encountered by people who are viewed by others as having some form of impairment- whether physical, sensory or intellectual. The barriers disabled people encounter include inaccessible education systems, working environments, inadequate disability benefits,

> discriminatory health and social support services, inaccessible transport, houses and public buildings and amenities, and the devaluing of disabled people through negative images of the media – films, television and newspapers. Hence the cultural environment in which we all grow up usually sees impairment as unattractive and unwanted (p. 21).

From the perspective of the social model, it is the society, but not the individual, that needs to be fixed (Anthony, 2011).

Like the medical model, the social model of disability has its own shortcomings. It tends to completely downplay the impact of the impairments of persons with disabilities on their functioning (Anthony, 2011). In other words, the model tends to deny entirely the fact that persons with disabilities' inability to participate fully in society is partly due to their internal impairments. In Low's words (cited in Anthony, 2011), the social model appears to mistranslate "not only individual" as "only social", and "the individual is not everything" as "the social is everything" (p. 1075).

2.1.4 International Classification of Functioning, Disease and Health (ICF)

The International Classification of Functioning, Disability and Health (ICF) is the World Health Organization's conceptual framework for the definition, measurement and policy formulations for health and disability (WHO, 2002). The ICF views disability as an interaction between features of the person and features of the overall context in which the person lives. In other words, the ICF definition of disability takes into account both factors in the person's body and factors within his environment. The ICF synthesizes the medical and social models, thereby providing a coherent view of health, taking into consideration biological, individual, and social factors. While acknowledging disability as a medical phenomenon, the model also acknowledges the environmental and social factors that interact with the medical condition to bring about disability.

Below is a diagrammatic representation of the ICF model.

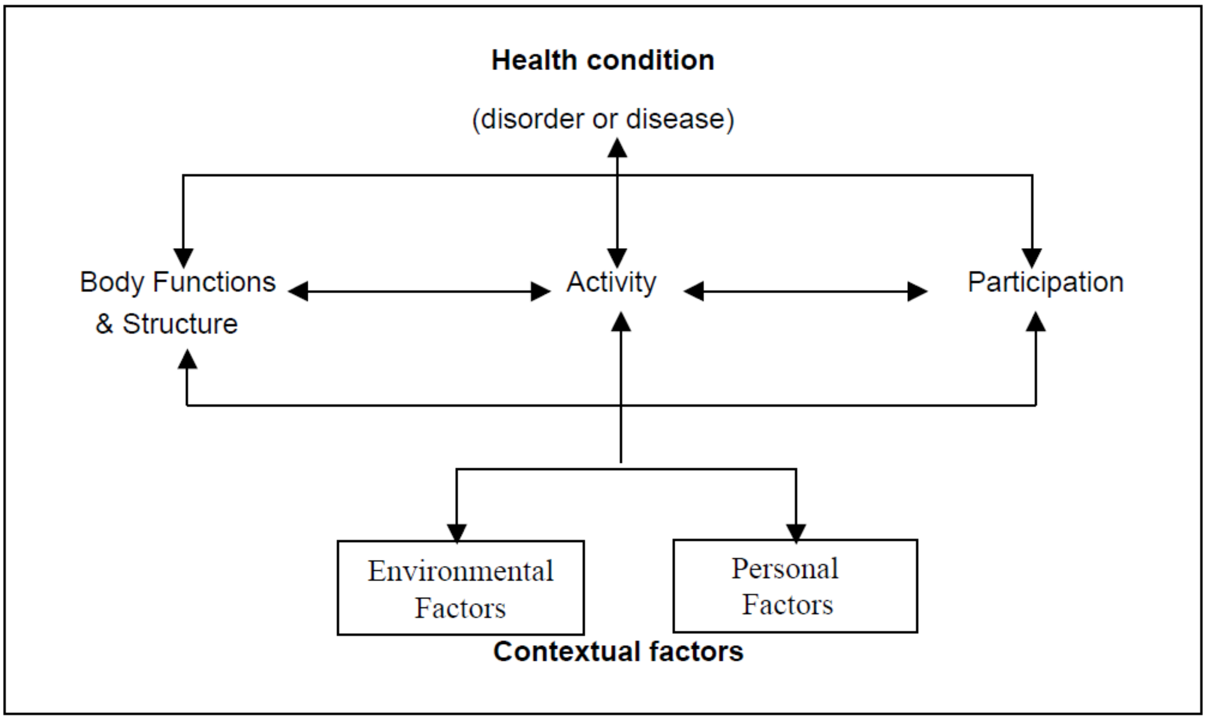

Figure 1: International Classification of Functioning, Disease and Health (WHO, 2002, p. 9).

As the diagram indicates, the ICF views disability and functioning as outcomes of interactions between health conditions and contextual factors. Health conditions include factors such as diseases, disorders, and injuries. Contextual factors consist of external environmental factors such as social attitudes, architectural characteristics, legal and social structures, climate, and terrain; and internal personal factors, such as gender, age, coping styles, social background, education, profession, past and current experience, and overall behaviour pattern of an individual.

The ICF classifies human functioning at three levels, namely, "the level of body or body part, the whole person, and the whole person in a social context" (WHO, 2002, p. 10). Disability is therefore an umbrella term used to describe any dysfunction that may occur at any of these levels. In other words, the term disability encompasses impairments at the body and body part level, person level activity limitations, and societal level restrictions of participation.

Clearly, the ICF does not see disability as an individual's intrinsic feature but a result of interaction in an environment. The model recognizes that the physical and social environment in which an individual lives affects, positively or negatively, the individual's performance as a member of society, and on the individual's capacity to perform tasks (WHO, 2001). Thus the interaction of the same person with the health condition may yield different functioning level in different environments.

This study looks at disability from the perspective of the ICF model, namely, that disability is a result of an interaction between a person with a health condition and that person's contextual factors. The study therefore adopts the definition of persons with disabilities as given by the UN Convention on the Rights of Persons with Disabilities quoted below:

> Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others (UN, 2006, Article 1, para. 2).

It is worthy to note, however, that the study focused mainly on the barriers in the social, cultural, and political environments within which persons with impairments live. As a result, no clear distinction between impairments is made in this paper.

It is also worth mentioning that all persons with disabilities interviewed in this study were persons with physical impairments. Two main reasons informed my decision to use only persons with physical impairments. First, considering the time frame for the study, it was easier and more convenient to deal with persons with physical disabilities because, unlike other forms of disability such as hearing impairment or intellectual impairment, interviewing persons with physical disabilities does not require any special communication skills. Besides, my experience as a Ghanaian has shown me that Ghanaians tend to put all persons with disabilities in the same bracket in term of perception and treatment; hence information obtained about persons with physical disabilities might also be applicable to, or at least give some insight into, other forms of disabilities.

2.2 Conceptualizing Disability in Ghana

In my personal experience as a Ghanaian, I have come to realise that the moral and the medical models of disability have been used extensively in the Ghanaian society. Available literature also point to this direction.

2.2.1 The Moral Model and the Ghanaian Society

The moral interpretation of disability in Ghana stems mainly from the traditional belief system of the people. Traditionally, Ghanaians believe that the world goes beyond what we see with our eyes. Beyond the physical or material world is the spiritual or the unseen world. In the spiritual world are a host of supernatural beings who, though unseen, participate actively in the daily lives of the people (Andin, 2008; Frimpong, 2011, Opoku,1978). Some of these spiritual beings are good while others are evil, hence they can influence human life for good or for evil (Andini, 2008; Frimpong, 2011). Notable among the supernatural beings are the Supreme Being or God, the ancestral spirits, the lesser gods, witchcraft, and sorcery. This categorization appears to be universal to all Ghanaians (Nukunya, 2003). The deities are briefly described below with specific reference to the Akans, from whom the sample for this study was taken.

According to Nukunya (2003), the concept of the Supreme Being is common to all Ghanaian societies. The Supreme Being, known in the Akan language as *Nyame* or *Onyankopon* (God), is believed to be the creator of the universe. He is the source of all power; he is therefore ranked highest among the spiritual beings. It is believed that the Supreme Being did not only create the universe, but he also sustains it. "There are traditional names, attributes, myths, symbols, proverbs greetings, and everyday sayings that together express God’s omnipotence, omniscience, goodness, dependability, immortality and other beliefs in him" (Frimpong, 2011, p. 26). It is a general belief that God is just; he therefore rewards people who practice virtue and punishes those who do evil (Frimpong, 2011; Opoku,1978). In the traditional Ghanaian worldview, the Supreme Being is transcendent; he hardly deals directly with humans. He therefore communicates with human beings through intermediaries- the gods and ancestral spirits (Afriyie, 2000; Frimpong, 2011; Opoku, 1978).

The cult of the ancestors, according to Pobee (1979), is "the most potent aspect of the Akan religion" (p. 95). Akans, and Africans in general, believe that man is made up of both material and immaterial substances (Frimpong, 2011). At death it is only the material part that dies; the immaterial or spiritual part known in Akan as the *Okra* (soul) moves on to the world of spirits (known in Akan as *asamando*) where he/she lives permanently (Frimpong, 2011; Gyekye, 1995). According to Pobee (cited in Frimpong, 2011), the term ancestors refers to people in the Akan community "who have completed their course here on earth and are gone ahead to the higher world to be the elder brothers of the living in the house of God" (p. 27). According to Dickson (1984), however, "it is not everyone who dies who becomes an ancestor", rather people who become ancestors are those who "must have lived exemplary lives" (p. 198).The ancestors are believed to mediate between the Supreme Being and the community. As intermediaries between God and human beings, the ancestors are believed to protect their communities and bestow them with blessings. The Akans therefore seek favour from their ancestors through pouring of libation (Frimpong, 2011). The ancestors are believed to be the custodians of law and order; they therefore reward the obedient and punish the disobedient (Avoke, 2002; Frimpong, 2011; Opoku, 1978). In this regard, the Akans tend to explain both fortunes and misfortunes as resulting from the actions of ancestors.

Another important cult in the traditional Ghanaian belief system is the cult of the lesser gods. They are known in Akan as *abosom*. The gods are believed to be children, messengers, or agents of the Supreme Being, from whom they derive their power (Andin, 2008; Frimpong, 2011; Opoku, 1978). It is believed that they were created by the Supreme Being to perform specific functions (Frimpong, 2011). Generally, the gods are supposed to help men in their daily lives, protect them from danger, and solve societal and personal problems (Andin, 2008; Frimpong, 2011; Opoku, 1978). The gods are believed to inhabit some objects and places in the environment such as trees, rivers, rocks, caves, and certain animals (Andin, 2008; Frimpong, 2011). Like the ancestral spirits, the gods are also believed to have destructive power, and can harm an individual or even the whole community when they are offended (Avoke, 2002; Frimpong, 2011).

Apart from the spiritual beings who are believed to work towards the wellbeing of man, Ghanaians also believe in the existence of evil spirits whose primary goal is to destroy human beings. Notable among them are witchcraft and sorcery. Witchcraft, known in Akan as *bayie,* is believed to be inherited from a parent or acquired by eating certain foods (Andin, 2008; Nukunya, 2003). A person being possessed by witchcraft then becomes *bayifoɔ* (a witch or wizard) with inherent supernatural powers to harm people that she/he hates or envies. Some people however believe that witchcraft may also be used to benefit oneself (Nukunya, 2003). Sorcerers, on the other hand, are people who are believed to have the ability to tap evil spirits and use their magical powers to injure or kill other people (Frimpong, 2011).

With the introduction of Christianity, Islam, and western education in Ghana, the intensity with which people adhere to the traditional belief system has reduced. Notwithstanding, the traditional belief system still influences the worldview of many Ghanaians, including those who profess to be Christians or Muslims (Andin, 2008; Salm & Falola, 2002).

In view of the traditional belief system presented above, disability in Ghana is often explained in terms of supernatural causes. It is believed in Ghana that disability is a curse placed on an individual by the Supreme Being, the lesser gods, or ancestral spirits either as a result of the individual's own misdeeds or those of his relatives (Agbenyega, 2007; Avoke, 2002; Kassah, 1998; Oliver-Commey, 2001). For instance, among the Lobis in the Upper West Region of Ghana, disability, especially blindness, is believed to be the result of an offence against the gods or ancestors (Avoke, 2002). Similarly, the Akpafus in the Volta region of Ghana, believe that cataract is a disease caused by the gods as an expression of their anger in response to an offence committed by an individual or a member of his family

(Agbenyega, 2003). In this regard, persons with disabilities and their families are often blamed for bringing disability upon themselves and are in many cases, marginalised (Avoke, 2002).

Some Ghanaians also believe that persons with disabilities are possessed by evil spirits and can be a source of bad omen for their families or community as a whole (Kuyini, Alhassan, & Mahama, 2011; Nepveux, Mwinibalono, & Kuomkugri, 2004). In many parts of Ghana, children with learning difficulties or Down’s syndrome are believed to be “children of the rivers and forest” (Avoke, 2002, p. 773). Others also believe that they are “snake spirits in disguise, who are capable of turning into big snakes at night to devour their enemies” (Kuyini et al., 2011, p. 250). In the past such children were taken to the forest or to the rivers, where they were believed to have come from, under the guise of helping them to go back to where they belong. According to Avoke (2002), however, "they were usually killed secretly by the fetish priest, while the parents naively assumed that the child had returned to its roots" (p. 773).

Some Ghanaians even believe that the supposed curses placed on persons with disabilities are contagious (Reynolds, 2010). For instance, it is believed that those who associate with persons with disabilities could also give birth to children with disabilities. An informant as quoted by Reynolds (2010) threw light on this: “Even in the society when people see a disability they don’t even like to touch them, because they think they might give birth to something of that sort” (p. 201). Nortey (2009), in her study of the deaf and hard of hearing in Ghana, also recounted her own experience as follows:

> It is regrettable that most people find it difficult to associate with the deaf. Most of this difficulty arises from the fear of bringing forth deaf children just by associating

> with them. Most people I met find it either amazing or appalling, my association with deaf and hard of hearing. They are often quick to remark that I will give birth to a deaf child if I do not stop my association with them (p. 6-7).

The belief that persons with disabilities could contaminate other people was so overwhelming in the past that, society tried as much as possible to avoid contact with persons with disabilities. Persons with disabilities were often hidden and were not allowed to go to public places (Kassah, 1998). Avoke (2001) asserts that the belief that persons with disabilities could contaminate society was so intense in the past that some communities even resisted the establishment of special schools within their midst. This, according to Avoke, explains why almost all special schools in Ghana were built on the outskirts of towns.

In extreme cases, children with disabilities were killed at birth in order to prevent them from contaminating society. A classic example was given by Avoke (2002) in the following excerpt:

> Among the Nchumuru people in the Volta Region of Ghana […] children with disabilities noticed at birth were often killed outright by dipping their heads into buckets of water. The mothers of these children were then forced to wash themselves in the water in order to prevent other children with disabilities from being born (p. 773).

According to Avoke (2002), with the advent of Christianity and western education in Ghana, children with disabilities are no longer killed. However, a recent investigation by an award-winning Ghanaian investigative reporter Anas Aremeyaw Anas, filmed for People & Power, a current affairs programme on Al Jazeera English, suggests that among some tribes in northern Ghana, children born with disability who are branded as spirit children are still being killed because they carry the blame for bringing ill fortune to those around them (Al Jazeera, 2013).

2.2.2 The Medical Model and the Ghanaian Society

The medical model of disability has also been used largely in Ghana. Traditionally, it is believed in Ghana that persons with disabilities are abnormal, sick, and unproductive individuals, who are nothing more than burdens on their families and the society (Kassah, 1998; Reynolds, 2010). According to Avoke (2002), this perception arose mainly as a result of military demands in the past. Wars were very rampant in Ghana during the pre-colonial and colonial times, and people were needed to fight to protect their communities. As a result, able-bodied persons who participated actively in the wars were considered to be healthy and productive, while persons with disabilities were regarded as abnormal, unhealthy and dependent.

The perception that persons with disabilities are unproductive has gained ground in the ideologies of some Ghanaian communities. This becomes apparent when one looks into some of the discourses currently used in Ghanaian. For example, the Logba speaking people of Ghana have a proverb that suggests that "individuals with disability, especially those of a physical nature do not sing war songs", implying that persons with disabilities cannot, and should not be permitted, to participate in wars (Avoke, 2002, p. 771). Among the Akans, people with mental impairment are usually referred to as *"Nea wanyin agya n'adwen ho"*, meaning "the one who has outgrown his other brain" (Avoke, 2002, p. 773); in other words, a stupid person. The Gas of Accra call people with mental impairment *buluu* meaning fools (Avoke, 1997), whilst the Ewes of Volta Region call them "*Asovi*", which means a fool or idiot (Avoke, 2002, p. 773). The frequency with which Ghanaians use these and other similar derogatory terms in relation to persons with disabilities without any sense of guilt (Avoke, 2002) seems to suggest that the use of such terms is upheld by the norms and values of the society.

Unfortunately the medical interpretation of disability does not appear to be limited to the traditional Ghanaian. It appears that the medical model, directly or indirectly, influences policy makers as well. "Within the Ghanaian context, official approaches to the provision of services has largely been medically orientated" (Avoke, 2002, p. 774). A brief look at the Ghanaian educational system throws light on this. Over the years Ghana has practiced dualism of education where persons with disabilities attend segregated schools, while other children attend mainstream schools (Agbenyega, 2003). Even after the country's commitments to inclusive education, segregated services for students with disabilities are still on the rise (Anthony, 2009; Avoke, 2002). Implementation of inclusive education is only on pilot basis (Anthony, 2009). Even such pilot schools, according to Gadagbui (2006), are not practising the principles for inclusive education but just integration. "This is because the school environments are largely unchanged; equal opportunities are not given in terms of facilities and participation; child is not the focus but the school is subject centred" (Gadagbui, 2006, p. 3). In some cases segregated classroom units are built for persons with disabilities onsite with mainstream schools, a practice not consistent at all with the principles behind inclusive education (Anthony, 2009).

2.2.3 Taking Environmental Factors into Account

Both the moral and the medical models of disability locate the problem of disability in the individual. The moral model views persons with disabilities (and in some cases, their families) as inviting the anger of the gods and the ancestors upon themselves through their offences. As a result, persons with disabilities are often treated as social misfits. The medical model, on the other hand, views disability as a biological or psychological abnormality that needs to be cured. Focusing solely on the individual, the models fail to take into account the influence of the environment on the development of persons with disabilities. A brief look into the daily experiences of persons with disabilities in the society, however, reveals that there are a number of social, political, cultural, and physical barriers which, if removed, will enable persons with disabilities to participate meaningfully in the Ghanaian society. This calls for models such as the social model and the ICF model that take the environmental factors of persons with disabilities into account.

The woes of persons with disabilities in Ghana begin right from childhood. The presence of a person with disability in a family tends to stigmatise the entire family (Reynolds, 2010). This is due to the perception that giving birth to a child with disability is a punishment for what the family did wrong. As a result, children with disabilities are hardly accepted by families. Some parents try to find all possible ways to eliminate their children with disabilities in order to avert the social stigma of having given birth to a person with disability (Abgenyega, 2007; Nepveux et al., 2004). Others try to hide their children with disabilities from public view. For instance, in their interview with Disabled Women Leaders from Ghana, Nepveux et al. (2004) had one of their informants recalling the following incidence: "A man had his disabled daughter in the room for 27 years, before she was sick and she died. He never took her to a doctor, so it was only then that we heard of her" (p. 1). The desire of parents to avoid public ridicule often leads to the denial of children with disabilities of access to healthcare, education, family activities, and social gatherings, since they are usually kept indoors.

The negative perceptions about disability might also affect how persons with disabilities are treated in school. Agbenyega (2007), for instance, identified “negative attitude and persistent low regard for students with disabilities" as a serious barrier to educational inclusion in Ghana (p. 43). The negative attitudes at school, coupled with the fact that most school buildings in Ghana are not disability friendly (Chronicle, 2011a), send signs of exclusion and keep many persons with disabilities out of school.

With limited access to education, many persons with disabilities grow up without employable skills. In a country where job opportunities are highly competitive, persons with disabilities in Ghana are mostly unemployed due to their lack of skills. Unfortunately, the few persons with disabilities who manage to acquire employable skills also find it difficult to get jobs because of the general perception that persons with disabilities are unproductive (Reynolds, 2010). As a result, many persons with disabilities in Ghana are seen begging on the streets in order to survive (Chronicle, 2011b).

Persons with disabilities are hardly catered for in terms of public infrastructural development in Ghana. Many public buildings in Ghana, including schools, hospitals, community centres, courts and government offices, do not have any provision for persons with disabilities (CHRI, 2011; GNA, 2012; Government of Ghana, 2012; Graphic, 2012; Reynolds, 2010). Similarly, many roads in Ghana have no provision for persons with disabilities, especially persons with physical disabilities who use wheelchairs (GNA, 2012). This restricts the free movement of persons with disabilities, thereby limiting their access to education, healthcare, employment, and social gatherings.

2.3 Theoretical Framework

The study uses the models of disability described in this chapter to enable readers to gain some understanding of the disability situation in Ghana. In addition, the study draws on Ervin Goffman's Stigma Theory and Urie Bronfenbrenner’s Bioecological Model of Human Development.

2.3.1 The Stigma Theory

The term stigma was originated by the ancient Greek to refer to a bodily sign designed to reveal something unusual and bad about the moral status of individuals (Goffman, 1963). The marks were made on slaves and criminals to make them easily identifiable (Goffman, 1963; Moloney, 2005). The word in its contemporary usage is credited to the sociologist Ervin Goffman (Reiher, Heinrich, & Roberts, 2008). In his classic book *Stigma: Notes on the Management of Spoilt Identity*, Goffman (1963) noted that the term in its contemporary usage refers to any "attribute that is deeply discrediting and that reduces the person from a whole and usual person to a tainted and discounted one" (p. 3). According to Goffman, society tends to create categories of people on grounds of normative expectations. Those who fall within such expectations are regarded as normal, while individuals who fall short of the expectations are branded deviants. Thus, according to Goffman, stigma is not an inherent characteristic of a person, but rather results from social reactions to individuals who are perceived to be negatively different (Susman, 1994).

Goffman identified three types of stigma. They include abominations of the body, consisting of physical disabilities; blemishes of individual character, such as mental disorder, dishonesty, homosexuality, and alcoholism; and the tribal stigma that results from belonging to a particular race, culture, or religion.

Goffman (1963) also identified what he called courtesy stigma. He postulated that stigma does not only affect the individuals who are different from what society anticipates, but spread on to people who are closely associated with the discredited person (Fjone, Ytterhus & Almvik, 2009). People who are likely to suffer courtesy stigma may include "the loyal spouse of the mental patient", "the daughter of the ex-con", "the parent of the cripple", and "the friend of the blind man" (Goffman,1963, p.30).

According to Goffman (1963), stigma tends to obtrude itself on our attention to the extent that we hardly see other attributes of the person in question. As a result, society tends to believe that a person with a stigma is not quite human. "On this assumption we exercise a variety of discrimination, through which we effectively, if often unthinkingly, reduce his life chances" (p. 5). In order to justify the discrimination against a person with stigma, society "constructs a stigma theory" through which a wide range of imperfections are imputed to the person on the basis of the original stigma, in order "to explain his inferiority and account for the danger he represents" (p. 5).

Unfortunately, stigmatised persons tend to internalise the standards set by society, thereby seeing themselves as socially unacceptable and inferior beings. According to Goffman, three management strategies are often used by stigmatised individuals to manage their condition, namely, passing, covering and withdrawal. Passing involves efforts made by stigmatized individuals in order that they can pass as normal persons (Carnevale, 2007). Stigmatised individuals who adopt this strategy either conceal information about their attribute where possible, or alter their stigmatic condition such as having surgery. Covering involves attempts made to maintain generally expected social interactions and relationships, despite the socially acknowledged presence of a stigmatic condition. Withdrawal occurs when the individual tries to isolate himself from situations that will make him identifiable (Carnevale, 2007).

2.3.2 The Bioecological Model of Human Development

The Bioecological Model of Human Development was first developed by Urie Bronfenbrenner to explain human development. The inability of persons with disabilities in Ghana to participate meaningfully in the society cannot be attributed to a single factor. The contributing factors can be very complex. There is therefore the need to look at the phenomenon in the context of the individual's total environment. The bioecological model therefore becomes applicable here because, it emphasises the importance of the immediate, as well as the external environments of the individual to his development.

According to the bioecological theory, an individual develops within the context of the system of relationships that form his environment. The environment, according to Bronfenbrenner, is made up of complex layers, each having a significant effect on a child’s development (Bronfenbrenner & Morris, 2006). Bronfenbrenner (1979) asserts that the layers within the environment interact not only with the active, developing individual, but also with each other to influence the individual’s development. Any conflict in any one layer can, therefore, ripple throughout other layers, thereby adversely affecting the growing person (Nelson & Prilleltensky, 2010). For healthy development of an individual, the systems must function effectively. The five interdependent layers or systems of the environment, according to Bronfenbrenner, include *microsystem, mesosystem, exosystem, macrosystem, and chronosystem* (Bronfenbrenner & Morris, 2006).

The diagram below represents the bioecological model of human development as postulated by Bronfenbrenner.

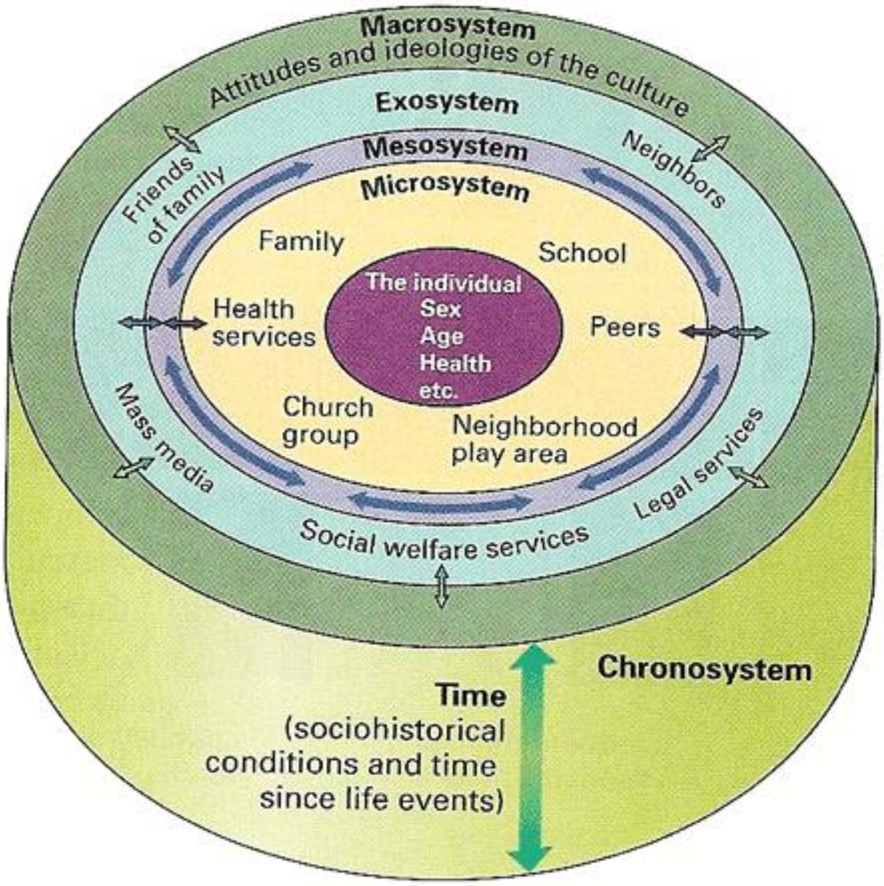

Figure 2: Bronfenbrenner: Ecological theory of child development (Santrock, 2008, p. 33)

The microsystem encompasses the relationships and interactions a child has with his immediate surroundings (Berk, 2000). It is the layer closest to the child and contains the structures with which the child has direct contact. Structures in the microsystem include family, school, neighbourhood, peers and childcare environments.

The mesosystem provides the relationship between the structures of the individual’s microsystems (Berk, 2000). It consists of “the interrelations among two or more settings in which the developing person actively participates” (Bronfenbrenner, 1979, p. 25). Examples include the interactions among the child’s home, school, peers, and neighbourhood.

The exosystem defines one or more settings in which the child does not function directly, but in which events occur that affect his development. The structures in this layer impact the child’s development by interacting with some structures in his microsystem (Berk, 2000). Some of the structures in the exosystem include parents’ workplace schedules, parents’ religious institutions, community-based family resources and welfare services within the community.

The macrosystem is the outermost layer in the child’s environment. This layer comprises government policies, laws, cultural values, customs, and belief systems. The effects of larger principles defined by the macrosystem have overarching influence throughout the interactions of all the other layers.

The chronosystem encompasses the dimension of time as it relates to a child’s environments. The chronosystem involves the socio-historical conditions, transitions and changes in the individual and his environment across time (Bronfenbrenner & Morris, 2006). Elements within this system can be either external, such as the timing of a parent’s death, or internal, such as the physiological changes that occur with the aging of a child.

Bronfenbrenner came out with five main propositions for positive development of a person. First, argues that in order to develop intellectually, emotionally, socially and morally, a child requires participation in progressively more complex reciprocal activities, on a regular basis over an extended period in his life. The child should perform these activities with one or more persons with whom he develops a strong, mutual, irrational, emotional, attachment and who is committed to the child's wellbeing and development. Second, the establishment of patterns of progressive interpersonal interaction under conditions of strong mutual attachment enhances the young child's responsiveness to other features of the immediate physical, social, and in due course symbolic environment. Third, the establishment and maintenance of patterns of progressively more complex interaction and emotional attachment between caregiver and child depend in substantial degree on the availability and involvement of another adult, a third party who assists, encourages, spells off, gives status to, and expresses admiration and affection for the person caring for and engaging in joint activity with the child. Fourth, the effective functioning of child-rearing processes in the family and other child settings requires establishing ongoing patterns of exchange of information, two-way communication, mutual accommodation and mutual trust between the principal settings in which the child participates. Among these settings are the home, childcare programmes, and the school. Lastly, the effective functioning of child-rearing processes in the family and other child-rearing settings require public policies and practices that provide place, time, stability, status, recognition, belief systems, customs and actions in support of child-rearing activities not only on the part of parents, caregivers, teachers and other professional personnel, but also relatives, friends, neighbours, co-workers, communities, and the major economic, social and political institutions of the entire society. Even though these propositions were initially developed to explain child development, Bronfenbrenner and Morris (2006) assert that they may also apply to relationships in adulthood and old age.

Bronfenbrenner acknowledges that the biological and psychological characteristics of an individual can substantially influence his development either positively or negatively. However, he contends that the actual effect of these personal characteristics depend to a large extent on the social and physical environment within which an individual finds himself.

In a nutshell, Bronfenbrenner’s Bioecological Model of Human Development posits that the development of an individual is not only the function of the biological factors within the individual, but the interaction between these biological factors and the individual’s immediate, as well as larger environment. Thus, given the perfect environment, individuals, irrespective of their innate characteristics, can fully develop his capabilities. Relating the model to disability, it can be said that, if structures such as the home, the school, the neighbourhood, cultural values, and national laws and policies are supportive, then persons with disabilities can fully develop their capabilities and contribute meaningfully to national development.

This study therefore applies the bioecological model in order to unveil the societal barriers that prevent persons with disabilities from participating meaningfully in the Ghanaian society throughout their lives, and show how these barriers influence their total wellbeing and development. The study examines the ruffling effects of three levels of the environment, namely, the microsystem, the mesosystem, and the macrosystem levels, on the social participation of persons with disability. At the microsystem level, the study examines the interaction between the person with disability and his immediate environment. Specifically, the study looks at the interaction between the individual and his family, school, workplace, and community. At the mesosystem level, the study looks at how the interactions among the family, the school, the workplace, and the community of a person with disability affect his development. At the macrosystem level, the study looks at socio-cultural values and religious beliefs that influence the perceptions and attitudes of people towards persons with disabilities. National laws and policies that seek to integrate persons with disabilities into the mainstream society are also examined at this level. Basically, the study looks at the most recent act that deals with disability issues in Ghana, namely, the Persons with Disability Act, 2006.

2.4 Definitions of Terms

Disability: Any physical, mental, intellectual, or sensory impairment which gives rise to physical, cultural or social barriers that substantially limits one or more of the major life activities of that individual.

Persons with Disabilities: Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others. In this study, however, only persons with physical impairment were interviewed.

Mainstream Participation: Active involvement in all social, economic, and political activities where an individual contributes and gains abilities and knowledge for development purposes. This study focused on active involvement in the family, the school, the workplace, and the community.

Barriers: Any physical, cultural, social, or political factor that makes it difficult or impossible for persons with disabilities to participate actively in society.

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CHAPTER THREE

METHODOLOGY

3.1 Research Design

Qualitative research methodology was used for the study. I adopted qualitative research methodology because, I sought to understand in depth the lived experiences of persons with disabilities in Ghana. According to Flick, von Kardoff, and Steinke (2004), qualitative research describes a phenomena "from the point of view of people who participate [...] to contribute to a better understanding of social realities and to draw attention to processes, meaning patterns and structural features" (p. 3). This was exactly what I sought to do. I sought to understand the lived experiences of persons with disabilities in Ghana from the perspective of persons with physical disabilities and their families in the Techiman municipality. Specifically, I sought to unearth the factors the prevent persons with disabilities from participating meaningfully in the Ghanaian society. Qualitative approach was relevant in this sense because, I wanted to explore nuances related to the phenomenon instead of imposing preconceived variables on informants. As Willig (2008) observed, the use of preconceived variables tends to suppress the personal opinions of informants relating to the phenomenon under study.

3.2 Research Setting

The setting for this research was Techiman, a town in the Brong Ahafo Region of the Republic of Ghana. Brong Ahafo is one of the ten administrative regions in Ghana. In terms of land surface area, Brong Ahafo is the second largest region in Ghana, covering 39,557 square kilometres out of Ghana's total land surface area of 238,533 square kilometres (Ghana

Statistical Service, 2012). The 2010 Population and Housing Census estimates the total population of Brong Ahafo Region at 2,310,983, constituting 9.4% of the total population of Ghana (Ghana Statistical Service, 2012). The report also estimates that 2.3% of the total population in the region have some form of disability, translating into 54,038 persons.

Brong Ahafo Region is sub-divided into 27 administrative districts. One of these districts is the Techiman Municipality with the capital of Techiman. I chose Techiman as my research setting for two main reasons. First, Techiman Municipality has a vibrant association of persons with physical disabilities, hence, having access to persons with physical disabilities was not difficult. The second reason was about proximity and convenience. I hail from Techiman Municipality, so doing my research there was less expensive in terms of time, transportation, and accommodation.

3.3 Participants/Sample

A total number of 19 participants were used for the study. They consisted 8 persons with physical disability, 8 parents to persons with disabilities, 1 key informants each from the National Council on Persons with Disability and the Department of Social Welfare, and 1 elderly man from the Techiman community, who served as an expert of chieftaincy[1] and culture. The participants aged between 18 and 69 years. I used purposive sampling to select participants. According to Ritchie, Lewis and Elam (2003), purposive sampling is used when the selection of participants is based on criteria or purpose. I therefore used purposive

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[1] Chieftaincy is the traditional system of governance in Ghana where communities are ruled by traditional rulers known as chiefs.

sampling to ensure that the sample with characteristics relevant for the study was obtained. As criteria, I expected that all the persons with disabilities used for the study were adults - 18 years or older. Besides, I expected that any parent interviewed should have stayed with his/her child with disability from birth for, at least, 5 years. Finally, I expected the key informants to have been in the field for , at least, 2 years.

3.4 Materials

The main materials I used for data collection were tape recorder, semi-structured interview guides, and a notebook. I used the tape recorder to audiotape the individual interviews and the focus group discussions. I constructed two different semi-structured interview guides, one for primary participants and the other for the key informants. The interview guides contained guiding questions for the individual interviews as well as the focus group discussions (see appendices I & II). I used the notebook to note down important points during the discussions as well as relevant observations I made during my informal encounters within the community. These field notes served as supplementary data to the recorded interviews during transcription and interpretation of data.

3.5 Procedure for Data Collection

Two main data collection methods were employed for the study: focus group discussion and individual interviews.

3.5.1 Focus Group Discussion

According to Kitzinger (1995), "Focus groups are a form of group interview that capitalises on communication between research participants in order to generate data" (p.

299). The rationale behind focus group discussions, according to Kitzinger, is that group processes can help participants to explore and clarify their views in ways that might not be available in individual interviews. Focus group is therefore a way to better understand how a group of people feel or think about a phenomenon (Krueger & Casey, 2000). I therefore employed focus group discussion to enable me to get broader knowledge about the lived experiences of persons with disabilities by allowing participants to clarify, affirm or disprove statements made by others.

I formed two focus groups, one each for persons with physical disabilities and parents to persons with disabilities. Each focus group consisted of 6 participants. While many researchers suggest that a focus group should consist of 6 to 12 participants (Chrzanowska, 2002; Dalton, Elias, & Wandersman, 2007; Kitzinger 1995; Krueger & Casey, 2000; Stewart, Shamdasani & Rook, 2007; Willig, 2008), I decided to stick to the minimum (i.e. 6) in order to guarantee effective moderation and ensure that each participant had ample time to express their views.

The focus group of persons with physical disabilities was made up of 3 males and 3 females, while that of parents was made up of 2 males and 4 females. Each focus group discussion lasted for approximately 2 hours.

3.5.2 Individual Interviews

According to Crabtree et al. (cited in Morgan, 1996), "Investigators' reasons for combining individual and group interviews typically point to the greater depth of the former and the greater breadth of the latter" (Morgan, 1996, p. 134). In other words, individual interviews help researchers to delve deeper into issues that, for one reason or the other, could not be pursued further in a focus group. I used individual interviews to enable me to delve deeper into important issues that I could not clarify in the focus group discussions, either due to time constraints or the presence of others.

I interviewed 2 persons with physical disabilities and two parents to persons with disabilities. These participants were not included in the focus group discussions. In order to throw more light on the current situation of persons with disabilities in the country, I also interviewed 2 key informants, 1 each from the National Council on Persons with Disability and the Department of Social Welfare. I conducted the interview with the officer from the National Council on Persons with Disability in Accra because the council is centralised and has no office in Techiman. I also interviewed an elderly man in the Techiman community in order to throw more light on socio-cultural ideologies regarding disability.

Each interview lasted for approximately 1 hour. In order to make good use of time, I tried as much as possible to avoid dealing with tangential issues.

3.5.3 Choice of Language for Data Collection

According to Polkinghorne (2005), "language is our primary access to people’s experiences" (P. 139). Wierzbicka (1999), in her cross-cultural study of words used to express emotional feelings, also found that “the way people interpret their own emotions depends, to some extent at least, on the lexical grid provided by their native language” (p. 26). Wierzbicka's assertion seems to suggest that, the extent to which a participant can explain his emotions and experiences depends on the number of words available to him. The choice of language for data collection then becomes very critical in any study. It is imperative that both the researcher and his participants have control over the language used during data collection.

English is the official language in Ghana. However, there are a number of local languages. Among the local languages, the Akan language, also known as Twi, is the most widely spoken. Akan is the native language of the people of Brong Ahafo Region, and for the matter, Techiman - the research setting. Considering this fact, and the fact that I am also a native speaker of Akan, I chose to use Akan for the data collection. However, I interviewed the key informants in English since they indicated that they would be more comfortable with English.

3.5.4 Reliability and Validity

According to Patton (cited in Golasfhani, 2003), "validity and reliability are two factors which any qualitative researcher should be concerned about while designing a study, analysing results and judging the quality of the study" (p. 601). According to Golasfhani (2003), reliability, in qualitative research paradigm, is concerned with precision, credibility, and transferability. Put differently, the concern of qualitative researchers as far as reliability is concerned is "whether the results of a study are consistent with the data collected" (Merriam, 1995, p. 56).

For reliability of a study to be established, researchers are expected to systematically document the entire process of their work so that other researchers can assess its consistency (Golasfhani, 2003; Merriam, 1995). To this end, I adequately documented all the procedures used in this study.

According to Joppe (cited in Golasfhani, 2003), "Validity determines whether the research truly measures that which it was intended to measure or how truthful the research results are" (p. 599). Hammersley (cited in Long & Johnson, 2000), also defined a research account as "valid or true if it represents accurately those features of the phenomena that it is intended to describe, explain or theorise" (p. 30).

In order to get valid account of the phenomenon under study, I interviewed persons with disabilities and parents to persons with disabilities, who have firsthand information about the lived experiences of persons with disabilities. Besides, I interviewed key informants who work hand-in-hand with persons with disabilities. I also interviewed a man who is experienced in chieftaincy and cultural issues in order to throw light on the cultural environment in which the persons with disabilities under study live.

One of the measures taken to achieve validity in qualitative research, according to Healy and Perry (2000), is the use of multiple methods in order to control biases that might occur if only one method was used. I therefore used two different methods to collect data, namely, individual interviews and focus group discussions. I transcribed and analysed the data from these sources thoroughly in the light of the themes that naturally emerged from the data. This gave me a better understanding of the phenomenon from the perspective of persons with physical disabilities and parents to persons with disabilities in Techiman.

Finally, I asked informants to clarify any statement that was not clear to me in the course of the individual interviews and focus group discussions. This was for the purpose of consensus building. I also listened to the audio recordings over and over again, and compared it with my field notes during data transcription in order to avoid any form of misrepresentation.

3.6 Transcription and Analysis of Data

Atkinson (1998) identified two major steps in qualitative data analysis, namely, transcription and interpretation of data in accordance with set objectives of the study.

According to Halcomb and Davidson (2006) "transcription refers to the process of reproducing spoken words, such as those from an audio taped interview, into written text" (p. 38). I transcribed the interviews with the key informants which were conducted in English language word-for-word. All other individual interviews, as well as focus group discussions which were held in Akan language were translated and transcribed into English for the purposes of standardization and easy interpretation. Local concepts and terminologies that have no direct English equivalents were, however, maintained. In order not to misrepresent participants, I listened to the audio recordings over and over again, and compared it with my field notes. The transcribed data was then categorized into themes that emerged naturally in the course of thorough and repeated reading of the transcribed text.

After the themes had emerged, texts from the different interview transcripts were then collated under the identified themes. I then analysed the positioning, ascriptions, and constructions of participants with regard to norms, values, belief systems, status, and socio-cultural ideologies of participants. Finally, I interpreted the data in relation to my research objectives, theory, available literature, and broad Ghanaian socio-cultural context.

3.7 Ethical Considerations

According to Silverman (2006), all relevant ethical issues should be observed by the researcher at all the steps of the research process. I adhered to ethically approved procedures throughout the study. Before data collection I sought ethical clearance from appropriate institutions both in Norway and in Ghana. In Norway, I submitted a copy of my project description to the Norwegian Social Science Data Services (NSD). NSD, after reviewing the project description, issued me with a clearance letter (see appendix III).

In Ghana, I submitted copies of my research protocol and the clearance letter from NSD to the Department of Social Welfare (DSW), the government department that ensures the welfare of persons with disabilities in Ghana. After reviewing my research protocol and the clearance letter from NSD, DSW issued me with a letter of introduction and recommendation (see appendix IV).

3.7.1 Informed Consent

"Central to most ethical guidelines is the idea of informed consent" (Silverman, 2006, p. 323). "Ethical standards in research require that prospective research participants be fully informed of the nature, procedures, risks and benefits involved in a research and that their participation in the same be not coerced or forced" (Agulanna, 2010, p. 208). In order to satisfy this requirement, I explained vividly to all prospective participants the purpose and nature of the research in the language they understood. To indicate their preparedness and willingness to participate in the study, informants were then given consent forms to sign. The consent form contained all relevant information regarding the purpose and nature of the study, expected benefits of the study, and issues relating to confidentiality and voluntary participation (see appendix V). Each participant signed the form in duplicate and was given a copy.

3.7.2 Confidentiality

I assured the participants that all information provided in the study would be held in absolute confidence. To ensure this, no participant was identified by their names, residential addresses or postal addresses. Instead of using their real names, participants were asked to adopt pseudonyms. The pseudonyms were used to identify participants during the interviews and focus group discussions, as well as during documentation of the research. After data collection I kept the audiotapes to myself, and ensured that they were always kept under lock to prevent other people from having access to them.

3.7.3 Voluntary Participation

I made it clear to participants that participation in the study was strictly voluntary, and that they could withdraw their participation at any time if they did not want to continue without giving any reason. Informants were also informed that they had the right to decline answering any question they felt uncomfortable with.

3.7.4 Debriefing

Since the study was about lived experiences of people, some informants got emotional in the course the discussions. As a result, I held debriefing sessions after each individual interview and focus group discussion to help relieve any distress that arose during the discussion.

3.8 Practical Challenges

I faced a number of challenges in the conduct of this study. Notable among them involved getting ethical clearance in Ghana. When I arrived in Ghana, I went to Noguchi Memorial Institute for Medical Research, the ethical committee in Ghana, to apply for ethical clearance. To my dismay, I was told that the committee met once every two months, and that the deadline for submission of research protocols for their next meeting passed the previous day. This became a great challenge to me because, waiting for the subsequent meeting day meant that, at least, two months would elapse before I could start to collect data. This did not seem feasible because my academic calendar required that I got back to Norway within barely two months. This challenge was, however, resolved when I went to Department of Social Welfare, where I was issued with a letter of introduction and recommendation.

I also faced one major challenge in the course of entering the field. When I got to Techiman, I went to the leadership of the Ghana Society of the Physically Disabled in the municipality to seek their consent in order to interview their members. I was then asked to join them during their next general meeting where I could introduce myself to all their members and call for volunteers, which I obliged. To my surprise, I was misconstrued as "*one of those guys*" who, according to them, come to them to gather information, write proposals under the guise of seeking sponsorship to support them, but end up misappropriating the funds thereof. I was therefore subjected to serious scrutiny. I was however allowed to go ahead and select volunteers after they were fully convinced that my research was for purely academic purposes.

CHAPTER FOUR

RESULTS AND DISCUSSION

The results of the study are presented in five sections. The first section deals with perceptions about disability in the Ghanaian society. This is followed by analysis the experiences of persons with disabilities in the various ecological environments in which they participate. The third section examines the impart of the Persons with Disability Act of Ghana on the lives of persons with disabilities in the country. This is followed by participants general view of the current situation of persons with disabilities in the country. Finally, participants suggestions concerning how to effectively include persons with disabilities in the mainstream Ghanaian society are presented.

4.1 The Ghanaian Perception about Disability

Responses from participants indicate that there are several perceptions about disability in Ghana. However, all the perceptions about disability mentioned by participants appear to hinge on two models of disability, namely, the moral model and the medical model, as discussed below.

4.1.1 Disability is a Curse

Participants indicated that disability is regarded as a curse in the Ghanaian society. This supposed curse, according to participants, is believed to be the result of the individual's own sins or the sins of his relatives. There were a number of discourses by participants that revealed that persons with disabilities are often blamed for bringing curses upon themselves. For instance, Kwadwo, a male participant with disability recounted his own experience as follows: "*There was a time I had an argument with a guy. This guy looked straight into my face and said, 'no wonder God has made you this way'"*. When I asked Kwadwo as to what that statement meant, he said, *"When you have a disability, they think that it is God who has cursed you because of your sins"*. The participant who served as expert of chieftaincy and culture also appeared to blame persons with disabilities for bringing curses upon themselves when he was discussing the possible causes of disabilities:

> *Many people acquire disability because of their own thoughts and actions. We have customs and values in the community but some people fail to observe them. At the end of the day, they invite curses from the gods and the ancestors upon themselves. Some people are also punished with disability because they think evil about others. If the gods get to know that you want to attack somebody, especially someone who is faultless, with your witchcraft or sorcery, they will not permit that. You know, my son, God hates evil so if you plan evil against your neighbour he will not let you go unpunished. This is one of the main reasons why people become disabled.*

Two main points come out of the expert's discourse above. First, a person may be inflicted with disability if he fails to observe the customs of the society. Second, a person with an evil spirit may be cursed with disability if he bewitches or decides to bewitch an innocent person. The second point as deduced from the expert's discourse was also expressed differently by Abena, a female participant with disability. According to Abena, some people call a person with disability *"bayifoɔ"* (a witch) *"thinking that you have been punished with the disability because you are possessed by evil spirits"*. Kwame, a male parent and Christian, also appeared to agree to the view that people are cursed with disability because of their own sins. Kwame said, "*I believe that disability can also be a curse from God because, in the* *bible we read of instances where God cursed some people with disabilities because of their sins".*

Participants' discourses above appear to confirm the findings by Agbenyega (2007), Avoke (2002), Kassah (1998), and Oliver-Commey (2001) that Ghanaians tend to blame individuals for inviting disability upon themselves. The attribution of disability to a curse from supernatural powers can be traced to the traditional Ghanaian belief system. It is believed that God, as the creator and sustainer of the universe, has the moral right to reward those who practice virtue and punish those who do evil. As a result, disability is often regarded as a curse from God. Aside from God, disability is also attributed to the acts of the lesser gods and the ancestral spirits. Traditionally, the gods and the ancestors are believed to act on behalf of God to protect the good people and punish the evil ones. One way by which the gods and the ancestors are believed to punish evil people is to inflict them with calamities, misfortunes and diseases. As a result, disability is usually believed to be a curse from the lesser gods or the ancestors.

The above discussion confirms my prior assumption that the moral model is still employed to explain disability in the Ghanaian society. As already indicated, the moral model of disability blames individuals for causing their own disability. This perception therefore impacts negatively on societal attitudes and behaviours towards persons with disabilities. Such attitudes and behaviours become invisible barriers, excluding persons with disabilities from the mainstream society. Generally, the perception that disability is a curse leads to stigmatization of persons with disabilities. This in turn leads to discrimination against persons with disabilities, which may consequently lead to social exclusion. Many participants pointed this out as will be thoroughly discussed later in this chapter.

Besides the perception that individuals invite disabilities upon themselves, one other perception that dominated the discourses of participants is the belief that a child may be inflicted with a disability by the gods, either before or after birth, due to offences committed by his parents or other members of the family. Participants noted that, some people look down on parents who give birth to persons with disabilities due to this perception. Afia, for example, stated that some of her friends gradually withdrew from her after she gave birth to a child with disability. She added that even some of her own relatives sometimes told her, without mincing words, that she gave birth to a child with disability as a result of her evil deeds.

"Unlike many societies where individuality is praised and sought after, Ghanaian culture is defined, in part, by communal relationships and responsibilities" (Anthony, 2011, p. 1078). According to Nukunya (2003), kingship forms the basis of many organizations and institutions in the Ghanaian society. Kingship and familial ties are so important that, according to Anthony (2011), "Individual identity is inextricably linked with the family's, and the behaviour of a single individual reflects upon, and is judged in relation to, the larger group" (p. 1078). In view of this, society often blames not only persons with disabilities, but also their relatives, for bringing curses upon themselves. This is in line with Avoke's (2002) finding that society tends to blame and ostracise parents who give birth to persons with disabilities. It also confirms Goffman's (1963) assertion that it is not only individuals who deviate from societal expectations that are stigmatised, but also their close relatives.

Participants observed, however, that the perception that disability is a curse, and the attribution of disability to supernatural forces in general, is gradually diminishing. Esi, a female parent, expressed the following during a focus group discussion:

> *Some time ago, the belief that disability is a curse was so strong that people did not even want to see persons with disabilities. However, through education many people have come to know that disability is not a curse. It is now known that several factors such as diseases, accidents, and unsuccessful abortion can lead to having a child with disability. This knowledge has minimised the intensity with which people attribute disability to supernatural forces.*

It is worthy to mention that, nobody in the focus group objected to this fact. This seems to suggest that Esi's assertion, that supernatural attribution of disability in Ghana is fading out, is a valid one.

4.1.2 Persons with Disabilities are Spirits (Nsuoba)

Apart from the perception that a child may be inflicted with disability for the sins of his parents, some people, according to participants, also believe that the gods simply send their own children, in the form of children with disabilities, to torment disobedient or wicked families. This is another manifestation of the moral model. Participants mentioned that, in such cases, the child is not regarded as a human being; it is simply a spirit. A female parent Yaa indicated that, children with disabilities are sometimes believed to have been given to their parents by river gods for the offences the parents committed. Among the Akans, such children, according to Yaa, are therefore given the name *"nsuoba"* to denote that they are children of river gods:

> *Some people believe that children with disabilities are given to their parents by the gods as a punishment for something they did wrong. They are usually believed to*

> *come from river gods, hence the term "nsuoba". It is said that rivers give such children to parents who are wicked or stingy.*

Yaa linked the concept of *nsuoba* to a belief in Ghana that the gods sometimes come, in the form of strangers, to visit individuals and families in the community. It is said that, when leaving the community, the gods bestow their blessings on the individuals or families that treated them generously, but leave curses on the wicked ones. Thus, giving birth to a child with disability, according to Yaa, is believed to be one of the curses that the gods impose on wicked or stingy families.

Some participants also mentioned that, having a child with disability is sometimes associated with non-observance of taboos. Aku, another female parent, touched on this:

> *Besides, eating fish from some rivers is regarded as a taboo. Some people therefore believe that a parent who eats fish from such rivers will give birth to a child with disability. For example, here in Techiman, it is a taboo to eat fish from river 'Tano', so people believe that parents who eat fish from the river can give birth to persons with disabilities.*

"A taboo is anything forbidden" (Nukunya, 2003, p. 20). Ghanaians observe a number of taboos. Some of the taboos relate to food, animals, things, sexuality, words, places, and days. Most of the taboos in Ghana go with threats of supernatural punishment. Thus giving birth to a child with disability, as Aku mentioned, is sometimes regarded a punishment for an individual's failure to observe taboos.

Yaa explained that *"the term nsuoba is often used to refer to a child with low muscle tone, flat face, wandering eyes, and protruding tongue"*. She added, however, that it is sometimes used to refer to persons with disabilities in general, especially those of physical nature, a notion which was also shared by most participants.

The Akans, and Ghanaians in general, hold their gods in awe. One would therefore expect that the *nsuoba* would be revered, or even worshipped, if it was indeed believed to be the child of a river god. However, the case is different. Kofi, a male parent, indicated that, *"In the past, any child who was identified as nsuoba was taken to the riverside in the night and left there for the river to take it back".* When I asked why the supposed child of a cherished god should be treated in this manner, Kofi said:

> *The belief is that, it is not a normal human being. It is a spirit sent in human form. It is not supposed to live among humans. Its mission is to punish the parents by causing problems in the family. After that it is supposed to return to where it came from.*

The concept of *nsuoba* has also been observed by some scholars. Avoke (1997) observed that the term *nsuoba* was used among the Akans to refer to a child with Down's Syndrome, denoting that it was given to its parents by a river god.

The concept of *nsuoba* as expressed by participants in this study is similar to the concept of the spirit child as used in the northern part of Ghana. In their study of the spirit child in the Nankani community of the Northern Region of Ghana, Denham, Adongo, Freydberg, and Hodgson (2010) observed that a child born with disability or chronic illness, and whose birth concurs with tragic events is likely to be identified as a spirit child. Similar to the *nsuoba*, who is believed to be a spirit sent by a river, the spirit child, from the Nankani perspective, is a spirit "sent from the bush to cause misfortune and destroy the family" (p. 608). As a result, such children are, in most cases, killed before they destroy the family.

Regarding the fate of *nsuoba* in the present-day, participants of the present study noted that children labelled as *nsuoba* are no longer left at the riverside or killed. This appears to confirm Avoke's (2002) observation that, with the advent of Christianity and western education, children with disabilities are no longer killed. However, there were a lot of discourses by participants that pointed to the fact that the term *nsuoba* is still used extensively in the Ghanaian society, and that it may have serious implications on the lives of children stigmatised as such, as well as their families. Participants observed that, once a child is labelled *nsuoba,* he is no longer regarded a human being; rather a spirit with evil intent to destroy the family and society. People therefore look on him with fear, and would feel reluctant to have any close contact with him. A female parent Ama, for instance, mentioned that some parents even warn their children not to play with a child labelled as *nsuoba*, saying that "*if he bites you will become like him*". This belief thus leads to stigmatisation and marginalisation of persons with disabilities right from infancy.

Participants also indicated that parents who give birth to children labelled as *nsuoba* are often despised by society for inviting the curse of the gods through their immoral behaviour.

4.1.3 Persons with Disabilities are Victims of Evil Attack

Another perception that emerged from the study is the notion that persons with disabilities are victims of attacks from evil spirits such as witchcraft and sorcery. Some participants expressed that disability is thought of as a spell cast on someone by witches or sorcerers. Ama, a female parent, expressed this as follows:

> *Some people also believe that a relative who possesses witchcraft, foreseeing that the person* [person with disability] *would become very successful in future, may out of envy, bewitch him so that he does not succeed to be what he is supposed to be.*

Kwame also expressed the same point in a different way:

> *You know, Satan and his angels are always at work seeking to devour the children of God. Even as we speak now, there are witches and demons around, just that we can't see them. Therefore such spirits cannot be ruled out when we are talking about disability.*

It is believed in Ghana that witches and sorcerers have the ability to use their magical powers to hurt, or even kill, the people that they hate. Thus, disability is sometimes seen as resulting from attacks by witches and sorcerers. Evans-Pritchard (cited in Nukunya, 2003) points out that "witchcraft does not strike at random and that for witchcraft accusation to come from someone, the supposed victim must have some relationship with the accused" (p. 59). Ama appeared to imply this when she mentioned that disability is perceived to be a result of attack by *"a relative who possesses witchcraft".* According to Ama, when this thought arises, people tend to look no further than the close relatives of the person with disability. Usually, parents, aunts, and grandparents of the person with disability are the most accused.

Some participants also mentioned that society sometimes draws a link between a person's disability and the riches of his family. This was pointed out by Asuo, a male parent:

> *When my wife gave birth to a child with disability, people said a lot of things. Coincidentally, that was the time when my business began to flourish. People*

> *therefore thought that I had gone for "sikaduro[2]" (juju money). They thought I had sacrificed my son's leg in exchange for money. This perception is very bad because if you are not someone who fears God, you may end up keeping your child with disability in the room for good, or even poison him due to what people will say about you.*

It is believed in Ghana that a parent can spiritually exchange his/her child's life or a part the child's body for riches. Sometimes, other relatives aside from parents are also implicated. Parents, or their relatives, are believed to consult sorcerers who have the ability to spiritually "sacrifice" any part of the person's body, which leads to them becoming rich within a very short time. It is believed that the sacrificed part of the body then becomes deformed. A similar observation was made by Agbenyega (2003).

The perception that disability is as a result of evil attack is, of course, another reflection of the moral model of disability. Here the person with disability per se may not be blamed. However, the family is stigmatized as being evil for having a person with disability. Unfortunately, however, the final result of this stigmatization, as observed by Asuo, might be borne by the child with disability. As indicated by Goffman (1963), one of the strategies that people use to manage stigma is to conceal the stigmatic condition. Parents may therefore hide the child with disability from public view, or even poison them, in order to avert the associated stigma. Similar observations were also made by Nepveux et al. (2004)

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[2] Sikaduro is Akan term for a process where spiritual assistance is sought for wealth often with dire consequences. It is believed that human life or part of a human body is sacrificed in the process.

However, like the perception that attributes disability to a curse, participants indicated that the perception that disability is the result of evil attacks is also dying out gradually due to public education.

4.1.4 Persons with Disabilities are Sick, Feeble and Unproductive

One other perception that came out of participants' discourses is that persons with disabilities are sick. According to Ama, a female parent, one general statement that people normally make about someone who gives birth to a child with disability, among the Akans, is "*w'awo yarefoɔ*" (she has given birth to a sick person). The perception that persons with disabilities are sick was also mentioned by many other participants. One of the participants who expressed concern about this perception was Kwasi, a male participant with disability. Kwasi noted that *"people normally refer to persons with disabilities as sick persons"*, adding that *"this is unacceptable because we all know that sick persons are supposed to be at the hospital"*.

According to Akosua, a female participant with disability, the notion that a person with disability is sick has two connotations. The sickness can either be physical or spiritual:

> *To say that a person with disability is sick does not completely rule out the supernatural explanation. While some people will see you as someone who needs physical treatment, others will also link the sickness to a curse from God or elsewhere.*

The concept of sickness in the Ghanaian context has two dimensions- physiological and spiritual. According to Gyekye (1995), a person, in Akan philosophy, is made up of two principal entities, namely the spiritual entity known as *okra* (the soul) and the material entity known as *honam* (the body). The soul and the body are believed to have causal influences on each other. The Akans therefore believe that, when the soul is "enfeebled or injured" it results in ill health (p. 101). This can be the action of the Supreme Being, the lesser gods, the ancestral spirits, or evil spirits.

> There are certain diseases that are believed to be "spiritual diseases" (*sunsum yareɛ*) and cannot be healed by application of physical therapy. In such diseases attention must be paid to both physiological and spiritual aspects of the person. Unless the soul is healed, the body will not respond to physical treatment (Gyekye, 1995, p. 101).

According to Wyllie (1994), however, it is not every sickness that is attributed to spiritual factors. Ghanaians also believe that there are diseases that are purely physiological. In his study about perceived causes of diseases among the Effutu in the Central Region of Ghana, Wyllie observed that, aside from spiritual causes, his participants also cited a number of factors "which can be regarded as naturalistic" (p.230).

Either explained spiritually or physiologically, the notion that persons with disabilities are sick can have a number of adverse implications on their lives. If it is explained in supernatural terms, then the commonest implication, as already dealt with, is that the individual has been cursed. This way, the individual is likely to be shunned by society for bringing a curse upon himself. On the other hand, if persons with disabilities are perceived to be sick physiologically, the reactions may range from pity and overprotection to rejection and total neglect. This can be clearly understood in the light of how sick persons are typically treated in the Ghanaian society as summarised by the key informant from the National Council on Persons with Disability below:

> *We know that , in the Ghanaian society sick persons are not supposed to work. They are not even supposed to perform chores once their relatives are around. In effect everything about them is supposed to be done by others. So if we say that persons with disabilities are sick, then, this is how we expect them to be. In short, to say that persons with disabilities are sick also implies that they are dependent and unproductive.*

As the officer mentioned in the above quote, a sick person in the Ghanaian society is, virtually, a dependant. Labelling persons with disabilities as "perpetually" sick therefore implies that they cannot, or should not, undertake any productive ventures. It can thus be said that, perceiving persons with disabilities as sick individuals also implies, indirectly, that they are unproductive. Thus, in a sense disability is equated with inability. This appears to support Kassah (1998) and Reynolds (2010) that persons with disabilities in Ghana are perceived to be unproductive.

Some participants also touched on how the perception that persons with disabilities are sick and unproductive impacts their lives. Perhaps, Kwasi's discourse below summarises it all:

> *Because they call us sick people, they also treat us as such. They treat us as feeble and unproductive individuals who should always depend on our families for sustenance. As a result, we are cut off from several opportunities; we are not considered at all in matters of education and work.*

The perception that persons with disabilities are sick and unproductive also supports my prior assumption that the medical model of disability is used extensively in the Ghanaian society. Locating the problem within the individual, environmental factors are completely overlooked. From this perspective, persons with disabilities are not participating in the society simply because they are sick, nothing else. A look at the situation from the perspective of the social model or the ICF model will rather reveal that, aside from their impairments, there are a whole lot of barriers that hinder the smooth participation of persons with disabilities in the Ghanaian society. As can be seen in the subsequent sections, persons with disabilities suffer various forms of oppression in their families, schools, workplace, and the community at large, due to the perception that they are sick, feeble, and unproductive. Perceived as economic burdens, persons with disabilities are often denied access to several opportunities and resources which, in the long run, results in their exclusion from the mainstream society.

4.1.5 Summary of Perceptions about Disability

The results indicate that two major models of disability are employed to explain disability in Ghana, namely, the moral model and the medical model. The moral model is manifested in three main forms in the study: disability is a curse; persons with disabilities are spirits; disability results from attacks by evil spirits. It is believed in Ghana that persons are inflicted with disability by supernatural forces- the Supreme Being, the gods, or the ancestors- either as a result of their own offences or the offences committed by their relatives. Some people also think that persons with disabilities, especially children born with disabilities, are not real human beings, but spirits sent by the gods to punish parents for their misdeeds. Yet others see disability as a spell cast on the individual by evil spirits such as witchcraft or sorcery. Such witchcraft and sorcery attacks are believed to be initiated by parents and close relatives either out of hatred or for their own benefit. Due to these perceptions, persons with disabilities and their families usually bear social stigma, and are often marginalised.

From the perspective of the medical model, on the other hand, persons with disabilities as seen as sick, feeble, unproductive, and dependent individuals who have nothing to offer society. This perception might also lead to marginalisation of persons with disabilities. Participants indicated that persons with disabilities are often cut off from several opportunities, especially education and employment, due to the societal perception that they are sick and unproductive.

The perceptions about disability in Ghana, as described above, reflect a typical stigmatisation process outlined by Goffman (1963). Ghanaians appear to have created their own standard of defining a normal person. Any individual who deviates from this standard is regarded as abnormal and undesirable. Seeing persons with disabilities as undesirable, society tries to explain their inferiority by ascribing other imperfections to them in order to justify the discrimination against them.

Participants observed, however, that the moral model of disability is gradually losing its intensity mainly due to public education, which throws more light on the actual causes of disability.

4.2 The Lived Experiences of Persons with Disabilities

As already mentioned, the discourses of participants point to the fact that the moral and medical models of disability are the dominant models used to interpret disability in the Ghanaian society. As the bioecological theory maintains, structures at the macrosystem level such as belief systems and ideologies have overarching influence on what goes on in the microsystem environments such as the family, the school, the workplace, and the neighbourhood or community. The results show that the attitudes and actions of parents, peers, teachers, employers, and key players in the community such as kingmakers are influenced substantially by the beliefs presented above, namely, that disability is a sickness, a curse, or a result from evil attacks. Due to this, persons with disabilities in the Ghanaian society suffer various forms of discrimination in different spheres of their lives.

4.2.1 Experiences in the Family

The family is the closest, most crucial, and most influential part of an individual's environment. A person's experiences within the family forms the basis for his overall development- physical, psychological, emotional, and social. The experiences of persons with disabilities in their families, especially during their childhood, therefore become very critical to their total development. Unfortunately, however, The experiences of persons with disabilities in their families as recounted by participants were not satisfying.

One major setback that participants with disabilities said they faced in the family was overprotection. Some participants mentioned that they were not involved in their families' activities at all. Adwoa, a female participant with disability, indicated that she was never involved in her family's activities, even though all her siblings were usually involved. According to Adwoa, she sometimes made an effort to join in but was usually met with a discouraging response, *"you can't do it"*. Kwabena also mentioned that his mother did not even want him to play with other children because she considered him to be too vulnerable. This was how Kwabena recounted his childhood experience:

> *When I was a child, my mother asked me a question when I was playing with a neighbour who had no disability, and this question has been with me to date. When*

> *she saw me play with him, she asked: 'So don't you think about yourself?' That question is very discouraging.*

The phrase *"think about yourself"* in the Ghanaian context simply implies that the individual in question is feeble, miserable, or helpless, and should therefore be cautious in order not to fall into trouble. Thus when asked to explain what his mother implied in her question above, Kwabena answered: *"It implies that you are too vulnerable to play with others, so you should see yourself as such and act accordingly".* Similarly, Abena mentioned that her mother prevented her from playing with others, referring to her as a sick person. Abena said: *"I do remember I was once playing with my cousin. My mother looked at me sternly and said, 'A sick person who doesn't think about herself'".*

Kofi, a male parent, who attested to the fact that parents tend to overprotect their children with disabilities, sought to justify why a parent may do so. According to Kofi, *"When they* (persons with disabilities) *are young, they look very fragile so you as a parent will always want to try your best to keep them from doing anything that you think can hurt them".*

The attitudes of parents towards their children with disabilities as presented by participants above reflect the medical model of disability. Some parents appear to accept the societal perception that their children with disabilities are sick and feeble. As the participants observed in the above quotes, some parents overprotect their children with disabilities due to this perception. Seen as vulnerable, parents try as much as possible to prevent their children with disabilities from all activities that they consider injurious. This is a new, very important finding that appears to have evaded many researchers in Ghana. Perhaps, attention has not been drawn to this point because protection of children from harm is considered to be one of the main responsibilities of parents. While it is important to protect children from harm, overprotection can become a barrier, limiting the ability of children with disabilities to explore their environment in order to unearth their potentials. It will therefore be more appropriate for parents to create a conducive environment in the home for their children with disabilities to explore than to overprotect them.

It becomes vivid from the above discussion that the inability of children with disabilities to get involved in their family activities, or adequately explore their immediate environment, is not only the result of their impairment but also of the attitudes of their parents. This is in line with the ICF model which posits that disability cannot be measured solely on an individual's impairment but as an interaction between an individual's impairment and his contextual factors. In this case, the attitudes of parents become environmental barriers that prevent children with disabilities from participating meaningfully in the family.

Some participants also observed that many parents pay less attention to the needs of their children with disabilities as compared to their siblings without disabilities. Many participants mentioned that parents usually hesitate to send their children with disabilities to school, or fail to provide their needs adequately, because they think that persons with disabilities are feeble and unproductive, and as such, cannot do anything to help the family. According to Adwoa, the purpose of sending children to school, for some parents, is that the children will succeed in life and, in turn, cater for their parents in their old age. This point was also observed by Nukunya (1992). Due to this, many parents, according to Adwoa, feel reluctant to send their children with disabilities to school because they think children with disabilities "*cannot do anything for the family*". Kwaku, a male participant with disability, also made a similar statement in support of Adwoa's point:

> *Some parents regard their children with disabilities as good for nothing. They think disability also means inability. They therefore channel all their resources to support their children without disabilities who they believe can help them in the future. I have two elder brothers, both of them were sent to school. As I speak to you now, my younger siblings are in school. My parents could have catered for my education too, but because of my disability, here I am not knowing what to do with my life.*

The attitude of parents not willing to send their children with disabilities to school or adequately cater for their needs, is also a display of the medical model of disability. The discourses above show that some parents fail to support their children with disabilities because they perceive the children to be feeble and unproductive. Parents perceive their children with disabilities as lacking the ability to acquire skills, get employed, and lead independent lives.

At the mesosystem level, the bioecological model requires that the relationship between the child's microsystem environments, in this case the family and the school, should be positive in order to guarantee the effective development of the child. Unfortunately, the relationship between the family and the school, as far as persons with disabilities are concerned, is not positive. The family, which is supposed to prepare children with disabilities for school, and collaborate with the school in training up the child, either fails to send them to school or fails to adequately provide their needs while in school. It is therefore tenable to argue that the inability of persons with disabilities to make it in school is partly due to the environmental barriers they face in the form of negative parental attitudes. The ICF model, as well as the social model, therefore require that these invisible barriers are checked to enable persons with disabilities to have access to education in order to develop their potentials.

Some of the discourses of participants with disabilities relating to their family experiences also pointed to the moral model of disability. Some participants with disabilities indicated that they were virtually not counted among their siblings, simply because their parents did not want to bear the stigma of having a child with disability. One of the participants who expressed concern about this was Akua. According to Akua:

> *Some parents feel reluctant to accept their children with disabilities due to what their neighbours will say about them. Sometimes they try to hide you (person with disability) from the people who come to the house because they don't want anyone to know that they have given birth to a curse. There was a time my father was introducing his children to a visitor and I was completely left out because of my disability.*

In relation to this, Adwoa also told her story rather emotionally:

> *My family never took me out with them when they were attending a wedding, a naming ceremony, or Christmas party. They did not even take me to church with them. When they are going out they will never go with you. Your duty is to watch over the house and report to them about what happened in their absence when they come back.*

Some parents affirmed that they found it difficult to accept their children with disabilities, especially in the first few months after birth, due to the societal perception that parents who give birth to children with disabilities are immoral. Yaa expressed her ordeal in the following excerpt:

> *It is very difficult coming to terms with the fact that you have given birth to a child with disability. We all know the discourses surrounding having a child with disability, so as soon as you get to know that your child is deformed, the first question that comes to mind is about what your neighbours will say about you. Of course, it is not always the case that people will accuse you for having a child with disability, but it is hard to believe otherwise. Whenever you see two or more people talking in low tones, you begin to imagine that they are gossiping about you. When I gave birth to Odupon[3], it took a very long time for me to accept him. For the first three months, I hardly went out of my house. I didn't even want to go for postnatal care. I was always in my room weeping. However, as time went on I had to accept the reality and move on in life.*

Afia also agreed with Yaa on this point:

> *Sometimes it becomes very hard to accept your own child with disability not because you don't love the child, but because of what your neighbours take you through. It becomes even harder when your own kinsmen begin to accuse you. I had a very tough time when I gave birth to my daughter.*

As aforementioned, society not only stigmatizes persons with disabilities but also their families. Families are often blamed for inviting the curses of the gods upon their members through their immoral deeds, for bewitching the member leading to a disability, or for spiritually sacrificing a part of the person with disability's body in exchange for money.

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[3] Odupon is not the child's real name.

Due to this stigma attached to having a child with disability, families tend to see children with disabilities as a source of shame and, may sometimes, hide them from public view in order to avoid name calling.

Many of the parents who were interviewed, however, dismissed the notion that they failed to go out with their children with disabilities because they wanted to avoid social stigma. They indicated that their failure to go out with their children with disabilities had less to do with societal attitudes; rather they found it difficult to go out with their children with disabilities mainly due to inaccessibility of infrastructure. A female parent Ama was very emphatic on this:

> *The fact is not that we feel ashamed to go out with our children with disabilities. Any parent who has a child with disability will tell you that it is not easy to attend a gathering with them. You know that most of our buildings have no provision for people who use wheelchairs or crutches, so if you go out with them, it means that you will be carrying them up and down until the programme comes to an end. In fact, there was a time I attended a party with my daughter and, along the line, she opted that I should send her home, simply because she was not comfortable with the environment.*

Esi, another female parent, shared this idea with Ama:

> *As I mentioned earlier, many people have now come to understand that disability is not a curse. So even though some people may treat us (parents who have children with disabilities) with contempt, others look on us with pity and are always willing to give us the necessary support. Therefore, when it comes to going out with our*

> *children with disabilities, the inhibiting factor is less of societal attitude; rather it is the nature of our buildings and transportation system that often discourages us from going out with them. Apart from the fact that many buildings are not accessible to persons with disabilities, transportation is also a major concern because many commercial vehicle*[4] *drivers feel reluctant to take persons with disabilities on board, especially persons with physical disabilities who use wheelchairs.*

Many other participants, including persons with disabilities, also observed that the situation where families hide their children with disabilities completely from the public is almost a thing of the past. To most of the participants with disabilities, most the challenges they face in their families do not result from their parents feeling ashamed to accept them, but rather because their parents perceive them to be too vulnerable to lead normal lives. This appears to suggest that the medical model of disabilities is more influential in Ghana than the moral model. It thus appears to support the earlier assertion by some participants that the perception that disability is a curse is gradually giving way.

It is also worth mentioning that the family experiences shared by participants were not all negative. A male participant with disability Kwasi, for example, mentioned that "*there are some parents who treat their children with disabilities even better than their siblings without disabilities*". Recalling his childhood experience, Kwasi said the following:

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[4] Commercial vehicles in Ghana do not have any special provisions for persons with disabilities.

> *I think my case was different. I was very fortunate to have my parents. My parents were very supportive and encouraged me in all that I did. In some instances, I may say that my parents even treated me better than my siblings. [...] I quite remember there was a time when my father's friend tried to discourage him from catering for my education on the grounds that I was not strong enough to work and support the family, but my father snubbed him. My parents did all they could to help me succeed in life.*

Kwadwo, another male participant with disability, also recounted positive family experiences. According to Kwadwo:

> *I did not notice any difference between me and my siblings in terms of how my parents treated us. My parents provided all my needs that were within their means and gave me tangible reasons for those that they could not provide.*

Kwadwo stated that he was able to withstand the negative attitudes of his classmates during his early school days due to the support that he received from his parents.

Some participants touched on the influence of parental attitudes on their psychosocial development. A female participant with disability Adwoa, for instance, indicated that she always felt inferior to her siblings and other children in her family due to negative attitudes of her parents. According to Adwoa, this feeling of inferiority has become part of her, making it difficult for her to form relationships with others. She said, for instance, that *" I find it very difficult to get along with others even today"*. All participants who reported negative childhood experiences also expressed similar sentiments. The conduct of such participants during the interviews also suggested their lack of confidence. They hardly looked into my face throughout the discussions. However, participants who reported positive experiences in the family, such as Kwasi and Kwadwo, also observed that they did not have much trouble getting along with other people outside the family. I also observed in the course of the interviews that they were very confident.

Negative attitudes of parents towards their children with disabilities tend to have profound effects on their overall development. First, the discourses presented above show that negative parental attitudes might lead to the denial of persons with disabilities of their fundamental human rights, such as the rights to education, right to healthcare, freedoms of assembly, and freedom of movement as enshrined in the 1992 constitution of the Republic of Ghana. Besides, negative attitudes of parents may impact negatively on the self worth of persons with disabilities. As the results show, many participants with disabilities perceive themselves as inferior to others due to their negative experiences in their families. This, however, is not the case with persons with disabilities who had supportive family experiences.

This observation is in line with the bioecological model of human development. In his bioecological theory, Bronfenbrenner asserts that a child's interaction in the family becomes a foundation based on which future relationships are formed. Negative parental attitudes such as failure to involve children with disabilities in family activities, failure to allow children with disabilities to explore their environment, failure to adequately provide the needs of children with disabilities, and the tendency to hide children with disabilities from the public, can impact negatively on their psychological development, which might eventually affect their future relationships. As Goffman (1963) observed, individuals who are stigmatised often end up accepting the societal perception that they are handicapped. Similarly, Smith (cited in Taleporos & McCabe, 2002) argued that an individual who is accepted in his environment will also accept himself, while an individual who is not accepted will have a negative self image. The negative attitudes of parents towards their children with disabilities therefore affect their self image negatively, making them to perceive themselves as inferior to others. This may negatively affect their future relationships with peers, in school, and in the community at large, which in the long run might cause persons with disabilities to seclude themselves from the mainstream society.

4.2.2 Experiences in Accessing Education

Similar to their experiences in their families, the experiences of persons with disabilities in accessing education in Ghana is not very encouraging. Participants reported that many persons with disabilities, due to negative parental attitudes, do not get access to education at all. Majority of persons with disabilities who get access to education, according to participants, also end up dropping out due to physical and social barriers that they face in school.

Out of the 8 persons with disabilities that took part in the study, 3 said they never had access to education. Three out of the 5 who said they were enrolled also dropped out before they could complete basic education. Only 2 of them, Kwasi and Kwadwo, were able to make it to second cycle level. Kwasi is a self-employed young man who provides secretarial services to private and some government organisations. Kwadwo, on the other hand, works with a local non-governmental organisation. Both Kwasi and Kwadwo are married and have children. The fact that Kwasi and Kwadwo have been able to make it in school and are gainfully employed defies the societal perception that persons with disabilities are too feeble to be productive. Their success exemplifies that, with the necessary support, persons with disabilities can lead meaningful lives.

Participants gave reasons why many persons with disabilities do not have access to education or drop out of school. Many participants made reference to inaccessible school buildings as a major barrier that tends to keep persons with disabilities out of school. A female parent Afia, lamented on inaccessibility of school buildings as one of the major factors that discourage parents from sending their children with disabilities to school:

> *When you look at the buildings in our schools, you don't need a prophet to tell you that a person with disability cannot make it there. The very first day I sent my daughter to school, the sight of the building put me in a dilemma as to whether I should enroll her in the school or take her back home. I stole a look at the washroom, and it was even worse. Most schools in Ghana have no provision for persons with disabilities. In a situation like this, a parent may decide to keep her child at home rather than send her to school to suffer.*

A number of participants also alluded to inaccessibility of buildings as one of the main causes of school dropout among persons with disabilities. According to Kwaku:

> *Many school buildings have high stairways without any ramp. If you are somebody who uses a wheelchair or crutches in such a school, then you will have to depend on others everyday to carry you in and out of your classroom. Persons with disabilities who cannot stand this embarrassment end up dropping out of school.*

Kwabena also recounted inaccessibility of school buildings as one of the main reasons why he drop out of school:

> *I attended school up to class six. When I was about to be promoted to the next level, I decided to stop. [...] First, looking at the nature of the buildings in the Junior*

> *Secondary School, I could only enter with the help of others and, you know, you can't expect someone to be carrying you to and from your classroom every day.*

Inaccessibility of school buildings to persons with disabilities is a clear manifestation of the medical model of disability. As Goffmann (1963) argues, stigma tends to blind society from seeing the other characteristics of the individual being stigmatised. The perception that persons with disabilities are sick thus appears to blind policy makers from seeing the ability of persons with disabilities to study alongside able-bodied students. As a result, there appears to be little provision, if at all, for persons with disabilities in terms of schools buildings and the general layout of school campuses. This makes it difficult for persons with disabilities to access mainstream education.

Participants also raised great concerns about segregated education in the Ghanaian educational system. Some of the participants indicated that government policies on education over the years, instead of integrating persons with disabilities into the society, rather end up excluding them from the mainstream society. They maintained that, instead of removing the barriers that prevent persons with disabilities from accessing mainstream schools, government rather seems to concentrate on building special schools and rehabilitation centres where persons with disabilities are usually given vocational training. This is congruent with observations made by Agbenyega (2003), Anthony (2009), and Avoke (2002) that segregated form of education is common in Ghana. Kwasi indicated that segregated education tends to reinforce the societal belief that persons with disabilities are inferior:

> *You see, right from the beginning the distinction is made clear: persons with disabilities cannot get along with the able-bodied so they should be in special schools and rehabilitation centres. So you the person with disability will very likely come to*

> *accept that you don't have the capacity to do what others are doing. Even worse, the concentration on rehabilitation centres has made society to believe that persons with disabilities cannot acquire knowledge and skills needed for white collar jobs. In fact, most people in Ghana today believe that the best a person with disability can do is to learn a vocation. So among persons with disabilities who work, a greater number of them are found in shoe making, tailoring, electronic repairs, and hairdressing.*

Kwasi's words appear to support Gibson (1986) who argued that "Segregated form of special education is an act of labelling and stigmatisation that legitimatise existing social inequalities, and those that so labelled, feel legitimately inferior and possess reduced control over the determination of their lives" (p.144). Segregated education does not only deny persons with disabilities the benefits of mainstream education, but also lays the foundation for further discrimination against persons with disabilities in their adult life. It sends a signal that persons with disabilities do not have the capability to do the same things as the able-bodied, thereby restricting their opportunities in the adult world.

It therefore behoves government and policy makers in Ghana to view disability from the perspective of the ICF model or the social model to enable them to see the physical barriers that militate against persons with disabilities in the mainstream schools. Removing the physical barriers will enable persons with disabilities to access mainstream education, acquire employable skills, and contribute their quota to national development.

Participants gave mixed comments about the social relations of persons with disabilities in school. Many of the participants who had some level of education observed that they had negative experiences during their first few weeks, or months, at school, but that the situation usually improved as time went on. Participants attributed their negative experiences at school to the societal perception that persons with disabilities are cursed or, rather, that they are spirits. According to participants, some of their colleague students, and sometimes teachers, appeared to fear or shun them during their early days at school, but later became more and more supportive as they had continuous contacts with them. Kwasi, for instance, noted the following:

> *In my first two or three weeks at school, I was always alone during break time. None of my classmates wanted to play with me. In class, my teacher hardly asked me to make contributions. However, after some time, they got to know that I was also a human being capable of learning so they began to draws close to me. We then began to do things together and they were always willing to help me whenever I had difficulty.*

Kwadwo rather had to bear the negative attitudes of his classmates for months. He indicated that it took him almost a whole term[5] to integrate fully into his class. He observed that the students were using two-person desks in class but *"nobody wanted to share a desk with me"*. According to Kwadwo, he stayed out of school several times due to the negative attitudes of his classmates, and that it was the support and encouragement from his father and his class teacher that urged him on. He added, however, that his classmates accepted him

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[5] In Ghana's educational system, the academic year at the primary and second cycle level is divided into three terms.

after the first term examination in which he performed marvellously. Since then, according to Kwadwo, *"all of them became my friends and many of them have become my friends to date".*

The discourses of Kwasi and Kwadwo above constitute a new, important finding, namely, that frequent interactions with persons with disabilities may be useful in changing people's perceptions about disability and, for that matter, attitudes towards persons with disabilities. It appears that through frequent contacts with persons with disabilities, people come to learn more about their situation and appreciate them as normal humans.

While Kwasi and Kwadwo were able to cope with the negative attitudes of their colleague students in school, Abena could not. Abena explained her ordeal as follows:

> *There was a girl in my class who screamed the very first day she saw me in class. Since then nobody in the class wanted to have an eye contact with me, let alone speak with me. I therefore had no other option than to drop out.*

Abena applied a stigma management strategy which Goffman called withdrawal to deal with her situation. Withdrawal, according to Goffman (1963) is where a person with a stigmatic condition withdraws from situations that will make him identifiable. However, Abena's inability to cope with school life was possibly due to the fact that her parents were not supportive. In contrast, Kwasi and Kwabena were able to cope because their parents gave them the necessary support; for Kwadwo stated categorically that his ability to bear the negative attitudes of his classmates in his early months at school was due to the support of his parents. This appears to support Bronfenbrenner's assertion that the positive outcomes of an experience in one ecological environment can buffer the negative effects of an experience in another environment.

One major concern that many participants with disabilities raised about their social relations in school, however, was that many teachers failed to involve persons with disabilities in extracurricular activities. Almost all the participants who said they had some level of education indicated that they were left out during activities such as sports, cultural displays, and working in school gardens, on the grounds that they were not strong enough to participate. This is a typical manifestation of the medical model of disability. Instead of teachers creating conducive environment for persons with disabilities to participate in extracurricular activities, they rather locate the problem within individuals with disabilities, thereby claiming that they are incapable. Similar to the overprotection of children with disabilities by their parents at home, this attitude of teachers has not gained any attention from researchers. While teachers might think that they do persons with disabilities favour by exempting them from extracurricular activities, this exemption, in effect, rather informs persons with disabilities that they are feeble and inferior, while at the same time reinforcing the perception of able-bodied students that they are superior to persons with disabilities.

Participants observed, however, that their social relations at school was less problematic than their use of facilities. Apart from Abena who said she dropped out of school due to negative attitudes of her classmates, there was no other participant who attributed his/her school dropout to negative social relations. Rather they cited inaccessibility as the major cause of their dropout. Kwasi and Kwadwo who were able to make it in school also cited inaccessibility as the major challenge that they faced in their academic carrier. Similarly, many parents also mentioned inaccessibility as the main factor that either discouraged them from sending their children with disabilities to school or caused their wards with disabilities to drop out of school.

As we can see from the above, the school which is supposed to build upon the foundation laid by the family, and prepare the child for future employment and social relationships, is also failing to cater for the needs of persons with disabilities. Thus, from the bioecological perspective, the mesosystem relationships between the miccrosystem environments, namely between the family and the school, and between the school and the workplace, are not healthy in the case of persons with disabilities. With limited access to education, many persons with disabilities develop into adults without employable skills which renders them unemployed.

4.2.3 Experiences in Accessing and Sustaining Employment

Participants indicated that most persons with disabilities in Ghana were unemployed. One obvious factor that many participants mentioned as a cause of the high unemployment rate among persons with disabilities was lack of employable skills due to their limited access to education.

Yet another factor that accounts for high rate of unemployment among persons with disabilities in Ghana, according to participants, is negative attitude of employers towards persons with disabilities. According to participants, some persons with disabilities, against all odds, manage to excel in education. However, most of them do not get jobs because employers regard persons with disabilities as generally unproductive. Kwaku maintained that *"Even if you* (person with disability) *have the qualification, employers would not like to employ you because they think you are not productive"*. He added that, *"After all they regard you as a sick person, so why should they employ you?"* The key informant from the from the National Council on Persons with Disability also appeared to agree with Kwaku. According to the officer, *"There is a general perception that persons with disabilities are unproductive,* *so employers feel reluctant to employ them no matter their qualification"*. This is a confirmation of an earlier observation by Reynolds (2010).

The discourses above show that employers in Ghana look at persons with disabilities through the medical model. Unless we look at their situation through the ICF model or the social model, persons with disabilities in Ghana will always be relegated to the background as far as employment is concerned. Since majority of persons with disabilities do not receive education, their involvement in the productive activities is rarely felt. It is therefore easy to conclude that persons with disabilities are unproductive. However, a critical look at their situation from the perspective of the ICF model or the social model will reveal, that the inability of persons with disabilities to participate meaningfully in productive activities is largely due to barriers in the educational system, which block their chances of acquiring employable skills. This realisation may encourage employers to, at least, try persons with disabilities who have skills, while drawing attention of government, policy makers, and other stakeholders to the need to eradicate the barriers in the educational system.

Apart from negative attitudes of employers, many participants also attributed the high unemployment rate among persons with disabilities in Ghana to inaccessibility of buildings and roads. Participants raised a concern that many public facilities in Ghana, including schools, hospitals, roads, community centres, courts and government offices, do not have any provision for persons with disabilities. According to participants, most public buildings are storey buildings, and that these buildings do not even have ramps, not to mention elevators to enable persons with disabilities to access them. Besides, participants raised concerns about lack of pavements along roads, and abundance of open gutters within communities which pose danger not only to persons with physical disabilities but also to those with visual impairment.

To most of the participants, inaccessibility is one of the major barriers that prevent persons with disabilities, especially those of physical nature, from accessing employment. Kwasi, for instance, observed that the unwillingness of employers to engage persons with disabilities might sometimes be attributable to the nature of buildings and roads in the country. According to Kwasi:

> *Even if an employer wants to employ a person with disability, the nature of our buildings and roads would rather discourage him from doing so. You know that employers usually want their employees to do certain things as swiftly as possible; you may be required, as a employee, to run errands for your employer. But considering the nature of our buildings and roads, you a person with disability cannot act as swiftly as required. And in fact, there are some places that if a person with disability, especially a person with physical disability, is employed to, the employer will end up carrying him in and out of this office everyday; and you will agree with me that no employer will do this. So when the employer takes all these into consideration, then he may opt for somebody else even though the person with disability may be the best among the applicants.*

As already established, the Ghanaian society appears to have no confidence at all in the capabilities of persons with disabilities due to the perception that they are sick and unproductive. As a result, persons with disabilities are hardly considered when it comes to infrastructural development. Most job environments in Ghana are thus not friendly to persons with disabilities. This renders many persons with disabilities unemployed even though they may have skills.

Participants noted that many persons with disabilities are compelled to depend solely on their families, or go about begging in the streets due to their lack of employment. Akua, a female with disability, was quite hard on this:

> *It is not our wish to become dependent. If all your effort to get employed end in nothing, what can you do? You will certainly end up becoming the burden society wants you to be. You either depend on your family throughout your life or go to the streets to beg in order to survive.*

Similarly, Abena, another female with disability, said: *"There are many persons with disabilities out there who just go begging on the streets simply because they have no work to do".*

Unable to get jobs, many persons with disabilities in Ghana end up depending on their families or begging for alms in order to survive. This tendency of persons with disabilities to depend on their families, due to their inability to secure jobs, was also found by Kassah (1998). Unfortunately, this may reinforce the societal perception that persons with disabilities are unproductive. The societal perception that persons with disabilities are feeble and unproductive thus becomes a self-fulfilling prophecy.

Some of the discourses reveal that the effects of the high unemployment rate among persons with disabilities go beyond financial hardships. It also appears to lead to learned helplessness, thereby discouraging persons with disabilities from seeking jobs entirely. Many of the participants with disabilities expressed that looking for jobs was not necessary. Kwabena, for instance, said: "*It is not worth trying; no matter how hard you try you still come back to naught. I have seen some of my colleagues who have been moving here and there in search of job but, nothing".*

Some of the discourses of informants also show that, the difficulty that persons with disabilities face in their quest to find jobs may discourage parents from sending their children with disabilities to school. This can be read from a male parent Kwame's words below:

> *Now my son is in school but I don't have any hope that he can get any job after school. Sometimes I even regret sending him to school. I have a friend whose son with physical disability completed polytechnic three years ago. All his colleagues are working now but he is still at home writing applications. Meanwhile he performed so well in his exams.*

The situation tends to discourage not only parents, but also persons with disabilities themselves, from seeking education. According to Kwaku, it is not worthy for a person with disability to go to school at all, considering the fact that persons with disabilities who have made it to higher education cannot get jobs. He stressed that *"Even those persons with disabilities who have made it to the university still find it difficult to get job. So what is the essence of going to school?"* Kwabena also recalled that the difficulty for persons with disabilities in getting employment was one of the factors that discouraged him from furthering his education. According to Kwabena, he decided to drop out of school when he was in class six because he realised that "*even those persons with disabilities who had been able to complete their schooling were still struggling to acquire jobs.* He therefore saw schooling as "*waste of time".*

It can be seen that the social and physical barriers in employment do not only prevent adults with disabilities from gaining employment in order to lead independent lives; they also discourage the education of children with disabilities. It thus becomes imperative to deal with these barriers with all the urgency it deserves.

4.2.4 Experiences in the Community

Participants' comments about their interpersonal relationships within the community appeared to be generally positive. Many of the participants with disabilities reported that, on the interpersonal level, their neighbours treated them with respect. They observed that their neighbours usually feel reluctant to interact with them on their initial contacts, but after a number of close contacts, their relations normalise. One such positive comment came from Kwadwo:

> *Things have improved when it comes to our relationships within the community. For instance, today there are prominent men in the community who relate well to us; sometimes we even eat together with them. Some time ago, when our age mates saw us they used to run away, but today, I have a lot of friends who have no disability. They even come looking for me. Normally, people feel reluctant to get close to you when they meet you for the first time. But as time goes on, and with more interactions, things become normal.*

Kwadwo's discourse above seems to suggest an improvement in societal perceptions about disability, especially the perception that disability is a curse. Data from this study, as well as available literature, indicate that people who see disability as a curse either despise persons with disabilities for bringing curses upon themselves, or avoid contacts with persons with disabilities for fear that persons with disabilities might contaminate them with their supposed curses. Thus for people to get closer to persons with disabilities to the extent of eating with them suggests, as other participants observed, that this perception is fading out. Kwadwo's comment that the relationships between persons with disabilities and their neighbours improve after a couple of interactions, also confirms an important finding of the present study, that is, frequent interactions with persons with disabilities helps to change people's perceptions about disability.

Even though all persons with disabilities interviewed in the present study indicated that their interpersonal relations in the community were less problematic, Kwasi and Kwadwo were more positive than the others. This is probably because, the positive relations they enjoyed in their families, coupled with their school experiences, prepared them for more positive relationships. Or, perhaps, it is an indication of Abena's assertion that *"society appears to regard persons with disabilities who are able to lead independent lives as normal humans, while those who depend on society are regarded as curses"*.

It appears, however, that the positive relationships enjoyed by persons with disabilities in their communities, as portrayed above, exist only on informal level. In more formal relationships, such as marriage and leadership, the picture is not very positive. Most participants observed that it was hard for persons with disabilities to get marriage partners. Here too, the medical interpretation of disability appears to plays a major role. According to participants, persons with disabilities find it difficult to get spouses because they are perceived to be sick persons who are too feeble to raise families. Kwadwo substantiated this point with his own experience:

> *Some people have still not been enlightened. I will use myself as an example.*
>
> *When I was going to marry, the girl's family said a lot of things about me. For instance, there was a time I overhead one of her relatives ask her: 'So couldn't you bring any other man home than a sick person?' They think that persons with disabilities are too vulnerable to marry and raise a family.*

This is a confirmation of Kassah's (1998) finding that persons with disabilities hardly marry and set up families. Kwadwo's words above can be understood better if we look at it in the light of how spouses are generally selected in Ghana. According to Nukunya (2003) one of the criteria for selecting a marriage partner is that the person should be hardworking. In a situation like this, it is not hard to understand why a person with disability, who is regarded as a sick, feeble, and unproductive, will find it difficult getting a partner.

Kwadwo noted further that some people in Ghana believe disability is hereditary. In other words, some people think that disability can be transmitted genetically from parent to offspring:

> *Some even think that if you marry a person with disability you are also going to give birth to a child with disability. But God being so good all persons with disability whom I know to have married have had healthy children.*

The above perception is another new finding that requires attention, especially in educational interventions meant to change societal attitudes about disability. The perception appears to correspond with one of the criteria for selecting spouses in Ghana. Nukunya (2003) indicated that, in selecting and accepting a potential spouse, "the relatives of each party make sure that their potential affines do not have any serious diseases such as epilepsy, lunacy, or leprosy" (p.42). Thus a family that regard disability as a "serious disease" will prevent their relatives from marrying persons with disabilities.

Another area of community life where participants with disabilities said they suffered discrimination was leadership and decision making. Most of the participants raised that persons with disabilities were virtually denied the opportunity to hold any leadership position in their communities. Exclusion from leadership, of course, implies exclusion from decision making. Kwaku was one of the participants who expressed deep concern about this:

> *We are not allowed to take leadership positions. We are not involved in any decision making. People decide for us on all matters. Even concerning how we use our portion of the District Assemblies Common Fund*[6]*, some people somewhere have to decide for us; meanwhile we know what we need most.*

Unlike the other forms of discrimination against persons with disabilities, many participants stated that exclusion from leadership, especially in the case of chieftaincy, was somehow institutionalized. This was first touched on by Kwasi in the following discourse:

> *The notion that a person with disability cannot be a leader is formally recognised and strictly adhered to in chieftaincy, so people see it as something normal. It is a taboo in Ghana for a person with disability to become a chief*[7]*. So even if you belong to the royal family, once you have a disability, you have no hope of becoming a chief.*

Kwasi added that people tend to extend the taboo that bars persons with disabilities from becoming chiefs to cover all other forms of leadership:

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[6] The 1992 Constitution of the Republic of Ghana mandates Parliament to annually allocate not less than five percent of the total revenues of Ghana to the District Assemblies for development. The amount is paid into the District Assemblies Common Fund. Two percent of this amount is allocated to persons with disabilities.

[7] A chief is a traditional ruler of a town or village in Ghana. Some chiefs, known as paramount chiefs, however rule over a wider area called traditional area, covering a number of towns.

> *Unfortunately society seems to have extended this taboo to cover all forms of leadership. As a matter of fact, I have never seen a person with disability who is a minister, a member of parliament , a district chief executive, or even an assembly member.*

The above excerpt is a confirmation of Bronfenbrenners assertion that structures in the macrosystem such as societal beliefs, values, and traditions determine events in all the microsystem environments.

Kwaku's assertion that a person with disability cannot become a chief in Ghana was affirmed by the participant who served as an expert of chieftaincy and culture. The expert maintained that a chief, according to tradition, should be an able-bodied person:

> *A chief should be an able-bodied person; he should not be blind, lame, crippled, or deaf. Even he shouldn't be an albino, left-handed, or too short. Besides, he should be of sound mind. In other words, he should not have any mental impairment, being it severe or mild.*

Clearly, this requirement of a chief excludes all persons with disabilities- physical, sensory, or intellectual. It also becomes clear that Ghanaian definition of disability or deformity is very broad, for the expert includes albinos, left-handed people, and those with profound short stature.

The expert gave reasons why persons with disabilities cannot become chiefs. Making reference to history, the expert stated that a chief, in the past, was supposed to be an able-bodied person because he was the commander of the community army:

> *In the past there were a lot of intertribal wars, so each chief was expected to lead his people either to attack other communities or defend his community against external attacks. In short, a chief was supposed to command his army to war and, you know, a person with disability cannot do this.*

This finding is similar to an observation by Avoke (2002) that military demands in the past made society to regard persons with disabilities as unhealthy and dependent individuals.

While acknowledging that wars are rare of late, the expert also maintained that there are yet other duties of a chief that a person with disability cannot perform:

> *You may say that there are no more wars today. Yes, but there are several other duties of a chief that persons with disabilities cannot perform due to their infirmities. A chief has to travel frequently, attend all sort of meetings, and move along with government officials and development partners when the need arises. Do you think that a person with disability can do all these, my son?*

Typically, the expert's argument above point to medical model of disability. Instead of considering factors that may help persons with disabilities function effectively as leaders, society simply regards them as weak and incapable individuals who cannot become leaders.

Kwadwo, who recounted his own experience, also attributed the exclusion of persons with disabilities from holding leadership positions to the societal perception that persons with disabilities are sick and unproductive:

> *The general perception that persons with disabilities are sick plays a major role here. When a person with disability contests for a position, they will never vote for him. In many cases they end up hurling all kinds of insults at you. I once contested for a*

> *public office but I totally regretted my decision. There were a number of times when I overheard people ask each other questions like these: 'Why should we vote for such a sick person?' 'What can he do for us?'*

Some participants also asserted that persons with disabilities are denied leadership positions because, society perceives them to be carrying curses which can contaminate the entire community should they be allowed to lead the community. Even though the participant who served as expert of chieftaincy and culture did not state categorically that persons with disabilities carry curses, he made a statement that appears to support this assertion. He mentioned that, crowning a person with disability a chief is a disgrace to the entire community, and hence, "*the gods will not approve of it"*. The expert added that *"this can be a source of curse to the entire community"*.

According to Kwasi, society perceives persons with disabilities to be "*so contaminated that chiefs are even forbidden to have close contacts with us* (persons with disabilities)". This assertion by Kwaku was somehow confirmed by the expert:

> *In the past chiefs were not even supposed to set an eye on persons with disabilities. Today things have been liberalised but even that, it will be very unlikely to see a chief communicating one-on-one with a person with disability. I don't think this has ever happened anywhere in the country.*

The above discourses point to the moral model of disability as a mode of interpreting disability in Ghana. However, the expert's latter comment that things have been liberalised in terms of taboos about disability also suggests that the moral model of disability is losing its intensity.

To most of the participants, exclusion of persons with disabilities from leadership positions, and from decision making in general, is one of the reasons why discrimination against persons with disabilities persists in the society. Kwasi, for instance, said: "*Our rights are being trampled upon day in day out because our voices are not heard; we don't have representatives in leadership positions to fight for our rights"*.

If the situation of persons with disabilities in Ghana is approached from the perspective of the ICF model or the social model, one will come to realise that persons with disabilities in Ghana are not seen in leadership not necessarily because they do not have the ability to lead; rather there are a number of social barriers, as well as physical barriers, that prevent persons with disabilities from holding leadership positions. As already established, societal perceptions that persons with disabilities carry curses, or that they are sick, have become invisible barriers alienating persons with disabilities from leadership positions. The perception that persons with disabilities are not strong enough to lead their communities is also strengthened by inaccessible infrastructure. If these barriers are removed, persons with disabilities can become leaders just like the able-bodied.

Perhaps, the fact that persons with disabilities are denied access to leadership positions is the most important finding of the present study. Exclusion of persons with disabilities from holding leadership positions, with its accompanying exclusion from decision making, is, possibly, the greatest barrier to their participation in the society. It can be cited as one of the major reasons why the fight for persons with disabilities to be included in the mainstream Ghanaian society has not yielded the desire result. As most participants observed, the voices of persons with disabilities are hardly heard because they have no representatives in leadership positions to fight for their rights. Social change can be more effective if it is led by persons who have influence in the society than persons relegated to the background.

Besides, persons with disabilities understand their situation better than any other person or group of persons. They could therefore make useful inputs if they were involved in making decisions that affect them.

4.2.5 Summary of Experiences of Persons with Disabilities

The results show that persons with disabilities face a number of challenges in the various environments in which the participate: the family, the school, the workplace, and the community at large. The challenges ensue mainly from the interpretations that the Ghanaian society gives to disability. The discourses of informants show that, basically, two models are used to explain disability in Ghana: the medical model and the moral model. The medical model regards disability simply as sickness or abnormality. People who look at persons with disabilities through this model, therefore, see them as sick, feeble, unproductive and dependants. The moral model, on the other hand, regards disability as a curse from a supernatural force or a spell cast on an individual by an evil spirit. The supposed curse is believed to be a punishment for the individual's own sins or the sins of his relatives. Thus, through the moral model, persons with disabilities and their families are often blamed for being responsible for their disabilities.

The results further indicate that the medical model is very influential in Ghana presently. There are a lot of discourses that express how the perception that persons with disabilities are sick determines the attitudes and behaviours of people towards persons with disabilities. In the family, the results show that parents fail to involve their children with disabilities in their family activities and, sometimes, prevent them from playing around with other children simply because they see them to be too feeble. The results also show that some parents fail to provide the educational needs of their children with disabilities because they think that persons with disabilities do not have what it takes to make it in school. In school, teachers often do not involve persons with disabilities in extracurricular activities, on the grounds that persons with disabilities are not strong enough to undertake such activities. School buildings and the general layout of school campuses are also less friendly to persons with disabilities, possibly because persons with disabilities are perceived to be abnormal persons who should be adjusted to suit the school environment, instead of adjusting the school environment to suit them. In terms of employment, employers hesitate to employ persons with disabilities because they consider persons with disabilities to be weak and unproductive. In the community, the perception that persons with disabilities are sick and unproductive makes it difficult for them to get spouses. Even more importantly, persons with disabilities are virtually denied access to leadership positions due to the societal perception that persons with disabilities are weak and unproductive.

There is, however, enough evidence from this study to the effect that, given the appropriate environment, persons with disabilities in Ghana can lead normal lives. With adequate family support, two of the participants with disabilities, Kwasi and Kwadwo, have been able to go through formal education, acquired jobs, and are living independently. Both of them are married and live happily with their families.

There were also discourses that pointed to the influence of the moral model on the lives of persons with disabilities. Such discourses related mainly to the family experiences of persons with disabilities. The results show that some parents tend to hide their children with disabilities from the public in order to avoid the social stigma of having given birth to a child with disability. This tendency may cut children with disabilities from vital opportunities and services, such as education and healthcare. Participants with disabilities who had some education also mentioned that their colleagues tended to shun them in their early days at school, probably due to the perception that persons with disabilities are evil. Some participants also attributed the denial of persons with disabilities of access to leadership positions to the societal perception that disability is a curse.

The results confirm my prior assumption that persons with disabilities face a number of challenges in different spheres of their lives. Most of the results also agree with existing literature on the fact that persons with disabilities are often marginalised in the Ghanaian society. However, there are a couple of new findings that deserve attention.

The present study found that parental attitudes towards their children with disabilities are influenced mainly by the medical model of disability. The study also found that some of the treatments given by parents to their children with disabilities, though negative, may not be ill-motivated. In other words, the parents might not consider their attitudes to be negative, rather they might think that it is a way of helping the child. For instance, it was found that the tendency of parents to keep their children with disabilities from engaging in family activities or playing with other children is sometimes motivated by the desire to protect the children with disabilities from physical harm. Some participants also indicated that, the unwillingness of parents to send their children with disabilities to school might sometimes be due to the desire to save the children from uncomfortable situations occasioned by unwelcoming school environments. These seem to suggest that some parents have the welfare of their children with disabilities at heart, but lack the requisite knowledge to nurture them. Thus, given the right information about disability, such parents will give their children with disabilities the necessary support. The same can be said about teachers who fail to involve students with disabilities in extracurricular activities.

Another new finding of the present study that deserves attention is the fact that frequent interactions with persons with disabilities has the possibility of changing people's perceptions about disability. Both Kwasi and Kwadwo observed that the attitudes of their classmates towards them were sour at the beginning, but that with continuous interactions, their attitudes changed for the better. They observed that their classmates, who did not even want to talk with them, ended up becoming their friends through frequent interactions. A similar observation was made by Kwadwo concerning interpersonal relationships of persons with disabilities in their communities. These appear to suggest that, through frequent interactions with persons with disabilities, people come to learn more about their situation and appreciate them as normal humans who can also lead normal lives. This finding can be very useful in planning interventions that aim at changing perceptions about disability. It can also be a strong point in advocating for inclusive education. Frequent interactions between able-bodied children and children with disabilities in classrooms and dormitories might lead the able-bodied children to form positive perceptions about disability and, hence, positive attitudes towards persons with disabilities. Such children will more likely develop into adults who are more supportive of persons with disabilities.

The present study also found that, some people in Ghana believe disability is hereditary. Kwadwo noted that, people who hold this perception oppose marriages between persons with disabilities and able-bodied persons. This finding is similar to twentieth century eugenics movement in Europe which advocated for extermination of persons with disabilities, arguing that persons with disabilities possess undesirable traits that could contaminate the genetic composition of the population (Mackelprang & Salsgiver, 2009; Wiggam, 1924). Not only did the eugenics movement lead to enactment of laws to authorize the sterilization of persons with disabilities to prevent them from procreating (Longmore, 1987; Mackelprang &

Salsgiver, 2009), but also led to the extermination of approximately 200,000 physically and mentally disabled persons in Germany alone (Mackelprang & Salsgiver, 2009). Considering the terrible consequences of a similar perception in the twentieth century Europe, this new finding of the present study becomes worthy of attention.

Yet another new and, perhaps, most important finding of this study is the fact that persons with disabilities are, either formally or virtually, cut off from holding leadership positions. Participants indicated that, the chieftaincy institution in Ghana formally bars persons with disabilities from becoming chiefs. This taboo, according to participants, appears to have been imbibed by many Ghanaians and are applied to almost all other forms of leadership. Thus, persons with disabilities are virtually cut off from holding almost all leadership positions in the country. This finding is very crucial as far as inclusion of persons with disabilities in society is concerned. It is a very important finding because, exclusion from leadership also implies exclusion from decision making. Thus breaking this barrier will give persons with disabilities the opportunity to take part in, and influence, decisions that affect them. Giving persons with disabilities the opportunity to hold leadership positions will also give them a formidable front to enable them to effectively fight for their rights.

4.3 The Persons With Disability Act, 2006 (Act 715)

The government of Ghana has ratified all international conventions on the rights of persons with disabilities. In accordance with the international conventions, Ghana has also made domestic laws and policies to cater for the needs of persons with disabilities. The most recent and most elaborate legislation on the rights of persons with disabilities in Ghana is the Persons with Disability Act, 2006. The Act was enacted in August 2006 to provide for persons with disabilities. The Persons with Disability Act, 2006 seeks to integrate persons with disabilities into the mainstream society by removing barriers that prevent equal access to education, health service, information, family life, social activities, public places, and employment, among others. Thus the act is more or less congruent with the ICF model and the social model of disability. This section examines participant's knowledge about the act and how they view its implementation.

Many of the participants expressed that they knew of the existence of the Act. However, only a few knew what the Act entailed. Two of the participants, Kwasi and Kwadwo, however demonstrated high knowledge of the Act. They quoted a number of provisions from the Act during our interactions. Kwasi and Kwadwo's deep knowledge about the Act might be due to the fact that they have formal education and have the ability to read and write.

Concerning the implementation of the act, participants observed that they had not seen much progress. Kwadwo, for instance said that "*the act is very beautiful on paper but practically, no concrete steps have been taken to implement it"*. Kwasi said something similar:

> *In Ghana we don't have problem writing laws but the implementation. The act was passed long ago but only a handful of Ghanaian know about it. For instance, the act states that if a person with disability shows an intention to cross a road the driver should stop for him, but if I decide to cross the road here, you'll see how long it'll take before a driver eventually gives me way.*

The key informants also observed that the Persons with Disability Act, 2006 had not been fully implemented. According to the key informants, implementation of the Act has not even materialised in government institutions, much less in private establishments. The key informant from the department of Social Welfare expressed worry over the fact that some government buildings built after the passage of the Act were not friendly to persons with disabilities. The key informant from the National Council on Persons with Disability expressed a similar concern about transportation networks that were constructed after the passage of the Act but had little no provisions for persons with disabilities.

The key informant from the National Council on Persons with Disability gave some reasons why the implementation of the act had delayed. According to the officer, even though the act was passed in August 2006, the National Council on Persons with Disability, which was supposed to formulate policies and strategies to fulfil the provisions in the act, was not inaugurated until 2009. He added that even the inauguration of the council did not guarantee full implementation of the Act. One major setback, according to the informant, is the absence of a legislative instrument, an operational framework for the implementation of the Act. Though the act touches on many important issues regarding the integration of persons with disabilities into the mainstream society, some of the provisions appear to be too vague to be implemented. He mentioned, for instance, that the Act states that a person with disability shall not be given differential treatment except it is required by the persons condition, but the Act does not specify which condition of a person with disability requires differential treatment. "*Similarly*", he added, "*the provision that says public places should be made accessible to persons with disabilities does not indicate what specific provisions should be made to public buildings*". There is therefore the need for an operational framework to operationally define each provision and set out modalities for its implementation.

4.4 Participants General View of the Current Situation of Persons with Disabilities

Participants' general evaluation of the current situation of persons with disabilities in the country was somewhat positive, and pointed to a brighter future. Some of the participants observed that there had been an improvement in the living conditions of persons with disabilities over the years, while others indicated that the improvement had just began.

Most of the improvements that participants observed related to their family experiences. Kwadwo, a male participant with disability, for instance, expressed the following in a focus group:

> *Currently, I will say that our situation is far better as compared to the past. I can say that, for now, our families have accepted us. For instance, some time ago we were not considered at all for education, but today, many parents have seen the need to send their children with disabilities to school.*

Kwadwo's observation above led to an interesting twist in the focus group that is worth mentioning. Kwadwo appeared to be the most knowledgeable and eloquent person among the participants in the focus group of persons with disabilities, probably due to his educational background. His views were, therefore, hardly challenged by other members in the group. This even compelled me to find ways to let other participants speak on issues first, before Kwadwo made his point. On this issue, however, some participants, particularly Kwaku, objected strongly to Kwadwo's submission. Even though Kwaku did not totally disagree with Kwadwo, he thought that Kwadwo's claim was somewhat an exaggeration. According to Kwaku:

> *We cannot say that our [persons with disabilities] families have completely accepted us. Of course our condition is improving, but to say that our families have accepted us is an overstatement. I would rather say that our families are in the process of accepting us.*

Kwasi, another male with disability, also observed an improvement in the family experiences of persons with disabilities:

> *I think parents of late are doing well. Hardly would you see, in those days, a person with disability who had even completed secondary school, but today, amid all obstacles, we have persons with disabilities who have completed university due to the support of their parents. So with time I hope persons with disabilities will be fully accepted in the society.*

Similar improvements were also observed by participants with disabilities in their interpersonal relations within the community. Kwadwo, for example, indicated that gone were the days when neighbours ran away from persons with disabilities. On this point too, other members of the focus group did not agree fully with Kwadwo. Some of them observed that there were still some people in the community who looked on persons with disabilities with disgust. Kwabena, for instance, mentioned that *"there are still some people who think that seeing a person with disability early in the morning is a bad omen".* Kwabena agreed, however, that there had been an improvement in how people related to persons with disabilities in the community, and hoped most people came to accept them soon.

Kwadwo's positive outlook might be due to the positive relationship that he enjoyed in his family. Bronfenbrenner and Morris (2006) assert that persons who have positive experiences in their families turn out to have positive outlook of the external world and, consequently, form more positive relationships.

Participants attributed the improvement in the situation of persons with disabilities mainly to public education and role modelling. Participants remarked that through public education, some people had come to understand that persons with disabilities were not evil, and that they also had the ability to contribute to society if they were given the necessary support. Kwadwo however added that this education became more successful when persons with disabilities were involved:

> *I think the education becomes more effective when persons with disabilities are involved. When we are involved in educating the public, because we understand our situation better, we are able to outline clearly the challenges we have been through and hammer on what we have been able to achieve because we were supported by our families and other people around us. When people get to know our achievements, they come to realise that persons with disabilities can also become independent and contribute to society if they are given the needed support.*

Kwadwo recalled one of such successful education programmes that persons with disabilities in Techiman had in collaboration with a non-governmental organisation. Kwadwo mentioned that *"many parents who had children with disabilities approached us after the programme, saying we had proved to them that their children with disabilities could also do something in life"*. Kwaku also recalled a similar educational campaign that persons with disabilities held in the Brong Ahafo regional capital Sunyani. According to Kwaku, a woman approached them during the campaign and said that she was at the verge of poisoning her daughter with disability due to the ridicule she suffered at the hands of her neighbours, and that through the campaign she had come to know that her daughter was also a human being capable of leading a normal life.

Kwadwo and Kwaku's observations above seem to suggest that role models play a vital role in changing perceptions about disability. The importance of role models was also mentioned by Kwasi. He indicated that many parents have seen the need to send their children with disabilities to school because they have seen some persons with disabilities who, after school, are contributing substantially to their families. The potential of role models in changing perceptions about disability was also observed by Andin (2008).

The key informants from the Department of Social Welfare and the National Council on Persons with Disability also attested to the fact that there had been an improvement in the situation of persons with disabilities in the country. Both informants observed that persons with disabilities currently have more access to education, healthcare, and employment than before. The informant from the Department of Social Welfare ascribed this improvement to public education and supportive government policies. He made specific reference to the *"Guidelines for the Disbursement and Management of the District Assembly Common Fund Allocation to Persons with Disability"*[8]. According to the officer, persons with disabilities initially had a number of challenges accessing their share of the District Assemblies Common Fund. However, the document, which was launched in 2010, has made it easy for persons

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[8] Guidelines for the Disbursement and Management of the District Assembly Common Fund Allocation to Persons with Disability is a policy document launched by the National Council on Persons with Disability in 2010 to streamline the disbursement and management of Persons with Disabilities' share of the District Assemblies Common Fund.

with disabilities to access funds from the District Assemblies Common Fund to support their education, engage in economic ventures, and access technical aids and other assistive devices and equipment. The informant from the National Council on Persons with Disability also attributed the improvement in the lives of persons with disabilities partly to education and the same document mentioned by the informant from the Department of Social Welfare. He cited the document as one of the main achievements of his outfit since its inauguration in 2009. He acknowledged, however, that the percentage of national income allocated to persons with disabilities was woefully inadequate to cater for the needs of all persons with disabilities.

4.5 Mainstreaming Persons with Disabilities into the Ghanaian Society

Participants suggested measures that could be taken in order to effectively include persons with disabilities in the mainstream Ghanaian society. Participants' suggestions centred mainly on maro level interventions that could lead to ideological and structural changes. Participants thus appeared to be in tune with Bronfenbrenner's proposition that a change at the microsystem level is occasioned by a change at the macrosystem level.

On ideological change, participants suggested vigorous public education on the phenomenon of disability. Kwadwo observed that *"without education, there is nothing that we can do about the negative perceptions"*. According to participants, society should be educated on causes of disability, and on the fact that persons with disabilities can also lead normal lives provided they are given the right environment. This, according to participants, will cause people to disabuse their minds of negative perceptions about disability and, consequently, accept persons with disabilities. Participants observed that people who have adequate knowledge and understand about disability tend to relate very well to them.

On structural changes, participants' suggestions revolved around accessibility to facilities and involvement in decision making. Most participants with disabilities indicated inaccessibility of public facilities as one of the major problems that militate against their involvement in the society. They therefore called for implementation of laws and policies that would make facilities accessible to them.

Participants also called for policies and legislations that would enhance the opportunities of persons with disabilities to take part in all decisions affecting them. Kwasi, for example, quoted a slogan of the Ghana Federation of the Disabled, *"Nothing about us without us"*. Kwasi argued that persons with disabilities can *"gain our freedom only if we are allowed to take part in all decisions that affect us*. He therefore suggested that, government should come out with a policy that would give persons with disabilities a quota of positions of government appointees[9] in each district assembly. Kwasi further called for arrangements that would give persons with disabilities the opportunity to become chiefs. Kwadwo and Kwabena suggested policies that would make persons with disabilities have a say in the use of their share of the District Assemblies Common Fund.

Ama, a female parent, suggested that government should give priority to persons with disabilities in certain jobs:

> *In our current situation, persons with disabilities cannot compete with the able-bodied for job opportunities. Besides, private entrepreneurs cannot be compelled to*

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[9] The 1992 Constitution of the Republic of Ghana mandates the president of the country to appoint up to 30 percent of members in each district assembly.

> *employ persons with disabilities. Government should therefore consider reserving certain positions in the public sector for qualified persons with disabilities.*

According to Ama, the government providing jobs for qualified persons with disabilities would not only enhance the living conditions of those individuals, but would also encourage parents to take good care of their children with disabilities.

The suggestions given by the key informants also centred on education and policy. The officers suggested vigorous and frequent educational campaigns aimed at changing perceptions about disability. According to the key informant from the National Council on Persons with Disability, *"our attitudes and behaviours are determined by our perceptions*. *Hence, a change in perception about disability will also lead to changes in attitudes and behaviours towards persons with disabilities"*. He called for the involvement of persons with disabilities in such educational campaigns since, according to him, this would portray to society that persons with disabilities also have something to offer. The informant from the National Council on Persons with Disability, as well as the informant from the Department of Social Welfare, suggested that government should make funds available for full implementation of the Persons with Disability Act, 2006.

CHAPTER FIVE

GENERAL DISCUSSION AND CONCLUSIONS

5.1 Overview of Findings

The results of this study as presented in the previous chapter indicate that the barriers that prevent persons with disabilities from participating meaningfully in the Ghanaian society are varied. The barriers operate at different levels of the society. This chapter summarises the results of the study, while employing the bioecological model to show clearly how the various ecological levels influence one another, and how their interactions influence the wellbeing and development of persons with disabilities. As already noted, this study focused mainly on three ecological levels, namely, the microsystem, the mesosystem, and the macrosystem levels.

According to the bioecological model, structures in the macrosystem such as laws, policies, socio-cultural ideologies, and belief systems of a society, to a greater extent, determine the attitudes and behaviours of its people. In view of this, Bronfenbrenner (1979) asserts that, the effective functioning of child-rearing processes in the family and other child settings requires public policies and cultural practices that are in support of child-rearing activities. The effective participation of persons with disabilities in their families and the mainstream society thus depends largely on the availability of laws, policies, socio-cultural ideologies, and belief systems that encourage inclusion of persons with disabilities in the mainstream society. Unfortunately, some of the socio-cultural ideologies and beliefs systems in Ghana, instead of including persons with disabilities in the society, rather tend to exclude them from the society.

The results of this study revealed that two models of disability are mainly used to interpret disability in the Ghanaian society- the medical model and the moral model. From the medical model, persons with disabilities are viewed to be sick, feeble, unproductive, and dependent. From the moral model, on the other hand, persons with disabilities are perceived to have been cursed by supernatural powers or bewitched by evil forces, while others simply see them as spirits sent in human form to torture wicked families. These perceptions appear to have been incorporated deeply into the belief systems and ideologies of the society, for they are found in the daily discourses relating to persons with disabilities. For instance, people who view disability as sickness generally refer to persons with disabilities as *ayarefoɔ* (Akan term meaning sick people), while those who view persons with disabilities as spirits usually call them *nsuoba (*meaning a child of a river in Akan language).

The findings thus confirm my prior assumption that the medical and the moral models of disability are used to explain disability in Ghana. In the same vein, the findings confirm earlier studies on disability in Ghana (Agbenyega, 2007; Avoke, 1997; Oliver-Commey, 2001; Reynolds, 2010), except that the findings of the present study are more tilted towards the medical model.

As Groce (1999) argues, cultural belief systems and explanatory models for disability tend to determine how persons with a disabilities are treated in their communities. The perceptions that Ghanaians hold about disability, and their corresponding labels, therefore determine the experiences of persons with disabilities in the various microsystem environments in which they participate.

The findings show that, in the home, parents feel reluctant to cater adequately for the needs of their children with disabilities due to the general perception that persons with disabilities are sick and unproductive. A female participant Adwoa, for instance, indicated that many parents consider the funding of their children's education as an investment; parents invest in their children's education so that the children can, in turn, cater for them in their old age. Unfortunately, society has made parents to believe that their children with disabilities are sick, and cannot undertake any productive venture, and that investing in them is tantamount to wasting resources. Due to this, parents often focus all their attention on their able-bodied children at the expense of those with disabilities.

The present study has, however, revealed that persons with disabilities are productive, and can contribute substantially to their families and the society at large provided they are given the necessary support. With adequate parental support, two of the participants with disabilities, Kwasi and Kwadwo, have been able to acquire education, obtain jobs, and establish families, while the others, without adequate parental support, hardly make ends meet. This confirms the ICF model's position that the performance of an individual is the outcome of interactions between the individual's health conditions and contextual factors. It also confirms the position of the social model of disability that persons with disabilities can function effectively if their needs are adequately catered for.

The findings show that the societal perception that persons with disabilities are sick has also given many parents the impression that children with disabilities are too feeble to explore their home and neighbouring environments. It is for this reason that many parents, according to participants of the study, fail to include their children with disabilities in their family activities, or even fail to allow them to play with other children. These attitudes of parents not only kill the initiatives of children with disabilities, but also makes them feel inferior to others.

The results indicated that the societal perception that disability is a curse or bewitchment also influences the attitudes of parents towards their children with disabilities.

Usually, parents are blamed for bringing the curse of disability on their children through their disobedience to societal norms. Similarly, some parents are accused of bewitching their own children, either out of sheer wickedness or for their own spiritual gains. Having a child with disability in the Ghanaian society thus becomes highly stigmatising. Some parents therefore tend to hide their children with disabilities from the public in order to avoid the social stigma of having given birth to a child with disability.

The family experiences of persons with disabilities as presented by participants of this study, especially those occasioned by supernatural interpretation, in many ways, confirm observations made by other researchers such as, Anthony (2011), Nepveux et al. (2004), and Nortey (2009). However, one finding stood out in the present study. It was found that, sometimes parents may not see their negative attitudes towards their children with disability as such. Rather, they might see such attitudes as ways of protecting their children with disabilities. For instance, it was found that the tendency of parents to keep their children with disabilities from engaging in family activities or playing with other children is sometimes motivated by the desire to protect the children with disabilities from physical harm. Some participants also indicated that, the unwillingness of parents to send their children with disabilities to school might sometimes be due to the desire to save the children from the hardships of unwelcoming school environments. With this background, one can then say that some parents have the welfare of their children with disabilities at heart, and that given the right information about disability, such parents will give off their best to their children with disabilities.

The negative attitudes of parents towards their children with disabilities have a lot of impacts on their lives. These negative attitudes of parents not only deny persons with disabilities of access to education, healthcare, and other important services, but also impacts negatively on their psychological development.

Being the first and closest environment of the developing person, the experiences of an individual in the family become very crucial to his overall development. From the ecological perspective, the interactions between the child and the parents is the foundation block upon which future development of the child is built. The attitudes of parents towards their children in the home therefore has the potential to influence the development of the child either positively or negatively. "Through interactions between the infant and the primary caregiver, the infant develops expectations of the caregiver's behaviour and complementary beliefs about him or herself" (Bronfenbrenner & Morris, 2006, p. 816). A child whose parents pay attention to his needs and involve him in family activities will not only develop a model that the parents are supportive, but will also form a complementary sense of self that he is important to the family. A child whose parents are not responsive, on the other hand, will not only model the parents as unsupportive, but will also develop a complementary sense of self that he is worthless. The findings show that, children with disabilities who have negative experiences in their families feel neglected by their families. The feeling of being neglected often leads to emotions such as fear, anger, hatred, insecurity, and inferiority complex. This makes it difficult, if not impossible, for persons with disabilities to form any strong attachments and relationships with their parents and siblings.

As Bronfenbrenner asserts, the kind of thoughts and feeling that children form about themselves and their close relatives tend to be extended to other settings within the mesosystem. "The child seeks, responds, and interprets events based on the model that he or she has developed during infancy, and that model is adapted based on new experiences with the environment" (Bronfenbrenner &Morris, 2006, p. 816). Children with disabilities therefore tend to extrapolate the negative thought patterns they form about their family relationships to their future interactions. Participants of the present study observed that, the feelings of rejection, insecurity, and inferiority formed in the course of family interactions is often extended to other environments such as school, neighbourhood, and peer group interactions. According to participants with disabilities, they often found it difficult to get along with others due to the negative experiences they had with their parents and close relatives.

According to Bronfenbrenner and Morris (2006), the propositions of the bioecological theory may also apply beyond childhood and adolescence to relationships in adulthood and old age. Therefore, the involvement of other persons aside from the parents, such as relatives, peers, teachers, mentors, spouses, co-workers, and supervisors also become imperative in the development of an individual. In other words, the attitudes of people that an individual meets in other settings such as in school, neighbourhood, community, and workplace, can also influence his development either positively or negatively. Unfortunately for persons with disabilities, their experiences in these environments also tend to reinforces the already negative emotions built in the family.

At school, participants observed that some teachers failed to involve persons with disabilities in extracurricular activities because they perceived persons with disabilities to be too feeble for that. It was also observed that, some students and teachers felt reluctant to interact with persons with disabilities, especially in their early days at school, probably for fear the they might be contaminated with the supposed curses carried by persons with disabilities. The negative attitudes of students and teachers only reinforce and compound the negative emotions already developed by persons with disabilities in the home, which, in the long run, might cause them to drop out of school. This confirms the assertion by Agbenyega

(2007) that negative attitudes towards persons with disabilities is a serious setback to their education.

The present study, however, made one finding about the school experiences of persons with disabilities that is particularly noteworthy. While participants observed that persons with disabilities had negative experiences with their social relations in school, some of them also indicated that their situations improved after a period of continuous interactions. This seems to suggest that, continuous interactions with persons with disabilities may be useful in changing people's perceptions about disability and, for that matter, attitudes towards persons with disabilities. It appears that through frequent contacts with persons with disabilities, people come to learn more about their situation and appreciate them as normal humans.

Participants' observations about the experiences of persons with disabilities in securing employment were mainly negative. According to participants, employers feel reluctant to engage persons with disabilities no matter their qualification because persons with disabilities are regarded as nothing more than feeble and unproductive beings. This finding supports earlier finding by researchers such as Kassah (1998) and Reynolds (2010). The repetition of similar negative experiences in the various microsystem environments is likely to lead to inferiority complex and learned helplessness for most persons with disabilities , who may eventually give up in life.

Participants gave mixed accounts about their experiences within the community. Participants' comments about their interpersonal relationships within the community appeared to be generally positive. Participants with disabilities observed that, on the interpersonal level, their neighbours treated them with respect. Participants indicated that their neighbours usually felt reluctant to interact with them on their initial contacts, but that after a number of close contacts, their relations became normal. This seems to confirm an important finding that emerged under persons with disabilities' experiences in school, namely, that frequent interactions with persons with disabilities help to change people's perceptions about disability.

The picture, however, becomes ugly when we turn our attention to formal relationships, particularly, marriage and leadership. The results show that persons with disabilities hardly get married because they are perceived to be too feeble to marry and raise family. Some families also refuse to let persons with disabilities marry their relatives because they perceive disability to be hereditary. The appears to confirm Kassah's (1998) assertion that persons with disabilities in Ghana rarely marry and raise families.

Perhaps the worst experience that persons with disabilities have in their community life is their virtual denial of the opportunity to become leaders. Participants indicated that the chieftaincy institution completely bars persons with disabilities from becoming chiefs, simply because persons with disabilities are perceived to be feeble or cursed. As if that was not enough, society, as Kwasi expressed, tends to extend the taboo that bars persons with disabilities from becoming chiefs to all other forms of leadership. This is a very important finding of the present study. As at the time of this research, no person with disability had served as a member of parliament, a district chief executive, or a minister, even though the constitution of Ghana mandates equal rights for all citizens. This has had serious implications on the rights of persons with disabilities. Without representatives in government, the voices of persons with disabilities are rarely heard. This might be one of the main reasons why the rights of persons with disabilities have been suppressed for too long. Besides, the ability of persons with disabilities to contribute to decision making is highly limited since they are relegated to the background. As a result, all decisions affecting persons with disabilities are taken by other people, who may not fully appreciate their plights.

Bronfenbrenne and Morris (2006) assert that in the development process, the individual does not only interact with people; rather the developing person also interacts with objects within the physical environment. For the interaction between the individual and the physical environment to have positive impact, the objects in the environment should lend themselves for exploration and manipulation. In other words, the physical set-up in the home, the school, the workplace, public buildings, and the community at large should allow free movement in order to facilitate exploration. Unfortunately, as far as persons with disabilities, especially those with movement impairment, are concerned, the physical environment in these settings inhibit, instead of facilitating movement. This, coupled with the negative attitudes of other people towards persons with disabilities, have the potential of excluding them from the mainstream society.

At the mesosystem level, the bioecological theory postulates that smooth interactions among the microsystem environments in which an individual actively participates are required for the positive development of the individual. That is to say, there should be a smooth interaction between the family and the school, between the school and the workplace, between the family and the community, and so on. Sadly, these interactions are not very smooth in the case of persons with disabilities. For instance, the family which is supposed to prepare the child psychologically for school and provide the material needs for the child while in school hardly does so in the case of children with disabilities. The results of this study, as already indicated, show that parents hesitate to send their children with disabilities to school, either because they want to avert the social stigma attached to having a child with disability or because they perceive the child with disability as feeble and unproductive. Some parents also send their children with disabilities to school but fail to provide their needs adequately. In most cases, the school also sends signals of exclusion to persons with disabilities through inaccessible structures and negative attitudes of some students and teachers towards persons with disabilities. These factors discourage parents from sending their children with disabilities to school. Similarly, the interaction between the school and the workplace is not positive as far as persons with disabilities are concerned. The school, in most cases, fails to equip persons with disabilities for the job market. Many children with disabilities drop out of school due to physical and attitudinal barriers. This renders many persons with disabilities unemployable. A similar negative interaction is seen between the community and the family where negative societal attitudes, in some cases, cause parents to hide or neglect their children with disabilities. The interaction between the family and the workplace is also negative, in that the inability of persons with disabilities to get jobs after school discourages parents from educating their children with disabilities.

As already established, the features of the various settings within the microsystem are determined by the overarching structures at the macrosystem level. Any change in the macrosystem therefore has the potential of bringing profound changes in the microsystem. Supportive laws, policies, and programmes are therefore required to create the conducive environment for the inclusion of persons with disabilities in the mainstream Ghanaian society. Such laws, policies, and programmes should emphasize values such as inclusion, participation, social justice and empowerment. The ratification of international conventions on disability, and further enactment of the Persons with Disability Act, 2006, by the government of Ghana to provide for persons with disabilities is therefore commendable.

The Persons with Disability Act is a very important legislation because, in consonant with the ICF model and the social model, the Act seeks to remove physical and attitudinal barriers in the society in order to pave way for persons with disabilities to be mainstreamed into the society. Unfortunately, however, almost seven years after its enactment, the Act, with all its laudable provisions, is yet to see complete implementation. Laws and policies cannot lead to change unless they are backed by action. There is therefore the need for the government to allocate enough resources towards the implementation of the act in order to bring about the desired social change.

It can be inferred at this point that, persons with disabilities in Ghana are unable to participate actively in the mainstream society mainly due to unfavourable conditions in the family and the larger society. The unfavourable conditions result mainly from unsupportive socio-cultural ideologies, unfavourable government policies, and dysfunctional laws.

The results indicate, however, that all is not lost for persons with disabilities in Ghana. Participants indicated that many people in the country are becoming more accepting and more supportive of persons with disabilities in recent times due to public education and role modelling. There were substantial discourses that pointed to the fact that negative perceptions about disability, particularly, the supernatural interpretations of disability are fading out.

Concerning how to mainstream persons with disabilities into the Ghanaian society, participants suggested macrosystem level interventions that would be geared towards ideological and structural changes. On ideological changes, participants suggested public education to help disabuse people's minds of negative perceptions about disability. Structurally, participants' suggestions centred on laws and policies that would make public facilities accessible to persons with disabilities, as well as those that would give persons with disabilities the opportunity to influence decisions that affect them. Some participants also called on the government to come out with policies that would reserve some job positions in the public sector for qualified persons with disabilities. Participants, especially key informants, also called for full implementation of the Persons with Disability Act, 2006, which has the potential to address most of the challenges faced by persons with disabilities in Ghana.

5.2 Limitations of the Study

Even though the study provides useful insights into the phenomenon of disability in Ghana, it cannot be said to be without any limitations. First, the sample size was very small and participants were drawn from only one geographical area. Besides, only persons with physical disabilities were interviewed. The generalisability and applicability of the findings are therefore limited. The findings could possibly be different if a larger, all encompassing sample was used. Besides, the sample consisted of only adults. Their account of childhood experiences in the family and the school may, therefore, not reflect clearly the current situation of a children with disabilities. Moreover, the purpose of the study presupposed that persons with disabilities in the Ghanaian society faced social exclusion. This could have influenced my understanding and interpretation of data in one way or the other.

5.3 Strengths of the Study

In spite of the aforementioned weaknesses, the present study provides useful exploratory insights into the phenomenon of disability in Ghana. By exploring lived experiences of persons with disabilities, the study has highlighted some of the structural and contextual factors that tend to exclude persons with disabilities from the mainstream Ghanaian society. By including an expert of chieftaincy and culture, the study has thrown more light on some cultural factors that tend to perpetuate the discrimination and exclusion suffered by persons with disabilities in Ghana.

5.4 Implications and Recommendations

5.4.1 Community Psychological Interventions and Praxis

The central problem of concern to community psychologists is "oppression", and the central goals of community psychology are "to work in solidarity with disadvantaged people, and to accompany them in their quest for liberation and wellbeing" (Nelson & Prilleltensky, 2010, p. 26). According to Nelson and Prilleltensky, liberation of disadvantaged people begins with helping them to tell their stories so that the dominant cultural narratives that have been imposed on them can be challenged and alternative stories promoted. Through this study the stories of persons with disabilities in Ghana have been told. The study has revealed that persons with disabilities suffer stigmatisation, discrimination, deprivation, and exclusion, due to negative societal perceptions about disability. The next step for community psychologists is to partner with persons with disabilities and work towards their empowerment and inclusion in the mainstream society.

The core of oppression is power inequality experienced at multiple levels of analysis: personal, relational, and community (Nelson & Prilleltensky, 2010). Exclusion of persons with disabilities from the mainstream Ghanaian society, like any other form of oppression, can thus be conceptualized as occurring at these multiple levels. At the individual level, persons with disabilities internalise the societal perception that they are inferior. Feeling inferior, persons with disabilities find it difficult, if not impossible, to strive for equal opportunities with the able-bodied. "Social change often begins with disadvantaged people's awareness and understanding of the unjust psychological and socio-political circumstances oppressing them"(Nelson & Prilleltensky, 2010, p. 29). Interventions at the individual level should therefore focus on educating persons with disabilities on psychological and socio-political conditions that create shame and stigma. This will enable persons with disabilities to recover their positive identity. Thus empowered, persons with disabilities can stand up and fight for their rights.

"In relationships with others, disadvantaged people are often seen as inferior and are treated as such by people who have more power" (Nelson & Prilleltensky, 2010, p. 27). From the results of the present study, this is exactly what happens in the case of persons with disabilities. Due to negative perceptions about disability, especially the perceptions that persons with disabilities are cursed and/or unproductive, they are often seen as burdens on society and are treated as such. Persons with disabilities are hardly considered in education, employment, marriage, and leadership. This calls for vigorous public education geared towards changing perceptions about disability. Through community-based workshops, in collaboration with stakeholders such as social workers, non-governmental organisations, community-based organisations, social movement organisations, self-help groups, and disability organisations, people can be educated to understand the true nature of disability. The involvement of persons with disabilities in such educational campaigns should be taken seriously, considering the finding of the present study and similar studies that role modelling plays a major role in disabusing people's minds of the misconception that persons with disabilities have nothing to offer society. Community psychologists can also collaborate with the media to create awareness of the true nature of disability and the situation of persons with disabilities in the country. With adequate understanding of disability, people can disabuse their minds of negative perceptions about disability, and appreciate persons with disabilities as normal human beings who, given the necessary support, are capable of living normal life.

The dominant-subordinate relationships between the able-bodied and persons with disabilities are embedded in structural arrangements that are manifested in public policies and community settings. At the collective level, community psychologists can lobby government institutions, such as the National Council on Persons with Disability, Ministry of Employment and Social Welfare, and the Ghanaian Parliament to formulate and enforce programmes, policies, and legislations that will enhance the equity of persons with disabilities in order to include them in the mainstream society. Inclusive education should be one of the core issues here. This is because, as participants observed, frequent interactions with persons with disabilities has the possibility of changing people's perceptions about disability. Inclusive education, which brings together children with disabilities and able-bodied children in classrooms and dormitories, should therefore be emphasised. This is in view of the potential that frequent interaction in these educational settings might lead the able-bodied children to form positive perceptions about disability and, hence, positive attitudes towards persons with disabilities. The Persons with Disability Act, 2006 promises to ensure the equity of persons with disabilities in Ghana. Community psychologists should therefore collaborate with other stakeholder and lobby for the passage of the legislative instrument that is required for the full implementation of the Act.

Community psychologists could also collaborate with other stakeholders, and lobby for policies that will give more persons with disabilities the opportunity to hold leadership positions in government and in their communities. Appointment of persons with disabilities for public offices will pave the way for the inclusion of person with disabilities in the mainstream society. Persons with disabilities in public positions will not only serve as the mouthpiece for persons with disabilities, but will also serve as role models for all persons with disabilities to strive for higher feats.

Advocating for persons with disabilities to become leaders might seem insurmountable, especially in the context of the chieftaincy institution. However, a spectacular event happened in the history of Ghana few months after my data collection that can be a source of inspiration. The president of the Republic of Ghana appointed one Dr Henry Seidu Daanaa, a visually impaired lawyer, to be the Minister for Chieftaincy and Traditional Affairs (Chronicle, 2013). What makes this appointment even more remarkable is the ministry that Dr Danaa was appointed to head. The Minister for Chieftaincy and Traditional Affairs deals directly with the chiefs of the land who, according to the participant who served as expert of chieftaincy and culture, are unlikely to communicate *"one-on-one with a person with disability"*.

As one would expect, some chiefs initially raised objection to the appointment of Dr Danaa, simply because of his impairment (Chronicle, 2013). However, the leadership of the National House of Chiefs[10] came out after a few days to endorse the nomination of Dr Danaa, and promised to work hand in hand with him (Graphic Online, 2013). This is a great sign of hope that, sooner or later, persons with disabilities can take their rightful place in the Ghanaian society. Community psychologists should therefore take advantage of this favourable environment and partner with persons with disabilities to work towards their empowerment and liberation.

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[10] National House of Chiefs: The paramount chiefs in each of the ten regions of Ghana constitute a council called the Regional House of Chiefs. The National House of Chiefs is composed of five chiefs from each Region of Ghana elected by the House of Chiefs of the Region.

5.4.2 Research on the Phenomenon of Disability

By exploring the lived experiences of persons with physical disabilities, the present study has illuminated some attitudinal and physical barriers that militate against persons with disabilities in their quest to participate in the Ghanaian society. In order to get a more holistic picture of the phenomenon, future studies should consider broader samples, including persons with different kinds of disabilities. Probably the experiences of persons with other forms of disabilities differ from those of persons with physical disabilities presented in the present research. Future studies should also include more persons without disabilities including students, teachers, employers, policy makers, and community leaders, in order to broaden our knowledge about societal perceptions about disability. Moreover, future studies should be conducted in different geographical settings. Findings from such studies might indicate that the situations of persons with disabilities in Ghana differ from one geographical location to another. Finally, future studies should begin without a preconceived idea that persons with disabilities in Ghana suffer social exclusion. Perhaps a more positive picture about experiences of persons with disabilities will emerge from such studies.

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APPENDICES

Appendix I

Interview Guide for Primary Participants

General Questions

1. What do you understand by disability?
2. Are there different kinds of disability?
3. If yes to (2) above, can you name some of them?

Microsystem Level

1. How would you describe the situation of persons with disability in the country?
2. Is there any difference between how families treat children with disabilities and those without disabilities?
3. Are disabled children in the country usually sent to school?
4. If no to (3), why?
5. If yes to (3), do they face any challenges in school as compared to non-disabled students?
6. In your opinion, are children with disabilities supposed to be sent to school? Why/why not?
7. Do persons with disability face any challenge in establishing social relations as compared to persons without disabilities?
8. Do persons with disability face any challenge in securing and/or sustaining a marriage relationship as compared to non-disabled persons?
9. Do you know any disabled person in the country who is a leader?
10. Do you think that disabled persons can make good leaders? Why/why not?
11. Do persons with disability in the country work?
12. If yes to (11), what kind of work do they normally do?

13. If no to (11), how do they survive?

Macrosystem Level

1. What causes do people in the country attribute to disability?
2. Do people attribute different causes to different disabilities?
3. Do you think that people's perception about how disability is caused has any influence on how persons with disabilities are treated?
4. If yes to (3), how and why?

Mesosystem Level

1. Do parents and relatives of disabled persons face any challenge in the society?
2. If yes to (1), how and why?
3. If yes to (1) above, how does this affect the treatment of the disabled person in the home?

Suggestions from participants

1. What is your own perception about the current situation of disabled persons in the country?
2. Do you think that something should be done about the current state of disabled persons in the country?
3. If yes to (2) above, what do you suggest should be done?
4. Is there anything else we have not spoken of that you would like to emphasise with regard to this topic?

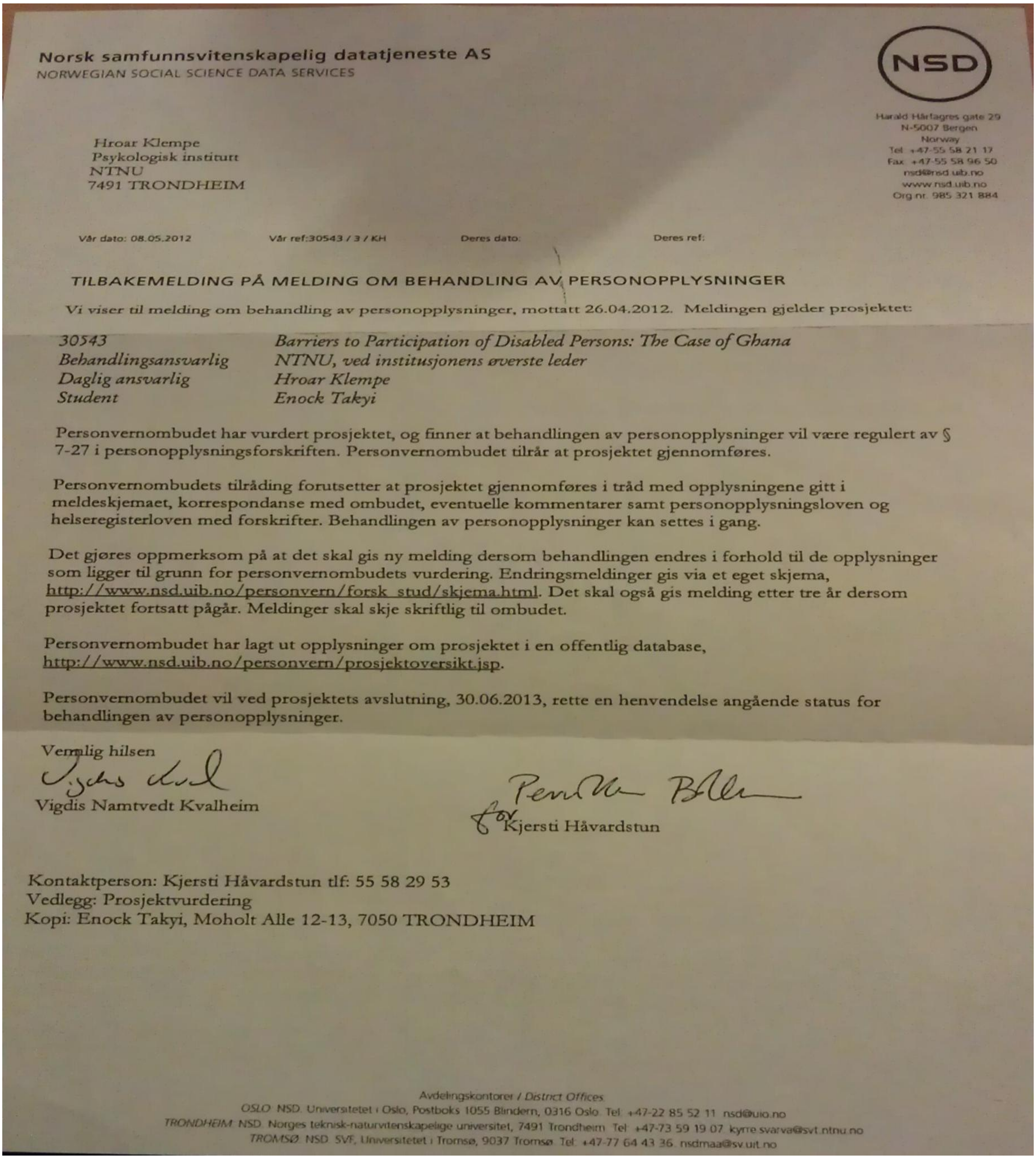
Appendix II

Interview Guide for Key Informants

1. How would you describe the current situation of persons with disability in the country?
2. What would you say about the Persons with Disability Act; has it made any impact?
3. Do you find any loopholes in the provisions of the act?
4. What about its implementation; are there challenges?
5. If yes to (4) above, what are some of the major challenges and how is your outfit dealing with them?
6. How do the attitudes of people towards disability affect the current state of disabled persons in the country?
7. Do you have any suggestions as to how the issue of disability should be addressed in order to yield the desired results?

Appendix III

Ethical Clearance Letter from NSD



Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

NSD

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel +47-55 58 21 17
Fax +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Hroar Klempe
Psykologisk institutt
NTNU
7491 TRONDHEIM

Vår dato: 08.05.2012 Vår ref:30543 / 3 / KH Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 26.04.2012. Meldingen gjelder prosjektet:

30543	*Barriers to Participation of Disabled Persons: The Case of Ghana*
Behandlingsansvarlig	*NTNU, ved institusjonens øverste leder*
Daglig ansvarlig	*Hroar Klempe*
Student	*Enock Takyi*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, eventuelle kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/forsk_stud/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://www.nsd.uib.no/personvern/prosjektoversikt.jsp.

Personvernombudet vil ved prosjektets avslutning, 30.06.2013, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Vigdis Namtvedt Kvalheim

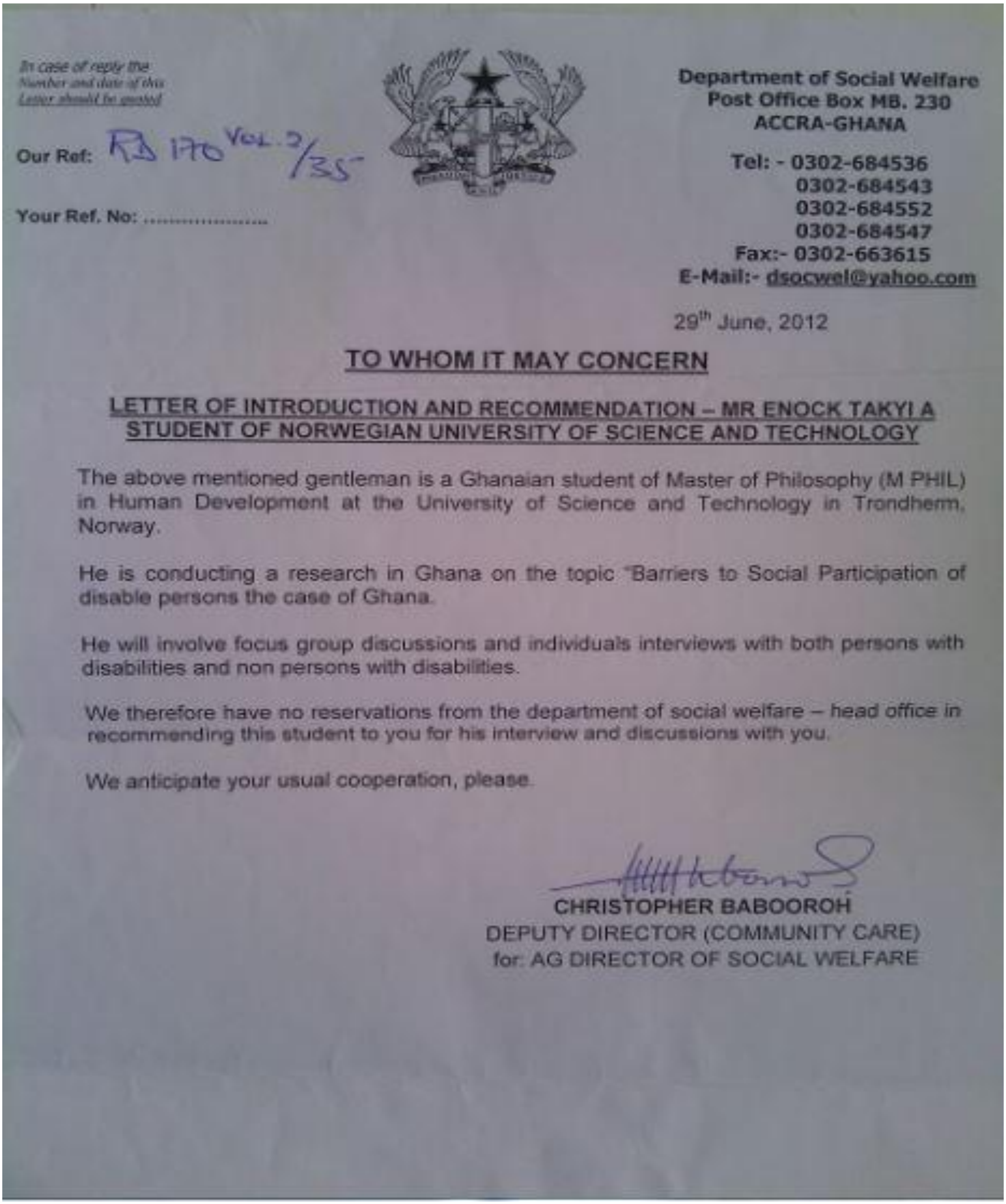
for Kjersti Håvardstun

Kontaktperson: Kjersti Håvardstun tlf: 55 58 29 53
Vedlegg: Prosjektvurdering
Kopi: Enock Takyi, Moholt Alle 12-13, 7050 TRONDHEIM

Avdelingskontorer / *District Offices*
OSLO: NSD. Universitetet i Oslo, Postboks 1055 Blindern, 0316 Oslo. Tel: +47-22 85 52 11. nsd@uio.no
TRONDHEIM: NSD. Norges teknisk-naturvitenskapelige universitet, 7491 Trondheim. Tel: +47-73 59 19 07. kyrre.svarva@svt.ntnu.no
TROMSØ: NSD. SVF, Universitetet i Tromsø, 9037 Tromsø. Tel: +47-77 64 43 36. nsdmaa@sv.uit.no

Appendix IV

Introductory Letter from Department of Social Welfare, Ghana



In case of reply the
Number and date of this
Letter should be quoted

Department of Social Welfare
Post Office Box MB. 230
ACCRA-GHANA

Tel: - 0302-684536
0302-684543
0302-684552
0302-684547
Fax:- 0302-663615
E-Mail:- dsocwel@yahoo.com

Our Ref: RD 170 Vol. 2/35

Your Ref. No: ....

29th June, 2012

TO WHOM IT MAY CONCERN

LETTER OF INTRODUCTION AND RECOMMENDATION – MR ENOCK TAKYI A STUDENT OF NORWEGIAN UNIVERSITY OF SCIENCE AND TECHNOLOGY

The above mentioned gentleman is a Ghanaian student of Master of Philosophy (M PHIL) in Human Development at the University of Science and Technology in Trondherm, Norway.

He is conducting a research in Ghana on the topic "Barriers to Social Participation of disable persons the case of Ghana.

He will involve focus group discussions and individuals interviews with both persons with disabilities and non persons with disabilities.

We therefore have no reservations from the department of social welfare – head office in recommending this student to you for his interview and discussions with you.

We anticipate your usual cooperation, please.

CHRISTOPHER BABOOROH
DEPUTY DIRECTOR (COMMUNITY CARE)
for: AG DIRECTOR OF SOCIAL WELFARE

Appendix V

Informed Consent Form

INFORMATION

My name is Enock Takyi, a Student of Master of Philosophy (MPhil) in Human Development at the Norwegian University of Science and Technology (NTNU), Trondheim, Norway. As part of my studies, I am conducting a research in Ghana on the topic “Barriers to Social Participation of Disabled Persons: The Case of Ghana.” The study will involve focus group discussions and individual interviews with both disabled persons and non-disabled persons. Key informants from the Department of Social Welfare (DSW) and the National Council on Persons with Disability will also be interviewed. Approval for the study has been obtained from the Data Protection Official for Research at Norwegian Social Science Data Services in Norway, as well as the Ethical Board in Ghana. The discussions and interviews would be audio recorded so that responses can accurately be documented. This would enable the researcher to review the topics and responses later for purposes of analysis.

BENEFITS

This study is significant in that the findings will help provide a better understanding of the situation of disabled persons in Ghana.

CONFIDENTIALITY

Information about participants will be kept strictly confidential. In reporting the study, no participant will be identified by his/her name; neither will the report include any postal or residential address. The tapes will always be kept in a safe place by the researcher and will never be given out to anyone for any reason. Under no circumstance will any person, apart from the researcher and his supervisor, have access to the tapes or any other information about the participants. The information will be destroyed when the entire research is over in August 2012.

PARTICIPATION

Participation is strictly voluntary. Participants have the right to decline answering any question(s) they feel uncomfortable with. Participants can also withdraw their participation at any time if they do not want to continue without giving any reason.

CONTACT

If you have any further questions or concerns, please contact me at ekt1082@yahoo.co.uk or enockt@stud.ntnu.no or by telephone on 0570322082. You can also contact my supervisor, Prof. Sven Hroar Klempe at hroar.klempe@svt.ntnu.no

____________________________ ______________

Signature of Researcher (Date)

(Enock Takyi)

Consent of Informant

I certify that the purpose of the study has been thoroughly explained to me in a language I understand to my satisfaction. The informed consent, of which I have been given a copy, has also been explained vividly to me. I understand that any information provided by me for this study will be kept strictly confidential. I understand that participation is voluntary and that I have the right to withdraw at any time in the process without giving any explanation. I agree to participate in this study.

__________________________________ ______________

Signature/Mark (Date)

(Informant)