Disability and Poverty: The plight of children with disabilities in Ghana

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Abstract

This dissertation set out to understand the impact of poverty on the lives of children with disability and their families. Specifically, it sought to assess access to education and healthcare for children with disabilities as well as to identify interventions for disabled persons and how these have contributed to improving the quality of lives of persons with disabilities. The study adopted Ghana as its case study and employed the use of existing data for its assessment and analysis. Journal articles, government reports, newspaper articles and other grey literature were reviewed for the purpose of this study. The study found that despite significant progress in securing general access to primary healthcare through the national health insurance scheme, persons with disabilities still struggled to access healthcare due to poverty, inability to pay insurance premium, distance and unfriendly infrastructure at healthcare centres for the disabled. Similarly, in education, there has been major improvement in access to education through the free compulsory universal basic education FCUBE policy and the free senior high school policy. Progress on access to education has been modest at best for children with disabilities due to unsuitable infrastructure, negative attitudes from school authorities and fellow students as well as distance to schools. Interventions identified that have helped reduce poverty among the disabled include the Disability Common Fund, the Livelihood Empowerment Against Poverty cash-transfer programme, and the community-based rehabilitation programme among others. Recommendations advanced in this dissertation to help reduce poverty and improve the quality of life of children with disabilities include, increase the allocation of the disability common fund, training and sensitization for healthcare workers and school authorities on serving the disabled as well as establishing a credible national database on persons with disabilities.

Table of Contents

List of Figures

List of Tables

List of Acronyms

ACRWC	African Charter on the Rights and Welfare of the Child
CwD	Children with Disabilities
CBRP	Community Based Rehabilitation Program
CRPD	Convention on the Rights of Persons with Disability
CHIPs	Community-based Health Planning and Services Centres
CRP	Community-based Rehabilitation Programme
CSOs	Civil Society Organizations
DCF	Disability Common Fund
DDT	Dichlorodiphenyltrichloroethane
DSW	Department of Social Welfare
ESP	Education Strategic Plan
FCUBE	Free Compulsory Universal Basic Education
GES	Ghana Education Service
GHS	Ghana Health Service
GLSS	Ghana Living Standards Survey
GSS	Ghana Statistical Service
GMDC	Ghana Medical and Dental Council
ICT	Information and Communication Technology
ILO	International Labour Organization
LEAP	Livelihood Empowerment Against Poverty
LESDEP	Local Enterprises and Skills Development Programme
MDGs	Millennium Development Goals
MOH	Ministry of Health
NCPD	National Council on Persons with Disabilities
NDPC	National Development Planning Commission
NHIS	National Health Insurance Scheme
NAD	Norwegian Association of the Disabled
OECD	Organization for Economic Co-operation and Development
PCBs	Polychlorinated Biphenyls
PwD	Persons with Disabilities
SAP	Structural Adjustment Programme

SDGs   Sustainable Development Goals

SHIA   Swedish Organizations of Disabled Persons International Aid Association

UNICEF   United Nations Children's Fund

UNESCO   United Nations Educational Scientific and Cultural Organization

UNDP   United Nations Development Programme

WHO   World Health Organization

1. Chapter One – Introduction

1.1 Introduction

'Two paddles one leg' is a story of a Ghanaian man with a physical disability, Emmanuel Ofosu Yeboah, who became a national hero in 2001 (Wilkens, 2015). Born with a missing right tibia (shin bone), Emmanuel was abandoned by his father due to the stigma and shame he encountered from family members and society, leaving him alone in the care of a single mother. Yeboah and his mother lived in a tiny room in Koforidua in the Eastern region of Ghana, where she sold vegetables in the market to help support their needs (Ibid). Though Yeboah was eligible for free public education as a Ghanaian, the closest school to him was about two miles away, and his mother struggled to be consistent in taking him to school. During his brief period in school, he was teased, bullied and prevented from taking part in co-curriculum activities as the only student with a disability.

At the age of 13, Emmanuel moved to Accra, the capital city of Ghana, where he worked as a shoeshine boy on the streets together with other children with disabilities who were already begging on the streets of Accra (Agyemang, 2014). His life changing moment came when through commitment and dedication, he decided to cycle across the country to raise awareness for himself and his colleagues. With only one functional leg, he cycled from the north to south of the country in a red shirt with the inscription 'pozo' on it. Pozo is a Ghanaian slang for a person with a leg impairment (Ibid). Throughout his 380km journey across the country, he stopped along the way in villages to give his speech to anybody who would listen, including market women and government officials, to raise awareness on the sufferings and plight of persons with disabilities. He spoke confidently against government policies on persons with disabilities (PwDs) and requested that PwDs should be given the same respect as the able-bodied.

Yeboah was propelled to global fame as a result of his journey. In 2005, he was the subject of a documentary titled "Emmanuel's Gift" and he was also a guest of the popular Oprah Winfrey show. He met with former United Nation's Secretary General Kofi Annan as well as United States President George W. Bush at the White House (Agyemang, 2014). In 2006, the government of Ghana also passed the Persons with Disability Act, 2006, (Act 715) to secure the rights of the disabled and Emmanuel's advocacy played an influential role in this (Ibid). Building on the success of his journey, Emmanuel declared his dream of building an academic and sports school for children with disabilities, and the government of Ghana, in recognition of his efforts, offered him a parcel of land for the project. He is currently in the process of raising $5 million for the project (Wilkens, 2015). Emmanuel's story is both inspiring and compelling. It presents a very strong narrative about the capabilities of persons with disabilities, and raises concerns about the need to protect and support all persons in such conditions to be able to pursue and attain their capabilities.

Disability is an enduring part of the human existence and persons with disabilities have always been part of society from time in memorial. According to the World Health Organization (2011), almost all human beings will at some point in their lives experience a personal disability, be it mental, physical or any other form. In fact, it is estimated that not less than 10% of the global population are impaired in one form or another, and this includes children (UNICEF, 2007). The reality is that these numbers are far from accurate, as the births of many children with disabilities are not recorded in most parts of the world

due to cultural and religious beliefs around disability that influence negative attitudes and behaviours towards persons with disabilities.

The reality is that persons with disabilities experience significant social challenges that compounds their disability situation. To begin with, having a disability affects a person's access to education and employment opportunities, and even for the few that get access, their experiences are unpleasant due to negative attitudes and behaviours towards them (Opoku et al, 2018). Given the general struggles of persons with disabilities around the world, Emmanuel's story has indeed motivated the researcher to understand the plight of children with disabilities (CwDs) from underprivileged and poor backgrounds, and how they cope in different spheres of life. Specifically, it seeks to focus on the nexus between poverty and disability and how poverty impacts the livelihoods of persons with disabilities.

1.2 Problem statement

According to the World Report on Disability (2011), people with disabilities are disproportionately more likely to experience poverty, and being in that situation in most cases creates a vicious cycle of poverty. On average persons with disabilities are significantly poorer than persons without disabilities. This is partly as a result of the difficulty in accessing educational and employment opportunities for persons with disabilities and partly due to its impact on the lives of the families of persons with disabilities. According to UNICEF (2007), a lot of persons with disabilities are unemployed and have to depend on employed family members without disabilities to take care of them. This significantly lowers family income as the persons with disability could have also been employed and earning enough to improve the income of the family. In fact, in some situations, able bodied family members have to quit their jobs to help take care of their disabled relatives. In situations where persons with disabilities are fortunate to be employed, they are likely to be engaged in low paying jobs due to their low level of skills or merely due to discrimination (Ibid). For persons with disabilities, accessing education for the purpose of acquiring employable skills for social mobility remains a strong challenge. In fact, UNICEF (2013) holds that globally, only 10% of children with disabilities get access to education, and more disturbingly, only half of them get to complete school successfully. The question then is, with this difficulty in accessing education, how are persons with disabilities supposed to undergo education and equip themselves with the skills needed in the employment market? Moreover, given the challenges in accessing employment even for skilled PwDs, how are they supposed to earn enough money to support themselves financially and not be a 'burden' to other family members.

The Africa Report on Children with Disabilities (2014, p.26) contends that, disability "among children living in poverty often reflects the failure of the state to meet its obligation to provide maternal health services for women during pregnancy and basic health services for children in early childhood." This raises a curious concern about the impact of poverty on disability and vice versa. From the above, the inability of poor women to access quality maternal health services potentially results in the birth of children with disabilities. "In many African cities, urban slum dwellers come in contact with stockpiles of obsolete pesticides such as Polychlorinated Biphenyls (PCBs), dioxins, and Dichlorodiphenyltrichloroethane (DDT) and e-waste that contaminate soil and water, causing reproductive and developmental disorders and damaging the nervous systems and

causing impairments" (ACPF, 2014, p.26). Thus, without access to good quality healthcare, children are more likely to develop a disability during their infancy. Thus, for the poor, the risk of getting a disability is high. At the same time, children with disabilities experience significant difficulties in accessing quality education, and as adults, they may also experience challenges accessing high paying jobs, thus ensuring their continuous poverty and creating a difficult situation as a result.

The relationship between poverty and disability is seen as a vicious cycle. In his analysis, Elwann, (1999) ascertained that higher rates of persons with disabilities in the developing countries are associated with factors such as higher illiteracy, poor nutritional status, lower inoculation and immunization coverage, lower birth weight, higher unemployment and underemployment rates, and lower occupational mobility. The report further acknowledged that lack and inappropriate health care can exacerbate disease outcome and a remedial impairment can become a permanent disability (Elwann, 1999). Poverty affect disability so strongly that the World Bank in their estimation said about 50 percent of disabilities are preventable which are directly related to poverty. Consequently, if they are left unaddressed, they generate social exclusion and stigma, which, in turn, generates another series of social disabilities and based on this, their access to education, work and health care becomes limited (Guernsey et al., 2006).

This far, what is clear is that disability significantly impacts access to health, education and employment, especially for the poor. Given this reality, persons with disability are more likely to be poor and their families are also more likely to have lower family income and wealth as a result. This vicious cycle is almost everywhere and significantly worse in developing countries. The case of Emmanuel Yeboah discussed in the introduction may be different, but even for him, he had to work for years as a shoeshine boy in Accra together with many other children with disabilities begging on the streets just to earn a living (Opoku et al, 2018). Focusing specifically on children, this study concerns itself with the impact of poverty on disability and vice versa. In particular, it looks at how children with disability access education and health. Situated in Ghana, the home country of the researcher and Emmanuel Yeboah, the study employs the use of secondary data for its analysis and discussions.

1.3 Research Aim and Questions

The main aim of this research is to assess the impact of poverty on the lives of children with disability and their families or caretakers. The research questions to guide the study in pursuing its aim are as follows:

1. How does poverty impact access to and quality of education for children with disabilities?
2. What is the impact of poverty on the health and health-seeking behaviours of children with disabilities?
3. What interventions exist for the disabled and how have these helped improve the well-being of children with disabilities?

Broadly, these questions will assist the researcher in conducting this case study within the framework of Ghana. The first research question focuses more on access to education for children with disabilities and poverty and the disability condition intersect to have

implications on this. The second question on health will also help explore dimensions of health as well as health-seeking behaviours of children with disabilities. Health-seeking behaviour is conceptualized in this study as actions taken by persons with disabilities to address their health needs. The third research question will guide the researcher in identifying interventions that have contributed to reducing the impact of poverty on persons with disabilities, the challenges faced by initiatives and how they can be improved.

1.4 rationale of the Study

Economic needs are very essential for every human for survival. Although basic needs are constructed as general, Wetherely (1996) argued that their satisfaction is very often relative across cultures depending on the available welfare resources in a given society as well as on the socially constructed nature of basic needs in different societies. This is in relation to the disabled and their access to quality health, education and employment. While disabled people in many Western societies are often concerned about equality and anti-discrimination legislation, disabled people in developing countries like Ghana are mainly calling for meeting their survival needs in context of widespread poverty (Opoku et al 2018). Also, many disabled children are subordinated and discriminated against in their social environment. Therefore, the researcher is concerned with understanding the situation regarding access to health and education for children with disabilities as well as access to employment for persons with disabilities. The researcher also will investigate and evaluate the impact and implementation of policies on disability in Ghana.

1.5 Outline of the Thesis

This dissertation is organized into five main chapters as follows:

Chapter 1 provided an introduction to the thesis by looking at the background of the study, statement of research problem, aims and questions, as well as the rationale for this study.

Chapter 2 focuses on Ghana, the country within which the study is situated. It outlines the cultural and religious believes on persons with disabilities, and examines the national and international laws in relation to people with disability. In sum, this chapter situates the study properly within the context of Ghana.

Chapter 3 presents the concepts, theoretical frameworks and methodology for the study. It covers the sources from which information was obtained for the study and the methods for analysis. It also presents the concepts and theoretical framework for the study.

Chapter 4 presents the findings and discussions based on the research aim and questions outlined in the first chapter.

Chapter 5 summarizes this dissertation and provides concluding remarks. It presents a summary of the findings of the research, limitations of the study as well as recommendations for policy and further research.

2. Chapter Two – The Ghanaian Context

2.1 Introduction

The first chapter discussed the background to this study, presented the research problem and highlighted the research questions that will guide this case-study. This chapter presents the context within which this study is situated, Ghana. The main aim of this case-study is to assess the impact of poverty on the lives of children with disabilities in Ghana. Specifically, the study focuses on access to education and healthcare services for children with disabilities, as well as different interventions that have been rolled out to help reduce the impacts of poverty on the lives of persons with disabilities.

This chapter provides an overview of the case-study context in Ghana. It presents information on the political and economic situation in the country before proceeding to discuss disability and poverty in Ghana. It provides an overview of statistics on persons with disabilities in Ghana including statistics on prevalence. It also provides details on poverty, both monetary and multidimensional poverty, among children in Ghana. This is to paint a better picture of the poverty situation in the country and how this potentially impacts the lives of children with disabilities.

The chapter also discusses the national legal framework on disability including policies and national institutions with mandates for enforcement and implementation. The international conventions discussed include the United Nations Conventions on the Rights of the Child UNCRC (1989), African Charter on the Rights and Welfare of Children ACRWC (1990) and the United Nations Convention on the Rights of Persons with Disabilities. Among the laws discussed are the Disability Act (2006), Children's Act (1998), and the National Health Insurance Act (2012).

Cultural and religious beliefs around disability are also discussed in this chapter together with their impact on the attitudes and behaviours of people in society. This is because Ghana is a multi-ethnic country and multi-religious country. As such, ethnic and religious believes are widespread in Ghanaian societies and influence how people treat and relate to persons with disabilities including children. Such influences of culture and religion may impact service delivery by professionals in the education and healthcare sector. This makes it important to consider the ethnic and religious context of the case-study country.

2.2 Ghana – Overview of Governance and Economy

Ghana is situated between Cote d'Ivoire and Togo along the coast of West Africa. As the first sub-Saharan African country to gain independence in 1957, Ghana inherited the British parliamentary system of government and a liberal democratic constitution that provided for a parliament, an independent judiciary, and guaranteed multi-party elections (Ninson, 1993). In April 1960, after a nationwide referendum, the country adopted a new constitution that provided for a presidential system of government. This ushered in Ghana's first republic with Kwame Nkrumah as the first president. The first republic was however short-lived. On February 24th, 1966, the National Liberation Council (NLC), led by General Afrifa and E. K. Kotoka overthrew the Nkrumah government and the constitution while Nkrumah was in China on his way to Vietnam (Essuman-Johnson, 1993).

The NLC was in power for less than three years, during which time they made arrangements for a new constitution to transition the country into the second republic. In August 1969, the NLC handed over the reins of power to the Progress Party (PP) led by Kofi Abrefa Busia after relatively stable elections (Essuman-Johnson, 1993). Again, just like the first republic, the government of the second republic did not serve their full term in office. Lt-Col I.K. Acheampong and his National Redemption Council (NRC) overthrew Busia's PP government in a coup on 13th January 1972, marking the end of the second republic. The NRC changed its name to the Supreme Military Council (SMC I) in 1975, and in July 1978, Lt-Col I.K. Acheampong was ousted in a palace coup and the SMC I was replaced by the SMC II under the leadership of Lt-Gen F.W.K. Akuffo. On June 4th, 1979, the Armed Forces Revolutionary Council (AFRC) led by the young Flt-Lt JJ Rawlings displaced the SMC II in a coup, stayed in power for three months, and handed over power to the Peoples National Party (PNP) led by Dr. Hilla Limann after a successful election was conducted under a new constitution in September 1979. This marked the beginning of Ghana's third republic (Ninson, 1993).

On 31st December 1981, history repeated itself when Flt-Lt JJ Rawlings led a coup that overthrew the Limann administration and the third republic, ushering in authoritarian rule, under the Provisional National Defense Council (PNDC) that persisted until 1992. The first three republics of the country had all been short-lived and no democratically elected president in the first three republics saw the end of their constitutional term in office. Thus, for the first three decades after independence, Ghana's political history was mainly one of political instability (Abdulai & Hickey, 2014).

Though the country experienced significant political turmoil and economic hardships between the 70's and the 80's, its economy eventually stabilized with the introduction of the World Bank's Structural Adjustment Policies (SAP) in the 80's (Meredith, 2005). The country runs a hybrid system of government with an executive president, a parliament from which cabinet ministers are selected, and an independent judiciary. The country has a vibrant free press, and also boasts of a very active civil society. The 1992 constitution ushered in the fourth republic, and multiparty democracy has since flourished. The projected estimate of Ghana's population based on the 2010 population and housing census is 29 million (World Bank, 2020). The Ghana Living Standards Survey Round 7 which was conducted in 2017 however puts the population at 28.4 million (GSS, 2017). The fourth republic, which was ushered in by Ghana's 1992 Constitution, also brought some stability within the political and governance environment. With the onset of the fourth republic, many legislations have been enacted with the aim to safeguard and protect marginalized groups, including persons with disabilities. The laws specific to disability will be discussed later in the chapter.

Ghana's economy is one of the most stable in west Africa. Over the past two decades, the economy has seen steady economic growth. This is partly as a result of the discovery of oil in Ghana in 2007 which helped elevate the country to middle-income status with growth rates averaging between 3% to 8% ever since (World Bank, 2020). In 2019 alone, Ghana's economy grew at 6.5%, with significant contributions from the mining, oil, services, real estates and agricultural sectors (Ibid). The agricultural sector alone employs about 50% of the population both directly and indirectly. The main areas of export that contribute to government revenue are gold, cocoa, oil and bauxite among other minerals and cash crops.

General employment within the country has also been stable over the years. This is in spite of the fact that the country has a large inactive population, some of whom are persons

with disabilities. Inactive population here is the section of the Ghanaian population who are not actively employed, and cannot work for reasons such as disability among others. According to the Ghana Living Standards Survey Round 7 (GSS, 2017), out of an estimated population of 28.4 million, the active work force stands at 12.9 million. 5 million, which is equivalent to 29.1 % of the population are inactive. Of the inactive population, 6.4% are persons with disability. This indicates that a large number of persons with disabilities in Ghana are inactive and unable to work to fend themselves. This has implications not just for them and their families, but also for the country, given that that government has to make provision for them through program and policy interventions.

Table 1 Inactive Population of Ghana and Reasons for Inactivity

Reason	Ghana			Urban			Rural		
	Male	Female	Both sexes	Male	Female	Both sexes	Male	Female	Both sexes
In school/training	59.2	40.8	49.0	64.4	43.7	52.6	52.8	36.7	44.2
Household duties	1.0	6.9	4.3	0.9	8.5	5.2	1.1	4.5	3.0
Too old/young	6.3	13.5	10.3	6.0	12.7	9.8	6.7	14.7	11.0
Disabled/unable to work/handicapped	6.4	6.9	6.7	5.5	6.7	6.2	7.5	7.3	7.4
Pensioner/retirement	4.2	2.5	3.3	6.6	3.6	4.9	1.3	0.9	1.1
Pregnancy	0.0	2.9	1.6	0.0	2.9	1.6	0.0	3.0	1.6
Off-season/awaiting the seasons work	0.4	0.2	0.3	0.3	0.1	0.2	0.5	0.2	0.4
Temporary layoff	0.9	0.6	0.7	0.5	0.4	0.5	1.4	0.9	1.1
No desire to work	2.8	1.8	2.3	3.4	2.0	2.6	2.2	1.5	1.8
Holiday	0.3	0.4	0.4	0.4	0.6	0.5	0.3	0.2	0.2
Engaged in own-use production work & not willing to change job*	14.0	11.4	12.6	6.3	4.4	5.2	23.6	21.4	22.4
Other	4.4	12.1	8.6	5.6	14.5	10.7	2.8	8.7	5.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Ghana Living Standards Survey Round 7 (GSS, 2017)

Table 1 contains the distribution of the inactive population across the sexes, as well as in urban and rural areas. It also captures the reasons for inactivity. The reason accounting for most of the inactive population is schooling or training. This accounts for 59.2% and includes mainly children because most children are in school. As earlier mentioned, disability accounts for 6.4%. Which essentially means that 6.4% of the 5 million inactive population in Ghana are persons with disabilities. This statistic helps highlight the point that persons with disabilities find it difficult getting employment in both the formal and informal sectors of the economy. This complicates their already fraught situation, and increases their vulnerability to the impacts of poverty.

2.2.1 Disability in Ghana

According to the 2010 population census in Ghana, about 3% of the general population have some form of disability or impairment (GSS, 2014). The data shows that about 17.8 percent of Persons with Disabilities in Ghana are between ages 0-14. The actual number may be higher than this because, as a result of the high stigma associated with disability

in most developing countries, parents and other family members may be reluctant to report that their child has a disability (Opoku et al, 2018). As a result of diagnosis and welfare systems in developed nations, the incentive to register a child's disability is higher in richer societies than in developing countries. This implies that the numbers may be higher than those officially registered.

Table 2 in this section captures the disability population in Ghana and the breakdown based on sex, type of disability and location in rural or urban areas. As depicted Table 2, there are more females with disabilities (3.1%) than males with disabilities (2.9%). There are also more persons with disabilities in rural areas than in urban areas. The data also shows that there are more people with visual impairments (40.1%) than in any other category of disability.

Table 2: Population of Persons with Disabilities in Ghana

Type	Total (N=24,658,823)			Male (N=12,024,845)			Female (N=12,633,978)		
	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
No disability	97	97.3	96.7	97.1	97.4	96.8	96.9	97.2	96.6
With a disability	3	2.7	3.3	2.9	2.6	3.2	3.1	2.8	3.4
Sight	40.1	40.8	39.5	38	38	37.9	42	43.2	40.9
Hearing	15	12.9	42.6	14.3	12.2	16	15.6	13.4	17.6
Speech	13.7	13.6	82.2	15.7	15.9	15.4	11.9	11.5	12.3
Physical	25.4	25.1	25.7	25.1	25.2	25	25.7	25.1	26.3
Intellectual	15.2	37.9	58.2	15.8	16.4	15.3	14.6	14.7	14.6
Emotional	18.6	19.5	17.7	49.3	19.6	17.9	18.4	19.4	17.6
Other	25.9	76.6	58.6	74.5	10.8	10.6	10.2	10.1	10.2

Source – Ghana Statistical Service 2014

2.2.2 Poverty in Ghana

There are many difference and conflicting definition of poverty. This difference according to Slim (1995) are as a result of indication of the obscurity of poverty. The challenges and difficulties in defining poverty is as a result of its elusiveness of the concept. Saunders (2004) has ascertained that poverty has been conflicting political agendas, ideologies and country specific contexts that have informed and guided the debates about finding a suitable definition and measurement of poverty. Therefore, the rising definition s of poverty have been a product of the interests championed by the defining groups. To this effect, by one measurement, a person would be described as poor and yet by another, he would be regarded as not poor, yet without a slightest change in his personal circumstances. The European Union in their attempt to define poverty emphasized that poverty involves Persons, families, and groups of persons whose resources (material, cultural, and social) are so limited as to exclude them from the minimum acceptable way of life in the Member State to which they belong (European Commission, 2007 P. 5). Though this definition did not cover all aspect of poverty, poverty in Ghana is more understood to be similar this.

Ghana is one of the few sub-Saharan African countries that has had a relatively impressive record in tackling poverty over the last three decades (World Bank, 2015). As the first country in sub-Saharan Africa to achieve the Millennium Development Goal 1 of halving

poverty by 2015, this success has come at the back of strong economic growth in the 90's and 2000's. According to the World Bank (2015), between 1991 and 2012, poverty levels in the country declined from 52.6% to 21.4%, almost halving poverty ahead of the MDG target year of 2015. With its relatively stable growth in recent years, the country appears to be on track in attaining target 1.2.1 of goal 1 of the Sustainable Development Goals of reducing to at least half, the proportion of the population living under the national poverty line.

Yet, despite all this progress, poverty remains widespread in the country especially in rural areas. According to Ghana Living Standards Survey (GLSS) Round 7 (2017) published by the Ghana Statistical Service (GSS), close to seven million people in Ghana are financially poor and survive on less than GHC 1, 314 per year, which on average is less than $1 a day. Unsurprisingly, majority of the poor are located in the rural areas according to the report (GSS, 2017).

Poverty among children is also prevalent in Ghana. A report on *Multidimensional Child Poverty in Ghana* published by the National Development Planning Commission in 2020 stated that 73.4% of children in Ghana were multidimensionally poor. This simply meant that 73.4% of children in Ghana were deprived in at least three of the following dimensions of wellbeing; nutrition, health, learning and development, child protection, water, sanitation, housing and information (NDPC, 2020). Only 2.5% of children in Ghana had no deprivation at all. 8.3% were also found to deprived in at least one dimension of well-being. These numbers are depicted in Figure 1.

Figure 1 Deprivation Headcount among Children

Total number of deprivations

Source: NDPC, based on MICS 6, (2016/17)
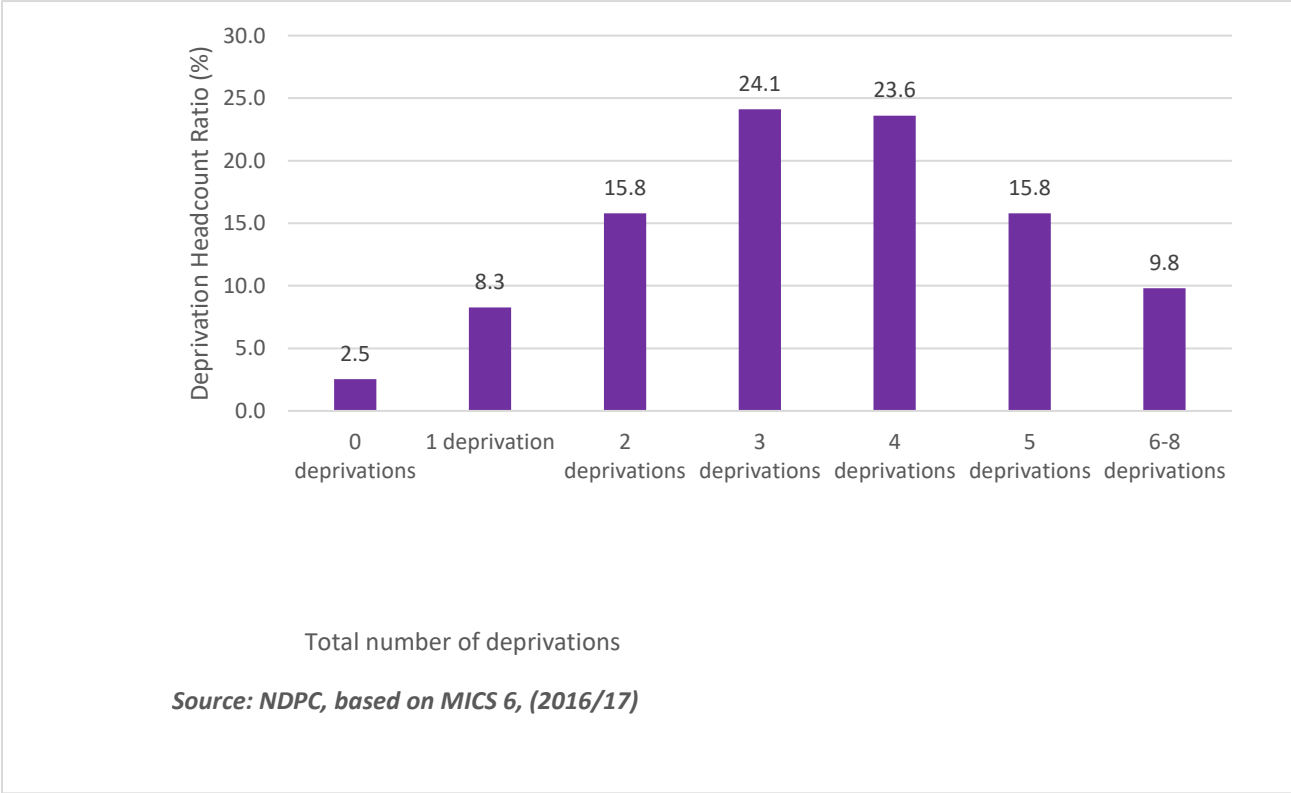
Source: Report on Multidimensional Poverty in Ghana NDPC (2020)

Figure 2: Dimensions of deprivation among children in Ghana
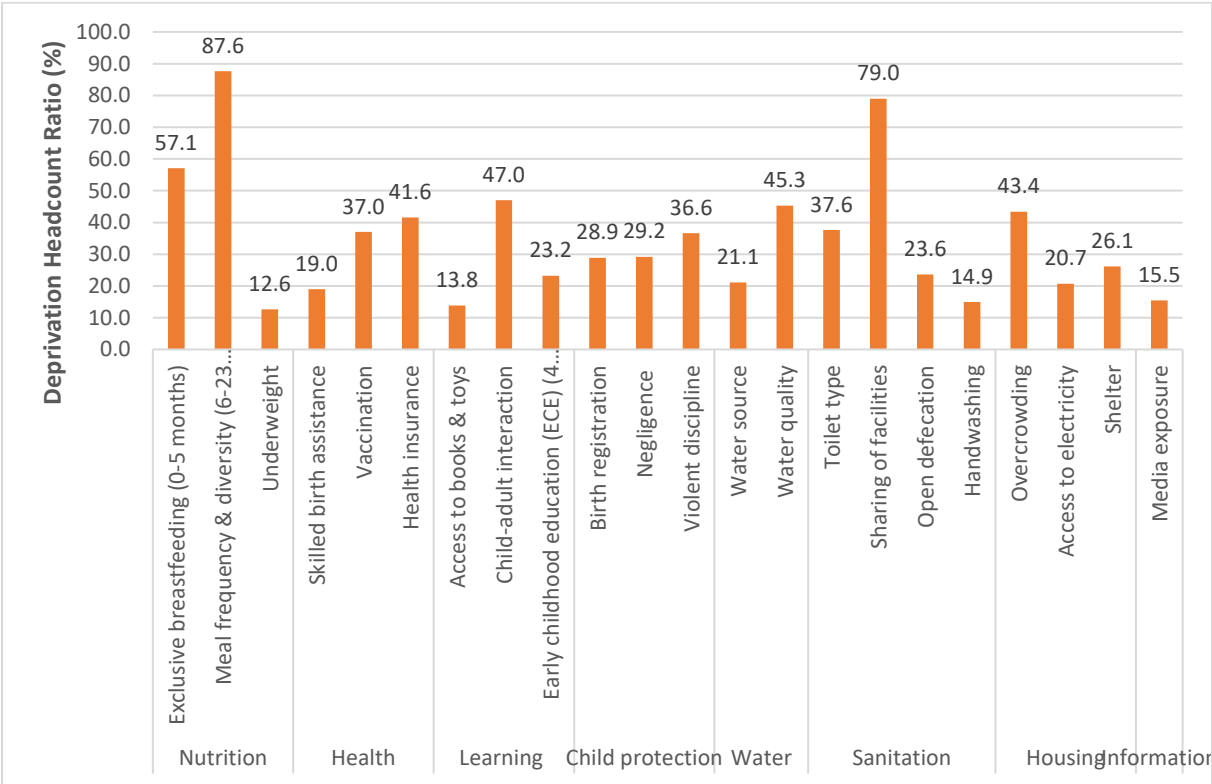
Source: Report on Multidimensional Poverty in Ghana NDPC (2020)

Dimensions of well-being such as nutrition and sanitation were the areas with the highest deprivations among children as depicted in Figure 2.

The Multidimensional Child Poverty in Ghana report also considered monetary poverty in its assessments using the national poverty line of GHC 1,314 (USD 220) per year. The findings showed that 23.4% of the national population were monetarily poor. The percentage for children is higher (28.2%), indicating that there are more children across the country living in households where the expenditure is less than GHC 1, 314 (USD 220) a year. Interestingly, a large majority of these children dwell in rural areas as indicated in Figure 3.

Figure 3 Children in Monetary Poor Households in Ghana
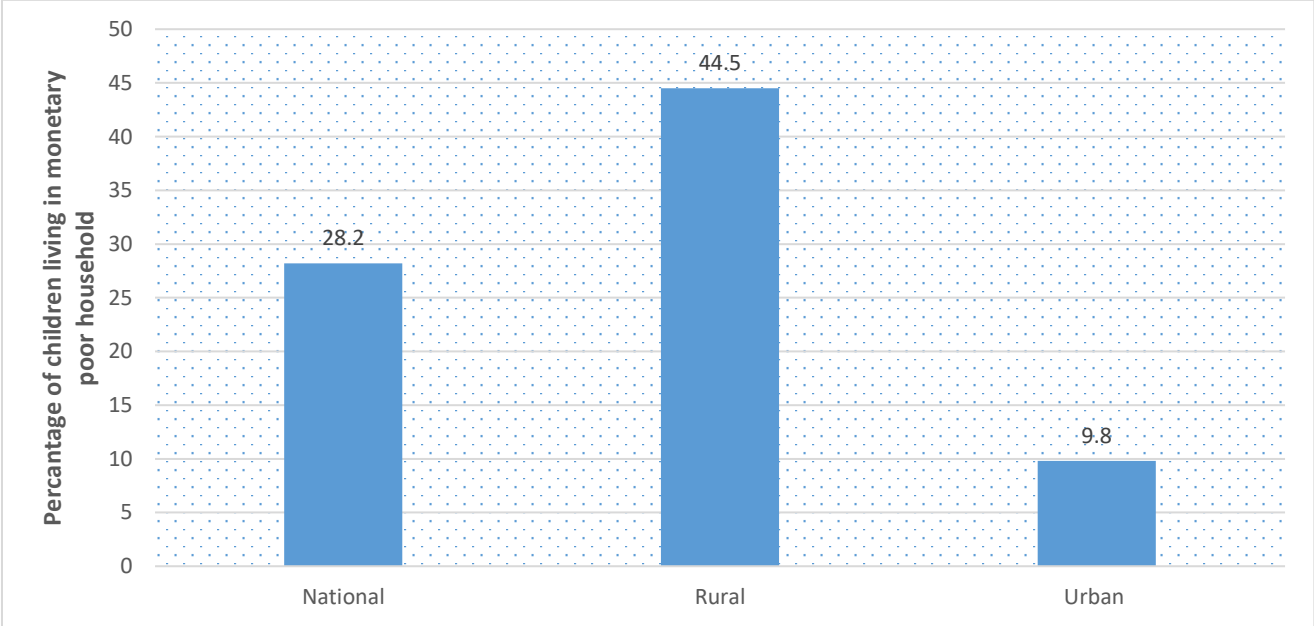
Source: Report on Multidimensional Poverty in Ghana NDPC (2020)

Persons with disabilities in Ghana are one of the subpopulation groups with high levels of poverty in the country. Though specific statistics on poverty among the disabled are rare, there are some studies such as Asuman et al (2020) that have established that the presence of a disabled person in household is likely to increase household expenditure by 26%. Given that many children with disabilities are unemployed, and therefore cannot

contribute to family income, household standards of living are likely to drop as a result of the increased expenditures (Ibid).

2.3 Cultural and Religious Beliefs on Disability

In many places around the world, persons with disabilities face challenges including physical and sexual abuse, stigmatization and discrimination among others. Often, such encounters have adverse effects that worsen the condition of the person, frustrates their access to decent employment and education, and generally makes live difficult. The way in which persons with disabilities are perceived and treated in society stems mostly from religion and culture. In Africa, many cultures are largely influenced by traditional religions and as a result cultural practices may be indistinguishable from religious ones. While some of these cultural and religious beliefs denigrates persons with disabilities, there are others that are empowering, and inspire admirable attitudes and behaviours towards them.

Nyangweso (2019, p.8) has advanced that in Tanzania and other African countries, it is believed that "albinos are cursed ghosts whose body parts can ward off bad luck and bring wealth and success." As a result, many persons with albinism have been killed in many African countries for ritual purposes including Ghana. In Ghana, religious, cultural and superstitious beliefs are common sources of explanations for the source or causes of disabilities, consequently influencing how disabled children are treated.

With about five main ethnic groups, the Ghanaian society remains ethnically and culturally diverse. Though the Akan ethnic group is the largest ethnic group, no single group dominates culturally, this is in spite of the fact that different cultures overlap. There is freedom of religious practice, but three main religions dominate in Ghana; Christianity, Islam and Traditional Religion. These three religions have had significant influences on the different ethnic groups and their cultural practices.

There are about eight main ethnic groups in Ghana; Akan, Mole-Dagbani, Ewe, Ga-Dangme, Gurma, Grusi, Mande and Guan. According to the 2010 population and housing census, the Akan ethnic group constitutes the largest ethnic group in the country with 47.3%. The Akan are followed by the Mole Dagbani (16.6%) and the Ewe (13.9%). Table 2 presents the regional breakdown of the different ethnic groups in the country.

Table 3 Ethnic Groups in Ghana by Region

Ethnic Group	Western	Central	Greater Accra	Volta	Eastern	Ashanti	Brong Ahafo	Northern	Upper East	Upper West
Akan	78.2	81.7	39.7	2.8	51.1	74.2	58.9	3.1	2.3	1.4
Ga-Dangme	3.1	2.5	27.4	1.5	17.9	1.2	1.3	0.3	0.1	0.1
Ewe	6.2	6.2	20.1	73.8	18.9	3.8	3.7	1.7	0.3	0.4
Guan	0.8	5.3	1.9	8.1	5.3	1.5	4.1	8.6	0.3	0.8
Gurma	0.9	0.9	1.6	11.3	1.6	2.8	6.9	27.3	4.7	1.2
Mole-Dagbani	8.6	1.7	5.2	0.5	3.2	11.3	18.2	52.7	74.7	73.0
Grusi	0.8	0.5	1.3	0.1	0.8	2.0	3.9	3.7	8.6	20.6
Mande	0.8	0.4	0.7	0.1	0.3	2.0	1.8	0.5	5.6	0.3
Others	0.6	0.8	2.0	1.8	0.8	1.1	1.3	2.1	3.4	2.1

Source: Ghana Statistical Service, 2010 population and housing census.

Ghana is a religious country to the extent that it guarantees religious freedom and its main religions are recognized by law. According to the 2010 population and housing census, 71.2% of Ghanaians are Christians, 17.6% are Muslims and 5.2% are Traditionalists. Most persons with disabilities also have religious affiliations and remain committed to the practices of their religions. Data from the 2010 census shows that over 65% of persons with disabilities in Ghana are Christians (different denominations) and 13.7% are Muslims. Table 4 provides a breakdown of the religious groupings of persons with disabilities in Ghana.

Table 4 shows that 7.9% of persons with disabilities do not have any religious affiliation. It also shows that there are more non-religious people in rural areas (9.2%), than in urban areas (6.4%). The data also shows that there are more non-religious males with disabilities (10.2%), than there are females with disabilities (5.9%), which suggests that females with disabilities tend to be more religious. A careful look at the breakdown of the various denominations also shows that there are more persons with disabilities in Pentecostal and Charismatic (24%), than in any other Christian denomination or religious group

Table 4 Religious Distribution of Persons with Disabilities in Ghana

Religion	Total (N=713,172)			Male (N=337,505)			Female (N=375,667)		
	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
No Religion	7.9	6.4	9.2	10.2	8.6	11.4	5.9	4.5	7.1
Catholic	13.8	12.2	15.2	13.9	12.6	14.9	13.8	11.8	15.5
Protestant (Anglican Lutheran etc.)	20.4	23.5	17.8	19	22.2	16.4	21.7	24.7	19.2
Pentecostal/ Charismatic	24	28.2	20.5	22.1	26	18.9	25.8	30.2	21.9
Other Christians	11.3	11.8	10.9	10.5	11.2	10	12	12.3	11.8
Islam	13.7	15	12.7	15	16.4	13.9	12.6	13.8	11.6
Traditionalist	7.8	2	12.7	8.4	2.1	13.4	7.2	1.9	11.9
Other	1.0	0.9	1.0	0.9	1.0	0.9	1.0	0.9	1.0

Source: Ghana Statistical Service, 2010 population and housing census

According to Lamptey (2018, p.1) among many Ghanaian cultures, "causes of disability include demonic possession, witchcraft, sorcery and punishment from deities for one's sins, family or ancestral sins." These common beliefs often lead to cruel and sometimes inhumane treatment towards these children.

Avoke (2002, p.771) articulated that the use of pejorative labels and the manner in which people with disabilities in Ghana are treated tends to be considered justified, because disability in the past was so strongly attributed to religious or magical models where evil was placed on an individual from the gods. In Ghana, the different ethnic groups have different understandings of disability. For instance, Avoke (2002, p.773) acknowledged that in some part of Ghana, the public understanding of disability among children is that they are children of the rivers and forest and, in the past, they were returned to the forest or to the rivers under the guise of helping them to go back to where they came from. Another belief is that children with disability are seen as a punishment from gods (Opoku at al., 2018).

Fefoame (2009) indicates that in some traditional communities, some creatures like crocodiles and snakes are believed to have supernatural powers, or in some cases, human beings change into such creatures, and therefore any cruelty against them can lead to a physical disability at birth. These beliefs invariably influence societal beliefs and perceptions about disability in Ghanaian traditional society. Fefoame again indicated that the only explanation for being disabled is that the gods are annoyed without considering other factors such as Rubella and German measles and poor nutrition during pregnancy in the case of women. Instead, emphasis is laid on the purported guilt of the family, which element is instrumental in curtailing the promotion and protection of the rights of people with disabilities (Fefoame, 2009). The main point here is that some religious and cultural beliefs provide causal explanations for poverty that influence the attitudes and behaviours of people in society towards PwDs.

In his anthropological study of the Ashantis in Ghana, Rattray (1954) observed that children born with deformities such as a sixth or extra finger are viewed as animal-like creatures originating from water bodies. These children are usually rejected and abandoned close to rivers and other water bodies so they can return to their origin. Though the practice is not as prevalent in recent times, such perceptions still remain. It is

instructive to note that among the Ashanti, persons with disabilities are ineligible to serve as king or chief. The fact that such practices still exist points to the strong sway of cultural beliefs on the actions and behaviours of people.

In Ghana, according to Agbenyega (2003, p.4), to safeguard against children being born with disabilities, several taboos are imposed on a pregnant woman. For instance, pregnant women in most rural settings are not allowed to eat eggs for the reason that the child might develop into hydrocephalus (big head). In my village in Ghana, pregnant women are also not expected to see and talk to PwDs regularly because the belief is that the frequency of such contact increases the possibility of giving birth to a child with a similar disability. Again, various names are labelled against people with disabilities. For instance, children with mental retardation among the Ewes and the Gas (ethnic groups in Ghana) are referred to as 'Asotowo', and 'Buluus' respectively, meaning idiots or fools in both languages (Avoke, 1997). Similarly, the Akans also label persons with intellectual disability as 'Nea wanyin agya n'adwene ho', which literally means 'feeble minded' (Ibid).

Commey (2001) noted that majority of Ghanaians, through these believes systems, labeled persons with disabilities as social misfits, social outcasts and in most cases treat them like animals. Superstition and the cultural belief system thus pose a consequential and ominous threat to inclusive education, because under such circumstances it is difficult for any interaction to occur between the 'normal' and the disabled. Thus, ascribing the causes of disability to punishment from the gods and evil forces is an act of submitting to a nebulous and possibly sinister influence which some consider as a cultural heritage (Agbenyega 2003, p.5).

Avoke (2002) indicates that in many communities in Ghana, pejorative labels and unkind treatment are meted out to people with disabilities. These treatments are as a result of the strong beliefs associated with disability that disability is the result of evil placed on an individual from the gods, for committing offences in the community or to the gods. This treatment could also be related to poverty. In identifying how people with disabilities are treated, A Community Based Rehabilitation Program (CBRP) discovered that disabled children in some Ghanaian societies are left by the river side to die, while others are left at the foot of anthills or under big trees with the belief that the deities from which they came from will come back for them (Kassah et al., 2012). Many Ghanaians avoid marrying anyone from a family with a disabled member. Traditionally, before marriage, some family member investigates the background of would-be partners to make sure that they do not have a history of disability or any serious disease. Even if a marriage takes place without the prior knowledge of the parties involved that there is a disabled person in the family, finding out later can constitute sufficient grounds for divorce. 'The marital vow of till death do us part is replaced by the maxim till disability do us part' (Attafuah, 2000, p.35). In the Northern region of Ghana, disabled children who were not killed right after birth were hidden and neglected to die because they do not receive any medical care.

Finally, on the documentaries sent to Aljazeera by the Under-Cover Journalist Anas Aremeyaw Anas in 2013, disclosed how a concoction of poisonous liquid from local roots and herbs prepared by a 'juju man' (local herbalist) to force feed the child with disability to death as the parent view the child 'as a spiritual child'. Below is a transcribed excerpt from the documentary.

'*Over time, this practice has become a perceived solution to any problems a family might be having at the time of a child's birth. By blaming the child for sickness in the family, or the father's inability to find work or provide money to support his dependents, these*

communities have found an otherworldly explanation for their problems ... But infanticide has always been a crime against humanity' (Excerpt from Anas 2013 documentary).

These notwithstanding, there are also some cultural beliefs in Ghana that evoke positive attitudes and behaviours towards PwDs. Among the Ga Adamge for example, persons with disability are treated kindly with respect and adoration. This positive behaviour is inspired by the belief that persons with disabilities are reincarnations of deities and as a result should be treated with respect and dignity (Nyangweso, 2019). Similarly, in Yuroba culture, Nyangweso (2019) has observed that the 'Obatala' myth on the origin of disability is another example of a religious belief that reinforces positive behaviours towards persons with disabilities. According to this tale, Obatala, a smaller god, was tasked by his father, Olodumare, to mould human beings from clay so he could breathe life into them. Obatala was however a drunk who frequently took palm wine while moulding the human beings. When intoxicated, he created people with physical and intellectual deformities. After he repented from his drunken behaviour, he became the patron of persons with disabilities and his worshippers, in reverence to him, started treating persons with disability with respect and dignity.

The preceding analysis suggests that cultural beliefs on disability are not homogeneous. While there are some that encourage respect and positive behaviours towards PwDs, there are others that also evoke hostile attitudes and violent behaviours towards PwDs. Given that culture is dynamic, there is the need to constantly evaluate beliefs and to do away with those that encourage hostile and violent behaviours towards PwDs and other marginalized groups, while maintaining beliefs that inspire harmony and respectful correlations in society. In the next sub-section, this study presents a discussion on the international and national frameworks on persons with disabilities including children.

2.4 International and National Laws on Persons with Disabilities

At the international level, the United Nations Convention on the Rights of Persons with Disability (CRPD), is the legal framework on disability with the widest reach and coverage. It was adopted in December 2006 and came into force in May 2008 with about 82 countries signing onto the treaty on its opening day. Ghana signed the CRPD in 2007 and ratified it in 2012 (Ocran, 2019). As the first international convention on persons with disability, the CRPD situates disability within a human rights perspective and views persons with disability not as objects of charity, but as active members of society with equal rights to participate in society and national development. After its adoption, the CRPD not only served as a guiding international document, but also laid the foundations for national laws on disability in countries around the world. The United Nations Convention on the Rights of the Child 1989 (CRC) also captures concerns for children with disabilities. Specifically, Article 2 of the Convention makes provision for non-discrimination and equity in the treatment of children with disabilities.

The African Charter on the Rights and Welfare of the Child 1990 (ACRWC) is another international treaty that captures concerns of protection and participation for children with disability. Its focus is however on the African continent. While the ACRWC is not a dedicated convention on disability, it contains provisions that urge states at the continental level to

ensure the protection of the rights of children with disabilities, protect their dignity and ensure their complete integration into the national development process. Specifically, Article 13 of the ACRWC implores member states to make provisions for the special protection of children with disabilities, and to put in place measures to facilitate their active participation in their communities.

At the national level, the 1992 Constitution of Ghana makes clear stipulations on person with disability. Article 29 of the constitution, which is dedicated to the rights of persons with disabilities, clearly articulates the rights of PwDs in society, disallows any form of discrimination and stipulates the need for a specific national law on persons with disability. In fulfilment of the constitutional requirement, the Parliament of Ghana passed the Persons with Disability Act (Act 715) in 2006 (hereon referred to as Disability Act). This Act serves as the overarching national legal framework on persons with disabilities in Ghana.

As the overarching national legal framework on disability, the Disability Act (2006) secures the rights of all persons with disability in every sphere of life, guaranteeing unrestricted access to public facilities and other buildings as well as free healthcare. The law provides a ten-year moratorium for all public buildings to be made disability friendly, but there is yet to be a comprehensive assessment of the fulfilment of this requirement. The Disability Act further establishes the National Council for Persons with Disability (NCPD) as the national institution responsible for ensuring the enforcement and implementation of disability laws and policies. The NCPD is also responsible for protecting the rights of PwDs and facilitating their inclusion in the national development process.

Beyond the national constitution and the Disability Act, the Children's Act 1998 (Act 560) also makes provision for the protection of children with disabilities (CwDs). Article 10 of Act 560 stipulates that every child with disability has a "right to care, education and training wherever possible to develop his maximum potential and be self-reliant." It also adds that no child with disability shall be treated in an undignified manner. In addition to the laws already discussed, the National Health Insurance Act 2012 (Act 852), Labour Act 2003 (Act 651) and the Education Act 2008 (Act 778) all make provisions for persons with disabilities in health, employment and education respectively. The Education Act is also supported by the Inclusive Education Policy (2015) in setting out a strategic pathway in making education inclusive for all, especially children with disabilities.

While the numerous laws outlined above suggest that Ghana has a robust institutional framework in relation to persons with disability, there still exists gaps that need to be addressed. The first and obvious is the definition of disability in the Disability Act. The Act in Article 59 defines a person with disability as "an individual with a physical, mental or sensory impairment including a visual, hearing or speech functional disability which gives rise to physical, cultural or social barriers that substantially limits one or more of the major life activities of that individual." In contrast to the definition of the World Report on Disability discussed in the beginning of this chapter, the definition presented by the Disability Act adopts an individual biomedical perspective that ignores the environmental influence on disability. As Ocran (2019, p.664) notes, this "is problematic because the definition affects the nature of the provisions in the laws and even what rights are conferred on disabled people or otherwise." Moreover, as the national legal framework on disability, its content does not only dictate actions but also conceptions and perceptions of and about PwDs in society.

Another gap in the current legal framework on disability is the obvious lack of provision in the Juvenile Justice Act 2003 (Act 653) on children with disabilities. Article 29(5) of the

1992 Constitution of Ghana states that in "any judicial proceedings in which a disabled person is a party the legal procedure applied shall take his physical and mental condition into account." Disturbingly, this clear constitutional provision did not find expression in the Juvenile Justice Act. The Act does not make any accommodation for children with disabilities at any stage of the process in pursuit of justice. In fact, a detailed review of the Act reveals that there is no mention of 'disability', 'impairment', or 'handicap' anywhere in the Act. This is worrying because as the legal framework guiding the pursuit of justice for child victims or offenders, its provisions serve as a guide not just for lawyers and judges in dealing with children, but also for the police and other law enforcement agencies as well.

2.5 Chapter Conclusion

This chapter presented the context within which this study is situated, Ghana. It began with a general overview of the country before highlighting statistics on the prevalence of disability in Ghana. The chapter further discussed religious and cultural beliefs and practices within the country and how these impacted behaviours and attitudes towards persons with disabilities, recognizing the diversity within these cultural practices. The chapter also outlined international and national laws on children and disability and discussed their adequacy for the purposes of protecting children with disabilities. The next chapter presents the methodology, concepts and theoretical frameworks for the study.

3. Chapter Three – Concepts, Theory, and Methods.

3.1 Introduction

The first chapter presented the background to this study, discussing the problem, aims and objectives as well as an overview of the rational for this study. The second chapter situated the study in the context of Ghana, providing details about the Ghanaian context, the prevalence of disability and measures in place to ensure their protection. Together, both chapters gave a background and context to this study.

This chapter focuses more on the concepts, theories and methods that will guide this case-study. The first part of this chapter focuses on the concepts. It discusses concepts that feature throughout this dissertation such as disability, impairment, and handicapped. It also presents models of disability including the religious model, the medical model of disability, as well as the social model of disability. It also includes an assessment of the intersection between poverty and disability.

This second part of the chapter mainly focuses theoretical perspectives for this study. Two theoretical frameworks are considered; child rights theories, and social constructionist theories. The final part of this chapter presents the methodology for the study. It highlights the general methodological approach of this dissertation as well as the sources of information for analysis. It concludes with limitations of the methodological approach and ethical considerations.

3.2 Concepts

There are different definitions of disability in the literature in different fields of study due to the different perspective on the issue. These diverse approaches have implications not just for understanding disability, but also in attempts to address this. While there is no universally acceptable definition for disability, there are a number of terms that help facilitate its understanding. Impairment is one such term that is mostly used interchangeably with disability. An impairment is an abnormality in the structure or function of any part of the body (Palmer & Harley, 2012). As such, being blind, or losing a limb, can be considered an impairment. A similar concept is handicap. Though used interchangeably with disability, handicap relates more to the impact of the physical environment on the functionality of an individual. A person is considered handicapped when their immediate environment restricts their normal functioning (Ibid).

The term disability is a very complex concept which includes multiple definitions, approaches and perspectives. The definition of disability is continuously changing, and it varies greatly not only from country to country but also within each country. In a review

of disability issues, The Asian Development Bank (2005, p.3) asserted the multidimensional concept of disability with both objective and subjective characteristics, when interpreted as an illness or impairment, disability is seen as fixed in an individual's body or mind and when interpreted as a social construct, disability is about the life of people with disabilities and their interaction with the community and the environment. Those defined as people with disabilities do not necessarily view themselves that way. Mitra (2006) has argued that multiple definitions abound for disability based on the perspective from which it is being considered. Some scholars have considered it from purely a medical perspective while others have focused more on social and political dimensions. Mitra adds that at the level of theory, attempts at conceptualizing disability are not based on semantics because theoretical definitions have implications on the social, economic and political realities of persons with disabilities.

However, WHO has generally defined disability as any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being (WHO, 2001). This implies that disability can be physical, cognitive, mental, sensory, emotional, and developmental or sometimes a combination of two or more of these. However, people are sometimes labelled disabled because they look different from the 'normal' based on their appearance and behaviour.

Bickenbach (2003) also added that disability is a fluid and continuous condition which has no boundaries and seen as the essence of human condition. This implies that disability can affect anyone at any time regardless of age, gender, culture, ethnicity or social class. Agbenyega (2003) has summarized it as a person who is unable to perform one or more activities, or who uses an assistive device to get around, or who needs assistance from another person to perform basic activities, is therefore considered to have a disability.

The World Report on Disability published by the World Health Organization in 2011 (WHO, 2011, p.4) ascertained that "Disability is the umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors)." The emphasis on 'interaction' in the above definition takes away the connotation that disability is an attribute, and opens up avenues for environmental modifications in order to facilitate the easy participation of persons with disability in their daily lives. The environmental factor is important because the design and appearance of a person's immediate physical environment not only impacts the person's experience, but also the extent and severity of a disability. For example, if the key-hole of an entrance door is situated 12ft above the ground, then a person of less than 5ft may struggle to open the door alone, making the room inaccessible. Similarly, a person on a wheelchair may not also be able to access upper floors of a storey building without an elevator or wheelchair friendly staircase. As the World Report on Disability (2011, p.4) rightly put it, "inaccessible environments create disability by creating barriers to participation and inclusion." Experiences of disability vary, and people with physical challenges are not the only persons with disabilities. Persons with disability also include children born with mental illnesses, women with arthritis, or persons suffering from glaucoma among others. Irrespective of the form of disability, what remains clear is that environmental and social factors cannot be ruled out of the equation. This conception of disability is applicable to all including children, who are the primary focus of this study.

The following sub-section discusses models of disability that have influenced people's world view and reactions to persons with disabilities. Understanding the various disability models will be very useful for the analysis of this study.

3.2.1 Religious Model - Disability as an act of God

In a Western Judea-Christian society, the roots of understanding difference in the physical appearance of human beings have been grounded in Biblical references, which has consequently impacted the attitudes and behaviours of the Christian church. One form of this disability model is that disability is a punishment from God. In their work, Henderson and Bryan (2011, p.7) explained that

"Some people if not many, believe that some disabilities are the result of lack of adherence to social morality and religious proclamations that warn against engaging in certain behaviour. To further explain this model, some beliefs are based upon the assumption that some disabilities are the result of punishment from an all-powerful entity. Furthermore, the belief is that the punishment is for an act or acts of transgression against prevailing moral and/or religious edicts".

Henderson and Bryson further argued that at times it is not only the individual sins that has made one disabled but any sin that may have been committed by their parents and/or ancestors. This seeks to suggest that disability is viewed as punishment for sin that a person or their parent or family has committed. Also, Theologian Nancy Eiesland (1994) explained how Christian tradition often demonized disabled people, or at least named disability as physically mark of a demonic character. This attitude toward disabled people singles them out as unworthy of God's love or unfit for participation in the worshipping community and therefore the consequences of such view could lead to the entire families being excluded from social participation in their local communities.

Another form of this model is that disabilities are essentially a test of faith or even salvific in nature (Retief & Letsosa, 2018). This example can be seen in the New Testament in the writings of Apostle John. He wrote, *'As he went along, he saw a man blind from birth. His disciples asked him, Rabbi, who sinned, this man or his parents, that he was born blind?" Neither this man nor his parents sinned said Jesus, but this happened so that the works of God might be displayed in him (John 9:1-3).* Niemann (2005, p.105) offers a concise description of the conception of disability as a test of faith, whereby 'individuals and families are specially selected by God to receive a disability and are given the opportunity to redeem themselves through their endurance, resilience, and piety.' This implies that disabled people are expected to receive God's physical healing and if such doesn't happen, it implies lack of faith.

Bennett and Volpe (2018) have observed that though many Christian communities provide places of shelter and care for persons of disability, many Christians still hold beliefs that persons with disability either have some demonic connections or are being punished by God. At the same time disabled persons are expected to wait on God for deliverance and healing. This religious model of disability as an act of God is useful for this study because Ghana is a religious country, and it helps in understanding not just what the biblical understanding is, but also how it influences people's behaviours and attitudes towards disabled peopled. Moreover, it is important to also understand how such beliefs impacts the world view of persons with disability. Though the latter is not the focus of this study,

it presents a useful area of inquiry for further research. In the following sub-section, the medical model of disability as a disease will be discussed.

3.2.2 Medical model – Disability as a disease

The medical model focuses on individual pathology and attempts to find ways of preventing, curing or caring for disabled people. Central tenets of the medical model of disability are that firstly, a person's 'impairment' can be diagnosed, cured, or at least rehabilitated, by modern medicine and/or medical technology, and secondly, such interventions will be provided by all-knowing professionals (Oliver, 1998). Disability in this model is seen as a phenomenon that is caused by functional limitations resulting from illness, injury or disability. Thomas and Woods (2003) referred to this model as individual tragedy because disability in this model is described negatively. Persons with disabilities deviate from the normal and that they are not comparable with their abled-bodied counterparts. Johnstone (2012, p.16) added that the interpretation of the medical model of disability project a dualism which tends to categorize the able-bodied as somehow 'better' or superior to people with disabilities.

Olkin (1999, p.26) holds that from a medical perspective, "disability is seen as a medical problem that resides in the individual. It is a defect in or failure of a bodily system and as such is inherently abnormal and pathological." This definition focuses more on disability as an attribute of the individual. Its view of disability as a pathology or abnormality is not only demeaning, but its implications are that attempts to address the disability focus on cure and rehabilitation of the individual and not environmental factors.

In describing what disabled people in this model should do, Kasser and Lytle (2005) contend that if disability is an illness, then there should be a change in the conditions that contribute to the person's disability when a medical treatment is applied. This implies that people with disabilities should be treated as sick people if they are to receive medical help and supports. It is through this 'sick role' that Llewellyn et al. (2008) argue that many chronically ill or disabled people do not consider themselves as sick and therefore the approach fails to take account of the vital distinction between impairment and sickness. This is true because many disabled people are not sick but rather impaired which they do not present itself as daily health problem. Understanding this medical model is important for this study because of its impact on the lives of children with disability through policy and institutional restructuring.

3.2.3 Social Model – Disability as a social construct

The social model of disability views disability as socially constructed and a consequence of society's lack of awareness and concern about those who may require some modifications to live full and productive live. This model argued that medical diagnosis, injury or illness had no part in disability but rather society is considered the cause of disability, which is considered a consequence of an environment created for the able-bodied majority. The social model explains that disability arises from barriers within static societies rather than from an impairment per se (Soder, 2009). It was primarily a result of society's response to disability and also disabled people's experience of the health and welfare system which

made them feel socially isolated and oppressed. The denial of opportunities, the restriction of choice and self-determination and the lack of control over the support systems in their lives led them to question the assumptions underlying the traditional dominance of the medical model (Carlson, 2010).

Disability as in this model is understood to be unequal relationship within a society in which the needs of people with impairments are often given little or no consideration. They are made disabled through their exclusion from participation within the mainstream of society as a result of physical, organizational and attitudinal barriers. Such barriers include access to education, information, employment, public transport, housing and social/recreational opportunities. The definition of disability presented by the World Report on Disability (2011) discussed earlier in this chapter fits well into this framing of disability as more of social and environmental concern. This framing is important for this study because it has implication at the policy level, as well as what could be done in practise to make life easier for children and all persons with disability so they can easily access infrastructure facilities and social services such as education and health.

3.3 Poverty and Disability

Poverty as a concept is not easily defined or measured. As a result, identifying the poor in the society for social interventions may be challenging. Poverty never results from the lack of one thing but from many interlocking factors that cluster in poor people's experiences and definitions of poverty. The ways poverty interventions and policies are shaped, has led to ambiguity as to how the term 'poverty' is used and as a result, a range of definitions exists, influenced by different disciplinary approaches, world views and ideologies (Handley et al., 2009). This is true because the understanding of poverty, its different approaches and the way of thinking about it leads to different ways of addressing it through policies or other social interventions.

Poverty is one of humankind's most enduring problems, yet views on its definition and conception have always diverged among scholars and policy makers alike. According to Hagnaars and de Vos (1988, p.212), definitions of poverty can be grouped into three main categories: "I. Poverty is having less than an objectively defined, absolute minimum, II. Poverty is having less than others in society, III. Poverty is feeling you do not have enough to get along."

In the first category, poverty is absolute, and can be objectively measured. The World Bank's definition of poverty as surviving on less than $1.90 a day fits within the first category. The second category focuses on the relative nature of poverty in society. The ILO (2020, p.1) defines relative poverty as "circumstances in which people cannot afford actively to participate in society and benefit from the activities and experiences that most people take for granted." The third category focuses on poverty as a subjective issue. This study is more concerned with the second category of relative poverty. This is primarily due to the strong correlation that has been observed over the years between poverty and disability.

In the literature on disability, there is consensus on the fact that persons with disability are more likely to experience poverty than persons without disability. Children with disabilities have unequal access to educational and unequal experiences in the labour

market when they grow up. Moreover, they are more likely to spend more on their health and wellbeing than those without disabilities. A study on the health expenditure of PwDs in Sierra Leone found that households that had persons with severe disabilities spent on average 1.3 times more on health care than did respondents without any disability (WHO, 2011). This is one example of a study that is instructive on the nexus between poverty and disability. The impact of poverty on disability is useful for understanding better the livelihoods of persons with disabilities and their access to basic social services such as health and education. This remains the primary focus of this study as it focuses on children.

3.4 Theoretical Perspectives on Children with Disability

As discussed earlier in this chapter, definitions and conceptions of disability have often diverged and as a result, theoretical framings on disability equally vary. The biomedical perspective, which views disability as an individual abnormality requiring cure and treatment was considered together with its implication earlier in this chapter. In this subsection, the study discusses social constructionist and human rights perspectives on disability and childhood. In doing so, it presents perspectives or framings on childhood that will guide the discussions in this study.

Social construction or the social constructionist perspective is a framework through which sociological issues are framed and understood. At its core is the premise that, the way issues such as gender, law, etc are framed today, are a product of social interactions within a specific culture or across cultures over a period of time (Nilsen, 2017). This implies that such issues, or concepts or however one frames them, are products of history and culture. Issues of gender, religion, disability and many other social concerns fit within such framings. While such an approach has afforded society a means through which to categorise and relate to specific groups of people, it holds implications for their wellbeing, protection and quality of life that transcends them (Ibid).

As the name suggests, the social constructionist perspective on disability views disability as socially constructed. As Jones (1996, p.6) put it, this "perspective depends upon an understanding that much of what is believed about disability results from meanings attached by those who are not disabled and challenges the assumptions upon which those meanings rest." From this perspective, understanding the concept of disability should thus be situated within the context of social interactions and how meanings are produced through these interactions. Proponents of this theory accept that aspects of disability are as a result of biological limitations, but nonetheless contend that the limitations and the biological fact cannot be properly understood unless within the context of the social structure and the interactions within this structure (Birenbaum, 1979). Such an understanding not only challenges strict biological framings of disability but holds good implications for the crafting of policies and programmes that recognize the social and environmental boundaries of disability and can facilitate the inclusion of PwDs in the national development process (Reynolds, 2010). Viewed in this sense, the social construction of disability holds some utility for program and policy interventions aimed at improving the quality of life of disabled persons. This is in spite of the fact there is potential

for marginalisation of persons with disabilities across different societies. For children however, the implications are more complicated.

The concept of the child or childhood is also recognized as a social construct with historical and cultural origins. Biddle (2017) contends that the concept of childhood as a category was created and entrenched by adult society in different cultures to facilitate and justify restrictions and controls placed over children. As Biddle (2017, p.11) put it, adults "exercise this control by institutionalizing children, discrediting their social and political contributions, and marginalizing them from public space." In most societies, children are not allowed to vote, get married, drive a car and even own a bank account or property in some cases without the approval of adults. While this mirrors historical oppression of groups like women, its utility is hinged on the fact that children are incapable of rational decision making. They are rather more prone to impulses and their animalistic nature. This approach ignores the agency of children and their already active participation in society. It worrying implications are that children are oppressed as a result and their actions or potential actions are limited within multiple spheres of social life including religion and politics.

Children with disabilities are situated at the intersection between childhood and disability. On one side, they are children, and belong to the childhood category, which is not only socially constructed, but marginalized and oppressed in different aspects of life based on this construction. As persons with disabilities, they also belong to the disabled category, which in itself is also a social construct based on the interaction between the impairment and the physical environment, as well as based on the interactions with others in society. The disabled, as has already been discussed, are one of the most marginalized groups across different societies. Not only are their voices restricted in certain cases, but their access to basic services such as health and education that are considered as human rights are also restricted due to environmental and social factors (WHO, 2011).

This intersection between childhood and disability creates a situation one can describe double jeopardy, where children with disabilities experience double oppression and marginalization due to the fact that they belong to both social categories. This significantly worsens the plight of children with disabilities. It further holds implications for their agency, the enjoyment of their basic rights, as well as their integration into the broader society as fuller functional members. The implications however differ to different societies, given the fact that social constructs are also specific to societies, despite their universalities.

Beyond being viewed as social constructs, disability, and childhood are also viewed as human rights issues. This is globally recognized by international treaties on children and persons with disabilities that aim to ensure respect and promotion of their human rights. Similar to the social constructionist perspective, the intersection between childhood as a human rights issue and disability as a human rights issue holds implications for children with disabilities and the way they are treated in society. It also holds implications for the way they children with disabilities view themselves. The following discussions in this subsection illuminates this contention.

According to Officer and Shakespeare (2011), the human rights perspective on disability was inspired by the unequal experiences of persons with disability in accessing healthcare, education, employment and political participation. It is also due to the violence experienced by PwDs and their denied autonomy due to their biological and environmental limitations.

This viewpoint was strongly articulated and popularized by the Convention on the Rights of Persons with Disabilities (CRPD). The CRPD implores signatory states to treat PwDs as persons with equal rights and agency, and to include them directly in legislative and policy decisions concerning them and more importantly on national development. Simply put by Officer and Shakespeare (2011, p.10) its 'core message is that people with disabilities should not be considered "objects" to be managed, but "subjects" deserving of equal respect and enjoyment of human rights.'

The idea that children have rights, given its widespread acceptance in today's world in taking for granted. The United Nations Convention on the Rights of the Child, the African Charter on the Rights and Welfare of the Child, as well as other international and national legislations on children all draw attention to this reality. Yet, in spite of this recognition, the limitation children's agency in politics and other spheres of live is more than apparent in every society (Biddle, 2017).

According to Wall (2008), this continued marginalization of children despite the widespread recognition of their rights in international law is as a result of the current adult-centred framing of human rights which does not recognize the agency of children. Under this adult-centred approach, children lack full rational capabilities, and need to be nurtured into fully functional adults through education. Wall contends that, for children's rights to be truly respected and honoured, then human rights need to view within the framework of responsibility towards each other in society. Within this framework of responsibility, the three approaches to human rights; developmental, bottom-up and top-down, all operate within a complimentary cycle. The developmental approach to human rights according to Wall (2008) views human rights as the socially agreed means through which the protection life, freedom and properties are ensured. Within this framing, self-preservation is the primary objective. Children here are thus to be educated to develop their rational capabilities in order for them to contribute to maintaining the social structure. This approach has its origins in the thinking and writings of English Philosopher John Locke. The bottom-up view in contrast, views human rights as a means to facilitate the expression of the collective will of free humans (Wall, 2008). Here the primary objective is not self-preservation but inclusion and collective expression. This approach is identified with the work of the French philosopher Jean-Jacques Rousseau. The top-down approach situates human rights within the context of self-legislations. The view is that human have animalistic instincts that need to be controlled through a stipulation of rights that each person is entitled to for the purpose of social order (Wall, 2008). As such, children in this framing lack full autonomy and self-control, and also require education in order to be able to fully appreciate and enjoy their rights. This approach originates from the works of German philosopher Immanuel Kant.

According to Wall, a society that truly respects human rights combines these three approaches within a cycle of responsibility towards each other as human beings. It is only through such an approach that the rights of children can be truly respected. This is because children will be recognized based on their responsibilities towards others and the society as a whole.

Figure 4 Human Rights in Light of Children
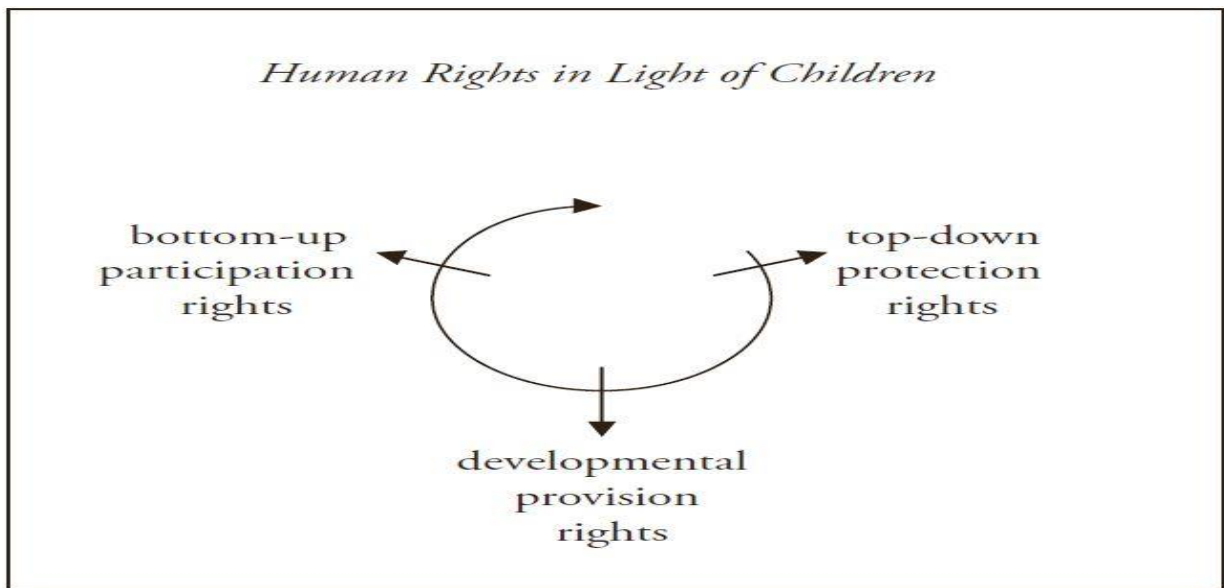
Source: Wall (2008, p. 539)

Within this framework of responsibility, human rights are socially constructed in a way that entrenches individual responsibilities towards others in society. In this regard the child as a member of society fits in the conception of 'other'. As depicted in figure four above, the three human-rights approaches function together and are interdependent within the cycle. For example, bottom-up rights of collective expression require protection against discrimination, marginalization and exclusion to be effective. Through this inclusive approach, the recognition of children, their responsibilities towards others are clearly captured. The CRC articulates this in some measure, and the extract below from Wall (2008, p.539) is instructive.

> "The 1989 CRC helps us imagine what such a circle of human rights might look like in concrete and practical terms. For although it is confined to children's rights specifically, its shows how the three kinds of rights explored above depend on a fundamentally dynamic relation of human beings to one another. From this angle, the CRC can be read as not just an application of human rights to children but a model for beginning to imagine human rights in a more humanly inclusive way."

The social constructionist and human rights approaches to children and the disabled provide useful tools for understanding the situation of children with disabilities, their rights and how they are treated across different societies. For this dissertation, its utility is in helping understand the state of children with disabilities in Ghana. The social constructionist approach helps in understanding the impact of poverty, culture, religion and history on the lives of disabled children as well as societies attitudes towards them. The human rights approach also helps in understanding how interventions to support children with disabilities have situated them either as agents in their own right or as actors lacking autonomy and rationality.

3.5 Methodology and Research Design

This study adopts a qualitative research design as its main approach. This is because the qualitative approach is well suited for the type of inquiry this study undertakes. The study aims to understand the nexus between poverty and disability and impact of poverty on access to education and healthcare for children with disabilities. Such an inquiry involves an in-depth understanding of the living conditions of children with disabilities, and their livelihood strategies, for which the qualitative approach is more suited. According to Mohajan (2018), the qualitative research approach is very effective for exploring in-depth insights into research problems as well as seeking the situated meanings and understandings of issues, which in this context is the impact of poverty on the lives of children with disability.

3.5.1 Data Sources and Analysis

This study employs secondary data sources and case-study analysis for assessments. The main sources of data are academic publications, conference papers, case studies, dissertations on related topics, national and international laws on disability, and grey literature such as online media articles, reports from non-governmental organizations (NGOs) and civil society organizations (CSOs) among others. Specifically, this includes academic journal publications on 'poverty and disability' among others.

Reports that were reviewed include reports on the United Nations Convention on the Rights of the Child, United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), the African Charter on the Rights and Welfare of the Child, the 1992 Constitution of Ghana, Persons with Disability Act in Ghana, as well as reports on the plight of persons with disability.

The case-study analysis was conducted on three levels. The first level, which is the preliminary level, involved a broad review to identify general issues, debates and themes on poverty and disability in Ghana. The second level narrowed the search to focus on the main themes and theories that are directly relevant to the assessment of the impact of poverty on access to education and healthcare for children with disabilities. The final level involved a high-level synthesis of the main themes, ideas, issues and theories that were essential for the final analysis.

Throughout the process, keywords such as on 'disability', 'poverty', 'disability in Ghana', 'theoretical perspectives on disability', and 'cultural beliefs on disability in Africa and Ghana' were searched in academic publication databases such as Google Scholar, JSTOR, Project MUSE, and SpringerLink among others to identify relevant publications for review. The list of references for each of the publications assessed also served as a source for identifying other studies that were also useful for this assessment.

Emerging issues from the review were then indexed in order to generate analytically useful categories to guide theoretical analysis and interpretation. The document analysis is useful because it helps to understand the scope of the relevant laws and policies, the extent of their application, and as Bowen (2009, p.27) puts it, "elicit meaning, gain understanding and develop empirical knowledge" on how poverty and disability intersect to impact the lives of children with disabilities, especially in accessing education and healthcare services.

Since this study will not involve the use of direct primary data, there will be the added advantage of time and resource efficiency in the data collection process.

3.5.2 Limitations

The methodology adopted for this study has some limitations, despite its usefulness in eliciting in-depth insights. First, employing a solely qualitative approach prevents the use of quantitative methodologies that could have been useful in providing numerical insights on the plight of persons with disabilities in Ghana. Moreover, this approach limits the potential for any generalization. Secondly, the use of secondary data sources alone, prevents the study from eliciting information directly from key persons with disability and officials of institutions responsible for their care. These insights would have been useful in expanded the analysis and conclusion of this study.

3.5.3 Ethical Considerations

This study mainly relies on publicly accessible documents for its analysis, and as such will not require institutional ethical approval for its data collection approach. Nonetheless, the researcher employs ethical considerations in reviewing the works of other authors and in presenting the interests, behaviours and attitudes of different stakeholders. The researcher conducted a thorough review of all the documents used in order to establish credibility and quality. All publications used for this assessment were also properly cited in-text and added to the reference list in order to recognize the sources and authors on which the current study builds.

3.6 Chapter Conclusion

This chapter presented an overview of the key concepts, laws and frameworks on disability that are integral to this study. It also discussed the theoretical framework and methodology for the study. It began by presenting the definitions of concepts such as handicap and impairment before proceeding to outline competing definitions of disability and poverty as well as the nexus between them. The chapter concluded with discussions on the social constructivist and human rights perspectives on disability.

4. Chapter Four – Findings and Discussions

4.1 Introduction

The main aim of this study is to understand the intersection between poverty and disability, and how poverty affects the lives of children with disabilities. The case-study focuses specifically on access to education and access to healthcare for children with disabilities as well as the different interventions in place to help reduce the impact of poverty on the lives of persons with disabilities in Ghana. The previous chapters have already presented the background for this study, situated it within the context of Ghana, and presented the methodology for the study. In chapter three, theories on social constructionism and child rights were presented to serve as a framework for the study.

This chapter presents the findings of this study informed by the review of the secondary data sources. Based on the research objective and questions, the first area of focus is access to education for children with disabilities. Here issues of access to education in Ghana are discussed and assessed together with issues of access to education for children with disabilities. The second area of focus is on access to healthcare for children with disabilities which is presented and assessed in this chapter as well.

The final area of focus is on interventions in place to help reduce the impact of poverty on the lives of persons with disabilities. The interventions discussed include, the Disability Common Fund (DCF), the Livelihood Empowerment Against Poverty initiative, the Local Enterprise and Skills Development Programme (LESDEP) and the Community-based Rehabilitation Programme (CRP). The outline of the section follows the order in which the issues have been presented here in the introduction.

4.2 Access to Education

Education is simply the process of systematic instruction within an environment structured for that purpose (WHO, 2011). It is held as an important value in all societies regardless of the political and economic ideologies that underpin those societies. As such access to quality basic education is a universal value underscored globally by the Millennium Development Goal (MDG) Two and the Sustainable Development Goal (SDG) Four. MDG Two aimed at achieving access to universal primary education by 2015. According to the UN (2015b), by 2015, developing countries around the world attained 91% enrolment in primary education. Building on MDG Two, SDG Four aims to ensure inclusive and equitable quality education and promote lifelong learning opportunities for all (UN, 2015a).

Education is especially important for children because their formative years is when the most impact can be achieved in basic training. It is during these early years that children are nurtured and are able to cultivate easily, traits and habits that will guide them in their lives as adults. Formal education during the formative years equips children with the necessary knowledge, values and skills required for their personal development and functionality as members of society. Education is also the avenue through which a society

shapes its future generations and ensures equal opportunities even for the most marginalized in society. As an essential element of equality of opportunity, education is widely recognized as a vehicle for social mobility, as such its importance, especially in developing countries cannot be overemphasized.

The benefits of education do not only accrue for the individual, but also for the family, community and country as a whole. In addition to the social mobility for the individual, families with more educated people are also likely to experience an increase in family income and wealth compared to others. This is partly due to the fact that when children have stable access to education, it allows their parents, especially the mothers, to undertake income earning activities in the labour market to augment family income (OECD, 2006).

In most societies, access to basic education is the responsibility of the state due to the importance placed on education in the society as well as for purposes of equity and equality of opportunity. There are also some societies where access to education is regulated by the market, and those with the ability to pay have access. In some other societies, the state regulates the education sector, and also provides public education while leaving room for private providers as well. There are some who have raised concerns about issues of quality of the education when the state is in control and there are others who maintain that access is a value that is salient over quality even though the two are preferred in tandem. While this debate is beyond the scope of this study, it nonetheless begins from the theoretical foundation that access to quality education is a primary value and the responsibility for ensuring equal access lies with the state. In the following sub-section, this study considers access to education in Ghana before assessing access to education for children with disabilities.

4.2.1 Access to Education in Ghana

Ghana is one of the few sub-Saharan African countries that has remained committed to improving access to education at all levels since independence, despite some period of stagnation in the 1970s and the 1980s. The Ministry of Education is responsible for education policy in the country while the Ghana Education Service is the enforcement and regulatory agency for basic and secondary education. Public schools in Ghana are funded by the Ghana government, but both private and public schools are regulated by the Ghana Education Service. Different interventions and policy measures have been adopted by successive governments since independence, both military and democratic, in order to facilitate access to education for all, especially the poor and vulnerable.

By the time Ghana gained independence in 1957, there were wide disparities in access to education at all levels between the southern regions that were relatively more developed than in the northern regions where development levels were still low (Little, 2010). While the southern regions, owing to earlier contact with the missionaries, had well advanced basic and senior secondary schools, there were only a few schools in the northern parts of the country, and access remained low due to inadequate capacity in these schools (Little, 2010). To address these disparities, the Nkrumah government introduced a scholarship scheme for children who hailed from the northern regions to attend primary, secondary and tertiary schools fee-free. As a result, elementary school enrolment more than doubled between 1961 and 1966 when Nkrumah was overthrown from power.

After the overthrow of Nkrumah, the military regime that took over power, led by Major General Ankrah were of the view that the priority placed on access by the Nkrumah administration had led to a compromise in the quality of education in the country (Ninson, 1993). The Educational Review Committee was then set up by the military government to make proposals for improving quality. While the process was still underway, the military regime handed over power to the democratically elected government of Professor Busia and the Progress Party. The tenure of the Progress Party was also short-lived as it was overthrown from power during another military coup in 1972. As discussed in chapter two, between 1972 and 1982, the country experienced political and economic instability that made the viability of any reform difficult. Moreover, even for the reforms that passed, sustainability became a difficulty as it was likely to be truncated by any successive military regime. As a result, access to education was frustrated as enrolment rates dropped significantly during those years of military rule (Essuman-Johnson, 1993).

Some semblance of stability remerged following the introduction of the World Banks's structural adjustment polices (SAP) in the 80's by the Provisional National Defence Council (PNDC). The SAP reforms, despite their controversies, succeeding in stabilizing the economy and making room for education policy reforms. The PNDC regime set up the National Education Commission in 1985 to assess the education situation in the country and propose reforms to address the decline in enrolment and education quality. While these reforms were underway, Ghana transitioned to democratic rule again in 1992 with its newly adopted 1992 constitution. Article 25 of the new constitution entrenched access to education as a right for all Ghanaians, thus introducing a new framework for education policy in the country. To operationalize this constitutional provision, the government through the Ministry of Education adopted the Free Compulsory Universal Basic Education (FCUBE) initiative. The main objectives of this strategic plan, according to Little (2010, p.23) "were increasing access and participation, increasing the quality of education and improving management efficiency." The idea was to decentralize education management up to the district level in order to allow decisions to be taken at the local levels to facilitate access.

In 2003, efforts to improve access to education were taken further with the introduction of the Education Strategic Plan (ESP) 2003 – 2015. This was in line with the Millennium Development Goal Two of achieving universal primary education. The ESP also includes measures for improving access to education for children with disabilities across the country. Together with the FCUBE, this strategic plan has been instrumental in driving up access to education especially for the poor in rural areas both in the southern and northern parts of the country. Building on the success of the free primary school initiatives, the government of Ghana in September 2017 introduced the Free Senior High School intervention to facilitate access to senior high schools for children across the country (Rahman et al., 2018).

Table 5 Educational attainment in Ghana by sexes

Educational attainment	Estimated population			Percent		
	Total	Male	Female	Total	Male	Female
Total	21,913,914	11,114,499	10,799,415	100.0	100.0	100.0
None	341,897	167,318	174,579	1.6	1.5	1.6
Kindergarten	2,035,496	1,063,818	971,678	9.3	9.6	9.0
Primary	7,122,651	3,355,878	3,766,773	32.5	30.2	34.9
JSS/JHS	5,326,615	2,533,324	2,793,290	24.3	22.8	25.9
Middle	1,939,607	1,010,026	929,581	8.9	9.1	8.6
SSS/SHS	2,894,248	1,618,149	1,276,098	13.2	14.6	11.8
Secondary	245,938	169,814	76,124	1.1	1.5	0.7
Voc/Tech/Comm	417,806	228,777	189,029	1.9	2.1	1.8
Teacher Training/Agric/ Nursing Cert	391,610	161,919	229,690	1.8	1.5	2.1
Polytechnic	281,424	188,968	92,456	1.3	1.7	0.9
University (Bachelor)	691,197	456,315	234,882	3.2	4.1	2.2
Unviersity (Post Graduate)	119,924	86,232	33,692	0.5	0.8	0.3
Professional	63,979	46,557	17,422	0.3	0.4	0.2
Don't know	41,523	27,403	14,121	0.2	0.2	0.1

Source: Ghana Living Standards Survey 2017

As depicted in table 5 above, access to education has improved significantly for Ghanaians in general. The policies earlier discussed have ensured that access to guaranteed at the primary level and secondary levels. In the table, primary, JHS, Middle school and SHS are the categories that record that highest educational attainment. The difference in the sexes is also marginal which indicates that parity in education access is gradually being attained. Thus, the impact of the FCUBE and free senior high school polices are clear from this. However, the data also indicates that at the tertiary level, the numbers decline significantly.

4.2.2 Education for Children with Disabilities

Children with disabilities are one of the marginalized groups in society with least access to quality education. According to UNICEF (2013), just 10% of children with disabilities across the globe get access to education, and of this, only half of them get to complete school. As discussed in the previous chapters, disability comes in different forms and as such, measures to address them may also vary. Given that children with disabilities are not a homogeneous group, different educational models have emerged over the years in attempts to address their special needs. A review of the literature suggests three main models of education for children with disabilities; special education, integrated education and inclusive education (Ras, 2008).

Special education is one of the earliest models of education developed to attend to the needs to children with disabilities. As the name suggests, special education is a form of education for children with special needs such as children with various forms of impairments (Addo, 2014). This form of education exists outside the regular education system. This educational model is underpinned by the thinking that the teaching and learning needs of children with disabilities cannot be addressed by the regular school system which was originally structured for children without disabilities. In the special school system, children are organized based on their disability that is blind, deaf etc, for the purpose of teaching and learning (Cain, 2002). Though the special education system may be useful attending to the special needs of children with disabilities, it has been heavily criticized for its exclusionist or approach of isolation which makes integration in society difficult for children with disabilities. The problem here is that education should include learning on how to integrate and live in a community with all others. The special education system does not address this need.

The integrated education model as the name also suggests, is the process of integrating children with disabilities into the same schools as children without disabilities. The main purpose is to allow disabled children learn how to integrate with their other colleagues in school and in society (Ras, 2008). This system empowers children with disabilities by emphasizing their abilities to participate in the regular school system with the other children. It also teachers them how to integrate well into the broader society. The main criticism with this model is that the regular school system is not adapted to the needs of children with as such, some CwDs are unable to integrate well (Addo, 2014). Also, some children with disabilities are the subjects ridicule in integrated schools, like the case of Emmanuel Yeboah discussed in the introduction.

The third model of education for children with disabilities is the inclusive education model which emerged as result of the shortfalls of the special and integrated models of education. The main approach of the inclusive model is to restructure the regular schools to make them sensitive and responsive to the needs to children with disabilities. It includes alterations in the curriculum and pedagogical approach based on the special needs on all the children to be educated, with or without disabilities. It also includes alterations in the physical environment of the school to ensure accessibility across the school environment. This model is currently the dominant model of education internationally for persons with disabilities as it recognizes their special needs as well as the need to integrate them into society (Inclusion Ghana, 2013). In this dissertation, attempt at ensuring access to education for children with disabilities through the various models discussed above will be considered in the case of Ghana.

4.2.3 Access to Education for Children with Disabilities in Ghana

Education for children with disabilities in Ghana has developed more slowly relative to education for children without disabilities. A review of the literature suggests that even though the country has experienced significant improvements in general access to education, improvements in access to education for children with disabilities has at best been modest (Addo, 2014; UNICEF, 2015). The modest achievement in access has however been as a result of the different measures that have been put in place since the colonial period to ensure the education of children with disabilities.

During the colonial period, the earliest attempts at educating children with disabilities began with the establishment of the special schools by the missionaries (Ametepee & Anastasiou, 2015). These special schools at the time were mainly for the blind and deaf children, and their education focused on literary courses as well as special training in basket weaving (Ibid). After independence in 1957, the Ghana government assumed responsibility for education in the country and this included the special education schools that were established by the missionaries. With the passage of the Education Act of 1961, the Ministry of Education took over the mandate for special education in the country from the Labour and Social Service Ministry. In 1970, the Special Education Unit was also established under the Ghana Education Service (GES) to coordinate education for children with disabilities across the country (Little, 2010). Special education schools that emerged during the period include the Hospital School in Asylum Down Accra (1971), the Dzorwulu School (1972), Sekondi Twin City Special School (1976) and the Kumasi Garden City Special School (1977) among others (Kassah et al., 2017).

As indicated in the previous sub-section, the approach of the special education system is to isolate children with disabilities in special schools based on their disability and to educate them with tools appropriately designed for that purpose. The special schools existed separate from the 'regular' schools and as a result, children with disabilities had little contact with their peers without disabilities because children spent most of the weekdays in school. This low level of interaction with others led to a situation where children with disabilities could not interact and engage well with others in society. This is problematic because formal education of children should be aimed at nurturing children to be fit well in society and to be able to make the best of their capabilities and opportunities. The special education approach is based on the medical model of disability, thus the tendency to separate children with disabilities is based on that.

By the 1980's, the shortfalls of such a system became evident as children with disabilities found it increasingly difficult to integrate well in their communities and among their colleagues without disabilities (Ametepee & Anastasiou, 2015). The system received widespread criticism in Ghana and other parts of the world where similar models were adopted. As a result, the Ghana government introduced the integrated system as an attempt to rectify the shortfalls of the special education model (Ibid). The dilemma was that even though the special schools were useful in providing customized education for children with specific disabilities, these children also needed to learn how to integrate effectively into bigger society from which they emerged.

The integrated model involved educating children with disabilities in the same schools as children without disabilities in order to encourage interaction and engagements between them so as to facilitate integration (Ras, 2008). Here, the Unit school system where children with severe disabilities such as blindness, deafness and severe learning disabilities were put into separate classes within the same school environment was adopted (Ametepee & Anastasiou, 2015). The Education Strategic Plan (ESP) 2003 – 2005 captured education for children with disabilities as a main priority area, thus increasing government commitment and resource allocation for that purpose. In 2013, after an extensive consultative process, the Ghana government introduced the Inclusive Education Policy (2013) to further facilitate the education of children with disabilities, ensure their seamless integration into the society and advance their participation in the national development process (Imoro and Sefa-Nyarko, 2020). As captured in the Inclusive Education Policy (2013, p.5) a key objective of the policy is to "improve and adapt education and related systems and structures to ensure the inclusion of all learners particularly learners with

special educational needs." It also includes provisions for ensuring that existing infrastructure in all public schools are made disability friendly (Ametepee & Anastasiou, 2015).

As a result of these measures, some improvements have been recorded regarding access to education for children with disabilities. For example, between 2001 to 2013, school enrolment for children with disabilities increased from 3361 to 6180, thus representing an increase of about 84% (Ametepee & Anastasiou, 2015). Though these improvements are significant, over 80% of children with disabilities still remain out of school. According to the 2010 population and housing census, only 17.4% of children with disabilities have received primary school education. Though information from the 2010 census is dated, it provides insights as to the situation regarding access to education for children with disabilities.

The disparities are worse when segregated by sex and location. As depicted in table 6, 40.1% of persons with disabilities have never attended any school, and of that, 49.8% are from rural areas while 28.9% are from urban areas. A critical look at the table below indicates that more persons with disabilities in rural areas are more likely than their colleagues in urban areas to have never attended school at all, or to have dropped out at some point before tertiary education. The disparity between the education levels of the disabled in rural and urban areas is telling about the impact of poverty on access to education for children with disabilities. This is primarily because of the fact that most of the poor in Ghana are rural dwellers.

In the dispersed rural settlements in Ghana, not every rural community has a basic school. Some of the schools are situated far away from the communities, and students have to journey for some kilometres by foot to get to these schools. For children with severe disabilities who have to be assisted in travelling to the schools on a daily basis, this presents a serious challenge. The lack of school buses and motor transportation in most of the rural areas also makes the situation worse. As a result, children with disabilities may opt not to attend school in order to avoid the daily stress of commuting to school with the assistance of a family member who may have to compromise of their own employment for this.

It is clear from the above analysis that poverty is one of the key factors that obstructs access to education for many children with disabilities, but poverty is not the only factor. According to UNICEF, multiple factors including poverty, restrictive infrastructure in schools, and hostile school environments among others interact to keep children with disabilities out of school.

Table 6 Education Level of Persons with Disabilities in Ghana

Type of Education	Total (N=713,400)			Male (N=337,543)			Female (N=375,857)		
	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
Never attended	40.1	28.9	49.8	31.5	20.1	40.7	47.9	36.4	58.3
Nursery	1.3	1.2	1.4	1.5	1.4	1.5	1.2	1.1	1.3
Kindergarten	2.1	1.9	2.2	2.3	2.2	2.4	1.8	1.6	2
Primary	17.4	16.5	18.1	17.8	16.4	19	16.9	16.6	17.2
JSS/JHS	10.6	12.4	9	11.5	13.2	10.1	9.8	11.8	8
Middle	15.6	18.2	13.3	18.9	20.5	17.5	12.6	16.2	9.4
SSS/SHS	4.3	6.5	2.4	5	7.4	3.1	3.6	5.7	1.8
Secondary	2.2	3.6	1	3.1	4.9	1.7	1.4	2.5	0.4
Voc./tech/com	2	3.2	0.9	2.3	3.6	1.2	1.7	2.9	0.6
Post middle/secondary certificate	1.4	2	0.9	1.7	2.2	1.4	1.1	1.8	0.5
Post-secondary diploma	1.7	3	0.6	2.3	4	1	1.2	2.1	0.3
Bachelor degree	1.1	2.1	0.3	1.6	3.1	0.4	0.6	1.2	0.1
Post graduate	0.3	0.6	0.1	0.6	1.1	0.1	0.1	0.2	*

Source: Ghana Statistical Service, 2010 Population and Housing Census

Source: 2010 Population and Housing Census, Ghana Statistical Service

The census data referred to here (GSS, 2010) is dated, but it still remains insightful because it is the most comprehensive and credible data set on demographics and access to social services. More importantly, the observations in the data have also been confirmed by recent studies including Ametepee and Anastasiou (2015), Addo (2014) and Imoro and Sefa-Nyarko (2020) among others. In the Report on the State of Child Protection in Ghana, Imoro and Sefa-Nyarko (2020) observed that despite the clear requirements by the Person's with Disability Act (2006) and the Inclusive Education policy (2013), about 70% of schools in the Greater Accra region did not have disability friendly facilities including toilets on their campuses. This is in spite of the fact that most of these schools have enrolled persons with disability into their schools as part of efforts to further inclusive education. Given that Accra is the capital of Ghana, it raises questions about the state of affairs in the remaining parts of the country especially the rural areas. It also seeks to suggest that there is still a wide gap between the commitment of the government in policy and its practical commitment since enough resources are not being channelled to address the access to education challenges for persons with disabilities.

In her study on access to education for the mobility impaired in Accra-Ghana, Addo (2014) notes that many of the children with disabilities drop out of school because of their difficulty in using school facilities that are not disability friendly. This includes the steep staircases, the absence of grab rails, narrow entrances, toilets without seats or support rails, and obstructions in pathways among others. In her analysis, she indicates that many of the disabled children do not always get the support they need from their colleagues or teachers in using these facilities, as such, it makes the school experience very uncomfortable, leading them to drop out. This she observed was particularly worse in low-income urban communities such as Kotobabi and its environs (Addo, 2014). The fact that the drop-out rates are higher in poorer communities is instructive about the influence of poverty on access to education for persons with disabilities. The rich who have children with disabilities have the option of taking their children to private schools that have disability friendly facilities in the schools as well as special support staff for the disabled. Such systems make it easier the disabled children to adapt within such environments and to participate in the learning process.
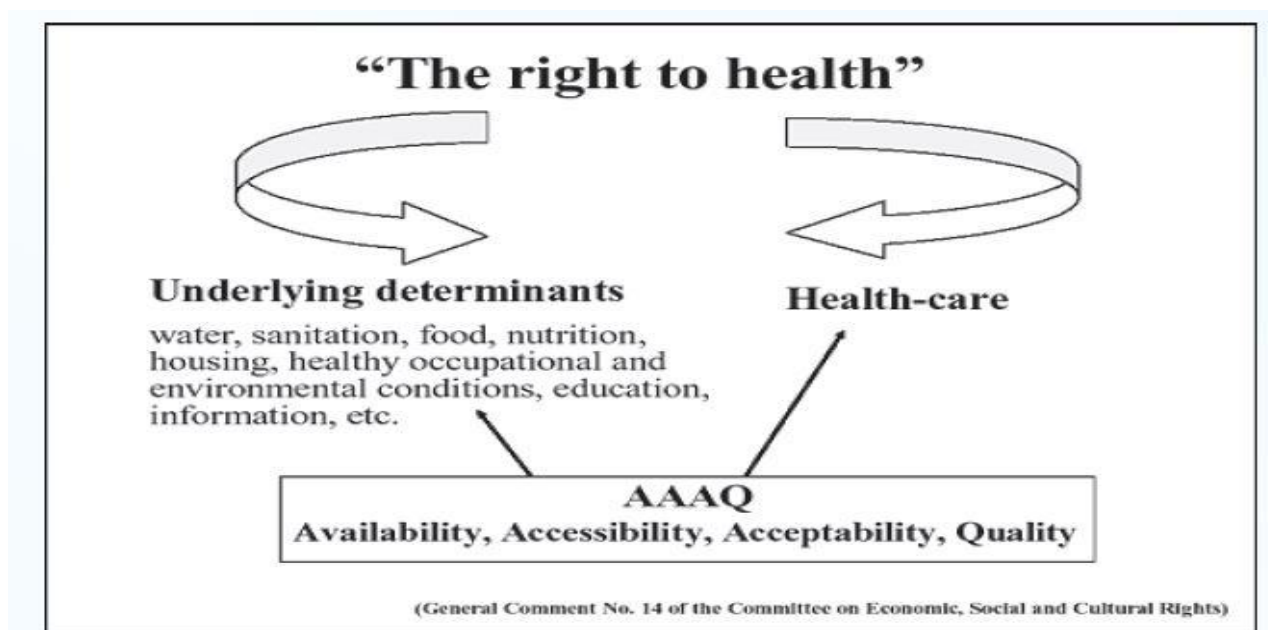
4.3 Access to Healthcare

One of the main objectives of this study is to understand how poverty impacts access to healthcare for persons with disabilities as well as their health-seeking behaviours. Health-seeking behaviours relates to measures adopted by children with disabilities and their families to satisfy their health needs (Abrokwah et al., 2020). This subsection presents and discusses the findings based a review of secondary data sources. It begins with an overview of access to healthcare before focusing on access to healthcare for children with disabilities.

At a human level, good health is necessary for survival and effective functioning of every person (Abrokwah et al., 2020). For an individual to be able to function well at school or at work, the person needs to be in good health. Often times people are absent from work, school or other important functions or events due to ill-health (Shakespeare et al., 2018). At the institutional and global levels, it is a basic universal right that every person irrespective of age and status should have access to. It is based on this recognition that goals four, five and six of the Millennium Development Goals all relate to the promotion of good health (WHO, 2018). As a matter of fact, goal three of the Sustainable Development Goals (SDGs) captures access to good health and wellbeing as an essential right for all in society. Closely related to this, goal six of the SDGs also articulates the need to clean water and good sanitation as a necessary requirement for healthy living (UN, 2016).

Beyond the MGDs and the SDGs, many of the international treaties and agreements underscore the importance of healthcare as a universal human right, and the need for governments to work to ensure access to quality reliable healthcare for their populations. Article 25 of the Universal Declaration of Human Rights (1948) points to the necessity of access to basic healthcare as a human right for all. Articles 23 and 24 of the United Nations Conventions on the Rights of the Child (1989) also captures healthcare as a universal right that states need to work towards ensuring their citizens. Article 16 of the African Charter on Human and People's Rights makes similar calls for member states to institute measures to ensure the provision of good quality healthcare for all their populations.

At its basic level, the right to healthcare has two main components; access to the institutional healthcare system and healthy environmental conditions such as good sanitation etc (Inclusion Ghana, 2013). The first part has to do with seeking healthcare services and treatment from healthcare professionals and providers in clinics and hospitals, while the second, which is more preventive, has to do with public health concerns such as good drinking water, good sanitation, good housing, and adequate nutrition among others (Ibid). As illustrated in the diagram below, these two components of health are complimentary, and both necessary requirements for the attainment of good health in a given society.

Figure 5 Components of right to health

Source: Inclusion Ghana 2013

4.3.1 Access to Healthcare in Ghana

Ghana is one of the sub-Saharan African countries that is making some progress towards the provision of basic healthcare for its population. The government of Ghana, through the Ministry of Health (MOH), the Ghana Health Service (GHS) and the Ghana Medical and Dental Council (GMDC), is the biggest health care provider and regulator of the healthcare industry in the country. The public health facilities in the country operate at four main levels; the teaching hospitals, regional hospitals, district hospitals/health-centres and community-based health planning and services centres (CHIPs) compounds. In addition to these, there are also private hospitals that operate within the country as autonomous health entities but under the regulation of the Ghana Health Service.

In 2003, the Ghana government passed the National Health Insurance Act 2003 (Act 650) which established the National Health Insurance Scheme, in order to ensure universal health coverage for Ghanaians and other persons living in Ghana at low or no cost at all (NHIA, 2021). The enactment of this legislation, and the subsequent establishment of the national health insurance scheme has been very instrumental facilitating access to healthcare for many in the country, especially the poor and marginalized.

According to the Ghana Living Standards Survey Round 7 (GSS, 2017), 77.7% of the population of Ghana have some form of health insurance coverage. Of the entire population who have health insurance, 77% of then are registered onto the national health insurance scheme, but 44.9% of these are covered. Coverage here means that the registered person's subscription to the scheme is active due to regular payment of the insurance premium.

Table 7 Health Insurance Coverage in Ghana by Region

Region/Locality	Health Insurance		National Health Insurance Scheme	
	Registered	Covered	Registered	Covered
Ghana	77.7	51.7	77.0	44.9
Western	73.4	46.8	72.2	42.3
Central	67.5	48.2	67.1	37.5
Greater Accra	69.9	45.9	67.9	40.2
Volta	79.9	54.2	79.7	42.7
Eastern	81.6	55.9	81.3	47.8
Ashanti	80.1	48.2	79.5	43.8
Brong Ahafo	88.5	57.8	88.2	53.7
Northern	75.3	50.6	75.1	43.8
Upper East	88.5	71.2	88.4	60.2
Upper West	88.3	69.0	87.9	57.5
Urban	79.7	56.2	78.7	50.1
Rural	75.6	47.1	75.3	39.5
Accra	68.3	42.0	67.0	37.3
Other Urban	81.3	58.1	80.2	51.8
Rural Coastal	68.7	49.1	67.8	37.1
Rural Forest	75.3	43.3	75.0	37.5
Rural Savannah	79.3	51.7	79.1	43.5

Source: Ghana Living Standards Survey Round 7

A shown in table 7 above, even though percentage of people registered onto the national health insurance scheme in urban (78.7) and rural areas (75.3) have little difference, the gap emerges with the active coverage. Under NHIS coverage, 50.1% of the urban population have their health insurance active, while that for rural areas is 39.5% (GSS, 2017). The difference is easily attributable to the widespread poverty in rural areas which makes it difficult for those in these areas to consistently afford the premiums. Without active coverage under the national health insurance scheme, they are left to seek other means to attend to their healthcare needs or pay cash for services in public hospitals or health facilities in case of emergencies (Asuman et al., 2020).

In Ghana, it is the responsibility of the parents to register their children onto the health insurance scheme. The family premium covers all in the family including the children. Thus, the data above also covers that for children as well. In addition to the NHIS, the government has also put in place some measures to ensure the preventative healthcare for children especially. This is in order to avoid potential impairments from disease or infection from any of the childhood diseases. This has most been through early vaccination of children under five years against diseases such as tuberculosis, measles, pertussis, poliomyelitis, tetanus and diphtheria. This has been very instrumental in reducing the rates of these diseases among children across the country. The issue however is that coverage is still not yet comprehensive, and many children in rural areas do not get covered by the vaccinations. Table 8 contains information about children less than age 5 who are not vaccinated against these diseases.

Table 8 Children less than 5 years not vaccinated by ecological zone

Age in years	Ghana	Accra (AMA)	Urban			Rural		
			Coastal	Forest	Savannah	Coastal	Forest	Savannah
All	2.2	0.9	0.5	0.5	0.7	1.1	1.9	6.7
< 1 year	3.5	7.0	1.1	0.4	0.7	5.4	3.7	7.4
1 year	1.1	0.0	0.0	0.0	2.0	0.0	1.9	2.4
2 year	1.7	0.0	0.0	0.7	0.1	0.0	1.6	6.2
3 year	3.7	0.0	1.8	0.7	0.6	1.5	1.9	11.9
4 year	3.2	0.0	0.0	1.0	1.3	1.2	2.2	11.7
5 year	0.2	0.0	0.0	0.0	0.0	0.0	0.3	0.8

Source: Ghana Living Standards Survey Round 7

As clearly shown in the table 8 above, 2.2% of children less than 5 years old have not been vaccinated against these diseases in the entire country. Out of this, the highest percentage, 6.7%, of children not vaccinated are from the rural savannah area, one of the poorest regions in the country.

4.3.2 Healthcare for Persons with Disabilities
The healthcare needs of persons with disabilities are complex and, in most cases, surmount the healthcare needs of persons without disabilities. On one level, disabled people have the same healthcare needs as others without disabilities including medical screening, preventive behaviours, vaccination against common infections, and treatment of diseases among others (Shakespeare et al., 2018). On another level, the healthcare needs of persons with disabilities goes beyond the needs of those without disabilities. This is mainly because, persons with disabilities have additional health needs that arise directly as a result of their primary impairment, as well as increased risk of secondary health conditions and co-morbidities. The extract below from Shakespeare et al. (2018, p.6) is instructive.

> "There is good evidence that persons with disabilities are more likely to have poorer health than the general population, due to a variety of possible mechanisms, which may be different for people with different impairments. First, by definition they have a *primary impairment*, which may or may not be a health condition which becomes progressively more significant, such as multiple sclerosis or muscular dystrophy. Some impairments do not directly affect health, they could be considered more as differences in functioning – such as Deafness or some aspects of neurodiversity."

In addition to primary impairments, persons with disabilities also have a greater risk of getting secondary health conditions which may be as a direct result of the primary

impairment. According to Shakespeare et al. (2018, p.6) "people with Down's syndrome are more likely to experience congenital heart disease, impaired hearing and early onset dementia. People with blindness due to diabetes may also experience kidney disease. People with cerebral palsy may develop osteoporosis. People with schizophrenia are at higher risk of diabetes." This increase in the health risk of disabled people also increases their health needs as a result.

There is also the possibility of co-morbidities that may arise as a result of social exclusion or poverty. Co-morbidities are health disorders that exist simultaneously in a given organism or body but may not be related or have a causal relationship. Persons with disabilities who are at high risk of poverty due to social exclusions in education and employment, are more likely to develop anxiety, depression and other illnesses common to poor people such as malnutrition and malaria (Ibid).

4.3.3 Access to Healthcare for Persons with Disabilities in Ghana

A review of the existing literature indicates that Ghana has over the last two decades made modest strides in improving access to primary healthcare for children with disabilities and all disabled people. Yet serious challenges remain that frustrate access to quality healthcare for disabled persons in Ghana (Dassah, 2019). At the institutional level, Ghana has signed on to the United Nations Convention on the Rights of Persons with Disabilities, and article 25 of the convention articulates good quality healthcare as a basic human right for disabled persons, and places the responsibility on the state, in this case Ghana, to provide this for its people. In furtherance of this, the Person's with Disability Act (2006), enacted by the government of Ghana, articulates the importance of health for persons with disabilities and makes provisions to secure access. Article 31 of the Disability Act (2006, p.9) states that "The Ministry of Health in formulating health policies shall provide for free general and specialist medical care, rehabilitative operation treatment and appropriate assistive devices for persons with total disability." Specifically with regards to children with disabilities, Article 34 states that, "The Ministry of Health in collaboration with the Ministries responsible for Education and Social Welfare shall provide for the periodic screening of children in order to detect, prevent and manage disability." In fact, Articles 31 to 35 of the Act are dedicated to the health concerns of persons with disability.

In addition to the provisions in the disability Act, the National Health Insurance Scheme also aims to make access to healthcare more affordable for Ghanaians, including the disabled. Under this scheme, subscribers are to pay an annual premium for healthcare which the government has subsidized. In the most current version of the health insurance law, Act 852 (2012), specific groups are exempted from payment in Article 29, and this includes children and persons with mental health disabilities. In tandem, these laws are supposed to ensure that children with disabilities have unrestricted access to healthcare services in the country.

The reality on the ground however is that despite the modest improvements in access to healthcare for children with disabilities through the institutional measures discussed above, significant barriers still remain for many disabled children, especially those from poor backgrounds in accessing primary healthcare in Ghana (Abrokwah et al., 2020; Dassah, 2019). The main barriers according to Abrokwah et al. (2020), are financial, attitudinal, structural and communication barriers. While the financial barrier is the most significant,

the interaction between all these factors worsens and complicates access to healthcare for children with disabilities.

Cost of medical care remains a challenge for many children with disabilities accessing healthcare for a number of reasons, chief of which is that the National Health Insurance Scheme does not comprehensively cover medical treatment and rehabilitation. Even for this limited coverage, not all disabled children have unrestricted access to the services covered under the insurance scheme. In 2015, a team of researchers with the Centre for Disability and Rehabilitation Studies at the Kwame Nkrumah University for Science and Technology conducted a cross-sectional study in the Kumasi Metropolis to understand the impact of finance on access to healthcare for persons with disability. Among other issues, the study found that just about 63.5% of persons with disabilities were enrolled onto the scheme and frequently sought healthcare services through the insurance scheme (Badu et al., 2015). The remaining either paid cash directly for healthcare services or sought treatment with traditional healers. This situation was mainly as a result of the fact that the insurance scheme only covered diagnosis and treatment for a limited number of diseases. A lot of prescription drugs required by the disabled were not covered by the insurance scheme, neither were rehabilitation services (Ibid). This meant that disabled children and their families still had to pay for healthcare in spite of the insurance scheme. The study found that families of children with disabilities spent on average about 10% of their income on healthcare, and this was dependent on the type pf disability, the insurance coverage, age and gender of the disabled child (Ibid).

An even more disturbing finding was the fact that not all children with disability qualified for the exemption from premium payments guaranteed by the scheme (Badu et al., 2015). This was because even though the policy indicated that children with disabilities from poor homes had to be exempt from paying the health insurance premium, clearance for this had to be granted by the Disability Common Fund, and this created bureaucratic hurdles that frustrated children with disabilities and their families in their attempts to secure healthcare services (Ghana Federation of the Disabled, 2013). The Disability Common Fund is a social protection initiative of the Ghana government that aims to reduce poverty among persons with disabilities through support for income generation activities and other support systems (NCPD, 2010). Part of its responsibilities includes covering the cost of exemptions from the NHIS premium, and thus requiring them to vet and approve disabled persons from poor backgrounds before exemptions are granted. Beyond the bureaucratic hurdles, the main challenge according to Addae-Koranky (2013) is that the criteria and processes for selecting the poor are ineffective and poorly executed. This leads to a situation where many disabled children from poor households do not qualify for the exemption. The result of this is that many disabled children and their families either opted to pay the annual premiums in order to benefit from the health insurance scheme, or to pay directly for healthcare services.

In a study assessing the perspectives of healthcare providers on the provision of healthcare services for children with physical disabilities, Dassah et al. (2019, p.5) noted that "participants especially indicated that although the national health insurance scheme covers most of the services, some of the clients with physical disabilities could not purchase or annually renew the insurance coverage because of poverty." In the same study, Dassah et al. (2019, p.5), health workers also "reported that many of their clients with disabilities were unemployed and thus lacked financial resources to cover the cost of care."

In addition to the direct cost of healthcare there are indirect factors such as transportation that also increases the cost of access to healthcare for children with disabilities. According to Badu et al. (2015), the form of disability, available family support and the distance impact the travel cost and the decision to travel based on this. As a result, in situations where the distance between the disabled person the health facility is very long and they require support in travelling, disabled persons decide not to access the health facilities due to the high costs. They only opt to go when the disabled child is in dire need of healthcare services (Dassah et al., 2019).

The environmental and structural factors have to do more with the environment of the medical facility and obstructions in there that can frustrate access to medical care for children with disabilities. Despite provisions in the Disability Act (2006) to ensure that all public facilities are made disability friendly, most of the structures in healthcare facilities across the country remain unfriendly especially to persons with physical disabilities (Dassah et al., 2019). In most hospitals, entrances remain inaccessible to the disabled due to obstructions at the entrances and in outpatient departments (OPD) (Ibid). According to Abrokwah et al (2020, p.127), the disabled "especially those with visual and mobility disabilities, lamented that most of the hospital furniture and equipment such as beds, laboratory chairs, examination tables and chairs, beds in the admission and labour wards were very high, making them difficult to climb onto. Some of them said they had slept on the floor during admission. The situation was worse for pregnant women with mobility disabilities who struggled for access to the beds while in labour." Dassah et al. (2019) similarly found that in some hospitals equipment such as weighing scales are not also disability friendly, resulting in situations where healthcare professionals had to guess the weights of the disabled in order to treat them. These physical and environmental factors frustrate children with disabilities anytime they seek healthcare treatment, and in order to avoid such embarrassing situations, some opt not to seek medical care from these healthcare centres.

Another major barrier that has been identified as negatively affecting access to healthcare for the disabled are negative attitudes of healthcare professionals such as Doctors and nurses towards disabled children and persons with disabilities generally. A study conducted by the Social Work Department of the University of Ghana on access to healthcare for persons with disabilities found that many persons with disabilities including children often experience negative such as rude and disrespectful behaviours from doctors, nurses and laboratory officers among other healthcare professionals when they visit the hospital (Abrokwah et al., 2020). This often makes the disabled feel disrespected and discriminated against, and often times influences their decisions not to seek treatment from the hospital or health centres. Such negative attitudes may be as a result of lack of awareness and sensitization on the part of the healthcare professionals, of the plight of the persons with disabilities (Ibid).

There are communication barriers that also impact access to healthcare for the disabled, but these are more with children with hearing disabilities. Most healthcare professionals do not understand nor can they communicate in sign language, and the most healthcare facilities do not have sign language translators (Abrokwah et al., 2020). This makes communication between the healthcare professionals and disabled children difficult, unless in cases where the child is accompanied by somebody capable of interpreting sign language for the healthcare professionals. This communication barrier not only hinders effective consultation and treatment, but also influences the decision of children with disabilities to seek treatment from healthcare centres.

4.4 Interventions to Support Persons with Disabilities

The third objective of this study is to identify the interventions in place to support the disabled and to assess how these have contributed to the wellbeing and protection of the disabled. Persons with disabilities go through many challenges as a result of their impairments, making it difficult for them to cope on their own. Over the years, a number of interventions have been rolled out by the government and some private sector actors in order to support the disabled. Both categories of interventions will be considered in this subsection. Among the interventions to be discussed here are the Disability Common Fund (DCF), the Livelihood Empowerment Against Poverty (LEAP), Local Enterprises and Skill Development Programme, and the Community-based Rehabilitation Programme.

4.4.1 Disability Common Fund (DCF)

The Disability Common Fund is a fund that was set up by the Ghana government as an initiative to help support persons with disabilities in the country. The main aim of the intervention is to help reduce poverty among the disabled and their families (TEERE, 2018). Established in 2005, the intervention operated as a quarterly cash transfer scheme where persons with disabilities receive cash transfers every quarter through their local district or municipal assemblies. The local offices of the National Council for Persons with Disabilities (NCPD) are also to assist in facilitating the distribution of the cash transfers through identifying the disabled and ensuring that they receive their transfers (Ibid).

The source of money for the DCF is the District Assemblies Common Fund (DACF). The DACF was established in 1993 as a fund to support the district, municipal and metropolitan assemblies in making autonomous development decisions at the local level. In 2009 the government of Ghana issued a directive that required that annually, about 2% of the District Assembly Common Fund in each district or municipality to be transferred to the DCF and used in assisting persons with disabilities, especially those in the informal sector (Edusei et al., 2018).

Since its establishment, the disability fund has been very useful in supporting the disabled children and those working in the informal sector to address their needs. Despite complaints about the insufficiency of the funds, studies including Edusei et al. (2017, p.1) note that the funds have been useful in the "procurement of assistive devices, awareness creation, enabling the environment, payment of school fees of dependents and assisting beneficiaries to access healthcare." This however remains insufficient as many of the disabled in remote areas struggle to access the funds, and for those that access the funds, only a few needs are met.

4.4.2 Livelihood Empowerment Against Poverty (LEAP)

The Livelihood Empowerment Against Poverty (LEAP) is a social protection initiative introduced by the Ghana Government in 2008 to support extremely poor and vulnerable

households (Amuzu et al., 2010). Captured under the Ghana National Social Policy Strategy (NSPS), the main objective of this cash transfer programme is to smoothen consumption and promote easy access to services such as healthcare and education, as well as other opportunities for the poor and vulnerable. A cash transfer is basically a direct transfer of money to an eligible recipient. They can either be conditional, where payments are based on the fulfilment of certain conditions by the recipient, or unconditional, where recipients have no obligations to fulfil any conditions (Bateman, 2011). Cash-transfers can also either be targeted, where there is a criterion for eligibility, or non-targeted where the disbursement is universal (ibid). The LEAP initiative is a conditional cash-transfer programme implemented by the Department of Social Welfare (DSW) under the Ministry of Gender Children and Social Protection.

The LEAP programme has three specific targets; orphaned and vulnerable children; persons with severe disabilities without any productive capabilities; and elderly persons above 65 years (MOGCSP, 2018). Specifically, the initiative aims to prevent and reduce the involvement of children, especially children with disabilities, in any form of child labour or street begging (MOGCSP, 2018). According to the MOGCSP, between 2008 and 2015, the LEAP programme benefited 146,074 households in 185 districts across the country. As at 2018, LEAP reportedly covered 112,367 households in northern Ghana alone, with the majority of the beneficiaries being older women and children with disabilities. Korboe (2011) notes that the cash transfers have in fact been instrumental in improving the wellbeing of some beneficiary households and helped improve crop production through better quality farm inputs such as seeds and equipment. He also notes that some households have been successful in keeping disabled children especially the girl-child in school through support from LEAP.

The programme also assists children with disabilities in accessing other social services provided by the state. According to the Ghana Statistical Service (2014, p.23) "a Memorandum of Understanding has been signed between the employment ministry and the health, education and agriculture ministries to provide free access to the National Health Insurance Scheme (NHIS), free school uniforms and access to agriculture support" for the disabled. The aim is to help the disabled have easy access to public healthcare services without having to worry about the cost. It is based on the recognition that many PwDs are poor and may be unable to access healthcare primarily due to the cost of healthcare.

Yet despite these broad benefits of the programme, concerns have been raised about the corruption in the selection of the beneficiaries which leads to the exclusion of many disabled persons and their families. At the local levels, the selection process is handled mostly by political party loyalists appointed to satisfy short-term electoral and political needs. This results in situations where the selection process is marred with corruption, thus frustrating disabled people who are legally entitled to the scheme (Amuzu et al., 2010).

4.4.3 Local Enterprises and Skills Development Programme (LESDEP)

The local enterprises and skills development programme is a public-private partnership between the government of Ghana, represented by the Ministry of Local Government and Rural Development, and the Entrepreneurs Foundation of Ghana. Launched in April 2011,

the aim of this social intervention was to provide free training for the poor and unemployed in a wide range of skills and entrepreneurial development. Persons with disabilities, including older children are part of the targets of the initiative. This is in order to enable them gain employable skills, or to establish their own businesses and be self-reliant through the entrepreneurial training. The training was provided in skills such as information and communications technology (ICT), tailoring, barbering, construction, photography, fashion design and farming, to name a few.

According to the Ghana Statistical Service (2014, p.22-23), since inception, the "initiative has helped in providing opportunities for PWD who otherwise would be unemployed and without any skills. Through a specialized hands-on training module, LESDEP has trained disabled persons to acquire viable skills to make them self-employed within the shortest possible time in their localities." Many of the disabled have been trained in skills such as décor management, beauty care, food catering, phone and electronic repairs, kente weaving and fashion design (GSS, 2014). Kente is a locally weaved fabric in Ghana that is popular as a traditional wear among the Akan ethnic group. After the successful completion of the training programme, participants are provided equipment and tools for their work as well as capital in assisting them establish businesses.

While anecdotal evidence (GNA, 2012) suggests that the LESDEP has been successful in equipping the poor and the disabled with skills and capital to establish businesses, there has been no state level efforts to evaluate to intervention to credibly ascertain its successes, challenges and learnings. Such an evaluation would provide insights that would be useful in reforming this initiative as well as in designing similar social intervention programmes.

4.4.4 Community-based Rehabilitation Programme (CRP)

The national community-based rehabilitation programme is a social intervention established in 1992 to support persons with disabilities. It was initiated by the Government of Ghana, under the auspices of the then Ministry of Employment and Social Welfare in collaboration with the Swedish Organizations of Disabled Persons International Aid Association (SHIA) and the Norwegian Association of the Disabled (NAD) with support from the World Health Organization (WHO), the International Labour Organization (ILO), United Nations Educational Scientific and Cultural Organization (UNESCO) and the United Nations Development Programme (UNDP). The Ministry of Employment and Social Welfare is now the Ministry of Employment and Labour Relations, and its social welfare is now the responsibility of the Ministry of Gender, Children and Social Protection.

The main objective of the initiative is to enhance the quality of life of persons with disabilities in Ghana. According to the WHO (2002, p.7), the specific goals of the programme are "to promote the human rights of persons with disabilities by raising awareness and mobilizing resources in the districts and communities; to establish links between service providers in health, education, community development and social welfare; to strengthen associations of disabled persons and; to develop a National Policy on Disability and appoint a National Advisory Committee on Disability." Under the programme, the community-based rehabilitation agents are employed and trained at the district level by the Department of Social Welfare to handle rehabilitation of the children with disabilities in the communities. The agents guide the families of the disabled child in

providing rehabilitation services at their homes (GSS, 2014). Specific peripatetic teachers are also trained to handle the inclusive education of children with disabilities in schools across the districts. The devolution strategy of this initiative allows for major decision making at the local district levels, leading to an increase in community participation and ownership of the initiative (Ibid).

Since its inception, the programme has been instrumental in improving the self-image and confidence of beneficiaries, increased social acceptance through community sensitization an awareness creation. The initiative has also been useful in enhancing the self-reliance of the disabled through an increase in their ability to manage their own lives and to support themselves and families financially through skills acquired (WHO, 2002). Yet, despite these milestones, the programme has a number of shortcomings that need to be addressed. These include limited coverage in districts across the country, lack of credible data on the prevalence of disability in Ghana as well as poor coordination between state agencies in rolling-out the initiative (Kuyini et al., 2011). The decline of funding for the programme in the last decade as also impacted the sustainability of the initiative as there are no funds to continue.

4.5 Chapter Conclusion

Health and education are basic human rights universally agreed upon and articulated by different international treaties and convention including the United Nations Human Rights Declaration. Governments, based on their social contracts with citizens have the primary responsibility to guarantee these basic rights for its populations either through directly providing these services for the people, or facilitating access to these. In fulfilling this role, priority ought to be given to the poor, underprivileged and marginalized in society. Persons with disabilities are among the poorest, underprivileged and most marginalized groups in society.

The purpose of this chapter was to assess the impact of poverty on access to health and education for children with disabilities, as well as to understand how the government of Ghana has over the years tried to improve the wellbeing of children with disabilities and persons with disabilities in general. To do this, the chapter assessed the state of general access to education and healthcare in Ghana in general before proceeding to discuss how this specifically affected disabled children. The discussions established that since independence, Ghana has made significant strides in advancing access to healthcare and basic population for the general population. Policies and interventions such as the free compulsory universal basic education initiative and the recent free senior high school directive have ensured that education at the primary and secondary levels are tuition free for all Ghanaians in public basic schools. The National Health Insurance Scheme introduced in the 2000s has also ensured improved access to primary healthcare in the country at meagre yearly premium. These interventions in the healthcare and education industries also apply to persons with disabilities as well. However, given their peculiar situations, attempts have also been made to improve their access to these services. Children with intellectual disabilities have been exempted from the paying the yearly premium for the health insurance scheme, and the government has also introduced an Inclusive Education Policy to ensure that disabled children receive education together with other children in public schools in order to aid their integration into the broader society. These efforts have

chalked modest success and as the discussions illustrate, much remains to be done about access to education and healthcare for children with disabilities.

The chapter also included discissions on other social interventions aimed at improving the well-being and quality of life of disabled children and persons with disabilities in general. The interventions discussed include the Disability Common Fund, the national Community-based Rehabilitation Programme, Local Enterprises and Skills Development Programme, and the Livelihood Empowerment Against Poverty programme. Though these initiatives have had varying impacts on the lives and wellbeing of persons with disabilities, their overall impact cannot be negligible, even though challenges remain that need to be addressed to ensure optimum impact. In the next chapter, this dissertation outlines recommendations that would be useful in improving the effectiveness and efficiency of these programmes in order to have the maximum impact in improving the quality of life of persons with disability.

5. Chapter Five – Recommendations and Conclusions

5.1 Introduction

This chapter is the concluding chapter to this dissertation. In the previous chapter, this dissertation discussed issues of access to education and health in Ghana for children with disabilities and how state interventions have improved the quality of life of persons with disabilities. The chapter established that despite the modest strides achieved in improving access to healthcare and education as well as improving the quality of life of the disabled, more needs to be done. This chapter in concluding the study, outlines recommendations for improving the interventions aimed at improving the wellbeing and quality of life of persons with disabilities before summarizing this dissertation.

5.2 Recommendations

This sub-section outlines and discussions recommendations to improve the wellbeing and protection of children with disabilities and the disabled in general. Recommendations to be discussed include building a credible and reliable database for persons with disabilities in Ghana, increasing the allocation of the Disability Common Fund, increasing training and sensitization for healthcare workers and school authorities among others.

Credible and Reliable Database on Persons with Disability in Ghana

The discussions in the previous chapters made it clear that existing data on persons with disabilities is far from complete (Opoku et al., 2018). This is mainly because due to stigmatization and discrimination, many families do not indicate that their children have disabilities for purposes of national records. The current most reliable database on persons with disabilities is the 2010 national population and housing census. The main concern is that this data is about a decade old, and even at the time of compilation did not contain a comprehensive account of persons with disabilities in the country. This lack of credible data makes it difficult to adequate design and implement interventions for the disabled. Resources required for interventions will have to be decided and provided based on the estimation of the needs of the beneficiaries to be covered by the initiative. Without accurate data such an estimation will not be possible, and the project implementation may suffer due to an inadequate estimation of the resources.

The recommendation of this dissertation is that efforts should be put in place by the state to put together a comprehensive database on persons with disabilities in Ghana. This can be done through the Ghana Statistical Service (GSS) and the National Council on Persons with Disabilities (NCPD) in the upcoming 2021 census. The GSS with its decades of experience in research and data collection is the best institution to undertake this task. The NCPD given its activities with persons with disabilities across the country will be instrumental in identifying families with disabilities and in encouraging disabled persons to be captured in the database. During the census, the population can be educated to understand the rationale behind putting together a comprehensive data set for persons with disabilities, and incentives can be provided for their families to increase the willingness

provide information on the disabled. Such a data set, if collected, will be instrumental not only for programming and policy planning, but also for understanding the general disability situation in the country, their plight and how to address this. Interventions to also improve access to education and healthcare access for the disabled will also benefit from such a comprehensive database.

Increase Disability Common Fund (DCF) Allocation

The discussions in chapter four highlighted the fact that the Disability Common Fund (DCF), despite its usefulness in supporting the wellbeing and activities of the disabled, remains insufficient (TEERE, 2018). Currently the allocation for the DCF is 2% of the District Assemblies Common Fund (DACF). This allocation is used to provide direct cash transfers to persons with disabilities as well as support other activities of the disabled persons in the districts. As Edusei et al. (2017) have pointed out, the allocation is insufficient addressing its primary objectives, thus creating pressure on the fund at the local levels.

The recommendation of this dissertation is that the allocation of the DCF be increased from 2% to 5% of the DACF. This is so that the fund can adequately cover the expenditures under its objective to alleviate poverty among persons with disabilities. The upcoming 2021 census will provide more clarity on the prevalence of disability in Ghana. What is clear is that, the numbers will increase, and if effort to create a credible database are successful, more funding and resources will be required. Increasing the allocation for the DCF will make sufficient funds available for implementing the cash transfer programme under the DCF and also for supporting community sensitization on concerns of persons with disabilities and their integration in society.

Under the DCF, the cash transfers to the families of disabled children should be made conditional and one of the main conditions should be for the families of disabled children to ensure that part of the money received is used to purchase school uniform and supplies, as well as transport children with disabilities to school. With the national database recommended earlier in this section, the government can monitor school attendance of the disabled children as well as compliance with the other conditions aimed at improving the wellbeing and quality of life of children with disabilities. This will partly help address challenges of children with disabilities in accessing basic education either due to transportation difficulties or cost of acquiring school supplies.

The increased allocation would also cover primary healthcare for children with disabilities, thus resolving the problem of access to healthcare for disabled children. The current practise is that even though children with disabilities are supposed to enjoy free healthcare coverage under the National Health Insurance Scheme, clearance needs to be sought from the DCF offices at the district level before that is possible. Due to the insufficiency of the funds, a lot of disabled children do not get clearance and have to find alternative means of meeting their healthcare needs. Increasing the allocation of the DCF will ensure that all children with disabilities are covered and will not have to constantly seek clearance from the DCF before receiving healthcare. This can made possible through the national database on persons with disability recommended earlier in this section. The database will serve as a means for identifying children with disabilities who will already be registered onto the system. Verification can be done on the system instead of through a lengthy bureaucratic process. Moreover, such a database also allows for easy monitoring of the disabled, their healthcare needs, and whether they are being adequately addressed.

Training and Sensitization

One of the issues that came out clearly in the discussions in the previous chapter were the negative attitudes and treatments received by disabled children from healthcare professionals and school authorities (Abrokwah et al., 2020; Badu et al., 2015). This makes disabled children feel discriminated against and further impacts their decision not to access services through these institutions, thus consequently impacting their access to healthcare and education. This situation can be blamed on lack of appropriate training and sensitization of professionals on the peculiarities and needs of persons with disabilities as well as the appropriate methods to relate with them in providing services to them.

The recommendation of this study is that healthcare professionals, teachers and others responsible for providing services to disabled persons should be taken through training and sensitization on the plight of the disabled and how to relate well with them in recognition of their human dignity. The government should assume responsibility for this and enact regulation to make this mandatory across public and private institutions. In public institutions, the NCPD should be charged with facilitating this training and sensitization as well as in monitoring compliance. The regulation should compel private service providers in health, education and other areas to provide the requisite training for their staff in relating properly to persons with disabilities when providing services for them. This approach will help reduce the bad reception disabled persons experience in institutions of education and health, as well as enhance their experience of receiving these basic services. This will encourage them and make them more willing to attend school and receive medical treatment from public institutions.

Improve Community-based Rehabilitation Programme

Established in 1992 to help improve the quality of life of persons with disabilities through home-based rehabilitation among others, the community-based rehabilitation programme (CRP) has been successful in enhancing the self-image, self-reliance and community acceptance of disabled persons (WHO, 2002). As discussed in chapter four, the initiative during its pilot stage and early years was supported by the Swedish Organization of Disabled Persons International Aid Association and the Norwegian Association of the Disabled (NAD) among others. Funding has however declined over the years the programme is no longer sustainable in the various districts.

Given the success of the programme, the recommendation of this dissertation is that the government of Ghana should increase funding for this initiative and solicit for more external funding to support the project. Maintaining this programme and increasing its funding will ensure that the benefits of the initiative are continually reaped by persons with disabilities and their families who are beneficiaries. The rehabilitation service will also serve to compliment other support services offered to children with disabilities and their families, consequently improving their quality of life.

5.3 Summary and Conclusion of Dissertation

This dissertation set out to understand the impact of poverty on the lives of children with disability and their families. Specifically, it sought to assess access to education and

healthcare for children with disabilities as well as to identify interventions for disabled persons and assess how these have contributed to improving the quality of lives of persons with disabilities. The study adopted Ghana as its case study and employed the use of existing data for its assessment and analysis.

Opening with the story of Emmanuel Yeboah, a young man with disability from Ghana, the introductory chapter to this dissertation discussed on the challenges of persons with disability and situated it within a broader global context. In many ways, the story of Emmanuel is telling about the value of courage and determination, but more importantly of the inherent capabilities of many persons with disabilities across the world. His journey around the country on a bicycle despite having lost one leg, brought to light the challenges of persons with disabilities in Ghana, prompted reform at the government level, and inspired many children with disabilities in Ghana and beyond. This was the primary motivation of the research in attempting to understand the plight of children with disabilities, the impact of poverty on their access to basic services, and the impact of interventions on their lives.

The first chapter of the study, building on Emmanuel's story, presented the problem of this dissertation. The problem statement highlighted some of the major challenges that children with disabilities faced and their marginalization in society. It also presented aim of this study together with the research questions. The focus was on three main issues; access to education for children with disabilities, access to health for children with disabilities, and interventions to support the quality of life of persons with disabilities.

The second chapter focused on the context within which the is situated. The chapter presented an overview of the political and economic situation in the country before proceeding to highlight background information on persons with disabilities in the country including children. The 2010 population and housing census currently holds the most credible information on persons with disabilities in the country, and it puts the prevalence of disability in the country at 3%. The population as indicated is certainly much more, given that this percentage was captured a decade ago and more importantly on the fact that most families to not record the birth of a child with disability in the birth and death registry due to potential stigmatization and discrimination (Avoke, 2002). This raises an issue of the culturally produced attitudes towards the disabled in the country.

Discussions on the cultural and religious views on persons with disabilities pointed to the fact that even though Ghana is a religious and culturally conservative country, the cultural views of persons with disabilities diverge based on the ethnic group. For example, while the Ga-Adamge treat persons with disabilities with care and kindness because they view them as reincarnated deities, the Ashanti's were not that receptive and sometimes took children with deformities to the riverside or waterbodies to ostensibly return to their 'evil' origins. Thus, the diversity in cultural traditions had different impacts on the way children with disabilities are treated.

The discussions in the second chapter also captured the poverty situation in the country. It underscored that fact that despite Ghana's success in halving poverty as a result of the Millennium Development Goals and resources allocated for that, poverty remains widespread in Ghana. It also highlighted the fact that most persons with disabilities in Ghana are poor and reside in the rural areas of the country. The Report on Multidimensional Poverty in Ghana (2020) also underscored that fact that about 70% of the population of children in Ghana were deprived in at least three dimensions of wellbeing (NDPC, 2020).

The dimensions include nutrition, health, learning and development, child protection, water, sanitation, housing and information (Ibid).

The second chapter also outlined the international laws relating to children with disabilities. These include the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities, and the African Charter on the Rights and Welfare of the Child. In addition to this, it discussed the Disability Act of Ghana, the Ghana Children's Act and the inclusive Education policy in order to sketch out the legal framework for the protection of children with disabilities in Ghana. The gaps in the framework including lack of recognition for the needs of children with disabilities in conflict with the law were also highlighted. The various issues discussed in the second chapter helped situate the study properly in Ghana and gave a background for a discussion of the findings.

The third chapter presented the concepts theories and methods that guided this study. It began with definition of impairment and handicap before outlining competing definitions of disability. Recognizing the controversies associated with terminologies on disabilities, it presented the biomedical, social and religious models in order to aid a broader understanding of this issues. Though various definitions for poverty were provided, the focus was on relative poverty in order to help situate the discussions well within the context of poverty and disability.

Two main theories were presented in the third chapter; the social constructionist theory and the human rights theory. Social constructionist approaches view both the concept of disability and childhood as products of culture and history. This view hold implications fir the way both groups are treated in society and for any policy interventions to support them. Both groups are also a marginalized and oppressed in different ways (Biddle, 2017). Children with disabilities are situated at the intersection between childhood and disabilities and this complicates their challenges and has significant impact on how they are treated in society. Children have human rights, and so do persons with disabilities. The human rights perspective presented in the third chapter problematized the current human rights approach as adult centred. Wall (2008), contends that for the rights of children to be acknowledged and respected, then human rights approach needs to be based on responsibilities towards the other in society. It is within this theoretical framing that the discussions of the paper rests. The approach of this study was primary qualitative, despite the inclusion of quantitative data to highlight some areas. Information used in the study included journal articles, government reports, international and national laws, newspaper articles, and other grey literature. Document analysis was employed for the assessment and the findings were grouped into themes reflecting the research questions for analysis.

In the fourth chapter, the findings of the dissertation were presented and discussed. A number of issues were identified regarding access to education. Over the last three decades, there has been significant improvement in access to education at the basic and secondary levels across the country through initiatives such the free compulsory universal basic education (FCUBE) and the free senior high school policies. Despite this, some children remain out of school, and many of these are children with disabilities. Previous attempts at ensuring special and integrated education in Ghana for children with disabilities saw mixed results and the critique of these led to the introduction of the Inclusive Education Policy. This was to ensure that children with disabilities attend the same schools as other children and are able to integrate well into their societies. The challenge with this was that many schools with children with disabilities still had facilities unfriendly to disabled children, the teachers were not trained and sensitized on how to relate with and educate disabled

children. This led to a situation where many children with disabilities found it difficult to cope in these schools and decided to stay at home instead.

The finding on access to healthcare is similar to that on access to education. The last two decades has seen significant improvement on access to healthcare in Ghana. This was since the introduction of the national health insurance scheme in 2003. Though the regulation of the scheme requires that subscribers pay a yearly premium, the Disability Act and the health insurance law make provisions that exempt children from paying. This provision is however subject to approval by the Disability Common Fund office at the district level. The insufficiency of the funds and bureaucratic hurdles, leads to the exclusion of many children with disabilities who should be benefiting from this provision. Moreover, the facilities in a lot of the hospitals and health centres in Ghana are not disability friendly, and this results in frustrating experiences for children with disabilities who visit hospitals. This has led to a situation where children with disabilities and their families would rather opt not to seek medical care from the hospitals unless they are in dire need.

There are a number of interventions that have place by the government of Ghana to help reduce poverty among the disabled in Ghana and to improve their quality of life. These include the Disability Common Fund, the Livelihood Empowerment Against Poverty, the Local Enterprise and Skills Development Programme (LESDEP), and the Community-based Rehabilitation Programme. The interventions, some of which have been through the support of development partners such as the World Health Organization, have been useful in providing financial resources, skills training and rehabilitation services for some disabled persons and their families across the country. These interventions, despite their modest successes, still require broader coverage and more funding to have a significant impact on the quality of lives of the broad cross section of disabled persons and their families.

Recommendations outlined in this chapter to help improve the impact of the interventions on the lives of persons with disabilities include; increase the disability common fund allocation from 2% to 5%, establishing a credible database of persons with disabilities in Ghana through and upcoming 2021 census, training and sensitization on service provision to disabled persons for healthcare workers and school authorities among others, and improving the community-based rehabilitation programme. Addressing all these issues together will be instrumental in improving the quality of life of the disabled, especially children with disabilities.

Areas for further research can focus on directly eliciting the views of children with disabilities on their experiences in schools, hospitals and other health centres. Studies can also focus on livelihood sources for the disabled and how persons with disabilities in rural areas attend to their daily needs. This will be instrumental in expanding the boundaries of knowledge on persons with disabilities, as well as in informing policy formulation and implementation.

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