KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICAL SCIENCES

DEPARTMENT OF COMMUNITY HEALTH

MANAGEMENT OF THE DISABILITY COMMON FUND: CHALLENGES AND IMPACT ON THE LIVES OF PERSONS WITH DISABILITIES IN KUMASI METROPOLIS OF GHANA

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Management of the Disability Common Fund: Challenges and Impact on the Lives of Persons with Disabilities in Kumasi Metropolis of Ghana

Thesis submitted to the Department of Community Health, School of Medical Sciences, College of Health Sciences, Kwame Nkrumah University of Science and Technology, in partial fulfillment of the requirements for the degree of

Master of

Science Disability Rehabilitation and Development.

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DECLARATION

I hereby declare that this study is my own work towards the award of Master of Disability Rehabilitation and Development and that, to the best of my knowledge, it contains no previously published material by another person, nor material which has been accepted for the award of any other degree of the University, except where due acknowledgment has been made in the text.

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DEDICATION

This thesis is dedicated to my husband Mr. Samuel oppong and my beloved children Ama Serwaa, Nana Boatemaa Oppong, Akosua Akyaa Oppong and Georgina Opoku for their support and encouragement throughout my education.

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ABSTRACT

This study aimed to assess the impact of the DCF on the socio-economic lives of PWDs and recommend ways to improve the programme. Cross-sectional study with qualitative methods was conducted with PWDs enrolled in the DCF in Kumasi Metropolis. Data were obtained from 125 respondents (120 PWD beneficiaries and fund management committee) using non probability purposive sampling technique. Open- and close-ended questionnaire were data collection instruments and analysed using Statistical Package Service Solution version 20. Results were generated through descriptive and analytical statistics. The findings show that education; employment and income levels were too low among PWDs to impact positively on their socioeconomic status. Although the mean monthly income of respondents was GHC 171.62, 56.7% earned between GHC50.00 to GHC100.00, below the national minimum wage whereas at May, 2014 was GHC180.00 per month. Mean monthly income was higher among respondents with tertiary qualification than those with no formal education (GHC369.00/GHC90.94; p=0.03). About 59.3% of PWDs had received the fund for only one year. The mean amount of money received from the fund was GHC 171.62. Although the funds were insufficient for PWDs yet PWDs agreed that it helped in their business and farming activities, payment of children school fees and assist in purchasing assistive devices. Monthly expenditure on food indicated that 85.7% of respondents paid between GHC180 and GHC600, healthcare was between GHC5 and GHC28. Education cost them between GHC100 and GHC300. Challenges associated with managing the DCF ranged from the demographics, socio-economic status of the respondents to the irregular payment of fund by the Common Fund Administrator into the District Assemblies Common Fund. The study suggests efforts to institute measures to promote education and employment among PWDs, increase the DCF from 2% to 5% to meet the excess application. Future research should also focus much on the financial risk protection offered by other social protection strategies like Livelihood Empowerment against Poverty for PWDs.

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CHPATER ONE INTRODUCTION

1.0 Background to the Study

Access to social services such as health, education, social protection and economic activities are major challenges confronting Persons with Disabilities (PWDs) in most developing countries which have therefore adopted *social grants* as support to mitigate most of these challenges of such vulnerable groups. The Disability Common Fund (DCF) is one of such programmes in Ghana to help integrate disabled Ghanaians into mainstream society.

All over the world, social grants have systematically been incorporated as a measure to mitigate the social and economic challenges confronting impoverished and vulnerable populations. Social grants improve access to social services such as education and health, and promote the welfare and consumptions of the beneficiaries. More importantly, it improves the receivers' ability to manage risk and insecurity and substantially empower the person (Neves *et al*., 2009).

As a member of United Nations Organizations, the Government of Ghana has over the past decade shown great commitment in improving the welfare among its citizens including PWDs. However, the need to emphasize disability issues has come to the fore. In view of this, policies towards eradicating poverty have been opted for and implemented. Some have achieved a considerable progress and others still need modification. Towards this vision, Ghana joined other countries in the year 2000 to sign the Millennium Development Goals (MDG) to alleviate extreme poverty by 2015. In achieving these goals, the Ghana poverty reduction strategy was developed, consisting of phase one and two from 2001 to 2005 and 2006 to 2009, respectively.

Social protection strategies like School Feeding Programmes, Capitation Grant, and National Health Insurance Scheme were developed as action programmes under the MDG (Abebrese, 2011; Sultan & Schrofer, 2008). These programmes have been implemented for almost half a decade yet the implementation of these policies and their impact on the beneficiaries is not known.

However, a 2012 World Bank Ghana profile indicated that poverty rate in the country was still high at 28.5% in 2006 despite 11% reduction from 1998 to 2006. The rate also remains high for those who lived in extreme poverty at 18% (World Bank, 2012). There is a wide disparity in the reduction of poverty and development across geographical or regional boundaries and social groups. Areas like the Northern part of the Ghana, rural areas and migrant communities continuously remain poorer than other places. Besides, vulnerable groups such as persons with disabilities remain poorest of the poor and underrepresented than other social groups in the community (Coulombe & Wodon, 2007; Inclusive Ghana, 2011; Sultan & Schrofer, 2008)

Although PWDs were not explicitly captured in most of the social grant programme under the Ghana Poverty Reduction Strategy (GPRS), exclusion from economic and social activities towards them from the mainstream Ghanaian society have received serious policy interest following the passage of Disability Act 715 in 2006 and also, the establishment of the National Council on Persons with Disabilities (NCPD) in 2010.

Coupled with this, Government also allocates 2% of the District Assembly Common Fund to PWDs each year. The aim of the programme is to reduce poverty among PWDs, especially those who are not employed in the formal sector through income generation activities. It also has as its objective, to support education for children with disabilities and build capacity of PWDs in general. More importantly, the Fund assists PWDs to

have access to assistive devices and technical aids, engage in agriculture, textiles and other trading activities (NCPD, 2010). However, it appears a systematic assessment of the management challenges and impacts of the programme on the lives of PWDs have not been done. Therefore, this study focuses on the assessment of the management and the impact of the programme on the lives of PWDs and makes recommendation on how the programme can be improved.

1.1 Problem Statement

In every society around the world, PWDs are highly over-represented among the poor (Fitzgerald, 2007). They are often unemployed and experience low education (Filmer, 2005) which substantially results in low income level (Mitra *et al.*, 2011). Engagement in economic activities will offer PWDs the opportunities to be contributing members in their communities and offer them independent living. Just like other vulnerable groups in societies, persons with disabilities in developing countries turn for support from their dependents and others engaged in begging to earn a living. In line with this, the District Assembly Common Fund was an effort by Government of Ghana (GoG) to improve the living conditions of PWDs in Ghanaian societies.

All over the world, sustainability of social grants policy to the vulnerable in society requires effective resource management and timely frequent inflow of funds. In most low- and middle-income countries however, social grant policies are over-dependent on grants from developed nations. Such dependency affects policy implementation, and may lead to imposition of ideas and threaten the sustainability of programmes.

The GoG has its own challenges pertaining to allocating of funds to keep the DCF programme running. The Government of Ghana has institutionalized by law, that 2%

of the DACF should be used for poverty alleviation within the disabled population. However, the basis for determining the DCF rate was not probably based on a needs assessment and environment of PWDs.

Perhaps accurate demographic data on disability was not used as a basis in deciding on the 2% of the DACF meant for PWDs. It is therefore difficult to establish the relationship between the programme and its impact on beneficiaries by district (Ghana Statistical Services, 2012; Sackey, 2009)

For a longer period since the implementation of the 2% DCF for PWDs, experiences from some beneficiaries of the programme show that, sometimes, they may have to borrow in advance with an expected income to settle debts. This may be common among beneficiaries who intend to use the funds for educational purposes. Aside this, there is also a weak collaboration between institutions to provide quality data that can be used to help improve the performance of social intervention programmes like the Disability Common Fund.

In addition, data on the implementation challenges and the impact of the DCF is scanty, or unavailable even though according to a SEND Ghana report, about 55% of Metropolitan Municipal Assemblies (MMA) in 50 districts across four administrative regions (Greater Accra, Northern, Upper East and Upper West) in Ghana had implementation challenges (SEND Ghana, 2010). In the districts, social workers are to deal with and manage the DCF but they may have little or no knowledge on disability case management. Improving management of DCF is therefore essential for the effective delivery of services, hence this study.

1.2 Research Questions

i. What are the implementation challenges and ways to improve the DCF in the

Kumasi Metropolis?

ii. What are the challenges that PWDs face in accessing the DCF in the Kumasi metropolis?

iii. What are the socio-economic and demographic situations of the PWDs enrolled DCF in the Kumasi metropolis?

iv. What is the socio-economic impact of the DCF on the lives of PWDs in the Kumasi metropolis?

1.3 Statement of Objectives

1.3.1 Principal Objectives

To assess the implementation challenges and the impact of the Disability Common Funds on Persons with Disability in the Kumasi Metropolis.

1.3.2 Specific Objectives

i. To ascertain the socio- economic and demographic situation of PWDs in the Kumasi Metropolis. ii. To access the management of the Disability Common Fund in the Kumasi

Metropolis. iii. To ascertain the challenges PWDs faces in accessing the DCF in Kumasi

Metropolis.

iv. To assess the socio-economic impact of the DCF on the lives of PWDs in the Kumasi Metropolis.

1.4 Justification

The latest population census in Ghana held in 2010 shows that persons living with some form of disabilities in Ghana constituted 737,743 (3%) of the entire Ghanaian population of 24 million(Ghana Statistical Service, 2012). However, World Health

Organization (WHO) estimates that 10% to 15% of every developing country's population live with some form of disabilities. With regards to the WHO rate, it can be estimated from the 2010 population census that between 2.4 million to 3.6 million Ghanaians live with some form of disabilities (World Health Organization, 2011).

According to a 2006 report by Handicap International, it is estimated by the United Nations that about 82% of PWDs live under the poverty line and that 20% of the world's poorest are disabled. In Ghana, PWDs experience high rate of poverty and are poorly motivated in all sectors of the Ghanaian economy (Sultan & Schrofer, 2008).
They fall behind other citizens in socio-cultural and economic dynamics.

However, DCF in combination with Livelihood Empowerment against Poverty (LEAP) are known strategies to facilitate integration of PWDs into the socioeconomic development agenda of the country. The transformation of the existing DCF programme into a more effective and efficient grant-providing scheme to facilitate the integration of PWDs into a mainstream society requires a multi-sector approach involving strong collaboration amongst different stakeholders like the metropolitan, municipal and district assemblies and the Ghana Federation for the Disabled and the National Council on Persons with Disabilities.

A better understanding of how to improve DCF will help policy makers in the Kumasi Metropolis to provide appropriate support to PWDs, thus helping to attain the Millennium Development Goals set target of eradicating extreme poverty by 2015.
Despite this, not much information is known about the DCF programme to inform policy makers to improve it. This study therefore aims at providing the needed information to properly structure the DCF in order to achieve the desired impact. It will also serve as the reference point for the improvement of the DCF programme in the whole of Ghana.

1.5 Limitations of the study

A study that deals with PWDs is prone to a lot of limitations due to the stigma that society attaches to having disability. PWDs felt reluctant to accept to participate in the study. However, those PWDs who agreed to participate saw it as worrisome. Also, a study that used purposive sampling methods was prone to selection bias as the researcher would want to select participant who will have the most characteristics of interest. These limitations were consistent with similar studies. This notwithstanding, measures such as pretesting and training of research assistants helped to minimize the effects these limitations could have had on the conclusions.

CHAPTER TWO LITERATURE REVIEW

2.0 Introduction

This chapter explores available literature on the impact of social grants like the Disability Common Fund on the lives of persons with disabilities in Ghana and around the world. Therefore, literature from social sciences and the humanities constitute the primary focus of this chapter. The discussions particularly focused on such policies in developing countries for PWDs. It started by exploring available definitions, concepts and rationale of social grants for the vulnerable in society. It then looks at social protection in other Africa countries particularly sub-Sahara and

Eastern Africa countries. The literature also looked into the use and effectiveness of DCF in the Ghanaian context. The sections are as follows:

1. Socio-economic status of Persons with Disabilities
2. Social protection
    I. Definition, Concepts and Rationale
    II. Evidence of Social protection from Africa for Persons with Disabilities

3. Social Protection in Ghana and Persons with Disabilities
4. The Disability Common Fund Programme in Ghana
    I. Impact and effectiveness of DCF
    II. Challenges of DCF programme

2.1 Socio-economic status of Persons with Disabilities

Disability has long been linked to poverty in almost every society. Poverty has a multi-dimensional relationship with disability. Persons with Disabilities (PWDs) perform poorly in areas that will lift them out of poverty. Their participation in education, employment, social life and asset ownership are not encouraging to move them up the ladder of poverty (Fitzgerald, 2007).

Comparatively, PWDs experience higher risks of not being employed than nondisable persons .Within the same age group, there is a significant gap between gaining employment among PWDs and non-PWDs. It has been found in the United States that 38% of PWDs got employed as compared to 78% of the non-disabled population in 2005. That same year reported a 23% poverty rate among Americans PWDs of working age as compared to only 9% of the non-disabled group (Palmer, 2011). In Zambia, the rate of employment among disabled and non-disabled were 45.5% to 56.5% in 2005 respectively (World Health Organization, 2011). According to McClain-Nhlapo (2007), World Bank data estimate suggest that, in five world's poorest people in society, one may live with some form of disability.

Furthermore, the background paper for the Organization for Economic Co-operation and PWDs Development (OECD) in 2009 shows that in membership countries, employment of PWDs has fallen behind other groups despite measures to integrate them. Relatively, in all OECD countries, PWDs are 60% unlikely to be employed as

the non-disabled. Unemployment among the disabled is estimated as high as twice that of the non-disabled population. On the average, the income of PWDs in OECD countries is 12% below national averages. The poverty line for PWDs in these countries is at 22% (OECD, 2009). In Australia, it has been reported that 45% of individuals living with disabilities live either near or below the poverty line. This rate is more than double the OECD average rate.

Countries with high rate of poverty are mostly located in Africa leading to increased vulnerable population every day. Countries in Southern and Eastern Africa recorded some of the highest prevalent rate of poverty and disabilities. Poor communities experience food crises as a result of food insecurity in most countries in the region. In Sub-Saharan Africa, maternal and child mortality continues to account for deaths in most societies. Access to health, education and other services that will improve people's welfare is also lacking in these countries (Devereux *et al*., 2005)

Filmer (2008), conducted a survey on 14 households from 13 countries in developing countries. The analysis suggests that children with disabilities lack the human capital to earn higher income. The availability of disability indicates possible low level of income. This is attributed to the fact that they have little chance of starting school. Disability limits children from schooling more than other factors such as area of residency (rural or urban), gender and economic status. It is however important to note that, poor people have the likelihood of becoming disabled through lack of access to health services, inadequate nutrition diet and working in dangerous places. Disability also deepens vulnerabilities to poverty such that disable people are likely to be discriminated against from participating in the mainstream labour market. This emphasises the link between disability and long run-poverty and creates a vicious cycle of poverty among PWDs (Babson *et al*., 2001; Elwan, 1999; Saunders, 2005).

Poverty does not only affect the present lives of PWDs but projects into the future. It affects the entire household of such a person. In circumstances where the head of such a family has a disability, the poverty rate is higher at 15% to 44% than a household not headed by a disabled person. The consumption level of a household headed by a PWD is comparatively lower than a household headed by a non-disabled person. The consumption level is 14% to 15% lower. For instance, research has revealed that, in Uganda, the likelihood of a household headed by a disabled person to be poor is 38% than a non-disabled breadwinner of a household. Another example from Zimbabwe shows that children with disabled family member are likely to be out of school (McClain-Nhlapo, 2007).

2.2 Social Protection: Definitions, Concepts and Rationale

Globally, social protection is increasingly receiving policy attention for its importance in protecting individuals, households and poor communities from risk and shocks like loss of breadwinners and natural disasters. It is adopted as a developmental tool by most countries towards the attainment of the Millennium Development Goals. The massive acceptance of this strategy both international and national came into light in the year 2000 (Chinsinga, 2007). Some literature (Devereux *et al*., 2005) reveals that, the introduction of social protection builds on the 1980 Safety Agenda Programme. It also uses ideas and experiences derived from ―sustainable livelihood approach, vulnerability analysis and multidimensional nature of poverty‖ in the 1990s.

Social protection has widely been defined by most researchers. Internationally, it has no precise definition. This study, therefore, employs the one used by Sabates‐Wheeler and Devereux (2007) and 2006 Conference on Social Protection in Zambia. Their

definition of the concept stands to be one of the definitions which focus on a broader perspective beyond economic risk and vulnerability. It is however stated that:

Social protection describes all initiatives that transfer income or assets to the poor, protects the vulnerable against livelihood risks and enhances the social status and rights of the marginalized; with the overall objectives of extending the benefits of economic growth and reducing the economic or social vulnerability of poor, vulnerable and marginalized people (Sabates_Wheeler & Devereux, 2007)

Social protection has widely been debated by researchers and international agencies to include different type of components. These components are referred differently by different studies but bear the same explanation and concepts. United Nations Children Fund (UNICEF) has developed a social protection strategy framework to be adopted in overcoming exclusion and economic vulnerabilities among poor people. This strategy identifies four key components of social protection including _social transfers programmes to ensure access to services, social support and care services and legislation and policy reforms‘ (UNICEF, 2008)

However, according to the study by Sabates_Wheeler and Devereux (2007), Social protection is categorized into four measures of operation such as provision measures, preventive measures, promotion measures and transformative measures.

2.2.1 Social Assistance (Provision measures)

Provision measures are sometimes referred by some writers as social assistance. For instance, Woolard (2003) showed that, Social Assistance is the benefits that vulnerable groups like PWDs, orphanages, children from poor households and the elderly receive from the government of a country.

The Organization for Economic Co-operation and Development (OECD) conducted a study on Social Assistance in its member countries. According to the report of the study, three types of Social Assistance emerged from these countries including general assistance, categorical assistance and tied assistance. The general assistance is a cash transfer benefit that targets poor people below a minimum income level of that country. Categorical assistance on the other hand targets specific group of people. Example is a group that has experienced disaster such as fire outbreak, earthquake and flood. These groups of people may be above the minimum income level. Finally, _tied assistance' involves provision of free goods or services. It can also be at a subsidized price. A typical example is housing project for citizens(Eardley, Bradshaw, Ditch, & Gough, 1996).

The vision of Social Assistance has now changed from food aid approach to cash transfer programmes with support of donor and multilateral agencies. Funding of these programmes comes with evidence based support to implement on pilot base. The leading agencies funding most cash transfer programmes in Africa include UNICEF, DFID from United Kingdom, GTZ from Germany, SIDA from Sweden, DANIDA from Denmark and the World Bank (United Nations Development Programme [UNDP], 2013).

In Africa, previous research has shown that cash transfer programmes usually cover few beneficiaries as compared to the total number of people in that group. Cash transfers targeting children can improve their wellbeing if it is given to the mother. Although fathers are seen as head of families, the mother helps to calm the pressure in the house. It is also important to note that most cash transfer programmes with complex conditionalities are not able to reach vulnerable groups (Villanger, 2008). In view of

this, most cash transfer programmes will be successful if they are unconditional, non-contributing and non-tested. It is, therefore, financed by public funds

2.2.2 Promotion measures

Promotion measures of social protection programmes target individuals and household income and capabilities. A typical example includes improving livelihood programmes like microcredit in the form of small scale enterprises.

2.2.3 Preventive measures (Social Insurance)

Preventive measures tackle programmes of poverty eradication through social insurance coverage. Individuals and communities in poverty are so marginalized and deprived of having access to basic services that will improve their living conditions.

Access to these services is seen as human rights that need to be addressed by the state. Preventive measures and strategies are needed to enhance access to services for people of economically disadvantaged populations. Barrientos and Santibáñez (2009) are of the view that social insurance are programmes that are implemented to protect individuals against circumstances such as disasters or employment catastrophes. It is either financed by the Government or contribution made by workers. They include health insurance, maternity care benefits, pension benefits and employment benefits.

2.2.4 Transformative measures

Transformative measures address issues of discrimination against minority groups such as people living with HIV/AIDs and PWDs at work places. It protects the right of vulnerable groups through regulatory framework. They are the policies that address inequalities and exclusions. Some researchers (Barrientos & Santibáñez, 2009) refer to this component as labour market regulation or legislation or policy reforms.

Furthermore, most researchers categorized social protection depending on the form of transfer. Research has identified four different categories of transfers. These include cash, food, inputs and assets. All these forms of transfers have different ways that can be handled to reach the beneficiaries. For instance, cash can be handed through bank accounts, bank notes or electronic cards of different types (Ellis *et al.*, 2009). According to this same study, different actors or stakeholders are involved in social protection programmes particularly in low-income countries in Africa. These actors include UN agencies, NGOs, public bodies and quasi-state agencies (Ellis *at al.*, 2009).

In African countries, the development and implementation of social protection policies is based on a number of factors. Devereux and White (2010) stated that, ―technocratic, political and ideological‖ factors are three agendas that determine the choice and outcome of social protection strategies among countries. Technocratic agenda in social protection policies are implemented through collaboration between NGOs and bilateral and multilateral partners. These stakeholders constitute the major actors in the design, implementation, monitoring, evaluation and funding of the programmes. It is usually based on evidence from a piloted project externally. National government involvement in these agenda is sometimes limited to providing documentation in the form of endorsement. On the contrary, some social protection policies are viewed as right issues. They are considered as an agreement between citizens and the government in the form of rights and entitlement. Lund and Srinivas (2000) hold that with increasing globalized and competiveness world, not all people will exercise their rights to work. Social protection should then be used to reach most vulnerable population. Social protection introduced through this agenda cannot be politically removed or cancelled. In Southern Africa, countries like Lesotho, Botswana, Namibia, Swaziland and South Africa, there are social pension schemes which are based on ideological agenda. These

social protection programmes are funded from domestic resources of such countries (Devereux & White, 2010; Hickey,

2007).

2.3 Evidence of social protection from Africa

Social Protection in Africa, particularly Sub-Saharan Africa, has emerged with different approaches as compared to other developing countries in the world. From the early 1970s to the year 2000, Social Protection introduced in the region was Social

Insurance and Social Assistance focusing on famine relief and emergency food aid. Social Insurance introduced during this period covered a section of the population like civil servants whereas Social Assistance during this period also focused mainly on humanitarian support and NGO initiatives (Barrientos & Hulme, 2008; Nino-Zarazua *et al.*, 2010).

An effort to strengthen Social Protection in the region has received serious attention by the Africa Union and its member states. This is evident from the Intergovernmental Regional Conference which was held in Livingstone, Zambia, on social cash transfers for Africa in 2006 among 13 countries. Countries which participated in this conference included Ethiopia, Kenya, Namibia, South Africa, Madagascar,

Lesotho, Uganda, Tanzania, Zimbabwe, Mozambique, Zambia, Malawi and Rwanda (African Union, 2006). It was identified at this conference that there was higher income inequality and lack of political will towards social protection in the region. To overcome this, delegates in this conference called for programmes such as cash transfers and social pensions to be an integral part of policy options for countries.

(Schubert & Beales, 2006). Box 2.1 is the summary of the conference;

Box 2.1. Livingstone Call for Action

- ❖ Greater cooperation between African and other countries in sharing and exchanging information, including experiences and action, on social protection and cash transfers.
- ❖ Cash transfer programmes to be a more-used policy option by African governments. Transfer programmes include social pensions and regular cash transfers to vulnerable children and households, older people and people with disabilities.
- ❖ Commitment at national and international levels to social protection and to the promotion of consensus between ministries and institutional coordination, to enable effective national plans
- ❖ African governments to prepare cost of cash transfer plans within two to three years that are integrated into national development plans and national budgets, which development partners can supplement.
- ❖ Increased investment in institutional and human resource capacity and accountability systems
- ❖ Reliable long-term funding for social protection, from national budgets and from development partners
- ❖ The institutionalisation of biannual conferences on social protection supported by the African Union.

Source: Livingstone, Zambia, 23 March 2006

(Source: African Union, 2006; Kazeze, 2008; Schubert & Beales, 2006)

The summary report in Box 2.1 emphasizes the important measures that African countries can employ to strengthen social protection on the continent.

Other social protection strategies include _African Union social policy framework for Africa and the 2010 Social Ministers Khartoum declaration on social policy towards social inclusion‘. All these efforts were geared towards improving the lives and access to services for poor and vulnerable people in Africa to promote national development and growth (African Union, 2008; Devereux & Getu, 2013)

Furthermore, Niño-Zarazúa *et al*. (2010) identified two main models of social protection that has been practiced in Africa over the years. These models include the Southern Africa model and Middle Africa model. According to this study, the Southern Africa model emerged before the mid-1990‘s and has gained recognition and acceptance in Southern Africa for the past decade. The focus of this model has been on social pension for vulnerable groups like Persons with Disabilities, the elderly and people with HIV/AIDS. It also focuses on children. Countries like Botswana, Namibia and South Africa and, more recently, Lesotho and Swaziland are the practitioners of this model. The middle Africa model, on the other hand, is the new social protection strategies towards a significant shift to ensure access to basic services for vulnerable populations. It is also referred to as social cash transfer (SCT). A typical example can be found in Ghana, Ethiopia, Kenya, Zambia, Nigeria, Malawi and other countries (Kebede, 2006; Ward *et al*., 2010). For the purpose of this research, the focus of social protection will be limited to those towards poverty reduction.

2.3.1 Current Social Protection Programmes in Africa by country 2008-2013

Programme name	**Country**	**Model**	**Beneficiaries**
Livelihood Empowerment Against Poverty programme 2008-2013	Ghana	Middle Africa	●Households with extreme poverty ●Orphans and vulnerable children ●PWDs ●Elderly
Protective Safety Net Programme (PSNT), 20062010	Ethiopia	Middle Africa	●Chronically food insecure households receive cash or food transfers.
Tigray SPP 2012-2014			
Cash Transfer for Orphans and Vulnerable Children (CT-OVC), Expansion 2012-2014	Kenya	Middle Africa	●Extreme poor families with vulnerable child of 18 years and below
Hunger Safety net programme, pilot 2010-2012			Households with food insecurity in semi-arid lands
National policy of social Action	Burkina Faso	Middle Africa	Extreme poor households and vulnerable children
Child Grants programme (CGP), 2011-2013	Lesotho	Middle Africa	●Vulnerable and poor households with children

Social Cash Transfer Expansion 2013-2014	Malawi		●Extreme poor individuals and Labour constraints ●Households with high dependency
Programma Subsidio Alimento, PSA, Expansion 2008-2009	Mozambique	Middle Africa	●Chronically sick individuals, people living with disabilities and elderly women and men of ages above 55 and 60 years respectively
Universal Old age pension, Orphan care benefit	Botswana	Southern Africa	●All Citizens of Botswana aged 65 years and above ●All orphan citizens of Botswana of aged younger than 18 years
Child support grant	South Africa	Middle Africa	●Poor households with children aged 13 years or below
Social pension		Southern Africa	●Old men above 65 years and women above 60 years
Burkina Faso, 2008-2010	Burkina Faso		
Social Cash Transfer, Pilot 2013-2015	Zimbabwe	Middle Africa	●Households in extreme poverty with orphans and other vulnerable children
SAGE, 2013-2015 ● Vulnerable Family Support Grants (VFSG) ●Senior Citizens Grant	Uganda	Middle Africa	●Vulnerable population such as young age, orphans, disables, old age, widowhood
		Southern Africa	● Old age individuals above 65 years
Tanzania Social Action	Tanzania		● Extreme poor and
Fund (TASAF), 2009-2012, Expansion 2012-2014			households with food insecurity
Social Cash transfer ●Multiple categorical programme (MCP), 2011 ●The Elderly programme ●The ultra-poor labour constraint	Zambia	Middle Africa	Households... ●Disabled member ●Headed by female keeping orphans ●Headed by elderly person over 60 years with orphans
Social Cash transfer... Child grant programme, 2010	Zambia	Middle Africa	●Households with children under 5 years old

Source: (Ellis *et al*., 2010; The Transfer Project, 2013; United Nations Development Programmes UNDP, 2013)

2.3.2 Impact of cash transfer

Assessing the impact of cash transfers is problematic since it may have different objective and design. The benefits of these programmes can also go beyond primary targets to families and communities. In reducing child poverty, Barrientos and DeJong (2006) found that cash transfer is an effective means. Particularly, measuring the impact on poverty reduction depends on the size of the transfer and how it contributes to household income (Tabor, 2002). However, in another development, evidence of cash transfer outcomes are identified on a hierarchy (Arnold *et al*., 2011). These are as follows;

(a) Raising living standards of the poor

(b) Human development or human capital

(c) Economic development and inclusion growth

(d) Empowerment and gender equality

(e) Climate change and national disasters

(f) Facilitating social cohesion and state building

Another study by Blomquist and Mackintosh (2003) suggests some of the features of a good cash transfer in developing countries. These include _managing programme type to need, beneficiary selection, programme generosity, promoting gender equality, securing and sustaining political support and building administrative support‘. Social grants support development such that it enables beneficiaries and family members to have improvement in consumption and welfare (Neves *et al*., 2009). It can improve the status of beneficiaries within their households.

2.3.2.1 Zambia, Mozambique and Namibia

Social cash transfer in most African countries has improved the income level of households, nutritional status, health, education and other MDGs related indicators. Although in unconditional social cash transfer programmes, there are no measures attached to how and what to spend the money on. However, experience from Zambia Social Cash Transfer (SCT) programmes shows that beneficiaries use the money in responsible ways including investing in agricultural activities like rearing animals and tilling their lands. Beneficiaries have therefore, achieved a considerable improvement in their lives. The level of begging among households reduced from 89% to 69% after their enrolment in the programme. Households with just a meal per day decreased from 19.3% to 13.3% whereas those benefiting from three meals increased from 17.8% to 23.7%. There has also been an increment in protein intake in seven days a week from 23.4% to 34.9% among households (Künnemann & Leonhard, 2008).

A case study from three southern Africa countries Zambia, Mozambique and Namibia confirmed that Cash transfer generates significant income multiplier for the reason that the money spent by one person is earned at another end by another person in the same locality. It provides a major stimulus to trade in local communities. In Mozambique and Zambia, experiences from GAPVU (Gabinete de Apoio à População Vulneráve) and Cash Transfer prograrmmes respectively experiences that, on the day of payments of the cash transfer, traders gather at offices and the point of payment. Also, majority of social pension beneficiaries in Namibia are granted credit facilities by local traders due to their guaranteed expected income monthly (Datt *et al*., 1997; Devereux, 2002).

2.3.2.2 Malawi and Kenya

In 2012, the International Centre for Inclusive Growth evaluated the Cash Transfer for –Orphans and Vulnerable Children (CT-OVC) programme in Kenya. It was revealed that the programme has achieved a 9% increase in secondary level (children 13-17 years) education (Kenya CT-OVC Evaluation Team, 2012)

2.3.2.3 Ethiopia and South Africa

It is estimated that cash transfers now cover between 750 million to one billion vulnerable people in developing countries with most people located in Africa. For example, the Protective Safety Net Programme (PSNP) in Ethiopia is estimated to have reached 1.5 million households constituting nearly 8 million people every year. Through this programme, 7.8 million people have gained improvement in food security. Also, the CGP in South Africa was expected to reach 2.4 million households including 10 million children by the end of 2009 (Arnold *et al.*, 2011). A study conducted in South Africa on the impact of Child Support Grant (CSG) on the nutrition of the beneficiaries confirmed that the programme significantly improved the nutrition of children from poor households when they were enrolled at early ages in their lives (Aguero, Carter, & Woolard, 2006).

2.4 The Disability Common Fund in Ghana

In 2005, the Government of Ghana saw the need to establish the Disability Common Fund programme to respond to the needs of PWDs in the Ghanaian economy. It is a programme that allocates 2% of funds allocated to each District Assembly for PWDs in the district. The percentage to be allocated was agreed at 5% but was later reduced to 2%. In spite of this percentage, the allocation of funds to each metropolitan, municipal or district assembly depends on Government‘s income within a year. There exist guideline principles governing the fund from the office of the Administration of DACF.

Yet, the disbursements of the funds to PWDs are district specific (NCPD, 2010; Sackey, 2009; SEND Ghana, 2010)

In most districts in the country, the funds are managed by the Department of Social Welfare (DSW). However, in some districts, the funds are first released to disabilityfocused associations before it finally reaches individuals with disabilities. Examples of such association include Ghana Blind Union (GBU), Ghana National Association of the Deaf (GNAD) and the Ghana Society of the Physically Challenged (GSPD). These organizations are being made to open bank accounts so that the funds can be transferred into them. Since the implementation of grant policy, some disabilityfocused Organizations have successfully accessed the funds and whereas others have encountered numerous challenges. A typical example of districts that have achieved success in such circumstance is the Birim District. Between 2006 and 2007, an amount of 39,500 cedis and 8,500 cedis, respectively, were disbursed among three Organizations of PWDs such as GAB, GNAD and GSPD in the district. In comparing this situation to Ho Municipality, the funds are being accessed through Volta Regional Disability Network (VOLDIN) (Sackey, 2009).

Eligibility critical in cash transfers to the vulnerable must be flexible to ensure that it reaches the most in need. Drawing from a similar programme in South Africa, eligibility to the fund is based on factors such as _medical criteria, working age of 18 years and subject to means test‘ (Neves *et al*., 2009).

2.4.1 Challenges to Implementation and Managing the DCF

To ensure effective social cash transfers for PWDs, Gooding and Marriot (2009) identifies three key principles that emerged from major stakeholders involved in the study of inclusion of PWDs in social cash transfers in developing countries. These principles include proper implementation and evaluation, strong legal backing to

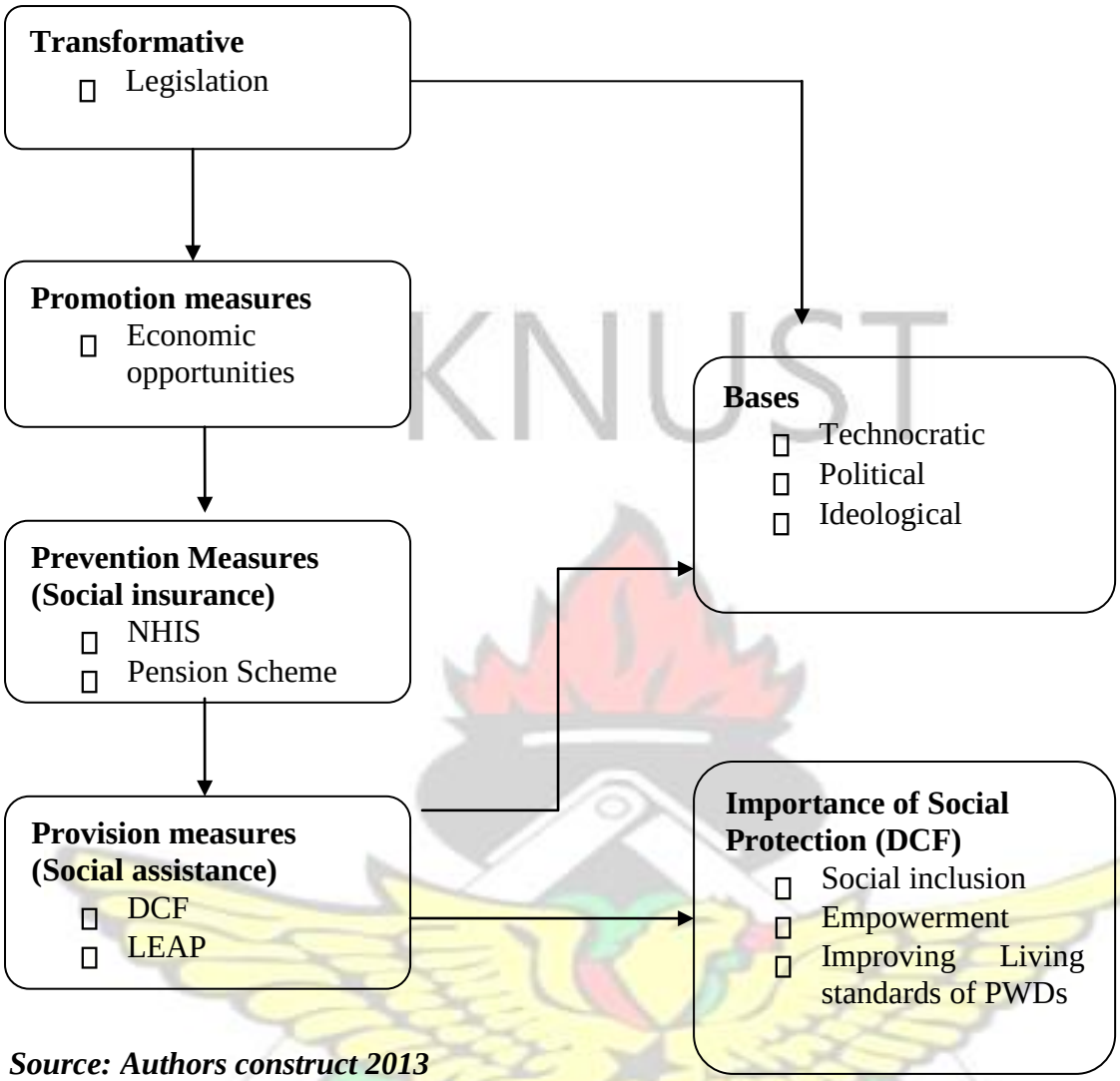
support programmes and involving PWDs in the design of programmes. When PWDs are involved in programme design, it helps to identify and remove accessibility barriers, generates true and fair eligibility criteria and reduces corruption. Again, legal backing of social cash transfers ensures it sustainability from political actions. It must conform to both national and international legislation. This will tackle the programme as entitlement and right and not charity or aid (Gooding & Marriot, 2009).

Social grants in developing countries face budget constraints which affect the expansion of the programme (Neves *et al*., 2009). Particularly, grants that target PWDs are limited and affect the number of beneficiaries (Gooding & Marriot, 2009). In India, research has found that it is difficult to obtain funding to support grants that targets PWDs (Erb & Harriss-White, 2002).

In developing countries, research has found that inadequate institutional capacity in the public sector is one major barrier that affect smooth implementation and management of cash transfer programmes (Tabor, 2002). Administrators for disability grants are relatively limited. The few may lack the skills and knowledge on handling
PWDs particularly when the disabled persons have communication problems (Dube, 2005; Gooding & Marriot, 2009). This acts as a barrier to the enrolment of disability grants. It is advisable for countries to examine which institutions can effectively administer cash transfer programmes like the Disability Common Fund. In most countries, disability grants just like any other cash transfers are administered by the Ministry for Social Welfare and Ministry of Labour. In Ghana, the DCF is being managed at the municipal and district level by the Department of Social Welfare in collaboration with disability organizations (NCPD, 2010; Sackey, 2009; SEND Ghana, 2010).

2.5 Conceptual Framework

The conceptual framework below explains the component of social protection that covers the vulnerable in society including PWDs. It uses the social protection components developed by Sabates - Wheeler and Devereux (2007) to develop a framework that can be used to study DCF in Ghana. It starts with transformative measures which provide legislation that protect the most vulnerable in employments. Transformative measures to a very large extent aims to achieve equity, empowerment and realization of social, economic and cultural rights among PWDs. This legislation helps PWDs to gain economic opportunities hence the promotion measures. The next component of social protection which is important in the lives of PWDs is prevention measures. These include health insurance and other schemes which allow them access to services that will continuously keep them safe in the economic opportunity above. Finally, the last component is provision measures which occur in the form of cash transfer. These variables include DCF and LEAP programme. These components of social protection are determined by three distinct factors. These factors are technocratic, political and ideological. It is the bases through which social protection like DCF is developed. From the framework below, social protection like DCF provides benefits such as social inclusion for the vulnerable, empowerments and gender equality and improving living standards of the vulnerable like PWDs.



Source: Authors construct 2013

CHAPTER THREE METHODOLOGY

3.0 Introduction

Chapter Three focused on the various methods and techniques that were used in collecting and analysing data. It comprised details of the methods including the study design, study area, target population, sampling techniques and sample size, data collection techniques and plan of data analysis that were used for a successful arrival at the conclusion based on the objectives of the study.

3.1 Study Area and Profile

Kumasi Metropolis was selected as the area for this research. The selection of this study site is based on its cosmopolitan nature. Participants were likely to come from diverse

socio-economic backgrounds in spite of the fact that participants are Persons with Disabilities. This ensured a successful completion of the work considering the limited timeframe for the study.

Kumasi Metropolis has a near central location in the middle belt of Ghana. The Metropolis is about 270 km North of Ghana's capital, Accra. It covers a total land area of 254 square kilometres (25,415 hectares) accommodating a resident population of 2,035,064 as at 2010. Kumasi is the major transportation hub between the northern and southern sectors of the country and has day time population of about 3 million. It is the traditional capital for the Asante Kingdom and has the largest open air market in the West African sub-region. Kumasi is bounded by agrarian districts which supply food products for the Metropolis. To the north of the metropolis is Afigya Sekyere District and Kwabre District; the south is Bosomtwe Atwima Kwanhuma District, to the west is Atwima District and east is Ejisu Juaben District. These districts play an important role in housing some of the active labor force that works in the Metropolis.

(KMA Medium Term Development Plan, 2013).

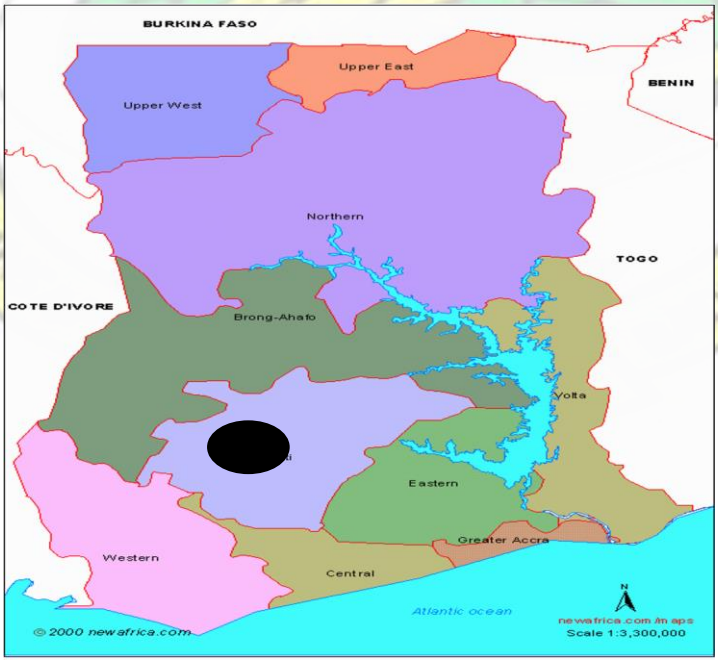


Fig 3.1: Map of Ghana showing the location of Kumasi Metropolitan Assembly

(Source: KMA, Town and Country Planning Department, 2010)

Fig 3.2: Map of Ashanti Region showing Districts that share boundary with Kumasi Metropolitan Assembly

(Source: KMA, Town and Country Planning Department, 2010)

The Metropolis on the other hand provides these districts with lucrative platform to market and sell their produce which contributes to revenue generation to these districts as well as Kumasi. It is also endowed with 189 health facilities ranging from teaching hospitals, clinics and maternity homes. About 150 of the health facilities representing 91 per cent are managed by private individuals. It also houses facilities such as universities which provide higher level education to the residents of these districts.

Furthermore, according to the 2010 Population Census, conducted by the Ghana Statistical Services (GSS), the Metropolis is divided into 10 sub-metropolitan districts. These include Asokwa, Asewase, Bantama, Suame, Manhyia, Oforikrom, Tafo, Nhyiaeso, Subin and Kwadaso. Kumasi Metropolis is quantitatively endowed with

human resources needed to support development. Approximately, 43.13% of the population aged 15 years and above constitute the economically active population.

The active population are those who can engage in productive employment activities. The census revealed that, 93.4% of the economically active population is employed whereas 6.56% is unemployed. However, 19.0% of the population are not economically active. Those who are not economically active constitute pensioners, students in full time education, homemakers, old people who cannot work, people who are too sick to work, too young and people with severe disabilities (Ghana Statistical Services, 2012). In spite of the above, it is difficult to obtain data on PWDs who are economically active against those who are not.

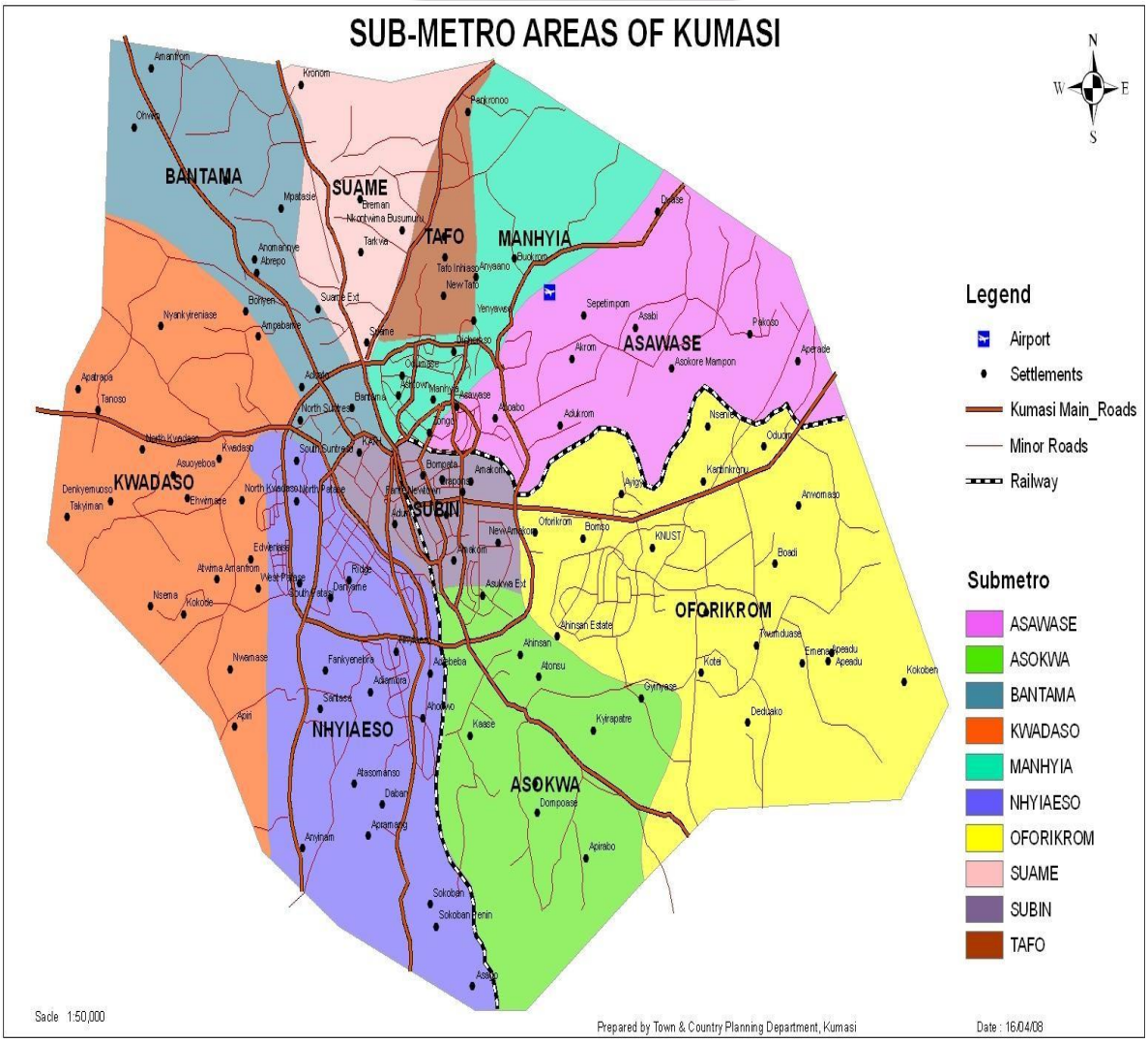


Fig: 3.3: Profile of Kumasi Metropolitan

(Source: KMA, Town and Country Planning Department, 2010)

3.2 Study methods and design

Research design is important for the study as it outlines a detailed plan of process to be carried out. This research used a cross- sectional design. The Cross- sectional design type helped the researcher to obtain the needed information on time. It is a study design that is conducted within a short period at a particular point in time (Levin, 2006). The study used qualitative data collection techniques to improve the quality of the research through information gathering.

3.3 Study population

The participants in this study were PWDs who have benefited from the DCF in order to have an in-depth insight into how the fund has improved their lives as well as management officials of the DCF.

3.4 Sampling techniques and sample size

Sampling is used to select participants from a larger population to represent the entire population for a study. It concerns the selection of a subset of individuals from within a population to estimate characteristics of the whole population (Kumekpor, 2002). This is because, not all prospective study participants can be studied considering resources such as time and money. The sampling consisted particular characteristics of the population of interest to ensure representativeness and generalization of the results of the study. The primary goal of sampling is to get a representative sample or a small collection of units or cases from a much larger collection or population such that the

researcher can study the smaller group and produce accurate generalizations about the larger group.(Creswell ,2013).

In view of this, a sampling technique that was used for a successful selection of study participants to get the optimum information is a non-probability purposive sampling. A purposive sampling is ‗the selection of sampling units within the segment of the population with the most information on the characteristics of interest' (Guarte & Barrios, 2006).

No formal data on PWDs can be found on the study population. However, between 2012 and 2013, it was recorded that 125 PWDs were registered to benefit from the DCF (Department of Social Welfare, 2013). For the purposes of the study type and data collection techniques, one hundred and twenty (120) PWDs such as Physically Challenged, Hearing and Visually impaired who are recipient of the Fund and five (5) officials managing it were purposively enrolled as participants of the study.

3.4.1 Sampling

Prior to the data collection, an introductory letter was obtained from the Department of social welfare to seek their approval of the study. They also assisted in the recruitment of PWDs who have benefited from the fund. An introductory letter was sent to all beneficiaries of the DCF programme in the Kumasi Metropolis explaining clearly the purpose of the study and the role they were going to play to assist in the study. The researcher therefore enrolled participants who responded to these letters positively and consented participation. Again, disability focused organization such as Ghana Federation of the Disabled (GFD), Ghana Blind Union (GBU), and Ghana Society for the Physically Disabled (GSPD) helped in the enrolment of respondents. The principal investigator and research assistant attended meetings of these associations

and identified prospective study participants. Individuals who qualified as beneficiaries and consented to participate in the study were enrolled.

3.5 Data collection techniques and tools

The study used different instruments to obtain information from the respondents. Copies of questionnaires were used to obtain data from participants. This study, to a large extent, used primary data and where necessary some secondary data were used. The primary data consisted of the responses to the administered questionnaires. The secondary data were records from the Department of Social Welfare about the beneficiaries of the fund in the Kumasi Metropolis. The interview questionnaires were open and close ended which was structured based on the objectives of the study. The respondents were guided by the researcher and research assistant. They explained clearly the interview questionnaires to the respondents. The Disability Common Fund Management Committee in the Kumasi Metropolis was included in the study. They answered open ended questions on the management of the fund, challenges they faced in handling the funds and suggestions on how the programmes can be improved.

Researchers have established the fact that respondents are very unwilling to talking to _unknown persons‘ on matters concerning their lives, particularly PWDs. Therefore, PWDs may find it reluctant to reveal information to unknown people due to stigma and discrimination.

3.6 Inclusion and exclusion criteria

Those included in the study were PWDs who have benefited from the DCF fund in the Kumasi Metropolis from 2010-2013 and were staying in the study area. People who were not included were those who do not meet these criteria. However, a participant

who qualified and refused to agree to participate in the study was assured of no sanction what-so-ever.

3.7 Pre-testing

The study methods were pretested to overcome any inconvenience. The pretesting helped the researcher to make some adjustment in the data collection tools where it became necessary prior to the implementation of the study. Pretesting consisted of 5 beneficiaries of the DCF fund. The pretesting asked questions on socioeconomic status of beneficiaries and the impact the DCF had on their lives after enrolment in the programme.

3.8 Data analysis procedure

All Data gathered from respondents were checked by a field supervisor to ensure completeness and consistency. The information was then kept confidential; only the principal investigator and project supervisor had access to the information.

In analysing the data obtained from the open ended questions administered to the officials of the DCF programme, the researcher transcribed the information into word documents and read over several times. The data was then grouped into categories from themes occurring several times.

On the contrary, data that was obtained from questionnaires from beneficiaries of DCF were analysed using descriptive statistics. Statistical analyses such as means, standard deviations were computed where necessary. Also, p-value was used to establish a relationship between the socio-demographic variables and income level of the respondents. Statistical Package software for Social Sciences Software (SPSS) was used in the analysis phase of the study. The final result of the study was presented using graphs and tables where necessary.

3.9 Ethical consideration

In a study that utilizes human participants and investigate the impact of a programme managed by a state institution, certain issues are likely to be hidden by participants because of identity. It was necessary to consider these issues for the purpose of ensuring the privacy as well as the security of the participants. Assurance of strict privacy motivated PWDs and officials of the DCF to enrol in the study. Among the significant issues that were considered include informed consent, confidentiality and data protection. A Committee for Human Research Publication and Ethics at KNUST reviewed and cleared the study protocols prior to the implementation of the study. A written informed consent was translated from English to a language that study participants understood prior to their enrolment in the study

CHAPTER FOUR RESULTS

4.0 Introduction

This chapter presents the findings of the study. The analysis involves responses from 120 PWDs who have benefited from the Disability Common Fund (DCF) and five (5) officials of the Fund Management Committee in the Kumasi Metropolis. The analysis consists of two sections comprising of the questionnaire administered for the purpose of this study to PWDs and open ended questions for the five officials of the DCF.

Findings are presented in tables and figures that are followed by narrations based on the objectives of the study. It ranges from the demographic characteristics of the respondents and the results related to the specific objectives of the study such as socio-economic status of PWDs enrolled in the DCF, the impact of DCF on the lives of PWDs and the challenges inherent in the disbursement of the fund in the Kumasi Metropolitan Assembly.

4.1 Socio-economic and Demographic Characteristics of beneficiaries of Disability Common Fund in Kumasi Metropolis

The socio-demographic characteristics are presented on Table 4.1.

Table 4.1: Socio-economic and demographic characteristics of respondents

Variables	*Characteristics*	*Frequency*	*Percentage*
Age (n=120)	▪ ≤20	2	1.7
	▪ 21 – 30*	26	21.7
	▪ 31 – 40*	32	26.7
	▪ 41 – 50*	34	28.7
	▪ >50	26	21.7
Gender (n=120)	▪ Male	75	62.5
	▪ Female	45	37.5

Level of Education (n=120)	▪ No formal education	18	15
	▪ Primary	37	30.8
	▪ Secondary	34	28.3
	▪ Tertiary	20	16.7
	▪ Other	11	9.2
Marital Status	▪ Single	50	41.7
	▪ Co-habitation	5	4.2
	▪ Married	39	32.5
	▪ Separated	12	10
	▪ Divorced	11	9.2
	▪ Widowed	3	2.5
Occupation	▪ Trading	22	18.3
	▪ Government (Civil Servant)	20	16.7
	▪ Farming	6	5
	▪ Apprenticeship	19	15.8
	▪ None	29	24.2
	▪ Other	24	20
Religion	▪ Christianity	105	87.5
	▪ Islamic	12	10
	▪ Other	3	2.5
Membership of Disability Organization	▪ Ghana Society of the Physically Disabled (GSPD)	30	25
	▪ Ghana Blind Union (GBU)	44	36.7
	▪ Ghana National Association of the Deaf (GNAD)	30	25.0
	▪ None	13	10.8
	▪ Other	3	2.5

Source: Field data, 2014 *Active population

Responses indicated that (36.7%) of respondents were registered members of the Ghana Blind Union (GBU) whereas 25% of respondents each were registered members of the Ghana Society of the Physically Disabled (GSPD) and Ghana National Association of the Deaf (GNAD), respectively. About 10% of respondents, however, were not registered as members of any disability organization.

The average age of the respondents was 28 years. Majority (28.7%) of the respondents were between 41 to 49 years whereas 21.7% were above 50 years. Males (62.5%) were dominant in the study than females (37.5%). Asked about respondents' Educational status, thirty-seven (37) PWDs representing 30.8% had primary education whereas 28.3% had Senior Secondary School education. About 16% of respondents had tertiary education with 15% reporting no formal education. On respondents marital status, majority of the respondents interviewed were single (41.7%) with 32.2% being married. Only 9.2% and 2.5% of respondents were divorced and widowed, respectively. Co-habitation also constituted 4.2% of total respondents.

Respondents' employment status revealed that 29 PWDs constituting 24.2% were not engaged in any employment. However, 18.3% of respondents were engaged in trading whereas 16.7% were employed in the government sector. Only 5% of respondents were engaged in farming with 20% reporting other activities such as working with private companies.

Table 4.2: Distribution of the type of Disability and Employment status

Variable		***Physical*** **N (%)**	***Visual*** **N (%)**	***Hearing*** **N (%)**
Occupation	**N**			
Trading	22	7 (31.8)	7 (31.8)	8 (36.4)
Government Services	20	6 (30)	6 (30)	8 (40)
Farming	6	2 (33.3)	2 (33.3)	2 (33.3)

Apprenticeship	19	7 (36.8)	7 (36.8)	5 (26.3)
Other (Private companies)	24	9 (37.5)	8 (33.3)	7 (29.2)
None	29	9 (31)	10 (34.5)	10 (34.5)

Source: Field data, 2014

From Table 4.2 out of the 22 respondents who were into Trading, 7(31.8%) were Physically Challenged, 7(31.8%) were Visually Impaired and 8(36.4%) were Hearing Impaired. Of the 20 respondents who were employers of the Government Services, 6(30%) were physically Challenged, 6(30%) were Visually Impaired and 8(40%) were Hearing Impaired. Regarding the 6 respondents who were farmers, 2(33.3%) were Physically Challenged, 2(33.3%) were Visually Impaired and 2(33.3%) were Hearing Impaired. The 19 respondents who were into Apprenticeship, 7(36.8%) were Physically Challenged, 7(36.8%) were Visually Impaired and 5(26.3%) were Hearing Impaired. Out of the 24 respondents who were on Private Companies 9(37.5%) were Physically Challenged, 8(33.3%) were visually Impaired and 7(29.2%) were Hearing Impaired. The remaining 29 respondents who were not employed had 9(31%), 10(34.5%), 10(34.5%) who were Physically Challenge, Visually Impaired and Hearing Impaired respectively.

4.1.1 Financial obligation on respondents due to dependants

Table 4.5 presents information on financial obligations of respondents with respect to food, health and education of dependents as against monthly income of respondents. About 70% of respondents have dependents who are 20 years or younger. Majority (0-5yrs=30.7%) of respondents would be completely responsible for such young children and toddlers. The 6-15 year-groups are equally dependent but with higher burden due to education, greater cost in food provision. That group represents 41.6%. These figures indicate that 72.3% had children and teenagers highly dependent on

them.

About a third of the respondents (30.6%) stated that, their income for a month fell below GHC 50.00 whereas 11.7% earned above GHC 300.00. Also, 26.1% of respondents earned between GHC 50.00 – 100.00 whereas 27% had a monthly income of GHC 100.00 – 200.00. The mean monthly income was GHC 171.62(±). The distribution of expenditure of respondents per month presented a range such that majority (31.4%) spent GHC 180.00–300.00 on food. Also, 24.8% and 20% of respondents spent GHC300.00–450.00 and GHC450.00–600.00, respectively, on their dependents monthly expenditure.

The study also elicited information on respondents‘ monthly expenditure on dependents healthcare. Majority, (41.7%) of respondents spent GHC 17.00 – 22.00, GHC 11 – 16.00 (31; 27%) and GHC 23 – 28.00 (12; 10%). About 16% however, cited other expenditure on healthcare for dependents. Annual expenditure on education of dependents indicated that about 15% spent between GHC100.00-150.00 whereas 21.4% spent GHC 150.00 – 200.00. Similarly, 19.4% spent between GHC 200.00 – 250.00 whereas 20.4% spent GHC 250.00 – 300.00. Majority, 23.5% cited other amounts they spent on respondents‘ education for a year.

Table 4.3: Level of dependency pressure on respondents

Variables	***Age group***	***Frequency***	***Percentage***
Age of dependents (n=101)	0–5	31	30.7
	6-10	11	10.9
	11-15	17	16.8
	16-20	14	13.9
	21 and above	28	27.7
Income/month (n=111)			
	(GHC) <50.00	34	30.6
	50.00–100.00	29	26.1

	100.00–200.00	31	27.0
	200.00–300.00	5	4.5
	>300.00	12	11.7
Monthly expenditure on dependents food (n=105)	30.00–150.00	15	14.3
	150.00–300.00	33	31.4
	300.00–450.00	26	24.8
	450.00–600.00	21	20.0
	Other	10	9.5
Monthly expenditure on dependents healthcare	5–10.00	5	4.3
	11.00–16.00	31	27.0
	17.00–22.00	48	41.7
	23.00–28.00	12	10.4
	Other	19	16.5
Yearly expenditure on dependents‘ education (n=98)	100.00–150.00	14	15.3
	150.00–200.00	21	21.4
	200.00–250.00	19	19.8
	250.00–300.00	20	20.4
	Other	24	23.5

Source: Field data, 2014

Majority, 36.3% were enrolled in Primary school whereas 11.8% were in Junior High Schools. Also, 25.5% were enrolled in Senior High Schools whereas 15.5% were in tertiary education with 10.8% being the least cited in Kindergarten. Majority (45%) had 1 to 2 persons whereas 21.7% and 10.8% had 3 – 4 people and 4 to 5 persons respectively as dependents. About 7% however disclosed they had 6 and more persons as dependents with 15% indicating no dependents.

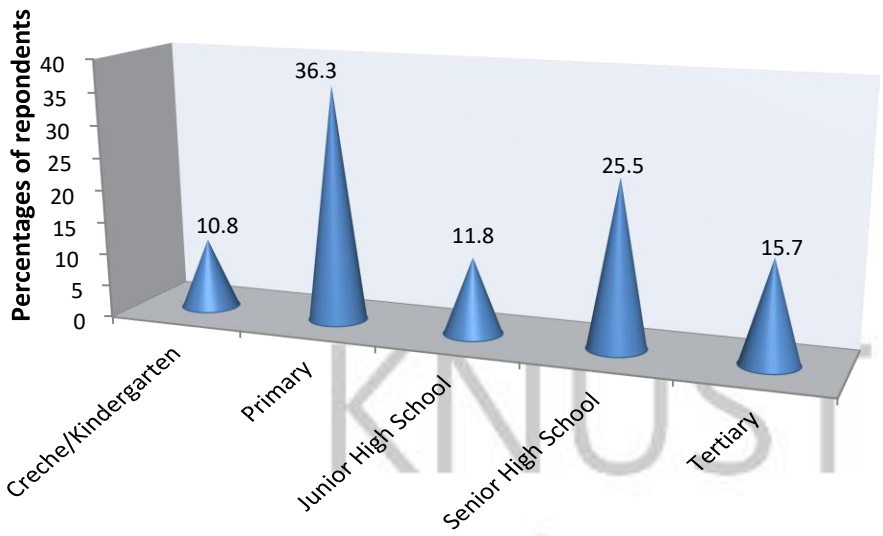


Fig 4.1: Distribution of Educational background of dependents of Respondents

Source: Field data, 2014

4.1.2 Relationship between background information and Income Levels of respondents.

Regarding the relationship between background information and income level of respondents, the mean monthly income of respondents varies significantly among the educational level of respondents.

Table 4.4 Relationship between background information of respondents and income

Variable	*Characteristics*		*Income per month*	
Age	▪ 21 – 30	24	223.96	0.11
	▪ 31 – 40	30	214.50	
	▪ 41 – 50	31	130.65	
	▪ >50	26	122.69	
Gender	▪ Male	68	185.44	0.36

	▪ Female	43	149.77	
Level of Education	▪ No formal education	16	90.94	
	▪ Primary	32	108.28	
	▪ Secondary	34	156.47	
	▪ Tertiary	20	369	0.00*
	▪ Other	8	158.89	
Marital Status	▪ Single	41	172.32	0.59
	▪ Co-habitation	5	87	
	▪ Married	39	202.95	
	▪ Separated	12	126.67	
	▪ Divorced	11	180.91	
	▪ Widowed	3	41.67	
Occupation	▪ Trading	22	121.82	
	▪ Government workers	20	261.25	0.03*
	▪ Farming	6	64.17	
	▪ Apprenticeship	17	83.53	
	▪ None	24	204.58	
	▪ Other	22	201.36	
Registered Disability Group	▪ Ghana Society of the Physically Disabled	26	180.19	
	▪ Ghana Blind Union	39	183.97	
	▪ Ghana National Association of the Deaf	30	74.67	
	▪ None	13	361.92	0.00*

N	**Mean *p*income**	***value* (GHC)**

Source: Field data, 2014 *p<0.05

The mean monthly income was higher among those with tertiary qualification than those with no formal education (GHC 369.00 versus 90.94). The data is statistically significant (p=0.03) that, the mean monthly income differs among the employment status of respondents. Respondents who were employed in the Government sector had higher mean monthly income than those who engaged in trading, farming and apprenticeship. Surprisingly, individuals who reported they were unemployed had higher mean income per month than farmers, traders and apprenticeship. Again, the mean monthly income varies whether respondents were registered with a particular disability group or not. Individuals who were not registered members of any disability groups had higher mean monthly income than those registered with Ghana Society of the Physically Disabled, Ghana Blind Union and Ghana National Association of the Deaf as shown in Table 4.4.

Also, the age, gender and marital status had no significant relationship with respondents' income level.

4.2 The Effect of Disability Common Fund on the of beneficiaries

Table 4.5 below provides information about the effect of the DCF on Persons with Disability in the Kumasi Metropolitan area.

Table 4.5: Effect of Disability Common Fund on the beneficiaries

Variables	*Frequency*	*Percentage*
Recipient of Disability Common Fund		
Yes	91	75.8
No	26	21.7
Number of years for receiving the fund		
1 year	64	59.3
2 years	25	23.1
3 years	16	14.8
4 years	3	2.8

How regularly have you been receiving money from the fund since you became a beneficiary (n=111)		
Every quarter	12	10.8
Every 6 months	6	5.4
Once a year	81	73.0
Others	12	10.8
Who issues the money (n=108)		
Department of Social Welfare	99	91.7
GBU	6	5.6
GFD	3	2.8
How much do you receive monthly/quarterly/yearly/occasionally		
- Below GHC 100.00	15	13.8
- GHC 100.00 – 200.00	23	21.1
- GHC 200.00 – 500.00	57	52.3
- GHC 500.00 – 1000.00	6	5.5
- Above GHC 1000.00	8	7.3

Source: Field data, 2014

As shown in Table 4.5, 7.8% of the respondents disclosed they had ever received the DCF while 22.2% have not received. Among those who had received it, 59.9% indicated they had it for one year whereas 23.1% reported 2 years. Also, 14.8% of respondents had received it for 3 years with 4 years being the least cited (2.8%). The study also elicited information on how regularly they have been receiving money from the fund since they became beneficiaries. Majority, 73% receive it once a year whereas 10.8% of respondents received it every quarter. Six respondents representing 5.4% received it every six months whiles 10.8% cited other period to receive the fund.

Responses indicate that, majority, 91.7% of PWDs in Kumasi Metropolis received their funds from the Department of Social Welfare. About 5.6% of respondents also indicate they received it from GBU with 2.8% citing GFD. Majority (52.3%) of respondents received between GHC 200.00 – 500.00 for the period they are entitled whereas 21.1%

received GHC 100.00 – 200.00. About 13% received below GHC 100.00 while only 5.5% received GHC 500.00 – 1000.00. Also, 6.7% of respondents reported to receive above GHC 1000.00.

4.2.1 Usefulness of DCF to the PWDs

Table 4.6 explains the opinions of PWDs on the level of usefulness of the DCF.

Table 4.6: Opinion of PWDs on level of usefulness of the Disability Common Fund

Variables	*N*	*Mean*	*Std. Deviation*
▪ Supports the education of my rights, potential and responsibilities	120	3.03	1.04
▪ Helps me pay my children's school fees	118	2.05	0.88
▪ Is insufficient for me and my family	120	1.56	0.82
▪ Improves my business and farming activities	120	1.95	1.00
▪ Makes it easier for me to access healthcare	120	2.82	1.24
▪ Creates an enabling environment for my full participation in national development	120	3.36	1.07
▪ Ensures that women with disabilities enjoy the same rights and privileges as their male counterparts	118	3.52	1.06
▪ Acquire assistive devices (wheel chair, hearing aid, Braille, electronic recording machine etc)	115	2.13	0.79
▪ Provides for care-giver	120	4.15	0.76

Source: Field data, 2014

Views of respondents were elicited with a scale of five (5) responses from strongly agree to strongly disagree (1 – strongly agree, 2 – agree, 3- neither agree nor disagree, 4 – disagree and 5- strongly disagree). Results demonstrate that majority of respondents strongly agree that the DCF is insufficient for them and their families (mean=1.56), improves their business and farming activities (mean=1.95) and makes it easier for them to access healthcare (mean=2.82. Respondents also admitted that it helps them pay their children's school fees (mean=2.05) and acquire assistive devices (mean=2.13). Majority also disagree that it supports education of their rights, potential and responsibilities (mean=3.03), creates an enabling environment for their full

participation in national development (mean=3.36), ensures that women with disabilities enjoy the same rights and privileges as their male counterparts (mean=3.52) and provides for care-giver (mean=4.15)

Table 4.7: Assistive devices provided by the Disability Common Fund to the PWDs in Kumasi Metropolitan Area.

Type of devices	*Number and Percentage provided with Devices requested N (%)*	*Number and Percentage provided DCF out of the total requesting for deviceN (%)*
Visual impaired		
Eye glasses	12 (17.6)	9 (70)
White cane	18 (26.4)	18 (100)
Braille	3(4.4)	2 (66.7)
Physically Challenge Wheel chair	3 (4.4)	3 (100)
Clutches	15 (22.1)	9 (60)
Braces	5 (7.4)	2 (40)
Hearing impaired Hearing aid	9 (13.2)	6 (66.7)
Total request/provision	**68 (100)**	**51 (75)**

Source: Field data, 2014

The study asked respondents about the Assistive Devices provided by the DCF. The number of respondents who said they needed assistive devices and were provided for by the fund was 75%. The study elicited information on the type of assistive devices respondents‘ used. The result is shown in Table 4.7.

Of the 120 participants, 65 requested for assistive devices consisting of Eye glasses 12(18.5%), white canes 18(27.7%), Braille machines 3(4.4), wheel chairs 3(15%), clutches 15(23.1%) with 5(7.7%) for braces and hearing aids 9(13.8%). The DCF

provided the following percentages of the requests made: eye glasses (70%), white canes (100%), wheel chairs (100%), clutches (60%), braces (40%) and hearing aids (66.7%).

4.2.2 Areas of Support by the DCF

As shown in Table 4.8, not all respondents indicated that the stated areas in their lives were supported by the DCF. More than 95% of PWDs who responded to these questions believes the DCF supports them in areas such as awareness raising, organizational development, and education support for children, students and trainees with disabilities, training of employable skills, supports in areas of providing technical aids, assistive devices whereas 38.3% oppose this opinion. About 94.3% also indicated that the DCF supports them in area of income generation registration.

Table 4.8: Opinion on areas in PWDs live that the DCF support

Variable	*Areas that DCF support in PWDs Live*	
	Yes	**No**
	N (%)	**N (%)**
▪ Awareness raising	93 (96.)	3 (3.1)
▪ Organizational Development	98 (100)	-
▪ Training in employable skills	89 (96.7)	3 (3.3)
▪ Income generation activities	99 (94.3)	6 (5.7)
▪ Educational support for children, students and trainees with disabilities	99 (100)	-
▪ Provision of technical aids, assistive devices	74 (100)	-
▪ Registration on the NHIS	67 (97.1)	2 (2.9)

Source: Field data, 2014

4.3 Challenges inherent in the disbursement of Disability Common Fund

4.3.1 Demographic characteristics of Disability Fund Management Committee

Table 4.10 below presents the demographic information of five (5) members of the Disability Fund Management. The demographic information received from the

respondents on an open ended questionnaires include age, gender, level of education, area of speciality in education, marital status, years served on the Disability Fund Committee and the position of the individuals on the committee.

Table 4.9: Demographic characteristics of Disability Fund Management Committee Members

Participants	*Characteristic (age, gender, education, specialization, marital position on the committee)*	*Years served on the Committee status,*
Participant one	▪ 29 years ▪ Male ▪ Tertiary ▪ Social Work ▪ Single ▪ Investigative officer	3 years
Participant two	▪ 59 years ▪ Female ▪ Tertiary ▪ Special Education (Blind) ▪ Married ▪ Special Education coordinator and as Secretary	4 years
Participant three	▪ 30 years ▪ Female ▪ Tertiary ▪ Journalism ▪ Single ▪ Friend of the Disables (member)	3 years
Participant four	▪ 40 years ▪ Male ▪ Tertiary ▪ Electrical Engineering ▪ Married ▪ Representative from KMA (Chairman for Social Services)	4 years
Participant five	▪ 40 years ▪ Male ▪ Tertiary ▪ Single ▪ Representative from Federation of Persons with Disabilities	

Source: Field data, 2014

Responses were gathered from three (3) males and females of the fund committee. Responses indicated that all committee members had tertiary education with different field of specialization. Two (2) were married whereas three (3) indicated they were single. The lowest age among respondents was 29 years with 59 years being the highest. The average age was however 39 years. Responses indicate that each member has spent at least three years on the committee with four years being the most cited.

4.3.2 The Disability Fund Management and Monitoring

Responses indicate that the Disability Fund Management is made up of a five member committee from different organisations and institutions in the Kumasi Metropolis. All respondents who answered the open ended questions disclosed the following people: ○ The Metropolitan Director of Social Welfare who is the chairperson, ○ Representative from the Ghana Education Service (GES), Special Education Unit who is the secretary to the committee, ○ Chairman of social services at Kumasi Metropolitan Assembly who is the

Government appointee, ○ Representative from Federation of Persons with Disabilities who is a Physically

Disabled persons, ○ A friend of Persons with Disabilities in the metropolis who act as a community member.

The investigative officer at DSW however confirmed that in order to avoid misuse of the fund and to conflict with other funds managed by the DSW, a separate bank account is opened with SGSSB Kumasi Central Branch, where the fund is directly deposited by the administrator of the common funds from the ministries. The cashier of KMA is immediately notified when it is deposited. The committee members who responded to the questions also attest to this fact that the rationale of separate bank account is to

ensure transparency, accountability and independency of the fund from the assembly and also, to clear any doubt in the minds of PWDs.

It is obvious from the responses that all the Fund Management Committee members perform the same responsibilities which include the following;

1. To seek to the disbursement of the fund such as conducting interview and vetting over applications,
2. Education on the fund to the beneficiaries such as the application procedure for the funds,
3. Monitoring the fund on behalf of the beneficiaries,
4. Evaluation – periodic assessment on how the fund has been disbursed in the form of report to KMA.

Similarly, the investigative officer who is not a member of the fund committee performs closely related responsibilities. He states that;

> *"I receive application for assistance from PWDs, interviews and assess the needs of applicants, approve or accept the application for funds based on applicants needs and monitoring of beneficiaries to ascertain whether or not they are putting their benefits into proper use".*

4.3.3 Mandate and Process of Monitoring of Beneficiaries

All responses from the participants indicate that, specific mandate of monitoring the utilization of the fund is done by the Disability Management fund committee in collaboration with the Metro Director of the Social welfare department and the Federation of PWDs (GFD, GBU etc), both at national and regional level and Metropolitan, Municipal District Assembly (MMDAs) and the Government.

Responses from participants again indicate that, the team from national level like the administrators of common fund come around collect books and check issued out to verify. Similarly, the committee members embark on unannounced rounds with them

to the individual beneficiaries. The monitoring is also done in the form of giving instant report. The quotation below supports it;

> *"The DSW pays unannounced visits to the beneficiaries' place of work for beneficiaries who use the money for trading, business and apprenticeship. Similarly, equal visit is done to schools to monitor students who are beneficiaries (Social investigator at the DSW)"*

He however fails to disclose the number of visits that is made to individual beneficiaries when he was asked.

4.3.4 Challenges with the Management of the DCF

All respondents expressed worry about the late arrival of the funds from the administrator of the common fund such that PWDs continuously visit their offices complaining about their problems. They however attributed it to the government's inability to release the fund early to the administrator of the common fund.

Respondents from the special education unit indicated that;

> *"The funds do not come regularly as it was proposed. The initial arrangement was that the fund should come quarterly. However, taking 2013 as an example, only two trenches out of the four came. Currently we are almost entering the first quarter of 2014 but have still not received it."*

Another major challenge respondent indicated was that, they receive a lot of applications which do not match the limited funds. Therefore, they work on first come-first serve basis. However, they set priority and respond to urgent needs when it arises. There are always excess applications. However, the few beneficiaries do not use the fund for the intended purposes. This is usually attributed to the fact that the fund is insufficient to perform such purposes.

4.3.5 How to overcome such challenges

From the social investigator's is perspective, the administrator of the common fund should as much as possible release the funds early (quarterly) for onwards disbursement

to beneficiaries. According to him, the quota of the district assembly common fund allocated to PWDs should as much as possible be increased from the current 2% to 5%. The reason given was that, the disability community is increasing and the number of applicants also increases daily. Again, another suggestion was to intensify monitoring and awareness programmes about the DCF. Similarly, proper and vigorous education should be organized for PWDs on the essence of the DCF.

One of the respondents acting as a friend of the disable reported that:

> *"We as committee members do not have hands in releasing the funds. So the best suggestion to the government is to immediately release the funds quarterly to clear-off all the awaiting applications."*

CHAPTER FIVE DISCUSSION

5.0 Introduction

Chapter Five presents a discussion of the study in relation to other published works on the impact of the Disability Common Fund on the lives of Persons with Disabilities (PWDs). The discussion is arranged per the objective of the study. It starts with the socio-economic and demographic characteristics of PWDs enrolled in the DCF, the impact of the DCF on the lives of PWDs and the management of DCE.

5.1 Socio-economic and Demographic Characteristics of PWDs enrolled in the *DCF*

The findings of the study (Table 4.1.) showed that males dominated in the study than females such that majority were from 41 to 50 years with mean age of 28 years. Majority had primary education with 15% having no formal education. However, 16.7% of respondents had tertiary education. The educational qualifications of respondents is relatively low and concur with the assertion made by Fitzgerald (2007) that, PWDs participation in education is not that encouraging to take them out of poverty. The findings from the study further suggested that Persons with Disabilities who were able

to climb the academic ladder to the tertiary level were most likely to get job at the government sector. The unemployed constituted majority of respondents. About a fifth (16.7%) was employed as civil servants. This also confirms other studies that emphasis lower employment among PWDs (McClain-Nhlapo, 2007; Mitra & Sambamoorthi, 2006; Palmer, 2011). It again reinforces the findings from the 2011 World report on disability that, there is lower employment rate and unemployment among working age disables than non-disables (WHO, 2011). These findings could be attributed to the low level of education which prevents them from accessing employment as reported by Lwanga-Ntale (2003) in Uganda and World Report on disability (WHO, 2011). According to a 1995 report by UNESCO, the poor participation in employment and education results in high rate of poverty among the disable in developing countries (UNESCO, 1995). Consistent with findings from previous research, majority of the present study participants were single with 32.2% married. Traditionally, adults at 30 and beyond must be married meaning that, at least 77% should be married and have families.

According to Lwanga-Ntale (2003), it is generally perceived in Uganda that disable women are unable to perform household chores, farm and care for themselves, thus preventing them from getting married.

According to the World Health Organization (2014), there is a limited access to assistive devices among people who require them such that only 5% to 15% of such individuals get them. This is attributed to the high cost of obtaining such devices, limited production coupled with scarce trained personnel to manage such devices. Majority (53.9%) of present study respondents needed or used assistive devices such that 15% and 12.5% uses clutches and white canes, respectively. The findings again showed that out of those who need assistive devices, majority (55.9%) were not provided or maintained by the

DCF. Despite this, about 58% of respondents reported none of their assistive devices being maintained or provided by the DCF. Considering the access rate to assistive devices in developing countries as reported by WHO, the present findings demonstrate an improvement. However, efforts need to be made to extend the rate of access to cover all PWDs who need assistive devices.

5.1.1 Financial Obligations of Dependents

The presence of dependants on PWD will further aggravate the financial burden on the person which will adversely affect the quality of life of the disabled person.

Research on the socioeconomic life of PWDs has not been given much attention in Africa especially in the Sub- Saharan region. However, the research conducted on inclusion of PWDs in actions to reduce poverty and hunger emphasizes the fact that families that are being headed by a disabled person are likely to be poorer by 15% to 44% than the one headed by non-disabled (McClain-Nhlapo, 2007).

Results from this study indicated that the mean monthly income among respondents was GHC 171.62. With this income, it falls below the national monthly minimum wage of GHC 180.00. This confirms the findings from OECD countries which have established that, PWDs‘ income is 12% below national averages (OECD, 2009). It concurs with another study which established the fact that the availability of disability predicts low income level (Filmer, 2008). Despite the findings that there is no significant relationship ($p>0.05$) between gender and monthly income of the present study, females earned less income than males (GHC 149.77 versus GHC 185.44). This, therefore, confirms the 2011 World report on disability that disable women commonly earn less than men with disabilities (WHO, 2011). Mean monthly income was higher among respondents with tertiary qualification than those with no formal education (GHC 390.00 vrs GHC 90.94; $p<0.00$), Table 4.4.

This study indicates that majority of respondents spend more than GHC 300 yearly on dependants‘ education. Dependants were mostly of age 0 to 5 years and were at primary schools. Considering the fact that respondents in this study earned below the average national minimum wage (GHC 180.00) such that majority earn GHC 50 or less, there could however be a huge financial burden to respondents and has the likelihood of affecting dependants‘ education and health. This was also evident as 41.7% of respondents spent GHC 17.00 – 22.00 on the healthcare of dependants on monthly basis. It again reinforced the fact that research had established between disability, access to healthcare, education, consumption level and long run poverty of household headed by a disabled person (Babson *et al*. 2001; Elwan, 1999; McClainNhlapo, 2007; Saunders, 2005).

5.2 Impact of Disability Common Fund on the socioeconomic life of PWDs in the Kumasi Metropolis

The direct impact of social grants to vulnerable population is not limited to their direct pocket expenditure on food and shelter but extends to other areas in their lives. It can extend beyond primary targets to immediate family and community members (Barrientos & DeJong, 2006). Cash transfer (example DCF) with complex and difficult conditionalities are not favourable to reach the vulnerable groups like the disabled (Villanger, 2008). Therefore, measures to ensure that DCF reaches the PWDs are of high importance to be able to examine the impact of the programme.

Results from this study showed the extent to which the DCF affects the socioeconomic life of PWDs in the Kumasi Metropolis. Findings turned out that majority (77.8%) of respondents had ever received the DCF but for only one year, with 42.7% receiving it for more than one year. In the review of literature on cash transfer, it was found that an

estimated 750 million to one billion of vulnerable population in developing countries benefited from cash transfers spaces (Arnold *et al*., 2011). About 73% of the present study respondents received the fund once a year. This shows the level of frequency of the fund to impact on the socio-economic life of PWDs. This confirmed the view by Villanger (2008) that cash transfer programmes in Africa usually covered few beneficiaries in a group. Receiving the DCF once within a year from a fund that is expected to be released quarterly had the implications that there were limited funds to cover many beneficiaries. Again, to be able to measure the impact of the cash transfer on the socio-economic life of beneficiaries depended on the size of the funds received and the contribution to household income (Tabor, 2002). Findings indicate that majority (52.3%) of PWDs in the Kumasi Metropolis received GHC 200.00 to 500.00 within the period they were entitled and 21.1% received GHC 100.00 to 200.00. Respondents in the study however confirmed that the fund was insufficient for them and their families. This confirms what researchers have established about the limited nature of disability grants especially in developing countries (Gooding & Marriot, 2009). In India for example, disability grants have been argued to be inadequate to cover large beneficiaries and household expenditure (Erb & Harriss-White, 2002).

Congruent with other cash transfer programmes like Zambia Social Cash Transfer, and Mozambique GAPVU (Gabinete de Apoio à PopulaçãoVulneráve), respondents from this study opined that the DCF has improved their business and farming activities as indicated on the likelihood scale on Table 4.4 (Datt *et al*.,1997; Devereux, 2002; Künnemann & Leonhard, 2008). Also, the fund helped PWDs in the

Kumasi Metropolis to pay their children‘s school fees, assisted them to acquire assistive devices and slightly enabled them access health services. This is consistent with the

study by Kenya CT-OVC Evaluation Team (2012) which evaluated the Cash Transfer for Orphans and Vulnerable Children in Kenya.

Despite the usefulness of the fund, respondents disagreed that the fund supported them in their education and rights, creates an enabling environment for their full participation in national development, ensures that women with disabilities enjoyed the same rights and privileges as their male counterparts and provided support to caregivers. This however is contrary to other studies in Africa on cash transfer and grants to vulnerable population (Arnold *et al*., 2011; Blomquist & Mackintosh, 2003; Künnemann & Leonhard, 2008).

More than 70% believe the DCF supported them in areas such as organizational development, income generation activities and education support for children, students and trainees with disabilities, training of employable skills and supports in areas awareness-raising. This is consistent with the areas in the lives of PWDs as set by the fund regulations (NCPD, 2010). Not all areas in PWDs live is however supported entirely by the fund as spelt out by the regulation (NCPD, 2010). The findings further indicated that slightly half of respondents expressed that the fund supported their health care.

5.3 Challenges inherent in the disbursement of Disability Common Fund in the Kumasi Metropolis

The Disability Common Fund is a very important intervention among social protection policies to enable PWDs enter and participate in the mainstream of national development and also remove them out of poverty (NCPD, 2010). However, the quality of the programme action and its significant influence on PWDs‘ lives is dependent on the process of disbursement and management to its usage by beneficiaries. According

to a 2010 report by SEND Ghana on the District Assembly Common Fund (DACF), it was found that there was non-adherence to the guidelines for the utilization of the 2% DCF (SEND Ghana, 2010). This study had as it objective to examine the challenges inherent in the disbursement of the Disability Common Fund in the Kumasi Metropolis. Findings suggested several potential interventions that could support and improve the DCF programme in the Kumasi Metropolis.

A Fund Management Committee had been spelt out to be a requirement in the guidelines for managing the DCF (NCPD, 2010). According to responses from this study, the Kumasi Metropolis has a five member committee for managing the fund, made up of the Metropolitan Director of Social Welfare (Chairperson), Special Educator from Ghana Education Services (Secretary), Government appointee from Kumasi Metropolitan Assembly, one disabled person as a representative from Federation of PWDs and a friend of PWDs in the metropolis who act as community memberss. It is however surprising that only one person on the Fund Management Committee has a disability and belongs to a registered disability organization as revealed by all respondents. This is a significant move as it will ensure smooth and proper disbursement of the fund especially with the involvement of a disabled person on the committee to generate true and fair eligibility criteria and reduces the tendency for corruption as confirmed by Gooding and Marriot (2009). This effort in the Kumasi Metropolis however contradicted with Tabor (2002) in respect of inadequate institutional capacity in the public sector which affects implementation of cash transfers in developing countries. The study further indicated that the fund was mostly managed and distributed by the social welfare department as significant 91.7% indicated and corresponds with the view of Sackey (2009).

According to a SEND Ghana report, about 55% of Metropolitan Municipal Assemblies (MMA) in 50 districts across four administrative regions (Greater Accra, Northern, Upper East and Upper West) in Ghana had no Disability Fund Management Committee as required by the regulation (SEND Ghana, 2010).

The study further confirmed that the DCF in the Kumasi Metropolis had a separate bank account where the fund was deposited directly. This again contradicts with findings by SEND Ghana as nearly two-thirds of the districts in their report had no separate bank accounts for managing the DCF (SEND Ghana, 2010). This has the implication that the FMC in the Kumasi Metropolis works to meet the requirement of the fund regulation than other districts in the country as reported by SEND Ghana.

Also, the findings indicate that the specific mandate of monitoring the utilization of the fund is done by the Fund Management Committee (FMC) that embarks on unannounced rounds to the individual beneficiaries. The monitoring was also done in the form of giving instant report. The team from the national level, like the administrators of the Common Fund also visits the FMC and verify books and checks issued out.

One major challenge that confronted the management of the fund was the late arrival of the funds from the Administrator of the Common Fund such that PWDs continuously visited the FMC complaining about their problems. This makes PWDs have some mistrust about information from the FMC. Despite this, the blame of late fund arrival should not be shifted to the administrator since they did not intentionally delay if the fund were available. The delay from that end has the implication that the Finance Ministry in collaboration with the Government do not release the cash early. This may be attributed to limited funds to be disbursed by the Ministry of Finance and Economic Planning (MoFEP). This confirms what researchers have found in

developing countries that fund for disabled persons face budget constraints which affects the expansion of the programme (Erb & Harriss-White, 2002; Gooding & Marriot, 2009; Neves *et al*, 2009). The fund has an initial arrangement per the District Assembly Fund regulation to be released quarterly. The FMC, however, expressed worry and cited example from 2013 that, they only received two tranches for the whole year out of the four. There were always excess applications from PWDs in the Kumasi Metropolis. With limited funds and excess application, the FMC indicated that they worked on first come-first serve basis which has the implication that majority of the applications they received would not be attended to. This confirms what majority of PWDs in this study disclosed that, they received the fund once a year.

The study further found that the few beneficiaries did not use the fund for the intended purposes. This is attributed to the fact that the fund was insufficient to perform such purposes. This makes the FMC to set priority and only responded to urgent needs when it arose. In view of this, areas that the FMC considered most were education, business and healthcare.

CHAPTER SIX CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

The chapter presents the conclusion and makes recommendations to improve the Disability Common Fund in Kumasi Metropolis. The conclusion is per the objective of the study such as the socioeconomic and demographic characteristics of PWDs enrolled in the Disability Common Fund (DCF), the challenges PWDs face in assessing the DCF, impact of the DCF on the socioeconomic life of PWDs and the management of the DCF.

6.1 Conclusion

6.1.1 Background

It can be concluded that males dominated in the study than females. The mean age was 28 years with majority between 41 to 50 years. The educational level of PWDs in the Kumasi Metropolis was low such that majority had primary education with 15% having no formal education. Also, employment among PWDs was low such that majority had no formal employment and are not married. More than half of the participants were not using assistive devices.

6.1.2 Socio-economic and demographic characteristics of Persons with Disabilities enrolled in the Disability Common Fund

Disability and its related low education and employment have a huge implication on income and lead to low socio-seconomic status. The average monthly income of participants was GHC 171.62 with majority earning GHC 50 or less. The mean monthly income level of PWDs in the Kumasi Metropolis was below the national monthly minimum wage of GHC 180.00 (average income formed about 95.3% of monthly minimum wage). This was due to low education and employment among PWDs. The low income was further seen in problems related to expenses on their dependants such as education and healthcare.

6.1.3 Impact of Disability Common Fund on the socioeconomic life of Persons with Disabilities

About 77.8% of PWDs in the Kumasi Metropolis have ever received the DCF such that 59.3% have received it for only one year. Most PWDs received the fund once within a year and received an amount of GHC 200 to GHC 500. It can be concluded that the

DCF is insufficient for beneficiaries and their families. However, the fund is useful as it improved PWDs business and farming activities, helped them pay their children's school fees, assisted in purchasing assistive devices and slightly ensured access to healthcare. Also, the fund failed to help PWDs in their education and rights, create enabling environment for their full participation in national development, ensuring that women enjoy the same rights and privileges as males and providing supports for caregivers.

6.1.4 Challenges inherent in the disbursement of Disability Common Fund

The availability of the Fund Management Committee and separate bank account for managing the fund seems to offer smooth and proper disbursement of the fund especially with a disabled on the committee. Managing DCF in the Kumasi Metropolis manifested huge complaints and excess applications from PWDs. This was due to late arrival of funds from the Administrator of Common Funds. The funds received are insufficient to respond to all applications which make FMC to work on first come bases and set priority areas. Few beneficiaries do not use the fund for the intended purposes such that the funds were limited to complete their intended purposes.

6.2 Recommendations

The following are the recommendations which are made to policy makers and all respective stakeholders to improve the Disability Common Fund in the Kumasi Metropolis based on the discussion and conclusion of the study. The recommendations target the Government, Kumasi Metropolitan Fund Management

Committee, Individuals with Disability and their Organizations and NGO's who are in the field of disability.

6.2.1 Government of Ghana/Ministries

- The study found out that the level of education, employment and income among PWDs is low to improve their socioeconomic status (Tables 4.4). Persons with Disabilities with no formal education formed the majority of respondents as compared to those with secondary and tertiary education. Income level was also less among PWDs who had no formal education than those with tertiary education. Similarly, the income was less among females than males. With higher education and employment, there is the implication that the income level of PWDs will increase to improve their socioeconomic status. There should therefore be efforts to institute programmes to promote education and employment among PWDs to avoid the risks which come along with huge financial burden on PWDs, dependants and the state. The Education Ministry should team up with other ministries and agencies to help provide educational needs and facilities for PWDs. Government initiatives such inclusive education should be improved to encourage schools to admit PWDs.

  These programmes should target females with disabilities since they experience double discrimination from their disability and education, employment and income level.

  These programmes are perhaps a long-term policy. However, in the short-run, programmes to offer training and skills development in areas such as agriculture, business development and vocational training will offer employment for PWDs to improve their income level.

- It was found in the study that the DCF is not released on time to meet the applications from prospective beneficiaries. Persons with Disabilities would

have to apply in advance and wait for when the funds will be released to the management committee. This has the implications that the budgeted expenditure on an intended project or purpose could increase with delay in obtaining funds and the frequent changes in the prices of goods and services in the Ghanaian economy. It is therefore recommended that the Government and the Finance Ministry should release the DCF quarterly as spelt out in the fund regulations. Alternatively, the Government could also first release the disabled share of the District Assembly Common Fund before the benefits of the District. This will make PWDs receive the funds early if there are limited funds to be shared for all District Assemblies.

- The fund was again found to be insufficient for beneficiaries such that they are not able to cover the intended purposes and not able to cover many beneficiaries. The Disability Fund Management Committee therefore suggested that the quota of the District Assembly Common Fund allocated to PWDs should as much as possible be increased from the current 2% to 5%. This is because the disability community is increasing with a corresponding increase in the application for the fund. Also, measures to increase the fund within certain period should be documented as part of the regulations. This will help to meet a corresponding increase in applications for the fund from time to time.

6.2.2 Kumasi Metropolitan Social Welfare Department/ Fund Management Committee

- The Fund Management Committee and all professionals involved with the DCF should be motivated enough to encourage the disbursement and monitoring effectively.

- The current monitoring and supervision of beneficiaries of the fund carried out by the Fund Management Committee in the Kumasi Metropolis should be strengthened enough.

6.2.3 Individual, Households and Community

- Individual households should as much as possible encourage the education of their disabled family members. Any support that deemed appropriate should be given out to help them attain higher education. Family members should again support disabled relatives who use their share of the common fund in business activities. Community members are also encouraged to involve PWDs in mainstream employment to improve their income level. They should again engage in business with PWDs. This will help PWDs who use their share of DCF in business to get the needed market for their products. It will further ensure effective usage of the fund.

6.2.4 NGOs/Other Stakeholders

- There is the need for international or local donors working in the field of disability to focus much on grants like the DCF to support the efforts of the Government of Ghana for PWDs in the Kumasi Metropolis. The donors can support through provision of funding for the payment of the DCF or introducing similar grant or fund for the disables in the Metropolis since the study found the DCF to be insufficient for the beneficiaries. The NGOs can also provide education to PWDs on the usefulness of the DCF and how it can be used effectively to meet the purpose as spelt out in the fund regulation.

6.2.5 Recommendation for future research

- Further research should be conducted to further determine the impact of the DCF on the communities where the fund is distributed. There is also the need to investigate the financial risk protection offered by other social protection strategies like Livelihood Empowerment Against Poverty for PWDs.

REFERENCES

Abebrese, J. (2011). Social Protection in Ghana, An overview of existing programmes and their prospects and challenges. Fredrich Ebert Stiftung, Germany.

African Union. (2006). The Livingstone call for action (intergovernmental regional conference ―Social protection—A transformative agenda‖). Livingstone, Zambia. Puede consultarse en http://www. helpage. org/News/Latestnews/ VIaB (visitado el 16 de enero de 2007).

African Union. (2008). Social policy framework for Africa. First Session of African Union Ministers in Charge of Social Development.

Aguero, J., Carter, M., & Woolard, I. (2006). The impact of unconditional cash transfers on nutrition: The South African Child Support Grant. University of Western Cape Town, South Africa.

Arnold, C., Conway, T., & Greenslade, M. (2011). Cash transfer literature review. Policy Division, Department for International Development, (DFID) UK.

Babson, O., Rosenblum, D., & Stevens, A. (2001). Disability, Poverty and Social Security. Economic Policy Research Institute (EPRI), Cape Town.

Barrientos, A., & DeJong, J. (2006). Reducing child poverty with cash transfers: A sure thing? *Development Policy Review*, 24(5): 537-552.

Barrientos, A., & Hulme, D. (2008). Social protection for the poor and poorest in developing countries: Reflections on a quiet revolution. Brooks World Poverty Institute Working Paper, University of Manchester, UK.

Barrientos, A., & Santibáñez, C. (2009). New forms of social assistance and the evolution of social protection in Latin America. *Journal of Latin American Studies*, 41(1): 1-26.

Blomquist, J., & Mackintosh, F. (2003). Assisting the Poor with Cash: Design and Implementation of Social Transfer Programs: World Bank.

Chinsinga, B. (2007). Social Protection Policy in Malawi: Processes, Politics and Challenges. Future Agricultures, Department of Political and Administrative Studies, University of Malawi, Malawi.

Coulombe, H., & Wodon, Q. (2007). Poverty, livelihoods, and access to basic services in Ghana. Paper presented at the Ghana CEM: Meeting the Challenge of Accelerated and Shared Growth, World Bank, Washington DC

Creswell, J. W. (2013). Research design: Qualitative, quantitative, and mixed methods approaches: Sage Publications Inc, University of Nebraska, Lincoln, US.

Datt, G., Payongayong, E., Garrett, J. L., & Ruel, M. T. (1997). The GAPVU cash transfer program in Mozambique: International Food Policy Research Institute (IFPRI).

Department of Social Welfare. (2013). Persons with Disabilities registered for Disability Common Fund. Social Welfare. Ministry of Gender, Children and Social Protection. Kumasi, Ghana.

Devereux, S. (2002). Can social safety nets reduce chronic poverty? *Development Policy Review*, 20(5): 657-675.

Devereux, S., & Getu, M. (2013). Informal and Formal Social Protection Systems in Sub-Saharan Africa: African Books Collective, Fountains Publishers, Kampala, Uganda. 10(7): 57-75

Devereux, S., Marshall, J., MacAskill, J., & Pelham, L. (2005). Making Cash Count: Lessons from cash transfer schemes in east and southern Africa for supporting the most vulnerable children and households. Save the Children, HelpAge International, Institute of Development Studies, University of Sussex, London.

Devereux, S., & White, P. (2010). Social protection in Africa: Evidence, politics and rights. *Poverty & Public Policy*, 2(3): 53-77.

Dube, A. K. (2005). The role and effectiveness of disability legislation in South Africa. Samaita Consultancy and Programme Design.

Eardley, T., Bradshaw, J., Ditch, J., & Gough, I. (1996). Social assistance in OECD countries: Synthesis Report (D. o. S. S. R. Report, Trans.). University of York, London, UK. 4(1): 4-6

Ellis, F. (2010). Social protection in Africa: where are we, and how did we get here? Frontiers of Social Protection brief, Johannesburg, South Africa.(7).

Ellis, F., Devereux, S., & White, P. (2009). Social protection in Africa: Edward Elgar Publishing, Cheltenham, UK.(4)

Elwan, A. (1999). Poverty and disability: A survey of the literature: Social Protection Advisory Service, World Bank.

Erb, S., & Harriss-White, B. (2002). Outcast from Social Welfare: Adult Disability, Incapacity and Development in Rural South India. Bangalore, India: Books for Change:. 11(3): 6-5

Filmer, D. (2005). Disability, poverty and schooling in developing countries: Results from 11 household surveys.

Filmer, D. (2008). Disability, poverty, and schooling in developing countries: results from 14 household surveys. *The World Bank Economic Review*, 22(1): 141163.

Fitzgerald, E. (2007). Disability and poverty. In C. Mel (Ed.), Welfare Policy and Poverty (pp. 229). Irreland: Combat Poverty Agency.

Ghana Statistical Service. (2012). 2010 Population & housing census: Summary report of final results Accra, Ghana: Ghana Statistical Service

Ghana Statistical Services. (2012). Population & Housing census: 2010 Summary report of final results Ghana Statistical Service, Accra, Ghana.

Gooding, K., & Marriot, A. (2009). Including persons with disabilities in social cash transfer programmes in developing countries. *Journal of International Development*, 21(5): 685-698.

Guarte, J. M., & Barrios, E. B. (2006). Estimation under purposive sampling. Communications in Statistics—*Simulation and Computation*®, 35(2): 277284.

Hickey, S. (2007). Conceptualising the politics of social protection in Africa. Palgrave/Macmillan.

Inclusive Ghana. (2011). Report on the level of Stigmatization, Discrimination and Exclusion of Persons with intellectual disabilities and their family in Ghana. In A. J. Odoom & K. v. Weelden (Eds.). Accra, Ghana: Inclusive Ghana

Kazeze, Z. (2008). Social protection and ageing in Malawi: Economic and Social Department, Food and Agricultural Organization, Rome

Kebede, E. (2006). Moving from emergency food aid to predictable cash transfers: Recent experience in Ethiopia. *Development Policy Review*, 24(5): 579-599.

Kenya CT-OVC Evaluation Team. (2012). The Impact of Kenya‘s Cash Transfer for Orphans and Vulnerable Children on Human Capital. *Journal of Development Effectiveness*, 4(1), 38 - 49.

Kumasi Metropolitan Assembly. (2010). Medium Term Development Plan of Kumasi Metropolitan Assembly, 2010-2013 Kumasi, Ghana: Ministry of Local Government & Rural Development, Accra.

Kumekpor, T. K. (2002). Research Methods & Techniques of Social Research, Section 1: Sonlife Printing Press and Services, Adenta, Ghana.

Künnemann, R., & Leonhard, R. (2008). A human rights view of social cash transfers for achieving the millennium development goals. FIAN International, medico international, Bonn/Stuttgart, Germany.

Levin, K. A. (2006). Study design III: Cross-sectional studies. *Evidence-based dentistry*, 7(1): 24-25.

Lund, F. J., & Srinivas, S. (2000). Learning from experience: A gendered approach to social protection for workers in the informal economy: International Labour Organization, Geneva, Swizerland

Lwanga-Ntale, C. (2003). Chronic poverty and disability in Uganda.

McClain-Nhlapo, C. (2007). Including people with disabilities in actions to reduce poverty and hunger: International Food Policy Research Institute, Washington, US.

Mitra, S., Pošarac, A., & Vick, B. (2011). Disability and poverty in developing countries: a snapshot from the world health survey: World Bank.

Mitra, S., & Sambamoorthi, U. (2006). Employment of persons with disabilities: evidence from the National Sample Survey. Economic and Political Weekly, 199-203.

National Council for Persons with Disabilities. (2010). Guidelines for the Disbursment and Management of the District Assembly Common Fund Allocation to Persons with Disabilities: National Council On Persons With Disability, Accra, Ghana.

Neves, D., Samson, M., van Niekerk, I., Hlatshwayo, S., & du Toit, A. (2009). The use and effectiveness of social grants in South Africa. Institute for Poverty, Land and Agrarian Studies (PLAAS), University of the Western Cape, Cape Town.

Niño-Zarazúa, M., Barrientos, A., Hulme, D., & Hickey, S. (2010). Social protection in Sub-Saharan Africa: Will the green shoots blossom? University of Western Cape Town, South Africa.

Organisation for Economic Co-operation and Development (OECD). (2009). Sickness, disability and work: Keeping on track in the economic downturn – Background paper: OECD.

Palmer, M. (2011). Disability and poverty: A conceptual review. *Journal of Disability Policy Studies*, 21(4), 210-218.

Sabates_Wheeler, R., & Devereux, S. (2007). Social protection for transformation. *IDS bulletin*, 38(3): 23-28.

Sackey, E. (2009). Strengthening the Disability movement in Ghana project, Pilot survey report; Birim, Ho, Manya: Ghana Federation of the Disabled, Accra, Ghana.

Saunders, P. (2005). Disability, Poverty and Living standards: Reviewing Australian evidence and policies. The Social Policy Research Centre, University of New South Wales, Sydney, Australia.

Schubert, B., & Beales, S. (2006). Social cash transfers for Africa: A transformative agenda for the 21st century: HelpAge International, London.

SEND Ghana. (2010). Making Decentralisation Work for the Poor. Accra, Ghana: SEND Ghana.

Sultan, S. M., & Schrofer, T. T. (2008). Building Support to have Targeted Social Protection Interventions for the Poorest–The Case of Ghana. Paper presented at the SOCIAL PROTECTION FOR THE POOREST IN AFRICA, Kampala, Uganda.

Tabor, S. R. (2002). Assisting the poor with cash: Design and implementation of social transfer programs. World Bank Social Protection Discussion Paper Series, Washington DC, USA.

The Transfer Project. (2013). Countries Retrieved December 12, 2013, from http://www.cpc.unc.edu/projects/transfer/countries

UNESCO. (1995). Overcoming obstacles to the integration of disable people. In R. Hurst (Ed.). Copenhagen, Denmark: UNESCO.

UNICEF. (2008). Social protection in Eastern and Southern Africa: A framework and strategy for UNICEF. UNICEF ESARO, Nairobi.

United Nations Development Programmes UNDP. (2013). Cash Transfer Programmes in Africa. Retrieved November 12, 2013, from http://www.ipcundp.org/PageNewSiteb.do?id=120&active=3

Villanger, E. (2008). Cash Transfers Contributing to Social Protection: A Synthesis of Evaluation Findings (E. Department, Trans.): Norwegian Agency for Development Cooperation, Oslo, Norway.

Ward, P., Hurrell, A., Visram, A., Riemenschneider, N., Pellerano, L., O'Brien, C., & Willis, J. (2010). Cash Transfer Programme for Orphans and Vulnerable Children (CT-OVC), Kenya: Oxford Policy Management, Oxford. 57-65

Woolard, I. (2003). Impact of government programmes using administrative data sets: Social assistance grants: Project 6.2 of the Ten Year Review Research Programme, University of Stellenbosch, South Africa.

World Bank. (2012). Data Countries and Economies: Ghana. Retrieved October 9, 2013, from http://data.worldbank.org/country/ghana

World Health Organization. (2011). World Report on Disability: World Health Organization and World Bank, Geneva, Swizerland

World Health Organization. (2014). Assistive devices/technologies: what WHO is doing. Retrieved May 18, 2014, from http://www.who.int/disabilities/ technology/activities/en/

APPENDIX A

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY, KUMASI

SCHOOL OF MEDICAL SCIENCES

(DEPARTMENT OF COMMUNITY HEALTH)

ASSESSING DISABILITY COMMON FUND ON LIVELIHOODS: A CASE STUDY OF PERSONS WITH DISABILITIES WITHIN THE KUMASI METROPOLITAN AREA

Questionnaire for Respondents

Dear Sir/Madam

The purpose of this questionnaire is to assess the contribution of the Disability Common Fund (DCF) on individual livelihoods in the Kumasi Metropolitan Area under the jurisdiction of the Kumasi Metropolitan Assembly (KMA). It would be greatly appreciated if you could complete this questionnaire. The study is for academic purposes. You are, however, assured of the strictest confidentiality and anonymity. Thank you.

Paulina Adjei Domfeh - PG 7913412

Please answer the following questions with a tick [√] where appropriate.

(A) Socio-demographic characteristics

1. Age: .....
2. Sex: a)...Male [ ] b)...Female [ ]

3. Level of education:
   a) No formal education
   b) Primary [ ]
   c). Secondary [ ]
   d) Tertiary [ ]
   e). other [ ] (specify).....

4. Marital status:
   a) Single [ ]

b) Co-habitation [ ]
c) Married [ ]
d) Separated [ ]
e) Divorced [ ]
f) Widowed [ ]
g) Deserted [ ]

5. Ethnic group.....
6. Hometown: .....
7. Nationality: .....

8. Occupation:
   a) Trading [ ]
   b) Government (Civil Servant) [ ]
   c) Farming [ ]
   d) Apprenticeship [ ]
   e) None [ ]
   f) Other (Specify): ..... [ ]

9. Religion: .....

10. In which disability organization are you registered as a member?
   a) Ghana Society of the Physically Disabled (GSPD) [ ]
   b) Ghana Blind Union (GBU) [ ]
   c) Ghana National Association of the Deaf (GNAD) [ ]
   d) Other (specify): ..... [ ]
   e) None [ ]

11. Which assistive device do you use? Tick
   a) Glasses [ ]
   b) Wheel chair [ ]
   c) Clutches [ ]
   d) Braces [ ]
   e) Hearing aid [ ]

f) White cane [ ]

g) Other [ ] specify.....

h) None [ ]

12. Which of the assistive devices is provided or maintained by the Fund

a) Glasses [ ]

b) Wheel chair [ ]

c) Clutches [ ]

d) Braces [ ]

e) Hearing aid [ ]

f) White cane [ ]

g) Other [ ] specify.....

h) None [ ]

(B) Financial obligation on dependants

13. How many dependants do you have?

a) 0 [ ]

b) 1-2 [ ]

c) 3-4 [ ]

d) 4-5 [ ]

e) 6 and above [ ]

14. What are the ages of your dependants (in years)?

a) 0-5 [ ]

b) 6-10 [ ]

c) 11-15 [ ]

d) 16-20 [ ]

e) 21 and above [ ]

15. What is/are the educational background(s) of your dependant(s)?

a) Creche/Kindergarten [ ]

b) Primary School [ ]

c) Junior High School [ ]

d) Senior High School [ ]

e) Tertiary [ ]

16. In a typical month, which one of the following best describes your income level.

a) Below GH 50 [ ]

b) GH 50 – 100 [ ]

c) GH 100 – 200 [ ]

d) GH 200 – 300 [ ]

e) Above GH 300 [ ]

17. How much money do you spend on the dependants' daily on food?

a) GHC 1.00 - 5.00 [ ]

b) GHC 6.00 - 10.0 [ ]

c) GHC 11.00 - 15. [ ]

d) GHC 16.00 - 20. [ ]

e) Other (specify)..... [ ]

18. How much money is spent on healthcare monthly?

a) GH.5-10.00 [ ]

b) GHC 11.00 - 16.00 [ ]

c) GHC 17.00 - 22.00 [ ]

d) GHC 23.00 - 28.0 [ ]

e) Other, specify GHC..... [ ]

19. How much money do you spend on your dependants' education in a year?

a) GHC 100.00 - 150.00 [ ]

b) GHC 150.00 - 200.0 [ ]

c) GHC 200.00 - 250.00 [ ]

d) GHC 250.00 - 300.00 [ ]

e) Other, (Specify) GHC.....[ ]

20. How much do you spend on the items listed in (a) to (g)?

a) Food GHC ……

b) School fees/uniforms, craft, etc GHC ……

c) Medicine/NHI/etc GHC ……

d) Clothing GHC ……

e) Business/trading/farming etc GHC ……

f) Caregiver/house help GHC ……

g) Other [ ] Specify …….. GHC ……

(C.) Effect of the Disability Common Fund on the lives of physically challenged, visually impaired and the hearing impaired.

21. Have you received any Disability Fund from the Kumasi Metropolitan Assembly?

Yes [ ] No [ ]

a) For how long have you been receiving money from the Fund?

a) 1 year [ ] b) 2 years [ ] c) 3 years [ ] d) 4 years [ ] 22 **(b)** How regularly have you been receiving money from the Fund since you became abeneficiary?

(a) Every quarter [ ] (b) Every 6 months [ ] (c) Once a year [ ] (d). Others [ ] Specify.....

22. Who issues the money? .....

23. How much do you receive monthly/quarterly/yearly/occasionally? GH₵.....

24. Please tick [√] to indicate your opinion on the following statements in Table 1. Table 1: Opinions of PWDs on level of usefulness of the Disability Common Fund

	Statement: *The fund.....*	**SA** (5)	**A** (4)	**N/A** (3)	**D** (2)	**SD** (1)
(a)	supports education of my rights, potentials and responsibilities					
(b)	helps me pay my children's school fees					
(c)	is insufficient for me and my family					
(d)	improves my business and farming activities					
(e)	makes it easier for me to access healthcare					
(f)	creates an enabling environment for my full participation in national development					
(g)	ensures that women with disabilities enjoy the same rights and privileges as their male counterparts					
(h)	acquire assistive devices (wheel chair, hearing aid, Braille, electronic recording machine etc etc					
(i)	provides for care-giver					

KEY

*Strongly agree **(SA)** = 5*
*Agree **(A)** = 4*
*Not applicable **(N/A)** = 3 Disagree*
***(D)** = 2*

*Strongly disagree **(SD)** = 1*

25. In your opinion, which area(s) of the life of a Person with Disability do(es) the Funds support? You may tick [√] more than one if you find the options applicable.

a) Awareness raising on the rights and responsibilities of PWDs [ ]
b) Organizational development [ ]
c) Training in employable skills/apprenticeship [ ]
d) Income generation activities [ ]
e) Educational support for children, students and trainees with disability [ ]
f) Provision of technical aids, assistive devices, equipment [ ]
g) Registration on the National Health Insurance Scheme [ ]
h) Other (specify): ..... [ ]

(D) Management of the Disability Common Fund

26. Which people constitute the Fund Management Committee?

a).....
b).....
c).....
d).....
e).....

27. How many members of the Fund Management Committee have disabilities or belong to registered disability organizations?

a) None [ ]
b) One [ ]
c) Two [ ]
d) Three or more (specify the number) [ ]

28. What are responsibilities of the Fund Management Committee?

a).....
b).....
c).....
d).....

(Add more on a separate sheet if necessary)

29. Who is/are those charged with the mandate of monitoring the utilization of the fund by individual persons with disabilities?

    a)……

    b)……

    c)……

    d) There is no monitoring …(tick)……[ ]

30. How is the monitoring done?

    a)……

    b)……

    c)……

    d)……

    (Add more on a separate sheet if necessary)

31. Is there an account specific to the management of the Fund? Yes [ ] No [ ]
32. If YES, Who are the signatories to the account?

    a) ……

    b) ……

    c) ……

33. Which of these signatories is a member of a recognized disability organization?
34. You may indicate any regulation that makes a member of the disability groups automatic signatory to the Disability Common Fund account

    ……

    ……

35. (a) Complete Table 2(a) to indicate the amount of money received into the Disability Common Fund from 2010 to 2013

Table 2(a): Disability Common Fund disbursement to Kumasi Metropolitan Assembly from the Office of the Administrator of the District Assemblies Common from 2010–2013

Year	**Quarter**				
	1st	**2nd**	**3rd**	**4th**	**Total**

2010					
2011					
2012					
2013					
Total					

36(b) Complete Table 2(b) to indicate the amount of money disbursed (**AMD**) and number of beneficiaries (**NOB**) for each quarter.

Table 2(b): Disbursement of Disability Common Fund to Persons with Disabilities (Kumasi Metropolitan Area – 2010-2013)

Year	**Quarter**									
	1st		*2nd*		*3rd*		*4th*		*Total*	
	AMD	**NOB**	**AMD**	**NOB**	**AMD**	**NOB**	**AMD**	**NOB**	**AMD**	**NOB**
2010										
2011										
2012										
2013										
Total										

AMD = *Amount of Money Disbursed* **NOB** = *Number of Beneficiaries*

(E) Challenges inherent with the management of the DCF.

36. State any major challenge(s) you have observed with the DCF?

.....

.....

37. In your view, what do you think could be done to minimise or possibly eliminate the stated (35) challenge?

.....

.....

.....

.....

38. State your opinion by a tick ( ) to indicate the level of your agreement with statements in Table 3.

Table 3: Challenges associated with the Disability Common Fund.

Statement.....	SA *(5)*	A *(4)*	N/A *(3)*	D *(2)*	SD *(1)*
Disabled persons recognised by the Assembly benefits from the Fund					
Disabled persons registered with registered Disabled Peoples Organizations must benefit from the Fund.					
Managers of the Fund use their discretion to select beneficiaries to the Fund at any particular time.					
Amount of money for disbursement is insufficient					
Amount of money given to each beneficiary is insufficient.					
There are other deductions from the Fund which do not benefit the PWDs.					
All administrative cost involved in disbursement must be charged to the Fund.					
There is lack of guidelines for how the funds should be spent					
The fund does not state how the needs of women with disabilities should be met					
The fund does not state how the needs of children with disabilities should be met					

39. General Comments

.....

.....

.....

.....

.....

.....

Thank you

APPENDIX B

Participant Information Leaflet and Consent Form

This leaflet must be given to all prospective participants to enable them know enough about the research before deciding to or not to participate

Title of Research:
Impact of Disability Common Fund on the lives of Persons with Disabilities in the Kumasi Metropolis

Name(s) and affiliation(s) of researcher(s): This research is being conducted by Paulina Adjei-Domfeh of the Community Health Department, Centre for Disability Studies, KNUST, **+233208785766**.

Background (Please explain simply and briefly what the study is about):

The Government of Ghana recognizes that Persons with Disabilities (PWDs) form an important part of vulnerable groups in Ghana. A number of Social Protection Strategies have been developed with the aim of mitigating poverty and its effects. ▪The Ghana Poverty Reduction Strategy was developed consisting of Phase I and II (2002-2005 and 2006-2009, respectively), ▪Ghana School Feeding Programmes (2005) , ▪Capitation Grant for basic schools, ▪National Health Insurance Scheme (2003), ▪Livelihood Empowerment Against Poverty (LEAP, 2008) (Abebrese, 2011). Ghana joined other countries in 2000 and signed the Millennium Development Goals (MDG) to alleviate extreme poverty by 2015. A World Bank profile on Ghana (2012) indicated that poverty rate in the country was still high at 28.5% in 2006 despite 11% reduction from 1998 to 2006. The rate also remains high (18%) for those living in extreme poverty (World Bank, 2012).

There is a wide disparity in the reduction of poverty and development across geographical or regional boundaries and social groups. Areas like the Northern part of the Ghana, rural areas and migrant communities continuously remain poorer than other places. Besides, vulnerable groups such as PWDs remain poorest of the poor and underrepresented than other social groups in the community (Coulombe and Wodon, 2007).

Persons with Disabilities were not explicitly captured in most of the Social Protection Programmes. The passage of Disability Act 715 in 2006 and the establishment of the National Council on Persons with Disabilities (NCPD) in 2010 is focusing attention on social protection for PWDs. Government, by law, has allocated 2% of the District Assembly Common Fund (DACF) (as Disability Common Fund – DCF) to PWDs each

year to support sustainable livelihoods, education, health and build capacity of PWDs in general. More importantly, the fund assists PWDs to have access to assistive devices and technical aids. (NCPD, 2010). This study is set out to assess the impact of the fund on beneficiary PWDs and the administration of the fund.

Purpose(s) of research:

The purpose of this study is to examine the impact of Disability Common Fund (DCF) on the lives of persons with disabilities and recommend ways of improving the programme.

Procedure of the research, what shall be required of each participant and approximate total number of participants that would be involved in the research:

The participant of this study will only be restricted to males and females PWDs who have benefited from the Disability Common Fund and officials of the Fund Management Committee. I will use a non-probability purposive sampling to select one hundred and twenty (120) PWDs and five (5) officials of the Fund Management Committee to get a total sample of one hundred and twenty-five (125) participants for the study. I will therefore provide you with structured questionnaires to conduct written interview with you. The questionnaires will involve both close and openended questions. I will guide you to clearly explain the questions where necessary. I will ask you as respondents' questions on the questionnaire for you to directly respond to the questions. What shall be required of you is to give me your views on the questions that is being asked base on the study variables. I will then analyse the data by using Statistical Package for Social Sciences Software 20. Results of the analysis will be generated through descriptive and analytic statistics. Your name will not be linked with any questions during the analysis.

Risk(s):
There will be inconvenience to respondents because they are mostly busy and will have to make time for me as far as the administration of the research tools are concerned.

Benefit(s): The study will give baseline information about the impact and challenges of the Disability Common Fund in Kumasi Metropolis and this will help in policy planning

Confidentiality:
Information collected will be coded and no name will be recorded. Data collected cannot be linked to any one in anyway. No name or identifier will be used in any publication. Voluntariness:

This study is voluntary. You may choose to be a part or not. No sanctions will apply.

Alternatives to participation:
If chosen not to participate in this research it will not affect you in anyway.

Withdrawal from the research: You may choose to withdraw from the research for which there will be no need to explain yourself..

Consequence of Withdrawal: There no consequence for withdrawing from the research neither will there be any benefit or care lost.

Costs/Compensation: A cake of soap or Key holder

Contacts: If you have any question concerning this study please do not hestitate to contact Paulina Adjei-Domfeh, +233208785766)

The Office of the Chairman
Committee on Human Research and Publication Ethics
Kumasi
Tel: 03220 63248 or 020 5453785

CONSENT FORM

Statement of person obtaining informed consent:
I have fully explained this research to _____ and have given sufficient information about the study, including that on procedures, risks and benefits, to enable the prospective participant make an informed decision to or not to participate.

DATE: _____ NAME: _____

Statement of person giving consent:
I have read the information on this study/research or have had it translated into a language I understand. I have also talked it over with the interviewer to my satisfaction.

I understand that my participation is voluntary (not compulsory).

I know enough about the purpose, methods, risks and benefits of the research study to decide that I want to take part in it.

I understand that I may freely stop being part of this study at any time without having to explain myself.

I have received a copy of this information leaflet and consent form to keep for myself.

NAME:_____

DATE: _____ SIGNATURE/THUMB PRINT: _____

Statement of person witnessing consent (Process for Non-Literate Participants):

I_____ (Name of Witness) certify that information given to (Name of Participant), in the local language, is a true reflection of what l have read from the study Participant Information Leaflet, attached.

WITNESS‘ SIGNATURE (maintain if participant is non-literate): _____

MOTHER‘S SIGNATURE (maintain if participant is under 18 years): _____

MOTHER‘S NAME: _____

FATHER‘S SIGNATURE (maintain if participant is under 18 years): _____

FATHER‘S NAME: _____