KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY

COLLEGE OF HEALTH SCIENCES

SCHOOL OF MEDICAL SCIENCES

DEPARTMENT OF COMMUNITY HEALTH

THE EFFECT OF THE DISABILITY FUND ON INDIVIDUAL LIVELIHOODS: A CASE STUDY OF PERSONS WITH DISABILITIES IN THE ATWIMA NWABIAGYA DISTRICT OF THE ASHANTI REGION OF GHANA

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B.A. Sociology and Social Work (Hon)

NOVEMBER, 2015

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The Effect of the Disability Fund on Individual Livelihoods: A Case Study of Persons with Disabilities in the Atwima Nwabiagya District of the Ashanti Region 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

Candidate's Declaration

I do hereby declare that this dissertation, with the exception of quotations and ideas attributed to specified sources and duly acknowledged, is entirely the result of my research work and that this work has neither in whole nor part been presented for the award of a degree elsewhere by me.

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DEDICATION

This piece is dedicated to my dear husband, Mr. Fredua Agyemang Prempeh and my lovely children, Kwabena Peasah Fredua Agyemang and Afia Afrakoma Fredua Agyemang.

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I thank the Almighty God for how far He has brought me by sailing me through the storms of life on campus. I wish to express my sincere gratitude and appreciation to my supervisor, Dr. Anthony K. Edusei who tirelessly read through this piece and through his effort has made this piece a reality. I am also indebted to all lecturers at the Centre for Disability and Rehabilitation Studies. To my parents, Mr. and Mrs.

Fred Darko, I say you have done a yoo man‘s job, not forgetting Mad Elizabeth Agyeiwaa, lecturer, Ghana Telecom University, Nana Kwadwo Ntiamoah, lecturer, KNUST, Miss Abigail Adjirackor and all my siblings who altogether have contributed immensely to the success of this work.

ABSTRACT

This study seeks to explore the effect of the Disability Fund on Persons with Disabilities in the Atwima Nwabiagya District of the Ashanti Region of Ghana. Particularly, the study accesses the effects of the Disability Fund on the lives of physically challenged, visually and hearing impaired, evaluates how the Disability Fund was managed and investigates the challenges associated with the management of the fund at the District Assembly level. The study uses quantitative method of analysis where a sample of 212 respondents was obtained using a register of Persons with Disabilities (PWDs), a random selection of respondents at meetings of the Disabled Persons Organisations (DPOs) and also questionnaires and interviews.

Statistical Package for Service Solution (SPSS) was employed to analyse the data. From the data, majority of the respondents (71.3%) agreed that the fund was useful for their livelihoods. The study findings show that for effective utilization of the fund, the National Council for Persons with Disabilities (NCPD) in collaboration with the Ghana Federation for the Disabled (GFD) under the authority of the Minister for Employment and Social Welfare, in cooperation with the District Assembly Common Fund (DACF) and with the approval of the Minister for Local Government and Rural Development, provides guidelines on the disbursement and management of the Fund to Persons With Disability. The research points out that out of five member management team, only one person is disabled. The study recommends that, the PWDs must be given more

representation of about 60% in the management team. They should be given the opportunity to make an input into how the Disability fund should be managed. In an attempt to bring all PWDs on board, it is further recommended that every PWD must be registered with a group in order to assess the fund. In conclusion, disability in the district is prevalent among female respondents and rural areas in the district. The disability fund affects respondents in several ways as it supports them in providing basic needs for themselves and their dependants. Even though the disability fund supports disabled persons who participated in the study, key challenges exist and need urgent attention.

LIST OF ACRONYMS

ADA	Americans with Disabilities Act
ANOVA	Analysis of Variance
DACF	District Assembly Common Fund
DMEC	Disability Management Employer Coalition
DPO	Disabled Persons Organisations
EMPAQ	Employer Measures of Productivity, Absence and Quality
ESCAP	Economic and Social Commission for Asia and the Pacific
GFD	Ghana Federation for the Disabled
GHDS	Ghana Human Development Scale
GNAD	Ghana National Association of the Deaf
GSPD	Ghana Society of the Physically Disabled
ICF	International Classification of Functioning
IEA	Insurance Educational Association
IF	International Funding
IRDM	Institute for Rehabilitation and Disability Management
NAD	Norwegian Association of the Disabled
NCPD	National Council on Persons with Disability
NIDRR	National Institute for Disability and Rehabilitation Research
PWDs	Persons with Disabilities
WBGH	Washington Business Group on Health
WHO	World Health Organisation

TABLE OF CONTENTS

LIST OF TABLES

TABLE **PAGE**

LIST OF FIGURES

FIGURE **PAGE**

CHAPTER ONE INTRODUCTION

1.1 Background Information

Stigma and discrimination against persons with disabilities have always been a problem. Physically Disabled persons are familiar to every class, culture and society. The number of moderately and severely disabled persons globally was 250 to 300 million in 1990 (Helander, 1993). Disabled persons have always been discriminated and stigmatized across cultures for thousands of years. Persons with physical disabilities do not face only physical problems but in fact they have to face social and psychological problems in life (Bodgan & Biklew, 1993). A persistent negative attitude and social rejection of persons with disabilities is evident throughout history and across cultures. Ancient Roman and Greek cultures viewed persons with physical disabilities as burdens on society and as less than human. Research has shown, however, that the degree of social rejection and social stigma varies with specific disabilities (Rubin & Roessler, 1995). But on the contrary Muslim scholars and leaders believed it is the duty of society to provide appropriate education to children with disabilities in inclusive environments. The society has an obligation to meet the educational and life needs of disabled persons by providing equal opportunities to education and employment (Naz & Aurangzeb, 2002).

Disability is often what we perceive; it is in the mind of the perceiver (Wright, 1983). Disability policies, programmes and practices of any country are manifestations of the attitudes that people in different cultures share. It is therefore, easy to assume that in developing countries where basic life conditions are hard to maintain, such prejudices would have far more dehumanizing consequences. People in their struggle to survive and feed their dependents go through all kinds of exploitations and degrading experiences. There is poverty, illness, illiteracy and massive unemployment, leading to

severe competition for diminishing resources. Under such conditions persons with disabilities are one of the most vulnerable groups, which suffers more due to societal prejudices than due to their disabling physical condition.

Mallory (1993) observed that in developing countries traditional attitudes of pity and charity are changing slowly. Miles (1996) on the basis of his study in Pakistan and other studies in 30 countries noted that the progressive development is from negative, stigmatizing and rejecting attitudes, through pity and compassion towards willingness to accept the physically challenged persons on equal terms. However, any such general conclusion needs to be tested with some standardized measures of attitudes and beliefs. In the last few decades, many developing countries have enacted laws to curb discriminatory practices in employment, health and education, and to equalize opportunities for the physically challenged. The Persons with Disabilities Act (1995) in India, the Disability Discrimination Act (2002) in Korea and the Human Rights and Equal Opportunity Commission Act (1986) in Australia are some of the examples of comprehensive legislative measures. Indeed, more than 70% of the disability-related laws in Asian and African countries have been enacted in the last quarter century only.

In spite of these legislative measures, full participation and equality of opportunity for persons with disability, especially in the field of health, education and employment, is still a distant dream. The social and physical environment is still designed without considering the special needs of persons with disabilities. Physical obstacles and social barriers prevent these people from participating in community and social life.
This is largely because negative social attitudes exclude persons with disabilities from an equal share in their entitlements as citizens.

Disabled persons, irrespective of where they live, are statistically more likely to be unemployed, illiterate, to have less formal education, and have less access to developed support networks and social capital than their able-bodied counterparts.

Consequently, disability is both a cause and consequence of poverty (Yeo, 2005). However, not much has been done to investigate ways of minimizing these social problems.

1.2 Statement of Problem

Persons with Disabilities in society are saddled with a lot of challenges. According to WHO (2014), about 1 billion people representing 15% of the world‘s population live with disability with 75% of them living in developing countries, and constituting one of the most poor, marginalized and socially excluded groups in any society (DFID 2005, Barron and Amerena, 2007).

Development agencies and practitioners are increasingly recognising disability as a key issue, inexorably linked to poverty, the extension of human rights and citizenship. In 2002, James Wolfensohn, former President of the World Bank, stated that unless disability issues were addressed, the UN Millennium Development Goal targets would not be met. Furthermore, the United Nations, in collaboration with civil society institutions successfully negotiated a convention regarding disability rights and ratified it at the 61st Session of the General Assembly in December, 2007.

Notwithstanding the high profile given to disability and development issues, there remains scant consensus on what are the most appropriate, sustainable strategies and operational modalities that should be employed for effective interventions within the disability sector. Hence, the study explores how the disability management fund is

affecting the lives of the physically challenged in the Atwima Nwabiagya District in the Ashanti Region.

1.3 Significance of Study

The study would equip major stakeholders on how to manage the disability fund for the betterment of the PWDs in society.

It would further help the general public to appreciate the problems and plight of persons with disabilities in society. This would educate them on stigmatization and discrimination against persons with disabilities. The study would add to the existing literature on disability management.

1.4 Research Questions

In carrying out the research, the study sought to determine solutions to the following questions:

1. What is the effect of the Disability fund on the livelihood of persons with disabilities?
2. How is the Disability fund managed in the Atwima Nwabiagya District?
3. What are the challenges associated with the Disability Fund at the District Assembly level of the Atwima District Assembly.

1.5 Objective

The general objective of this study was to explore the contributions of the Disability Fund on livelihoods of PWDs in the Atwima Nwabiagya District. The specific objectives were to:

1. Assess the effects of the disability fund on the livelihood of Persons with disabilities in the Atwima Nwabiagya District.

2. Evaluate how the Disability Fund is managed in the Atwima Nwabiagya District.

3. Investigate the challenges associated with the Disability fund at the District Assembly level at Atwima Nwabiagya District Assembly.

1.6 Delimitation of Study

The study assessed the effects of the Disability fund on PWDs, evaluated how the Disability Fund was managed as well as the challenges associated with the fund in the Atwima Nwabiagya District. The study was limited to Atwima Nwabiagya District in the Ashanti Region due to proximity, financial constraints and limited time.

CHAPTER TWO LITERATURE REVIEW

2.0 Introduction

This section reviewed works done by other researchers on the subject matter. This was done in line with the objectives that guided the study. The reviewed literature is summarised under broad headings below:

2.1 Persons with Disabilities

According to the ICF (International Classification of Functioning), ―disability is an umbrella term for impairments, activity limitations and participation restrictions. It denotes the negative aspects of the interaction between an individual (with a health condition) and that individual‘s contextual factors (environmental and personal factors)‖ (WHO 2001). Thus, this model starts with a health condition (for example, diseases, health disorders, injuries, and other health related conditions) which in interaction with contextual factors may result in impairments, activity limitations, and

participation restrictions. The ICF defines that impairments are problems in body function or structure such as a significant deviation or loss; activity is the execution of a task or action by an individual; activity limitations are difficulties an individual may have in executing activities; participation is involvement in a life situation; participation restrictions are problems an individual may experience in involvement in life situations; environmental factors make up the physical, social and attitudinal environment in which people live and conduct their lives; and personal factors are the particular background of an individual‘s life and living, including gender, race, and age (Mitra, *et al*. 2011).

Myers (2005) mentions two interpretations of disability; one medical and the other social. According to him, the medical explanation of disability is that: Impairment (loss of limb, organ, function or sense) has traumatic physical and psychological effects on people that they cannot ensure a reasonable quality of life for themselves by their own efforts. This perception of disability is solely in terms of physical, intellectual or sensory limitations, which makes a person handicapped or disabled.

The author criticizes the medical approach for ignoring society‘s handicapping effects on PWDs for instance, the effects of inaccessible physical environment on a wheel chair user, society‘s negative attitude towards PWDs, the impact of a society that is insensitive and hostile to minority rights for example, in acceptance of sign language for the deaf, and of the significance of white cane for visually impaired persons. For that matter, the above author ascribes to the social model.

The social model, which has been developed by PWDs themselves, considers the medical approach as a shallow and inadequate conceptualization of disability. To its credit, the author has the following arguments in support of the social model on disability: The social model argues that it is economic, cultural, attitudinal, physical

and social barriers, which stop persons with disabilities or impairments participating fully in society. It, therefore, advocates the removal of barriers and conception of disability as a human rights issue. Ndeezi (2004)surmises that the social model is liberating; it gives PWD groups identity, pride and a common cause to rid society of discriminatory barriers while taking into account the uniqueness of individual members of society. It accords PWDs their uniqueness, as with everybody else, without stigmatizing them, it recognizes their human rights and dignity as useful members of the human race and sets an agenda for actions to rid the world of all forms of discrimination not only for PWDs but all humanity as a whole.

2.1.1 Types of disability

According to the World Report on Disability (2011), the concept of disability has been a contested one; as authors have viewed it from either medical or social perspectives. However, disability should not be viewed as purely medical or purely social: persons with disabilities can often experience problems arising from their health condition. Three disability measures have been commonly used in applied disability research: measures of impairment, functional limitation measures and activity limitation measures (WHO, 2001). Hence, disability comes in various forms which have been elaborated below.

- **Physical disability**

Physical disability is any impairment which limits the physical function of limbs or gross motor ability. Other physical disabilities include impairments which limit other facets of daily living, such as severe sleep apnea (Helander, 1993).Physical disabilities include conditions such as cerebral palsy, muscular dystrophy, spina bifida, rheumatoid arthritis, skeletal deformities, and amputations. Chronic health conditions that tend to

restrict physical activity, such as heart disease, leukemia, and cystic fibrosis, can also be considered physically disabling. This is by no means an all-inclusive list.

The majority of people with physical disabilities have problems that are exclusively medical and do not interfere with their intellectual abilities. For some, academic progress may be retarded because of excessive absences from school. In the past, architectural barriers prevented many individuals with physical disabilities from attending public schools. They either attended special schools or were taught through homebound programs. Modern architectural and vehicular design, together with new legislation addressing the problems of accessibility to public buildings and the education of handicapped children in isolated environments, has triggered a growing enrolment in public schools of children with physical disabilities.

- **Sensory disability**

Sensory disability is impairment of one of the senses. The term is used primarily to refer to vision and hearing impairment, but other senses like taste and smell can be impaired as well. (Hewstone, 1994; Galvin, 1983).

- **Visual impairment**

Visual impairment (or vision impairment) is vision loss (of a person) to such a degree as to qualify as an additional support need through a significant limitation of visual capability resulting from either disease, trauma, or congenital or degenerative conditions that cannot be corrected by conventional means, such as refractive correction, medication, or surgery (Wright, 1983). This functional loss of vision is typically defined to manifest with:

- ✓ Best corrected visual acuity of less than 20/60, or significant central field defect;

- ✓ Significant peripheral field defect including homonymous or heteronymous bilateral visual, field defect or generalized contraction or constriction of field;
- ✓ Reduced peak contrast sensitivity with either of the above conditions (Rubin & Roessler, 1995).

- **Hearing impairment**

Hearing impairment or hard of hearing or deafness refers to conditions in which individuals are fully or partially unable to detect or perceive at least some frequencies of sound which can typically be heard by most people. Mild hearing loss may sometimes not be considered a disability. A hearing impairment can also mean a person has no hearing at all, or has hearing loss at a particular range of frequencies, or may have tinnitus (noise in the ears). It may be congenital or acquired and may have an effect on speech and language development if it occurs early (Livneh, 1980).

- **Olfactory and gustatory impairment**

Impairment of the sense of smell and taste are commonly associated with aging but can also occur in younger people due to a wide variety of causes.

- **Balance disorder**

A balance disorder is a disturbance that causes an individual to feel unsteady, for example when standing or walking. It may be accompanied by symptoms of being giddy, woozy, or have a sensation of movement, spinning, or floating. Balance is the result of several body systems working together. The eyes (visual system), ears (vestibular system) and the body's sense of where it is in space (proprioception) need to be intact. The brain, which compiles this information, needs to be functioning effectively (Kerr, 1999).

- **Intellectual disability**

Intellectual disability is a broad concept that ranges from mental retardation to cognitive deficits too mild or too specific (as in specific learning disability), to qualify as mental retardation. Intellectual disabilities may appear at any age. Mental retardation is a subtype of intellectual disability, and the term intellectual disability is now preferred by many advocates in most English-speaking countries as a euphemism for mental retardation (Holmes and Karst 1990).

- **Mental health and emotional disabilities**

A mental disorder or mental illness is a psychological or behavioural pattern generally associated with subjective distress or disability that occurs in an individual, and perceived by the majority of society as being outside of normal development or cultural expectations.

2.2 Poverty and Persons with disabilities

Globally, systematic evidence on socio-economic status of persons with disabilities and the relationship between disability and poverty in its various dimensions (income/expenditure and non-income) is limited, albeit the situation greatly differs between developed and developing countries (Mitra, *et al,* 2011).Typically, the empirical evidence on persons with disabilities is derived from population censuses, and population and household surveys. Administrative statistics is much less commonly available even in developed countries. The majority of surveys are crosssectional. In developing countries, surveys are often conducted as stand-alone researches (Mitra, *et al,* 2011). Longitudinal surveys which are required in order to observe changes in socio-economic status prior to, immediately after, and for a longer time following the onset of disability are only available in a handful of developed countries. However, even in

those countries, the data sources are argued to be in need of improvement (Houtenville, *et al,* 2009). It should be emphasized that available data has many limitations. Following Houtenville, *et al,*(2009) those include: (i) operational definition of disability which may exclude some parts of the population with disabilities; (ii) changes in the definition of disability within the same survey which may hamper comparability over time; (iii) data collection methods may exclude persons with disabilities (for instance, by definition, household surveys exclude institutionalized disabled persons); (iv) sample sizes are often too small to capture persons with disabilities even at the national level, or allow data to be disaggregated geographically, by administrative levels, or by types of disability; and (v) data on social, physical and information barriers are rarely collected. Another issue is the quality of the field work, because interviewers may not be adequately trained to survey persons with disabilities. As a result, it is often not possible to neither estimate disability prevalence nor get a robust description of social and economic status of persons with disabilities, which is essential for design of the evidence-based disability policies and monitoring of their implementation.

In developing countries, the quantitative literature, while still small, has recently grown. Similar to the findings for developed countries, this literature, as presented below, suggests lower social and economic status of persons with disabilities, but inconclusively. Regarding employment, a large majority of studies show that persons with disabilities are less likely to be employed as studied in Chile and Uruguay (Contreras *et al,* 2006), Namibia (Eide *et al,* 2003b), Zambia (Eide and Leob 2006) and Mozambique (Eide and Kamaleri, 2009) have shown.

With regard to education, most of the evidence suggests that children with disabilities tend to have lower school attendance rates. An analysis of 14 household surveyed in 13 developing countries in Africa, Latin America, and South East Asia found that in all

countries studied, children with disabilities between 6-17 years of age were less likely to start school or to be enrolled at the time of the survey (Filmer, 2008). Similar results were found in Malawi (Leob and Eide, 2004), South Africa (Leob *et al*, 2008), Eastern Europe (Mete, 2008), Rwanda (Rischewski *et al,* 2008), Afghanistan and Cambodia (Trani and VanLeit, 2010), Zimbabwe (Eide *et al*, 2003a), Namibia (Eide *et al*, 2003b), Zambia (Eide and Leob, 2006), Mozambique (Eide and Kamaleri, 2009) and India (World Bank, 2009) as cited in Mitra, 2011.

Regarding access to health care, the literature on disparities across disability status in developing countries is very limited. The World Bank (2009) and Trani *et al*. (2010) show that individuals with disabilities have a reduced access to health care in India and urban Sierra Leone, respectively. Mitra (2011) also shows that on average, persons with severe or very severe disabilities spent more on health care than nondisabled respondents.

Although there is a close linkage between poverty and disability, little research has been carried out into analysing the mechanisms behind this relationship (Elwan, 1999). An abundance of literature has shown living conditions among individuals with disabilities in high-income countries to be low compared with non-disabled persons.

2.3 Livelihood of Persons with Disabilities

A number of studies conducted in the Asian region shows that people experience wide discrimination because of their disabilities. Literature in this area provides substantial evidence that the physically challenged do feel discriminated in all societies (Miles, 2000). In a National Survey conducted in Korea (2002), about 85% of the population with disabilities felt that they were discriminated against because of their physical condition (Kim, 2004).Similar findings were also obtained in India. In two studies conducted in the rural areas in Northern India, Dalal *et al*, (2000) found that the

prevailing disability attitudes of local communities and families of persons with disabilities were negative and patronizing. It was found in this comprehensive survey that 50% of the families in the rural sector felt that their members having disabilities could do nothing in terms of contributing to family income. These negative attitudes are considered major sources of social discrimination in terms of delayed treatment and rehabilitation, school drop-out and giving low priorities to disability services. Conducting a survey using the same measures in south India, Paterson (2000) found that the attitudes of Community Based Rehabilitation (CBR) workers towards persons with disabilities were not affected by age, gender, marital status, CBR work experience and contact with a person with disability. Their attitudes were slightly more positive towards those with orthopaedic disabilities and more negative towards persons with a visual impairment. The only significant influence on attitudes was the overall years of school attended.

2.4 Disability trends in Ghana

Despite the non-existence of accurate national survey to determine the disability rate in the country, the World Health Organisation (WHO) estimates the disability rate of Ghana in 2010, to be between 7 and 10 per cent, which equated approximately 1.5 – 2.2 million people in the country. Earlier surveys of individual districts by the Ghana Human Development Scale (GHDS) in 1993 and the Norwegian Association of the Disabled (NAD) in 1998 and 1999 indicated that:

- The three most prevalent types of disability are those related to visual impairment, hearing impairment and physical disabilities;
- The disability rate is the same for males and females;
- The rate is higher in rural areas than in urban areas; and
- The rate is lowest in the 0 to 5 years age group and highest for persons who are

50 years of age or older.

Politically, Ghana gained independence from Britain on March 6, 1957. The government is a constitutional democracy headed by a President. The parliament has 275 seats, all elected on 4 year terms. The country is divided into 10 administrative regions and 216 Metropolitan, Municipal and District Assemblies (MMDAs). No special recognition has of yet been given to the representation of persons with disabilities to any of these assemblies. Only in a few districts have persons with disabilities (PWD‘s) managed to be elected or appointed to the assemblies. As published in the Medium-Term National Development Policy Framework (20102013), the prevention of disability and the care of PWDs as productive citizens is an important aspect of the development of the nation‘s human resources. It argues that, disability has achieved a significant milestone with the enactment of the Disability Act (2006) and the establishment of the Disability Council. Among the issues for urgent attention are the lack of a legislative instrument and time table to drive the implementation of the Disability Act; high incidence of poverty among PWDs due to very low levels/lack of formal education; inaccessible public transport for PWDs; inadequate and unfriendly walk-ways for PWDs as pedestrians; inaccessible and unfriendly environmental, water and sanitation facilities such as uncovered drains/gutters; inadequate appropriate software for PWDs; lack of research on disability issues; and inappropriate agricultural extension services for PWDs. More so, as stated in the policy document of the National Council on Persons with

Disabilities, persons with disabilities are allocated a percentage of the District Assembly Common Fund (DACF), currently 2%. The aims of the DACF for PWDs are the following:

• Minimization of poverty among all PWDs particularly those outside the formal sector of employment, and

• The enhancement of their social image through dignified labour.

2.5 Disability management

Disability management refers to a set of practices designed to minimize the disabling impact of injuries and health conditions that arise during the course of employment. Because of the multitude of such practices, it is actually a very difficult term to define precisely. Disability management should be differentiated from traditional safety and prevention activities, which aim at preventing an accident or disease from occurring, although there is a preventive aspect to disability management. It should also be differentiated from medical and vocational rehabilitation efforts, which take the injury or disease as given and attempt to overcome or mitigate the long-term disabling effects; although disability management arose in a rehabilitation context and is frequently carried out by rehabilitation professionals. Last, disability management is not synonymous with ―return-to-work (Galvin, 1992).While this is one of the main indicators of success for disability management programs, it is not the only payoff. This chapter examines the historical development of disability management within the government-mandated workers‘ compensation insurance environment. We choose to locate the nexus of disability management practice between the occurrence of an injury or health condition and the potential disability which may result. However, that usage is far from universal. In some applications, the focus has shifted ―upstream‖ to prevention and in others the focus has broadened to ―absence management‖ and ―presenteeism.‖

Disability management techniques are also applied by employers or insurers between the occurrence of an accident or occupational disease and the full realization of the

long-term effects of any resulting impairment. Its purpose is to interrupt the negative progression of an injury or disease. It seeks to maintain the workplace attachment for workers who acquire a disability condition and are at risk of losing their employment. Thus, disability management is both time- specific and employer-focused (Akabas *et al,* 1992).

According to the classic work by Akabas *et al*, (1992),‖ disability management is a workplace prevention and remediation strategy that seeks to prevent disability from occurring or, lacking that, to intervene early following the onset of disability, using coordinated, cost conscious, quality rehabilitation service that reflects an organizational commitment to continued employment of those experiencing functional work limitations‖ . They stated that the major goals of disability management are to:

- Improve the competitive condition of the company in a global economy;
- Achieve a healthier, more productive work force by reducing the occurrence and impact of disability among the labour force;
- Reduce the cost of medical care and disability benefits;
- shorten the time of absence and workplace disruption caused by the onset of disability among employees;
- Reduce the personal cost of disability to employees;
- Enhance morale by valuing diversity; and
- Achieve compliance with the Americans with Disabilities Act (ADA) or other legislation.

On their part, Habeck *et al,* (1991) provide a more direct interpretation: ―Disability management can be described in general terms as a proactive, employer-based approach developed to (a) prevent the occurrence of accidents and disability, (b) provide early

intervention services for health and disability risk factors, and (c) foster coordinated administrative and rehabilitative strategies to promote cost effective restoration and return to work. Disability management promotes a ―win-win‖ philosophy of gains for both the employer and the employee. The employee gets back to work sooner with less wage loss and a reduced expectation of permanent impairment. The employer gets the employee back at work to minimize interference with production and with reduced costs for workers‘ compensation and other benefit programs. Successful resolution relies primarily on the flexibility and willingness of the workplace to make accommodations and modifications, either temporary or permanent, to enable the worker to perform productive work successfully and safely
(Scott 2003).

2.5.1 Origins of Disability Management

In the United States, largely as a result of the recommendations of the National Commission on State Workmen‘s Compensation Laws, there was a great flurry of legislative action updating workers‘ compensation statutes among the states beginning after the publication of the National Commission‘s Final Report in July 1972. A set of 86 ―Essential Recommendations‖ were set forth by the Commission, with the provision that if the states did not meet the recommended standards by July 1, 1975, Congress (i.e., the Federal government) should step in and guarantee compliance with the recommendations.

The burst in legislation caused a rapid escalation of workers‘ compensation costs. The period from 1972 to 1979 came to be known as ―The Era of Reform.‖ While workers‘ compensation benefits increased at 8.5 percent per year from 1960 through 1971, the annual rate increased to 15.8 percent from 1972 through 1979 (Thomason *et al,*2001).

Aggregate real workers‘ compensation benefits increased more than fourfold from 1970 to 1980, and benefits as a percentage of payrolls increased by 45 percent (Thomason *et al,* 2001). This rapid increase in employer costs did not go unnoticed. U.S. employers began to search for ways to combat spiralling workers‘ compensation costs. Meanwhile, in 1980 the World Rehabilitation Fund sponsored a lecture tour by AilaJarvikoski of the Rehabilitation Foundation of Helsinki, Finland. He spread the word about a program of early intervention among employees of the City of Helsinki to identify those in need of ―early‖ rehabilitation to prevent disability. This program provided assessment, counselling, changes in work tasks, work redesign, and job reassignment as needed (Tate *et al*, 1986). The 1978 City of Helsinki ―Early Rehabilitation‖ pilot program was based upon a study of the health, working conditions, and rehabilitation needs of the city‘s workers. Researchers found that 50 percent of hourly and 43 percent of salaried employees reported ―one or more chronic illnesses, physical defects, injuries, or other symptoms‖ (Anon Brief, 1981). Selfreports indicated that about 15 percent of hourly and 8 percent of salaried employees needed immediate rehabilitative measures because of chronic disorders. Both objective and subjective criteria were used to develop referrals for the pilot programs at the Port Authority and the Water Works. Most were self-referrals, but individual workers with ―excessive‖ absences were also invited for evaluation. The early rehabilitation team involved an occupational health nurse, rehabilitation counsellor, and rehabilitation physician. Treatment began with an interview by the occupational health nurse, followed by a review of workplace issues by the rehabilitation counsellor, and a medical examination by the rehabilitation physician. If necessary, the workplace was also assessed. After the team had assessed the employee‘s

situation, the rehabilitation counsellor would meet with the employee to consider the implications of the findings and to plan for the appropriate ―early rehabilitation‖ activities to prevent further disability. While the majority of treatments were educational in nature, new work assignments were recommended for 23 percent of referrals at the Port Authority and 8 percent at the Water Works. After the pilot programs were concluded, employees at both sites requested that it be continued..

These same techniques were applied in the U.S. at Burlington Industries in North Carolina, in a pilot program to identify and manage osteoarthritis and rheumatoid arthritis among employees (Mitchell and Winfield, 1980). Similar developments were occurring with progressive employers in Sweden (Volvo) and Australia (VicRail), among others. Before long, many private and public employers began to realize that they might gain control of their spiralling workers‘ compensation and disability costs through application of the tools of disability management. Independent disability management consultants were early advocates of interventions and they disseminated the positive results of their consulting work with employers and state agency systems. Reflecting the real concerns of large employers, the Washington Business Group on Health (WBGH) completed a poll of employer member practices in health promotion and risk reduction among their employees in 1979 (Anon, 1979). A search for ―best practice‖ continues to the present day in such efforts as Employer Measures of Productivity, Absence and Quality (EMPAQ) officially launched by the National Business Group on Health in 2004. (Kerr, 2006) At about this same time the National Institute for Disability and Rehabilitation Research (NIDRR) of the U.S. Department of Education awarded a grant to Michigan State University to support the ―University Center for International Rehabilitation.‖ Don Galvin, a rehabilitation professional with

a Ph.D. and rehabilitation agency administrative experience, headed this effort. He wrote a review article for the Centre‘s newsletter in 1983 entitled, ―Health Promotion, Disability Management, and Rehabilitation at the Workplace‖ (Galvin, 1983) which laid out both the rationale for and the history of disability management efforts. It featured the Helsinki early rehabilitation example, but also the experiences of the Victorian Railway Company from Australia, and Volvo automotive from Sweden. It included some leading U.S. practitioners of disability management techniques, including Burlington Industries in North Carolina, Control Data Corporation in Minnesota, and Herman Miller in Michigan. He provided an annotated bibliography for those desiring a deeper understanding of the subject as well. Galvin intuitively grasped the appeal of disability management techniques to employers concerned about spiralling disability costs and became an effective advocate for the disability management ―movement‖ in the U.S.A. In 1989, Don Galvin became the Vice President for Programs of the Washington Business Group on Health (WBGH) and also the Director of the Institute for Rehabilitation and Disability Management (IRDM). From this ―bully pulpit‖ he preached the gospel of disability management.

2.5.2 Current approaches to Disability Management

Elsewhere, researchers (Otmani *et al,* 2009; Imrie and Kumar, 1998) have discovered that the built environment, which is generally not disabled- friendly, discriminates against PWDs, by excluding them from social life. As Baris *et al,* (2009) describe it, today, the disabled persons face many kinds of discriminations, posing difficulties and disadvantages of different sizes as it was also the case in the past, and barriers, such as access to buildings, toilets, insufficient knowledge or discriminatory behaviours, caused disabled persons' exclusion from social life. When the problems of the disabled are considered, the built environment can be shown as the most outstanding symbol of

disabled persons' exclusion from social life. Wellington (1992) reports that it is not a common practice for disabled person to be active users of public buildings and spaces owing to the traditional conception of the disabled as a person who has to be dependent. He maintains that, traditionally in Ghana, similar to many other African countries, the disabled person has been regarded as one who should be dependent on the extended family within the confines of the domestic space and within the immediate limits of the community where there are willing neighbours to assist him or her traverse the physical barriers in the way of movement to, and utilisation of social and communal facilities. This form of social exclusion and discrimination has, over the years, led to agitation for legislation and programmes in many countries of the world to protect the rights of the disabled.

The introduction of the *United Nations Convention on the Rights of Persons with Disabilities and Optional Protocol* (UN, 2006) marks a shift in thinking about disability from a social welfare concern, to a human rights issue. It recognises that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others.

During the latter part of the 20th century, the concept of disability moved toward a strong emphasis on personal rights and desired personal outcomes, and an awareness of the effects of discrimination and marginalisation on persons with disabilities (Schalock, *et al* 2002).

In policy systems internationally, there have been moves to a citizenship/inclusion approach particularly in Canada, Scandinavia, the United States and the United Kingdom: Included in this shift, in the 1980s and 1990s, was an active campaign by

the disability movement for the right for disabled person to be given the cash to purchase their own support (Leece and Leece 2000 cited in Thomason *et al,* 2001). International Funding (IF) of disability supports is viewed by many in the field as a mechanism for ensuring that the paradigm shift is grounded in genuine options and increased control for individuals and families.

Internationally, there is a shift from the traditional model used to fund disability support services to an individualised approach with an increasing trend to directfunding. The former relies more on the type of service and less on individual need; the latter identifies individual support needs, which in turn guide the allocation of funding resources (Australian Institute of Health and Welfare (Anon, 2002).

The alternative to traditional modes of funding and service provision for persons with disabilities to support them to make choices and to be included goes under many different names, including person-centred services; self-directed support; persondirected service; independent living; consumer control; self-determination; self-directed services; consumer-directed services; IF. All alternative models are based on the same principle: if disabled persons are to participate and contribute as equal citizens they must have choice and control over the funding and support they need to go about their daily lives (Glynn *et al,* 2008). The key concepts to this new approach are defined for this study as:

- ***Self-determination/consumer-direction/self-direction***: beliefs based on the understanding that people have both the right and responsibility to exercise controls over the services they receive (Moseley *et al*, 2005).

- ***Individualized Funding***: is a style of funding community services where funds needed to purchase required community services and support go directly to the individual, based on a plan that is negotiated with government. Financial resources and a greater degree of decision-making power will thus be placed in the hands of persons with disabilities and their personal networks (Anon, 1998).

- ***Independent living in the community:*** definitions vary; however, common themes relating to this value include consumer sovereignty, self-reliance, inclusiveness, and integration (Glynn, *et al,* 2008).

Glynn, *et al*.(2008) argue that allocating funding at the person level enhances the capability to develop individualized support strategies, contributes to portability, and promotes individual choice. Managing funding at the person level hinges on developing funding methods that are service-independent. The goal is to determine an amount of funding that attaches to the person and thereby is not contingent on the person‘s being slotted into a particular type of service.

In Scandinavia, the shift between the institutional and the community tradition of support has resulted in a citizen perspective towards persons with disabilities (Weinbach, 2004 cited in Glynn, *et al,* 2008). In this perspective, the aim is to make services offered to the general public available for persons with disabilities. In Europe, place-related funded systems of specialised assistance services are still in existence.

In the United Kingdom, IF arrangements such as direct payments have been implemented, underpinned by legislation, since 1996 (Glynn *et al*, 2008). Persons with disabilities can use the cash to purchase services directly including employing personnel to provide direct care (Anon, 2007). A number of recent reforms in the UK

are aimed at increasing the use of IF, particularly direct payments, by implementing a new funding structure, whereby several funding streams will be brought together in the form of _individualised budgets‘. Individuals will be able to choose whether to take these budgets as cash (direct payments) or as services. There are also proposals for new forms of support to help people currently excluded from direct payments, such as the use of _agents‘ to assist persons with severe cognitive impairments who are deemed unable to consent; and support to control their budget without the responsibilities of becoming an employer.

Research involving 38 individuals‘ experiences of direct payments revealed that most of the respondents appeared to be able to secure greater continuity of care with direct payments than they might have experienced previously through local authorityarranged provision (Mc Mullen, 2003). It was evident that direct payments have introduced a level of flexibility for many respondents that had not been enjoyed previously (Mosely *et al,* 2005).

The first evaluation of the implementation of personalised approached to social care in the UK and the impact on users, support processes, workforce, commissioning and providers was recently published (Anon, 2008). The evaluation included a randomised controlled trial of almost 1000 service users across 13 sites where pilots of individual budgets were being trialled. The evaluation found that Individual budgets were used to purchase personal care, assistance with domestic chores, and social, leisure and educational activities. People receiving an Individual budget were more likely to feel in control of their daily lives, compared with those receiving conventional social care supports. Little difference was found between the average cost of an individual budget and the costs of conventional social care support. The average weekly cost of an

individual budget was £280, compared to £300 for people receiving conventional social care (Anon, 2008).

In North America, particularly in Canada, there is a much longer history of IF than in the UK. In the United States, Mosely *et al,* (2005) reported that in 2002 some form of individual funding was in place in nearly three quarters of the 43 states they surveyed. Although there is great variation in its applications, IF is rapidly becoming a mainstream funding mechanism in the US.

A recent study by the Research and Training Centre on Community Living examined the extent to which states have implemented both individual budgets and consumer control over services for Home and Community based services. At the time of the interviews, 13 states had state wide availability of individual budgets and consumer control for at least some Home and Community based (Anon, 2009).

2.6 The Disability Fund in Ghana and its challenges

In order to democratise, decentralize state power, and institutionalise decision making at the grassroots level, the 1992 Constitution effectively decentralised political and administrative authority under the District Assemblies. The District Assemblies make and implement decisions and engage in activities required to meet the needs of the people in the areas under their jurisdiction in economic, educational, health, environmental hygiene, recreation and utility services. This means that the needs of PWDs have to be administered at the district level, as spelled out in the Local Government Act 2010. It is the duty of the District Assemblies to plan and secure implementation of services with assistance from specialised Governmental Agencies and NGOs to enable persons with disabilities go to school, have access to quality health care, secure skills training and support for employment and income generating

opportunities and participate in the social life of their communities (Ghana Federation of the Disabled, 2008).

The decentralisation process has thus transferred most of the responsibility for service delivery to the district level. However, this has not been effectively supported by a decentralisation of resources for running costs or monitoring. The financial resources delegated to the district assemblies is called _the Common Fund‘ and is divided among the districts based on a number of indicators that reflect poverty, population size, the amount of internally-generated funds (IGF) and the "need factor", which is introduced to reduce the current imbalances in development. In this way, districts with high levels of poverty get more funds (Ghana Federation of the Disabled, 2008).

In the guidelines for the use of the Common Fund, it is stipulated that 2 % of the funds should be set aside for disability-related support. The District Assemblies have complained that there was a lack of guidelines for how the funds should be disbursed including how the needs of women with disabilities should be met. For this reason, guidelines were developed in 2007 by the Ministry of Local Government and submitted together with the 2007 allocation of funds to the District Assemblies.

In general, demands have been put forth by the District Assemblies that all applications submitted by organisations accessing the funds are made according to a joint plan for the disbursement so that the District Assemblies do not have to deal with requests on individual basis. This preference resulted in a demand from the Administrator of Common Funds that all applications must be coordinated through local disability networks or _district committees‘ increasing the need for cooperation within disability organisations at the local level. However, in several districts there have been tensions

between PWDs and the Assemblies over the disbursement of the fund (Ghana Federation of the Disabled, 2008).

2.6.1 The role of key stakeholders of the disability fund in Ghana

There has been the establishment of the National Council on Persons with Disabilities (NCPD), whose objective is to propose and evolve policies and strategies to enable persons with disabilities enter and participate in the mainstream of the national development process. For effective utilization, the NCPD, in collaboration with the GFD, under the authority of the Minister for Employment and Social Welfare, in cooperation with the District Assembly Common Fund (DACF) and with the approval of the Minister for Local Government and Rural Development, provides these guidelines on the disbursement and management of the DACF to Persons With Disabilities (Ghana Federation of the Disabled, 2008).

2.6.2 Aim of the District Assembly Common Fund for PWDs

The aims of the DACF for PWDs are the following:

- Minimization of poverty among all PWDs particularly those outside the formal sector of employment, and
- The enhancement of their social image through dignified labour.

2.6.3 Objectives of the fund

The objectives of the fund are to:

- Support the income generating activities of individual persons with disabilities as a means of economic empowerment;
- Provide educational support for children, students and trainees with disabilities;

- Build the capacity of Organisations of Persons with Disabilities(OPWDs) in the districts to enable them to advocate and assert their rights and undertake awareness raising and sensitization on disability issues; and
- To support persons with disabilities to have access to technical aids and other assistive devices and equipment (Anon, 2010).

2.6.4 Information and communication on the fund (posting, arrival, quantum, etc.) from National to District level

Information on purpose of fund

- The beneficiary PWDs of the Disability fund should be well sensitised about the actual purpose of the Fund allocated to PWDs;
- Stakeholders to be sensitised include: Metropolitan/Municipal/District Chief Executives, core management staff of assemblies, assembly members, especially members of the Finance & Administration and Social Services Sub-Committees; and other relevant stakeholders; and
- The sensitization exercise should be done by District Disability Fund Management Committee (DFMC) and GFD.

2.6.5 Communication on DACF

- The office of the Administrator of DACF shall in each quarter furnish the NCPD with allocations made to MMDAs and their corresponding percentage for PWDs. The Secretariat of the NCPD shall circulate the information received to GFD and other relevant stake holders.
- District GFD Committees shall send regular feedback on the fund directly to GFD or through GFD member organizations for onward transmission to the office of the Disability Council.

- The District Assembly shall present quarterly reports on the disbursement of the Fund to NCPD and GFD.

2.6.6 Fund management committee

Each MMDA shall form a special committee, Disability Fund Management Committee (DFMC), for the purpose of managing the Disability fund for PWDs.

Composition

The membership of the committee includes:

- District representative, NCPD;
- Chairperson, Social Services Sub-committee;
- District Director, Department of Social Welfare;
- District GFD representative;
- Co-opted technical members that the Committee deems fit; and
- The chairperson of this committee shall come from within the committee.

2.6.7 Responsibilities of the Committee

The responsibilities of the committee include the following:

- Vet and approve applications received from PWDs and OPWDs
- Monitor and supervise the utilization of the funds (e.g. committee members embark on follow-ups to find out whether the beneficiaries are using their benefits for the purposes upon which, they were given)
- Sensitise all relevant stakeholders at the District level
- Present quarterly reports on the management of the Fund to District Assembly and district NCPD representative.

2.6.8 Areas for funding

The under-listed are the areas for support under the Disability fund for PWDs.

- Advocacy/awareness raising on the rights and responsibilities of PWDs;

- Strengthening of OPWDs (Organizational development);
- Training in employable skills/apprenticeship;
- Income generation activities (input/working capital);
- Some educational support for children, students and trainees with disability; and
- Provision of technical aids, assistive devices, equipment and registration of NHIS.

2.6.9 Access to DF

Both groups and individuals shall have access to the fund. Individual PWDs who are not members of any OPWD can access funding from the Disability fund for any of the purposes stated above. The fund can be abused since both groups have access to it.

2.6.10 Monitoring of the utilization of fund

National Level: At the national level, the following institutions are charged with the duty of monitoring the fund. They include: NCPD, MLGRD, MESW, DACF Secretariat, and GFD.

*Local Level***:** At the local level**,** NCPD, GFD Committee, District Assembly and Department of Social Welfare are responsible.

2.6.11 Bank accounts for the fund

- A separate Bank account to be opened in each MMDA for the purpose of managing the Disability fund for PWDs;
- In this account will be lodged the quarterly allocation for persons with disabilities to secure it for their use;
- Signatories to this account should be the MMD Coordinating Director and Finance Officer; and
- There shall be no borrowing from the account. However, loans can only be arranged by NCPD and on the basis of approval resolution passed by the

relevant MMDAs with minutes attached. This shall enable deductions at source for repayment (Anon, 2010,).

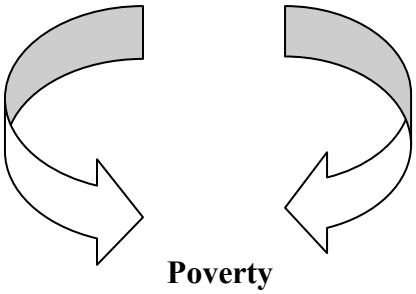
2.6.12 Effects of the disability management fund on the lives of physically challenged, visually and hearing impaired.

The disability fund has numerous benefits for its beneficiaries. In simple terms the following are some of the benefits of the fund on local livelihoods. It...

- Supports education of PWDs on their rights, potentials and responsibilities
- Creates an enabling environment for the full participation in national development and ensures access of PWDs to education and training at all levels;
- Facilitates the employment of PWDs in all sectors of the economy ;
- Promotes disability friendly roads, transport, and housing facilities ;
- Ensures access of PWDs to effective health care and adequate medical rehabilitation services ;
- Ensures that women with disabilities enjoy the same rights and privileges as their male counterparts;
- Encourages full participation of PWDs in cultural activities; and
- Ensures access of PWDs to the same opportunities in recreational activities and sports as other citizens (Scott et al, 2003).

2.7 Development of conceptual framework

Disability



Poverty

Source: (Kett, 2011)

According to Kett (2011), the concepts of disability and poverty are all best understood in terms of dynamic social processes and this study sets out an approach to disability and poverty based on the social model of disability. It argues that _disability' is both different from and more comprehensive than _impairment', and defines disability as the consequence of various forms of social discrimination and exclusion for persons with impairments.

Disability is not the same as impairment, and the problems and methods of dealing with impairment prevention and with disability are, therefore, often, although not always, significantly different. Disabled persons have increasingly challenged the view that disability should be equated with impairment (the medical model of disability), arguing that what disabled persons encounter are the various social and physical barriers and negative attitudes, which prevent equal participation in community life. Within this social model, disability is seen as the result of social exclusion and discrimination – as a dependent variable (Scot *et al,* 2003).

CHAPTER THREE METHODOLOGY

3.0 Introduction

This chapter contains the profile of the study area, methods of data collection and tool of analysis. Other important aspects included sources of data, sampling techniques, data analysis and presentation.

3.1 Study Area

Atwima Nwabiagya District is one of the largest Districts in the Ashanti Region. The District lies approximately on latitude 6º 75‘N and between longitude 1º 45‘ and 2º0‘ W. It is one of the 30 Districts in Ashanti Region of Ghana. It shares common boundaries with Ahafo Ano South and Atwima Mponua Districts to the West, Offinso Municipal to the North, Amansie-West and Bosomtwe-Atwima Kwanwoma Districts to the South, Kumasi Metropolitan area and Kwabre District are to the East. The study area covers about 294.84 sq km. The district capital is Nkawie (Figure 3.1).

Figure 3.1: Map of Atwima Nwabiagya District of Ashanti Region

Source: Carthographic section of the Department of Geography and Regional Planning, University of Cape Coast (UCC) Ghana (Adopted)

3.2 Research Design

The design was cross-sectional, based on selection of representatives of three disability groups, and determined those benefiting from such District Assembly Common Fund and also ascertained the significance of the fund in their livelihoods.

3.3 Sources of Data

Both primary and secondary sources of data were employed. Primary data was collected from the Persons with Disabilities using questionnaire. Secondary data, including registers of disabled persons and Annual Reports were collected from the District Assembly.

3.4 Target population

The target population of this study included the physically challenged, the hearing and visually impaired and finally the management team of the disability common fund. Significantly, only respondents aged 18 years and above constituted the respondents. Minors were excluded.

3.5 Sampling technique

Stratified sampling, a probability sampling procedure in which the target population is first separated into mutually exclusive, homogeneous segments (strata), and then a simple random sample selected from each segment (stratum), was used. The sample was obtained from the physically challenged, visually and hearing impaired persons.

The samples selected from the various strata were then combined into a single sample (Cresweel, 2005; Sarantakos, 2005). This sampling procedure is sometimes referred to as ―quota random sampling.‖

3.6 Data Collection Procedure

Familiarisation tour embarked by the researcher revealed that the target population holds meeting on last Friday of every month. This enabled the researcher to administer the questionnaires to those who attended the meeting with the help of their team leader. Their team leader introduced the researcher to them and briefed them on the objectives of the study. After their meeting session, they were grouped into strata using their type of disability as a yardstick. Sheets were folded and _YES‘ and _NO‘ were indicated on these sheets. Through the lottery method, those who selected _YES‘ were given the questionnaires to answer depending on the quota assigned to each group.

3.7 Sample size

With a total target population of 470 persons, the sample size was 212 using the Raosoft online sample size calculator with 95% confident level and 5% error margin. Table 3.1 provides the break-down of the sample size.

A means Number of PWDs in Register, **T** means total number of PWDs in Register and **D** means the distribution of respondents.

Table 3.1: Sample size determination for PWDs

List of key intermediaries	Number of PWDs in Register(A)	Distribution of respondents (D) =[A/T × 100] (%)	Sample size distribution = (D/100× sample size)
Physically challenged	200	43	91
Hearing impaired	100	21	45
Visually impaired	150	32	68

Management team	20	4	8
Total arrivals	**470**	**100.00**	**212**

3.8 Data collection methods/ instruments

The questionnaire was designed in line with the objectives set for the study. Section One of the questionnaire addressed the socio- demographics of the respondents and involved variables such as age, sex, education , marital status and others. Section Two dealt with how the disability fund affects the lives of the physically challenged, visually and hearing impaired. Issues were centered on the importance of the Disability Fund at the District. Section Three addressed the management of the disability fund of the DACF. The last section bordered on the major challenges with the Disability Fund.

3.9 Data Analysis

Data was analysed using Statistical Product for Service Solution (SPSS version 16). This quantitative data processing software was used to generate cross-tabulation and the data was presented in tables, pie charts and bar graphs using excel. The research utilised quantitative method of analysis. It distinguishes between cross-sectional and longitudinal designs but most surveys conducted in practice are based on crosssectional design. Cross-sectional surveys are studies aimed at determining the frequency (or level) of a particular attribute, such as a specific exposure, disease or any other.

3.10 Ethical Considerations

This study ensured that the rights of respondents are protected.

3.10.1 Privacy and Consent

Research of this nature is aimed at obtaining information concerning attitudes, beliefs, opinions, and behaviours. Thus, pursuing the goals of science, while guarding against unnecessary invasion of participants‘ privacy, presents complex issues (Punch, 2003;

Sarantakos, 2005). The researcher ensured this by not divulging the data collected on the field to a third party and all administered questionnaire were locked in a personal cabinet for privacy purposes.

Consent involves the procedure by which an individual may choose whether or not to participate in a study. The researcher's task was to ensure that participants have a complete understanding of the purpose and methods to be used in the study, the risks involved, and the demands placed upon them as participants (Best and Kahn 2006; Jones and Kottler 2006 cited in Cooper and Schindler 2006). The participant was made to understand that he or she has the right to withdraw from the study at any time. The researcher therefore showed an introductory letter from her department to the respective respondents to appreciate the objective of the study which was purely academic.

3.10.2 Confidentiality and Anonymity

Ensuring confidentiality means that what has been discussed will not be repeated, or at least, not without permission, and anonymity is the state of not being known or identified by name. The notion of confidentiality and anonymity was invariably raised and discussed with research participants prior to their participation in research. The study did not allow respondents to provide their names on the questionnaires making traceability impossible, thereby ensuring confidentiality.

CHAPTER FOUR RESULTS

4.0 Introduction

This chapter presents the results of the study. Socio-demographic characteristics and information relating the specific objectives are presented in the various sections.

4.1 Socio-demographic characteristics of study participants

Table 4.1 presents the socio-demographic characteristics of respondents in the study. Of the 212 respondents, 42.5% were males and 57.5% were females. Perhaps this may reflect on the overall population of Ghana where females out-number males (Ghana Statistical Service, 2010). In terms of age, the study found that majority (30.6%) of the respondents were in the 40-49 age bracket followed by 30-39 years (21.2%), 2029 years (17.9%), 10-19 years (18.8%) and 50 years and above (11.3%). In terms of education, majority (41.0%) of the respondents had no formal education. This was followed by those with primary education (25.5%), secondary education (17.9%), tertiary education (9.4%) and other qualifications (6.1%). Majority of persons with disabilities (PWDs) had low education (Table 4.2), by implication less income.

Respondents' marital statuses were such that 71.7% were single and 28.3% married. With respect to ethnicity, majority of respondents were Asantes (42.0%). This was followed by Fantes (14.6%), Kusasis (12.7%), Frafras (11.8%), Bandas (10.4%), and Gonjas (8.5%).

Table 4.1: Socio-demographics of study participants

Variable	Frequency	Percentage (%)
Sex		
Male	90	42.5
Female	122	57.5
Age (years) 10-19	40	18.8
20-29	38	17.9
30-39	45	21.2
40-49	65	30.6
50+	24	11.3
Level of education		
No formal education	87	41.0
Primary	54	25.5
Secondary	38	17.9

Tertiary	20	9.4
Other	13	6.1
Marital status Single		
	152	71.7
Married	60	28.3
Ethnic group		
Frafra	25	11.8
Asante	89	42.0
Gonja	18	8.5
Banda	22	10.4
Kusasi	27	12.7
Nationality		
Ghanaian	212	100.0
Occupation		
Farmer	31	14.6
Student	30	14.2
Dressmaker	60	28.3
Apprentice	31	14.6
Unemployed	60	28.3
Religion		
Christianity	152	71.7
Islam	60	28.3

Source: Field Data, 2013

The study found that all respondents were Ghanaians (100.0%) and belonged to either Christian (71.7%) or Islamic (28.3%) religions (Table 4.1). Occupation of respondents included dressmaking (28.3%), unemployed (28.3%), farming (14.6%), apprenticeship (14.6%) and student (14.2%). The analysis showed the major challenges of disabled persons when it comes to employment. Moreover, given the low qualification of respondents (87%), unemployment (60%) was very high (Table 4.1).

Table 4.2: Other socio-demographic variables

Variable	**Sex Male[%] (n=90)**	**Female [%] (n=122)**
Age (years) 10-19	33.3 (30)	8.1 (10)
20-29	28.8 (26)	9.8 (12)
30-39	27.7 (25)	16.3 (20)

40-49	5.5(5)	49.1 (60)
50+	4.4 (4)	16. 3(20)
Total	**100.0**	**100.0**
Level of education		
No formal education	40.0(36)	41.8(51)
Primary	26.7 (24)	24.6(30)
Secondary	17.8(16)	18.0(22)
Tertiary	8.9 (8)	9.8(12)
Other	6.7(6)	5.7(7)
Total	**100.0**	**100.0**
Marital status	66.7 (60)	75.4 (92)
Single		
Married	33.3 (30)	24.6 (30)
Total	**100.0**	**100.0**

Source: Field Data 2013

Matching sex with age, the result revealed that 28.8% and 27.7% of male respondents fell within the age group of 20-29 and 30-39 respectively. However, majority of the females 49.1% counterparts fell within the age group of 40-49.

On the level of education of respondents, the study revealed that most males 40.0% and females 41% had no formal education.

On marital status, singles dominated. These comprised 66.7% males and 75.4% females. In addition to the profile of respondents, the study also sought the disability organisation within which respondents were registered as members. Figure 4.1 presents the details of respondents‘ views. From Figure 4.1, majority of respondents 87.7% were members of the Ghana Society of the Physically Disabled [GSPD]; with the remaining belonging to Ghana National Association of the Deaf [GNAD] 6.6% and Ghana Blind Union 5.7%.

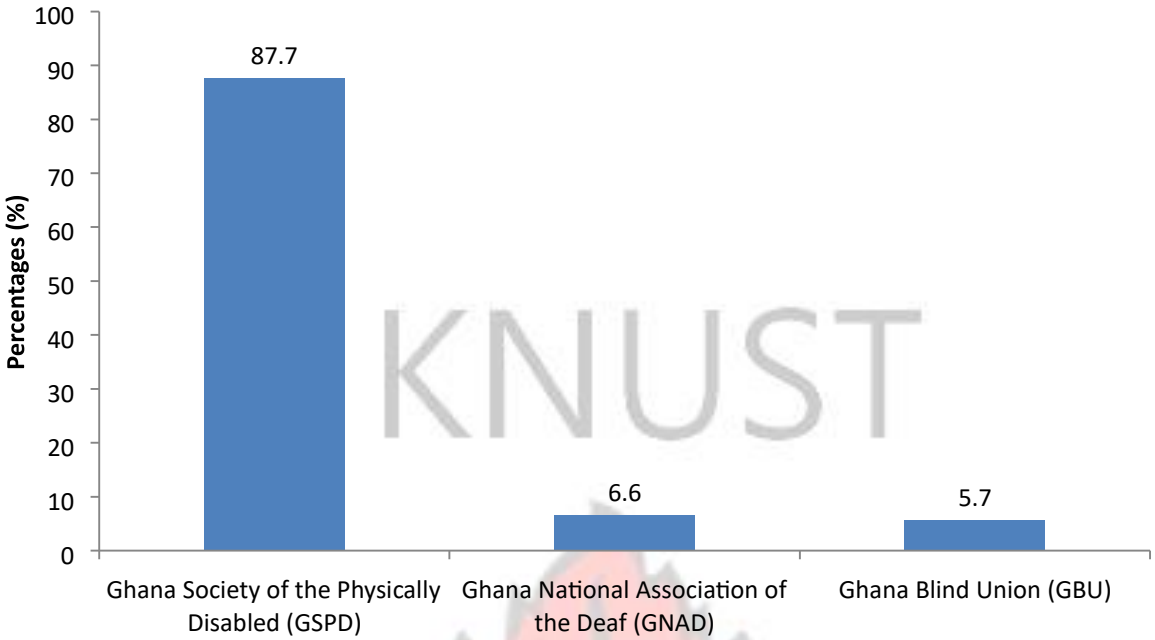


Figure 4.1: Distribution of PWDs by Association in Atwima Nwabiagya District

Source: Field Data 2013

4.2 Socio-economic situation of the Persons with Disability in the District

Figure 4.2(a) identified the assistive devices used by respondents in their daily activities. Thus, in addition, the study also found that respondents were using devices including wheel chair (29.0%), clutches (28.0%), none of the devices (28.0%), and eye glasses (15%).

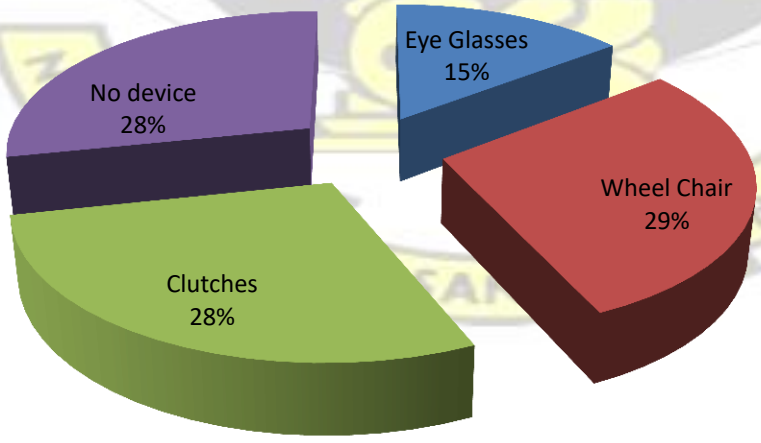


Figure 4.2a: Distribution of Assistive devices used by PWDs in Atwima Nwabiagya District

Source: Field Data 2013

Moreover, Figure 4.2 (b) displays distribution of assistive devices provided by the Disability Fund to respondents who participated in the study. According to Figure 4.3, respondents who stated that the Disability Fund provided no devices were in majority (42.5%). Others listed some devices including Clutches (28.3%), Wheel Chairs (14.6%), and Eye Glasses (14.6%).

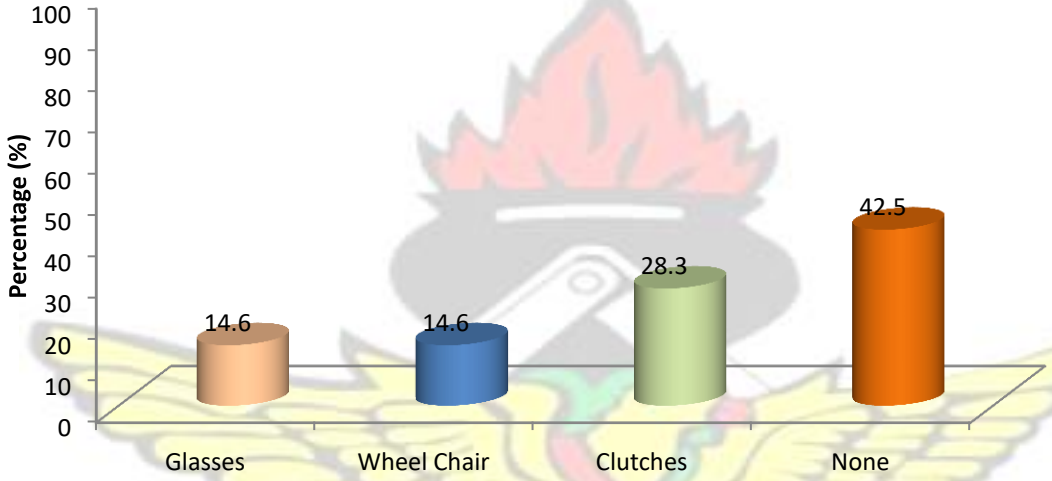


Figure 4.2b: Distribution of Assistive devices provided by the Disability Fund to PWDs in Atwima Nwabiagya District Source: Field Data 2013

Figure 4.3 presents the number of dependants of respondents who participated in the study. In all, respondents had dependants ranging from 4-5 people (44.0%). This was closely followed by 3-4 dependants (30.0%), 1-2 dependants (17.0%), 6+ dependants (5.0%) and no dependant (4.0%).

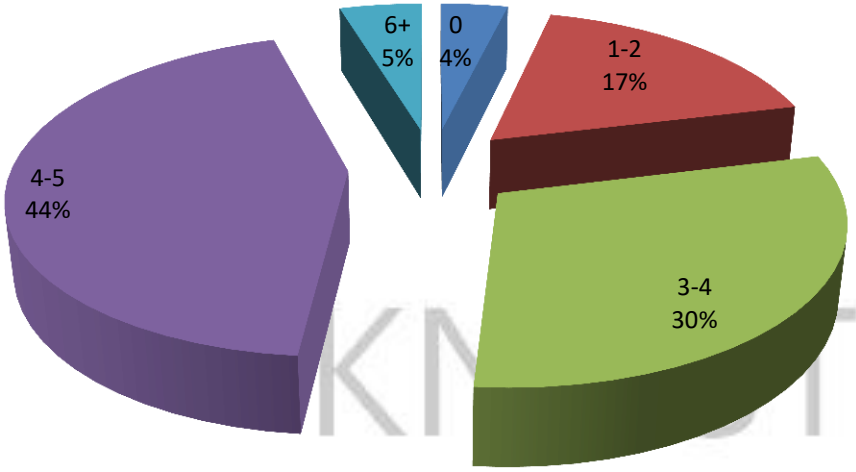


Figure 4.3: Distribution of Number of dependants of PWDs in Atwima Nwabiagya District

Source: Field Data 2013

The age range of dependants of respondents' is captured in Figure 4.4. From Figure 4.4 dependants were mostly aged 6-10 years (42.0%), 11-15 years (29.0%), 16-20 (14.0%) 21 and above (15.0%). Hence, this was evident in Figure 4.5 which shown the level of education of respondents' dependants. From Figure 4.5, majority of respondents' dependants were in primary education (42.9%).

This was followed by Tertiary (14.6%), Crèche/Kindergarten (14.2%), Senior High School (14.2%); Junior High School (14.2%).

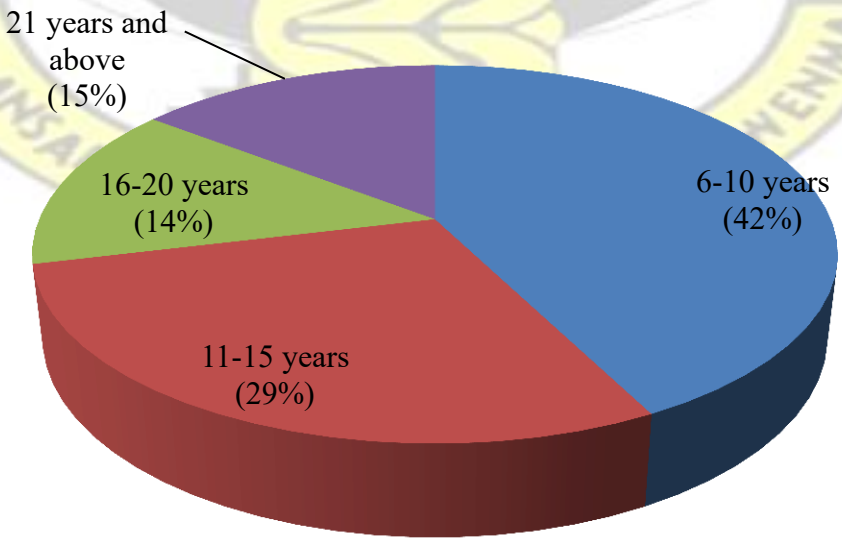


Figure 4.4: Age range of dependants of PWDs in the Atwima Nwabiagya District

Source: Field Data 2013

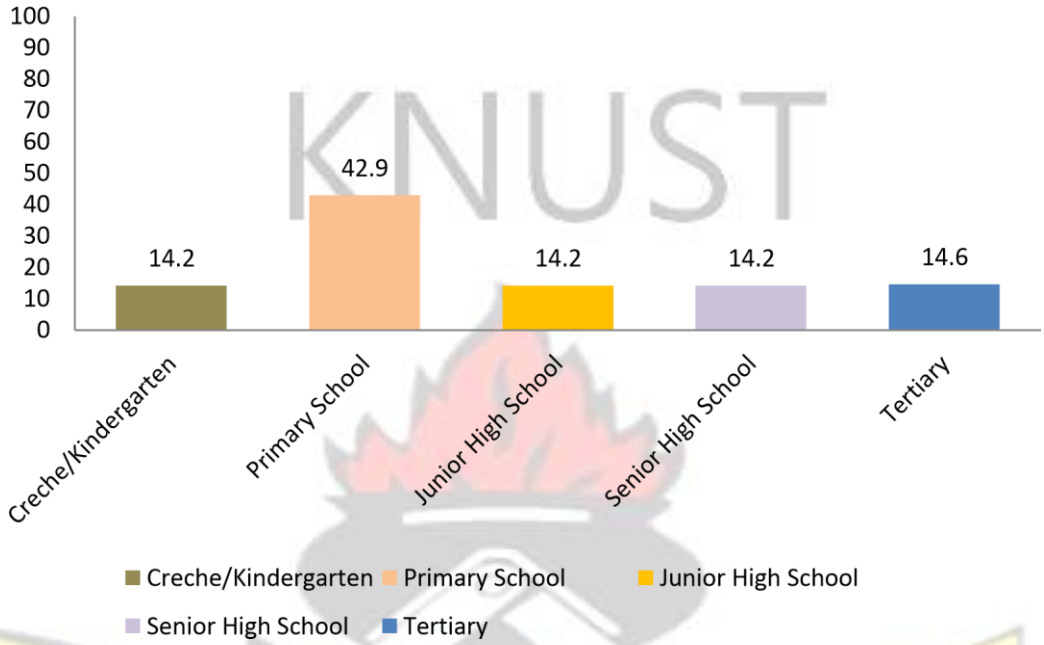


Figure 4.5: Level of education of dependants of PWDs in Atwima Nwabiagya District

Source: Field Data 2013

Figure 4.6 presents the daily expenditure on dependants of respondents. Respondents were spending a daily amount of GHC11.00-15.00 (29.0%); GHC 6-10.00 (29.0%); GHC1.00-5.00 (28.0%) and GHC16.00-20.00 (14.0%). At minimum daily wage of GHC 7, 72% respondents were spending between GHC 6-20 per day on dependants. Only 28% spent below GH 6 daily.

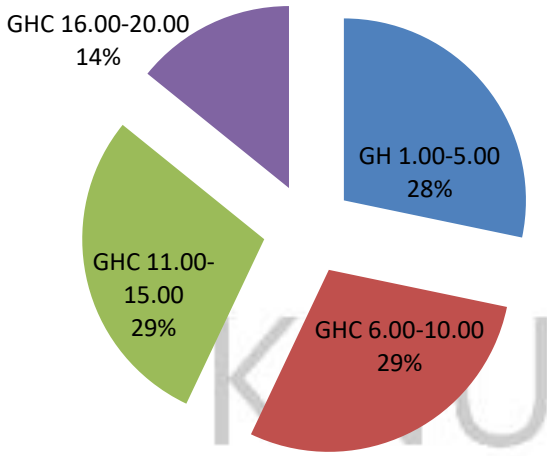


Figure 4.6: Daily expenditures on dependants of PWDs in the Atwima Nwabiagya District.

Source: Field Data 2013

Figure 4.7 presents the monthly expenditure on health care by respondents. The monthly healthcare expenses of respondents were between GHC 5.00-28.00; that is GHC 5.00-10.00 (29.0%), GHC 11.00-16.00 (43.0%); GHC 17.00-22.00 (14.0%) and GHC 23.00-28.00 (14.0%). The analysis gives a clear picture of the various expenditures made by respondents on monthly basis.

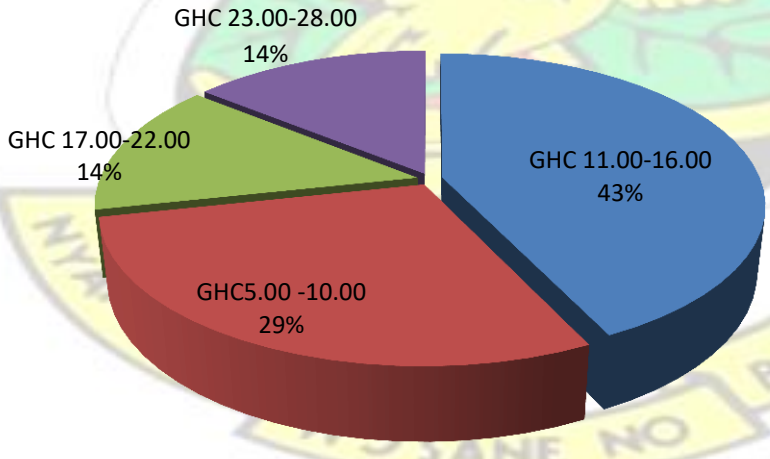


Figure 4.7: Distribution of monthly expenditure on health care by PWDs in Atwima Nwabiagya District. Source: Field Data 2013

Figure 4.8 presents the yearly expenditure on education of dependants‘. From Figure

4.8 respondents spend various amounts like GHC 5.00-10.00 (28.8%), GHC11.0016.00 (42.5%), GHC 17.00-22.00 (14%), and GHC23.00-28.00(14.6%) on their dependants' education.

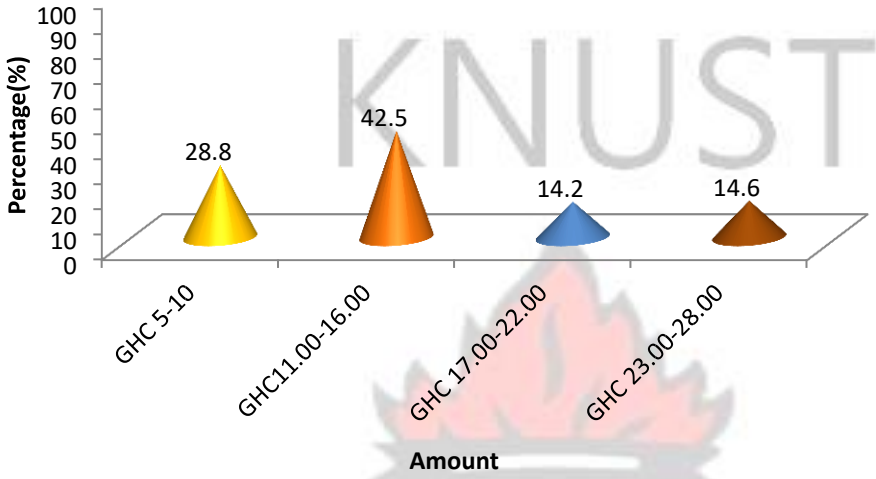


Figure 4.8: Yearly expenditure on education of dependants of PWDs in Atwima Nwabiagya District

Source: Field Data 2013

4.3 The impact of the Disability fund on the lives of physically challenged, visually and hearing impaired

As part of examining the role the disability fund played in the lives of respondents, respondents were questioned about the frequency of benefit from the fund. Figure 4.9 presents the frequency of benefit from the Disability Fund. According to Figure 4.9, respondents received the funds annually (42.9%), semi-annually (42.9%) and others (14.2%).

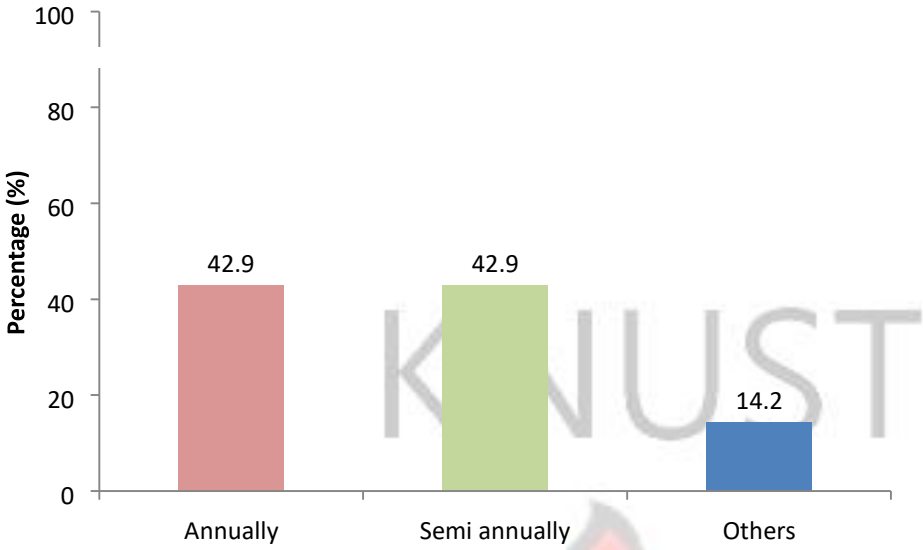


Figure 4.9: Frequency of benefit from the Disability Fund by PWDs in the Atwima Nwabiagya District Source: Field Data 2013

Connected to the frequency of Disability Fund, was the usage of the funds. Figure 4.10 presents the utilisation of funds received from Disability Fund. Respondents spend most of the money on food (29.0%), School fees (29.0%), Medicine (14.0%), Clothing (14.0%) and Business (14.0%).

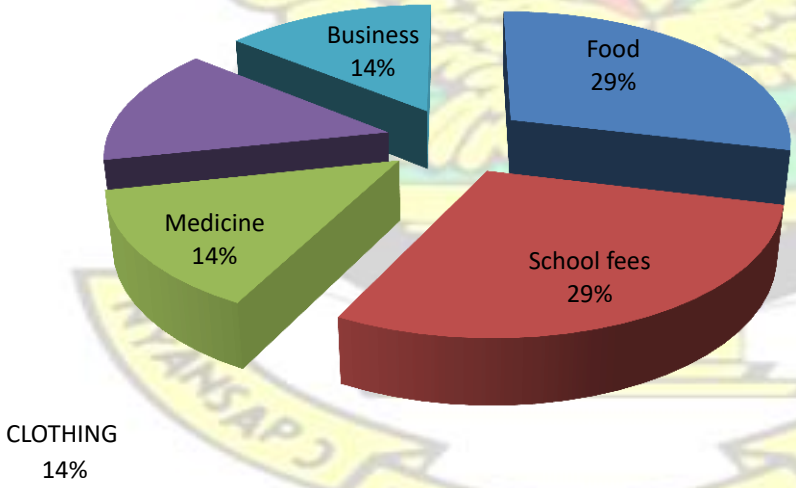


Figure 4.10: Items on which funds received by PWDs in the Atwima Nwabiagya District are utilised

Source: Field Data 2013

Figure 4.11 presents the areas supported by the fund. According to Figure 4.11, the areas of support included Income generating activities for PWDs/DPOs (28.8%); Registration of the National Health Insurance Scheme 14.6%, Organisational development of disabled persons organization 14.2%, Training in employee skills/ apprenticeship for PWDs 14.2%, Educational support for children, students and trainees with disability 14.2%, and Provision of technical aids, assistive devices and equipment 14.2%.

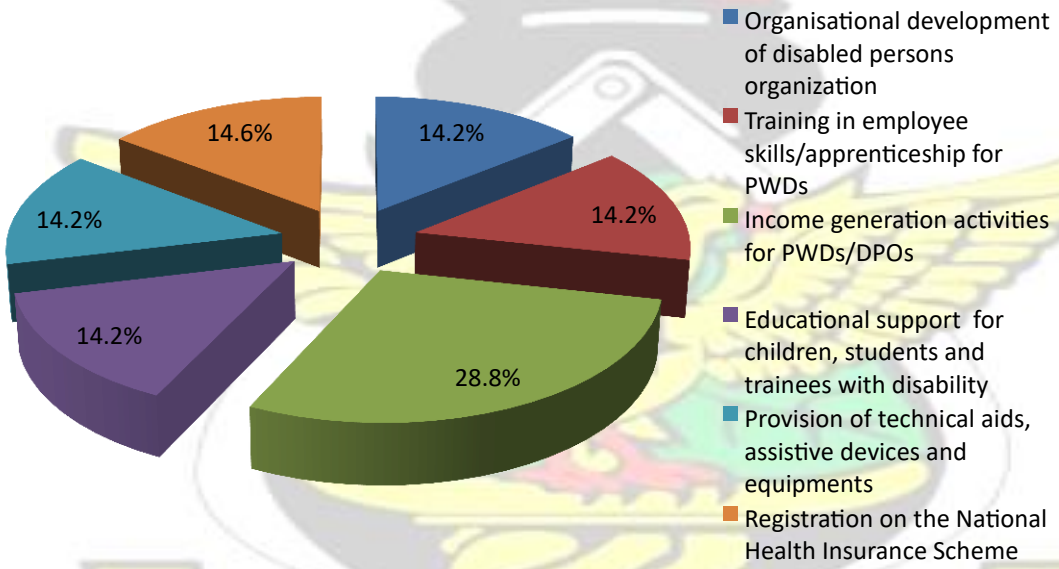


Figure 4. 11: Areas supported by the Disability Fund from Atwima Nwabiagya District

Source: Field Data 2013

4.3.1 PWDs' views about the overall impact of the Disability Fund on their livelihood

Table 4.3 presents the effects of the DACF on respondents' livelihoods. Respondents disagreed (43.4%) on the whole that the fund supports education of their rights,

potentials and responsibilities with about (28.3%) being neutral to the statement. The remaining 28.3% agreed to the statement. Moreover, respondents agreed (28.8%) that the fund helps them to pay their children's school fees with about (28.8%) uncertain of their position on the statement, with the remaining (42.4%) disagreeing to the statement. Majority of the respondents disagreed (56.7%) that the fund is sufficient for them and their family. However, 14.2% were uncertain, whereas 29.1% agreed to the statement. About 28.3% were of the view that the fund improves their business and farming activities. However, about 28.8% disagreed to that statement with the majority (42.9%) being uncertain. Majority of the respondents (71.3%) agreed that the fund is useful for expanding their farming/trading activities. On the contrary, 14.2% were uncertain with, 14.6% disagreeing to the statement. Respondents on the whole disagreed (70.8%) that the fund makes it easier for them to access healthcare. However, 14.6% agreed to the statement, whereas 14.6% were not sure of their position on the statement.

Table 4.3: Effects of the Disability Fund on Respondents Livelihoods

	Statement: *The fund...*	**N/A (5)**	**SA (4)**	**A (3)**	**D (2)**	**SD (1)**
a	supports education of my rights, potentials and responsibilities	28.3	14.1	14.2	28.8	14.6
b	helps me to pay my children's school fees	28.8	14.2	14.6	28.3	14.1
c	is sufficient for me and my family	14.2	14.5	14.6	14.2	42.5
d	improves my business and farming activities	42.9	28.3	0.0	14.2	14.6
e	is useful for expanding my farming/trading activities	14.2	57.1	14.2	0.0	14.6
f	makes it easier for me to access healthcare	14.6	0.0	14.6	28.3	42.5
g	facilitates my employment in all sectors of the economy	14.2	0.0	28.8	0.0	57.1
h	creates an enabling environment for my full participation in national development	14.2	14.2	14.2	14.6	42.9
i	ensures that women with disabilities enjoy the same rights and privileges as their male counterparts	14.6	57.1	28.3	0.0	0.0

Source: Field Data 2013

Majority of respondents (57.1%) disagreed that the fund facilitates their employment in all sectors of the economy. However, about 28.8% were in support of this statement. About 14.2% of the respondents were uncertain. Majority (57.5%) of respondents disagreed that the fund creates an enabling environment for their full participation in national development. However, about 28.4% of the respondents agreed to this statement with about 14.2% being uncertain. Majority 85.3% of the respondents supported the view that the fund ensures that women with disabilities enjoy the same rights and privileges as their male counterparts. However, 14.6% were uncertain.

4.4 Management of the Disability fund of the DACF

The Disability Fund is received from the District Assembly Common Fund (DACF). By law, two percent (2%) of the District Assembly Common Fund is allocated to the Disability Fund (The Disability Act 2006), and there is a separate account into which the Fund is put. The Disability Management Fund Committee (DMFC) decides on how the money should be disbursed. Part of the money may be used to buy assistive devices needed by PWDs, part for development projects that will be beneficial to the PWDs and the other part given out to the PWDs upon applications received in cash.

Figure 4.12 presents the composition of management committee. Majority of the respondents maintained that the management committee is made up of the Social Service Sub Committee (35.8%), G.F.D (20.8%), District Committee Development Officer (15.1%), Education Staff (14.2%), and District Social Welfare Officer (14.2%).

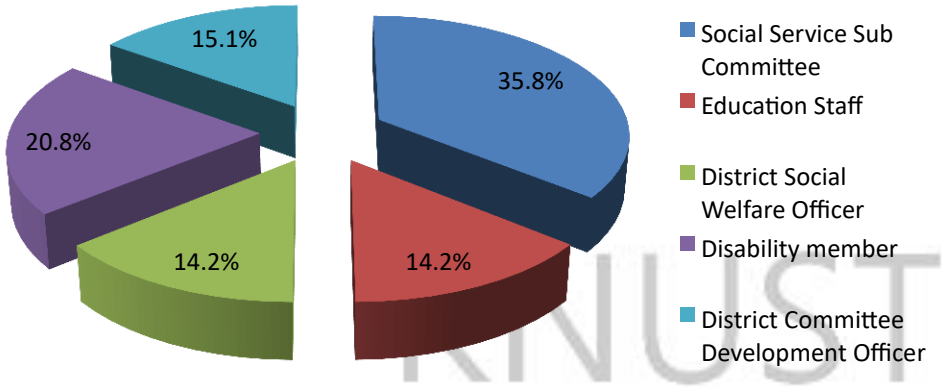


Figure 4.12: Composition of Management Committee of the Disability Fund in the Atwima Nwabiagya District

Source: Field Data 2013

Figure 4.13 presents the number of management members with disability. According to the results, majority of respondents 57.1% stated that one member of the committee was disabled. Others however held different views regarding membership of Persons with Disability of the management committee. Whilst 14.6% stated that 3 or more management members were Persons with Disability, 14.2% of the respondents indicated 2 and 14.2% also indicated none.

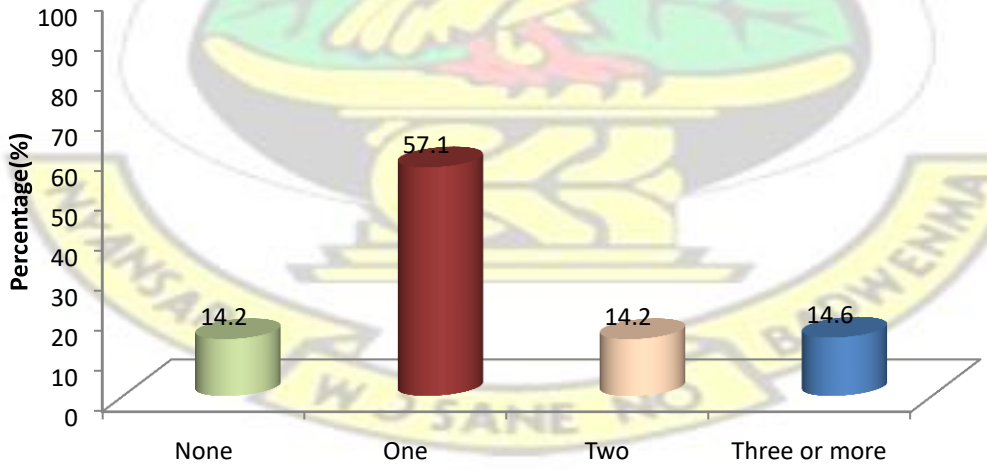


Figure 4.13: Number of management members with disability in the Atwima Nwabiagya District Assembly Source: Field Data 2013

In furtherance to the above, Figure 4.14 presents the responsibilities of the fund management committee. According to respondents, the responsibilities of the fund managers were to monitor and supervise the use of the funds 57.1%, to sensitise all stakeholders at the district about issues concerning disability 28.8% and to approve applications for funds by disabled persons 14.2%.

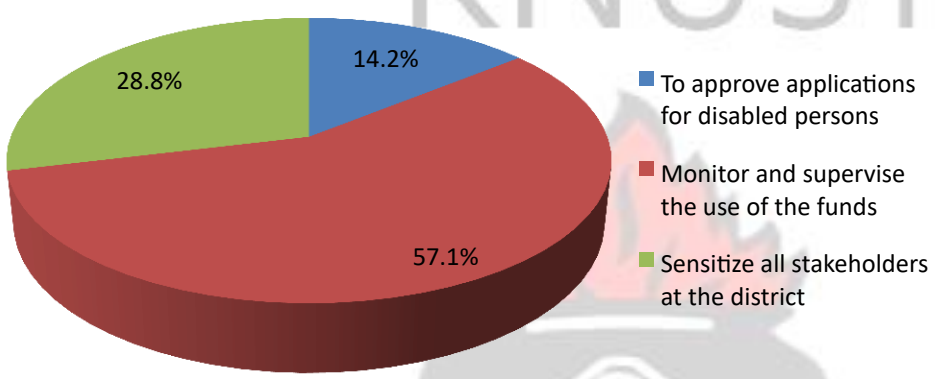


Figure 4.14: Responsibilities of the fund management committee

Source: Field Data 2013

Figure 4.15 presents monitors of fund. Respondents listed Staff of Social Welfare Department (42.9%), members of DFMC (28.8%); Executive members of disability group (28.3%) as those responsible for the monitoring of the fund. Each member contributed a significant role in the monitoring of the funds distributed to respondents. The above findings confirm existing literature that management committee members provide guidelines on the disbursement and management of the Disability Fund to Persons with Disabilities (NCPD, 2010).

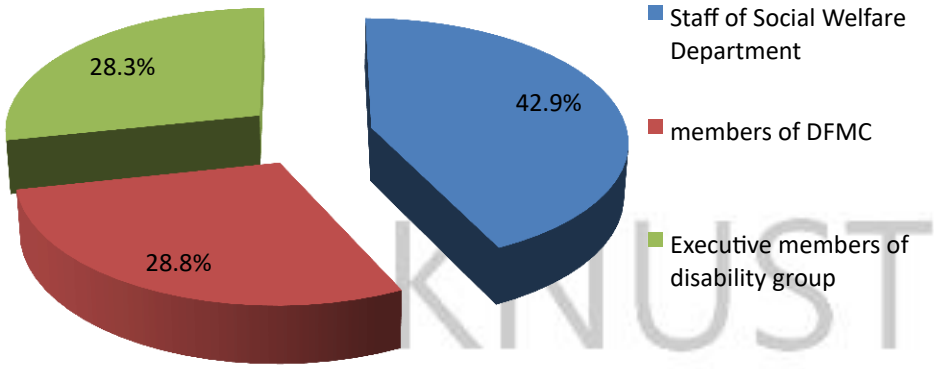


Figure 4.15: PWDs' views on the Monitors of the Disability fund in Atwima Nwabiagya District

Source: Field Data 2013

The literature identifies several ways in which disability funds are monitored. In the present study, respondents' views were sought on how the funds were monitored. Figure 4.16 presents the ways of monitoring the funds. According to respondents, the fund managers monitor the funds through area council basis 57.1%, through the use of monitoring forms 28.3% and through annual data collection 14.6%.

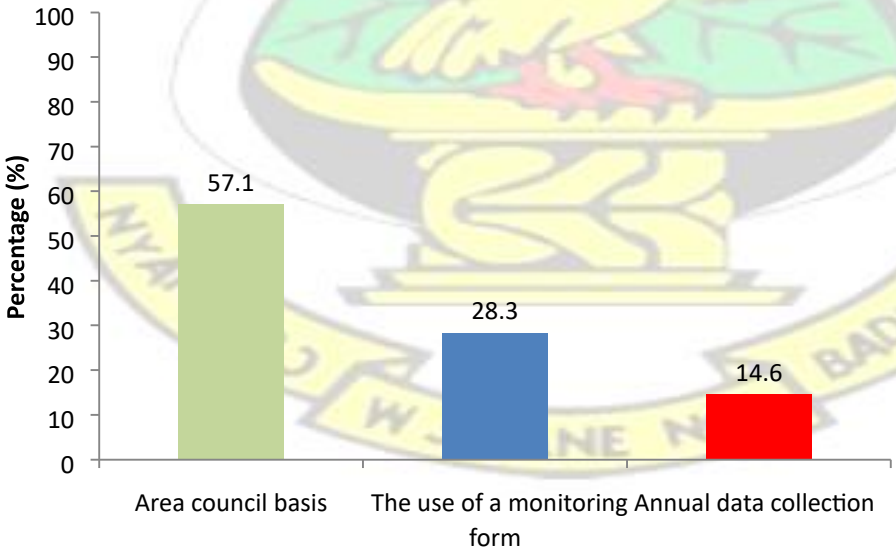


Figure 4.16: Ways of monitoring the funds in the Atwima Nwabiagya District

Source: Field Data 2013

4.4.1 Major challenges with Disability Fund management

Respondents were asked to state categorically specific challenges with the Disability Fund management. Figure 4.17 presents the challenges of Disability Fund from respondents‘ perspectives. Two main challenges were outlined by respondents; these included irregular disbursement (57.1%) and insufficient amount (42.9%).

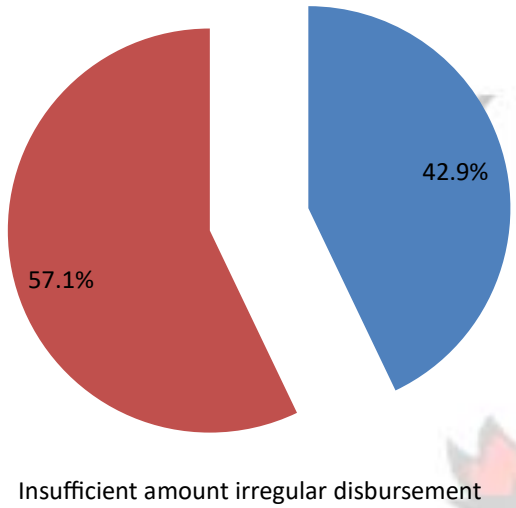


Figure 4.17: Major Challenges with Disability Fund Management in Atwima Nwabiagya District

Source: Field Data 2013

Table 4.4 presents the challenges associated with the disability management fund. In all, respondents agreed in majority (71.2%) that only disabled persons known about the District Assembly benefit from the fund. However, 14.2% of the respondents disagreed to the statement whereas about 14.6% were uncertain. Moreover, respondents agreed 71.3% to the statement that the money disbursed is too small which confirms Figure 4.18. However, 14.2% disagreed whereas 14.2% were uncertain. Most respondents 57.1% on the whole complained that the fund takes a longer time before it reaches them. However, 28.8% of them disagreed to the statement with about 14.2% being uncertain. About 43.3% were uncertain as to whether there were a lot of deductions from the money. About 14.2% agreed that there are a lot of deductions from the money; however,

42.5% disagreed. A majority 42.9% of the respondents disagreed that there is lack of guidelines on how the funds should be spent. However, 42.5% agreed to statement that there is lack of guidelines on how the funds should be spent, but 14.6% were uncertain about the statement.

Majority 42.9% disagreed to the statement that the fund does not state how the needs of women with disability should be met. However, about 28.3% were uncertain, and 28.3% were in agreement.

Table 4.4: Challenges associated with the disability management fund

	Statement	N/A	SA	A	D	SD
A	Only disabled persons known by the district Assembly benefit	14.6	42.9	28.3		0.0
B	The money is too small	14.6	57.1	14.2	14.2	0.0
C	It takes a longer time before it reaches us	14.2	57.1	0.0	14.2	14.6
D	There are a lot of deductions from the money	43.3	0.0	14.2	14.2	28.3
E	There is lack of guidelines for how the funds should be spent	14.6	28.3	14.2	0.0	42.9
F	The fund does not state how the needs of women with disability should be met	28.3	0.0	28.3	42.9	0.0
		(5)	**(4)**	**(3)**	**(2)** 14.2	**(1)**

Source: Field Data 2013

CHAPTER FIVE DISCUSSION

5.0 Introduction

This chapter looks at the discussions of the study. The discussions comprise comments, deductions and inferences of the findings of the study. The sections are arranged in consistence with the results.

5.1 Socio-demographic characteristics of respondents

Ghana Human Development Scale (GHDS, 1993) states that disability rate is the same for males and females, the present study found that females dominated. Given the study-setting for this study, it was expected that Akans dominate. However, many other ethnic groups were represented. This finding confirms the assertion by Ghana Human Development Scale (GHDS) in (1993) that disability is prevalent in rural areas. Perhaps, given the fact that the region in which the study took place is dominated by Christians, a similar pattern was recorded by the current study.

Most of the male respondents were in their youthful age, whereas the females were more matured.

The finding of the study confirms Filmer (2008), Loeb *et al*. (2008) and Eide and Kamaleri (2009) that for education, most children with disabilities tend to have lower school attendance rates. The writers found that PWDs have lower levels of education. The linkage between levels of education of PWDs and their income stems from the discrimination they suffer as a result of their disability as confirmed by Miles (2000) and Kim (2004). They are therefore, denied opportunities into formal employment which exposes them to little or no income. Contreras *et al*. (2006) and Eide and Loeb (2006) found that PWDs have difficulty with employment. This employment gap creates a situation of low income. What worsens their case is the lack of access to

healthcare as cited by the World Bank (2009) and Trani *et al*. (2010). The interplay of these factors poses substantial financial burden on PWDs. It makes their livelihoods very pathetic and increases their vulnerability. The situation of the respondents is an indication of unfavourable living conditions as portrayed in their level of education and expenditure on healthcare (figures 4.7 and 4.8).

An analysis of 14 household surveys in 13 developing countries in Africa, Latin America, and Southeast Asia found that in all countries studied, children with disabilities of between 6 and 17 years of age were less likely to start school or to be enrolled, at the time of the survey. Similar results were found in Leob and Eide 2004 (Malawi), Loeb et *al*. 2008 (South Africa), Mete 2008 (Eastern Europe). Barely 8.9% of males and 9.8% females were in the tertiary level.

This could perhaps be due to the financial constraints most the respondents found themselves.

This implies that all respondents were members of a particular association and can easily go there for assistance. According to Habeck *et al*., (2002), most disabled persons register with some formal institution for assistance. Moreover, the World Report on Disability (2011) states that in low-income and middle-income countries, supporting service provision through civil society organizations can expand the coverage and range of services. Community-based rehabilitation programmes have been effective in delivering services to very poor and underserved areas. Information provision, financial support, and respite care will benefit informal carers, who provide most of the support for persons with disabilities worldwide.

5.2 Socio-economic situation of Persons with Disability in the Atwima Nwabiagya District

The results suggested that respondents had numerous responsibilities to cater for. This explains their impoverished situation (figure. 4.3). Studies have shown that there is a close linkage between poverty and disability (Elwan, 1999). PWDs with low incomes tend to give birth to more children so as to be accepted in the society. The study took place within an Akan community where most of the respondents had Akan descent with the notion that ones' social status could be measured by the number of children one had**.** This perception creates a comfort zone for some PWDs to give birth without recourse to their financial situation. The study shows that 74% of respondents had between 3 and 5 dependents (Figure. 4.3). This implies that there is a greater financial need on PWDs with lower education/income Dalal *et al*. (2000)**.** The study found that most respondents rather had a lot of dependants. This puts so much financial pressure on PWDs and that some funds given them relief are very essential.

The financial demands on PWDs were observed in the patterns of expenditure on health, household money for upkeep for themselves and dependants as well as for other mandatory bills. These made the livelihoods of persons with disabilities very difficult to cope with. The type of employment they engaged themselves in was mainly artisanal types. Such jobs have very irregular and inconsistent flow of income hence unreliable.

Low level of education is related to low level of employment, hence low income. It must be emphasized that even those without disabilities with low level of education earn low income, how much more those with disabilities. It is for this view that there is the need for social intervention like the Disability Fund for persons with disability.

This is consistent with the findings of Kim (2004) that, some disability organizations provide support in the form of devices and funds to cushion its members. This is however contrary to World Report on Disability (2011), that persons with disabilities are particularly vulnerable to deficiencies in services such as health care, rehabilitation, support and assistance. Data from four South African countries found that only 26–55% of people received the medical rehabilitation they needed; 17–37% received the assistive devices they needed; 5–23% received the vocational training they needed; and 5–24% received the welfare services they needed,(WHO, 2011).

The result suggests that respondents had numerous responsibilities to cater for and explains their impoverished situation or condition. For instance studies have shown that there is a close linkage between poverty and disability (Elwan 1999). An abundance of literature has shown living conditions among individuals with disabilities in high-income countries to be low compared with non-disabled. The results suggest that respondents‘ dependants were mostly young.

Thus, given the age group of respondents and the average school age in Ghana, it was expected that most of them would be in primary school as affirmed by the present study.

The highest amount spent on respondents‘ dependants‘ education brings to mind the kind of school in which these dependants are sent to. Thus, given the low income level of respondents, a cheaper form of education will be patronised than an expensive one. This result shows that majority of these dependants were minors thus 6-10 years (42%) and 11-15 year (29%).This means that the PWDs have a greater financial problem to deal with. Therefore the Disability Fund is very crucial as a social intervention strategy.

5.3 Impact of the Disability Fund on the lives of PWDs

According to Leece and Leece (2006), disability fund has a significant influence on the livelihoods of disabled persons. The analysis emphasises the relevance of basic needs like food in the life of human being. Hence, much of the usages were connected to food and access to assistive devices. This finding supports Weinbach (2004) assertion that disabled persons use disbursed funds to support their livelihoods.

5.3.1 PWDs' Views about the Overall Impact of the Disability Fund on their Livelihoods

Respondents were of the view that the Fund supports them in their livelihood. This confirms their views expressed in section 4.3.1. For instance, it has helped them in expanding their farming and trading activities as well as paying for their dependants school fees among others. The finding is consistent with an observation by Kett (2011) who states that disability fund is able to support disabled persons and reduce poverty among them.

5.4 Management of the Disability Fund

Advocates and families from South Fraser, North Shore and Capital regions (1998) reported that individualized disability management approach was a style of funding community services where funds needed to purchase required community services and supports went directly to the individual based on a plan that was negotiated with government (Funding and service options for Persons with Disability 2009). This is the approach being adopted in Ghana where a percentage of the District Assembly Common Fund is given to individuals with disability to purchase necessary logistics to address their life challenges. Smith and Fortune (2008) cited in Glynn *et al*. (2008) argued that allocating funding at the person level enhances the capability to develop

individualized support strategies, contributes to portability, and promotes individual choice. Managing funding at the person level hinges on developing funding methods that are service independent. These references support the fund management concept where funds are disbursed to individuals with disability. However, the composition of the fund management and their *modes operandi* needed to be looked at dispassionately.

Schalock, (2004) asserts that during the latter part of the 20th century, the concept of disability moved towards a strong emphasis on personal rights and desired personal outcomes, and an awareness of the effects of discrimination and marginalisation on persons with disabilities. Specifically in Ghana, the decentralisation process has, thus, transferred most of the responsibility for service delivery to the district level. However, this has not been effectively supported by a decentralisation of resources for running costs or monitoring. The financial resources delegated to the district assemblies is called ‗the Common Fund' and is divided between the districts based on a number of indicators that reflect poverty, population size, the amount of internally generated funds (IGF) and the "need factor", which is introduced to reduce the current imbalances in development. In this way, districts with high levels of poverty get more funds.

According to the National Council On Persons With Disabilities (2010), The Article 41 of the Persons with Disability Act, 2006 (Act 715) provides for the establishment of the National Council on Persons with Disability (NCPD), whose objective is to propose and evolve policies and strategies to enable persons with disabilities enter and participate in the mainstream of the national development process. For effective utilization, the NCPD in collaboration with the Ghana Federation for the Disabled (GFD) under the authority of the Minister for Employment and Social Welfare, in cooperation with the District Assembly Common Fund (DACF) and with the approval

of the Minister for Local Government and Rural Development, provides these guidelines on the disbursement and management of the Disability Fund to Persons With Disabilities (NCPD, 2010).

There is an established committee that oversees the affairs of the disability fund and its management. The management committee is made up of the District representative, NCPD; Chairperson, Social Services Sub-committee; District Director, Department of Social Welfare; District GFD representative; Co-opted technical member that the committee deems fit. The chairperson of the committee shall come from within the committee (NCPD, 2010).

Of the five membership of the Disability Management Fund Committee only one of them have some form of disability. However, some respondents were not familiar with the management committee members and were not certain about their physical condition or disability status.

This situation has the tendency to create gaps in the appreciation of the concerns of the disabled person. There seem to be marginalization of persons with disabilities and portrays a picture as if they are incapable of managing their affairs. Marginalization and discrimination of persons with disabilities have been cited by Schalock (2004) as a canker and very endemic within all societies especially in developing countries which militate against efforts to improve the situation of the disabled.

Another issue on the management of the fund is the monitoring. It looks as if the monitoring does not cut across monitoring the committee members and monitoring the beneficiaries to ensure they utilize the money received for the purpose for which it was intended. The question of who watches the watchman arises if there is no mechanism

in place to ensure that the fund management committee members are kept on their toes. The committee members should be checked to ensure that there is no diversion on the disbursement of the fund. The role of the Disability Fund Committee seems to be limited to fund disbursement and not fund management. Fund management is so broad enough to identify and explore reliable and diversified source of funds and the commitment of the fund into areas which will go a long way to grow the fund in a sustainable manner. The skills, experience and fund management capabilities of the committee members seem to be in doubt as far as this function is concerned.

From the study, it was deduced that the fund was not well disbursed because some PWDs do not get their fair share as to an amount they applied for, whilst others get exactly what they applied for. Also in spite of the fact that the fund should be shared on first come- first- serve basis, some may be served earlier even though they might submit their application late.

Also, the Fund Management Committee does not monitor the beneficiaries of the fund to see whether they are using it for the purpose for which the money was given to them. This is because beneficiaries were made to state in their application what they intend to use the money for.

5.4.1 Challenges of the fund management

The Disability Fund though should be received quarterly, does not come as expected. It takes a very long time in coming and even at times instead of four times a year, it comes two times. In the year 2011, the Administrator of the disability common fund received money for only the first and third quarters. In the year 2012 the money was received for the first two quarters which was claimed to be that of the second and fourth quarters

of the previous year (2011), (Figure 4.17).That notwithstanding, the money is insufficient (Figure 4.17) which makes disbursement very hectic, considering the fact that part will be used for purchases and other development project and program funding. There is a vocational centre for Women with disabilities at the District which was established and still maintained with part of the money. Also, the district pays transportation cost for PWDs who attend programs outside the district and even outside the region. The district also organizes programs like games and end of year party for the PWDs, in all these, part of the money is used. In view of this, applications were considered on first-come-first-serve basis. At certain times, the money should be disbursed across board, irrespective of the amount applied for due to the insufficiency of the money so that all applicants could have something to take home.

The challenge of insufficiency of amounts given to beneficiaries has been confirmed greatly. A look at the number of dependants of respondents shows that they have higher financial commitments and demands. Most respondents (74%) had between 35 dependants (Figure 4.3). Most of these dependants are aged between 6-20 years and are at school going age (Figure 4.5). This shows that there is so much reliance on the funds for their upkeep. Linking this to their employment status shows that they engaged in artisanal jobs with very unpredictable and inconsistent cash flows (Table 4.1).

Dalal *et al*. (2000) studied PWDs in India and found that the prevailing attitudes of families and local community members of persons with disabilities were negative because they could not contribute any income to the family. This is the same in Ghana where families of persons with disabilities are shunned on the basis of poverty and stigmatisation. A look at the daily expenditure (Figure 4.6) shows that most of the respondents fall within the category of the poor. This is in view of the fact that, with a

daily minimum wage of GH7.00 for employers, most PWDs do not enjoy this minimum wage because they are not gainfully employed because of their low level of education. The expenditure cuts across basic daily upkeep, healthcare and education. In the opinion of Weinbach (2004), persons with disabilities use the money given to them to cater for their daily livelihood. Disabled persons encounter difficulties as far as their livelihood is concerned, Mitra (2011). The problem becomes exacerbated when the funds, which they rely on, suffer challenges like delay in the release and insufficiency. Respondents emphasized that these challenges have had serious repercussions on not only themselves but their dependants as well (Table 4.3).

CHAPTER SIX CONCLUSION AND RECOMMENDATIONS

6.0 Introduction

This chapter presents the conclusions and recommendations.

6.1 Conclusion

Based on the specific objectives set and findings of the study, the following conclusions were drawn. The study found out that Disability in the district under study is prevalent among female respondents and rural areas— of the two hundred and twelve (212) respondents, one hundred and twenty-two (122) constituting 57.5% were females as against ninety (90) males 42.5%. This by implication has resulted in denial of opportunities into formal employment which has exposed them to little or no income.

The disability fund affects respondents in several ways as it supports them in providing basic needs for themselves and their dependants. This is evident from the field of study where respondents revealed that they are now able to expand their trading and farming activities.

There is a management committee for the disability fund consisting of several stakeholders who are charged with the mandate of ensuring successful disbursements and monitoring of the funds among disabled persons. The members consist of District representative, NCPD; Chairperson, Social Services Sub-committee; District Director, Department of Social Welfare; District GFD representative and Co-opted technical member(s) that the committee deems fit. The chairperson of the committee comes from the within (NCPD, 2010). Of the five member committee, only one person is disabled.

Even though the disability fund supports disabled persons who participated in the study, key challenges exist including irregular disbursement and insufficient amount.

6.2 Recommendations

In connection with the key findings, the study submits the following recommendations:

- The District Assembly should use part of its internally generated funds to support disabled persons in the district.
- Government in collaboration with the District Assembly should put structures in place to ensure regular disbursement of the fund. For instance, the District Assembly should make provision for funds to the disabled persons if the common fund is not ready to enhance their livelihood.
- Government should increase the amount credited to persons with disability from 2% to 10% so that PWDs could get more.
- The District Assembly should register all PWDs in the District so that they could be tracked for support. However, non-registered PWDs should not be allowed to access the fund. This will make it easier to get all PWDs in the district for proper statistics.

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APPENDIX

KWAME NKRUMAH UNIVERSITY OF SCIENCE AND TECHNOLOGY
SCHOOL OF MEDICAL SCEINCES

ASSESSING THE CONTRIBUTION OF THE DISABILITY MANAGEMENT FUND ON INDIVIDUAL LIVELIHOODS: A CASE STUDY OF THE PHYSICALLY CHALLENGED, VISUALLY AND HEARING IMPAIRED PERSONS IN THE ATWIMA NWABIAGYA DISTRICT OF ASHANTI REGION

Questionnaire for Respondents

Dear Sir/Madam

The purpose of this questionnaire is to assess the contribution of the disability management fund on individual livelihoods. It would be greatly appreciated if you could complete this questionnaire. The study is purely for academic purposes and nothing else. You are however, assured of the strictest confidentiality and anonymity. Thank you.

Esther Fredua Agyemang (PG 6026611)

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

Socio-demographic characteristics

1. Age: .....
2. Sex: a. Male [ ] b. Female [ ]
3. Level of educational: a. Non formal education b. Primary [ ] c. Secondary [ ] e. Tertiary [ ] f. Other [ ] specify.....
4. Marital status: a. Single [ ] b. Co-habitation [ ] c. Married [ ] d. Separated [ ] e. Divorced [ ] f. Widowed [ ]
5. Religion.....
6. Hometown: .....
7. Nationality: .....
8. Occupation: .....
9. Ethnic group:.....

10. Type of disability ..... a. physically challenged [ ] b. Visually impaired [ ] c. hearing impairedd)other [ ] specify.....
11. I resort to ..... a. Wheel chair [ ] b. Crutches [ ] c. Braces [ ] d.Glasses [ ] e. Other [ ] specify.....

Module One: How the disability fund affects the lives of physically challenged, visually and hearing impaired

12. Do you receive any disabled fund from the District Assembly Common Fund (DACF)? Yes [ ] No [ ]
13. How often do you receive the fund? a. Daily [ ] b. weekly [ ] c. Fortnightly [ ] d. Monthly [ ] e. Annually [ ] f. Others [ ] specify….
14. Who issues the money? .....
15. How much do you receive? GH₵.....Daily/ Weekly/ Fortnightly /Monthly/Yearly
16. What do you use the money for? .....
17. Which areas do the fund support? a. awareness raising on the rights and responsibilities of PWDs [ ] b. Organizational development [ ] c. Training in employable skills/apprenticeship [ ] d. Income generating activities [ ]

e. educational support for children, students and trainees with disability [ ]

f. Provision of technical aids, assistive devices, equipment and registration of NHIS [ ]

g. Other [ ] specify .....

18. Please tick [√] to indicate your position on the following statements

1. Strongly agree (SA) = 5
2. Agree (A) = 4
3. Not applicable (N/A) = 3
4. Disagree (D) = 2
5. Strongly disagree (SD) = 1

Statement –The fund...	SA	A	N	D	SD
helps me pay my children‘s school fees					
is insufficient for me and my family					
improves my business and farming activities					
is useful for expanding my farming/trading activities					

makes it easier for me to access healthcare					
Facilitates my involvement in all sectors of the economy					
creates an enabling environment for my full participation in national development					
Ensures that women with disabilities enjoy the same rights and privileges as their male counterparts					

Module Two Evaluate how the disability management fund is managed

19. Which people constitute the fund management committee? .....

20. What are their responsibilities?

    .....

    .....

    .....

    .....

21. Who are those charged with the mandate of monitoring utilization of the fund?

    ……

22. How is the monitoring done?

    ……

    ……

23. Is there a separate account for the management of the fund? Yes [ ] No [ ]

    (i)If yes, why and where is it created?

    ……

    (ii)If no why and where is it kept?

    .....

Module Three

24. State any major challenge you have observed with the DF.....

.....

25. In your view, what do you think could be done to minimise or possibly eliminate the stated challenge in (24) above? .....

.....

26. Challenges associated with the disability management

Statement	SA	A	N	D	SD
Only disabled persons known by the District Assembly benefit					
The money is too small					
It takes a longer time before it reaches us					
There are a lot of deductions from the money					
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					

27. **General Comments**

.....

.....

.....

.....

Thank you