



2010 POPULATION & HOUSING CENSUS REPORT



DISABILITY IN GHANA



Ghana Statistical Service
October, 2014

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PREFACE AND ACKNOWLEDGEMENTS

The mandate of the Ghana Statistical Service (GSS), like many other national statistical offices, includes data collection, compilation and analysis as well as dissemination of statistical information in an accessible and user-friendly manner. In order to satisfy the needs of users, GSS is required to analyse and interpret statistics in a form that makes it easily understood for people to appreciate the value of the statistical information. There is also the need to disseminate widely all the statistics produced by GSS so that all data users including potential data users can have access to it.

Ghana, like many other developing countries, relies mainly on survey and population census data for planning at the national and the sub-national levels. Detailed analysis of such data provides users with a wealth of information for planning and policy formulation. Analysis of the 2010 Population and Housing Census data on topical issues, therefore, provides information for effective planning at all levels.

Several reports, including six monographs, were prepared using the 2010 Census data and published in 2012 and 2013. The published reports from the census data was a collaborative effort between the GSS and Local consultants from research institutions and universities in Ghana with funding from the Government of Ghana and various Development Partners (DPs). In order to strengthen the report writing capacities of the Ghana Statistical Service (GSS) and Ministries, Departments and Agencies (MDAs) which are engaged in population-related activities, professional staff of GSS and these MDAs were paired up with consultant writers to prepare the reports.

The monograph on ‘Disability in Ghana’ is one of the additional eight monographs that has been prepared from the 2010 Population and Housing Census data and is meant to inform policy makers on issues relating to Persons with Disability (PWDs) in Ghana. The report focuses on the prevalence and type of disability as well as the socio-economic characteristics of PWDs in Ghana.

The Ghana Statistical Service wishes to thank the United Nations Children’s Fund (UNICEF) and the United Nations Population Fund (UNFPA) for providing funds for the preparation of this monograph and the lead role UNFPA played in mobilizing resources from the UN System and from other DPs for the 2010 PHC. Our appreciation also goes to Dr. Akwasi Kumi-Kyereme and Mr. Richard Sasu for the dedication and competence they demonstrated during the preparation of this report.

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CHAPTER ONE

INTRODUCTION

1.1 Overview of Disability

Disability is an inescapable human condition and at one point or another, almost every person is exposed to, and may experience temporal or permanent disability (WHO & World Bank, 2011). Disability evokes different social constructions depending on the setting in which the concept is used. It is neither a straightjacket social nor a biological construct; instead, it is often hinged on the interactions among health, environmental and personal factors (WHO & World Bank, 2011). Disability can occur at three levels: impairment in body function or structure; a limitation in activity, such as the inability to read or move around; a restriction in participation, such as exclusion from school or work. As such, people with disability include those who are traditionally understood as disabled (for example wheelchair users, people who are blind or deaf or people with intellectual impairments), and people who experience difficulties in functioning due to a wide range of health conditions such as chronic diseases, severe mental disorders, multiple sclerosis and old age (WHO, 2013).

The 2004 Global Burden of Diseases (the most recent) report estimated that about 978 million, thus about 15.3% of the world's population had moderate or severe disability while about 3% (185 million) had severe disability. The burden of disability was higher among those aged 15 and above. For those under 15 years, moderate and severe disabilities were 5.1% and 0.7% respectively whereas for those 15 and over years, moderate and severe disabilities were 19.4% and 3.8% respectively (WHO & World Bank, 2011). The regional distribution shows that the African region reported slightly the highest proportion of people with severe disability, around 3.1% while the Americas reported 2.6% as the least. Overall disability (severe and moderate) records placed the European region with the highest proportion - 16.4% whereas the Eastern Mediterranean reported the minimum.

With fertility declining in most parts of the world and the ageing population, age-related disability is rising and is predicted to rise in the coming decades. National patterns of disability are influenced by trends in health conditions, environmental and other factors - such as road traffic crashes, natural disasters, conflict, diet and substance abuse. Disability disproportionately affects vulnerable populations, in particular, women, older people and people that are poor. Low-income countries have a higher prevalence of disability than high-income countries (WHO, 2013).

In terms of life outcomes, disabled people have some of the worst outcomes in health, education, economic and work activity participation, and higher rates of poverty and vulnerability (WHO & World Bank 2011). With the coming into operation in 2008 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), the disability "industry" is flourishing and it is being increasingly recognized as a developmental and human rights imperative rather than health situation.

The barriers and challenges disabled people encounter in their routine lives are far greater than those encountered by people who are not disabled. These obstacles are manifested through access to health services (rehabilitation services inclusive), education, transport, and employment and these barriers are worsened by inadequate policies and standards, stigma

and discrimination against people with disability, inadequate funding, inappropriate technologies and formats for information and communication, and lack of participation in decisions that directly affect their lives. In this report, the main preoccupation is to provide a detailed analysis of prevalence of disabilities, that is, visual, physical, speech, hearing, emotional and intellectual in Ghana.

1.2 Definitions and types of disability

Definitions

The measurement of disability has important implications for law and policy. There is no universally accepted definition for disability. There are, however, a number of conceptual models that guide measurement. No model can encompass all the dimensions of disability, but different models serve different purposes and provide useful perspectives on disability in a given context (Palmer & Harley, 2012). Disability represents a complex process and is not a single, static state. It refers to the outcome of the interaction of a person and his/her environment (physical, social, cultural or legislative) and represents a measure of the negative impact of environmental factors on one's ability to participate. The complexity of the concept has resulted in the proliferation of statistics on disability that are neither comparable nor easy to interpret (Madans, Loeb & Altman, 2011) and that demand definitions that are flexible but able to capture disability in various manifestations (Loeb, Eide, & Mont, 2008).

With the burgeoning interest in disability studies, civil society groups, disability organisations, and researchers - both social and medical scientists, have contested the concept itself. The contestations arise from the complex, multidimensional and dynamic nature of the concept. However, the discussion converges at two broad perspectives about disability - its social and medical domains, thus the awareness that disability portends both social and physical barriers. To that extent, the Washington Group on Disability Statistics (2010) argued that disability should not be framed within the political, social and medical sciences' discourses but rather within the realms of scientific balance. In the introduction to the CRPD, it was also pointed out that disability is an evolving concept, and was further surmised that, "disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinder their and effective participation in society on an equal basis with others" (p. 56).

According to a WHO (1980) model, disability is "any restriction or lack of ability to perform an activity in the way or within the range considered normal for a human being". Examples include walking disability, dressing disability or shopping disability. Disability is to be distinguished from handicap, the latter being defined as a "disadvantage for a given individual, resulting from impairment or a disability that limits or prevents the fulfilment of a role that is normal for that individual" (p. 291).

Nagi (1991) defined disability as "inability or limitation in performing socially defined roles and tasks expected of an individual within a sociocultural and physical environment" (p. 3151). Limitations in performing various tasks commonly referred to as activities of daily living, such as dressing, shopping or driving, are "part of the set of expectations inherent in family, vocational and a variety of other roles" (p. 3171) and, therefore, are components of the concept of disability.

Disability is perceived to be caused by physical impairments resulting from disease, injury or health conditions (Barnes & Mercer, 2003). Impairment leads directly to the loss of bodily

and social functioning. Hence interventions are primarily medical, including rehabilitation and institutional care, as well as social assistance programmes such as special education, vocational training and social welfare (Palmer & Harley, 2012).

The International Classification of Disability and Handicaps framework conceptualizes disability in the following domains - impairment, disability and handicap. The International Classification of Functioning, Disability and Health (ICF) define disability as an umbrella concept that embraces impairments, activity limitations, and participation restrictions.

- Impairment: any loss or abnormality of psychological, physiological or anatomical structure or function. This could include blindness or deafness, loss of limb.
- Disability: any functional restriction or lack (resulting from an impairment) of ability to perform an activity within the range considered normal for a human being. This could include walking, stretching, lifting, feeding and so on.
- Handicap: this is the relationship between impaired and/or disabled people and their surroundings affecting their ability to participate normally in a given activity and which puts them at a disadvantage.

The social model presents disability as societal construction as opposed to individual interpretation. Social changes are therefore required in reframing who is disabled and who is not. This view discounts the importance of impairment. Impairment is seen to occur depending on structural arrangements that either impede or promote the functioning of individuals in societies. One of the influential proponents of the social model, Michael Oliver argued that, ‘disablement has nothing to do with the body’, and ‘impairment is in fact nothing less than a description of the physical body’ (Hughes & Paterson, 1997). One of the motivations of social reconstructing is to challenge the medical view that unconsciously presents the disabled people as “other”. The social model has served as the basis for political organisations and demands for empowerment of people with disability (PWD). The social model however, does not preclude impairments entirely except that its advocates insist that disability is contingent on social conditions (Thomas, 2004; Reindal, 2009). For instance, Allotey et al., (2003) found that paraplegia patients in Cameroon and Australia reported different disabling experiences largely due to the social context – the later country being much supportive of PWD.

Although useful, serving both political and empowerment interests, the social model proponents have been criticized for neglecting the centrality of impairment – real experience of disabled people. One of the key critics, Bury (2000) contended:

I do not believe that the ‘social model’ has really engaged with the real issues facing the vast majority of disabled people, and, despite its rhetoric and undoubted attractions for some, it has not produced a cogent approach which can serve the real practical needs of disabled people, or indeed the research community (p.1075).

Despite the criticisms against the social model, its importance lies in an outlook to reduce the burdens and barriers to PWD.

Types of impairment/disabilities

In order to appreciate the depth and magnitude of PWD, it is important to identify the various categories of impairment from which challenges can be explored. Some of the popular impairments are visual, hearing, physical speech, emotional and intellectual.

Visual impairment

Visual impairment represents a continuum, from very poor vision, to people who can see light but no shapes, to people who have no perception of light at all. Low vision is defined as vision that is between 20/40 and 20/200 after correction. (20/200 means that something at 20 feet would be just as visible as something at 200 feet would be to someone with normal 20/20 vision). A person is termed legally blind when their visual acuity (sharpness of vision) is 20/200 or worse after correction, or when their field of vision is less than 20 degrees. Blindness can be present at birth, acquired through illness or accident, or associated with ageing (glaucoma, cataracts, macular degeneration, optic nerve atrophy, diabetic retinopathy). According to the American Foundation for the Blind, almost 1 person in every 1,000 under age 45 has a visual impairment of some type, while 1 in every 13 individuals older than 65 has a visual impairment which cannot be corrected with glasses. With current demographic trends toward a larger proportion of elderly, the prevalence of visual impairments will certainly increase.

Hearing impairment

Hearing impairments are classified into degrees based on the average hearing level for various frequencies (pitches) by decibels (volume) required to hear, and also by the ability to understand speech. Loudness of normal conversation is usually 40-60 decibels. A person is considered deaf when sound must reach at least 90 decibels (5-10 times louder than normal speech) to be heard, and even amplified speech cannot be understood, even with a hearing aid (Olusanya, Bamigboye & Somefun, 2012).

Hearing impairment may be Sensorineural or conductive. Sensorineural involves damage to the nerves used in hearing (i.e., the problem is in transfer from ear to brain). Causes include ageing, exposure to noise, trauma, infection, tumours and other disease. Conductive hearing loss is caused by damage to the ear canal and mechanical parts of the inner ear. Causes include birth defects, trauma, foreign bodies or tumours (Gopinath et al., 2012).

Hearing impairments can be found in all age groups, but loss of hearing acuity is part of the natural ageing process. The number of individuals with hearing impairments will increase with the increasing age of the population and the increase in the severity of noise exposure (Freeland, Jones & Mohammed, 2010).

Speech impairment

Disorders in speech are an impairment of the articulation of speech sounds, fluency, and or voice (ASHA Ad Hoc Committee on Service Delivery in the Schools, 1993). Speech impairment includes any symptom that causes an adult to have difficulty with vocal communication. Such problems may include slurred, slowed, hoarse, stuttered, or rapid speech. Other symptoms may include stiff facial muscles, drooling, poor accessibility of words, and sudden contraction of vocal muscles. Speech impairment can occur suddenly or can gradually progress. Each speech impairment type has a different cause, which is what sets

it apart. Some of the popular forms of speech impairment include spasmodic dysphonia¹, aphasia², dysarthria³, and vocal disturbances⁴ (Ashley, Duggan & Sutcliffe, 2006).

Emotional disturbance/impairment

Emotional disturbance/impairment means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child's educational performance: an inability to learn that cannot be explained by intellectual, sensory, or health factors; an inability to build or maintain satisfactory inter- personal relationships with peers and teachers; inappropriate types of behavior or feelings under normal circumstances; a general pervasive mood of unhappiness or depression and a tendency to develop physical symptoms or fears associated with personal or school problems. Emotional disturbance/impairment includes schizophrenia (Federal Register, 2006, p. 46756). Emotional impairment may be explained by (a) biological factors, such as genetics, brain damage or dysfunction, malnutrition and allergies, temperament, or physical illness; (b) family factors, such as the family definition and structure, family interaction, family influences on school success and failure, and external pressures affecting families; and (c) school factors, such as deficiencies in the ability of school personnel to accommodate students' variable intelligence, academic achievement, and social skills (Kauffman, 2001).

Intellectual impairment

Intellectual disability (ID) or general learning disability is a generalized disorder appearing before adulthood, characterized by significantly impaired cognitive functioning and deficits in two or more adaptive behaviors. Intellectual disability is also known as mental retardation (MR), although this older term is being used less frequently in some areas and even being eliminated in others altogether. Intellectual disability is subdivided into syndromic intellectual disability; in which intellectual deficits associated with other medical and behavioral signs and symptoms are present, and non-syndromic intellectual disability, in which intellectual deficits appear without other abnormalities. The signs and symptoms of intellectual disability are all behavioural. Most people with intellectual disability do not look like they are afflicted with such, especially if the disability is caused by environmental factors such as malnutrition or lead poisoning. The so-called typical appearance ascribed to people with intellectual disability is only present in a minority of cases, all of which are syndromic. Children with intellectual disability may learn to sit up, to crawl, or to walk later than other children, or they may learn to talk later and in about one-third of children, the causes of intellectual impairments are unknown (Daily, Ardinger & Holmes, 2000). Low supply of iodine, problems during birth (e.g., low oxygen), exposure to some diseases such as whooping cough, malnutrition, alcohol consumption during pregnancy

¹ An abnormal brain functioning originating in the basal ganglia (part of the brain that controls muscle movement in the body)

² Brain damage from a stroke or blood clot

³ Degenerative muscle and motor conditions, such as multiple sclerosis, muscular dystrophy, cerebral palsy, and Parkinson's disease may cause this condition

⁴ May be caused by throat cancer, ingestion of certain drugs, such as caffeine, antidepressants, and amphetamines

(foetal alcohol syndrome), genetic disorders are some of the known causes of intellectual impairment (Siderius et al., 1999; Laumonnie et al., 2005; Wines, 2006; Sundaram et al., 2008).

1.3 Global Policies and Programmes Targeting Persons with Disability

The UN CRPD is the major international policy or legal tool for addressing the needs of PWD. The Convention recognizes that disability results from the interaction between persons with impairments and the barriers (both attitudinal and environmental) that hinder their full and effective participation in society on an equal basis with others. The Convention is intended as a human rights instrument with an explicit social development dimension. It recognizes the broad diversity among persons with disabilities and reaffirms that all persons with all types of disabilities should enjoy every human right and fundamental freedom. More specifically, included among the Convention's general principles are the full and effective participation and inclusion in society, non-discrimination, accessibility and equality of opportunity for people with disabilities. Some of the pertinent articles in the Convention are highlighted.

Article 3 of the Convention provides general principles. These are respect for inherent dignity and autonomy; non-discrimination, full and effective participation and inclusion in society; respect for differences and acceptance of PWD; equality and opportunity; accessibility; equality between men and women and respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Another important article is Article 4 that prescribes obligations on all member states. These obligations comprise adoption of appropriate legislative, administrative and other measures for implementation of the rights in the Convention; abolishing or modifying existing laws, regulations, customs and practices that discriminate against PWD; promotion of research and development that advance goods, services, equipment and facilities of PWD; provision of accessible information to persons with disabilities about mobility aids, devices and assistive technologies, including new technologies, as well as other forms of assistance, support services and facilities; and promotion of training of professionals and staff to work with PWD as a way of advancing the rights guaranteed in the Convention.

The Convention also includes specific requirements (Article 33) that focus on the establishment of mechanisms that would ensure the implementation and monitoring of the Convention at the national level. Implementation and monitoring of the Convention will require the collection of data on the population with disabilities for countries that have ratified the Convention as a way of helping achieve targeted interventions.

1.4 Appraisal of Specialized World institutions in Place for Persons with Disability

There are a number of international organisations dealing with issues of disability. Whereas the overriding goal of these organisations is geared towards the promotion of the rights and interests of PWD, the focus and sub-populations of target sometimes differ. Some are also global in perspective while others are regional or continental in nature. Among these international bodies are the UNICEF, UN, WHO and the World Bank.

UNICEF

The focus of UNICEF in addressing the needs of PWD is largely centred on children and somehow, women, particularly, those in the reproductive ages. The UNICEF has responded to the needs of children with disabilities through two broad frameworks – Convention of Rights of the Child (CRC), 1989, and Convention on Elimination of All Forms of Discrimination against Women (CEDAW). In 2006, UNICEF adopted the UN Convention on Rights of People with Disabilities. It is the position of UNICEF that children affected by disabilities experience more marginalisation and exclusion compared to their counterparts who are not. This is manifested in negative attitudes, lack of adequate policies and legislation. Children with disabilities have higher risk of being poor, not attending school, not accessing medical services and also are unlikely to participate in decision-making. The three key driving principles guiding the organisations activities in respect of disabilities are being an inclusive organisation for all, seeking to develop leadership on the rights of children with disabilities through capacity development of staff and partners and mainstreaming disability concerns across all programmes and policies, whether development or humanitarian. The State of the World’s Children Report for 2013 by UNICEF was devoted to children with disabilities with “from exclusion to inclusion” as one of the core principles of the report (UNICEF, 2013).

UN

The most conspicuous disability oriented outlook of the UN is the leadership provided in designing the CRPD starting from the 1980s and consummated in 2006. Prior to the promulgation of the CRPD, there had been different activities, policies and programmes to address issues of disability. The UN was founded on the principle of equality for all and this is evidently captured in the preamble to the UN Charter, which advances the dignity and worth of every human being through the pursuit of social justice in that direction. Article 25 of the Universal Declaration of Human Rights posits that “the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in the circumstances beyond control” must be safeguarded. The International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, which came into force in 1966, were passed to further strengthen anti-discrimination which is of primary importance in human rights. The activities and milestones of the UN in relation to disability can be summed into two broad eras: 1945-1978 and 1980-present. The milestones are presented in Table 1.1.

Table 1.1: Activities of the UN in relation to disabilities

First era: 1945 – 1978	Second era: 1980 – present
1945 – 1955, The United Nations Secretariat and the Economic and Social Council	1980s - Numerous efforts, substantive and promotional; nationally and internationally targeted at increased integration and improvements in physical and psychological adjustment of persons with disabilities within their communities.
1946 - The Social Commission	1982 - The General Assembly adopted the World Programme of Action concerning Disabled Persons. Disability policy was now structured in three main areas: prevention, rehabilitation, and equalization of opportunities.
1950 - At its sixth session the Social Commission considered two reports: “the social rehabilitation of the handicapped” and “the social rehabilitation of the blind	1983 - 1992 - With the proclamation of the United Nations Decade of Disabled Persons, 1983-1992, the General Assembly encouraged Member States to use the Decade to implement the World Programme of Action
1955 - 1970 - The focus of the United Nations on disability issues shifted in the late 1950s from a welfare perspective to one of social welfare.	1993 - The Standard Rules on the Equalization of Opportunities for Persons with Disabilities were adopted by the General Assembly.
1970s - The 1970s marked a new approach to disability. The concept of human rights for persons with disabilities began to be accepted internationally	2000 - The first Millennium decade - The negotiation and adoption of the Convention on the Rights of Persons with Disabilities
1978 - The Secretary-General established the intergovernmental Advisory Committee for the International Year of Disabled Persons.	2006 – On 13 December the Convention on the Rights of Persons with Disabilities was adopted by the General Assembly

Source: UN (Unpublished, available at: <http://www.un.org/disabilities/default.asp?id=121>)

The World Bank

The World Bank situates disability in the context of development and disability issues, based within its programme on social protection and labour. Recognising that about 15% of the world’s population experience different kinds of disabilities with about 110 - 190 million of these living with significant disabilities, the Bank seeks to provide avenues for developing the intellectual and manual labour of PWD for accelerated socioeconomic development. To achieve this, the strategy of the Bank is driven by integration of disability issues into existing and new projects in education, safety nets, transport, infrastructure, health, water and sanitation, post-conflict, and natural disasters.

The Bank also seeks to improve physical access of PWD by supporting “Universal Design”, which ensures that public civil works do not restrain the accessibility of PWD. Apart from funding projects that promote rights of PWD, the Bank is promoting cooperation of bilateral and multilateral development organisations in addressing disability matters. For instance, through the Japanese Policy and Human Resources Development Fund (PHRD), and the Multi Donor Trust Fund on Global Partnership for Disability and Development (GPDD), World Bank has coordinated the Disability and Development Donor Forum. The World Bank also worked with partners on key global events such as the United Nations High-Level Meeting on Disability and Development held in September 2013. In collaboration with the WHO, the first World disability report was published in 2011.

WHO

The guiding framework of the WHO in addressing disability issues is outlined within CRPD precepts. The WHO appreciates that discourses and policies on disability should not be considered as a stand-alone thematic policy matter but rather should be mainstreamed. With that recognition, disability will not be viewed as charity and medicine and care issue; instead, PWD would be seen as having legitimate rights to equality, justice and self-determination. In 2013, the WHO developed a programme/plan of action from 2014-2021, themed, *better health for persons with disabilities*. The plan of action is guided by CRPD, universal health coverage, life course approach (continuum) of care, multi-sectoral concerns and person centredness (empowerment of PWD). For individual member states, the WHO with its partners is working to achieve the following:

- Supporting the awareness and implementation of the Convention on the Rights of Persons with Disabilities by disseminating information on the Convention and the Optional Protocol, promoting understanding of the importance of the Convention and supporting Member States in implementing obligations under these instruments.
- Mainstreaming the Rights of PWD in the work of WHO by setting up a Task Force to ensure that the rights of PWD are appropriately mainstreamed in WHO programmes and projects and offices, information resources and employment opportunities non-discriminatory in whatever manifestation.

In line with these, the following objectives will be pursued to achieve the goals of the world health body:

- Address barriers and improve access to health care services and programmes;
- Strengthen and extend rehabilitation and rehabilitation services, including community based rehabilitation, and assistive technology; and
- Support the collection of appropriate and internationally comparable data on disability, and promote multi-disciplinary research on disability

1.5 Rights of Persons with Disability

The rights of PWD are also human rights. To that extent, the rights enshrined in the CRPD are similar to the UN Human Rights Charter of 1948. The right to life is recognised, as the first important right for PWD. It is stated “states and parties reaffirm that every human being has the inherent right to life and shall take all necessary measures to ensure its effective enjoyment by persons with disabilities on an equal basis with others”.

Other equally important rights include right to recognition everywhere as persons before the law, right to liberty and security of person, freedom from torture or cruel, inhuman or degrading treatment or punishment, freedom from exploitation, violence and abuse, right to acquire and change a nationality and freedom from arbitrary deprivation of nationality on the basis of disability. Children with disabilities also have right to name, and right to know and be cared for by their parents.

Additional rights include choice of place of residence, mobility, right to expression and opinion, and access to information, marriage and to found a family on the basis of free and full consent of the intending spouses; freedom to decide freely and responsibly on the number and spacing of their children and to have access to age-appropriate information, reproductive

and family planning education are recognized, and the means necessary to enable them to exercise these rights are provided. PWD also have right to education, health, work and employment, Participation in political and public life and right to cultural life, recreation, leisure and sport.

1.6 Challenges of Persons with Disability

Disability increases vulnerability of people affected in diverse ways. It is therefore important that in attempting to deliver tailor-made interventions for PWD, their burdens and challenges be properly understood. Some of these challenges are poverty, access to healthcare, education, employment, stigma and discrimination.

According to Acton (1983), the combination of poverty and disability is a fearsome one. Either one may cause the other; or their presence in combination has a tremendous capacity to destroy the lives of people with impairments and to impose on their families' burdens that are too crushing to bear. Poverty and disability seem to be inextricably linked. It is often noted that disabled people are poorer, as a group, than the general population, and that people living in poverty are more likely than others to be disabled.

The principle of equal access to health is captured in Article 25 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). Providing equal access to health across all people regardless of their ability is important in realizing the targets for the Millennium Development Goal 4 (gender equality) and MDG 5 on maternal health. Yet, PWD face challenges with access to healthcare. Trania et al. (2011) found that disabled women, compared to those who are not are less likely to have access to government health facilities in Sierra Leone. Mprah (2012) also observed that reproductive health needs of deaf people in Ghana are not adequately taken care of, particular in health communication messages.

Disabled people also experience challenges in work and employment. Disability partly reduces active capability of PWD. However, as pointed out earlier, the impact on functionality could be dependent on the context in which an individual experiences disabling condition, particularly whether PWD is in a developed or developing context. Coupled with the physical impairment, the social context can also reduce work and employment opportunities of PWD. For instance, PWD are less likely to have adequate education and skills required for certain jobs, and on account of the level of education obtained, be excluded from securing jobs, whether in the formal or informal sector.

Apart from the built environment of some workplaces hindering the access of PWD, negative perceptions about the capabilities of disabled persons also affect their chances of being employed. PWD also encounter difficulties in accessing education. Just like work and employment and health care, PWD are either consciously or unconsciously denied formal education as result of physical and socio-cultural barriers. Even in households, PWD risk being ignored and preference given to 'able' siblings when household resources are not sufficient to educate all children. Also worth mentioning is the fact that disabled children may experience significant stigmatisation from both peers and teachers and therefore drop out of school.

1.7 Data Source and Methods

Sources of data

The data for this report are based on the 2010 PHC. The 2010 Population and Housing Census (PHC) just like the preceding censuses was based on defacto enumeration – people were captured based on where they were on the census night. The census night was fixed on 26th September 2010 with actual enumeration starting on the 27th September 2010. Based on the 2010 PHC enumeration list, a 0.67% (250 EAs) sample was drawn for a post-enumeration survey (PES). Overall, the findings from the PES did not deviate substantially from the main census despite that about 1.3% population was found to have been erroneously included in the census. The main highlights of information collected in the census include demographic and social characteristics, such as, age, sex, marital status, ethnicity, religion, literacy, education, economic characteristics, ICT, disability, fertility, mortality, agricultural activity and housing.

Methods and limitations

This monograph utilised data derived from the disability and socioeconomic modules of the 2010 PHC. The figures are based on descriptive statistics. Prevalence of various impairments/disabilities is reported based on within-group analysis. This was done to ensure that the burdens of impairment in the various categories are clearly captured. One important limitation of the data that needs emphasis is the fact the impairments are based on self-report of individuals captured in the census. This suggests the need for cautious interpretations, as self-reported disabilities may be inaccurate when gauged against ‘objective’ biomedical measurement.

1.8 Organisation of the Report

The monograph comprises ten chapters. The introductory chapter (Chapter One) gives an overview of disability focusing on measurement and definitions of disability, global policies and programmes and specialized World institutions in place for persons with disability. Rights of persons with disability, types of disabilities and challenges of persons with disability are also presented. The Ghanaian context including national policies and programmes targeting persons with disability, institutions and associations of persons with disability, traditional perceptions and constraints to integration of persons with disability are outlined in Chapter Two.

The discussion of the study moves on to the profile of persons with disability (Chapter Three). The main themes include the distribution of persons with disability by age, marital status, level of education, activity status, region, ethnic group and religion. Chapters Four to Nine present the situational analysis of persons with visual impairment, physical disability, speech disability, hearing impairment, emotional/behavioural disability and intellectual disability. The main idea discussed in the Chapters is the prevalence of disabilities. The summary, conclusions, recommendations and policy implications are outlined in Chapter Ten.

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CHAPTER TWO

NATIONAL CONTEXT

2.1 Introduction

Ghana has signed, ratified and adopted various international agreements including the Convention on the rights of PWD and the African Decade of the Disabled Persons. Although the goal of these agreements is to protect the fundamental freedoms and human rights of all PWD and to promote and respect their inherent dignity, PWD in Ghana continue to face various forms of discriminations.

They are confronted with numerous challenges including low self-esteem, limited mobility, high dependency and poverty, lack of access to education, health care and other social services (WHO, 2011). Some regard PWD as unproductive and incapable of contributing to national development, while others believe their unfortunate circumstance is a curse or punishment from God. Consequently, PWD are unable to fully and effectively participate in the Ghanaian society compared with persons without disabilities.

The issue of disability in Ghana has evolved from being a human rights concern to being a developmental issue because of its link to poverty. In that regard, the disability movement and civil organizations in recent years have made strides in pushing forward the disability agenda. As a result, government in 2006 passed the Persons with Disability Act (715) which deals with issues such as rights, education, health care, employment, transportation, housing, medical rehabilitation services, generation and dissemination of relevant information and participation of PWD in cultural activities.

Further, the National Council for Persons with Disabilities was established in accordance with Article 41 of the Persons with Disability Act 2006. Other initiatives include the three percent allocation of the District Assembly Common Fund (DACF) to assist PWD, and the Ghana Shared Growth and Development Agenda (2010 – 2013) Volume I which aims to develop and implement an action plan to fulfill the provisions of the Persons with Disability Act 2006 and develop social interventions for PWD.

In spite of the advances made by the disability movement, civil society organizations and government towards promoting the disability agenda through inclusion, there are still challenges to be addressed. These challenges can only be addressed through well informed policy decisions backed by proper implementation.

This chapter therefore seeks to discuss the national context of disability in Ghana. The chapter proceeds first with an overview of national policies and programmes targeting PWD. This is followed by an appraisal of specialized institutions dealing with PWD, measures in place to fight against disabling diseases, associations of PWD, projects and programmes in place to provide assistance to PWD, traditional perceptions of persons with disability and constraints to integration of PWD.

2.2 Overview of National Policies and Programmes Targeting Persons with Disability

Ghana is a signatory to a number of international agreements that seek to make provisions that safeguard the rights of PWD. Notable are the UN Convention on the Rights of Persons with Disability, 2006 and the African Charter on Human and People's Rights and the African Decade of the Disabled 2000-2009. Following that, a number of policies and programmes have been put in place at the national level targeting and including the needs of PWD, either separately or across different sectors. They include the Fourth Republican Constitution of 1992, Persons with Disability Act, 2006, the Children Act 1998, the Labour Act, 2003 and the National Disability Policy, 2000.

The fourth republican constitution of 1992

The 1992 Constitution of the Republic of Ghana makes provision for the fundamental human rights of all Ghanaians. Article 29 of the 1992 Constitution specifically imposed an obligation on Parliament to legislate laws to protect and promote the rights of persons with disability (PWD).

The Constitution makes provision for the rights of PWD including the right to live a decent life with their families or foster parents and to participate fully in social and recreational activities. The Constitution further guarantees the rights of PWD against all forms of exploitation, discriminatory or abusive regulations of all kinds. The constitution also preserves the right of PWD to uninterrupted access to all public places. Some special incentives such as tax exemptions are also guaranteed for PWD engaged in business and employers who employ PWD.

Although the 1992 Constitution of the Republic of Ghana specifically imposed an obligation on Parliament to legislate laws to protect and promote the rights of PWD, this obligation was however not discharged for various reasons until 14 years later in 2006 when the Disability Act (Act 715) was passed.

The national disability policy 2000

The National Disability Policy 2000 document is targeted at addressing the needs of PWD. The policy seeks to ensure that PWD receive the appropriate training, adequate technical aides and necessary support services in order to increase their capacity to deal with tasks and challenges of life in a dignified manner.

The goal of the National Disability Policy is to ensure that by 2020 PWD are found actively participating in the national development process through equalization of opportunities that will improve the quality of life of PWD. The policy also aims at creating awareness among the general public about according equal respect to PWD in society. Due to the lack of appropriate legal backing, the policy has not been able to achieve much of the objectives set in the policy documents. That notwithstanding, the National Disability Policy paved the way for the passage of the Disability Act 2006 (Act 715). A number of the issues stipulated in the Disability Act 2006 were adopted from the National Disability policy.

The disability act 2006 (Act 715)

Six years after the adoption of the National Disability Policy, the disability Act (Act 715) was passed by Parliament in 2006 following relentless lobbying and advocacy by civil society

organizations. The Act gives a great deal of power to PWD, civil society organizations and Ghanaian people in general, to engage the government through advocacy, lobbying, and political pressure to make government and other duty-bearers in the law act accordingly. The Act has eight major sections all aimed at advancing the course of PWD in the country. Section one of the act provides for the rights of PWD, section two focuses on employment, section three looks at education for PWD, section four concentrates on transportation and five on health. The sixth section of the Act focuses on miscellaneous provisions while the seventh and eighth sections talk about the establishment of the National Council for Disability and its administrative and financial provisions.

The Act established the National Council on Persons with Disability. The council is made up of a multi-faceted forum comprising key state agencies and representatives from civil society organizations charged with the responsibility of proposing and evolving policies and strategies to enable PWD enter and actively participate in the mainstream of the national development process of Ghana. The Council, which was officially inaugurated in 2009, is supposed to coordinate overall disability related activities in Ghana and function as an advisor to the government on disability issues. The council is mandated to act as a watchdog and monitor the implementation of the Disability Act.

2.3 Appraisal of Specialized Institutions in Place for Persons with Disability

There are a number of both government and non-governmental organizations (NGO) and agencies in Ghana dealing with the issues of PWD. Through their efforts a number of specialized institutions have been set up mainly to provide services to PWD aimed at offering training and rehabilitations to PWD. The Ministry of Education has a Special Education Division responsible for these specialised institutions among which are schools for the deaf, the blind and a number of vocational training centres for PWD.

There are more than ten primary schools for the deaf. However, there is only one secondary school for the deaf at Mampong in the Ashanti Region, which admit about 250 students a year. There are two schools in Ghana for the blind, one located in Wa in the Upper West Region and the other in Akropong in the Eastern Region. In line with policy, some strides have been made to integrate blind persons in the normal school system. Hence, a number of schools are provided with special support for this purpose. The ministry of Education also runs three assessment centres, seven regional mobile centres for children with learning difficulties and other development problems and nine schools for the mentally disabled.

In addition, there are about 38 National Vocational Training (rehabilitation) centres situated throughout the country. The one in Biruwa, near Cape Coast accepts mostly men at the boarding facility and trains approximately 45 PWD a year in vocational skills. The other 37 centres accept only persons with minor disabilities. To be accepted at a centre, Junior High School graduation is required and a fee must be paid. However, an application can be made to the local District Assembly for a fee waiver for PWD.

The University of Winneba has dedicated a whole Division to Special Education. This gives trained teachers the opportunity to supplement their training in special education. The idea is to increase the number of qualified persons working at rehabilitation centres or public schools with a number of disabled students. However, only few teachers take up this supplementary training in special education.

Apart from such institutions at the government level, some NGOs also have programmes for training of PWD. Among some of these programmes are the computer- training centre of the Ghana Society for the Blind, the boarding school for mentally disabled in Echoing Hills and the Autism Awareness Care and Training Centre provides training for autistic children.

Ghana Education Service and Voluntary Service Overseas (VSO) are working together in a project for the assessment of children with disabilities. The plan is to train assessment officers further to enhance their capacity. Plans are also underway to train educators and parents to communicate in sign language, train more sign language interpreters, and develop a sign language dictionary to help improve communication for the deaf.

2.4 Measures in Place to Fight Against Disabling Diseases

Diseases contribute significantly to disability. However, many of the diseases that result in disability are preventable. The Ministry of Health (MOH) and other partner organizations have instituted a number of programmes and are working through the primary health care system to prevent and fight against both infections and chronic disabling diseases. These programmes include the Expanded programme on Immunization (EPI), the Ghana National Neglected Tropical Diseases (NTD), the National Buruli Ulcer Control programme, the Regenerative Health and Nutrition programme among others.

Expanded programme on immunization (EPI)

Ghana launched the Expanded Programme on Immunization (EPI) in June 1978 with six antigens – BCG, measles, diphtheria-pertussis-tetanus (DPT) and oral polio for children under one year of age together with tetanus toxoid (TT) vaccination for pregnant women. The launch was in response to the national health policy to reduce morbidity (including disability) and mortality of vaccine preventable diseases which then contributed significantly to both infant and child mortality in the country. It was also in consonance with the immunization policy of the government which sought to ensure that all children receive these vaccines before their first birthday of life (MOH, n.d).

The EPI has over the decades contributed immensely to the prevention of disabling diseases. A key component of the EPI programme aimed at preventing disability is the Polio Eradication Initiative (PEI). Poliomyelitis is a disease which affects the limbs of the child often leading to physical disability. The PEI was also introduced in 1996 with National Immunization Days (NIDs) and Sub-national Immunization Days (SNIDs) set aside yearly for the nationwide administration of the oral polio vaccine to under five year olds. In order to strengthen the PEI, weekly updates on Acute Flaccid Paralysis (AFP) surveillance are undertaken. Huge successes have been achieved with the PEI.

No wild polio virus was found in the country from September 2003 until September 2008 when Ghana suffered another setback after 2003 with 8 cases of wild poliovirus reported in the Northern Region. Series of house-to-house polio outbreak response campaigns have been conducted to break transmission of the virus in the country and the outcome of the campaigns is positive (MOH, n.d).

The Ghana national neglected tropical diseases (NTD)

Trachoma, Lymphatic Filariases, Onchocerciasis, Schistosomiasis and Soil-transmitted Helminths are the five out of the thirteen neglected tropical diseases causing severe health problem in Ghana (MOH & GHS, n.d). These ancient diseases are of public health

significance and are geographically located in all ten regions of Ghana. Except schistosomiasis, the others often lead to disabilities if left untreated. For instance,

Trachoma which is a recurrent infection of the upper eyelid conjunctiva with the *Chlamydia trachomatis* organism often results in visual loss. Lymphatic filariases, also known as elephantiasis causes enlargement of the entire leg or arm, the genitals, vulva and breast and can result in physical disability in the affected person. Microfilaria invasion of the eyes resulting from Onchocerciasis leads to various eye lesions with associated visual impairment. The end stage of onchocercal eye lesions is blindness which can occur as early as the age of 20 years (MOH & GHS, n.d).

To prevent the suffering and disabling effects of these neglected tropical diseases, Ghana Neglected Tropical Disease Control Programme (NTD) was initiated in 2006. The overall goal of the NTD programme is to prevent, control, eliminate or eradicate these NTDs by 2015. All five (5) diseases - Trachoma, Lymphatic Filariases, Onchocerciasis, Schistosomiasis and Soil-transmitted Helminths - rely on preventive chemotherapy and use Mass Drug Administration (MDA) as the main control strategy. The programme implemented its first round of MDA in 2007 after the re-structure, where Azithromycin was given for the treatment of Trachoma in endemic regions.

This was followed two weeks later with the distribution of Albendazole and Ivermectin to manage Onchocerciasis, Lymphatic Filariasis and Soil Transmitted Helminths (GHS, 2008). The integrated NTD programme has completed 5 years of its implementation activities since its inception in 2006. An impact survey conducted with support from several partners in 2009 confirmed the achievement of the ultimate intervention goal for active trachoma in Ghana. A transmission assessment survey (TAS) for Lymphatic Filariases confirmed interrupted transmission in four districts in the Central Region. As a result, the last round of Lymphatic Filariases MDA in these districts was completed in 2011 (RTI, 2012)

The national buruli ulcer control programme

The Ghana National Buruli Ulcer Control Programme was initiated after the disease was first brought to public attention in Ghana in 1993 when severe cases were reported from the Amansie West district of Ashanti Region (MOH, 2004). The disease is caused by *Mycobacterium ulcerans* (MU) infection. The infection affects the skin, subcutaneous tissue, and sometimes the bone. It starts with a painless nodules or papule in the skin and, without appropriate therapy, causes massive skin ulceration and fibrosis, scarring, calcification, and contractures after which permanent disabilities may result (Stienstra et al., 2001).

Patients tend to report to the hospital late in the development of the disease due to local perceptions about the disease. The result is that patients present it at the hospital when the disease is advanced to a stage where amputation is the only reasonable treatment option available.

For this reason, the National Buruli Ulcer Control Programme has over the years focused on health education on early identification and reporting, avoidance of contact with marshy environment, and polluted water bodies, (MOH, 2004). Other measures taken under the control programme include training of community-based agents (school teachers, herbalists and chemical sellers) on suspecting and reporting buruli ulcer, training of health workers on diagnosis, use of combination therapy, specimen collection and transportation, wound care, surgery and prevention of disability.

Regenerative health and nutrition programme

The Ministry of Health (MOH) in Ghana as part of its effort to reduce the incidence of preventable diseases and to promote regenerative health in the country adopted the concept of “Regenerative Health and Nutrition (RHN)”. The programme was adopted in 2005 and piloted in 2006, with the main objective of promoting healthy lifestyles, dietary practices and mother and child care practices that would help eliminate the many diseases that impact on the health and well-being of Ghanaians (MOH, 2007).

One key objective of the programme is to help fight the increasing incidence and prevalence of non-communicable diseases such as hypertension, stroke, diabetes, cancer and other chronic non-communicable diseases from Ghanaian communities. These diseases are linked to unhealthy lifestyle behaviours particularly poor dietary practices, physical inactivity and smoking (Tagoe & Dake, 2011). Many of these diseases are preventable with lifestyle modification. However, without timely and proper management, they often can lead to limited functionality or permanent disability. For example, it is estimated that 15-25% of diagnosed diabetic patients worldwide will develop foot ulceration in their lifetime and may require limb or life-saving lower extremity amputation (Chin et al., 2012).

The RHN programme therefore, is a way of responding to the high incidence of non-communicable diseases which can have disabling effect on affected persons and also a way of improving the outcomes of such diseases. The programme covers three main modules; (a) mother and child care (b) healthy lifestyle and (c) regenerative nutrition. Key interventions under the program are geared towards; healthy diet (increasing consumption of fruits and vegetables, drinking more water, reducing the intake of meat, salt and saturated oils/fats, reducing or eliminating smoking and alcohol intake); exercise (increasing daily physical activity including cardiovascular exercise); rest (adopting regular relaxation practices to minimize physical and emotional stress) and environmental sanitation (MOH, 2007).

In addition, the programme trains change agents and advocates in the principles and practices of RHN and they in turn educate their community members. Through this initiative, over 50,000 change agents and advocates were trained throughout the country between 2006 and 2010. Mass communication through the use of both print and electronic media serves as a means of reaching the population with the messages of the program (Tagoe & Dake, 2011).

2.5 Associations of Persons with Disability

The disability movement in Ghana has seen some evolution over the decades. The disability movement in Ghana started before 1963 with special institutions for the disabled and charitable organisations for the disabled, often founded by expatriates with true social involvement. By 1963 the disabled themselves established self-help groups through which they could express their concerns, needs and aspirations. The situation resembles that of many other countries where organisations of blind and deaf persons were started by students at special schools.

With increased national and international activity in the disability movement and formulation of basic principles, and human rights oriented declarations and policies in the early 1980s, there was a shift from advocacy towards a blend of advocacy and service delivery (The Danish Council of Organizations of Disabled People, 2007). In 1987, the first umbrella body - Federation of Disability Associations (FODA) – for all the disabled groups was established with support from the Norwegian Association of the Disabled (NAD) and Disabled People’s

International (DPI). The name was later changed to Ghana Federation of Disabled People (GFD) (The Danish Council of Organizations of Disabled People, 2007).

Ghana federation of the disabled

Ghana Federation of the Disabled (GFD) was established in 1987 as a national umbrella organization of PWD. Its current membership include the Ghana Society of the Physically Disabled (GSPD), Ghana Association of the Blind (GAB), Ghana National Association of the Deaf (GNAD), Parents Association of Children with Intellectual Disability (PACID), Society of Albinos Ghana (SOAG) and Share Care Ghana – an organization of people with neurological difficulties (Slikker, 2009).

GFD started with a branch in Accra, but was faced with complains from its member organizations in 2007 and 2008 about the incapability of GFD to fulfill its role as an umbrella organization due to its focus on international policies and activities. Its members argued that the GFD lacked awareness of the problems that PWD face at grass root level as a result of its concentration on international policy issues concerning PWD. GFD acknowledged this problem and is currently embarking on a decentralization process. GFD now has about 20 district branches (Slikker, 2009).

GFD provides a common platform for Organization of Persons with Disabilities (OPWD) and coordinates the Ghana National Disability Network, a forum of organizations, institutions and individuals working in the area of disability to promote the rights of PWD at policy levels. The mission of GFD is to create awareness about the capacities and capabilities of PWD and to promote the equalization of opportunities of PWD through advocacy, lobbying and collaboration with other relevant agencies. To that extent, GFD educates executives of Ministries, Departments and government agencies about the Disability Law and other issues concerning disability. GFD tries to empower its members at district level to enable them take advantage of the opportunities available at all levels for PWD.

Ghana association of the blind (GAD)

Historically, the GAB originally started with the establishment of a sheltered workshop for the blind at Mangoase in the Eastern Region of Ghana. The workshop was set up by the Ghana Society for the Blind in the late 1950s. The students at this workshop founded the organisation in 1963 (The Danish Council of Organizations of Disabled People, 2007). Its mission is to advocate for the blind, and work for their total integration into society through the development of services in education, rehabilitation, awareness creation and the promotion of the rights of women, youth and children.

GAB raises public awareness about the need for inclusion of people with visual impairments in the society; encourages parents to send their children to school; sponsors children with a visual impairment to go to school; and engages the civil society. Besides these activities GAB also educates people with visual impairment about their rights and encourages them to accept their disability and to use their potentials, organises workshops for members on how to face the challenges of their disability and to sharpen their leadership skills and trains female members in empowerment, assertiveness, vocational and leadership skills among others.

Ghana national association of the deaf (GNAD)

The GNAD has a vision to work for an active and productive deaf community ensuring access to education, information, and steady economic activities that can sustain and maintain quality and security of life. Its mission is to mobilize members, remove communication barriers, create awareness on deaf issues, and advocate for equal opportunities for the deaf. People with hearing impairments face an extra challenge in advocating for their own rights due to the communication barrier (Slikker, 2009). Lobbying and advocacy often depends on communication which comes as a major challenge. Persons with hearing impairments always require an interpreter to communicate, but there is a huge lack of interpreters in Ghana. The communication barrier further complicates their cooperation with other OPWD.

GNAD encourages self-employment for the hearing impaired and embarks on income generating activities like batik, crop farming and citrus farming. GNAD organizes workshops for its members to empower them to realize that they are capable of doing everything a person without a disability can do. It also encourages people with a hearing impairment to aim at higher levels of the educational ladder so as to serve as role models for others. GNAD educates the public and parents about causes and prevention of deafness and the capabilities of people with hearing impairments.

Ghana society of the physically disabled (GSPD)

GSPD was founded in 1980 with the vision to empower the physically disabled so they are productive and contribute positively to society. It promotes the welfare of its members by creating awareness of the capacities and capabilities of persons with physical disabilities through advocacy and by lobbying for their rights (Slikker, 2009). In an effort to contribute positively to national development the GSPD set up a chalk factory where persons with physical disabilities can work. GSPD also organizes cultural activities and sports tournaments for the physically disabled.

Like the other OPWD, GSPD has awareness-raising programs for the general public about the capacities, needs and rights of PWD and the challenges they meet in terms of health, education and employment. GSPD also offers a training program for its members to learn leadership skills to enhance their capacity to manage, advocate and lobby for their own rights.

Parents association of children with intellectual disability (PACID)

The PACID was established in September 2001 to give support to the many parents and guardians of children having an intellectual disability in Ghana and also to advocate for policies and programmes that will serve their interest. PACID is made up of parents, guardians, teachers, doctors and other professionals throughout Ghana. The PACID aims mainly to spread education, awareness and good news about children with intellectual disability.

The PACID has a small office in Ho, Ghana, which is focused on organizing and supporting parents and educating them on how to take care of children with intellectual disability. Mothers are taught how to train their children in eating, bathing and getting dressed so that these children will be able to do things by themselves. PACID also encourages parents to bring such children out of hiding and gives education in communities and churches about intellectual disabilities.

2.6 Projects and Programmes to Provide Assistance to Persons with Disability

Persons with Disabilities need support and assistance to be able to improve upon their wellbeing and participate in social and economic life on equal basis with others. A number of projects and programmes have been put in place by both governmental and non-governmental organizations to provide support and assistance to PWD in Ghana. Some of these programmes include the Livelihood Empowerment against Poverty, Local Enterprises and Skill Development Programme (LESDEP), District Assembly Common Fund (DACF), and the national Community Based Rehabilitation (CBR) programme.

Livelihood empowerment against poverty (Leap)

The Ghana Livelihood Empowerment Against Poverty (LEAP) cash transfer programme is the Government of Ghana's flagship programme under the Ghana National Social Policy Strategy (NSPS). Launched in 2008, the LEAP programme aims to 'empower' the poor by enhancing their capacity to access government interventions and enabling them to 'LEAP out of poverty' (FAO, 2013). Department of Social Welfare (DSW) under the then Ministry of Employment and Social Welfare (MESW) is the main implementing institution of the LEAP programme and targets extremely poor households with elderly, disabled persons or Orphans and Vulnerable Children (OVCs).

Through the LEAP programme, a number of PWD who were languishing in poverty are currently benefitting from LEAP transfers every two months through a local pay point. In addition to the provision of cash, LEAP promotes an 'integrated social development approach' with the objective of linking beneficiaries with complementary services. For instance, a Memorandum of Understanding has been signed between the MESW and the health, education and agriculture ministries to provide free access to the National Health Insurance Scheme (NHIS), free school uniforms and access to agriculture support. There are also plans to set up micro-credit schemes as complementary service for LEAP beneficiaries.

The programme ensures that PWD as well as people over 65 years receive unconditional LEAP transfers. On the other hand, OVC 'caretakers' must adhere to certain conditionalities such as enrolment and retention of school-age children in school; birth registration of new born babies and their attendance at postnatal clinics; full vaccination of children up to the age of five; and non-trafficking of children and their non-involvement in the 'worst forms of child labour' before they can receive the LEAP transfer. The number of beneficiary households of the LEAP programme has grown from 1,654 in 21 districts to over 70,000 across 100 districts nationwide (FAO, 2013).

Local enterprises and skill development programme (LESDEP)

Under the Government's Local Enterprise and Skills Development Programme (LESDEP), PWD are being empowered through training in skills and are being supported with equipment and machinery. LESDEP is a public – private partnership programme under the auspices of the Ministry of Local Government and Rural Development that creates and facilitates the acquisition of technical, entrepreneurial skills and other specialized skills aimed at promoting the creation and management of businesses by the unemployed, especially the youth.

This initiative has helped in providing opportunities for PWD who otherwise would be unemployed and without any skills. Through a specialized hands-on training module,

LESDEP has trained disabled persons to acquire viable skills to make them self-employed within the shortest possible time in their localities.

A number of PWD have been trained in ICT, fashion, beauty Care, transport, décor management, photography, mobile phone repairs, local foods and catering, local garment and fashion designing, kente weaving, among others. Apart from the training equipment such as computer and mobile phone repair kits, hand sewing and embroidery machines, ovens and multi-purpose tricycles, funds are provided to enable them set up their own businesses.

District assembly common fund (DACF)

In 2009, new guidelines were released by the government of Ghana for the unitization of the District Assembly Common Fund (DACF). According to the guidelines, three percent of the DACF allocations to MMDAs are to be used to assist the activities of PWD, especially those outside the formal sector. This is aimed at minimizing poverty among all PWD and enhancing their social image through dignified labour. However, most local people do not know that there is an allocation made to cater for the needs of PWD. The local people see the support provided by the District Assembly to the PWD as a privilege to the PWD and not a right (Ahiabor, 2013). This being the case, PWD are not empowered to insist that these funds be utilized to their full benefit.

The DACF was originally established in 1993 to give the Metropolitan, Municipal and District Assemblies (MMDAs) financial autonomy to actually make decisions at the local level of governance. In accordance with Article 252 of the 1992 Constitution, subject to the provision of this Constitution, Parliament shall annually make provision for the allocation of not less than 5% of the total revenue of Ghana to the District Assemblies for development; and the amount shall be paid into the DACF in quarterly installment. The purpose of this fund was to facilitate developmental activities at the grassroots and to execute the political agenda of the government.

The DACF has since been instrumental in various attempts poverty through implementation of developmental programmes and projects MMDAs (Fynn, 2011). The three per cent share of DACF earmarked to assist PWD can go a long way to alleviate some of the challenges PWD face, particularly marginalisation, poverty and unemployment. However, there are some constraints in terms of access to the two percent allocation to PWD. For example, most of the local people including PWD are not aware of such an allocation made for the needs of PWD. Also those aware are unable to access the allocation due to institutional setbacks at MMDAs.

The national community based rehabilitation programme (CBR)

The Government of Ghana initiated a national CBR programme for PWD in 1992. The general purpose of the CBR programme was to improve the quality of life of PWD by promoting their rights, establishing links to service providers, and strengthening disabled persons organizations (DPO).

The programme was implemented on a pilot bases in 10 administrative districts using a combined National Management Team that included the then Ministry of Employment and Social Welfare, the Ministry of Education, and the Ministry of Health. By 1994 the number of pilot districts was expanded to 20. Funding for the program was provided by the Norwegian Association of the Disabled (NAD) and the Swedish Handicap Organization from 1992 to 1999. Financial support also came from the United Nations Development Programme

(UNDP) to expand the projected national coverage of CBR from 1999 to 2002 (Kuyini et al., 2011).

The CBR programme was to provide home-based rehabilitation services, delivered by family members of PWD, with the support of trained volunteer local supervisors. Each community was expected to mobilize local community resources to support and sustain the CBR programme activities. National participatory evaluations of the Ghana CBR programme in the past have indicated positive results in the direction of the program's objectives (O'Toole et al., 1996; Tamm & NAD, 2000). The reports highlighted both the successful establishment of CBR structures and the implementation of rehabilitation activities.

However, sustainability of the programme has been a major challenge since the withdrawal of donor funding (Kuyini et al., 2011). Further, most of the vocational training provided by the CBR programme to PWD is focused on outmoded rural crafts which have no market in these modern times. Though there has been the recent introduction of modern skills like catering, the necessary training materials and tools are lacking (Slikker, 2009).

In an effort to ensure that CBR did not become one of the many donor-supported projects that collapsed when external funds ceased to flow, the Government of Ghana accepted the recommendations of CBR programme management to decentralise the management to district assemblies. Although the MMDAs are to be the principal structure of administration and financing of CBR, budget constraints at that level have affected funding for CBR in the districts.

2.7 Traditional Perceptions of Persons with Disability

A huge part of the reason why PWD in Ghana continue to suffer stigma, marginalization and discrimination is the societal perceptions and myths about PWD. These misperceptions and myths are traditionally rooted in superstition and the cultural belief systems to the extent that disability is believed to be a curse or punishment for sins committed either by the PWD, parents of the PWD, or one of his or her ancestors (UNDP, 2007).

In the Ghanaian society, pregnancy and birth are highly regarded as a blessing and are characterized with high expectations. There is no reason a family can give to explain why a child is born with a disability except that the anger of the gods has been visited on them. Avoke (2002) reports that in many communities in Ghana, children born with intellectual disabilities were generally believed to be 'children of the rivers and forest'. Such children were returned to the forest or to the rivers under the guise of helping them 'to go back to where they came from' (p.773).

In typical traditional communities, crocodiles, and snakes are considered to have some special powers and any cruelty against them can lead to the individual giving birth to a child with disability. Avoke (2002) explains further that pejorative labels and unkind treatment were meted out to people with disabilities and that these were justified by the strong belief that disability was the result of curse placed on an individual by the gods, for committing offences in the community or against the gods.

Others view disability in Ghana as a result of witchcraft, sorcery, 'juju' and magic (Agbenyega, 2003). Hence, many people also believe that parents can exchange any part of the child's body spiritually, with money such that the part so exchanged will become defective. For this reason, rich families in which there are disabled persons in Ghana are viewed with mixed feelings and are labelled "sikaduro" (juju money).

In some Ghanaian communities, people with epilepsy are believed to be filled with demons that sometimes torment them in the form of seizures and fits (Agbenyega, 2003). For example among the Ewes persons with epilepsy are labeled ‘dzeanyikplatowo,’ derogatory tribal language which literally means ‘falling down sicknesses’ and no one is allowed to touch or be near them when seizures occur, in the belief that anyone who does so will also be possessed by the demons and will become epileptic. According to Dogbe (1995), in some parts of the Volta and Northern Regions of Ghana, certain eye disease are believed to be a punishment from the gods for offences the victims or their family members have committed.

2.8 Constraints to Integration of Persons with Disability

Some positive strides have been made in ensuring the inclusion and integration of PWD in Ghana. However, the basic rights of PWD in Ghana continue to be grossly violated and opportunities for social interaction, education, medical care have been denied. The major obstacles to the integration and inclusion of PWD in all spheres of life in the Ghanaian society can broadly be categorized into two; socio-cultural and institutional factors.

Various cultural, social and religious belief systems have interacted to shape the perceptions of Ghanaians about disability in general and this is reflected in their attitudes and behaviours towards PWD. Superstitious connotations such as curses or punishments for sins committed either by the PWD, parents of PWD, or one of his or her ancestors are ascribed to PWD (UNDP, 2007). Hence, the focus traditionally has been on finding explanations and obviating the curses of disabled persons rather than improving their living conditions. The result therefore is the marginalization, discrimination and exclusion of PWD.

The disability movement, civil society organization and the government have taken various positive steps by formulating laws and policies to ensure the promotion and protection of the human rights of Ghanaians including persons with disability. They include the passage of the persons with disability bill into the persons with disability Act 2006 (Act 715) mental health Act among others. However, there continue to be weaknesses at the institutional level thereby preventing the full implementation of measures to ensure that PWD enjoy all the provisions and benefits made for them.

Thus many PWD continue to face marginalization and discrimination, thereby slowing the process of ensuring the integration of PWD. For example, the legislative instrument for the disability Act 715 is yet to be developed since the passage of the Act in 2006. The Act states that PWD are to enjoy free education, and those in self-employment special incentives. Some of the provisions in the Act for PWD cover employment, education, health care, transportation among others. However, without the legislative instrument PWD cannot have full access to some of the benefits provided under the law.

In addition GFD and the OPWD are weak due to their poor infrastructure, poor information and documentation systems, and lack in human resource capacity. There is also poor coordination between and among the OPWD in terms of planning of programmes, lobbying and advocacy initiatives. Things are improving gradually but efforts should be geared towards communication and sharing of information.

The socio-cultural constrains, coupled with piecemeal approach to legislation and policy implementation is hindering progress towards integration of PWD. There is the need for greater education and campaign on disability issues, as well as the fast-tracking of legislation and policy to facilitate the inclusion of PWD in the national development agenda.

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CHAPTER THREE

PROFILE OF PERSONS WITH DISABILITY

3.1 Introduction

Article 12(2) of the 1992 Constitution of the Republic of Ghana guarantees the fundamental human rights and freedoms of the individual including persons with disability (PWD). Article 29 of the Constitution spells out the rights of PWD. In pursuance of the constitutional provisions of the Republic, a National Disability Policy was formulated in 2000 and the Disability Act (Act 715) was enacted in 2006.

Subsequently, there have been a number of projects and programmes targeting PWD. PWD are however confronted with numerous challenges including low self-esteem, limited mobility, high dependency and poverty, lack of access to education, health care and other social services (WHO, 2011). In Ghana, persons who are unable to or are restricted in the performance of specific tasks/activities due to loss of function of some part of the body as a result of impairment or malformation are classified as PWD (GSS, 2012). Understanding the profile of PWD is essential in designing and implementing interventions to address their challenges.

3.2 Sex Composition of Persons with Disability

Three percent of Ghanaians are classified as PWD as shown in Table 3.1. Generally, the percentage of females (3.1%) with disability is slightly higher than males (2.9%). There are more PWD in the rural areas compared to the urban centres. Sight/visual impairment accounted for 40.1% of disabilities followed by physical disability (25.4%). Speech impairment accounted for the lowest percentage (13.7%).

Table 3.1: Distribution of disability by sex and type of locality

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

Source: Ghana Statistical Service, 2010 Population and Housing Census

3.3 Age Distribution of Persons with Disability

The 65 years and above age group accounts for the highest percentage (22.2%) of PWD (Table 3.2). All the other age groups account for less than 10% each. For instance, PWD aged 15-19 and 55-59 constitute 6.9% and 4.7% respectively. There are no discernable differences in the percentage distribution of PWD by sex and type of locality.

Table 3.2: Age distribution of PWD by sex and type of locality

Age Group	Total (N=737,743)			Male (N=350,096)			Female (N=387,647)		
	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
0 - 4	5.6	5	6.2	6.2	5.7	6.6	5.2	4.4	5.8
5 - 9	6	5.1	6.7	6.8	5.9	7.5	5.3	4.5	6
10 -14	6.4	6	6.7	7.1	6.4	7.6	5.8	5.5	6
15 - 19	6.9	7.1	6.6	7.2	7.3	7.2	6.5	7	6.1
20 - 24	6.6	7.5	5.8	6.7	7.6	5.9	6.5	7.4	5.7
25 - 29	6.5	7.3	5.7	6.5	7.6	5.7	6.4	7.1	5.7
30 - 34	6	6.6	5.5	6.2	7.1	5.5	5.8	6.2	5.4
35 - 39	5.8	6.1	5.5	5.9	6.3	5.6	5.6	5.9	5.4
40 - 44	6	6.2	5.8	6	6.2	5.9	6	6.2	5.8
45 - 49	5.8	6.1	5.6	5.9	6	5.8	5.8	6.1	5.5
50 - 54	6.4	6.4	6.3	6.3	6.3	6.3	6.4	6.5	6.3
55 - 59	4.7	5	4.4	4.8	5.1	4.5	4.6	5	4.3
60 - 64	5.3	5.1	5.4	5.2	5.1	5.3	5.4	5.1	5.6
65 +	22.2	20.4	23.6	19.2	17.4	20.7	24.8	23	26.5

Source: Ghana Statistical Service, 2010 Population and Housing Census

3.4 Marital Status of Persons with Disability

About four out of 10 persons aged 12 years and older with disability are married and 27.3 percent are never married (Table 3.3). The percentage of persons with disability who are married varies by sex and residence. Forty-seven percent of males and 34.4% of females are married. Generally, the percentage of married PWD is higher in the rural areas than in the urban centres. For instance, 49% of males in rural areas are married compared to 44.3% of the urban residents.

Table 3.3: Marital status of PWD 12 years and older by sex and type of locality

Marital Status	Total (N=638,718)			Male (N=294,494)			Female (N=338,224)		
	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
Never married	27.3	30.7	24.2	34.1	37.4	31.3	21.3	25.2	17.8
Informal/consensual union/living together	4.4	4.6	4.2	4.2	4.5	3.9	4.5	4.6	4.4
Married	40.3	37.5	42.7	47	44.3	49.4	34.4	32	36.6
Separated	3.4	3.6	3.3	2.9	3	2.9	3.8	4.1	3.6
Divorced	7.8	7.8	7.9	6.4	5.9	6.8	9.1	9.3	8.9
Widowed	16.8	15.8	17.8	5.4	4.9	5.8	26.8	24.8	28.7

Source: Ghana Statistical Service, 2010 Population and Housing Census

3.5 Educational Level of Persons with Disability

Four in 10 PWD aged 3 years and older have no formal education (Table 3.4) whilst 17.4% have had primary school education. The educational levels differ by sex and residence. The percentage of the females with no formal education is higher than males among both urban and rural dwellers. Majority of females (58.3%) with disability in the rural areas have no formal education compared with 40.7% of their male counterparts.

Table 3.4: Educational level of PWD 3 years + by sex and type of locality

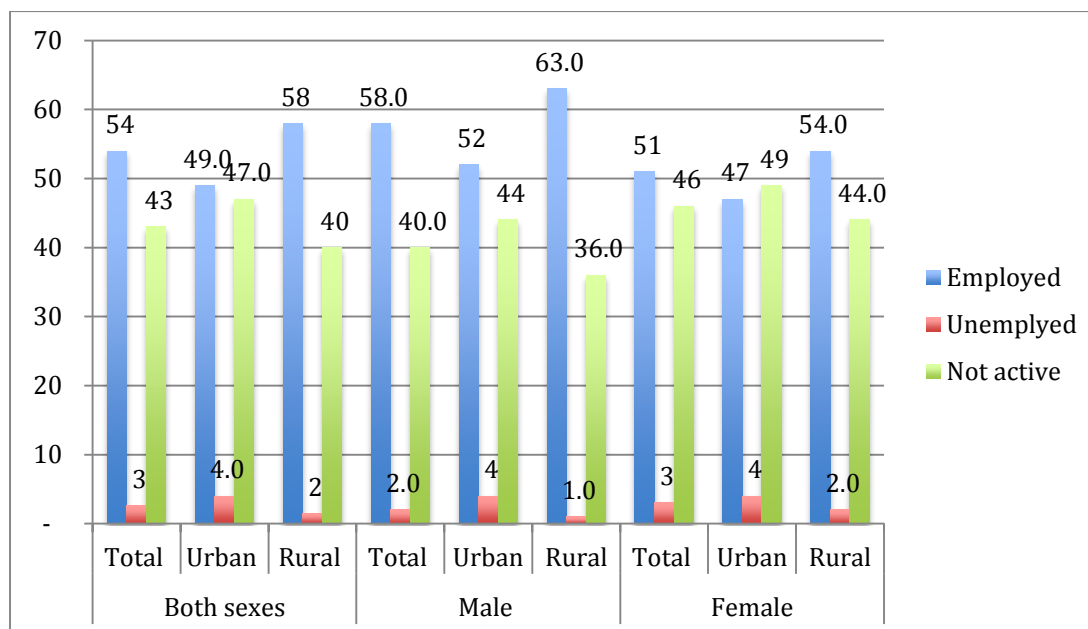
Type of Education	Total (N=713,400)			Male (N=337,543)			Female (N=375,857)		
	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
Never attended	40.1	28.9	49.8	31.5	20.1	40.7	47.9	36.4	58.3
Nursery	1.3	1.2	1.4	1.5	1.4	1.5	1.2	1.1	1.3
Kindergarten	2.1	1.9	2.2	2.3	2.2	2.4	1.8	1.6	2
Primary	17.4	16.5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

Source: Ghana Statistical Service, 2010 Population and Housing Census

3.6 Economic activity Status of Persons with Disability

Majority (54.1%) of PWD aged 15 years and older are employed and three percent are unemployed (Figure 3.1). The percentages differ by sex and residence even though the patterns are similar. The percentage employed is higher among males (52%) than females (47%). The percentage of PWD in rural areas employed is higher than those in urban centres for both males and females.

Figure 3.1: Economic activity status of PWD 15 years and older by sex and type of locality



Source: Ghana Statistical Service, 2010 Population and Housing Census

3.7 Region of Persons with Disability

Ashanti and the Upper West Regions have the highest (16.9) and the lowest (3.5) percentages of persons with disability in Ghana respectively (Table 3.5). The pattern of percentage distribution among males and females is similar even though the values are different. There are differences in the distribution of persons with disability in the urban and rural areas. Greater Accra Region registered the highest (27.5%) among the urban communities whilst the Volta Region registered the highest (16.6%) in the rural areas. Upper West Region registered the lowest percentage of persons with disability in the urban and the rural areas.

Table 3.5: Region of PWD by sex and type of locality

Type of locality	Total (737,743)			Male (N=350,096)			Female (N=387,647)		
	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
Western	8.9	7.9	9.8	9.3	8.1	10.3	8.6	7.7	9.4
Central	10.3	9.3	11.2	9.8	8.8	10.6	10.7	9.6	11.7
Greater Accra	14.1	27.7	2.4	14	28.4	2.4	14.1	27.2	2.5
Volta	12.4	7.6	16.6	11.8	7.4	15.4	13	7.8	17.7
Eastern	12.8	11.8	13.7	12.6	11.3	13.6	13	12.3	13.7
Ashanti	16.9	21.2	13.2	16.6	20.9	13.1	17.1	21.5	13.2
Brong Ahafo	7.3	6.9	7.7	7.7	6.9	8.3	7	6.8	7.1
Northern	8.3	4.8	11.3	8.9	5.2	11.9	7.8	4.4	10.7
Upper East	5.4	1.7	8.5	5.6	1.8	8.6	5.2	1.7	8.4
Upper West	3.5	1.1	5.6	3.7	1.1	5.7	3.3	1	5.4

Source: Ghana Statistical Service, 2010 Population and Housing Census

3.8 Ethnic Composition of Persons with Disability

As shown in Table 3.6 the Akan ethnic group accounted for 46.5% of all disabilities followed by the Ewes (16.7%). Mande and all other ethnic groups constituted 1% and 1.1% of PWD respectively. Majority (53.3%) of PWD in the urban centres were Akans. Among PWD in the rural areas however, the Akans were 40.8% followed by the Mole-Dagbani ethnic group. The distribution of PWD by sex in the urban and rural areas shows similar patterns (Table 3.6).

Table 3.6: Ethnic composition of PWD by sex and type of locality

Ethnicity	Total (713,172)			Male (N337, 505)			Female (N=375, 667)		
	Total	Urban	Rural	Total	Urban	Rural	Total	Urban	Rural
Akan	46.5	53.3	40.8	45	52.3	39.3	47.8	54.2	42.2
Ga-Adangbe	8.5	11.8	5.7	8.4	11.4	5.9	8.6	12.1	5.6
Ewe	16.7	14.6	18.4	16.4	14.8	17.8	16.9	14.5	19
Guan	3.9	3.6	4.2	3.9	3.6	4.1	4	3.6	4.3
Gurma	4.9	2.1	7.3	5.4	2.2	7.8	4.5	1.9	6.8
Mole-Dagbani	14.6	9.9	18.5	15.6	10.7	19.6	13.6	9.3	17.4
Grusi	2.8	1.9	3.6	3	2	3.8	2.6	1.8	3.3
Mande	1	1.2	0.9	1.1	1.3	1	0.9	1.1	0.8
Other tribes	1.1	1.6	0.8	1.2	1.7	0.8	1.1	1.5	0.7

Source: Ghana Statistical Service, 2010 Population and Housing Census

3.9 Religion of Persons with Disability

The Pentecostal/Charismatic religion accounted for 24% of all PWD, followed by the Protestants (20.4%). The patterns of distribution of religious affiliation of PWD by sex and type of locality are similar (Table 3.7).

Tables 3.7: Disability by religion, sex and type of locality

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

Source: Ghana Statistical Service, 2010 Population and Housing Census

3.10 Discussion

Three percent of Ghana's population of 24,658,823 people was found from the 2010 Ghana Population and Housing Census to have one type of disability or the other. Prior to this, the population of PWD in Ghana was estimated to be about two to three times higher (7-10%) (UNDP, 2007) than currently estimated from the 2010 Census. As found in South Africa, the results show that majority of PWD suffered from visual followed by physical disabilities. On the contrary, Wiman et al. (2002) estimated that of all disabilities in a developing country mobility accounts for the majority, followed by mental or learning (intellectual) impairment.

Disability in Ghana was found to be more common among females and rural residents. This is consistent with the 2011 world report on disability (WHO, 2011), as well as studies conducted in South Africa (SSA, 2005), Bangladesh (Titumir and Hossain, 2005) and Pakistan (Singal et al., 2009). As it is in most developing countries, females and rural residents in Ghana are disadvantaged in terms of access to education and health care services mainly for economic reasons, thereby increasing their exposure to health compromising behaviours and subsequent disability.

Women are especially faced with various forms of discrimination on account of cultural beliefs and practices that make them socially and financially dependent on the male members of the family for their needs (Naami et al., 2012). Those in rural localities are also more likely to be exposed to various infectious diseases, but are however less likely to have access to appropriate treatment due to the lack of health care services. Such diseases if left untreated may lead to various forms of impairment or disability.

Previous studies (Peng et al., 2010; Pascual & Canterero, 2007) have demonstrated that disability is strongly associated with ageing, mainly due to the deterioration of health that comes with ageing. The analysis reveals a huge gap in disability between all age groups and

those 65 years and older age group. For instance, whereas the percentages of PWD in all age groups were below 10%, those aged 65 and older accounted for 22.2%.

This finding reflects Ghana's rapidly increasing ageing population (Mba, 2004), but at the same time suggests a corresponding increase in the population of PWD disability in the coming years. Consequently, there is no doubt about the need for planning comprehensive health and social welfare services for the double burden of Ghana's disabled and ageing population. Whereas ageing is inherently inevitable, its disabling effects may be mitigated with the promotion of healthy life styles across all age groups.

Unlike many other parts of the world, marriage in Ghana is seen as an important marker of adulthood, rather than an option, and remains the most important social institution. Studies examining specific types of disabilities have found disability to be higher among those previously married (widowed, separated and divorced) compared to those married (Chong, et al., 2009; Varma et al., 2004). The data in this analysis revealed that majority of PWD were married. This is a positive sign, considering that PWD often require the assistance of others for their daily functioning. It is however not possible to determine from this current analysis whether such marriages preceded disabilities or the vice versa. This is probably an issue worth exploring.

Education is a right for all, including PWD. However, there are still a large number of children and youth who are prevented from attending school due to stigma and intimidation (Slikker, 2009). Consistent with other reports (WHO, 2011; Slikker, 2009), educational attainment for PWD was found to be generally low from this analysis. About 40% of PWD had had no formal education at all, while only 17% had primary school education. Without education, the plight of PWD may be worsened since it may limit their access to opportunities for employment and income generation.

Evidence from across the globe suggests that people with disabilities are less likely to participate in the labour market, more likely to be unemployed and earn less than their counterparts (WHO, 2011). In contrast more than half of PWD were found to be employed. Although this may be proportionately lower compared with those without disability, it highlights the important contribution that PWD may be making to the economy of the country. Nevertheless, most of those employed may be engaged in agricultural or traditional crafts, considering that 58% of this group were in rural localities. This opens a window for further enquiry towards increasing our understanding of employment situation of PWD, as this will inform policies directed towards equity and inclusion of PWD in the labour market.

The disability pattern by region seemed to be a reflection of the pattern of population distribution across the country. Ashanti Region had the highest percentage of PWD. In urban centres, however Greater Accra had greater preponderance of PWD. This could be due to migration of PWD from other regions to the capital city where they mostly engage in begging as a form of livelihood strategy (Kassah 2008). Invariable, the Akan ethnic group whose home region is the Ashanti Region had the highest percentage of PWD. The lower average household size for heads of households with disability compared with their counterparts without disability could plausibly be as a result of the traditionally negative beliefs, attitudes and practices towards PWD. Traditionally, persons perceived to have disabilities are not allowed to hold leadership position and are rejected by their families sometimes (Appiagyei 2006; Kassah 2008).

3.12 References

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CHAPTER FOUR

PREVALENCE OF VISUAL IMPAIRMENT

4.1 Introduction

Visual impairment refers to a functional limitation of the eye(s) or visual system due to a disorder or disease that can result in a visual disability or a visual handicap. A visual disability is a limitation of the ability(ies) of the individual (in this example, the inability to read small print), while a visual handicap refers to a limitation of personal and socio-economic independence. Simply put, a visual impairment may be considered as vision inadequate for an individual's needs (American Optometric Association, 2007).

As at 2006, the World Health Organization estimated the global magnitude of visual impairment due to uncorrected refractive errors to be around 153 million people. At least 13 million are children (aged 5–15) and 45 million are working-age adults (aged 16–49) were affected globally (WHO, 2007). Further, visual impairment is unequally distributed across age groups, as more than 82% of all blind people around the world are 50 years of age or older. Females in every region of the world and of all ages have a significantly higher risk for being visually impaired than males, mostly because of their longer life expectancy and, in poorer societies, because of their lack of access to services. In terms of distribution, more than 90% of the world's visually impaired people live in developing countries (WHO, 2007).

This chapter therefore seeks to discuss prevalence of visual impairment in Ghana, by focusing on some key demographic and socio-economic characteristics such as age, marital status, educational attainment, economic activity status, region, ethnicity and religion. The proportions of visually impaired within each population sub-group are discussed.

4.2 Visual Impairment and Age

The distribution of visual impairment by age, sex and type of locality is shown in Table 4.1. The proportion of the population with visual impairment increased with age. However, this was generally lower than the national figure of 1.2% in all age groups below 40 years. The proportion of the visually impaired aged 65+ increased over six times the national figure. A similar pattern was observed across sex and type of locality, with higher proportions in each age group for females than males and in rural than urban localities.

Table 4.1: Visual impairment by age distribution, sex and type of locality

Age group	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	1.2	12,545,229	1.1	12,113,594	1.3
0 - 4	3,405,406	0.3	1,541,391	0.3	1,864,015	0.4
5 - 9	3,128,952	0.4	1,389,660	0.4	1,739,292	0.4
12-14	2,916,040	0.5	1,391,229	0.5	1,524,811	0.4
15 - 19	2,609,989	0.6	1,364,124	0.6	1,245,865	0.6
20 - 24	2,323,491	0.6	1,356,838	0.6	966,653	0.6
25 - 29	2,050,111	0.7	1,194,867	0.6	855,244	0.7
30 - 34	1,678,809	0.8	955,698	0.7	723,111	0.8
35 - 39	1,421,403	0.9	781,852	0.8	639,551	1.1
40 - 44	1,186,350	1.5	632,049	1.3	554,301	1.6
45 - 49	938,098	2.2	487,192	2.1	450,906	2.3
50 - 54	833,098	2.8	421,478	2.6	411,620	2.9
55 - 59	523,695	3.3	275,958	3.2	247,737	3.6
60 - 64	475,849	4.1	225,385	3.8	250,464	4.4
65 -	1,167,532	7.8	527,508	7.1	640,024	8.4
Male						
Total	12,024,845	1.1	6,016,059	1	6,008,786	1.2
0 - 4	1,731,787	0.3	783,017	0.3	948,770	0.4
5 - 9	1,589,632	0.4	697,031	0.4	892,601	0.4
12-14	1,477,525	0.5	672,906	0.5	804,619	0.5
15 - 19	1,311,112	0.5	651,829	0.5	659,283	0.5
20 - 24	1,100,727	0.6	642,140	0.5	458,587	0.6
25 - 29	943,213	0.7	553,927	0.6	389,286	0.7
30 - 34	790,301	0.7	455,204	0.7	335,097	0.9
35 - 39	676,768	0.9	373,678	0.8	303,090	1.1
40 - 44	572,620	1.3	304,875	1.1	267,745	1.5
45 - 49	452,975	2	231,146	1.8	221,829	2.2
50 - 54	394,600	2.6	195,556	2.4	199,044	2.9
55 - 59	258,582	3.2	132,984	3	125,598	3.5
60 - 64	227,050	4	105,738	3.6	121,312	4.3
65 +	497,953	7.7	216,028	7	281,925	8.3
Female						
Total	12,633,978	1.3	6,529,170	1.2	6,104,808	1.4
0 - 4	1,673,619	0.3	758,374	0.3	915,245	0.4
5 - 9	1,539,320	0.4	692,629	0.4	846,691	0.4
12-14	1,438,515	0.4	718,323	0.5	720,192	0.4
15 - 19	1,298,877	0.7	712,295	0.7	586,582	0.6
20 - 24	1,222,764	0.7	714,698	0.7	508,066	0.6
25 - 29	1,106,898	0.7	640,940	0.7	465,958	0.7
30 - 34	888,508	0.8	500,494	0.8	388,014	0.8
35 - 39	744,635	1	408,174	0.9	336,461	1.1
40 - 44	613,730	1.6	327,174	1.6	286,556	1.7
45 - 49	485,123	2.3	256,046	2.3	229,077	2.3
50 - 54	438,498	2.9	225,922	2.8	212,576	3
55 - 59	265,113	3.5	142,974	3.3	122,139	3.6
60 - 64	248,799	4.3	119,647	4	129,152	4.6
65 +	669,579	8	311,480	7.3	358,099	8.6

Source: Ghana Statistical Service, 2010 Population and Housing Census

4.3 Visual Impairment and Marital Status

Table 4.2 shows that 1.6% of the population at the minimum eligible age (16 years) for marriage was visually impaired, with a greater proportion in rural (1.8%) compared to urban localities. The proportion of the visually impaired among those widowed was 7.1%, compared to 0.7% of those who were never married. A similar pattern runs across rural and urban localities with higher proportions in rural localities compared to urban centres. The distribution according to sex shows that there were more females (1.7%) than males (1.5%) with visual impairment.

Table 4.2: Visual impairment by marital status, sex and type of locality

Employment Sector	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	16,886,306	1.6	9,037,989	1.4	7,848,317	1.8
Never married	7,087,098	0.7	4,148,038	0.7	2,939,060	0.7
Informal/consensual union/living together	847,735	1.2	452,413	1.1	395,322	1.3
Married	7,237,730	1.7	3,556,630	1.5	3,681,100	1.8
Separated	315,910	2.8	173,447	2.7	142,463	3
Divorced	574,271	3.9	307,399	3.4	266,872	4.4
Widowed	823,562	7.1	400,062	6.2	423,500	7.8
Male						
Total	8,072,481	1.5	4,252,234	1.2	3,820,247	1.7
Never married	3,947,792	0.6	2,213,375	0.6	1,734,417	0.7
Informal/consensual union/living together	370,191	1.2	199,643	1.1	170,548	1.4
Married	3,364,153	2	1,653,073	1.8	1,711,080	2.3
Separated	107,970	3.2	53,274	3.1	54,696	3.4
Divorced	176,509	4.5	83,603	3.9	92,906	5.1
Widowed	105,866	8.3	49,266	7.1	56,600	9.3
Female						
Total	8,813,825	1.7	4,785,755	1.5	4,028,070	1.9
Never married	3,139,306	0.7	1,934,663	0.7	1,204,643	0.7
Informal/consensual union/living together	477,544	1.1	252,770	1.1	224,774	1.2
Married	3,873,577	1.4	1,903,557	1.3	1,970,020	1.4
Separated	207,940	2.6	120,173	2.5	87,767	2.8
Divorced	397,762	3.6	223,796	3.2	173,966	4
Widowed	717,696	6.9	350,796	6.1	366,900	7.6

Source: Ghana Statistical Service, 2010 Population and Housing Census

4.4 Visual Impairment and Educational Characteristics

The results on visual impairment and level of education indicate that 2.2% of Ghanaians who have never attended school were visually impaired, majority of whom live in urban (2.3%) localities (Table 4.3). Among the population that had had some education, the proportion of visually impaired was greater among those who had had middle school education (2.7%), with more in rural (3.2%) localities compared to urban (2.4%).

Over 2% of the population with post graduate level education were visually impaired. Unlike the case of those with Middle school education, a greater proportion of this group resided in urban (2.2%) than rural (2.0%) localities. The distribution according to sex shows that there were more females (2.4%) than males (1.9%) with visual impairment who had never attended

school. The pattern for educational attainment among visually impaired persons by type of locality does not depart very much from that of the general.

Table 4.3: Visual impairment by educational level, sex and type of locality

Educational level	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	22,624,110	1.3	11,599,522	1.2	11,024,588	1.4
Never attended	5,299,884	2.2	1,646,020	2.3	3,653,864	2.2
Nursery	714,204	0.4	342,479	0.4	371,725	0.4
Kindergarten	1,232,827	0.3	580,951	0.3	651,876	0.4
Primary	5,615,573	0.7	2,667,686	0.7	2,947,887	0.8
JSS/JHS	4,048,059	0.6	2,322,080	0.6	1,725,979	0.6
Middle	2,067,507	2.7	1,231,583	2.4	835,924	3.2
SSS/SHS	1,756,714	0.7	1,279,124	0.7	477,590	0.7
Secondary	349,221	2.3	272,180	2.2	77,041	2.5
Vocational/technical/commercial	369,365	1.8	293,178	1.8	76,187	2
Post middle/secondary certificate	243,739	2.1	175,201	2	68,538	2.6
Post-secondary diploma	484,766	1.3	399,342	1.3	85,424	1.4
Bachelor degree	373,641	1.1	328,707	1.1	44,934	1.1
Post graduate (Cert. Diploma Masters PHD etc.)	68,610	2.1	60,991	2.2	7,619	2
Male						
Total	10,988,971	1.2	5,535,088	1	5,453,883	1.3
Never attended	2,058,897	1.9	538,986	2	1,519,911	1.9
Nursery	364,111	0.4	175,066	0.4	189,045	0.4
Kindergarten	631,100	0.4	297,141	0.4	333,959	0.4
Primary	2,713,950	0.7	1,233,922	0.6	1,480,028	0.8
JSS/JHS	1,984,748	0.6	1,091,882	0.5	892,866	0.6
Middle	1,123,490	2.8	618,241	2.3	505,249	3.3
SSS/SHS	967,287	0.6	678,407	0.6	288,880	0.6
Secondary	223,952	2.2	167,237	2	56,715	2.6
Vocational/technical/commercial	192,496	1.7	147,557	1.6	44,939	2.2
Post middle/secondary certificate	125,572	2.3	81,564	2	44,008	2.9
Post-secondary diploma	304,666	1.3	244,902	1.2	59,764	1.4
Bachelor degree	246,711	1.1	214,342	1.1	32,369	1.2
Post graduate (Cert. Diploma Masters PHD etc.)	51,991	2.2	45,841	2.2	6,150	2.1
Female						
Total	11,635,139	1.4	6,064,434	1.3	5,570,705	1.5
Never attended	3,240,987	2.4	1,107,034	2.4	2,133,953	2.3
Nursery	350,093	0.4	167,413	0.4	182,680	0.4
Kindergarten	601,727	0.3	283,810	0.3	317,917	0.3
Primary	2,901,623	0.8	1,433,764	0.7	1,467,859	0.8
JSS/JHS	2,063,311	0.6	1,230,198	0.6	833,113	0.6
Middle	944,017	2.7	613,342	2.5	330,675	3
SSS/SHS	789,427	0.8	600,717	0.8	188,710	0.8
Secondary	125,269	2.5	104,943	2.5	20,326	2.1
Vocational/technical/commercial	176,869	1.9	145,621	1.9	31,248	1.8
Post middle/secondary certificate	118,167	2	93,637	2	24,530	2
Post-secondary diploma	180,100	1.4	154,440	1.4	25,660	1.4
Bachelor degree	126,930	1.1	114,365	1.1	12,565	0.9
Post graduate (Cert. Diploma Masters PHD etc.)	16,619	1.9	15,150	2	1,469	1.6

Source: Ghana Statistical Service, 2010 Population and Housing Census

4.5 Visual Impairment and Economic Activity Status

In terms of economic activity status as presented in Table 4.5, 1.7% of the population within the working age group were visually impaired. A greater proportion was within the not active group (2.5%). The proportion of working age group with visual impairment residing in rural (2.0%) localities was higher than those in urban (1.5%) localities. While there were more females (2.7%) in the not active category than males (2.2%), the proportion was the same for both the employed males and females.

Table 4.5: Visual impairment by economic activity status, sex and type of locality

Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	15,208,425	1.7	8,222,949	1.5	6,985,476	2
Employed	10,243,476	1.4	5,125,635	1.2	5,117,841	1.6
Unemployed	632,994	1.1	445,567	1	187,427	1.1
Not active	4,331,955	2.5	2,651,747	2.1	1,680,208	3.2
Male						
Total	7,225,901	1.6	3,863,105	1.3	3,362,796	1.9
Employed	5,005,534	1.4	2,477,284	1.1	2,528,250	1.6
Unemployed	283,346	1	200,219	1	83,127	1
Not active	1,937,021	2.2	1,185,602	1.8	751,419	2.9
Female						
Total	7,982,524	1.8	4,359,844	1.6	3,622,680	2.1
Employed	5,237,942	1.4	2,648,351	1.3	2,589,591	1.6
Unemployed	349,648	1.1	245,348	1.1	104,300	1.2
Not active	2,394,934	2.7	1,466,145	2.3	928,789	3.4

Source: Ghana Statistical Service, 2010 Population and Housing Census

4.6 Visual Impairment and Region of Residence

With respect to region of residence, the results in Table 4.5 indicate that the proportion of the population ranged from 0.7% in the Northern Region to 1.9% in the Volta Region. Central, Eastern and Upper East Regions follow, each with 1.5% of their population with visual impairment. The proportion of persons with visual impairment was higher in rural than urban localities in all regions except Greater Accra. The proportion of females with visual impairment was higher than males in all regions except Northern and Brong Ahafo.

Table 4.6: Visual disability by region, sex and type of locality

Sex/District	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	1.2	12,545,229	1.1	12,113,594	1.3
Western	2,376,021	1.2	1,007,969	1.1	1,368,052	1.2
Central	2,201,863	1.5	1,037,878	1.3	1,163,985	1.6
Greater Accra	4,010,054	1.1	3,630,955	1.1	379,099	1.1
Volta	2,118,252	1.9	713,735	1.6	1,404,517	2.1
Eastern	2,633,154	1.5	1,143,918	1.4	1,489,236	1.6
Ashanti	4,780,380	1	2,897,290	1	1,883,090	1.1
Brong Ahafo	2,310,983	0.8	1,028,473	0.7	1,282,510	0.8
Northern	2,479,461	0.7	750,712	0.6	1,728,749	0.7
Upper East	1,046,545	1.5	219,646	1	826,899	1.7
Upper West	702,110	1.4	114,653	0.9	587,457	1.5
Male						
Total	12,024,845	1.1	6,016,059	1	6,008,786	1.2
Western	1,187,774	1.1	490,699	1	697,075	1.2
Central	1,050,112	1.3	489,237	1.1	560,875	1.5
Greater Accra	1,938,225	1	1,752,132	1	186,093	1
Volta	1,019,398	1.7	336,560	1.4	682,838	1.8
Eastern	1,290,539	1.4	542,670	1.3	747,869	1.5
Ashanti	2,316,052	1	1,382,251	0.9	933,801	1
Brong Ahafo	1,145,271	0.8	491,681	0.7	653,590	0.8
Northern	1,229,887	0.7	370,476	0.6	859,411	0.8
Upper East	506,405	1.5	105,082	0.9	401,323	1.6
Upper West	341,182	1.3	55,271	0.8	285,911	1.4
Female						
Total	12,633,978	1.3	6,529,170	1.2	6,104,808	1.4
Western	1,188,247	1.2	517,270	1.2	670,977	1.2
Central	1,151,751	1.6	548,641	1.5	603,110	1.7
Greater Accra	2,071,829	1.2	1,878,823	1.2	193,006	1.1
Volta	1,098,854	2.1	377,175	1.7	721,679	2.3
Eastern	1,342,615	1.6	601,248	1.6	741,367	1.7
Ashanti	2,464,328	1.1	1,515,039	1.1	949,289	1.1
Brong Ahafo	1,165,712	0.8	536,792	0.8	628,920	0.8
Northern	1,249,574	0.7	380,236	0.7	869,338	0.7
Upper East	540,140	1.6	114,564	1.1	425,576	1.7
Upper West	360,928	1.4	59,382	1	301,546	1.5

Source: Ghana Statistical Service, 2010 Population and Housing Census

4.7 Visual Impairment and Ethnicity

Table 4.6 shows that the proportion of the population with visual impairment by ethnic group ranged from 0.8% among the Gruma and Other category to 1.6% among Ewes. Ewes (1.9%) had the highest proportion of the visually impaired in rural localities compared to the Ga-Adangbes (1.5%) in urban localities. In terms of the distribution by sex, there were more females than males with visual impairment among the Ewe, Ga-Adangbe, Guan, Akan and Grusi ethnic groups.

Table 4.7: Visual impairment by ethnicity, sex and type of locality

Ethnicity/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	23,823,594	1.2	12,076,954	1.1	11,746,640	1.3
Akan	11,321,568	1.2	6,539,270	1.1	4,782,298	1.3
Ga-Adangbe	1,766,287	1.5	1,129,997	1.5	636,290	1.5
Ewe	3,323,072	1.6	1,620,419	1.3	1,702,653	1.9
Guan	879,861	1.2	425,885	1	453,976	1.3
Gurma	1,363,502	0.8	305,620	0.8	1,057,882	0.8
Mole-Dagbani	3,963,017	0.9	1,473,061	0.7	2,489,956	1.1
Grusi	594,248	1.3	219,319	1.1	374,929	1.5
Mande	269,842	1	148,298	1	121,544	1
Other	342,197	0.8	215,085	0.9	127,112	0.6
Male						
Total	11,591,394	1.1	5,772,748	1	5,818,646	1.2
Akan	5,435,472	1.1	3,101,899	1	2,333,573	1.2
Ga-Adangbe	857,458	1.3	534,004	1.3	323,454	1.5
Ewe	1,624,944	1.4	780,605	1.2	844,339	1.7
Guan	426,188	1.1	201,847	1	224,341	1.3
Gurma	683,301	0.8	151,568	0.8	531,733	0.8
Mole-Dagbani	1,969,428	0.9	720,520	0.7	1,248,908	1
Grusi	294,058	1.3	104,512	1	189,546	1.4
Mande	134,958	1	73,622	1	61,338	1.1
Other	165,587	0.8	104,171	0.8	61,416	0.7
Females						
Total	12,232,200	1.3	6,304,206	1.2	5,927,994	1.4
Akan	5,886,096	1.3	3,437,371	1.2	2,448,725	1.4
Ga-Adangbe	908,829	1.6	595,993	1.6	312,836	1.6
Ewe	1,698,128	1.7	839,814	1.4	858,314	2
Guan	453,673	1.3	224,038	1.1	229,635	1.4
Gurma	680,201	0.8	154,052	0.8	526,149	0.8
Mole-Dagbani	1,993,589	0.9	752,541	0.8	1,241,048	1.1
Grusi	300,190	1.4	114,807	1.1	185,383	1.5
Mande	134,884	1	74,676	1	60,208	1
Other	176,610	0.8	110,914	0.9	65,699	0.6

Source: Ghana Statistical Service, 2010 Population and Housing Census

4.8 Visual Impairment and Religion

As shown in Table 4.7, among the religious groups, the proportion of visually impaired among traditionalist (1.9%) was more than twice as those who practice Islam (0.8%). There were more visually impaired persons in rural localities compared to urban localities across all religious groups except for Islam and traditional religion. With respect to sex, there were more visually impaired females compared to males in all religious groups.

Table 4.8: Visual impairment by religion, sex and type of locality and religion

Religion/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	1.2	12,545,229	1.1	12,113,594	1.3
No Religion	1,302,077	1.5	479,550	1.4	822,527	1.5
Catholic	3,230,996	1.3	1,405,575	1.3	1,825,421	1.4
Protestant (Anglican Lutheran etc.)	4,534,178	1.4	2,540,118	1.4	1,994,060	1.5
Pentecostal/Charismatic	6,980,792	1	4,140,660	0.9	2,840,132	1.1
Other Christians	2,800,871	1.2	1,476,093	1.1	1,324,778	1.3
Islam	4,345,723	0.8	2,264,792	0.8	2,080,931	0.8
Traditionalist	1,270,272	1.9	140,267	2.1	1,130,005	1.9
Other (Specify)	193,914	1.5	98,174	1.4	95,740	1.6
Male						
Total	12,024,845	1.1	6,016,059	1	6,008,786	1.2
No Religion	804,239	1.4	307,011	1.3	497,228	1.5
Catholic	1,571,079	1.2	679,560	1.2	891,519	1.3
Protestant (Anglican Lutheran etc.)	2,132,619	1.3	1,180,722	1.2	951,897	1.4
Pentecostal/Charismatic	3,240,237	0.9	1,894,241	0.8	1,345,996	1
Other Christians	1,331,390	1.1	695,457	1	635,933	1.2
Islam	2,203,837	0.8	1,138,846	0.8	1,064,991	0.8
Traditionalist	646,380	1.9	71,653	1.9	574,727	1.9
Other	95,064	1.4	48,569	1.3	46,495	1.5
Female						
Total		1.3	6,529,170	1.2	6,104,808	1.4
No Religion	12,633,978	1.6	172,539	1.6	325,299	1.6
Catholic	497,838	1.4	726,015	1.3	933,902	1.4
Protestant (Anglican Lutheran etc.)	1,659,917	1.6	1,359,396	1.6	1,042,163	1.7
Pentecostal/Charismatic	2,401,559	1.1	2,246,419	1	1,494,136	1.2
Other Christians	3,740,555	1.4	780,636	1.3	688,845	1.5
Islam	1,469,481	0.8	1,125,946	0.9	1,015,940	0.8
Traditionalist	2,141,886	2	68,614	2.3	555,278	1.9
Other	623,892	1.6	49,605	1.4	49,245	1.7

Source: Ghana Statistical Service, 2010 Population and Housing Census

4.9 Discussion

As found in other studies (Guzek et al., 2006; Jadoon, 2006) the analyses indicate that females and rural inhabitants bear a greater burden of visual impairment in Ghana across all the factors considered. The situation for females may be rooted in the general marginalisation of women in the Ghanaian society due to cultural beliefs and practices perpetuate gender inequality. Females are socially and financially dependent on the male members of the family for their needs.

These barriers may result in lower uptake in eye care services. The high prevalence among rural inhabitants may be linked to the high infectious disease such as trachoma and

onchocerciasis which used to be prevalent in most parts of rural Ghana (Budenz, et al., 2012). Also, rural residents are disadvantaged with regard to access to healthcare services, including eye care services, mainly due to their low education and poor economic status.

The analyses reveal that the prevalence of visual impairment increases with the advancement of age, especially after 60 years old. The linkage between ageing and disability is a biological fact, particularly visual impairment. Increasing age and its association with the risk of visual impairment has been consistently reported in Ghana (Study (Budenz, et al., 2012) and elsewhere (Dandona et al., 2002). Cataract and glaucoma are the most common cause of visual impairment with advancing age (Guzek et al., 2006). These diseases lead to blindness if not detected and treatment early enough. This raises the issue of availability and access to eye care services for Ghana's rapid increasing population of aged.

Similar to reports in other studies show that (Chong et al., 2006; Lui et al., 2001), visual impairment was relatively high among those with no education. Persons with no education may have limited access to public health information and messages that seek to prevent visual impairment due to their inability to read or understand. They are also more likely to be exposed to certain hazards that may cause visual impairment, and are more unlikely to seek appropriate eye care when the need arises.

Nevertheless, visual impairment was equally high among those with education beyond the elementary level, particularly those with Middle school level of education. This may be explained by the fact that there are a number of specialised educational institutions in Ghana that aim at providing the educational needs of the visually impaired. Ghana's educational system has over the decades provided opportunities for the inclusion of visually impaired in the regular school system all the way to the university level. Many visually impaired persons have taken advantage of such opportunities.

This finding highlights a window of opportunity for harnessing the human resource capacity of persons with visual impairment. This can be done by continually expanding the educational system towards an increased inclusion of persons with visual impairment. Parents also need to be encouraged to take advantage of the educational opportunities for persons with visual impairment by sending their affected wards to school.

Studies elsewhere have found visual impairment to be more associated with being never married, separated, divorced and widowed (Chong, et al., 2006). Similarly, the analyses indicate that visual impairment was higher among those who had previously married, but more so among the widowed. This finding may plausibly be a reflection of the social support network associated with being married.

Married individuals are more likely than their unmarried counterparts to feel added pressure from their spouses to engage in positive health behaviours, including seeking appropriate health care (Chong et al., 2006). The absence of a spouse could therefore be a disincentive to maintain good health. The onset of a visual impairment most often leads to abandonment or the dissolution of a marriage, perhaps as a result of the general stigma associated with disability. This may particularly account for the high proportions of visual impairment among those separated and divorced.

Most previous studies examining visual impairment and economic activity status have classified economic status as simply employed or not. In general, these studies showed that visual impairment was more common among unemployed persons than those with

employment (Chong et al., 2006; Varma et al., 2004). In the current analyses, economic activity status was classified into three categories (employed, unemployed and not active), with visual impairment found to be most common among those not active. This is perhaps as a result of the negative effect visual impairment may have on the acquisition of employable skills to enable their active participation in the economy.

This raises the issue of rehabilitation of persons with visual impairment. On the other hand, over one percent of those employed are visually impaired. This provides evidence regarding the potential of visually impaired persons to contribute actively to the development agenda of Ghana.

The Volta Region calls for public health concern, considering that the proportion of visually impaired in the region is almost twice the national figure. A population-based cluster survey conducted in three districts of the Volta Region in 2001 noted the prevalence of bilateral blindness to 4.4% (Guzek et al., 2006). In that same study, cataract and glaucoma were found to be the main causes of visual impairment in the Volta Region. Onchocerciasis – a water related disease in communities located close to water – used to be prevalent in the Volta region especially in communities along the Volta Lake. Although onchocerciasis has been significantly reduced in the region through the neglected tropical disease control programme, the condition may have accounted for a considerable number of visually impaired persons in the region.

Despite being the smallest major religious group in Ghana, Traditional religion had the higher proportion of visual impairment according to the results. This could be explained by the negative perceptions often held by Traditionalist about the causation of disease or disability. Such perceptions may influence their health care seeking behaviour. They often consider disabilities as curses or repercussions of sins committed either by the affected person, his or her parents, or one of his or her ancestors (UNDP, 2007). Hence, traditional or spiritual healing methods are often employed when disease conditions that could lead to visual impairment occur. In addition, traditionalists mostly reside in rural areas with limited access to modern eye care services and as a result are unable to access care for treatable eye diseases or injuries.

4.10 References

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CHAPTER FIVE

PREVALENCE OF PHYSICAL IMPAIRMENT

5.1 Introduction

Physical impairments include visceral, skeletal and disfiguring impairments such as amputations, paralysis, limping and lameness, deformity, and hunched back. This type of impairment is defined as any physiological disorder or condition, cosmetic disfigurement, or anatomic loss affecting one or more of the following body systems: neurological, musculoskeletal, lymphatic, skin, and endocrine systems (Chiteraka, 2010). It is currently estimated that out of the ten percent of the world's population afflicted with various forms of impairments, about 500 million are physically impaired (Baser, 2008).

According to the 2010 Ghana Population and Housing Census, physical impairment was the second most common type of disability in Ghana after visual impairment in both urban (25.1%) and rural (25.7%) localities in Ghana. The results of the distribution by sex show that there were more females (25.7%) than males (25.1%) (GSS, 2013).

In this chapter, physical impairment in Ghana is discussed according to selected demographic and socio-economic characteristics using data from the 2010 Population and Housing Census. The characteristics considered include age, marital status, educational attainment, economic activity, region, ethnicity and religion. All analyses of physical impairment in this chapter are segregated according to sex and type of locality.

5.2 Physical Impairment and Age

The distribution of physical impairment by sex, type of locality and age as presented in Table 5.1 shows that the proportion of the population with physical impairment increased with age, exceeding 1% by age 50 for both males and females and in both rural and urban localities.

By age 65+, the proportion of the population with physical impairment increased above 4% for both sexes in both rural and urban localities. Generally, males had higher proportions of physically impaired compared to females in all age groups up to the 50-54 age group in both rural and urban localities.

Table 5.1: Physical impairment by age distribution, sex and type of locality

Age group	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.8	12,545,229	0.7	12,113,594	0.8
0 - 4	3,405,406	0.3	1,541,391	0.2	1,864,015	0.3
5 - 9	3,128,952	0.3	1,389,660	0.2	1,739,292	0.3
10 - 14	2,916,040	0.3	1,391,229	0.3	1,524,811	0.4
15 - 19	2,609,989	0.4	1,364,124	0.3	1,245,865	0.5
20 - 24	2,323,491	0.4	1,356,838	0.4	966,653	0.5
25 - 29	2,050,111	0.5	1,194,867	0.4	855,244	0.6
30 - 34	1,678,809	0.6	955,698	0.5	723,111	0.8
35 - 39	1,421,403	0.7	781,852	0.6	639,551	0.9
40 - 44	1,186,350	0.9	632,049	0.7	554,301	1
45 - 49	938,098	1	487,192	0.9	450,906	1.2
50 - 54	833,098	1.4	421,478	1.3	411,620	1.5
55 - 59	523,695	1.8	275,958	1.7	247,737	2
60 - 64	475,849	2.5	225,385	2.5	250,464	2.5
65+	1,167,532	4.9	527,508	5	640,024	4.9
Male						
Total	12,024,845	0.7	6,016,059	0.7	6,008,786	0.8
0 - 4	1,731,787	0.3	783,017	0.2	948,770	0.3
5 - 9	1,589,632	0.3	697,031	0.2	892,601	0.3
10 - 14	1,477,525	0.3	672,906	0.3	804,619	0.4
15 - 19	1,311,112	0.4	651,829	0.3	659,283	0.5
20 - 24	1,100,727	0.5	642,140	0.4	458,587	0.6
25 - 29	943,213	0.5	553,927	0.4	389,286	0.7
30 - 34	790,301	0.7	455,204	0.6	335,097	0.8
35 - 39	676,768	0.8	373,678	0.7	303,090	0.9
40 - 44	572,620	0.9	304,875	0.8	267,745	1
45 - 49	452,975	1.1	231,146	1	221,829	1.2
50 - 54	394,600	1.4	195,556	1.3	199,044	1.5
55 - 59	258,582	1.8	132,984	1.7	125,598	1.9
60 - 64	227,050	2.4	105,738	2.4	121,312	2.4
65+	497,953	4.5	216,028	4.6	281,925	4.4
Female						
Total	12,633,978	0.8	6,529,170	0.7	6,104,808	0.9
0 - 4	1,673,619	0.2	758,374	0.2	915,245	0.3
5 - 9	1,539,320	0.2	692,629	0.2	846,691	0.3
10 - 14	1,438,515	0.3	718,323	0.2	720,192	0.3
15 - 19	1,298,877	0.4	712,295	0.3	586,582	0.5
20 - 24	1,222,764	0.4	714,698	0.3	508,066	0.5
25 - 29	1,106,898	0.5	640,940	0.4	465,958	0.6
30 - 34	888,508	0.6	500,494	0.5	388,014	0.7
35 - 39	744,635	0.7	408,174	0.6	336,461	0.8
40 - 44	613,730	0.8	327,174	0.7	286,556	1
45 - 49	485,123	1	256,046	0.9	229,077	1.1
50 - 54	438,498	1.4	225,922	1.2	212,576	1.5
55 - 59	265,113	1.9	142,974	1.7	122,139	2
60 - 64	248,799	2.6	119,647	2.5	129,152	2.6
65+	669,579	5.2	311,480	5.3	358,099	5.2

Source: Ghana Statistical Service, 2010 Population and Housing Census

5.3 Physical Impairment and Marital Status

The data in Table 5.2 shows that 1 percent of population eligible for marriage was physically impaired, out of which 0.9 percent and 1.1 percent reside in urban and rural localities, respectively.

In terms of marital status, the proportion of physical impairment was higher among those who had previously married, particularly the widowed (4.5%). The same pattern was observed across sex and type of locality, although proportions were generally higher among males than females, and in rural localities compared to urban localities.

Table 5.2: Physical impairment by marital status, sex and type of locality

Marital Status/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	16,886,306	1.0	9,037,989	0.9	7,848,317	1.1
Never married	7,087,098	0.6	4,148,038	0.5	2,939,060	0.7
Informal/consensual union/living together	847,735	0.7	452,413	0.6	395,322	0.8
Married	7,237,730	0.9	3,556,630	0.8	3,681,100	0.9
Separated	315,910	2.1	173,447	1.8	142,463	2.4
Divorced	574,271	2.8	307,399	2.4	266,872	3.2
Widowed	823,562	4.5	400,062	4.4	423,500	4.7
Male						
Total	8,072,481	1.0	4,252,234	0.8	3,820,247	1.1
Never married	3,947,792	0.6	2,213,375	0.5	1,734,417	0.7
Informal/consensual union/living together	370,191	0.8	199,643	0.7	170,548	0.8
Married	3,364,153	1.1	1,653,073	1.0	1,711,080	1.1
Separated	107,970	2.7	53,274	2.5	54,696	2.8
Divorced	176,509	3.7	83,603	3.4	92,906	3.9
Widowed	105,866	5.4	49,266	5.2	56,600	5.6
Female						
Total	8,813,825	1.0	4,785,755	0.9	4,028,070	1.2
Never married	3,139,306	0.5	1,934,663	0.4	1,204,643	0.7
Informal/consensual union/living together	477,544	0.7	252,770	0.5	224,774	0.8
Married	3,873,577	0.7	1,903,557	0.6	1,970,020	0.8
Separated	207,940	1.8	120,173	1.5	87,767	2.2
Divorced	397,762	2.3	223,796	2.0	173,966	2.8
Widowed	717,696	4.4	350,796	4.3	366,900	4.5

Source: Ghana Statistical Service, 2010 Population and Housing Census

5.4 Physical Impairment and Educational Characteristics

On level education (Table 5.3), the data indicates that the proportion of physical impairment within the population of those who had never attended school (1.6%) was more than three times those who had at least primary school education (0.5%). Majority of the physically impaired who had never attended school resided in urban (1.9%) localities compared to rural (1.4%) localities.

Across the various levels of education, the proportion of person with physical impairment was higher in rural than urban localities, ranging from 0.2% for those who had had Kindergarten education to 1.7% for those who had had Middle school education. In terms of sex distribution, the proportion of physical impairment for those who had never attended

school is higher for females (1.7%) compared to males (1.4%), while the reverse was the case for those who had had Middle school education (1.7% for males and 1.3% for females). The pattern did not depart much from the general in terms of type of locality for males and females.

Table 5.3: Physical impairment by level of education, sex and type of locality

Level of Education/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	22,624,110	0.8	11,599,522	0.7	11,024,588	0.9
Never attended	5,299,884	1.6	1,646,020	1.9	3,653,864	1.4
Nursery	714,204	0.2	342,479	0.2	371,725	0.3
Kindergarten	1,232,827	0.2	580,951	0.2	651,876	0.2
Primary	5,615,573	0.5	2,667,686	0.4	2,947,887	0.5
JSS/JHS	4,048,059	0.4	2,322,080	0.3	1,725,979	0.5
Middle	2,067,507	1.5	1,231,583	1.3	835,924	1.7
SSS/SHS	1,756,714	0.3	1,279,124	0.3	477,590	0.4
Secondary	349,221	1.2	272,180	1.1	77,041	1.4
Vocational/technical/commercial	369,365	0.9	293,178	0.8	76,187	1.3
Post middle/secondary certificate	243,739	1.1	175,201	0.9	68,538	1.4
Post-secondary diploma	484,766	0.5	399,342	0.5	85,424	0.7
Bachelor degree	373,641	0.4	328,707	0.4	44,934	0.5
Post graduate (Cert. Diploma Masters PHD etc.)	68,610	0.7	60,991	0.6	7,619	1.0
Male						
Total	10,988,971	0.8	5,535,088	0.7	5,453,883	0.9
Never attended	2,058,897	1.4	538,986	1.7	1,519,911	1.3
Nursery	364,111	0.2	175,066	0.2	189,045	0.3
Kindergarten	631,100	0.2	297,141	0.2	333,959	0.2
Primary	2,713,950	0.5	1,233,922	0.4	1,480,028	0.5
JSS/JHS	1,984,748	0.4	1,091,882	0.4	892,866	0.5
Middle	1,123,490	1.7	618,241	1.5	505,249	1.8
SSS/SHS	967,287	0.4	678,407	0.3	288,880	0.5
Secondary	223,952	1.3	167,237	1.3	56,715	1.6
Vocational/technical/commercial	192,496	1.1	147,557	0.9	44,939	1.4
Post middle/secondary certificate	125,572	1.4	81,564	1.2	44,008	1.8
Post-secondary diploma	304,666	0.6	244,902	0.6	59,764	0.9
Bachelor degree	246,711	0.5	214,342	0.5	32,369	0.6
Post graduate (Cert. Diploma Masters PHD etc.)	51,991	0.8	45,841	0.7	6,150	1.1
Female						
Total	11,635,139	0.8	6,064,434	0.7	5,570,705	0.9
Never attended	3,240,987	1.7	1,107,034	2	2,133,953	1.6
Nursery	350,093	0.2	167,413	0.2	182,680	0.2
Kindergarten	601,727	0.2	283,810	0.2	317,917	0.2
Primary	2,901,623	0.5	1,433,764	0.5	1,467,859	0.5
JSS/JHS	2,063,311	0.4	1,230,198	0.3	833,113	0.4
Middle	944,017	1.3	613,342	1.2	330,675	1.5
SSS/SHS	789,427	0.3	600,717	0.2	188,710	0.3
Secondary	125,269	0.8	104,943	0.8	20,326	0.9
Vocational/technical/commercial	176,869	0.8	145,621	0.7	31,248	1.1
Post middle/secondary certificate	118,167	0.7	93,637	0.7	24,530	0.8
Post-secondary diploma	180,100	0.4	154,440	0.4	25,660	0.4
Bachelor degree	126,930	0.2	114,365	0.2	12,565	0.3
Post graduate (Cert. Diploma Masters PHD etc.)	16,619	0.3	15,150	0.3	1,469	0.8

Source: Ghana Statistical Service, 2010 Population and Housing Census

5.5 Physical Impairment and Economic Activity Status

In terms of economic activity status as presented in Table 5.4, physical impairment was higher among the non-active group with a greater proportion among females (2.2%) than males (2.0%). In addition, females in the non-active group had greater preponderance in rural as well as urban localities. The proportions did not vary between employed and unemployed persons with physical impairment for males and females and in rural and urban localities, although males (0.7%) generally had higher proportions than females (0.6%) in similar categories, and across rural and urban localities.

Table 5.4: Physical impairment by economic activity status, sex and type of locality

Sex/Activity	Total		Total		Total	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	15,208,425	1.1	8,222,949	0.9	6,985,476	1.2
Employed	10,243,476	0.6	5,125,635	0.5	5,117,841	0.8
Unemployed	575,807	0.6	410,267	0.6	165,540	0.8
Not active	4,389,142	2.2	2,687,047	1.7	1,702,095	2.7
Male						
Total	7,225,901	1	3,863,105	0.9	3,362,796	1.2
Employed	5,005,534	0.7	2,477,284	0.6	2,528,250	0.8
Unemployed	254,955	0.7	182,894	0.6	72,061	0.8
Not active	1,965,412	2	1,202,927	1.6	762,485	2.5
Female						
Total	7,982,524	1.1	4,359,844	0.9	3,622,680	1.3
Employed	5,237,942	0.6	2,648,351	0.5	2,589,591	0.7
Unemployed	320,852	0.6	227,373	0.5	93,479	0.7
Not active	2,423,730	2.2	1,484,120	1.8	939,610	2.9

Source: Ghana Statistical Service, 2010 Population and Housing Census

5.6 Physical Impairment and Region of Residence

The data presented in Table 5.5 indicate that the proportion of the population with physical impairment exceeded that of the national (0.8%) prevalence in three regions i.e. Volta (1.2%), Eastern (1.1%) and Central (1.0%). In most regions, the proportion of the population with physical impairment was slightly higher in rural localities compared to urban localities.

Table 5.5: Physical impairment by region, sex and type of locality

Sex/Locality	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.8	12,545,229	0.7	12,113,594	0.8
Western	2,376,021	0.7	1,007,969	0.7	1,368,052	0.7
Central	2,201,863	1	1,037,878	0.8	1,163,985	1.1
Greater Accra	4,010,054	0.6	3,630,955	0.6	379,099	0.6
Volta	2,118,252	1.2	713,735	0.9	1,404,517	1.3
Eastern	2,633,154	1.1	1,143,918	1	1,489,236	1.1
Ashanti	4,780,380	0.7	2,897,290	0.6	1,883,090	0.8
Brong Ahafo	2,310,983	0.6	1,028,473	0.7	1,282,510	0.6
Northern	2,479,461	0.5	750,712	0.5	1,728,749	0.4
Upper East	1,046,545	0.8	219,646	0.6	826,899	0.9
Upper West	702,110	0.8	114,653	0.6	587,457	0.8
Male						
Total	12,024,845	0.7	6,016,059	0.7	6,008,786	0.8
Western	1,187,774	0.7	490,699	0.7	697,075	0.7
Central	1,050,112	0.9	489,237	0.8	560,875	1
Greater Accra	1,938,225	0.6	1,752,132	0.6	186,093	0.6
Volta	1,019,398	1.1	336,560	0.9	682,838	1.1
Eastern	1,290,539	1	542,670	0.9	747,869	1
Ashanti	2,316,052	0.7	1,382,251	0.6	933,801	0.8
Brong Ahafo	1,145,271	0.6	491,681	0.6	653,590	0.6
Northern	1,229,887	0.5	370,476	0.5	859,411	0.5
Upper East	506,405	0.9	105,082	0.6	401,323	0.9
Upper West	341,182	0.8	55,271	0.5	285,911	0.8
Female						
Total	12,633,978	0.8	6,529,170	0.7	6,104,808	0.9
Western	1,188,247	0.7	517,270	0.7	670,977	0.8
Central	1,151,751	1.1	548,641	0.9	603,110	1.2
Greater Accra	2,071,829	0.6	1,878,823	0.6	193,006	0.7
Volta	1,098,854	1.2	377,175	1	721,679	1.4
Eastern	1,342,615	1.1	601,248	1.1	741,367	1.1
Ashanti	2,464,328	0.7	1,515,039	0.6	949,289	0.8
Brong Ahafo	1,165,712	0.7	536,792	0.7	628,920	0.7
Northern	1,249,574	0.4	380,236	0.5	869,338	0.4
Upper East	540,140	0.8	114,564	0.6	425,576	0.9
Upper West	360,928	0.8	59,382	0.6	301,546	0.8

Source: Ghana Statistical Service, 2010 Population and Housing Census

With respect to sex distribution, females exceeded males in all the three regions (Volta, Central and Eastern) in terms of physical impairment. In addition, there were more females than males by type of locality.

5.7 Physical Impairment and Ethnicity

Table 5.6 shows that the proportions of the population with physical impairment did not vary remarkably by ethnic groups, ranging from 0.5% among the Gurma to 0.9% among the Ga-Adangbe and the Ewe. Generally, the proportion of physically impaired was higher in rural than urban localities across all ethnic groups, but hardly ever exceeded 1% in any ethnic group.

Table 5.6: Physical disability by ethnic group, sex and type of locality

Sex/Ethnicity	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	23,823,594	0.8	12,076,954	0.7	11,746,640	0.8
Akan	11,321,568	0.8	6,539,270	0.7	4,782,298	1.0
Ga-Adangbe	1,766,287	0.9	1,129,997	0.9	636,290	0.9
Ewe	3,323,072	0.9	1,620,419	0.7	1,702,653	1.1
Guan	879,861	0.8	425,885	0.8	453,976	0.9
Gurma	1,363,502	0.5	305,620	0.5	1,057,882	0.5
Mole-						
Dagbani	3,963,017	0.6	1,473,061	0.5	2,489,956	0.6
Grusi	594,248	0.7	219,319	0.7	374,929	0.8
Mande	269,842	0.7	148,298	0.7	121,544	0.7
Other	342,197	0.6	215,085	0.6	127,112	0.5
Male						
Total	11,591,394	0.7	5,772,748	0.7	5,818,646	0.8
Akan	5,435,472	0.7	3,101,899	0.6	2,333,573	0.9
Ga-Adangbe	857,458	0.8	534,004	0.8	323,454	0.9
Ewe	1,624,944	0.9	780,605	0.7	844,339	1.0
Guan	426,188	0.8	201,847	0.7	224,341	0.8
Gurma	683,301	0.6	151,568	0.5	531,733	0.6
Mole-						
Dagbani	1,969,428	0.6	720,520	0.5	1,248,908	0.6
Grusi	294,058	0.8	104,512	0.7	189,546	0.8
Mande	134,958	0.7	73,622	0.7	61,336	0.7
Other	165,587	0.6	104,171	0.6	61,416	0.5
Female						
Akan	5,886,096	0.8	3,437,371	0.7	2,448,725	1.0
Ga-Adangbe	908,829	0.9	595,993	0.9	312,836	1.0
Ewe	1,698,128	1.0	839,814	0.7	858,314	1.2
Guan	453,673	0.9	224,038	0.8	229,635	1.0
Gurma	680,201	0.5	154,052	0.5	526,149	0.5
Mole-						
Dagbani	1,993,589	0.5	752,541	0.5	1,241,048	0.6
Grusi	300,190	0.7	114,807	0.6	185,383	0.7
Mande	134,884	0.7	74,676	0.7	60,208	0.7
Other	176,610	0.6	110,914	0.6	65,696	0.5
Total	12,232,200	0.8	6,304,206	0.7	5,927,994	0.9

Source: Ghana Statistical Service, 2010 Population and Housing Census

The proportion of physically impaired for males was higher than females in all ethnicities except the Ewe. However, in terms of type of locality, the proportion of physically impaired in rural localities was higher for females than males among the Ewe, Ga-Adangbe and Akan ethnic groups.

5.8 Physical Impairment and Religion

As shown in Table 5.7, only those with no religious affiliation and Traditionalist had proportions of physical impairment above 1%. While the proportion did not vary by type of locality for those with no religious affiliation, Traditionalist had higher proportions of physically impaired persons in urban (1.3%) than rural (1.1%) localities. This pattern was similarly observed with respect to sex distribution of physically impaired by religious affiliation.

Table 5.7: Physical impairment by religion, sex and type of locality

Region/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.8	12,545,229	0.7	473,685	0.8
No Religion	1,302,077	1.2	479,550	1.2	1,394,612	1.2
Catholic	3,230,996	0.8	1,405,575	0.8	2,519,344	0.9
Protestant (Anglican Lutheran etc.)	4,534,178	0.9	2,540,118	0.8	4,118,819	1
Pentecostal/ Charismatic	6,980,792	0.6	4,140,660	0.5	1,466,414	0.7
Other Christians	2,800,871	0.8	1,476,093	0.7	2,251,241	0.9
Islam	4,345,723	0.6	2,264,792	0.6	138,396	0.5
Traditionalist	1,270,272	1.1	140,267	1.3	97,453	1.1
Other	193,914	0.8	98,174	0.7		0.9
Male					5,976,643	
Total	12,024,845	0.7	6,016,059	0.7	303,466	0.8
No Religion	804,239	1.2	307,011	1.2	674,252	1.2
Catholic	1,571,079	0.8	679,560	0.8	1,171,657	0.8
Protestant (Anglican Lutheran etc.)	2,132,619	0.8	1,180,722	0.8	1,884,971	0.9
Pentecostal/ Charismatic	3,240,237	0.6	1,894,241	0.5	691,277	0.7
Other Christians	1,331,390	0.7	695,457	0.6	1,132,042	0.8
Islam	2,203,837	0.6	1,138,846	0.6	70,759	0.5
Traditionalist	646,380	1.1	71,653	1.2	48,219	1.1
Other	95,064	0.8	48,569	0.7		0.8
Female					6,483,321	
Total	12,633,978	0.8	6,529,170	0.7	170,219	0.9
No Religion	497,838	1.3	172,539	1.3	720,360	1.3
Catholic	1,659,917	0.8	726,015	0.8	1,347,687	0.9
Protestant (Anglican Lutheran etc.)	2,401,559	0.9	1,359,396	0.9	2,233,848	1
Pentecostal/ Charismatic	3,740,555	0.7	2,246,419	0.6	775,137	0.8
Other Christians	1,469,481	0.8	780,636	0.7	1,119,199	1
Islam	2,141,886	0.6	1,125,946	0.6	67,637	0.5
Traditionalist	623,892	1.1	68,614	1.4	49,234	1.1
Other	98,850	0.9	49,605	0.7	473,685	1

Source: Ghana Statistical Service, 2010 Population and Housing Census

5.9 Discussion

Contrary to studies elsewhere (Srivastava et al., 2012), the analysis shows that the prevalence of physical impairment among females is generally higher than males although the gap is not very remarkable. Again, physical impairment assumed a rural dimension as indicated in the results and as shown from other studies. The high prevalence of physical impairment among rural inhabitants may be linked to infectious disabling diseases such as polio, leprosy, buruli ulcer, Lymphatic Filariases, and Soil-transmitted Helminths which used to be prevalent among the rural poor in Ghana. Although many of such diseases are not very common today, they have left many of their victims with various forms of physical impairments. The characteristics of rural life (negative perception about disease or impairment, poverty, agricultural activities, low education and less access to primary health care) also predisposes rural inhabitants to physical impairment. .

Ghana's population is ageing rapidly as a result of increasing longevity (Mba, 2004), and this is evidenced in the current analysis by the high proportions of physical impairment among those aged 60 years and above. This is simple because physical impairment increases as one grows older, either as a result of the ageing process or as a result of disabling diseases such as arthritis, stroke, diabetes or a combination of these. Consequently, there is a potential need for comprehensive health and social welfare services for Ghana's ageing population with physical impairments, as this will have implications for poverty alleviation. In addition, since higher physical impairment among older people may reflect an accumulation of health risks across a lifespan of disease, injury, and chronic illness, the promotion of healthy living across the life course for younger generations is necessary.

Physical impairment was greater among those with no education. There are still a large number of children and youth with physical impairment who are prevented from attending school due to stigma, intimidation and unfriendly architecture of the school environment (Slikker, 2009). Some families would also choose to educate a child without any impairment rather than the one with impairment. However, the few that manage to persevere through the formal educational system often do succeed in attaining higher levels.

With respect to marital status, physical impairment was dominated by those widowed, followed by those separated and those divorced. Studies (Chong, et al., 2009; Varma et al., 2004) examining other types of impairments have reported similar findings. The reasons for the high proportion of physical impairment among the widowed are beyond the scope of the current analysis. Acquiring a physical disability or impairment may mark the end of a once vibrant union, owing to the negative perceptions and attitude towards persons with impairments. This is likely to be the explanation for the relatively higher prevalence rates among those separated and divorced.

Economic activity status was classified into three categories (employed, unemployed and not active) in the analyses, with physical impairment higher among the not active category. Studies elsewhere (Smith (2007; Chong et al, 2009) have reported high prevalence of disability among unemployed. However, this could be as a result of the different classifications of economic activity status. Currently job acquisition in Ghana is very competitive even for those who have had formal education and without any form of impairment. Physically impaired persons who are mostly not educated most often lose in the very strong competition in the job market. Improving the capacity of the physically impaired through education and skills development is important. There is also the need to put measure in place at the institutional level in order to ensure that there is equity in the job market for those with impairments.

5.10 References

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CHAPTER SIX

PREVALENCE OF SPEECH IMPAIRMENT

6.1 Introduction

Effective communication skills are central to a successful life for all humans. Communication disorders can affect education, employment and overall well-being (National Institute on Deafness and Other Communication Disorders, 2006). In a systematic review, McCormack, McLeod, McAllister and Harrison (2009) found that speech impairment may be associated with the following activity limitations and/or participation restrictions: learning to read/reading, learning to write/writing, focusing attention and thinking, calculating, communication, mobility, self-care, relating to persons in authority, informal relationships with friends/peers, parent-child relationships, sibling relationships, school education, and acquiring, keeping and terminating a job. All or some of the activity limitations have the potential of obstructing human and economic development of individuals and communities. In this regard, this chapter focuses on speech impairment in connection some demographic and socio-economic variables.

6.2 Speech Impairment and Age

In Table 6.1, results on speech impairment by sex, type of locality and age are presented. The data shows that speech impairment, just like hearing, sight and other forms impairments, ageing appears to be a risk factor. Despite the fact that the total prevalence of speech impairment is 0.4%, it rises to about twice more among those aged 65+ years old. It is important noting that speech impairment remains twice less among those aged 0-44 years compared to the oldest (65+ years). In both urban and rural areas, the pattern virtually does not change as can be noted from Table 6.1. On the basis of sex, the proportion of males with speech impairment is about 0.1% higher than females (0.4%).

Table 6.1: Speech impairment by age distribution, sex and type of locality

Age group	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.4	12,545,229	0.4	12,113,594	0.5
0 - 4	3,405,406	0.3	1,541,391	0.3	1,864,015	0.3
5 - 9	3,128,952	0.3	1,389,660	0.3	1,739,292	0.4
10 - 14	2,916,040	0.4	1,391,229	0.3	1,524,811	0.4
15 - 19	2,609,989	0.4	1,364,124	0.3	1,245,865	0.4
20 - 24	2,323,491	0.4	1,356,838	0.3	966,653	0.4
25 - 29	2,050,111	0.4	1,194,867	0.3	855,244	0.5
30 - 34	1,678,809	0.4	955,698	0.4	723,111	0.5
35 - 39	1,421,403	0.4	781,852	0.4	639,551	0.5
40 - 44	1,186,350	0.4	632,049	0.4	554,301	0.5
45 - 49	938,098	0.5	487,192	0.4	450,906	0.5
50 - 54	833,098	0.5	421,478	0.5	411,620	0.5
55 - 59	523,695	0.5	275,958	0.5	247,737	0.6
60 - 64	475,849	0.6	225,385	0.6	250,464	0.7
65 +	1,167,532	0.8	527,508	0.9	640,024	0.8
Male						
Total	12,024,845	0.5	6,016,059	0.4	6,008,786	0.5
0 - 4	1,731,787	0.3	783,017	0.3	948,770	0.4
5 - 9	1,589,632	0.4	697,031	0.3	892,601	0.4
10 - 14	1,477,525	0.4	672,906	0.4	804,619	0.5
15 - 19	1,311,112	0.4	651,829	0.4	659,283	0.5
20 - 24	1,100,727	0.4	642,140	0.4	458,587	0.5
25 - 29	943,213	0.5	553,927	0.4	389,286	0.5
30 - 34	790,301	0.5	455,204	0.4	335,097	0.5
35 - 39	676,768	0.5	373,678	0.4	303,090	0.5
40 - 44	572,620	0.5	304,875	0.4	267,745	0.6
45 - 49	452,975	0.5	231,146	0.5	221,829	0.6
50 - 54	394,600	0.6	195,556	0.5	199,044	0.6
55 - 59	258,582	0.6	132,984	0.6	125,598	0.6
60 - 64	227,050	0.7	105,738	0.7	121,312	0.8
65 +	497,953	0.9	216,028	0.9	281,925	0.9
Female						
Total	12,633,978	0.4	6,529,170	0.3	6,104,808	0.4
0 - 4	1,673,619	0.3	758,374	0.3	915,245	0.3
5 - 9	1,539,320	0.3	692,629	0.2	846,691	0.3
10 - 14	1,438,515	0.3	718,323	0.3	720,192	0.4
15 - 19	1,298,877	0.3	712,295	0.3	586,582	0.4
20 - 24	1,222,764	0.3	714,698	0.3	508,066	0.4
25 - 29	1,106,898	0.3	640,940	0.3	465,958	0.4
30 - 34	888,508	0.4	500,494	0.3	388,014	0.4
35 - 39	744,635	0.4	408,174	0.3	336,461	0.4
40 - 44	613,730	0.4	327,174	0.3	286,556	0.4
45 - 49	485,123	0.4	256,046	0.3	229,077	0.5
50 - 54	438,498	0.4	225,922	0.4	212,576	0.5
55 - 59	265,113	0.5	142,974	0.4	122,139	0.5
60 - 64	248,799	0.6	119,647	0.5	129,152	0.6
65 +	669,579	0.8	311,480	0.8	358,099	0.8

Source: Ghana Statistical Service, 2010 Population and Housing Census

6.3 Speech Impairment and Marital Status

Disorders in communication as may be reflected in speech impairment can negatively affect almost all aspects of social life, particularly in relation to interactions. Table 6.2 presents results from an analysis on speech impairment by sex, type of locality and marital status. Of the population aged 12 years and older whose marital status was asked during the census, 0.4% had various forms of hearing impairment. A slightly higher rate of hearing impairment was reported in rural areas (0.5%) as against the reported prevalence in urban areas (0.4%). Among males, those separated, divorced and widowed in both urban and rural areas reported higher rates of speech impairment than females within the same categories in urban and rural areas.

Table 6.2: Speech impairment by marital status, sex and type of locality

Sex/Marital Status	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	16,886,306	0.4	9,037,989	0.4	7,848,317	0.5
Never married	7,087,098	0.5	4,148,038	0.4	2,939,060	0.6
Informal/consensual union/living together	847,735	0.4	452,413	0.3	395,322	0.4
Married	7,237,730	0.3	3,556,630	0.3	3,681,100	0.4
Separated	315,910	0.7	173,447	0.6	142,463	0.8
Divorced	574,271	0.7	307,399	0.6	266,872	0.8
Widowed	823,562	0.8	400,062	0.7	423,500	0.8
Male						
Total	8,072,481	0.5	4,252,234	0.5	3,820,247	0.6
Never married	3,947,792	0.5	2,213,375	0.5	1,734,417	0.6
Informal/consensual union/living together	370,191	0.4	199,643	0.4	170,548	0.4
Married	3,364,153	0.4	1,653,073	0.4	1,711,080	0.4
Separated	107,970	0.8	53,274	0.8	54,696	0.8
Divorced	176,509	1	83,603	0.9	92,906	1.1
Widowed	105,866	1	49,266	1	56,600	1.1
Female						
Total	8,813,825	0.4	4,785,755	0.3	4,028,070	0.5
Never married	3,139,306	0.4	1,934,663	0.4	1,204,643	0.5
Informal/consensual union/living together	477,544	0.3	252,770	0.3	224,774	0.4
Married	3,873,577	0.3	1,903,557	0.3	1,970,020	0.3
Separated	207,940	0.6	120,173	0.5	87,767	0.8
Divorced	397,762	0.6	223,796	0.5	173,966	0.7
Widowed	717,696	0.7	350,796	0.7	366,900	0.8

Source: Ghana Statistical Service, 2010 Population and Housing Census

6.4 Speech Impairment and Educational Characteristics

Education is an important tool for elimination/reduction of social exclusion. With physical impairment as one key predictor of social exclusion, it is important that a report of this nature highlights issues of impairment vis-à-vis formal educational attainment. With an overall speech impaired population of 0.4%, 0.5% and 0.4% of males and females had traces of speech impairment. The results in Table 6.3 further points to the fact that the rate of speech impairment in urban and rural areas were 0.4% and 0.5% respectfully.

Table 6.3: Speech impairment by level of education, sex and type of locality

Education/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	22,624,110	0.4	11,599,522	0.4	11,024,588	0.5
Never attended	5,299,884	0.7	1,646,020	0.8	3,653,864	0.7
Nursery	714,204	0.3	342,479	0.2	371,725	0.3
Kindergarten	1,232,827	0.3	580,951	0.2	651,876	0.3
Primary	5,615,573	0.3	2,667,686	0.3	2,947,887	0.4
JSS/JHS	4,048,059	0.3	2,322,080	0.3	1,725,979	0.3
Middle	2,067,507	0.4	1,231,583	0.4	835,924	0.5
SSS/SHS	1,756,714	0.2	1,279,124	0.2	477,590	0.3
Secondary	349,221	0.4	272,180	0.4	77,041	0.4
Vocational/technical/ commercial	369,365	0.4	293,178	0.4	76,187	0.5
Post middle/secondary certificate	243,739	0.3	175,201	0.3	68,538	0.4
Post-secondary diploma	484,766	0.2	399,342	0.2	85,424	0.3
Bachelor degree	373,641	0.2	328,707	0.2	44,934	0.2
Post graduate (Cert. Diploma Masters PHD etc.)	68,610	0.3	60,991	0.3	7,619	0.3
Male						
Total	10,988,971	0.5	5,535,088	0.4	5,453,883	0.5
Never attended	2,058,897	0.9	538,986	1.1	1,519,911	0.8
Nursery	364,111	0.3	175,066	0.3	189,045	0.3
Kindergarten	631,100	0.3	297,141	0.3	333,959	0.3
Primary	2,713,950	0.4	1,233,922	0.4	1,480,028	0.4
JSS/JHS	1,984,748	0.3	1,091,882	0.3	892,866	0.3
Middle	1,123,490	0.5	618,241	0.5	505,249	0.5
SSS/SHS	967,287	0.3	678,407	0.3	288,880	0.3
Secondary	223,952	0.5	167,237	0.5	56,715	0.4
Vocational/technical/ commercial	192,496	0.5	147,557	0.5	44,939	0.6
Post middle/secondary certificate	125,572	0.4	81,564	0.4	44,008	0.5
Post-secondary diploma	304,666	0.3	244,902	0.3	59,764	0.3
Bachelor degree	246,711	0.2	214,342	0.2	32,369	0.2
Post graduate (Cert. Diploma Masters PHD etc.)	51,991	0.3	45,841	0.3	6,150	0.3
Female						
Total	11,635,139	0.4	6,064,434	0.3	5,570,705	0.4
Never attended	3,240,987	0.7	1,107,034	0.7	2,133,953	0.6
Nursery	350,093	0.3	167,413	0.2	182,680	0.3
Kindergarten	601,727	0.2	283,810	0.2	317,917	0.3
Primary	2,901,623	0.3	1,433,764	0.3	1,467,859	0.3
JSS/JHS	2,063,311	0.2	1,230,198	0.2	833,113	0.2
Middle	944,017	0.3	613,342	0.3	330,675	0.4
SSS/SHS	789,427	0.2	600,717	0.2	188,710	0.2
Secondary	125,269	0.3	104,943	0.3	20,326	0.3
Vocational/technical/ commercial	176,869	0.3	145,621	0.3	31,248	0.3
Post middle/secondary certificate	118,167	0.2	93,637	0.2	24,530	0.2
Post-secondary diploma	180,100	0.2	154,440	0.2	25,660	0.1
Bachelor degree	126,930	0.1	114,365	0.1	12,565	0.1
Post graduate (Cert. Diploma Masters PHD etc.)	16,619	0.2	15,150	0.1	1,469	0.3

Source: Ghana Statistical Service, 2010 Population and Housing Census

Again, there were few of the population with bachelors' and above degrees, who included both males and females and who resided in urban and rural areas. Although it is difficult at this point to suggest any form of causality, it is possible that the low prevalence of hearing impairment among those in higher education category could have arisen because the lack of speech impairment served as a facilitator to obtaining higher education, particularly, when the prevalence rate of those who have never attended school are considered – overall (0.7%), urban (0.8%) and rural (0.7%).

6.5 Speech Impairment and Economic Activity Status

In a context where impairment of any sort does not become a barrier to active economic participation, dependency levels are likely to be low. It is within this remit of discourse that a look is taken at the economic participation of the Ghanaian population with speech impairment.

Of the total economically active population, there were 0.4% and 0.7% in urban and rural areas respectively with speech impairment, with a total prevalence of 0.5%. When this is disaggregated by employed, unemployed and not active status, there is consistency in higher speech impairment among those categorised as 'not active' at both types of localities and sex levels. That is, in each case, those economically inactive have the highest proportion. For instance, with both sexes, the prevalence rate among the 'not active' was 0.7% and in urban and rural areas, 0.6% and 0.8% respectively (Table 6.4).

Table 6.4: Speech impairment by economic activity status, sex type of locality

Economic Activity Status/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	15,208,425	0.5	8,222,949	0.4	6,985,476	0.7
Employed	10,243,476	0.4	5,125,635	0.3	5,117,841	0.4
Unemployed	575,807	0.4	410,267	0.3	165,540	0.4
Not active	4,389,142	0.7	2,687,047	0.6	1,702,095	0.8
Male						
Total	7,225,901	0.5	3,863,105	0.5	3,362,796	0.6
Employed	5,005,534	0.4	2,477,284	0.4	2,528,250	0.5
Unemployed	254,955	0.4	182,894	0.4	72,061	0.4
Not active	1,965,412	0.8	1,202,927	0.7	762,485	0.9
Female						
Total	7,982,524	0.4	4,359,844	0.4	3,622,680	0.5
Employed	5,237,942	0.3	2,648,351	0.3	2,589,591	0.3
Unemployed	320,852	0.3	227,373	0.3	93,479	0.4
Not active	2,423,730	0.6	1,484,120	0.5	939,610	0.8

Source: Ghana Statistical Service, 2010 Population and Housing Census

6.6 Speech Impairment and Region of Residence

In Table 6.5, prevalence of disability rate by sex, type of locality and region are shown. It could be noted that the Volta Region recorded the highest in the country. Related to this, the Eastern and Volta regions recorded the highest prevalence rates of 0.5% in urban communities while the Volta (0.6%) topped for the rural communities. In all, there are 0.4% people with speech impairment in urban areas compared to 0.5% in rural areas with a total aggregate of 0.4% in the country. The pattern observed for males and females does not starkly differ from what has been described in relation to type of locality as can be seen from Table 6.5.

Table 6.5: Speech impairment by region, sex and type of locality

Sex/Region	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.4	12,545,229	0.4	12,113,594	0.5
Western	2,376,021	0.4	1,007,969	0.4	1,368,052	0.4
Central	2,201,863	0.4	1,037,878	0.4	1,163,985	0.5
Greater Accra	4,010,054	0.3	3,630,955	0.3	379,099	0.3
Volta	2,118,252	0.6	713,735	0.5	1,404,517	0.6
Eastern	2,633,154	0.5	1,143,918	0.5	1,489,236	0.6
Ashanti	4,780,380	0.4	2,897,290	0.3	1,883,090	0.4
Brong Ahafo	2,310,983	0.4	1,028,473	0.4	1,282,510	0.4
Northern	2,479,461	0.3	750,712	0.3	1,728,749	0.3
Upper East	1,046,545	0.5	219,646	0.3	826,899	0.5
Upper West	702,110	0.4	114,653	0.3	587,457	0.4
Male						
Total	12,024,845	0.5	6,016,059	0.4	6,008,786	0.5
Western	1,187,774	0.4	490,699	0.4	697,075	0.4
Central	1,050,112	0.5	489,237	0.4	560,875	0.6
Greater Accra	1,938,225	0.4	1,752,132	0.4	186,093	0.3
Volta	1,019,398	0.6	336,560	0.5	682,838	0.7
Eastern	1,290,539	0.6	542,670	0.6	747,869	0.6
Ashanti	2,316,052	0.4	1,382,251	0.4	933,801	0.5
Brong Ahafo	1,145,271	0.4	491,681	0.4	653,590	0.5
Northern	1,229,887	0.3	370,476	0.3	859,411	0.3
Upper East	506,405	0.5	105,082	0.4	401,323	0.6
Upper West	341,182	0.4	55,271	0.4	285,911	0.5
Female						
Total	12,633,978	0.4	6,529,170	0.3	6,104,808	0.4
Western	1,188,247	0.3	517,270	0.3	670,977	0.4
Central	1,151,751	0.4	548,641	0.3	603,110	0.5
Greater Accra	2,071,829	0.3	1,878,823	0.3	193,006	0.3
Volta	1,098,854	0.5	377,175	0.5	721,679	0.6
Eastern	1,342,615	0.5	601,248	0.4	741,367	0.5
Ashanti	2,464,328	0.3	1,515,039	0.3	949,289	0.4
Brong Ahafo	1,165,712	0.3	536,792	0.3	628,920	0.4
Northern	1,249,574	0.3	380,236	0.3	869,338	0.3
Upper East	540,140	0.4	114,564	0.3	425,576	0.4
Upper West	360,928	0.3	59,382	0.3	301,546	0.3

Source: Ghana Statistical Service, 2010 Population and Housing Census

6.7 Speech Impairment by Ethnicity

The results in Table 6.6 show ethnicity and its relationship with speech impairment, generally. Speech impairment ranged from 0.3% to 0.5% for the total population and in urban areas, the pattern was similar to the national trends while in rural areas the range was 0.4% to 0.6%. Among males and females in urban and rural areas, speech impairment does not vary much from one ethnic group to another.

For males in urban areas, Gurma and Mole-Dagbani's reported the least (0.3%) prevalence of speech impairment and in rural areas, Gurmas, Mole-Dagbanis and Mandes recorded 0.4% of speech impairment each. Among females in urban areas, it is the same Gurmas and Mole-Dagbanis who had the least prevalence of speech impairment (0.2%) with about twice more among Ewe, Ga-Adangme and Guans (Table 6.6). Similar patterns are observed among females in rural areas.

Table 6.6: Speech impairment by ethnicity, sex and type of locality

Sex/Ethnicity	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	23,823,594	0.4	12,076,954	0.4	11,746,640	0.5
Akan	11,321,568	0.4	6,539,270	0.4	4,782,298	0.5
Ga-Adangbe	1,766,287	0.5	1,129,997	0.5	636,290	0.5
Ewe	3,323,072	0.5	1,620,419	0.4	1,702,653	0.6
Guan	879,861	0.4	425,885	0.4	453,976	0.4
Gurma	1,363,502	0.3	305,620	0.3	1,057,882	0.4
Mole-Dagbani	3,963,017	0.3	1,473,061	0.3	2,489,956	0.4
Grusi	594,248	0.4	219,319	0.4	374,929	0.4
Mande	269,842	0.4	148,298	0.3	121,544	0.4
Other	342,197	0.3	215,085	0.3	127,112	0.4
Total	11,591,394	0.5	5,772,748	0.4	5,818,646	0.5
Male						
Akan	5,435,472	0.5	3,101,899	0.4	2,333,573	0.5
Ga-Adangbe	857,458	0.5	534,004	0.5	323,454	0.5
Ewe	1,624,944	0.5	780,605	0.4	844,339	0.6
Guan	426,188	0.5	201,847	0.4	224,341	0.5
Gurma	683,301	0.4	151,568	0.3	531,733	0.4
Mole-Dagbani	1,969,428	0.4	720,520	0.3	1,248,908	0.4
Grusi	294,058	0.5	104,512	0.4	189,546	0.5
Mande	134,958	0.4	73,622	0.4	61,336	0.5
Other	165,587	0.4	104,171	0.4	61,416	0.4
Female						
Total	12,232,200	0.4	6,304,206	0.3	5,927,994	0.4
Akan	5,886,096	0.4	3,437,371	0.3	2,448,725	0.4
Ga-Adangbe	908,829	0.4	595,993	0.4	312,836	0.5
Ewe	1,698,128	0.5	839,814	0.4	858,314	0.5
Guan	453,673	0.4	224,038	0.4	229,635	0.4
Gurma	680,201	0.3	154,052	0.2	526,149	0.3
Mole-Dagbani	1,993,589	0.3	752,541	0.2	1,241,048	0.3
Grusi	300,190	0.3	114,807	0.3	185,383	0.3
Mande	134,884	0.3	74,676	0.3	60,208	0.4
Other	176,610	0.3	110,914	0.3	65,696	0.3

Source: Ghana Statistical Service, 2010 Population and Housing Census

6.8 Speech Impairment by Religion

In this section the connection between speech impairment, sex, type of locality and religion are presented (Table 6.7). Throughout the country, the population not affiliated to any religious group had the highest prevalence of speech impairment (0.7%) and the same prevalence rate is observed in urban and rural areas. Ghanaians who subscribed to Islamic faith recorded the least (0.3%). Respondents with no religious attachment also reported the highest prevalence of speech impairment among males and females in urban and rural areas.

Table 6.7: Speech impairment by religion, sex and type of locality

Religion/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.4	12,545,229	0.4	12,113,594	0.5
No Religion	1,302,077	0.7	479,550	0.7	822,527	0.7
Catholic	3,230,996	0.4	1,405,575	0.4	1,825,421	0.4
Protestant (Anglican Lutheran etc.)	4,534,178	0.4	2,540,118	0.4	1,994,060	0.5
Pentecostal/ Charismatic	6,980,792	0.4	4,140,660	0.3	2,840,132	0.5
Other Christians	2,800,871	0.4	1,476,093	0.4	1,324,778	0.5
Islam	4,345,723	0.3	2,264,792	0.3	2,080,931	0.3
Traditionalist	1,270,272	0.5	140,267	0.5	1,130,005	0.5
Other	193,914	0.5	98,174	0.5	95,740	0.5
Male						
Total	12,024,845	0.5	6,016,059	0.4	6,008,786	0.5
No Religion	804,239	0.7	307,011	0.7	497,228	0.7
Catholic	1,571,079	0.5	679,560	0.4	891,519	0.5
Protestant (Anglican Lutheran etc.)	2,132,619	0.5	1,180,722	0.4	951,897	0.5
Pentecostal/ Charismatic	3,240,237	0.4	1,894,241	0.4	1,345,996	0.5
Other Christians	1,331,390	0.5	695,457	0.4	635,933	0.5
Islam	2,203,837	0.4	1,138,846	0.3	1,064,991	0.4
Traditionalist	646,380	0.5	71,653	0.5	574,727	0.5
Other	95,064	0.5	48,569	0.5	46,495	0.5
Female						
Total	12,633,978	0.4	6,529,170	0.3	6,104,808	0.4
No Religion	497,838	0.7	172,539	0.7	325,299	0.7
Catholic	1,659,917	0.4	726,015	0.3	933,902	0.4
Protestant (Anglican Lutheran etc.)	2,401,559	0.4	1,359,396	0.3	1,042,163	0.4
Pentecostal/ Charismatic	3,740,555	0.3	2,246,419	0.3	1,494,136	0.4
Other Christians	1,469,481	0.4	780,636	0.3	688,845	0.4
Islam	2,141,886	0.3	1,125,946	0.3	1,015,940	0.3
Traditionalist	623,892	0.5	68,614	0.5	555,278	0.5
Other	98,850	0.5	49,605	0.4	49,245	0.5

Source: Ghana Statistical Service, 2010 Population and Housing Census

6.9 Discussion

This chapter has focused on prevalence of speech impairment analysed by sex and type of locality on one hand and age, education, marital status, activity status, educational attainment, region of residence, ethnicity and religion. The findings on speech impairment reveal variations among the different variables. The most outstanding observation in this chapter is in respect of the relationship between speech impairment and ageing. Ageing comes with biological degeneration and the most obvious signals of system degeneration are seen from impairments such as speech. This observation is consistent with some of the studies (Ashley, Duggan, & Sutcliffe, 2006) that have explored the links between ageing and speech impairment.

Speech impairment was also found to be higher among the widowed population than the others. This observation appears to have a connection with the observation regarding age. Given the prevailing life expectancy in the country, which is around 60 years, the proportion of the widowed with speech impairment is not out of the ordinary.

The proportion of the population with speech impairment who are not economically active was higher than the other categories. As McCormack et al. (2009) noted, speech impairment leads to enormous activity limitation. Self-employment and otherwise may therefore be obstructed leading to this pattern.

This analysis has also shown that the prevalence of speech impairment was higher among those who have never had formal education. Across sex and type of locality, the population without education reported speech impairments higher than the national average. Snowling, Adams, Bishop, Susan and Stothard (2009), Wolke, Samara, Bracewell and Marlow (2008) have shown that educational attainment of individuals with specific speech impairment poorer are poorer than those without impairments.

6.10 References

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CHAPTER SEVEN

PREVALENCE OF HEARING IMPAIRMENT

7.1 Introduction

Hearing impairment contributes significantly to the global burden of diseases yet less is known about this phenomenon particularly in developing countries (Stevens et al., 2013). Hearing impairment has a number of risk factors, with infections such rubella, measles and meningitis being some of the popular ones. Apart from these, the uses of ototoxic⁵ drugs are other risk factors (Freeland, Jones & Mohammed, 2010).

In Tanzania for instance, Freeland et al. (2010) found that ototoxic drugs given to children with fever with dosage not corresponding to child weight and poor gentamicin monitoring was a probable cause of about one-third moderate to severe deafness in Zanzibar, the study site. Away from the risk factors, hearing impairment can restrict social engagements such as schooling, and lead to other experiences such as emotional distresses as a result of hearing impairment (Gopinath et al., 2012). This chapter presents prevalence of hearing impairment in the country disaggregated by age, marital status, level of educational attainment, economic activity status, region, religion and ethnicity with sex and type of locality remain constant in all the comparisons.

7.2 Hearing Impairment and Age

In this section, the motivation is to examine the prevalence of hearing impairment in the country by sex, type of locality and age. Overall, prevalence of hearing impairment is highest among the oldest of the population, thus those 65+ years old among both males and females. Thus, about two out of every 100 (2.3%) old people in the country have hearing impairment. Gauged against locality, the highest prevalence is noted among the rural folks, the prevalence higher than the national average (2.7%).

The general trends in hearing impairment point to an age gradient with hearing impairment increasing towards the oldest. In terms of sex, the proportion of females with hearing impairment is higher than males and the females with hearing impairment in rural areas slightly outnumber those in urban areas. Possibly, the gender differentials could be accounted for by the relatively higher life expectancy among females than males in the country since ageing is one of the key determinants of hearing impairment.

¹ Ototoxic is a group of drugs that is harmful to the ear. They are generally found within the genre of antibiotics such as gentamicin. Apart from antibiotics, a number of non-steroidal anti-inflammatory drugs (NSAIDs) have also been shown to be ototoxic, leading to loss of sensor neural hearing, disequilibrium, or both, capable of causing temporary or permanent damage

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Table 7.1: Hearing impairment by age, sex and type of locality

Sex/Age Group	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.4	12,545,229	0.3	12,113,594	0.6
0 - 4	3,405,406	0.2	1,541,391	0.2	1,864,015	0.2
5 - 9	3,128,952	0.3	1,389,660	0.2	1,739,292	0.4
10 - 14	2,916,040	0.3	1,391,229	0.3	1,524,811	0.4
15 - 19	2,609,989	0.3	1,364,124	0.3	1,245,865	0.4
20 - 24	2,323,491	0.3	1,356,838	0.3	966,653	0.4
25 - 29	2,050,111	0.3	1,194,867	0.3	855,244	0.4
30 - 34	1,678,809	0.4	955,698	0.3	723,111	0.5
35 - 39	1,421,403	0.4	781,852	0.3	639,551	0.5
40 - 44	1,186,350	0.5	632,049	0.3	554,301	0.6
45 - 49	938,098	0.5	487,192	0.4	450,906	0.6
50 - 54	833,098	0.6	421,478	0.5	411,620	0.8
55 - 59	523,695	0.7	275,958	0.5	247,737	0.9
60 - 64	475,849	1	225,385	0.8	250,464	1.3
65 +	1,167,532	2.3	527,508	1.9	640,024	2.7
Male						
Total	12,024,845	0.4	6,016,059	0.3	6,008,786	0.5
0 - 4	1,731,787	0.2	783,017	0.2	948,770	0.2
5 - 9	1,589,632	0.3	697,031	0.2	892,601	0.4
10 - 14	1,477,525	0.3	672,906	0.3	804,619	0.4
15 - 19	1,311,112	0.3	651,829	0.3	659,283	0.4
20 - 24	1,100,727	0.3	642,140	0.3	458,587	0.4
25 - 29	943,213	0.3	553,927	0.3	389,286	0.4
30 - 34	790,301	0.4	455,204	0.3	335,097	0.5
35 - 39	676,768	0.4	373,678	0.3	303,090	0.5
40 - 44	572,620	0.4	304,875	0.3	267,745	0.6
45 - 49	452,975	0.5	231,146	0.3	221,829	0.6
50 - 54	394,600	0.6	195,556	0.4	199,044	0.8
55 - 59	258,582	0.7	132,984	0.5	125,598	0.9
60 - 64	227,050	0.9	105,738	0.7	121,312	1.1
65 +	497,953	2	216,028	1.6	281,925	2.3
Female						
Total	12,633,978	0.5	6,529,170	0.4	6,104,808	0.6
0 - 4	1,673,619	0.2	758,374	0.2	915,245	0.2
5 - 9	1,539,320	0.3	692,629	0.2	846,691	0.3
10 - 14	1,438,515	0.3	718,323	0.3	720,192	0.4
15 - 19	1,298,877	0.3	712,295	0.3	586,582	0.4
20 - 24	1,222,764	0.3	714,698	0.3	508,066	0.4
25 - 29	1,106,898	0.3	640,940	0.3	465,958	0.4
30 - 34	888,508	0.4	500,494	0.3	388,014	0.5
35 - 39	744,635	0.4	408,174	0.3	336,461	0.5
40 - 44	613,730	0.5	327,174	0.4	286,556	0.6
45 - 49	485,123	0.5	256,046	0.4	229,077	0.7
50 - 54	438,498	0.7	225,922	0.5	212,576	0.8
55 - 59	265,113	0.8	142,974	0.6	122,139	1
60 - 64	248,799	1.1	119,647	0.9	129,152	1.4
65 +	669,579	2.5	311,480	2	358,099	2.9

Source: Ghana Statistical Service, 2010 Population and Housing Census

7.3 Hearing Impairment and Marital Status

Generally, there is a positive relationship between marital status and health. Although the trajectories of marital status and health appear complex, it is largely accepted that married people are more likely to engage in health promoting behaviours than unmarried people. The married are inclined towards health promoting behaviours because of feeling of being responsible to some significant others. However, extent of connection between physical impairment and marital status is not clearly understood; particularly whether it constrains prospects of marriage.

The relationship between hearing impairment and marital status is presented in Table 7.2. In all, 0.5% of the married population (males and females) reported hearing impairment and by type of locality, 0.4% of the population in marriageable age group in urban communities reported this impairment while 0.7% in rural areas reported so. The specifics do not show much variation. However, the rate of hearing impairment among the widowed is about four (2.2%) times higher compared to the overall (0.5%). Similar higher prevalence of hearing impairment is noted by sex and type of locality (Table 7.2%).

Table 7.2: Hearing impairment by marital status, sex and type of locality

Marital Status/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	16,886,306	0.5	9,037,989	0.4	7,848,317	0.7
Never married	7,087,098	0.4	4,148,038	0.3	2,939,060	0.5
Informal/consensual union/living together	847,735	0.4	452,413	0.3	395,322	0.4
Married	7,237,730	0.5	3,556,630	0.3	3,681,100	0.6
Separated	315,910	0.8	173,447	0.6	142,463	1.1
Divorced	574,271	1.1	307,399	0.8	266,872	1.4
Widowed	823,562	2.2	400,062	1.7	423,500	2.7
Male						
Total	8,072,481	0.5	4,252,234	0.4	3,820,247	0.6
Never married	3,947,792	0.4	2,213,375	0.3	1,734,417	0.5
Informal/consensual union/living together	370,191	0.3	199,643	0.3	170,548	0.4
Married	3,364,153	0.5	1,653,073	0.4	1,711,080	0.7
Separated	107,970	0.9	53,274	0.7	54,696	1.1
Divorced	176,509	1.2	83,603	0.9	92,906	1.5
Widowed	105,866	2.4	49,266	1.9	56,600	2.8
Female						
Total	8,813,825	0.6	4,785,755	0.4	4,028,070	0.7
Never married	3,139,306	0.4	1,934,663	0.3	1,204,643	0.5
Informal/consensual union/living together	477,544	0.4	252,770	0.3	224,774	0.5
Married	3,873,577	0.4	1,903,557	0.3	1,970,020	0.5
Separated	207,940	0.8	120,173	0.6	87,767	1
Divorced	397,762	1	223,796	0.7	173,966	1.3
Widowed	717,696	2.2	350,796	1.7	366,900	2.7

Source: Ghana Statistical Service, 2010 Population and Housing Census

7.4 Hearing Impairment and Educational Characteristics

In a developing country setting, hearing impairment can be a delimiting condition to obtaining educational opportunities. This may also be underlined by lack of facilities that provide friendly learning environments. It is therefore important to determine the linkages between hearing impairment, type of locality and level of education. As can be observed from Table 7.3, there is not a very clear-cut difference in hearing impairment by type of locality, sex and education. However, the near-to-obvious is the relationship between never attended school and hearing impairment. Exactly 1% of all Ghanaians who have never attended school had hearing impairment and this is the case in both urban and rural areas and same prevalence cuts across the sexes. It could be that these are those with permanent hearing and speech difficulties and must have as well prevented them from obtaining formal education.

Table 7.3: Hearing impairment by level of education, sex and type of locality

Education/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	22,624,110	0.5	11,599,522	0.4	11,024,588	0.6
Never attended	5,299,884	1.0	1,646,020	0.9	3,653,864	1
Nursery	714,204	0.2	342,479	0.2	371,725	0.3
Kindergarten	1,232,827	0.2	580,951	0.2	651,876	0.3
Primary	5,615,573	0.4	2,667,686	0.3	2,947,887	0.4
JSS/JHS	4,048,059	0.3	2,322,080	0.2	1,725,979	0.3
Middle	2,067,507	0.5	1,231,583	0.4	835,924	0.6
SSS/SHS	1,756,714	0.2	1,279,124	0.2	477,590	0.3
Secondary	349,221	0.4	272,180	0.3	77,041	0.5
Vocational/technical/ commercial	369,365	0.4	293,178	0.3	76,187	0.4
Post middle/secondary certificate	243,739	0.3	175,201	0.3	68,538	0.4
Post-secondary diploma	484,766	0.2	399,342	0.2	85,424	0.2
Bachelor degree	373,641	0.2	328,707	0.2	44,934	0.1
Post graduate (Cert. Diploma Masters PHD etc.)	68,610	0.2	60,991	0.2	7,619	0.3
Male						
Total	10,988,971	0.4	5,535,088	0.3	5,453,883	0.5
Never attended	2,058,897	0.9	538,986	0.9	1,519,911	0.9
Nursery	364,111	0.2	175,066	0.2	189,045	0.3
Kindergarten	631,100	0.2	297,141	0.2	333,959	0.2
Primary	2,713,950	0.4	1,233,922	0.3	1,480,028	0.4
JSS/JHS	1,984,748	0.3	1,091,882	0.2	892,866	0.3
Middle	1,123,490	0.6	618,241	0.5	505,249	0.7
SSS/SHS	967,287	0.2	678,407	0.2	288,880	0.3
Secondary	223,952	0.4	167,237	0.3	56,715	0.5
Vocational/technical/ commercial	192,496	0.4	147,557	0.4	44,939	0.5
Post middle/secondary certificate	125,572	0.4	81,564	0.4	44,008	0.5
Post-secondary diploma	304,666	0.2	244,902	0.2	59,764	0.3
Bachelor degree	246,711	0.2	214,342	0.2	32,369	0.2
Post graduate (Cert. Diploma Masters PHD etc.)	51,991	0.2	45,841	0.2	6,150	0.3

Table 7.3: Hearing impairment by level of education, sex and type of locality (cont'd)

Education/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Female						
Total	11,635,139	0.5	6,064,434	0.4	5,570,705	0.6
Never attended	3,240,987	1	1,107,034	1	2,133,953	1
Nursery	350,093	0.2	167,413	0.2	182,680	0.3
Kindergarten	601,727	0.2	283,810	0.2	317,917	0.3
Primary	2,901,623	0.4	1,433,764	0.3	1,467,859	0.4
JSS/JHS	2,063,311	0.3	1,230,198	0.2	833,113	0.3
Middle	944,017	0.5	613,342	0.4	330,675	0.6
SSS/SHS	789,427	0.2	600,717	0.2	188,710	0.3
Secondary	125,269	0.3	104,943	0.3	20,326	0.4
Vocational/technical/commercial	176,869	0.3	145,621	0.3	31,248	0.4
Post middle/secondary certificate	118,167	0.3	93,637	0.3	24,530	0.3
Post-secondary diploma	180,100	0.2	154,440	0.2	25,660	0.1
Bachelor degree	126,930	0.1	114,365	0.1	12,565	0.1
Post graduate (Cert. Diploma Masters PHD etc.)	16,619	0.2	15,150	0.2	1,469	0.3

Source: Ghana Statistical Service, 2010 Population and Housing Census

7.5 Hearing Impairment and Economic Activity Status

In both urban and rural areas, hearing impairment appears to be a barrier to active participation in economic activities. It is observed from Table 7.4 that the population with hearing impairment was relatively higher than the employed and unemployed. About 1% of those not active economically reported hearing impairment. Between urban and rural areas, some minor variations are noted. Thus, about 1.1% of the not active population in rural areas compared to 0.6% in urban areas reported some form of hearing impairment. The prevalence of hearing impairment against sex by type of locality also portends slim differences. As can be seen from Table 7.4, the overall females not active with hearing impairment constituted 0.9% and this also varied minimally by type of locality (0.7% in urban and 1.3% in rural areas).

Table 7.4: Hearing impairment by economic activity status, sex and type of locality

Sex/Activity	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	15,208,425	0.6	8,222,949	0.4	6,985,476	0.7
Employed	10,243,476	0.5	5,125,635	0.3	5,117,841	0.6
Unemployed	575,807	0.3	410,267	0.3	165,540	0.5
Not active	4,389,142	0.8	2,687,047	0.6	1,702,095	1.1
Male						
Total	7,225,901	0.5	3,863,105	0.4	3,362,796	0.7
Employed	5,005,534	0.4	2,477,284	0.3	2,528,250	0.6
Unemployed	254,955	0.3	182,894	0.3	72,061	0.4
Not active	1,965,412	0.7	1,202,927	0.5	762,485	0.9
Female						
Total	7,982,524	0.6	4,359,844	0.5	3,622,680	0.8
Employed	5,237,942	0.5	2,648,351	0.3	2,589,591	0.6
Unemployed	320,852	0.4	227,373	0.3	93,479	0.5
Not active	2,423,730	0.9	1,484,120	0.7	939,610	1.3

Source: Ghana Statistical Service, 2010 Population and Housing Census

7.6 Hearing Impairment by Region of Residence

Differences in spatial conditions can occasion varying health disparities. Usually, such variations could be accounted for by specific environmental conditions that predispose residents to health hazards. This provides a good motivation for exploring hearing impairment by type of locality and region of residence. Overall, hearing impairment in the country in respect of region of residence ranged from 0.3% in the Western Region to 0.8% in the Upper East Region and in terms of urban-rural dimension, the rate of hearing impairment in the urban Volta and Upper West Regions were about the same; 0.8% while in the rural area areas, Upper East reported the highest prevalence of hearing impairment.

Table 7.5: Hearing impairment by region, sex and type of locality

Sex/Region	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.4	12,545,229	0.5	12,113,594	0.6
Western	2,376,021	0.4	1,007,969	0.4	1,368,052	0.4
Central	2,201,863	0.5	1,037,878	0.4	1,163,985	0.6
Greater Accra	4,010,054	0.3	3,630,955	0.6	379,099	0.3
Volta	2,118,252	0.7	713,735	0.8	1,404,517	0.7
Eastern	2,633,154	0.6	1,143,918	0.6	1,489,236	0.6
Ashanti	4,780,380	0.4	2,897,290	0.4	1,883,090	0.5
Brong Ahafo	2,310,983	0.4	1,028,473	0.5	1,282,510	0.4
Northern	2,479,461	0.4	750,712	0.5	1,728,749	0.5
Upper East	1,046,545	0.8	219,646	0.4	826,899	0.9
Upper West	702,110	0.7	114,653	0.8	587,457	0.7
Male						
Total	12,024,845	0.4	6,016,059	0.5	6,008,786	0.5
Western	1,187,774	0.4	490,699	0.4	697,075	0.4
Central	1,050,112	0.4	489,237	0.4	560,875	0.5
Greater Accra	1,938,225	0.3	1,752,132	0.5	186,093	0.3
Volta	1,019,398	0.6	336,560	0.7	682,838	0.7
Eastern	1,290,539	0.5	542,670	0.6	747,869	0.6
Ashanti	2,316,052	0.3	1,382,251	0.4	933,801	0.4
Brong Ahafo	1,145,271	0.4	491,681	0.5	653,590	0.4
Northern	1,229,887	0.4	370,476	0.5	859,411	0.5
Upper East	506,405	0.7	105,082	0.4	401,323	0.8
Upper West	341,182	0.6	55,271	0.8	285,911	0.6
Female						
Total	12,633,978	0.5	6,529,170	0.5	6,104,808	0.6
Western	1,188,247	0.4	517,270	0.4	670,977	0.4
Central	1,151,751	0.5	548,641	0.4	603,110	0.6
Greater Accra	2,071,829	0.3	1,878,823	0.6	193,006	0.3
Volta	1,098,854	0.7	377,175	0.8	721,679	0.8
Eastern	1,342,615	0.6	601,248	0.7	741,367	0.7
Ashanti	2,464,328	0.4	1,515,039	0.4	949,289	0.5
Brong Ahafo	1,165,712	0.4	536,792	0.5	628,920	0.5
Northern	1,249,574	0.4	380,236	0.5	869,338	0.5
Upper East	540,140	0.9	114,564	0.4	425,576	1
Upper West	360,928	0.7	59,382	0.9	301,546	0.7

Source: Ghana Statistical Service, 2010 Population and Housing Census

Considered by gender, hearing impairment ranged from 0.3% to 0.7% in the Greater Accra and Upper East Regions respectively with Upper West recording the highest rate among males while the Upper East had the highest among females (Table 7.5). In a further look at

the pattern by type of locality, hearing impairment in urban areas by sexes is found to be higher among those in the Upper West Region for both sexes but in rural areas, it is rather higher in the Upper East among males and females.

7.7 Hearing Impairment and Ethnicity

As can be seen from the Table 7.6, the data reveal some minor ethnic variations in prevalence of hearing impairment. Akan, Ewe, Mande and Others recorded the least rate of hearing impairment of 0.4% while Mole-Dagbani was slightly ahead with 0.6%. By locality, Grussis and Ewes in urban and rural communities topped with 0.7% of the population with hearing impairment. In respect of the sexes, virtually no ethnic differences are among males in general and in urban and rural areas except that male Grussis in rural areas somewhat reported higher rates of hearing impairment (0.7%). Almost the same pattern is seen among females overall and in urban areas, albeit Mole-Dagbanis and Ga-Adangbe's in rural areas reported the highest prevalence.

Table 7.6: Hearing impairment by ethnic group, sex and type of locality

Ethnicity/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	23,823,594	0.4	12,076,954	0.6	11,746,640	0.6
Akan	11,321,568	0.4	6,539,270	0.5	4,782,298	0.5
Ga-Adangbe	1,766,287	0.5	1,129,997	0.5	636,290	0.5
Ewe	3,323,072	0.4	1,620,419	0.7	1,702,653	0.7
Guan	879,861	0.5	425,885	0.5	453,976	0.5
Gurma	1,363,502	0.5	305,620	0.5	1,057,882	0.5
Mole-Dagbani	3,963,017	0.6	1,473,061	0.6	2,489,956	0.6
Grusi	594,248	0.5	219,319	0.7	374,929	0.7
Mande	269,842	0.4	148,298	0.6	121,544	0.6
Other	342,197	0.4	215,085	0.4	127,112	0.4
Male						
Total	11,591,394	0.4	5,772,748	0.3	5,818,646	0.5
Akan	5,435,472	0.4	3,101,899	0.4	2,333,573	0.5
Ga-Adangbe	857,458	0.5	534,004	0.4	323,454	0.6
Ewe	1,624,944	0.4	780,605	0.4	844,339	0.4
Guan	426,188	0.5	201,847	0.3	224,341	0.5
Gurma	683,301	0.5	151,568	0.3	531,733	0.6
Mole-Dagbani	1,969,428	0.5	720,520	0.4	1,248,908	0.6
Grusi	294,058	0.5	104,512	0.4	189,546	0.7
Mande	134,958	0.3	73,622	0.3	61,336	0.4
Other	165,587	0.4	104,171	0.3	61,416	0.5
Female						
Total	12,173,592	0.4	6,280,612	0.4	5,892,980	0.6
Akan	5,860,010	0.4	3,424,905	0.4	2,435,105	0.5
Ga-Adangbe	904,781	0.6	593,648	0.4	311,133	0.7
Ewe	1,688,631	0.5	836,424	0.4	852,207	0.6
Guan	451,460	0.5	223,104	0.4	228,356	0.5
Gurma	676,844	0.5	153,501	0.4	523,343	0.6
Mole-Dagbani	1,983,427	0.6	749,896	0.5	1,233,531	0.7
Grusi	298,269	0.5	114,232	0.4	184,037	0.6
Mande	134,203	0.4	74,349	0.3	59,854	0.4
Other	175,967	0.4	110,553	0.4	65,414	0.6

Source: Ghana Statistical Service, 2010 Population and Housing Census

7.8 Hearing Impairment and Religion

The interface between religion and health has become popular, given the prominence of religion to African life (Gyimah, 2007; Yirenskyi, 2000). Religion can affect people's attitudes towards specific health issues and subsequent health seeking behaviours. Hearing impairment in this section is discussed with religion as the key factor. In all, 0.4% of the population had hearing impairment; with the proportion in urban areas being 0.3% while 0.6% was in rural areas.

As expected, some religious groups reported more rates higher than the national averages. For instance, Traditionalists with hearing impairment were 0.9% compared to 0.4% reported among Protestants, Pentecostal/Charismatics, Other Christians and those of the Islamic faith. In terms of urban-rural manifestations, Traditionalist showed higher experiences of hearing impairment than all the other religious groups (Table 7.7). Analysed by gender, males and females affiliated to Traditional religion in both urban and rural areas reported the highest rates of hearing impairment compared to those of other religions.

Table 7.7: Hearing impairment by religion, sex and type of locality

Religion/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.4	12,545,229	0.3	12,113,594	0.6
No Religion	1,302,077	0.7	479,550	0.6	822,527	0.8
Catholic	3,230,996	0.5	1,405,575	0.4	1,825,421	0.6
Protestant (Anglican Lutheran etc.)	4,534,178	0.4	2,540,118	0.4	1,994,060	0.5
Pentecostal/Charismatic	6,980,792	0.4	4,140,660	0.3	2,840,132	0.5
Other Christians	2,800,871	0.4	1,476,093	0.4	1,324,778	0.5
Islam	4,345,723	0.4	2,264,792	0.3	2,080,931	0.4
Traditionalist	1,270,272	0.9	140,267	0.8	1,130,005	0.9
Other	193,914	0.5	98,174	0.5	95,740	0.6
Male						
Total	12,024,845	0.4	6,016,059	0.3	6,008,786	0.5
No Religion	804,239	0.6	307,011	0.5	497,228	0.7
Catholic	1,571,079	0.4	679,560	0.3	891,519	0.5
Protestant (Anglican Lutheran etc.)	2,132,619	0.4	1,180,722	0.3	951,897	0.5
Pentecostal/Charismatic	3,240,237	0.3	1,894,241	0.2	1,345,996	0.4
Other Christians	1,331,390	0.4	695,457	0.3	635,933	0.4
Islam	2,203,837	0.4	1,138,846	0.3	1,064,991	0.4
Traditionalist	646,380	0.8	71,653	0.8	574,727	0.8
Other	95,064	0.5	48,569	0.4	46,495	0.5
Female						
Total	12,633,978	0.5	6,529,170	0.4	6,104,808	0.6
No Religion	497,838	0.8	172,539	0.7	325,299	0.8
Catholic	1,659,917	0.5	726,015	0.4	933,902	0.6
Protestant (Anglican Lutheran etc.)	2,401,559	0.5	1,359,396	0.4	1,042,163	0.6
Pentecostal/Charismatic	3,740,555	0.4	2,246,419	0.3	1,494,136	0.5
Other Christians	1,469,481	0.5	780,636	0.4	688,845	0.6
Islam	2,141,886	0.4	1,125,946	0.4	1,015,940	0.4
Traditionalist	623,892	0.9	68,614	0.9	555,278	0.9
Other	98,850	0.6	49,605	0.5	49,245	0.7

Source: Ghana Statistical Service, 2010 Population and Housing Census

7.9 Discussion

This chapter aimed at highlighting the prevalence of hearing impairment among the various categories of age, marital status, activity status, level of educational attainment, ethnicity, religion and region of residence and across sex and type of locality (urban-rural). The most obvious difference observed is in relation to age and hearing impairment. The pattern of hearing impairment shows positive association with ageing. With increasing life expectancy in the country, the population of the aged is expected to increase as more successes are made in the control of infectious diseases.

Prior studies have shown that the hearing impairment arising from ageing is bilateral and gradual processes that affect peripheral and central structures of the auditory system (Gates & Mills, 2005). Findings by Lee, Matthews, Dubno and Mills (2005) show that among adults aged 60 and over, the degenerative process results in a decrease of 1dB hearing threshold per annum. Aged men have also been found to be at a higher risk of experiencing hearing impairment (Cruickshanks et al., 1998; Jerger, Chmiel, Wilson, & Luchi, 1995), although the findings in this report show a contrary situation – the rate of hearing impairment is higher among females than males. The normal decline in the ability to hear with age is called presbycusis. With presbycusis, people lose the ability to hear higher-pitched sounds (Yorgason, Piercy, & Piercy, 2007).

The results also show that hearing impairment is higher among widowed women than men. When one spouse develops a hearing loss, communication and interactions between a couple once taken for granted, can become difficult, adversely affecting relationship (Hétu, Jones, & Getty, 1993; Piercy & Piercy, 2002). Hearing-related communication difficulties may be especially challenging for couples where one spouse acquires a hearing loss after relationship patterns have become established, such as in later life. Although couples may encounter communication barriers when one spouse has a hearing loss, they may develop strengths in response to the challenges they face. The finding that hearing impairment was higher among the widowed who were more likely to be females may be related to higher life expectancy among females than males.

The “not active” population was also found to have higher prevalence of hearing impairment than the remaining groups. Although there is a potential of reverse causality in hearing impairment and activity status, the most likely in this case is that hearing impairment is likely to serve as barrier to active participation in economic activities. Laplante-Lévesque, Hickson and Worrall (2010) have reported that hearing impairment may lead to activity limitation as a result of withdrawal from previous involvement in community life; and avoidance of interpersonal interactions amongst others.

Religious differences are noted in hearing impairment with Traditionalist at higher risk. Religion and health issues have received recent academic discourses (see, Gyimah, 2006; Gyimah, 2006; Gyimah, Adjei & Takyi, 2011; Gyimah, Takyi, & Addai, 2006; Gyimah, Takyi & Tenkorang, 2008; Gyimah, Tenkorang, Takyi, Adjei, & Fosu, 2010) albeit, none has explored religion-disability interface.

7.10 References

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CHAPTER EIGHT

PREVALENCE OF EMOTIONAL/BEHAVIOURAL DISABILITY

8.1 Introduction

Emotional disability has to do with the kind of impairment that stifles an individual's ability to recognise, interpret and express basic emotions in life (Jordan, 2006). Emotional disability may manifest itself through depression, anxiety or inappropriate types of behaviours or feelings under normal circumstances. Emotional impairment most usually referred to as emotional disability (ED) is among the common types of impairment world over (Mullins & Preyde, 2013). It has the tendency to affect one's daily dealings and interactions with societal members. Subsequently, it is imperative to discuss the dynamics across different demographic variables in order to ascertain the true picture of emotional disability in the country.

8.2 Emotional Disability and Age

Table 8.1 shows that there was 0.6% of the population with emotional/behavioural disability and a higher proportion (0.6%) lived in rural areas as compared to urban areas (0.5%). People aged 65 years and above had higher proportion (1.3%) of emotional/behavioral impairment followed by those in the age category of 50-54 (0.9%), and those in the ages of 60-64, 45-49 and 40-44 with a proportion of 0.8%. The age group with the least proportion of people with emotional impairment is those aged between zero (0) and four (4) years with a proportion of 0.3%. However, for the age group of 65 years and above, there was higher proportion of people with emotional disability in urban communities (1.3%) than rural communities (1.2%).

The proportion of females with emotional disability is higher (0.6%) than males (0.5%). There are generally equal proportions of males and females with emotional disability across most of the age categories except the age group of 65+ where there were more females (1.3%) than males (1.2%) as well as age group of 55-59.

Table 8.1: Emotional disability by age, sex and type of locality

Age Group/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.6	12,545,229	0.5	12,479,030	0.6
0 - 4	3,405,406	0.3	1,541,391	0.3	1,537,059	0.3
5 - 9	3,128,952	0.3	1,389,660	0.3	1,385,577	0.3
10 - 14	2,916,040	0.4	1,391,229	0.3	1,386,534	0.4
15 - 19	2,609,989	0.5	1,364,124	0.4	1,358,323	0.5
20 - 24	2,323,491	0.5	1,356,838	0.5	1,350,216	0.6
25 - 29	2,050,111	0.6	1,194,867	0.6	1,187,992	0.7
30 - 34	1,678,809	0.7	955,698	0.6	949,581	0.7
35 - 39	1,421,403	0.7	781,852	0.6	776,803	0.8
40 - 44	1,186,350	0.8	632,049	0.7	627,485	0.8
45 - 49	938,098	0.8	487,192	0.7	483,608	0.9
50 - 54	833,098	0.9	421,478	0.8	418,099	0.9
55 - 59	523,695	0.8	275,958	0.8	273,651	0.9
60 - 64	475,849	1	225,385	1	223,233	1
65 +	1,167,532	1.3	527,508	1.3	520,869	1.2
Male						
Total	12,024,845	0.5	6,016,059	0.5	5,985,300	0.6
0 - 4	1,731,787	0.3	783,017	0.3	780,779	0.3
5 - 9	1,589,632	0.3	697,031	0.3	694,935	0.3
10 - 14	1,477,525	0.4	672,906	0.3	670,697	0.4
15 - 19	1,311,112	0.5	651,829	0.4	649,108	0.5
20 - 24	1,100,727	0.5	642,140	0.5	639,164	0.6
25 - 29	943,213	0.6	553,927	0.6	550,786	0.7
30 - 34	790,301	0.7	455,204	0.7	452,200	0.8
35 - 39	676,768	0.7	373,678	0.6	371,328	0.8
40 - 44	572,620	0.8	304,875	0.7	302,689	0.9
45 - 49	452,975	0.8	231,146	0.8	229,395	0.9
50 - 54	394,600	0.9	195,556	0.8	194,018	0.9
55 - 59	258,582	0.8	132,984	0.8	131,942	0.8
60 - 64	227,050	1	105,738	0.9	104,769	1
65 +	497,953	1.2	216,028	1.2	213,490	1.2
Female						
Total	12,633,978	0.6	6,529,170	0.5	6,493,730	0.6
0 - 4	1,673,619	0.3	758,374	0.3	756,280	0.3
5 - 9	1,539,320	0.3	692,629	0.3	690,642	0.3
10 - 14	1,438,515	0.4	718,323	0.3	715,837	0.4
15 - 19	1,298,877	0.5	712,295	0.4	709,215	0.5
20 - 24	1,222,764	0.5	714,698	0.5	711,052	0.6
25 - 29	1,106,898	0.6	640,940	0.6	637,206	0.7
30 - 34	888,508	0.7	500,494	0.6	497,381	0.7
35 - 39	744,635	0.7	408,174	0.7	405,475	0.7
40 - 44	613,730	0.8	327,174	0.7	324,796	0.8
45 - 49	485,123	0.8	256,046	0.7	254,213	0.8
50 - 54	438,498	0.8	225,922	0.8	224,081	0.9
55 - 59	265,113	0.9	142,974	0.9	141,709	0.9
60 - 64	248,799	1	119,647	1	118,464	1
65 +	669,579	1.3	311,480	1.3	307,379	1.3

Source: Ghana Statistical Service, 2010 Population and Housing Census

8.3 Emotional Disability and Marital Status

Table 8.2 shows that there is 0.7% of the population in the marriage age with emotional disability out of which there was a higher proportion living in the rural areas (0.7%) than urban areas (0.6%). Those who are separated, divorced or widowed had higher proportion (1.3%) of people with emotional disability than other marital statuses. However, there is higher proportion of separated (1.3%) and divorced (1.3%) people with emotional disability living in rural than urban communities while the proportion of widowed with emotional disability was same (1.3%) in rural and urban communities.

There are equal proportions (0.7%) of males and females and, in rural (0.9%) and urban areas (0.8%) with emotional disability. The proportion of males who are separated, divorced and widowed with emotional disability was higher than that of females. Divorced males have higher proportion of people with emotional disability (1.5%) than divorced females (1.2%).

Married males and females have the lowest proportion of people with emotional disability (0.6%). There are more divorced males with emotional disability in rural areas (1.7%) than females (1.4%) as well as more separated (1.4%) and widowed (1.4%) males in rural areas than females. Also the proportion of separated (1.4%), divorced (1.4%) and widowed (1.4%) with emotional disability in the urban is higher than that of females. There are more married people (males and females) with emotional disability (0.6%) in rural areas than urban areas (0.5%).

Table 8.2: Emotional disability by sex, type of locality and marital status

Marital Status / Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	16,886,306	0.7	9,037,989	0.6	7,848,317	0.7
Never married	7,087,098	0.6	4,148,038	0.5	2,939,060	0.7
Informal/consensual union/living together	847,735	0.8	452,413	0.8	395,322	0.9
Married	7,237,730	0.6	3,556,630	0.5	3,681,100	0.6
Separated	315,910	1.3	173,447	1.2	142,463	1.3
Divorced	574,271	1.3	307,399	1.2	266,872	1.5
Widowed	823,562	1.3	400,062	1.3	423,500	1.3
Male						
Total	8,072,481	0.7	4,252,234	0.6	3,820,247	0.7
Never married	3,947,792	0.6	2,213,375	0.6	1,734,417	0.7
Informal/consensual union/living together	370,191	0.8	199,643	0.8	170,548	0.9
Married	3,364,153	0.6	1,653,073	0.5	1,711,080	0.6
Separated	107,970	1.4	53,274	1.4	54,696	1.4
Divorced	176,509	1.5	83,603	1.4	92,906	1.7
Widowed	105,866	1.4	49,266	1.4	56,600	1.4
Female						
Total	8,813,825	0.7	4,785,755	0.6	4,028,070	0.7
Never married	3,139,306	0.6	1,934,663	0.5	1,204,643	0.6
Informal/consensual union/living together	477,544	0.8	252,770	0.8	224,774	0.9
Married	3,873,577	0.6	1,903,557	0.5	1,970,020	0.6
Separated	207,940	1.2	120,173	1.1	87,767	1.3
Divorced	397,762	1.2	223,796	1.1	173,966	1.4
Widowed	717,696	1.3	350,796	1.3	366,900	1.3

Source: Ghana Statistical Service, 2010 Population and Housing Census

8.4 Emotional Disability and Educational Characteristics

Those who have had any formal education have the highest proportion of emotional disability (0.9%), followed by those who have had middle school education (0.8%) as shown in Table 8.3. Middle school leavers have the highest proportion of emotional disability in rural areas (0.9%) followed by those who have never had any formal education (0.8%). However, those without any formal education have the highest prevalence among urban residents (1.0%).

The highest proportion of those with emotional disability among both sexes are people who have never had any formal education (0.9%). Also the proportion of males with emotional disability who have had middle school education in rural areas is higher (0.9%) than females (0.8%). Generally, there were equal proportions of males and females with emotional disability living in rural and urban areas across most of the educational levels.

Table 8.3: Emotional disability by level of education, sex and type of locality

Sex/Education	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	22,624,110	0.6	11,599,522	0.5	11,024,588	0.6
Never attended	5,299,884	0.9	1,646,020	1	3,653,864	0.8
Nursery	714,204	0.3	342,479	0.3	371,725	0.3
Kindergarten	1,232,827	0.3	580,951	0.2	651,876	0.3
Primary	5,615,573	0.5	2,667,686	0.4	2,947,887	0.5
JSS/JHS	4,048,059	0.5	2,322,080	0.5	1,725,979	0.5
Middle	2,067,507	0.8	1,231,583	0.8	835,924	0.9
SSS/SHS	1,756,714	0.4	1,279,124	0.4	477,590	0.4
Secondary	349,221	0.7	272,180	0.7	77,041	0.7
Vocational/technical/ commercial	369,365	0.6	293,178	0.6	76,187	0.7
Post middle/secondary certificate	243,739	0.6	175,201	0.6	68,538	0.7
Post-secondary diploma	484,766	0.4	399,342	0.4	85,424	0.5
Bachelor degree	373,641	0.4	328,707	0.4	44,934	0.3
Post graduate (Cert. Diploma Masters PHD etc.)	68,610	0.4	60,991	0.4	7,619	0.5
Male						
Total	10,988,971	0.6	5,535,088	0.5	5,453,883	0.6
Never attended	2,058,897	0.9	538,986	1.1	1,519,911	0.8
Nursery	364,111	0.3	175,066	0.3	189,045	0.3
Kindergarten	631,100	0.3	297,141	0.2	333,959	0.3
Primary	2,713,950	0.5	1,233,922	0.4	1,480,028	0.5
JSS/JHS	1,984,748	0.5	1,091,882	0.5	892,866	0.5
Middle	1,123,490	0.8	618,241	0.8	505,249	0.9
SSS/SHS	967,287	0.4	678,407	0.4	288,880	0.5
Secondary	223,952	0.7	167,237	0.7	56,715	0.8
Vocational/technical/ commercial	192,496	0.6	147,557	0.6	44,939	0.7
Post middle/secondary certificate	125,572	0.6	81,564	0.6	44,008	0.8
Post-secondary diploma	304,666	0.4	244,902	0.4	59,764	0.5
Bachelor degree	246,711	0.4	214,342	0.4	32,369	0.3
Post graduate (Cert. Diploma Masters PHD etc.)	51,991	0.4	45,841	0.4	6,150	0.5

Table 8.3: Emotional disability by level of education, sex and type of locality (cont'd)

Sex/Education	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Female						
Total	11,635,139	0.6	6,064,434	0.6	5,570,705	0.6
Never attended	3,240,987	0.9	1,107,034	0.9	2,133,953	0.8
Nursery	350,093	0.3	167,413	0.3	182,680	0.3
Kindergarten	601,727	0.3	283,810	0.2	317,917	0.3
Primary	2,901,623	0.5	1,433,764	0.5	1,467,859	0.5
JSS/JHS	2,063,311	0.5	1,230,198	0.5	833,113	0.5
Middle	944,017	0.8	613,342	0.7	330,675	0.8
SSS/SHS	789,427	0.4	600,717	0.4	188,710	0.4
Secondary	125,269	0.7	104,943	0.7	20,326	0.7
Vocational/technical/ commercial	176,869	0.7	145,621	0.7	31,248	0.7
Post middle/secondary certificate	118,167	0.5	93,637	0.5	24,530	0.5
Post-secondary diploma	180,100	0.4	154,440	0.5	25,660	0.4
Bachelor degree	126,930	0.4	114,365	0.4	12,565	0.3
Post graduate (Cert. Diploma Masters PHD etc.)	16,619	0.3	15,150	0.3	1,469	0.5

Source: Ghana Statistical Service, 2010 Population and Housing Census

8.5 Emotional Disability and Economic Activity Status

Table 8.4 shows that there is 0.7% of the population in the working age group had emotional disability out which a higher proportion lived in rural communities (0.8%). Among the non-active group, 1.0% has emotional disability. The prevalence is higher among those who live in rural communities (1.1%) as opposed to those in urban centres (0.8%). Among those employed, 0.6% of them have emotional disability with a slightly higher proportion being residents of rural than urban localities (0.5%). For those who were unemployed, 0.7% of them have emotional disability and equal proportion (0.7%) of them lived in rural and urban areas.

Table 8.4: Emotional disability by economic activity status, sex and type of locality

Sex/Activity	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	15,208,425	0.7	8,222,949	0.6	6,985,476	0.8
Employed	10,243,476	0.6	5,125,635	0.5	5,117,841	0.6
Unemployed	575,807	0.7	410,267	0.7	165,540	0.7
Not active	4,389,142	1.0	2,687,047	0.8	1,702,095	1.1
Male						
Total	7,225,901	0.7	3,863,105	0.6	3,362,796	0.8
Employed	5,005,534	0.6	2,477,284	0.5	2,528,250	0.7
Unemployed	254,955	0.6	182,894	0.6	72,061	0.7
Not active	1,965,412	0.9	1,202,927	0.8	762,485	1.1
Female						
Total	7,982,524	0.7	4,359,844	0.7	3,622,680	0.8
Employed	5,237,942	0.6	2,648,351	0.6	2,589,591	0.6
Unemployed	320,852	0.7	227,373	0.7	93,479	0.7
Not active	2,423,730	1.0	1,484,120	0.8	939,610	1.1

Source: Ghana Statistical Service, 2010 Population and Housing Census

There are more not economically active females (1.0%) with emotional disability than males (0.9%). However, the proportion of employed males with emotional disability is same (0.6%) as that of females. The proportion of employed males with emotional disability in rural communities is higher (0.7%) than those in urban communities (0.5%). Also, employed males with emotional disability in rural areas are more than (0.7%) employed females with emotional disability in rural areas but the employed females with emotional disability in urban communities exceeded (0.6%) males (0.5%).

8.6 Emotional Disability and Region of Residence

Table 8.5 indicates that there is 0.6% of the population of Ghana with emotional disability with a higher proportion (0.6%) living in rural areas than urban areas (0.5%). Volta Region has the highest proportion (0.9%) of people with emotional disability followed by Eastern and Upper West Regions (0.7%). The region with the least proportion of people with disability is Ashanti (0.4%). The Volta Region has the highest prevalence among PWD living in rural areas (1.0%). However, the Volta and Upper West Regions registered the highest prevalence of emotional disability (0.8%).

Table 8.5: Emotional disability by sex, type of locality and region

Sex/Region	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.6	12,545,229	0.5	12,113,594	0.6
Western	2,376,021	0.5	1,007,969	0.4	1,368,052	0.5
Central	2,201,863	0.5	1,037,878	0.4	1,163,985	0.6
Greater Accra	4,010,054	0.6	3,630,955	0.6	379,099	0.4
Volta	2,118,252	0.9	713,735	0.8	1,404,517	1
Eastern	2,633,154	0.7	1,143,918	0.6	1,489,236	0.7
Ashanti	4,780,380	0.4	2,897,290	0.4	1,883,090	0.4
Brong Ahafo	2,310,983	0.5	1,028,473	0.5	1,282,510	0.5
Northern	2,479,461	0.6	750,712	0.5	1,728,749	0.6
Upper East	1,046,545	0.5	219,646	0.4	826,899	0.5
Upper West	702,110	0.7	114,653	0.8	587,457	0.6
Male						
Total	12,024,845	0.5	6,016,059	0.5	6,008,786	0.6
Western	1,187,774	0.4	490,699	0.4	697,075	0.4
Central	1,050,112	0.5	489,237	0.4	560,875	0.6
Greater Accra	1,938,225	0.5	1,752,132	0.5	186,093	0.4
Volta	1,019,398	0.9	336,560	0.7	682,838	0.9
Eastern	1,290,539	0.6	542,670	0.6	747,869	0.6
Ashanti	2,316,052	0.4	1,382,251	0.4	933,801	0.4
Brong Ahafo	1,145,271	0.5	491,681	0.5	653,590	0.5
Northern	1,229,887	0.6	370,476	0.5	859,411	0.6
Upper East	506,405	0.5	105,082	0.4	401,323	0.6
Upper West	341,182	0.7	55,271	0.8	285,911	0.7

Table 8.5: Emotional disability by sex, type of locality and region (cont'd)

Sex/Region	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Female						
Total	12,633,978	0.6	6,529,170	0.5	6,104,808	0.6
Western	1,188,247	0.5	517,270	0.4	670,977	0.5
Central	1,151,751	0.5	548,641	0.4	603,110	0.6
Greater Accra	2,071,829	0.6	1,878,823	0.6	193,006	0.4
Volta	1,098,854	1	377,175	0.8	721,679	1
Eastern	1,342,615	0.7	601,248	0.7	741,367	0.7
Ashanti	2,464,328	0.4	1,515,039	0.4	949,289	0.4
Brong Ahafo	1,165,712	0.5	536,792	0.5	628,920	0.5
Northern	1,249,574	0.6	380,236	0.5	869,338	0.6
Upper East	540,140	0.5	114,564	0.4	425,576	0.5
Upper West	360,928	0.6	59,382	0.9	301,546	0.6

Source: Ghana Statistical Service, 2010 Population and Housing Census

8.7 Emotional Disability and Ethnicity

Table 8.6 shows that Ga-Adangbes and Ewes registered the highest prevalence of emotional disability (0.7%) followed by Grusi and Gurma ethnic groups (0.6%). There are more Ewes with emotional disability living in rural areas (0.9%) followed by Ga-Adangbe, Guan, Gurma, and Grusi ethnic groups (0.6%). However, there are more Ga-Adangbes with emotional disability living in urban areas (0.8%) followed by Ewes and Grusi (0.6%).

Table 8.6: Emotional disability by ethnic group, sex and type of locality

Ethnicity/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	23,823,594	0.6	12,076,954	0.5	11,746,640	0.6
Akan	11,321,568	0.5	6,539,270	0.5	4,782,298	0.5
Ga-Adangbe	1,766,287	0.7	1,129,997	0.8	636,290	0.6
Ewe	3,323,072	0.7	1,620,419	0.6	1,702,653	0.9
Guan	879,861	0.5	425,885	0.5	453,976	0.6
Gurma	1,363,502	0.6	305,620	0.4	1,057,882	0.6
Mole-Dagbani	3,963,017	0.5	1,473,061	0.5	2,489,956	0.5
Grusi	594,248	0.6	219,319	0.6	374,929	0.6
Mande	269,842	0.4	148,298	0.5	121,544	0.4
Other	342,197	0.4	215,085	0.4	127,112	0.4
Male						
Total	11,591,394	0.5	5,772,748	0.5	5,818,646	0.6
Akan	5,435,472	0.5	3,101,899	0.5	2,333,573	0.5
Ga-Adangbe	857,458	0.7	534,004	0.8	323,454	0.6
Ewe	1,624,944	0.7	780,605	0.6	844,339	0.8
Guan	426,188	0.5	201,847	0.4	224,341	0.6
Gurma	683,301	0.6	151,568	0.4	531,733	0.6
Mole-Dagbani	1,969,428	0.5	720,520	0.5	1,248,908	0.5
Grusi	294,058	0.6	104,512	0.6	189,546	0.7
Mande	134,958	0.5	73,622	0.5	61,336	0.4
Other	165,587	0.4	104,171	0.4	61,416	0.5

Table 8.6: Emotional disability by ethnic group, sex and type of locality (cont'd)

Ethnicity/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Female						
Total	12,232,200	0.6	6,304,206	0.5	5,927,994	0.6
Akan	5,886,096	0.5	3,437,371	0.5	2,448,725	0.5
Ga-Adangbe	908,829	0.7	595,993	0.8	312,836	0.7
Ewe	1,698,128	0.8	839,814	0.7	858,314	0.9
Guan	453,673	0.6	224,038	0.5	229,635	0.6
Gurma	680,201	0.6	154,052	0.4	526,149	0.6
Mole-Dagbani	1,993,589	0.4	752,541	0.5	1,241,048	0.4
Grusi	300,190	0.6	114,807	0.6	185,383	0.6
Mande	134,884	0.4	74,676	0.4	60,208	0.4
Other	176,610	0.4	110,914	0.4	65,696	0.4

Source: Ghana Statistical Service, 2010 Population and Housing Census

The Ewe ethnic group has the highest proportion of females with emotional disability (0.8%) while the Ga-Adangbe and Ewe ethnic groups have the highest proportion of males with emotional disability (0.7%). There are more Ewe females with emotional disability living in rural areas (0.9%) than males (0.8%). Similarly, there are more Ga-Adangbe females with emotional disability living in rural areas (0.7%) than males (0.6%). However, there are more Ga-Adangbe males (0.8%) and females (0.8%) with emotional disability residing in urban areas than those in rural areas. For most of the ethnic groups, there are more people in both sexes with emotional disability residing in rural areas than urban areas.

8.8 Emotional Disability and Religion

Table 8.7 shows that people without any religion have the highest proportion of emotional disability (1.0%) followed by people of other unspecified faiths (0.8%) and traditionalist (0.7%). The least proportion of emotional disability is among Catholics, Pentecostals, other Christians and Muslims (0.5%). People without any religion have the highest proportion of males (1.0%) and females (1.0%) with emotional disability. Those with other unspecified religion have the second highest proportion of females with emotional disability (0.8%) followed by traditionalist (0.7%).

8.9 Discussion

The results indicate that emotional/behavioural disability is prevalent among the elderly than the younger populace. This finding perhaps underscores the importance of ageing in the discourse of disability in general and emotional/behavioural disability in particular. Ideally, old age should come with a leisurely pace of lifestyle.

However, in the Ghanaian context few people are able to plan effectively for their retirement and as a result are not able to enjoy that kind of desired leisurely lifestyles and that perhaps tends to pose a worrying challenge to the aged who eventually end up with emotional disability. Such aged with emotional/behavioural disability are more likely to suffer from depression as a result of not being able to meet their economic needs and that of their families (Eide & Loeb (2006). The fact that the results show that most of the aged with emotional/behavioural disability are rural folks is an indication that most might also be lacking the essential health care services which are needed to make the ageing process smooth.

Table 8.7: Emotional disability by religion, sex and type of locality

Religion/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.6	12,545,229	0.5	12,479,030	0.6
No Religion	1,302,077	1	479,550	1.2	473,961	0.9
Catholic	3,230,996	0.5	1,405,575	0.5	1,398,592	0.5
Protestant (Anglican Lutheran etc.)	4,534,178	0.6	2,540,118	0.6	2,525,985	0.6
Pentecostal/Charismatic	6,980,792	0.5	4,140,660	0.5	4,120,821	0.5
Other Christians	2,800,871	0.5	1,476,093	0.5	1,468,914	0.5
Islam	4,345,723	0.5	2,264,792	0.5	2,254,139	0.5
Traditionalist	1,270,272	0.7	140,267	0.9	138,993	0.7
Other	193,914	0.8	98,174	0.6	97,625	1
Male						
Total	12,024,845	0.5	6,016,059	0.5	5,985,300	0.6
No Religion	804,239	1	307,011	1.2	303,447	1
Catholic	1,571,079	0.5	679,560	0.5	676,339	0.5
Protestant (Anglican Lutheran etc.)	2,132,619	0.5	1,180,722	0.5	1,174,504	0.5
Pentecostal/Charismatic	3,240,237	0.5	1,894,241	0.4	1,885,977	0.5
Other Christians	1,331,390	0.5	695,457	0.4	692,328	0.5
Islam	2,203,837	0.5	1,138,846	0.5	1,133,323	0.5
Traditionalist	646,380	0.7	71,653	0.8	71,054	0.7
Other	95,064	0.7	48,569	0.5	48,328	1
Female						
Total	12,633,978	0.6	6,529,170	0.5	6,493,730	0.6
No Religion	497,838	1	172,539	1.2	170,514	0.9
Catholic	1,659,917	0.5	726,015	0.5	722,253	0.6
Protestant (Anglican Lutheran etc.)	2,401,559	0.6	1,359,396	0.6	1,351,481	0.6
Pentecostal/Charismatic	3,740,555	0.5	2,246,419	0.5	2,234,844	0.6
Other Christians	1,469,481	0.5	780,636	0.5	776,586	0.6
Islam	2,141,886	0.5	1,125,946	0.5	1,120,816	0.5
Traditionalist	623,892	0.7	68,614	1	67,939	0.7
Other	98,850	0.8	49,605	0.6	49,297	0.9

Source: Ghana Statistical Service, 2010 Population and Housing Census

The results suggest that the prevalence of emotional/behavioural disability is high among males and females who are separated, widowed and divorced. It can be speculated that the trauma associated with separation, divorce or loss of the husband may be the explanation for the high prevalence among these groups. Similar observations have been made by Geng-qing, and Qu (2003) who intimated that single but ever married people may have high incidence of emotional disability due to the trauma of losing the partner especially in the early days preceding the loss of the partner. However, the emotional disability that is usually associated with people who have lost their partners may be as a result of depression rather than behavioural disorder.

Emotional/behavioural disability is high among those without any formal education. This probably underscores the importance of education in health seeking behavior. Perhaps with formal education, one's horizon on some of the conditions that lead to emotional disability are broadened and hence early detection and treatment are sought which may help reduce the

incidence. Hill and Blanck (2009) share this view. They observed that the incidence of depression was high among those who had received little formal education as compared to those who had had considerable formal education up to the bachelor's degree. Rovner (2004) opined that education is key in appreciating what emotional disability is and help in its detection and seeking for help.

The fact that the results show that there is more not active population with emotional disability is perhaps an indication of some of the psychological traumas that such people experience. Thus, since they are not able to work to support themselves, this may subject them to serious psychological traumas and eventually making them emotionally disabled. There is a general support in the literature for the idea that being in the 'not active' group in itself may lead to loneliness and eventually lead to emotional disability (O'Reilly, 2003; Quinn, 2009). Emotional/behavioural disability may be compounded by not being economically active and hence being unable to meet basic needs (Oliver, 1996; O'Reilly, 2003). -160.

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CHAPTER NINE

PREVALENCE OF INTELLECTUAL DISABILITY

9.1 Introduction

Intellectual disability is one of the types of disability that was measured in the 2010 Population and Housing Census. Intellectual disability is a generalised disorder that is characterised by significant impairment of cognitive functions. Intellectual disability manifests itself in two areas namely intellectual functioning and adaptive behaviours (Vickerman, 2012).

Intellectual functioning also known as intelligent quotient (IQ) mainly has to do with a person's ability to learn, reason, make decisions and solve problems while adaptive behaviours are the skills necessary for day to day life such as ability to communicate effectively, interact with others and take care of oneself. People who experience mental health conditions or intellectual impairments appear to be more disadvantaged in many settings than those who experience physical or sensory impairments (Vickerman, 2012). Subsequently, there is the need for adequate planning for the special needs of people with this kind of disability, there is the need to understand the dimensions within the population.

9.2 Intellectual Disability and Age

Table 9.1 shows that the proportion of people with intellectual disability tends to increase as their ages increase. The prevalence rates ranged from 0.3% (among the 0-4, 5-9 and 10-14) to 1.1% (among 65+ age group). Generally, prevalence of intellectual disability is higher in the rural (0.5%) than urban (0.4%) areas and also among males (0.5%) than females (0.4%).

Table 9.1: Intellectual disability by age, sex and type of locality

Sex/Age Group	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.5	12,545,229	0.4	12,492,681	0.5
0 - 4	3,405,406	0.3	1,541,391	0.3	1,537,291	0.3
5-9	3,128,952	0.3	1,389,660	0.3	1,386,037	0.3
10-14	2,916,040	0.3	1,391,229	0.3	1,387,111	0.4
15 - 19	2,609,989	0.4	1,364,124	0.4	1,359,265	0.4
20 - 24	2,323,491	0.4	1,356,838	0.4	1,351,852	0.5
25 - 29	2,050,111	0.5	1,194,867	0.4	1,190,033	0.5
30 - 34	1,678,809	0.5	955,698	0.5	951,197	0.6
35 - 39	1,421,403	0.5	781,852	0.5	778,001	0.6
40 - 44	1,186,350	0.6	632,049	0.5	628,669	0.6
45 - 49	938,098	0.6	487,192	0.6	484,455	0.6
50 - 54	833,098	0.6	421,478	0.6	418,954	0.7
55 - 59	523,695	0.6	275,958	0.6	274,277	0.7
60 - 64	475,849	0.7	225,385	0.7	223,792	0.8
65 +	1,167,532	1.1	527,508	1.1	521,747	1.0

Table 9.1: Intellectual disability by age, sex and type of locality (cont'd)

Sex/Age Group	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Male						
Total	12,024,845	0.5	6,016,059	0.4	5,990,366	0.5
0 - 4	1,731,787	0.3	783,017	0.3	780,863	0.3
9-May	1,589,632	0.3	697,031	0.3	695,173	0.3
14-Oct	1,477,525	0.3	672,906	0.3	670,883	0.4
15 - 19	1,311,112	0.4	651,829	0.4	649,421	0.4
20 - 24	1,100,727	0.4	642,140	0.4	639,640	0.5
25 - 29	943,213	0.5	553,927	0.4	551,457	0.6
30 - 34	790,301	0.6	455,204	0.5	452,871	0.6
35 - 39	676,768	0.6	373,678	0.5	371,729	0.7
40 - 44	572,620	0.6	304,875	0.6	303,178	0.7
45 - 49	452,975	0.7	231,146	0.6	229,702	0.7
50 - 54	394,600	0.7	195,556	0.6	194,290	0.7
55 - 59	258,582	0.6	132,984	0.6	132,173	0.6
60 - 64	227,050	0.7	105,738	0.7	104,996	0.7
65 +	497,953	0.9	216,028	0.9	213,990	0.9
Female						
Total	12,633,978	0.4	6,529,170	0.4	6,502,315	0.5
0 - 4	1,673,619	0.3	758,374	0.3	756,428	0.3
5 - 9	1,539,320	0.3	692,629	0.3	690,864	0.3
10 - 14	1,438,515	0.3	718,323	0.3	716,228	0.4
15 - 19	1,298,877	0.4	712,295	0.3	709,844	0.5
20 - 24	1,222,764	0.4	714,698	0.3	712,212	0.5
25 - 29	1,106,898	0.4	640,940	0.4	638,576	0.5
30 - 34	888,508	0.5	500,494	0.4	498,326	0.5
35 - 39	744,635	0.5	408,174	0.5	406,272	0.6
40 - 44	613,730	0.6	327,174	0.5	325,491	0.6
45 - 49	485,123	0.5	256,046	0.5	254,753	0.6
50 - 54	438,498	0.6	225,922	0.6	224,664	0.7
55 - 59	265,113	0.7	142,974	0.6	142,104	0.7
60 - 64	248,799	0.8	119,647	0.7	118,796	0.8
65 +	669,579	1.2	311,480	1.2	307,757	1.1

9.3 Intellectual Disability and Marital Status

Table 9.2 indicates that 0.5% of the population of the marriage age had intellectual disability. The prevalence rates are high among males and females who were either separated, divorced or widowed. Generally, slightly higher proportions were registered among residents of rural than urban areas.

Table 9.2: Intellectual disability by marital status, sex and type of locality

Marital Status/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	16,886,306	0.5	9,037,989	0.5	7,848,317	0.6
Never married	7,087,098	0.6	4,148,038	0.5	2,939,060	0.7
Informal/consensual union/living together	847,735	0.4	452,413	0.4	395,322	0.4
Married	7,237,730	0.4	3,556,630	0.3	3,681,100	0.4
Separated	315,910	1	173,447	0.9	142,463	1.2
Divorced	574,271	1	307,399	0.9	266,872	1.2
Widowed	-					
Male						
Total	8,072,481	0.5	4,252,234	0.5	3,820,247	0.6
Never married	3,947,792	0.6	2,213,375	0.6	1,734,417	0.7
Informal/consensual union/living together	370,191	0.3	199,643	0.3	170,548	0.4
Married	3,364,153	0.4	1,653,073	0.3	1,711,080	0.4
Separated	107,970	1.1	53,274	1	54,696	1.2
Divorced	176,509	1.2	83,603	1.2	92,906	1.3
Widowed	105,866	1.1	49,266	1.1	56,600	1.2
Female						
Total	8,813,825	0.5	4,785,755	0.5	4,028,070	0.6
Never married	3,139,306	0.5	1,934,663	0.4	1,204,643	0.7
Informal/consensual union/living together	477,544	0.5	252,770	0.5	224,774	0.4
Married	3,873,577	0.4	1,903,557	0.3	1,970,020	0.4
Separated	207,940	0.9	120,173	0.8	87,767	1.2
Divorced	397,762	0.9	223,796	0.8	173,966	1.1
Widowed	717,696	1.1	350,796	1.1	366,900	1.1

Source: Ghana Statistical Service, 2010 Population and Housing Census

9.4 Intellectual Disability and Educational Characteristics

As shown in Table 9.3, 0.5% of the entire population of school going age had intellectual disability. People without formal education recorded the highest prevalence (0.9%) of intellectual disability. A similar pattern was observed among males and females as well as residents of both urban and rural localities.

Table 9.3: Intellectual disability by level of education, sex and type of locality

Sex/Education	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	22,624,110	0.5	11,599,522	0.4	11,024,588	0.5
Never attended	5,299,884	0.9	1,646,020	1	3,653,864	0.8
Nursery	714,204	0.3	342,479	0.2	371,725	0.3
Kindergarten	1,232,827	0.2	580,951	0.2	651,876	0.3
Primary	5,615,573	0.4	2,667,686	0.4	2,947,887	0.4
JSS/JHS	4,048,059	0.3	2,322,080	0.3	1,725,979	0.3
Middle	2,067,507	0.5	1,231,583	0.5	835,924	0.6
SSS/SHS	1,756,714	0.3	1,279,124	0.2	477,590	0.3
Secondary	349,221	0.6	272,180	0.6	77,041	0.6
Vocational/technical/commercial	369,365	0.4	293,178	0.4	76,187	0.4
Post middle/secondary certificate	243,739	0.4	175,201	0.3	68,538	0.5
Post-secondary diploma	484,766	0.3	399,342	0.2	85,424	0.3
Bachelor degree	373,641	0.2	328,707	0.2	44,934	0.3
Post graduate (Cert. Diploma Masters PHD etc.)	68,610	0.3	60,991	0.3	7,619	0.4
Male						
Total	10,988,971	0.5	5,535,088	0.4	5,453,883	0.5
Never attended	2,058,897	0.9	538,986	1.2	1,519,911	0.8
Nursery	364,111	0.3	175,066	0.2	189,045	0.3
Kindergarten	631,100	0.2	297,141	0.2	333,959	0.3
Primary	2,713,950	0.4	1,233,922	0.4	1,480,028	0.4
JSS/JHS	1,984,748	0.3	1,091,882	0.3	892,866	0.3
Middle	1,123,490	0.6	618,241	0.5	505,249	0.6
SSS/SHS	967,287	0.3	678,407	0.3	288,880	0.3
Secondary	223,952	0.6	167,237	0.6	56,715	0.6
Vocational/technical/commercial	192,496	0.4	147,557	0.4	44,939	0.4
Post middle/secondary certificate	125,572	0.5	81,564	0.4	44,008	0.5
Post-secondary diploma	304,666	0.3	244,902	0.3	59,764	0.4
Bachelor degree	246,711	0.2	214,342	0.2	32,369	0.3
Post graduate (Cert. Diploma Masters PHD etc.)	51,991	0.3	45,841	0.3	6,150	0.4
Female						
Total	11,635,139	0.5	6,064,434	0.4	5,570,705	0.5
Never attended	3,240,987	0.8	1,107,034	0.9	2,133,953	0.8
Nursery	350,093	0.3	167,413	0.2	182,680	0.3
Kindergarten	601,727	0.2	283,810	0.2	317,917	0.3
Primary	2,901,623	0.4	1,433,764	0.4	1,467,859	0.4
JSS/JHS	2,063,311	0.3	1,230,198	0.3	833,113	0.3
Middle	944,017	0.5	613,342	0.5	330,675	0.5
SSS/SHS	789,427	0.2	600,717	0.2	188,710	0.3
Secondary	125,269	0.5	104,943	0.5	20,326	0.6
Vocational/technical/commercial	176,869	0.3	145,621	0.3	31,248	0.4
Post middle/secondary certificate	118,167	0.3	93,637	0.3	24,530	0.3
Post-secondary diploma	180,100	0.2	154,440	0.2	25,660	0.2
Bachelor degree	126,930	0.1	114,365	0.1	12,565	0.2
Post graduate (Cert. Diploma Masters PHD etc.)	16,619	0.2	15,150	0.2	1,469	0.3

Source: Ghana Statistical Service, 2010 Population and Housing Census

9.5 Intellectual Disability and Economic Activity Status

Table 9.4 shows that 0.5% of the working age population had intellectual disability. People in the not active group had the highest prevalence of intellectual disability among both males (1.0%) and females (0.9%). Between urban and rural areas, some minor variations were noted. Thus, about 1.2% of the not active population in rural areas compared to 0.8% in urban areas reported some form of intellectual disability.

Table 9.4: Intellectual disability by economic activity status, sex and type of locality

Sex/Activity	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	15,208,425	0.5	8,222,949	0.5	6,985,476	0.6
Employed	10,243,476	0.4	5,125,635	0.3	5,117,841	0.4
Unemployed	575,807	0.5	410,267	0.4	165,540	0.6
Not active	4,389,142	1	2,687,047	0.8	1,702,095	1.2
Male						
Total	7,225,901	0.6	3,863,105	0.5	3,362,796	0.6
Employed	5,005,534	0.4	2,477,284	0.3	2,528,250	0.4
Unemployed	254,955	0.5	182,894	0.5	72,061	0.6
Not active	1,965,412	1	1,202,927	0.9	762,485	1.2
Female						
Total	7,982,524	0.5	4,359,844	0.5	3,622,680	0.6
Employed	5,237,942	0.4	2,648,351	0.3	2,589,591	0.4
Unemployed	320,852	0.4	227,373	0.4	93,479	0.5
Not active	2,423,730	0.9	1,484,120	0.8	939,610	1.2

Source: Ghana Statistical Service, 2010 Population and Housing Census

9.6 Intellectual Disability and Region of Residence

Table 9.5 shows that there are regional variations in the prevalence of intellectual disability. Volta Region has the highest rate (0.7%) of people with intellectual disability, followed by Eastern Region (0.6%). In terms of urban-rural dimension, Volta Region had 0.6% and 0.8% in the urban and rural areas respectively.

Table 9.5: Intellectual disability by sex, type of locality and region

Economic Activity Status/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.5	12,545,229	0.4	12,113,594	0.5
Western	2,376,021	0.4	1,007,969	0.4	1,368,052	0.4
Central	2,201,863	0.4	1,037,878	0.4	1,163,985	0.5
Greater Accra	4,010,054	0.4	3,630,955	0.4	379,099	0.5
Volta	2,118,252	0.7	713,735	0.6	1,404,517	0.8
Eastern	2,633,154	0.6	1,143,918	0.5	1,489,236	0.6
Ashanti	4,780,380	0.4	2,897,290	0.3	1,883,090	0.4
Brong Ahafo	2,310,983	0.4	1,028,473	0.4	1,282,510	0.4
Northern	2,479,461	0.4	750,712	0.4	1,728,749	0.4
Upper East	1,046,545	0.5	219,646	0.4	826,899	0.5
Upper West	702,110	0.5	114,653	0.5	587,457	0.5
Male						
Total	12,024,845	0.5	6,016,059	0.4	6,008,786	0.5
Western	1,187,774	0.4	490,699	0.4	697,075	0.4
Central	1,050,112	0.5	489,237	0.4	560,875	0.5
Greater Accra	1,938,225	0.4	1,752,132	0.4	186,093	0.5
Volta	1,019,398	0.7	336,560	0.6	682,838	0.7
Eastern	1,290,539	0.6	542,670	0.5	747,869	0.6
Ashanti	2,316,052	0.4	1,382,251	0.4	933,801	0.4
Brong Ahafo	1,145,271	0.4	491,681	0.4	653,590	0.4
Northern	1,229,887	0.4	370,476	0.4	859,411	0.4
Upper East	506,405	0.5	105,082	0.4	401,323	0.6
Upper West	341,182	0.5	55,271	0.6	285,911	0.5
Female						
Total	12,633,978	0.4	6,529,170	0.4	6,104,808	0.5
Western	1,188,247	0.4	517,270	0.4	670,977	0.4
Central	1,151,751	0.4	548,641	0.4	603,110	0.5
Greater Accra	2,071,829	0.4	1,878,823	0.4	193,006	0.5
Volta	1,098,854	0.8	377,175	0.6	721,679	0.8
Eastern	1,342,615	0.6	601,248	0.5	741,367	0.6
Ashanti	2,464,328	0.4	1,515,039	0.3	949,289	0.4
Brong Ahafo	1,165,712	0.4	536,792	0.3	628,920	0.4
Northern	1,249,574	0.4	380,236	0.3	869,338	0.4
Upper East	540,140	0.5	114,564	0.4	425,576	0.5
Upper West	360,928	0.4	59,382	0.5	301,546	0.4

Source: Ghana Statistical Service, 2010 Population and Housing Census

Volta and Eastern Regions registered the highest proportions of intellectual disability among both males and females even though females had higher prevalence than males in each of the two regions.

9.7 Intellectual Disability and Ethnicity

Table 9.6 shows that the highest prevalence of intellectual disability was registered among the Ewe and the Ga-Adangbe (0.6%) ethnic groups followed by the Guans and Gurmas (0.5%). Among the males and females the prevalence rates were the same for the Ewes and the Ga-Adangbes. Similar patterns can be observed among both urban and rural localities although the prevalence rates registered in the rural localities are higher among some ethnic groups.

Table: 9.6: Intellectual disability by sex, type of locality and ethnicity

	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	23,823,594	0.5	12,076,954	0.4	11,746,640	0.5
Akan	11,321,568	0.4	6,539,270	0.4	4,782,298	0.5
Ga-Adangbe	1,766,287	0.6	1,129,997	0.6	636,290	0.6
Ewe	3,323,072	0.6	1,620,419	0.5	1,702,653	0.7
Guan	879,861	0.5	425,885	0.4	453,976	0.5
Gurma	1,363,502	0.5	305,620	0.4	1,057,882	0.5
Mole-Dagbani	3,963,017	0.4	1,473,061	0.3	2,489,956	0.4
Grusi	594,248	0.4	219,319	0.4	374,929	0.4
Mande	269,842	0.4	148,298	0.4	121,544	0.4
Others	342,197	0.4	215,085	0.5	127,112	0.4
Male						
Total	11,591,394	0.5	5,772,748	0.4	5,818,646	0.5
Akan	5,435,472	0.4	3,101,899	0.4	2,333,573	0.5
Ga-Adangbe	857,458	0.6	534,004	0.6	323,454	0.6
Ewe	1,624,944	0.6	780,605	0.4	844,339	0.7
Guan	426,188	0.5	201,847	0.4	224,341	0.5
Gurma	683,301	0.5	151,568	0.4	531,733	0.5
Mole-Dagbani	1,969,428	0.4	720,520	0.4	1,248,908	0.4
Grusi	294,058	0.5	104,512	0.5	189,546	0.5
Mande	134,958	0.4	73,622	0.4	61,336	0.5
Others	165,587	0.5	104,171	0.5	61,416	0.4
Female						
Total	12,232,200	0.4	6,304,206	0.4	5,927,994	0.5
Akan	5,886,096	0.4	3,437,371	0.4	2,448,725	0.5
Ga-Adangbe	908,829	0.6	595,993	0.6	312,836	0.6
Ewe	1,698,128	0.6	839,814	0.5	858,314	0.8
Guan	453,673	0.5	224,038	0.5	229,635	0.5
Gurma	680,201	0.4	154,052	0.4	526,149	0.5
Mole-Dagbani	1,993,589	0.4	752,541	0.3	1,241,048	0.4
Grusi	300,190	0.4	114,807	0.4	185,383	0.4
Mande	134,884	0.3	74,676	0.4	60,208	0.3
Others	176,610	0.4	110,914	0.4	65,696	0.4

Source: Ghana Statistical Service, 2010 Population and Housing Census

9.8 Intellectual Disability and Religion

People with no religious affiliation had the highest prevalence of intellectual disability (1.0%) followed by the Traditionalists (0.6%) as can be observed in Table 9.7. Islam, Catholic, Pentecostal/Charismatic and other Christians registered the least prevalence rates of people with intellectual disability. People who professed no religion registered the highest prevalence rates among both males and females in the urban and rural localities.

Table 9.7: Intellectual disability by religion, sex and type of locality

Religion/Sex	Total		Urban		Rural	
	Number	Percent	Number	Percent	Number	Percent
Both sexes						
Total	24,658,823	0.5	12,545,229	0.4	12,492,681	0.5
No Religion	1,302,077	1.0	479,550	1.1	474,457	0.9
Catholic	3,230,996	0.4	1,405,575	0.4	1,399,860	0.4
Protestant (Anglican Lutheran etc.)	4,534,178	0.5	2,540,118	0.4	2,528,917	0.5
Pentecostal/ Charismatic	6,980,792	0.4	4,140,660	0.4	4,125,579	0.5
Other Christians	2,800,871	0.4	1,476,093	0.4	1,470,797	0.4
Islam	4,345,723	0.4	2,264,792	0.4	2,256,224	0.4
Traditionalist	1,270,272	0.6	140,267	0.8	139,194	0.6
Other	193,914	0.5	98,174	0.5	97,653	0.5
Male						
Total	12,024,845	0.5	6,016,059	0.4	5,990,366	0.5
No Religion	804,239	1.0	307,011	1	303,824	0.9
Catholic	1,571,079	0.4	679,560	0.4	676,793	0.4
Protestant (Anglican Lutheran etc.)	2,132,619	0.5	1,180,722	0.4	1,175,411	0.5
Pentecostal/ Charismatic	3,240,237	0.4	1,894,241	0.4	1,887,530	0.5
Other Christians	1,331,390	0.4	695,457	0.4	693,009	0.4
Islam	2,203,837	0.4	1,138,846	0.4	1,134,334	0.4
Traditionalist	646,380	0.6	71,653	0.7	71,145	0.6
Other	95,064	0.5	48,569	0.5	48,320	0.6
Female						
Total	12,633,978	0.4	6,529,170	0.4	6,502,315	0.5
No Religion	497,838	1.0	172,539	1.1	170,633	1
Catholic	1,659,917	0.4	726,015	0.4	723,067	0.4
Protestant (Anglican Lutheran etc.)	2,401,559	0.5	1,359,396	0.4	1,353,506	0.5
Pentecostal/ Charismatic	3,740,555	0.4	2,246,419	0.4	2,238,049	0.5
Other Christians	1,469,481	0.4	780,636	0.4	777,788	0.4
Islam	2,141,886	0.4	1,125,946	0.4	1,121,890	0.3
Traditionalist	623,892	0.6	68,614	0.8	68,049	0.6
Other	98,850	0.5	49,605	0.5	49,333	0.5

Source: Ghana Statistical Service, 2010 Population and Housing Census

9.9 Discussion

Intellectual disability was high among the aged population and for that matter may be attributed to the ageing process. As one ages the body becomes less resistant to certain kinds of ailments and some functions tend to recede in its ability to function properly. Thus, aging may be associated with the lowering of ones IQ (Burke, 2013) which is one of the forms of intellectual disability. Also the finding that there are more separated and divorced people with intellectual disability may be attributed to the psychological trauma that these people may encounter as part of the separation or divorced. Usually when people loss their partners, they may be psychologically disturbed that it may lead to intellectual disability (Morris, 2004). Power (2013) observed that the circumstances surrounding one losing his or her partner has

the tendency to affect the intellectual health of the individual. Similarly, Siminski (2003) have intimated that the pain for some partners during divorce and separation may be so severe that immediate rehabilitation is needed to prevent the development of intellectual disability.

It emerged from the results that people without formal education have high proportion of people with intellectual disability. This finding may explain why they have not been able to progress in terms of formal education since their IQs may be low comprehend basic things in school. This finding is similar to observations made by other studies. For instance, Armstrong (2003) and Madriaga (2007) indicated that intellectual disability, especially low levels of IQ is more prevalent among people with no or little education. Burke (2002) further argued that intellectual disability may hinder one's ability to fully access the formal educational system and hence people with intellectual disability may have little or in some cases no formal education experience especially in developing countries.

The results show that the not active population has higher prevalence of intellectual disability than those employed and unemployed. According to Kassah (2008) people with disabilities are usually not considered as active workforce because of their disability. Also, the results indicate that there is more of the non-active workforce with intellectual disability in rural areas than urban areas.

People with no religion have the highest prevalence of intellectual disability. Perhaps their lack of belief makes them less concern about disability. Watters (2010) suggests that illness and disability in Islam are not viewed as punishment, but rather as an opportunity to endure suffering in order to receive Allah's grace. Christianity, on the other hand, views illness and disability as challenges and tests to overcome. In both religions, disability can be seen as a test of faith (Schuelka, 2013).

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CHAPTER TEN

SUMMARY OF FINDINGS, CONCLUSIONS AND POLICY IMPLICATIONS

10.1 Summary of Findings

The profile of PWD and the prevalence of visual, physical, speech, hearing, emotional/behavioural and intellectual disabilities within different age groups, marital status, educational level, economic activity status, region of residence, ethnic group and religious affiliation were examined by sex and type of locality. The results show that PWD constituted three percent of Ghana's population of 24,658,823 people. While four in every ten PWD were visually impaired, a quarter of all PWD were physically impaired. Generally, there were more females with disability than males and lived in rural than urban localities.

The highest percentage (22.2%) of PWD was recorded among the 65 years and over group. About four in ten PWD were married compared with 27% in the never married category. There were generally more married PWD in rural (42.7%) than urban (37.5%), and more males (47.0%) compared with females (34.4) in the same group. Educational attainment of PWD was generally low. While four in ten PWD had never had formal education, 17.4% had had primary school education. The educational levels varied with regard to sex and type of locality.

More than half of all PWD aged 15 years and older were employed compared to those without employment (3.0%). Among those employed, the percentage was higher for males (52%) than females (47%) and higher in rural (58%) than urban (49%) localities. Ashanti and the Upper West Regions recorded the highest and the lowest PWD respectively. However, Greater Accra Region (27.7%) had the highest percentage of PWD in urban centres, whereas Volta Region (16.6%) had the highest percentage of PWD in rural areas. The Akan ethnic group accounted for 46% of all PWD followed Ewes (16.7%). The Akans also had the majority of PWD in both urban (53.3%) and rural (40.8%) localities.

About 1.2% of the total population was visually impaired, with higher proportion in rural (1.3%) than urban (1.1%) localities. The proportion of persons with visual impairment increased with age with greater preponderance for females and those in rural localities. About 7% of the widowed were visually impaired compared to 1.7% of those married. Overall, there were proportionately more visually impaired among those who have had Middle school education (2.7%).

Prevalence of visual impairment varied by economic activity status. For instance, 2.5% of those in the economically not active group were visually impaired compared to those who were employed (1.4%). For all categories of economic activity status, there were more visually impaired females than males, and more in rural than urban localities. The proportion of the population with visual impairment ranged from 0.7% in the Northern Region to 1.9% in the Volta Region, with higher proportions among females and in rural dwellers in most regions. Ewes had the highest proportion of persons with visual impairment and least was among the Gurma (0.8%) ethnic group. In terms of religious affiliation, Traditionalists had the highest proportion (1.9%) of visually impaired persons.

Less than one percent of Ghana's population was physically impaired with higher prevalence among females and rural localities. Generally there was a gradual increase in the proportions of persons with physical impairment for both males and females and in both rural and urban localities with increase in age. Physical impairment varied in terms of marital status, with higher proportions among the widowed (4.5%) compared to those married (0.9%). The proportion of physical impairment for those who had never been to school (1.6%) was higher than the proportions for all other categories of educational attainment. In terms of economic activity, physical impairment was more common among the non-active group (2.2%) with no variation between employed and unemployed for males and females. The proportion of the population with physical impairment ranged from 0.5% in the Northern Region to 1.2% in the Volta Region. In terms of religious affiliation, the proportions of physical impairment were generally lower than one percent except among the Traditionalists and those with no religious affiliation.

Prevalence of speech disability among Ghanaians was less than one percent. The proportions increased with ageing among males and females as well as urban and rural dwellers. It was also observed that widows reported more speech impairment than the currently married or the never married. The population without any form of education and those in the not economically active group reported highest prevalence of speech impairment. Volta Region registered the highest prevalence of speech disability, however, there were no discernable patterns by sex and locality. The prevalence rates within the ethnic groups ranged from 0.2 to 0.5 with no clear pattern sex and locality. Ghanaians who professed no religion had the highest prevalence rate among both sexes and type of locality.

The prevalence of hearing impairment was 0.4% but increased with ageing and varied across sex and type of locality. The rates differed by marital status and the widowed (both males and females) were at higher risk of experiencing hearing impairment. Ghanaians who had never had formal education and those who were not active economically were more likely to report hearing impairment. The Upper East Region registered the highest prevalence of hearing impairment although the sex and spatial variations are difficult to decipher. The prevalence rates by the ethnicity and type of locality show no clear pattern, however, Traditionalists had the highest rate for males and females and rural-urban localities.

Emotional/behavioural impairment was reported by less than one percent of the Ghanaian population. There elderly (65+) had the highest prevalence rate especially in the rural areas and among females. The highest prevalence rate of emotional/behavioural impairment was (1.3%) among those separated, widowed and divorced. People without any formal education and those in the economically not active category had the highest proportion of emotional impairment for males and females in both rural and urban localities. Both males and females in the Volta Region had the highest prevalence of people with emotional disability even though the pattern is not consistent by type of locality. The Ga-Adangbe and the Ewe ethnic groups reported the highest proportion of people with emotional disability (0.7%). People who professed no religion had the highest proportion of emotional disability by sex and locality.

The highest prevalence of intellectual disability was reported among the aged females and residents of rural localities. There were high proportions of separated and divorced people with intellectual disability (1.0%) than those in the other marital categories. People without any formal education have the highest prevalence of intellectual disability (0.9%). Generally, prevalence of intellectual disability is higher in rural than urban localities. Within the

working age population, 0.5% has intellectual disability with higher prevalence among rural residents (0.6%). In terms of regional variations, Volta Region has the highest prevalence of people with intellectual disability (0.7%). In the prevalence of intellectual disability is higher in rural areas than urban areas across the ten regions of Ghana. Intellectual disability was more prevalent among males and females of the Ewe and the Ga-Adangbe ethnic groups in both urban and rural localities.

10.2 Conclusions

This report provides a detailed analysis of prevalence of visual, physical, speech, hearing, emotional/behavioural and intellectual disabilities in Ghana. Prevalence of disabilities was analysed by sex and type of locality on one hand and; age, education, marital status, economic activity status, educational attainment, region of residence, ethnicity and religion

Generally, there is a gender and spatial dimension to disability across demographic and socio-economic aspects of the population in Ghana. The results suggest that there is potential for investment in the development of the human resource capacity of PWD. This is reflected in the relatively greater proportions of visually impaired with education beyond the basic school level. There is every opportunity for harnessing human resource capacity of PWD in order to enhance their contribution towards national development. This claim is supported by the proportionately greater physically impaired among those who have never been to school, and among the not active economic group of the population.

The dominance of Volta Region with respect to disability also calls for concern even though it is unclear from the current analysis as to what could have accounted for the situation in that region. Consequently, the Ewe ethnic group who dominate the Volta Region has high prevalence of disabilities. This could possibly be reflecting inequalities in healthcare delivery or variation in environmental or other risk factors.

While this report does not seek to establish causality, the findings suggest that Traditional religion is a risk factor for plethora of negative health outcomes. Although no exact explanations exist up to this point to explain this relationship, the consistent conclusion is that those who subscribe to Traditional religion are less likely to seek early orthodox treatment of a number of ailments.

10.3 Recommendations

- Ministry of Education should make efforts towards improving the human capital of PWD through education and skills development. This should include the establishment of more special schools for PWD, while at the same time promoting the inclusion of some PWD in all schools. Educational support services and aids should be made more available in order to encourage and facilitate children with disability at all levels to participate actively in the educational process like all others. Above all, parents should be incentivized to take their affected children to school by offering comprehensive scholarships packages that will cater for all the educational needs of such children.
- That the burden of disability being higher among the aged suggest that their needs are factored into programmes and policies meant to reduce the burden of disability. It is therefore important the MOH undertakes regular screening for the population edging towards 60 years plus. For instance, national eye screening programme should be instituted to ensure that early corrective interventions are put in place.

- The government should adopt policy initiatives aimed at promoting training and skills development of PWD. For example, the Community-Based Rehabilitation Programme (CBRP) could be revamped to offer skills development training programmes that will enhance the employability of physically impaired persons.
- There is the need for relevant ministries to work towards integration of PWD in the labour force as they reported lower participation in economic activities.
- Research into the likely reasons for the high prevalence of disabilities in the Volta Region and people who professed Traditional religion is warranted. As part of contributing to the depth and breadth of knowledge on disability further studies (both qualitative and quantitative) are recommended.