EXPLORING THE EXPERIENCES OF CHILDREN AND YOUTH WITH MOBILITY IMPAIRMENTS IN FOUR BASIC EDUCATIONAL SETTINGS IN GHANA

NSEIBO JOB KOFI – NSBJOB001

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Supervisor: Associate Professor Judith McKenzie

Co-Supervisor: Dr Jane Kelly

DECLARATION

I, **Nseibo Job Kofi,** do hereby declare that this thesis titled, *Exploring the experiences of children and youth with mobility impairments in four basic educational settings in Ghana* is my own work and it has not been submitted to any other University for a degree or examination. I also do hereby declare that all the sources of information I have used or quoted have been acknowledged and indicated in the reference list. I have used the 7th edition of the American Psychology Association referencing style.

Signed by candidate

Signed:

Name: …...... Nseibo, Job Kofi Date……… 31/08/2020

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“He put a new song in my mouth, a hymn of praise to our God. Many will see and fear the Lord and put their trust in Him” (Psalm 40:3, NIV)

God designed my life on this earth before I was born. People within my immediate and external environments thought that I could not go to school because I was disabled. The design of the Lord upon my life with regards to education has come to pass. May his name be praised now and forever more.

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DEDICATION

I dedicate this thesis to my daughter, Jemima Adwoa Nseibo (University of Health and Allied Sciences, Ho) and my sons, Caleb Kwaku Nseibo (Prempeh College Basic A, Kumasi) and Joseph Albert Mensah Nseibo (John William Montessori School, Kumasi Tanoso).

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OPERATIONAL DEFINITIONS

Activity and Participation: This is defined as the person’s functional status, including communication, mobility, interpersonal interactions, self-care, learning, applying knowledge and others (WHO, 2001).

Body Function: The physiological functions of body systems (including psychological functions) (WHO, 2001).

Body Structure: Anatomical parts of the body such as organs, limbs and their components (WHO, 2001)

Children and Youth with Mobility Impairments: Refers to any person who is subject to a physiological defect or deficiency regardless of its cause, nature or extent that renders the person unable to move about without the aid of crutches, a wheelchair or any other form of support, or that limits the person’s functional ability to ambulate, climb, descend, sit or rise or to perform any related function (Euroqol Group, 2009; Disabled World, 2015).

Disability: Disability refers to long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder the full and effective participation in society of people with impairments on an equal basis with others (UNCRPD, 2008).

Education: The act or process of imparting or acquiring general knowledge, developing the powers of reasoning and judgment, and generally of preparing oneself or others intellectually for mature life (Graham, 2013).

Environmental Factors: These are factors that are not within the person’s direct control, such as family, work, government agencies, laws and cultural beliefs. That is to say, the physical, social and attitudinal environment in which people live and conduct their lives. These are either barriers to or facilitators of the person’s functioning (WHO, 2010).

Impairment: Problem in body function and structure such as significant deviation or loss (WHO, 2001).

Inclusive Education: Inclusive education is an educational setting or system where children with disabilities and those without disabilities receive equal education under the same roof with a network of supportive system. It seeks to address the learning needs of all children (UNCRPD, 2010).

Mainstream School: Mainstreaming, in the context of education, is the practice of educating students with special needs in regular classes during specific time periods based on their skills. This means regular education classes are combined with special education classes (Cannor & Gabel, 2013).

Parents: Implies a biological father or mother of the child or any person taking care of the child and playing the role of a parent to the child with mobility impairment.

Rehabilitation Centre: A rehabilitation centre is a place where a set of measures are available to enable people with disabilities to achieve and maintain optimal function within their environment (UNCRPD, 2008). A rehabilitation centre is a place where guidance, counselling and appropriate training are offered to persons with disability (Republic of Ghana, 2006).

Special Education School: A school with a specially designed instruction, at no cost to the parents, to meet the unique needs of a child with disability (IDEA, 2004).

ABBREVIATIONS

ARS	Akokor Rehabilitation School
BS	Basic School
CAQDAS	Computer Assisted Qualitative Data Analysis Software
DA	Document Analysis
DBS	Dabokpa Basic School
DSE	Disability Studies in Education
ESP	Education Strategic Plan
EST	Bronfenbrenner’s Ecological System Theory
fCUBE	Free Compulsory Universal Basic Education
GES	Ghana Education Service
GNA	Ghana News Agency
GSS	Ghana Statistical Service
GSPD	Ghana Society of Physically Disabled
IBE	International Bureau of Education
ICF	International Classification of Functioning, Disability and Health
ICT	Information and Communication Technology
IDEA	Individuals with Disabilities Education Act
IPA	Interpretive Phenomenological Analysis
ISPF	Inclusive Schooling Practices Framework
KSC	Kamame School Complex
MI	Mobility Impairments

MoE	Ministry of Education
OSS	Ohiamankyene Special School
PCT	Post-Colonial Theory
PWMI	People with Mobility Impairments
SAP	Special Attention Project
SDG	Sustainable Development Goals
SIG	Special Interest Group
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disability
UNESCO	United Nations Education, Scientific and Cultural Organisation
UPIAS	Union of the Physically Impaired Against Segregation
WHO	World Health Organisation
WHODAS	World Health Organisation Disability Assessment Schedule

ABSTRACT

Education is a fundamental right for children all over the world. In Ghana, education for children with mobility impairments (MI) is one area that needs attention because little research has explored the experiences of these children and youth in basic educational settings. The research question that guided this research was: What are the educational experiences of children and youth with MI in education in Ghana? Understanding educational experiences of children and youth with MI will allow policymakers, the Ministry of Education, and educational researchers to develop educational support systems for children with MI. This is very important especially in the low-and-middle-income countries like Ghana where resources are limited. This study drew on three theoretical frameworks: Disability studies in education; Bronfenbrenner's ecological system theory and post-colonial theory. These theoretical frameworks guided the exploration of the educational experiences of children and youth with MI in four basic school settings (mainstream, inclusive, rehabilitation and special schools) with consideration to the implementation of inclusive education in Ghana. The child development and learning processes were researched in terms of complex systemic interactions between children with MI and their environment, and the advancement of liberation and the colonial legacy of the study in context. Data were drawn from 20 children with MI, from four head teachers and from 20 parents of children with MI through in-depth semi-structured interviews and focus group interviews. Thematic analysis was used to analyse the data. This study revealed inequities in the basic school curriculum within the four school settings. These inequities that existed in the school curriculum contributed to parents not achieving the expected results they had hoped for by sending their children to the rehabilitation centre and the special schools. This study also showed the inadequacy of the educational support systems (for example, student support teams, parents support teams, teacher support teams and education support teams) in the four educational settings. The study concludes that the absence of educational support systems contributed to the struggle that children with MI and their parents experienced during their children's educational trajectories. From the findings of this study, it is imperative to have further research to consider a general basic school curriculum to promote inclusivity in all four school settings. The study critically showed how the experiences of children and youth with MI were characterised by the inequity of basic school curriculum, negative attitude towards disability and the unavailability of an educational support system. This study also contributes towards the development of inclusive schooling practices in Ghana by providing a framework which promotes inclusion of children and youth with MI. The new knowledge not only adds to the limited literature on the educational experiences of children with MI, but also assists policymakers, stakeholders of education and researchers to promote practices that encourage inclusive education.

CHAPTER ONE: INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 Introduction

The education system in Ghana has excluded children and youth with mobility impairments (MI) who do not fit into the current educational structures (e.g. mainstream schools) and sets these students apart or at times ignores them completely (Gyimah et al., 2008; Lieberman, 2018; Ministry of Education, 2015a). Consequently, a generation of children and youth with MI, who could contribute to their society's progress through their dynamism, creativity, and intelligence, is simply not able to do so because they have been excluded from education and the community. In Ghana, there are separate basic educational settings for the visually impaired, hearing impaired and the intellectually impaired that are called special schools (Ghana Education Service, 2015; Nseibo, 2013; Owusu, 2016). However, information about educational provision for persons with MI is not available. Hence, children and youth with MI find themselves either in the special schools, rehabilitation centres or mainstream schools, which are often characterised by an environment that is not favourable to them (Auberon & Odoom, 2016; Giri-ph, 2016; Gregorius, 2016). This includes inaccessible buildings as in the case of mainstream schools and special schools; the absence of support systems; inappropriate teaching materials and unavailability of trained teachers in the other educational settings (Gregorius, 2014; Mohammed, 2014a). The literature focuses on the lack of resources for children with disabilities in general, but there is a knowledge gap in research focusing specifically on children and youth with MI. This study will attempt to provide more information on the experiences of children with MI, as opposed to disability in general.

This study seeks to explore the experiences of children and youth with MI who have at least one year of educational experiences either in the mainstream school setting, special education setting, inclusive education (IE) school or a rehabilitation centre (rehabilitation school) in the Ashanti and Oti regions of Ghana. The needs of children and youth with MI are not well catered for in the special schools, rehabilitation centres and the mainstream schools and so this research will attempt to elucidate the reasons for this through the experiences of children and youth with MI in these schools (Auberon & Odoom, 2016; Republic of Ghana, 2006).

Consequently, children with MI drop out of school or struggle their way through the educational ladder under a suppressed and unfriendly disabling environment in the mainstream schools (Gregorius, 2016; Opoku et al., 2017). All children should be entitled to good and quality education despite their disabilities or challenges so as to be included in their communities (Mckenzie & Macleod, 2011; UNESCO, 2014). What is more worrisome is that there are very good educational policies and acts to protect the rights of all children of school going age (Avramidis, & Kalyva, 2007; Westbrook & Croft, 2015). Yet, children and youth with MI in Ghana still face challenges in their educational trajectories.

There are many policies related to children and youth with disabilities and education, and these will be discussed in Chapter 2. I will now provide some historical information (context of the study) about the beginning of education in Ghana, my position in this research and the importance of the research. I will further discuss the aim of the research, the research questions, and the general outline of the thesis chapters to provide an overview of the thesis for the reader.

1.2 Context of the study

This study is situated in Ghana, West Africa, as seen on the map of Ghana below.

Figure 1 Map of Ghana in the context of West Africa

Source: https://futurepump.com/distribution-ghana/ghana-west-africa/

The country was first known as the Gold Coast and adopted the name Ghana after gaining independence in 1957 (Graham, 1971; Nkrumah, 1971). The country prides itself on being the first sub-Sahara African country to have gained independence from Britain (Buah, 1980). Ghana lies along the Gulf of Guinea towards the south and shares borders with three French speaking countries: Togo to the east, Cote D’Ivoire to the west and Burkina Faso to the north (Briggs, 1998). At present Ghana has 16 administrative regions (Kojo, 2019).

This study was conducted in two regions of Ghana, namely, Ashanti region with Kumasi as the capital city and Oti region with Dambai as the capital city (see Figure 2 below). Ashanti region was chosen because it has the largest population in the country and has the highest number of mainstream, special education and rehabilitation centres (Ghana Education Service, 2015). Oti region was chosen because I am interested in a school which is in a semi-urban setting and a deprive region to explore experiences of children and youth with MI. Details about Oti region will be provided in the next section. This research is an area that has not been previously studied and was conducted because children with MI face inadequate resources and are ostracised because of their disability in mainstream schools, rehabilitation centres and special schools. The study attempts to find the reasons for this through studying their educational experiences.

Figure 2 Map of Ghana showing location of Ashanti and Oti regions[1]

1.2.1 Ashanti region

Ashanti region is centrally located in the middle belt of Ghana. It shares boundaries with Bono East to the north, Eastern region to the east, Western North, Western and Central regions to the south, Brong-Ahafo and Ahafo regions to the west (Kojo, 2019). As of 2010, the region had a population of 4,780,380 representing the highest proportion (19.4%) of the total population of 24,658,823 in the country (Ghana Statistical Service, Ghana Health Service, 2015). The region occupies 24,389 sq. km. or 10.2% of the total land area of Ghana.

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[1] Adopted from: https://s3.amazonaws.com/wp-haunsinafrica/wpcontent/uploads/2018/12/29162823/2019_Regions_of_Ghana-430x600.png

In Ashanti region, persons with disability numbering 124,501, or 16.9% of all persons with disability in the country. The proportion of persons with disability in the region is higher than in the other regions where the proportions range from 3.5% in the Upper East region to 14.1% in the Ashanti region. About one third of the population with disability has never been to school (33%) and 3.3% have only pre-primary school level education (Ghana Statistical Service, 2010). Children with disabilities with primary school to Junior High School (JHS) levels of education constitute the highest proportion (48.7%) and those with secondary school, SSS/SHS and vocational/technical/commercial levels of education constitute 9.7%. Those with tertiary education are 1.7% (Ministry of Education, 2015a).

The mainstream school, the special school and the rehabilitation centres used for the research in the Ashanti region are located in the urban areas of Kumasi compared to the Oti Region where the inclusive education schools are situated in semi-urban and mostly in rural settings.

1.2.2 Oti region

The Oti region is bordered in the north by the Northern region, in the south by the Volta region, and the east by Bono East region. Oti region has eight political administrative districts with Dambai as its regional capital (Kojo, 2019). The region is much drier than the Ashanti region. This is because of its nearness to the Sahel and the Sahara. Predominantly, the vegetation of the region consists of grassland with several drought resistant trees like baobabs or acacias. The dry season is between December and April and the wet or rainy season is between July and November. The region has an average annual rainfall of 750 to 1050mm (30 to 40 inches). The temperature ranges between 14^0 C (59^0 F) at night and 40^0 C (104^0 F) in the day (Briggs, 1998; Kojo, 2019). Oti region is one of the major agricultural production and marketing centres in Ghana. Close to half of its land is suitable for food and tree crop production and livestock rearing, whilst the other part of the land is drained by large water bodies such as River Oti, Asokawkaw and the Volta Lake that run all year round and which are suitable for farm irrigation and aquaculture (Kojo, 2019). The president of the Republic of Ghana, His Excellency, Nana Addo Dankwa Akufo-Addo, used Ghana's 1992 Constitutional Instrument (CI112) and carved the Oti region out of the Volta region on the 15th February, 2019 (Ghana News Agency, 2019). This region was recently created and as such there was no available data about the general population and that of persons with disabilities in the region.

1.3 The researcher

In this section, I outline my educational experiences and, as a person with mobility impairment, I will highlight my motivation for the choice of this research topic.

Birth and onset of disability

I was born on the 5th of May 1972 at Chinderi, a village in the Volta region of Ghana, which has now become a district capital of Krachi-Nchumbru District in the Oti region. I am the sixth child out of ten siblings belonging to the Nana Denteh Kwamena family at Chinderi. I became paralysed on my lower limbs at age three as a result of poliomyelitis. At age six, I was still kept at the house because of my disability. However, my younger siblings were sent to school. When I was nine years old, my parents prepared me for a rehabilitation centre in Kumasi, the second largest city in Ghana. A few months later, considering how young I was to be far from home, my father rescinded his decision and brought me to the mainstream school in the village where I could be well catered for by the family.

Schooling experiences

I went through several challenging schooling experiences including unfriendly school layout, difficulties in accessing classrooms and negative attitudes towards me as a MI person, to mention but a few. When I was in primary five (Grade 5), I arrived late at school and my punishment was to uproot a tree stump. I went to the house with tears rolling down my cheeks to get a cutlass to go and uproot the tree stump. My dad, who was named Francis Kwadwo Nseibo Denteh, was disturbed upon listening to my story. He never reacted badly and never requested for an explanation for the punishment allotted for a child who is disabled and had mobility difficulties, but rather took a mattock and a pickaxe and took me along to the tree stump. He did not go to the head teacher nor the teachers. He went straight to the stump and uprooted it and delivered me to the class and went back home. This news was all over the village. Shortly after my primary education, my dad, passed away. Going to the secondary school was a miracle, as I had no one to pay the bills of my secondary education. In addition to unavailability of resources to pay my school fees, the family was not willing to send me to the school because it was a common belief that children with disabilities cannot learn (Avoke, 2001; Baffoe, 2013a). I went into petty trading (selling eggs and tea) and an uncle (Migyikra Yaw Tawiah Denteh) assisted me to pay the admission fee. I passed the West African School Certificate and General Certificate Examination (SC/GCE) with a first division and proceeded to 'A' 3-Year Post-secondary school[2] where I was trained as a professional teacher from 1994 to 1997 at Atebubu Training Collage (now Atebubu Collage of Education).

In the year 2000, I gained admission to the University of Education, Winneba-Kumasi, where I pursued a 4-year Bachelors of Education Degree in Financial Accounting - and in 2009 I continued my academic career at the Kwame Nkrumah University of Science and Technology (KNUST) where I was awarded a Master of Science Degree in Disability, Rehabilitation and

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[2] 'A' 3-Year Post-secondary school is a teacher training college that trains professional teachers to teach in the basic schools (Primary and Junior Secondary Schools).

Development. After I graduated from the master's degree programme, I was coincidentally posted to the same rehabilitation centre where my parents initially wanted me to get my education when I was nine years old. It was coincidental because there were several special and rehabilitation centres in Kumasi and in the Ashanti region at the time. This raised a question about why I was posted to the rehabilitation centre in Kumasi. A personal reflection and thoughts about my decision to undertake this research will be explored in the next section.

Reflections whilst working at the rehabilitation centre

Reflecting on the initial decision made by my parents about an educational setting for me, I realised that my parents were uncertain about an educational setting that would meet my educational needs. I also realised that, if I had remained in the rehabilitation centre, I might not have had the opportunity to pursue my education to the current level. My personal educational experiences regarding challenging schooling experiences, including unfriendly school layout, difficulties in accessing classrooms and negative attitudes towards persons with disabilities, to mention but a few, influenced my decision to undertake this current study.

Several questions ran through my mind. These included - How are the basic schools responding to inclusive practices in Ghana? What educational support systems are available to enhance equal, accessible, and quality education for children and youth with MI in the basic school settings in Ghana? I am of the view that the voices of children and youth with MI as well as their parents should be heard by policymakers and stakeholders of education. Voices of parents and children with MI could be amplified if there is research to explore the experiences of children with MI in the school settings. Through exploring the educational experiences of children with MI, appropriate educational support systems to enhance equal participation and quality education in Ghana can be identified. Attaining equal and quality education in the educational settings will prepare children with MI for a good livelihood and will minimise negative attitudes and unpalatable cultural beliefs around persons with disabilities. The rationale for this study will be discussed in the next section.

1.4 Importance of the study (rationale)

In this study, MI is defined as the inability to walk safely and independently, a critical requirement for the performance of daily school activities and other activities within the community (Republic of Ghana, 2006; Special Attention Project (SAP), 2011). MI includes upper or lower limb loss, or manual dexterity and disability in co-ordination with different organs of the body and can either be congenital (during birth) or acquired (after birth) (Disabled World, 2015).

Inclusive education with children and youth with MI in the mainstream educational system continues to be a major issue and concern faced by many developing nations including Ghana (UNCRPD, 2006; UNESCO, 2014). The only difference between children with MI and children with disabilities in general is that children with MI may not require any special educational need and they are able to move with or without assistive devices (Disabled World, 2015). Most individuals with disabilities in general face the challenges of exclusion from any form of education and witness the failure of society to recognise their capabilities and rights (Avoke, 2002; Gyimah et al., 2008). There is limited literature on the education of children with MI in Ghana and the voices of these individuals are hardly heard by policymakers, government as well as stakeholders in education (Avoke, 2002; Gyimah et al., 2008).

It is important to explore the educational experiences of children and youth with MI, as their experiences can inform community awareness, promote equity and access to education and social justice and make policymakers sensitive towards the rights of children and youth with MI to quality education (Gyimah et al., 2008). Furthermore, exploring the educational experiences of children and youth with MI will enable the identification of appropriate educational support systems to enhance equal participation and quality education in the various educational settings in Ghana.

The Ministry of Education (MoE) and the Ghana Education Service (GES) implemented the Education Strategic Plan (ESP) for 2010-2020 to address the rights of all Ghanaians regardless of gender, sexual orientation, disability, religion, culture or language to receive basic quality education and to have access to any educational institution (Ministry of Education, 2015a). According to Auberon and Odoom (2016), despite these educational policies and strategic plans as well as the international influence on inclusive education, many children and youth with disabilities are uncertain about what educational services are available in the mainstream, special, rehabilitation and inclusive education that can serve their needs. As a result, children and youth with MI move from one educational setting to the other and, subsequently drop out of school because of inappropriate educational support systems (Auberon & Odoom, 2016).

A gap exists between policy statements on provision of equal education to children and youth with MI on the one hand and actual practices on the other (Awal, 2014; Kuyini et al., 2016). Also, the implementation of inclusive education programmes are still casting doubts on whether children and youth with MI will greatly benefit from accessing quality education, considering the inappropriate and unfriendly infrastructure in most schools, distance to schools and overcrowded classrooms with few teachers, the majority of whom are not specialised in educating children with disabilities (Aheto-tsegah, 2011; Peter & Nderitu, 2014). Children and youth with MI may not have their learning abilities affected by their impairments and may not need any special educational needs. Therefore, to assess the policy and practice of inclusive education (IE) it is informative to look at children and youth with MI as a straightforward case to bring to light the inherent knowledge gaps in education of children with MI in Ghana. The next section discusses the historical background of education in Ghana to aid the understanding of how the educational needs of children and youth with MI were not well catered for in the basic educational settings in Ghana.

1.5 Historical background of education in Ghana

Before the arrival of European settlers, education in Ghana was mainly informal and based on apprenticeship. The Europeans built a formal education system for their children and a few Ghanaian elites who assisted them in doing translations from the English language to the local language (Graham, 1971). With the independence of Ghana in 1957, a regular education system (mainstream) became an important political objective. The magnitude of the task as well as economic difficulties and political instabilities slowed down attempted educational reforms (Macbeth, 2010). In 1996, the Government of the Republic of Ghana embarked on a donor funded reform programme called the Free Compulsory and Universal Basic Education (fCUBE) programme which included a basic, secondary, and tertiary education system. This was to address the perennial problem of access and provision of physical structures, among others. The next section will examine basic education in the country by dividing its policy, history and practice into three major phases: the pre-independence era, the period between 1951-1986 and the period from 1987-2003 (Graham, 1971).

Pre-independence era

The pre-independence era was dominated by missionary activities in relation to the development of literacy for trade and the teachings of the Bible. Before the arrival of European settlers, education in Ghana was mainly informal and was based on apprenticeship. Traditional education that shows changes in a child's developmental abilities and the role of the community members were taught (White, 1996). Educational practices that served as schools included games, story-telling, initiation practices like puberty rites, child naming and marriage ceremonies (Yitah & Komasi, 2009). Other trainings that prepare the individuals to live independently included farming, fishing, hunting and apprenticeship (Fletcher, 2013).

Furthermore, indigenous education was responsible for the transmission of culture, inheritance, moral values and attitudes (Fletcher, 2013). Also, indigenous, and traditional knowledge were viewed as fundamental human rights that sustained the community. This kind of education that was viewed as fundamental human rights was universal and compulsory to all members of the community and was integral to African society before the arrival of the European merchants (Fletcher, 2013; Yitah & Komasi, 2009).

The history of Ghana's western style of education can be traced to the "castle schools" of European traders from Portugal, the Netherlands, Denmark and Britain, for the education of European children and other children from prominent indigenous families (Nkrumah, 1971). The introduction of western-style education in Ghana was said to be the European merchants and missionaries. They set up the first schools and Christian missionaries in early 1765 (Buah, 1980; Graham, 1971). These institutions were established by Presbyterian and Methodist missionaries and were in the south of the country that was called the British Gold Coast Colony. The aim of these established schools was to train the local inhabitants as interpreters for purposes of trade and to convert Ghanaians to the Christian religion. Between 1919 and 1927, there were early attempts to improve the quality of primary education in Ghana (previously Gold Coast) by Sir Gordon Guggisberg while in a role as Governor. Gordon Guggisberg emphasised on quality teaching and improved management of schools. However, inadequate supply of teachers and funding meant that his plans for improving basic education were hardly achieved (McWilliams & Kwamena-Po, 1975; Nyarkoh & Intsiful, 2018).

Basic education from 1951 to 1986

This second phase faced political instability coupled with high cost of fuel. As a result, several teachers left the teaching field. This had a serious impact on the Ghanaian basic education system (Adu-Gyamfi et al., 2016; Nyarkoh & Intsiful, 2018). In 1951, Dr Kwame Nkrumah (the first president of the Republic of Ghana), embarked on a massive expansion of the education system to improve the pace of educational development in the (then) Gold Coast. This action by Dr Nkrumah was to respond to a demand for education for the citizenry and to the government's intention to organise a planned campaign to reduce illiteracy. An initiative to promote basic education was followed by further developments with Ghana's independence in 1957. The next 35 years saw a wide range of developments and reform initiatives taking place in Ghana's education system. Within this period three significant stages can be discerned. These were (1) the Accelerated Development Plans (ADPs) for Education in 1951 and 1961, (2) the findings of the Dzobo Committee of 1973 and (3) The New Structure and Content of Education Plan in 1974.

The Accelerated Development Plan gained legal support through the 1961 Education Act. The support gained enabled the ADP to enforce the implementation of fCUBE. Also, the ADP used the 1961 Education Act as a legal instrument and empowered the Local Authority Council (L/A) to manage the basic institutions whilst parents were engaged as partners for the running of the basic institutions. The Local Authority Council is a governing body at the community level (Little, 2010). The formation of the Dzobo committee in 1973 was to submit a report to consider a restructuring of the education system in Ghana. The findings of the committee gave birth to one of the major post-independence education reforms in the pre-tertiary education. This reform is generally called the New Structure and Content of Education (NSCE) (Little, 2010). The major change by NSCE was a reduction of the length of pre-tertiary education from 17 years to 13 years (Little, 2010). The intentions associated with the new military government of the Provisional National Defense Council (PNDC) in 1981 led to further changes in the basic education reform from 1987 to the current stage (Adu-Gyamfi et al., 2016) as discussed below.

Basic education from 1987 Education Reform to date

This third phase had the major education reform. For example, the 'Free Compulsory Universal Basic Education (fCUBE)' reform of 1996 emerged. This was acknowledged by Ghana's participation in, and endorsement of, international agreements. Such agreements include, Education for All, the Declaration on the Rights of the Child, the Beijing Declaration on Women's Rights and the Lome Convention (Kadingdi, 2004). This meant that the government of the Republic of Ghana is obliged to remain committed to her constitutional obligations as a guide to policy. It worth noting that the constitution of the Republic of Ghana was influenced by the international agreements and by the bilateral and multilateral negotiations it had taken part in. Also important to this study in this period was the strong ambition of the government to reform the education system by 'leaving no stone unturned' in the development and restructuring the nation's economic base to bring it to conform with the financial credibility criteria required by the World Bank. With this financial credibility condition being met, Ghana had the opportunity to negotiate for credits and grants to finance major education reform. Apart from the World Bank credits, several donor agencies like the USAID, UNDP; countries like Switzerland, the United Kingdom, Norway, Canada and concessional loans from the OPEC fund (World Health Organisation, 2011) came to the aid of Ghana in her reform implementation, a greater part of which was directed to basic education.

Despite the development of basic education and the introduction of educational reforms as discussed above, the educational needs of children and youth with MI are not well catered for in the basic educational settings. There are a number of barriers that affect children and youth with MI in the basic school settings (Auberon & Odoom, 2016). These barriers in the basic schools which affected children with MI gave rise to the reason for undertaking this study as discussed in the next section.

1.6 Aim of this study

The aim of this study is to explore the experiences of children and youth with MI in four basic education settings, with the purpose of identifying appropriate educational support systems to enhance their educational trajectories in context with inclusive education in Ghana.

1.7 Research questions

In pursuance of the research aim, I addressed the following research questions in this study:

- What are the experiences of children and youth with MI in education in Ghana?
- What barriers do children and youth with MI experience in the basic educational settings in Ghana?
- How can children and youth with MI be supported in the basic educational settings in Ghana?

1.8 Outline of thesis chapters

Chapter 1: Chapter 1 is an introductory chapter which identified the knowledge gap in relation to the educational experiences of children with MI in four educational settings of Ghana. The chapter also describes the study settings in two regions of Ghana. This was followed by my personal educational experiences as a mobility impaired person, and the rationale behind this research. The chapter showed that Ghanaians have their indigenous way of education before the arrival of the European merchants. The chapter also outlined the aim of the study in relation to the experiences of children and youth with MI in the Ghanaian basic educational settings.

Chapter 2: Chapter 2 reviews literature related to this study, beginning with a discussion of the definition of disability in relation to the prevalence of disability in Ghana. Then, the structure of education from kindergarten to the tertiary level is explored in the four basic educational settings in Ghana. This exploration gives insight into why children with MI may be present in all educational settings. The literature also examines international and national documents that serve as legislative instruments and acts that protect children with disabilities in general. These legal frameworks identify educational rights of children with disabilities, and the extent of their inclusivity in the schools and in the societies. The chapter also discusses the dominant views about disabilities in Ghana to highlight the understanding, perceptions, cultural beliefs, and attitudes towards children with disabilities both in schools and in the communities. The ultimate reason was to analyse the link between acts of the community members and the educational experiences of children and youth with MI. The final part of the chapter discusses the educational support services and the school curriculum and assessment that impact on the experiences of children with MI in the four basic educational settings in the country.

Chapter 3: Chapter 3 presents the theoretical and the philosophical standpoint of the research where I articulate three overarching theories, namely, Disability Studies in Education (DSE), Bronfenbrenner’s Ecological System Theory (EST) and Post-Colonial Theory (PCT). To enrich my exploration of this study, I draw from the views of the proponents of DSE which holds that children with disabilities are not different from children without disabilities, and therefore children with disabilities should not be segregated. I also used EST which explains that schooling and development of children with MI begins with an interaction between parents, siblings, peers in the schools, teachers, head teachers, education officers and other stakeholders in education as well as the environments. Also, this chapter elaborates on the third theory which explores the influence of foreign culture on the Ghanaian basic educational system, where the local cultural value systems are ignored, and posing difficulties in the educational trajectories of children with MI in Ghana.

Chapter 4: Chapter 4 outlines the methodology followed in this research study, including the process used in the recruitment of participants, the tools used to generate data, and how this data was managed and stored. Also in this chapter, I explain the six steps suggested by Clarke and Braun (2017) for the data analysis. After this, I describe the scientific rigor which shows the credibility and the reliability of this study. I end the chapter with the various ethical protocols that are pertinent to this research and a reflexivity.

Chapter 5: Chapter 5 presents the first part of the analysis of this study, focusing on the two schools in the Ashanti region of Ghana. These schools are Kamame Basic School Complex (mainstream school) and Dabokpa Basic School (inclusive school). The chapter discusses the reason the two schools were analysed together. The chapter also analyses stories generated from the data from the two schools. The stories generated give a central theme, that is, “Am I not part of them?” This theme illustrates how children and youth with MI struggled before they gained admission to the basic schools. Though children with MI were accepted in the mainstream and inclusive schools, they were excluded from all social activities like games and entertainment. In some cases, the unfriendly school layout and the poor school buildings further excluded them from their educational rights. This chapter also shows that there was an inadequate supply of teachers and unavailability of educational support systems like student support teams, teacher support teams and education support teams in the two schools.

Chapter 6: Chapter 6 presents the second part of the analysis of this study, that is the results from the other two schools, namely, Akokor Rehabilitation and Ohiamankyene Special Schools. The chapter shows the demographic data of all the participants in the two schools. It further discusses findings about the experiences of children and youth with MI in the rehabilitation and the special school settings. The theme which summarises the experiences of these children with MI was the "school as a witch camp". This chapter analyses how the schools were portrayed as a witch camp and demonstrates how children with MI were abandoned by their communities and ostracised by the mainstream school system in Ghana. The chapter also demonstrates the plight of children and youth with MI who were likened to the alleged witches in Ghana who were abandoned and thrown to a camp somewhere in the northern parts of Ghana.

Chapter 7: This chapter brings all four school settings together by showing two major aspects of educational experiences of children with MI in the basic schools and the theoretical implications of the study. These major aspects are compared between the four educational settings and the key findings of the research are presented. The comparison of educational experiences of children with MI in the four school settings reveals that parents are more concerned about finding a cure to the disability than about the education for their children with MI. The key findings of this research also show the complex nature of educational experiences that have been greatly influenced by barriers, which have made the schools unpleasant places for children with MI. The chapter shows that school admission for children with MI was problematic and that all four school settings lacked adequate educational support systems. The chapter further shows that inadequate educational support system made the basic schools unprepared for inclusive schooling practices.

Again, the chapter shows that inequity in basic school curriculum made children with MI alienated from their fundamental educational rights. Finally, this chapter shows the implications of theories that were adopted as lens for this study and explains how the theories enhanced the understanding of the educational experiences of children with MI in the four basic educational settings in Ghana.

Chapter 8: This chapter provides an overview of the entire research and provides an inclusive schooling practices framework that was developed based on the findings. The chapter also presents the recommendations that arise from the findings of this study at various levels of education using the ecological system theory: a) policies (macrosystem), b) institutional communities (exo-system) and c) immediate community (micro and mesosystem). The chapter concludes the entire study and illuminates the possibility of further research in this understudied area in Ghana and in Africa as a whole.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Education for children with disabilities is a concern for every nation (UNESCO, 2014) including Ghana. However, little has been done to improve the education of children and youth with MI in Ghana. The education of children and youth with MI is the area of interest for this research. This is because, although there have been many studies on educating children and youth with disabilities in general (Opoku et al., 2017; Singal, Ware, & Bhutani, 2017), there is little literature about children and youth specifically with MI. That is, researchers focused on education of children with visual, hearing, and intellectual disabilities, and not necessarily on children with MI. The assumption may be that children and youth with MI may be easily accommodated in the mainstream school settings. This assumption may not be true considering barriers such as attitudes towards children with disability and the poor infrastructure in the mainstream schools. This is significant because more research must be conducted into the field of education of children and youth with MI to develop an inclusive schooling practices framework and support systems to meet their educational needs and improve the learning experiences of these students. This is also important because most of these students are being ostracised and marginalised because of their disabilities (Gregorius, 2014).

I reviewed literature published in the English language, the oldest being in the year 1962. This was the year when the first president of the Republic of Ghana began to focus activities on assisting with the education of children with disabilities in Ghana. The latest was published in 2020 so as to get a frame of reference on educational trajectories of children and youth with MI in the Ghanaian educational settings. Using the Boolean system, I searched for some keywords such as the following: (experiences* OR experience* OR feelings*) AND (child OR children OR youth*) AND (disabilities OR disabled OR impairments* OR mobility OR walking) AND (Ghana OR Africa) on the following databases hosted on the EBSCOHost platform: MEDLINE, Academic Search Premier, Africa-Wide Information, ERIC. I also used the University of Cape Town (UCT) Google Scholar and did manual searches in the UCT Libraries from July 2016 to December 2019.

This chapter is divided into two sections. The first section discusses literature with regards to disability, as well as experiences of children and youth with MI in accessing education in the basic educational settings in Ghana, considering the barriers associated with inaccessibility to education. The second section discusses the current Ghanaian educational structure with an emphasis on basic education. This is to provide a background on how basic education in Ghana is structured, including educational provisions for children with disabilities.

Themes discussed in the second section include: international and national policies and legal frameworks; understanding of disability; cultural beliefs and attitudes towards disability; structural barriers to accessing education; and educational support systems, curriculum and assessment. The focus of this review is on children with disabilities in general, and those with mobility impairments, and their educational experiences. This will enable me to have an understanding about the current situation of educational experiences of children and youth with MI and to identify gaps that are necessary to promote equal, accessible and quality education for children and youth with MI in Ghana. Unlike children with intellectual disability who may find it difficult to cope with the basic school curriculum (McKenzie, 2009), children and youth with MI may have minimal educational needs to cope with the school curriculum. The barriers in the school may be elements involving physical activity and participation. For example, children and youth with MI who use wheelchairs, crutches or prostheses may have difficulties moving around the school compound and may need extra space in their classroom. Therefore, findings from the current study may inform policymakers to consider children with MI as a straightforward case in order to assess policy and practice with regards to inclusive education.

The following section will discuss the literature related to disability and the educational experiences of children and youth with MI.

2.2 Definition of disability

Disability is part of human life and people with disabilities can be found in every society, every culture and every community throughout the world (United Nations, 2018a). People are either born with or acquire disability through circumstances or events (Gyimah et al., 2008). At the international level, the International Classification of Functioning, Disability and Health (ICF) is a World Health Organisation (WHO) framework that defines disability through domains that help to understand and describe changes in body function and structure. That is, what a person with disability can do in a standard environment and what he or she actually does in his or her environment (WHO, 2013). The 191 WHO Member States endorsed ICF as the international standards to describe and to measure health and disability both at individual and population level (WHO, 2013). The ICF conceptualises a person's level of functioning as a dynamic interaction between a person and his or her health conditions, factors within his or her environment and personal factors. It is a biopsychosocial model of disability based on an integration of the social and medical models of disability (this will be discussed further in sections 3.3.1.1 and 3.3.1.2).

Defining disability is complex, controversial, multidimensional and is still evolving to date (Albrecht et al., 2001). As a result, there is no single standard definition of disability that is accepted worldwide. The meaning of disability in this study draws upon the United Nations (UN) Convention on the Rights of Persons with Disability which was also drawn from the ICF to include mental, physical, mobility, intellectual and sensory disabilities. The Convention states that:

> Persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in schools and in the society on an equal basis with others. (United Nations, 2006, p. 3)

This research looks at disability not just as a health challenge to a person's body but as a multifaceted interaction of the human body in relation to educational trajectories and the society in which the person lives (World Health Organisation, 2011). This study focuses on mobility impairments as a type of disability. Mobility impairments may be caused by several factors such as disease, an accident, or a congenital disorder and may be the result from neuro-muscular and orthopaedic impairments. Also, persons with conditions like the spinal cord injury, paralysis, muscular dystrophy and cerebral palsy may be seen as mobility impairments. It may be combined with other problems as well (that is, injury from the brain, learning disability, hearing or visual impairment). Mobility impairment covers a wide range of impairments, from the ability to move quite freely with minimal assistance, to reliance on a motorised wheelchair. In some conditions the person may experience pain, continuous muscle contraction (spasticity), or lack of coordination. In other conditions there are intermittent flare-ups (when a student might be absent from class) and periods of remission, where the person seems to have no impairment of function (i.e. multiple sclerosis). Some students who use wheelchairs may stand but may not walk. Some may walk with little assistance or by the use of an aid like canes, braces and crutches (Disabled World, 2015; Republic of Ghana, 2006; SAP, 2011; Yarfi et al., 2017). Mobility impairment is defined as the inability to walk safely and independently, a critical requirement for the performance of daily school activities and other activities within the community (Republic of Ghana, 2006; SAP, 2011). Mobility impairments according to Clarke et al. (2007) relate to difficulty in walking and that is what makes children with mobility impairments different from their non-disabled peers (Singal, Mahama-Salifu, Iddrisu, Casely-Hayford, & Lundebye, 2015). For example, as mentioned earlier, children and youth with MI may have difficulties in physical activity and participation in the general school activities. Mobility impairments can either develop in the early years of childhood (congenital) or at a later period in life (acquired) (Ackah-Jnr & Danso, 2019; Yarfi et al., 2017). In this study, children and youth with MI are children and youth who have no additional impairments other than mobility impairments. To complement the definition of disability, this study reflects on prevailing international and local disability statistics as a measure of the impact of disability at a population level.

In 2011 the World Health Organization (WHO) reported an estimate for disability prevalence as 15% of the world population of more than 1 billion people (World Health Organisation, 2011). This figure indicates an upward increase from previous WHO/UN statistics of 10% of world population of 650 million people in 2001. The United Nation estimates that more than 80% of disabled people live in developing regions like Africa, Asia, Latin America and the Caribbean. Furthermore, it has been estimated that in Great Britain as a whole around one in four households contain at least one person with some form of disability and that around 70% of those people that are disabled have mobility impairments (United Nations, 2018b).

Current precise and reliable data on disability prevalence in Ghana is not available (Ghana Education Service, 2015; Gregorius, 2016). However, approximate statistics can be deduced from the WHO, World Bank and UN standards. The United Nations, World Population Prospects 2019, reports a current population of thirty million, five hundred thousand people in Ghana (United Nations, 2019b). This means that, based on WHO estimates, there are approximately 4,575,000 people with disabilities. The Ghanaian 2010 population and housing census revealed the most prevalent disabilities to be visual impairments, hearing impairments and mobility impairments (Ghana Statistical Service, 2010). Generally, the Ghanaian 2010 population and housing census revealed that out of a total population of 24,658,823 three percent were persons with disabilities (PWDs), classified as follows: visual impairments leading with 40.1%, followed by physical disabilities with 25.4%. The rest were: emotional disabilities 18.6%, intellectual disabilities 15.4%, hearing impairments 15%, speech disorders 13.7% and other types (not specified) 25.9% (Ghana Statistical Service, 2010). Earlier surveys of individual districts by the Ghana Human Development Scale (GHDS) in 1993 and the Norwegian Association of the Disabled (NAO) in 1998 and 1999 indicated that the three most prevalent types of disability are those related to visual impairments, hearing impairments and mobility impairments. In Ghana, the disability rate is the same for males and females. About 80% of disabled persons are found in the rural areas rather than urban areas, and they are often excluded from all mainstream school systems (Gadagbui, 2008; World Health Organisation, 2011). The mainstream school system is divided into three main levels within the Ghanaian educational structure as discussed in the next section.

2.3 The Ghanaian current educational structure

The Ghanaian current educational structure is divided into three levels: (i) basic education level (eleven years' 'free' education comprising eight years' primary and three years' junior high school education); (ii) senior high school (three years), free for every Ghanaian, (Blampied et al., 2018); and (iii) tertiary education (fee payable with a subsidy by the government) (Aheto-tsegah, 2011). According to the Ministry of Education and Ghana Education Service (2015), Ghana has 21,309 primary schools, 13,840 junior high schools, and 828 senior high schools, 18 special education schools, 529 inclusive education schools and 15 rehabilitation centres. At the tertiary education level, there are 33 universities, 10 polytechnics (upgraded to a university status), and at least 130 other specialised post-secondary professional institutions (UNESCO-IBE, 2011).

The Education Act of 1987, followed by the Constitution of 1992, gave a new impetus to educational policies in the country (Adu-Gyamfi, Donkor, & Addo, 2017). As mentioned above, education is divided into three levels: the first level is basic education. This is further sub-divided into Kindergarten (KG) School (2 years), Primary School (6 years) and Junior High School (3 years). The second level is secondary education (upper secondary school, technical and vocational education, 3 years) and the third level is tertiary education (universities, 4 years and polytechnics and colleges, 3 years) (Blampied et al., 2018; Lamptey, Villeneuve, Minnes, & McColl, 2015). Education is compulsory between the ages of four and 15 (basic education) (Blampied et al., 2018). The official age for a child to start a school is five or six years (Blampied et al., 2018). The language of instruction is mainly English.

Since the Education Reform Programme of 1987, one main objective has been to make education more relevant to the socioeconomic realities of the country, so that children with and without disabilities are able to live a productive and independent life (UNESCO-IBE, 2011). The reforms emphasised the achievement of equity and equality, which are cardinal principles that are particularly important for children with MI. In addition, current education sector strategies focus increasingly on providing Free Compulsory Universal Basic Education (fCUBE), aimed at developing assistance and accessibility to education in deprived areas, increasing the quality of teachers, improving training and learning material, and adopting information and communication technology (ICT) at the pre-tertiary level (Ghana Education Service, 2015; Kadingdi, 2004). Aheto-Tsegah (2011) reports that even though there are increasing primary school enrolment rates, Ghana’s education system continues to face major challenges in the areas of equal access and participation (Aheto-tsegah, 2011). Auberon and Odoom (2016) postulate that there are still many students who do not finish secondary school due to financial constraints (such as not being able to buy basic school necessities like ‘chop-boxes’ (lockers) and school uniforms), poor academic performance, inadequate infrastructure or for other socioeconomic and socio-cultural reasons. School facilities in rural areas are particularly poor and often lack furniture, equipment, teaching materials and have a disabling environment (Auberon & Odoom, 2016; Giri-ph, 2016). In addition to the inadequate physical environment, Gregorius (2016) observed that children and youth with MI often experience physical and emotional abuse as part of their educational trajectories. It is not uncommon to see children with disabilities being marginalised from full participation in education in these levels of education, especially at the basic level (Auberon & Odoom, 2016) as discussed below.

2.4 Basic education in Ghana

Basic education in Ghana is grouped into four educational settings, namely, mainstream, special, rehabilitation centres and inclusive schools (Adu-Gyamfi et al., 2017). The development of educational settings in Ghana has evolved through a series of stages during which education systems have explored different ways of responding to children and youth with MI and to other students who experience difficulties in learning (Ghana Education Service, 2015; Ministry of Education, 2015a), as discussed below.

Mainstream school: Until the middle of 1940, mainstream schools were the only type of basic educational setting in Ghana (Macbeth, 2010) (see ‘the Ghanaian current educational structure’ above). The mainstream schools only accommodated those children who did not have a disability and who readily could fit into it as it was currently run, deeming those who are disabled to be unable to be educated with everyone else (Lieberman, 2018). In the Southern Asia countries like Afghanistan, Bangladesh, Bhutan, India, the Maldives, Nepal, Pakistan and Sri Lanka mainstream schools are called integrated schools (Kalyanpur, 2014). Similar to the mainstream schools in Ghana (which is also known as integrated schools), a challenge that the integrated schools in the South Asian countries face is that a child with a disability is expected to change in order to fit into the school system, rather than the education system changing to fit the child (Kalyanpur, 2014; Opoku, 2016). The Ministry of Education through GES oversee all activities about teaching and learning as well as posting of trained teachers to the mainstream schools. The inaccessible nature of the mainstream schools in Ghana called for the establishment of rehabilitation centres.

Rehabilitation centre: The rehabilitation centres can trace their origin from the time when Osagyefo Dr Kwame Nkrumah became the president of the Republic of Ghana in 1957. Soon after he was sworn in as the president, Dr Nkrumah formed a committee to work on the formation of rehabilitation centres (Grischow, 2011; Nkrumah, 1971). This committee, led by John Wilson, expressed their concern about how children with disabilities were abandoned, neglected by society and in some cases killed. The committee added that the existing school system did not provide for the integration of children with disabilities and recommended that rehabilitation centres, special and vocational schools should be founded in all regions of Ghana to cater for the employable skills of persons with disabilities (Grischow, 2011). Based on the recommendations by Wilson's committee, Dr Nkrumah launched a mass registration of persons with disabilities, and in 1962 incorporated disability education into the national educational policies which was followed by the development of rehabilitation centres and special education schools across the country (Grischow, 2011). This move by Dr Kwame Nkrumah in 1962 gave birth to several special and rehabilitation centres. Whereas special schools are under the auspices of the Ghana Education Service, rehabilitation schools are under the Department of Social Welfare (Republic of Ghana, 2006). The formation of special schools and rehabilitation centres is also reflected in the 1992 constitution of the Republic of Ghana which specifies that "All persons shall have the right to equal educational opportunities and facilities and with a view to achieving the full realization of that right - (a) basic education shall be free, compulsory and available to all" (Republic of Ghana, 1992, p. 26). While this confirmation in the constitution was clear about including all children, it did not give clear guidelines about how to cater for the education of persons with disabilities. However, the Disability Act 715 of 2006 gave more details about the educational rights of children with disabilities and the responsibilities of their parents, guardians or custodians. For example, article 16 of the Disability Act 715 of 2006 among others, states:

> A parent, guardian or custodian of a child with disability of school going age shall enroll the child in a school … A parent, guardian or custodian who contravenes sub-Section (1) commits an offence and is liable on summary conviction to a fine, not exceeding ten penalty units, or to a term of imprisonment not exceeding fourteen days (Republic of Ghana, 2006, p. 6).

Special schools: Just like the rehabilitation centres, special education schools have been provided as a supplement to the mainstream educational provision for persons with disabilities (Kuyini et al., 2016). The foundation for special schools can be traced back to the mid-1940s when the Basel missionaries established a school for students with visual impairment in Begoro and Akropong-Akwapim, which were later followed by the emergence of special schools for other disability categories (Avoke, 2001; Obeng, 2012). Currently, Ghana has separate special schools for children with visual impairments, hearing impairments and intellectual disability. These special schools, except intellectual disability follow the general basic school curriculum (Avoke, 2001;

Obeng, 2012; Opoku, 2016). In addition to these special schools that cater separately for different disability types, Ghana has other special schools and rehabilitation centres that are supposed to meet the educational needs of all children with disabilities, including those with visual, hearing and mobility impairments in one school (Nseibo, 2013; Obeng, 2012). In this study, the selected special school and rehabilitation centres are the educational settings that have children with different types of disabilities. In spite of the positive development of education, including policy initiatives that have been enacted to safeguard the education of children and youth with disabilities in Ghana, a lot of children and youth with MI remain unable to access quality education as a result of barriers and disabling environments (Auberon & Odoom, 2016).

The focus of persons with disabilities in the special educational setting was firmly placed on the bodily impairment of the person, the impairment being viewed as the source of the person's social exclusion (McKay, 2016; Mckenzie & Macleod, 2011; Opoku et al., 2017). With the more recent development of a social model of disability (see Chapter 3) from the 1960s, and the adoption of a human rights perspective as embodied in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD, 2006) attention has shifted to societal responses to the bodily impairments that create educational exclusion (WHO, 2001). This exclusion is framed within a human rights discourse as a violation of the educational rights of children and youth with MI and is accompanied by a call for the promotion and protection of their rights (Mckenzie & Macleod, 2011; Nseibo, 2017; UNCRPD, 2006).

As mentioned in the mainstream school earlier, special schools are also under the auspices of the Ministry of Education through GES. Within GES is the Division of Special Education (SPED). The SPED works towards the creation of equal opportunities for learners and young people with disabilities and Special Educational Needs at the basic education level through the efficient management of resources, provision of suitable and sustainable support structures in an inclusive school environment. As a result of the promotion of educational rights for children and youth with MI, inclusive education (IE) was founded in some selected regions including Ashanti and Volta regions of Ghana (Auberon & Odoom, 2016; Opoku et al., 2017).

Inclusive education: Inclusive education can be seen as a process which addresses and responds to the diversity of the needs of children with disabilities, including children with MI "through increasing participation in learning, cultures and communities and reducing and eliminating exclusion within and from education" (UNESCO, 2017, p. 21). Inclusive education also refers to guaranteeing, and securing the right of all children including those with disabilities to access, presence, participation, and achievement in their schools (Ainscow & Miles, 2009; Slee, 2020). According to Slee (2020) and Booth et al., (2006), access to education and presence in the classroom refer to the basic human right for all children. This basic right is enshrined in the Universal Declaration of Human Rights (see 3.5 below). The participation in quality and inclusive school settings by all children is equally the fundamental human right for all children. The fundamental human rights are stated in the Convention on the Rights of Persons with Disabilities (UNCRPD, 2006). Children with MI should have full participation of all activities in the education system. This will influence effective participation in the society on an equal basis with other members of the community (Kalyanpur, 2014; United Nations, 2006). The second element identified in the definition of inclusive education is participation. Participation of all children in school may also pave the way for fairness, justice and equity. The third element in the definition is achievement. Achievement refers to the evidence of learning outcomes across the school curriculum (IBE-UNESCO, 2016; Slee, 2020).

The definitions of IE above indicate that communities and stakeholders of education are called upon to build capacity to eliminate barriers to access, presence, participation, and achievement in order to provide educational experiences and outcomes for all children (Kalyanpur, 2014). The definitions of IE above go beyond issues of disability and include quality teaching and learning, enrolment and retention of children with disabilities and the involvement of all children in all school activities, including children with MI. The definition of inclusive education also involves changes and modifications in content, approaches, structures and other strategies with a common vision which covers children with MI and all other children of the appropriate school age, and a conviction that it is the responsibility of the regular educational system to educate all children (Opoku et al., 2017; UNESCO, 2017). An inclusive school system may refer to a school that continually works to ensure that each child in the school has access to a learning friendly and barrier free school environment to actively participate in the school community, so that all children develop to their full academic, social, emotional and physical potentials (Mckenzie & Macleod, 2011; Opoku et al., 2017; Tudge et al., 2016).

In Ghana, IE started as a pilot in some selected regions including, the Ashanti, Brong Ahafo and the Western regions and later extended to the Volta region (Opoku et. al., 2017). In their study entitled "*Decade of inclusive education in Ghana: Perspective of educators*", Opoku et. al., (2017) found that, the selection of regions and districts as well as the distribution of schools for the pilot of inclusive education were not accurate representative samples of schools. They also found that, the districts selected by the government to pilot the inclusive education programme were only concentrated in certain parts of the country, specifically, around the coastal areas. They argued that key regions such as the Ashanti and the Brong Ahafo regions were excluded from the pilot of the inclusive education programme (Opoku et. al., 2017). Further, Opoku et. al., (2017) found that several schools were supposedly practising inclusive education in Ashanti region but human resources, teacher support and learning materials were unavailable to facilitate inclusive practices for students with disabilities.

In this study, the inclusive school setting has no track record in the form of history about how inclusive education started in the Oti region (formally in the Volta region). For example, all basic schools in the district of the study area are considered as inclusive schools (Field Notes July, 2018). This may not be realistic, as it will be very challenging to practice IE in all schools within the district. However, inclusive schools in this study area remained on paper. The next section discusses how inclusive education in Ghana was influenced by international legislative instruments.

2.5 International legislative instruments

Inclusion of children with disabilities has involved a series of changes at the societal and classroom level that have been accompanied by a number of legal instruments at the international level (UNESCO, 2017). The right to education for all children has been implicitly advocated since the Universal Declaration of Human Rights in 1948, and it has been mentioned at all stages in a number of key UN declarations and conventions, some of which are discussed below.

1. Universal Declaration of Human Rights (1948): This ensures the right to free and compulsory basic or elementary education for all children
2. UN Convention on the Rights of the Child (1989): Ensuring the right for all children to receive education without discrimination on the grounds of disability. Article 23 of this Convention stipulates that:

> … effective access to and receive education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in

> a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development. (Article 23)

3. The World Declaration on Education for All (1990): The Jomtien World Conference on Education for All (1990) sets the goal of Education for All (EFA). UNESCO, along with other UN agencies and international development agencies as well as a number of international and national non-governmental organisations, has been working towards achieving this goal.
4. The UN Standard Rules on the Equalization of Opportunities for Persons with Disabilities Rule 6 (1993): Though not legally binding, the rule not only affirms the equal rights of all children and youth with MI to education but also states that education should be provided in "an integrated school settings" and in the "general school settings." (UNESCO, 2005, p. 12)
5. The Salamanca Statement (1994): The Government of Spain in corroboration with UNESCO organised a conference which brought together education officials, administrators, policymakers as well as representatives of the United Nations and the specialised agencies, other nationals, NGOs and donor agencies with the aim of enforcing inclusive education, particularly for children with disabilities and those with special educational needs. The aim was also to build good relationships between children with disabilities and their non-disabled counterparts. The Salamanca Statement, among others, states:

> Within inclusive schools, children with special educational needs should receive whatever extra support they may require to ensure their effective education.

> Inclusive schooling is the most effective means for building solidarity between children with special needs and their peers. Assignment of children to special schools – or special classes or sections within a school on permanent basis - should be the exception, to be recommended only in those in frequent cases where it is where it is clearly demonstrated that education in regular classrooms is incapable of meeting a child's educational or social needs. (UNESCO, 1994, p. 7)

6. World Education Forum Framework for Action (2000), Dakar, (EFA goals) and Millennium Development goals: This is to ensure that all children have access to complete free and compulsory basic education by the year 2015.
7. United Nations Convention on the Rights of Persons with Disabilities (2006): This Convention promotes the rights of persons with disabilities and mainstreaming disability in development.
8. The Sustainable Development Goal 4 (SDG4): This is to ensure inclusive and equitable quality education that will promote lifelong learning opportunities for all children including those with MI. The SDG4 focuses on basic and secondary education that lead to relevant learning outcomes (United Nations, 2019a).

The policies and legislative instruments of Ghana that focused on the inclusion of children and youth with disabilities are mainly influenced by the above-mentioned international policies. Ghana's national policies will be discussed in the following section.

2.6 National policies

1. Article 25(a) of the 1996 (Amendment Act 527) of the Constitution of the Republic of Ghana states, "All persons shall have the right to equal educational opportunities and facilities and with the view to achieving the full realization of this right, basic education

shall be free, compulsory and available to all" (Republic of Ghana, 1996, p. 41). The constitution also provides for the protection of children and youth with disabilities from discrimination and abusive treatment (Article 29), mandates the legislature to enact appropriate laws (Article 37) and requires access to Free Compulsory Universal Basic Education (fCUBE) "The State shall provide educational facilities at all levels and in all the Regions of Ghana, and shall, to the greatest extent feasible, make those facilities available to all citizens" (Republic of Ghana, 1996, p. 51)

2. The Children's Act (560) of 1998 also enjoins the government to promote the physical, mental and social well-being of every child. Also, in the Children's Act is the National Disability Policy, June 2000. This is one of the legislations which guarantees security to specific rights of children with MI. This policy was largely in response to the United Nations standard rules on the equalization of opportunities for children and youth with disabilities (United Nations, 1993). It promotes the rights of children and youth with disabilities with regards to education, transportation, community acceptance, housing and employment (Blampied et al., 2018).
3. Government of Ghana's Education Strategic Plan (ESP) 2003-2015 (revised to 2020): The ESP echoes the Ghanaian government's dedication to EFA and dictates that all schools within Ghana provide inclusive environments for children with disabilities by the year 2015. (Ministry of Education, 2015a).
4. Special Educational Needs Policy Framework (2005): Based on key policy objectives indicated in the ESP, this framework addresses the challenges of marginalization, segregation and inequality that have previously constituted barriers to the education of

students with disabilities (Ackah-Jnr & Danso, 2019; Ministry of Education, 2015a; Mohammed, 2014a).

5. Persons with Disability Act, (Act 715) June 2006: This constitutional act fulfils the Ghanaian constitutional requirements and incorporates suggestions from ratified human rights conventions (Republic of Ghana, 2006)
6. The Education Act (778) of 2007 provides for inclusive education at all district levels (Article 5). It also makes two years of kindergarten part of basic education, extending basic education to 11 years.

These international conventions and national legal frameworks have served as policy drivers by the government of the Republic of Ghana to ensure universal access to quality education and opportunities to enable all children including those with MI to participate meaningfully in the socio-economic development of their communities (ESP 2010–2020). It is important to note that despite the positive influence of the international and national legal frameworks regarding equal access to quality education, there has been less effort to promote education for children with disabilities in Ghana (Mantey, 2017a), especially children and youth with MI whose disabling conditions may not prevent them from being a part of the mainstream or inclusive schooling system. For example, like their non-disabled peers, children and youth with MI may not need any special educational needs to cope with the basic school curriculum. What children and youth with MI may need is environmental adaptation. It is important to state that there may not be a direct correlation between children and youth with MI and the inability to cope with the school curriculum (Opoku et al., 2017). Therefore, children and youth with MI should benefit from the inclusive schooling practices in the district. The gap that exists is that inclusive education is not functioning in the Oti region. In addition to the school environment as a barrier, it appears that children with MI experience diverse forms of discrimination in society which affect their rights to education (Mprah et al., 2016). That means that they are not provided with equal access to education by the state. Consequently, they are denied equal opportunities to basic education, including other educational institutions. In this regard, Reynolds (2010) argues that national education policies are influenced by international principles and guidelines, and that national policies therefore are conflicted between national belief systems based on the individual model of disability and international principles and guidelines based on the social model of disability.

This research is set within the context of Article 24 of the UN Convention on the Rights of Persons with Disabilities (UNCRPD). In addition, goal four of the Sustainable Development Goals (SDGs) seeks to ensure equal access to quality education for all children globally by 2030 (United Nations, 2019a). Ghana's 1992 constitution guarantees universal primary education for all Ghanaian children, including children with MI who may have diverse educational needs.

All of these legal frameworks are based on international human rights agreements which support the development of an education system that recognises a wide range of diverse needs and ensures a wide range of appropriate responses (Blampied et al., 2018; UNESCO, 2005). These frameworks articulate the goals of equity and the rights of all learners to equal access to educational opportunities.

In addition, it must be acknowledged that Ghana can learn from the western model of inclusive education for children with disabilities and for those with mobility impairments, which is the focus of this study. However, cultural values of the citizens must not be overlooked because inappropriate modelling cannot work for a developing country like Ghana. For example, Mantey (2017, p. 69) states that "schooling is so closely tied into local conditions and cultures that the importation of practices from elsewhere is fraught with difficulties". As a result, a Ghanaian model of inclusive schooling practices should be developed to help these groups of children with MI to enable them to access equal and quality education in all basic school settings. Therefore, attention should be given to the challenges faced within the national and local context, some of which may include cultural beliefs around attitudes towards disability, as discussed below.

2.7 Cultural beliefs and attitudes towards disability

Studies that have been carried out in Ghana reveal that there are cultural beliefs with regards to disability (including mobility impairment) where persons with disability are seen as being evil, cursed, or exposed to witchcraft and punishment, resulting in stigma and discrimination (Avoke, 2001; Baffoe, 2013a). These beliefs are often based on fear, misunderstandings and stereotypes of children with disabilities that expose them to the denial of educational rights and resources that are afforded to all citizens (Baffoe, 2013a). The importance of understanding the different ways in which disability is generally perceived is necessary because societies address disability issues based on the ways they conceptualize disability. It is their understanding of disability that influences their attitudes towards children with disabilities (Avoke, 2002; Baffoe, 2013b).

For example, Avoke (2002) reports that the general attitude in many communities in Ghana towards children with disability is that, in the past, they were returned to the forest by the “okomfo” (fetish priest) or to the rivers under the guise of helping them to return to where they came from. In addition, Awal (2014) states that the negative attitudes towards disabilities are the biggest barriers preventing children with disabilities from accessing and benefiting from basic education. Negative attitudes can be observed at all levels, including parents, community members, peers and teachers in schools, government officials and even children with MI themselves (Kuyini et al., 2016).

Consequently, it is the fear, shame, lack of knowledge, misinformation and socio-economic values about human dignity and respect which encourage negative attitudes towards children and youth with disabilities (Baffoe, 2013a; Kuyini et al., 2016). Children and youth with MI in this study are often faced with prejudice, stereotyping and discrimination in society (Mprah et al., 2016; Opoku et al., 2017). Sometimes they become conscious of how society will perceive them. The fear of children with MI facing prejudices and stereotypes within schools and the society as a whole prevents them from exploring and experiencing their full potential. The impact of such attitudes is evident in the home, school, community and at the level of national policy-making, where the needs of children with MI are not incorporated into the planning, budgeting and programming stages (Auberon & Odoom, 2016).

Further, Reynolds (2010) indicates that in some traditional communities in Ghana some creatures like crocodiles and snakes are believed to have supernatural powers or, in some cases, human beings change into such creatures, and therefore any cruel attitude against the powerful animal can lead to an individual giving birth to a child with a disability. Such beliefs invariably influence societal understanding of disability, beliefs and perceptions about such individuals in Ghanaian traditional society.

In Ghana, as in many other African countries, children and youth with disabilities have historically been considered burdens on their families and communities (Gregorius, 2016). Avoke (2002) further indicates that in many communities in Ghana exclusion from school and unkind treatment were meted out to children with disabilities. Such treatments were considered justifiable due to the strong belief that the disability was the result of evil placed on children and youth with disabilities from the gods for committing offences in the community or against the supernatural powers. The understanding of disability was based on the assumption of traditional African philosophies which hold that the birth of a child with a disability is a bad omen or an act of bewitchment (Mantey, 2015; Reynolds, 2010). According to Baffoe (2013), the only explanation to offer when a woman gives birth to a child with a disability is that the gods are annoyed. These cultural beliefs, attitudes and perceptions about children and youth with disabilities in Ghana have created situations that have led to further isolation from school and the community as a whole (Avoke, 2002; Baffoe, 2013a; Reynolds, 2010). Some parents and community members believe that disability is a punishment from the ancestors for having committed a sin against the spiritual or moral values of society, hence children and youth with disabilities are not allowed to go to school or go out to any public gathering (Mantey, 2017a). These communities view disability as a stain on the social status of a family, often leading to these children with MI being isolated and hidden away or placed in segregated institutions where they are excluded from the mainstream society (Agbenyega & Deku, 2011; Obeng, 2012).

In resonance with the above notions, children and youth with MI are excluded from the mainstream school system and other mainstream activities because the cultural beliefs and understanding about disability influence the community to impose social barriers on children and youth with MI (Barnes, 2012; Owusu-Ansah et al., 2018; Yarfi et al., 2017). Such barriers limit the ability of children with MI to access the opportunities, privileges and resources in society such as equal access to information, education, employment, public transport, housing and social and recreational opportunities (Gregorius, 2016; Kuyini et al., 2016; Opoku et al., 2017). Recognition of the educational rights and capabilities of children and youth with MI is still very limited in many parts of Ghana, as evidenced by the minimal effort made to include children with MI into the mainstream educational system (Gyimah et al., 2008; Obeng, 2012). Many children and youth with MI continue to receive their education in segregated, residential special schools and rehabilitation centres which are mainly located at the outskirts of large cities. These special and rehabilitation educational settings have been portrayed as "*safe havens*" where children with MI are protected from exposure to the hazards which are associated with inclusion in mainstream society (Avoke, 2001; Badu, 2016, p. 16; Barnes, 2012). On the contrary, disability advocates attribute enrolment of children with MI in the special schools and rehabilitation centres that are away from the major cities to prevailing cultural beliefs, attitudes and understanding of disability (Adu-Gyamfi et al., 2016; Mantey, 2017a; Reynolds, 2010). Meanwhile, children and youth with MI who are enrolled in the mainstream schools or in the segregated rehabilitation and special schools encounter structural barriers in the educational settings as discussed below.

2.8 Structural barriers to accessing education

Children and youth with MI encounter structural barriers to educational services, such as inaccessible school buildings and layout, lack of ramps and elevators in multi-level school buildings, heavy doors, inaccessible bathrooms, transportation to and from school, and overcrowded classrooms (Ashigbi et al., 2014; Kuyini et al., 2016; Opoku et al., 2017). Bronfenbrenner's ecological system theory and the social model of disability indicate that disability results from interactions between individuals and the environment (Tudge et al., 2016; World Health Organisation, 2011) (see Chapter 3). This in turn consists of complicated arrays of social, cultural, political, climatic, topographic, architectural, and technological components (Ackah-Jnr & Danso, 2019; Yarfi et al., 2017).

The built or architectural environment is generally defined as all buildings, spaces and products that are created or modified by people (Curtin et al., 2007), including schools, workplaces, footpaths and transportation systems. This research is focused on the educational settings. The role of accessible, safe, well-designed architectural environments for optimal schooling for children and youth with MI is increasingly being recognised (Gregorius, 2016; Opoku et al., 2017). This is because surrounding social and physical environments are likely to be consequential for the independence of children and youth with MI (Addo, 2014; UNESCO, 2017). Restrictions placed on mobility and access by a poorly designed architectural environment are more obvious than the institutional discrimination in the lives of children with disabilities (Barnes, 2012; Connor et al., 2008).

With respect to children with MI, poorly designed school communities can make it difficult for them to move about in their environment. The lack of ramps, barrier-free school layout, overcrowding in the classrooms and inadequate bathroom facilities are some of the environmental barriers that can prevent accessibility to basic schools (Addo, 2014; Nseibo, 2017; Owusu-Ansah et al., 2018).

According to Danso et al. (2019), policies that regulate the construction of school buildings in Ghana have not been revised to incorporate barrier-free designs. This means Ghana, as a nation, does not have a policy framework that regulates and obliges the stakeholders in the building construction industry to follow the standards of universal design and to build school buildings that are user friendly to children with MI. Addo (2014) notes that Ghana had no statutory policy that protects the educational rights of children with MI until the year 2000 when a policy draft in favour of children and youth with disabilities was laid before the cabinet of the Republic of Ghana.

This policy document - which will serve as a legal framework and a guide to the building and construction industries on building accessible schools - ‘slept’ on the desk of the parliament of the Republic of Ghana until June 2006 when the Persons with Disability Act called ‘Act 715’ was passed into law (Addo, 2014; Adu-Gyamfi et al., 2016). However, since the enactment of the Disability Act 715, little has been done to encourage equal access to education by children with

MI (Addo, 2014). Opoku et al. (2019) argue that policymakers and education stakeholders should make modifications to the Disability Act and other educational policies to ensure that school environments are made more accessible to persons with disabilities, including children and youth with MI. Physical and curricular modifications can be outlined and supported in school materials such as the book called the “Head Teachers’ Guide” which is a guide that gives instructions about day to day activities of a school including school admission procedure. According to Singal et al. (2015), some modifications have been made to schools; however, these modifications and changes were undertaken in both regular and special schools, suggesting some ambivalence about inclusion of children with disabilities in the basic educational settings, considering the limited educational support services and the nature of the curriculum in the basic schools (Singal et al., 2015).

Along with the built environment, the educational support services and the curriculum of the school play an important role in the inclusion of children with MI in the basic educational settings as will be discussed in the next section.

2.9 Educational support system, curriculum, assessment, and materials

An educational support system in this study includes material resources, human resources, and educational support teams. The material resources refer to physical, material resources that make teaching and learning more meaningful. These include cumulative record books, cardboard, papers, marker pens, libraries, computer labs and others. In the rehabilitation centres and special schools, material resources include pliers, stitching machine, sewing machine, leather kit, library materials and computers Human resources and educational support teams are about teachers, networks of people and other measures put in place to make teaching and learning more accessible to children and youth with disabilities (Mariga et al., 2014).

Educational support systems and materials are important for children and youth with MI to access equal and quality education (Opoku et al., 2019). Because access to basic educational settings has been identified as being vital to improving the well-being and acceptance of children and youth with MI in the schools and in their communities, mechanisms need to be put in place to promote their education in these community educational settings (Singal et al., 2015). In addition, teaching and learning materials like computers, overhead projectors, sewing machines, knitting machines, puncheon board, hot and cold dryers, cutters, shoe linen leather, hammers, fattening nails, shoe sole, punch needles, scissors, strands of hair and assistive devices like crutches, wheelchairs and callipers are necessary for the success of children and youth with MI (Mantey, 2017a; Opoku et al., 2017).

However, inclusive practices seemed to have been stalled in schools in Ghana because of the lack of appropriate teaching and learning materials (Mantey, 2017a; Mprah et al., 2016; Nseibo, 2017). It cannot be over emphasised that the education of children and youth with MI will not succeed in an environment in which limited support is provided to students and teachers. In the pursuit of having educational support services in the basic educational settings, Opoku et al. (2017) report that an attempt has been made to place special education teachers in schools to support classroom teachers, but this has not been effective due to improper planning and the unsupportive nature of the curriculum at the basic school levels in Ghana (National Education Assessment Unit, 2016; Opoku et al., 2017).

The Ghanaian basic school curriculum is based largely on the objective model of curriculum development, adopted from Ghana's colonial masters (Mereku, 2012; SAP, 2011). This model was rooted in the beliefs and culture of the global west and was used in many developed countries in the last half of the 20th century (Mereku, 2012). According to Hitt and Tyler (1991), the syllabus follows a four-step sequence: (1) identifying objectives; (2) selecting the means for the attainment of these objectives; (3) organising these means; and (4) evaluating the outcomes. A major characteristic of the model is its emphasis on the statement of instructional objectives which should describe the desired and prescribed learning outcomes in terms of specific learner activities. Though objectives of this model enable teachers to judge the quality of their teaching, the model has been criticized because not all the outcomes of a particular lesson can be specified in a limited number of instructional objectives. This argument is vital because there is no assessment or examination conducted in the rehabilitation and special schools (evaluating the outcomes, the fourth step in the above-mentioned sequence), unlike as practiced in the mainstream schools (Opoku, 2016).

The main use of the objective model as prescribed by Hitt and Tyler (1991) in the Ghanaian basic school curriculum led to over-emphasis on the products of learning (that is, knowing basic facts, principles, skills and procedures) at the expense of the processes of learning which involve higher cognitive competencies such as applying; thinking critically, creatively and practically; connecting ideas about people and realms of life; and learning how to learn (Hitt & Tyler, 1991; Mereku, 2012). Teachers' expectations of children are linked to theoretical curricula, rather than a practical curriculum which could focus on technical trades such as carpentry. As a result, examinations do not encompass both theoretical and practical components and this can hinder the potential of learners (Opoku, 2016). Children and youth with disabilities in the rehabilitation and special schools do not write the Basic Education Certificate Examination (BECE) that could enable them to have certificates and to be placed in the job market (Kwao, 2017; Mereku, 2012; Muzata, 2017). What is problematic is that schooling is not likely to happen in the rehabilitation and special educational settings at all.

This is because the school curriculum, which is supposed to cater for individualised curricular accommodations (that is, accommodations in curriculum access and accommodation in curriculum elements), are not readily available (National Education Assessment Unit, 2016). The question may be: why are these curricula which serve children with disabilities not available in the rehabilitation and special schools? Accommodation can be seen as curriculum access and curriculum elements (Muzata, 2017). Accommodation in curriculum access includes teaching and learning materials and resources that are essential for children and youth with disabilities in the various educational settings (Muzata, 2017; National Education Assessment Unit, 2016). Curriculum access also encompasses all efforts taken by the school to eliminate architectural, material and communication barriers to ensure that children with MI who find themselves in the inclusive classroom, mainstream schools and rehabilitation and special schools learn the same content effectively as their peers who are non-disabled, and can easily navigate in the schools without much difficulty (Mereku, 2012; Muzata, 2017; National Education Assessment Unit, 2016). Although accessibility in schools is guaranteed by national and international laws, spaces are still built based on the reference point of non-disabled students. This raises a concern about why building regulations are not being followed. Accommodations in curriculum elements, on the other hand, are the components in the curriculum and the various teaching strategies that are adopted to provide knowledge and development of skills, attitudes, values which are essential to personal development that are necessary for living in and contributing to a developing and changing society in the country (Kwao, 2017; Mereku, 2012; SAP, 2011). Curriculum access and curriculum elements should prepare children and youth with MI for assessment that leads to the award of a certificate that is acceptable in the job market and in the society as a whole.

Assessment should adapt different styles and possibilities of expression to cater for all children in schools. Assessment practices affect all students in the school, since they create a competitive environment, and mask, enhance, or even create needs and difficulties that exclude, label and stigmatise children with MI in the rehabilitation and special schools (Kwao, 2017; Muzata, 2017; National Education Assessment Unit, 2016). Since children and youth with MI and children with disabilities in general are required to progress from one educational level to the next, there is an obvious need to modify the curriculum and assessment in the rehabilitation and the special schools.

While the school curriculum can be a barrier to learning and participation, curricular accommodations support teachers and learning and participation, not only for children with MI in the rehabilitation and special educational settings, but also for all learners in all school settings. Moreover, the curriculum is a critical tool that affects the implementation and the practice of education for all in Ghana. The way the curriculum is structured influences the learning potential of children with MI. Therefore, access to a curriculum that is more practical based for children with MI should be implemented not only in the rehabilitation and special schools but in all basic school settings (Kwao, 2017; Owusu, 2016; SAP, 2011). Thus, there is gap in the curriculum development and delivery in meeting educational needs for all students, including those children with MI in the rehabilitation and special educational settings. Ghana's school curriculum is subject based, highly rigid and demanding for teachers to modify it and to try out new ways of delivering what will enhance full participation and access to all children with disabilities (Mereku, 2012; SAP, 2011). In conclusion, all teaching subjects must be given equal preference to help develop diverse talents and potentials that are essential for human development, placements and job opportunities (Kwao, 2017).

2.10 Chapter summary

In this chapter, I have discussed the definition of disability. The definition of disability portrayed the complexity and the controversy of disability as a problematic phenomenon. The chapter also discussed the Ghanaian current educational structure with emphasis on basic education where adequate educational support needs for children with MI were not available. The second section dealt with the international and national policies as well as legal frameworks that support equal access and educational rights of children and youth with MI. Also, in the chapter was a review of understanding of disability in relation to cultural beliefs and attitudes towards disability. This section showed that cultural beliefs influence the negative attitudes towards persons with disabilities which subsequently lead to the segregation of children and youth with disabilities in general. This chapter showed that structural barriers explain the inaccessible nature of the basic educational settings in Ghana. This further portrayed how children and youth with MI struggle in their attempts to receive quality education in the country. Finally, in this chapter was a discussion about educational support services, curriculum and assessment.

The absence of the voices of children and youth with MI about their educational experiences with regards to inadequacy of educational support services might contribute to the inequity in the basic school curriculum. There are minimal studies on the experiences of children with MI in the four basic school settings in Ghana. This explains why I am interested in this research to find out more about the experiences of children with MI. The educational experiences of children with MI will be informative to develop an inclusive schooling practices framework and educational support systems to promote access, equity and inclusive practices in the basic school settings in Ghana. I discuss the philosophical and theoretical standpoint in the next chapter.

CHAPTER THREE: PHILOSOPHICAL AND THEORETICAL FRAMEWORKS

3.1 Introduction

The philosophical standpoint of a researcher brings to light a researcher’s thoughts, following the new and reliable knowledge about the research he obtained (Žukauskas et al., 2018). That is, the researcher’s philosophy is the basis of the research, which involves the choice of research strategy, formulation of the problem, data collection, processing, and analysis of the research which will be discussed in the next chapter (Chapter 4). The philosophy of the researcher determines what theoretical framework to use as a directional lens for the research.

When a researcher recognises that a research problem cannot be meaningfully researched by using one theory, the researcher may synthesise a number of related theories in an effort to use such integrated concepts to comprehensively understand a research problem (Imenda, 2014). In line with such an assertion I integrate three related theoretical frameworks as lenses. These are, Disability Studies in Education (DSE), Bronfenbrenner’s Ecological System Theory (EST) and Post-Colonial Theory (PCT). This chapter is divided into two sections. The first section will discuss my philosophical paradigms in the research, and the second section will discuss the three theories that guided the study.

3.2 Section one: Philosophical paradigms

Mertens (2015) and Djamba and Neuman (2002) state the three main influential paradigms which underpin research: the positivist, critical and interpretive theories. I will discuss these three paradigms separately and take my position at the end of each discussion, beginning with the positivist paradigm.

Positivism holds that genuine knowledge is gained by observing and recording of a phenomenon in a logical manner, and is trustworthy (Hughes, 2010). The proponents of positivism depend on quantifiable observations that lead to statistical analyses (Ahmad, 2014). Researchers in positivist studies have their role limited to data collection and interpretation in a quantitative way (Ahmad, 2014; Hughes, 2010). This way of thinking by positivists contradicts my personal philosophy that reality can also be found by allowing individuals to share their lived experiences of phenomena, which may not be quantifiable statistically. As an interpretivist, I believe in description of meanings that are formed by the experiences of children and youth with MI in the Ghanaian basic schools.

The second paradigm stated by Mertens (2015) and Djamba and Neuman (2002) is critical theory. Critical theory is in contrast to traditional theory which is concerned with the understanding or explanation of a phenomenon (Crossman, 2019). Proponents of critical theory focus on excavating beneath the surface of social life and unearthing the assumptions that keep researchers from a full and exact understanding of how the world works (Crossman, 2019; Hughes, 2010). Critical theorists further argue that a common knowledge about democratic societies are not as democratic as was generally alleged (Crossman, 2019). This is because citizens of a democratic government are being regulated by the forces of power operating in the space of deception and individuals are acculturated and drilled to feel happy in relation to either domination or subordination, rather than fairness and interdependence (Crossman, 2019). Critical theory upholds an individual's dignity and freedom irrespective of gender, race or location in the web of reality, and analyses contending power relations among groups and individuals in a society, thus identifying who advances and who loses in a specific state of affairs (Crossman, 2019; Hughes, 2010). Critical theory has been criticized by other scholars on the basis that assumptions raised by the critical theorists are unattainable and that "the central argument of critical theory is that all knowledge, even the most scientific is historical and broadly political in nature" (Friesen, 2019, para. 2). As an intepretivist, I hold that the researcher and realities are inseparable. As such, realities could be disassociated from politics.

My stand in this research is to go by the interpretive paradigm. This is because the interpretive paradigm integrates human interest, believing that reality is multiple and relative (Djamba & Neuman, 2002). Philosophers in an interpretive study avoid stiff structural frameworks such as in positivist research, and embrace more personal and flexible research structures which are receptive to capturing meanings in human interaction and make sense of what is reality (Creswell, 2014; Denzin & Lincoln, 2018, 2000; Djamba & Neuman, 2002).

Also the interpretivist paradigm holds that "reality is socially constructed" and that "researchers should attempt to understand the complex world of lived experiences from the point view of those who lived it" (Mertens, 1998, p. 11, 2015). The interpretive paradigm helped me to explore a real life situation of children with mobility impairments and hence collect quality and in-depth data (Creswell, 2014; Stake, 2006). It further suited the research topic which was aimed at exploring the experiences of children and youth with MI, with regards to barriers and support services available in the four basic educational settings in Ghana. As reality is socially constructed, I am able to reflect deeply on the experiences of participants and hence attach meaning to the data. My intent in the interpretive study was to understand the deeper meaning of the phenomenon. Interpretive research allows the exploration of unseen reasons behind complex, interrelated or social processes in the world of children with disabilities (Hanhela, 2014). The choice of interpretive research best suited this study because it does not often research for specific answers, but for understanding of a social process as it unfolds over time (Denzin & Lincoln, 2018; Hanhela, 2014).

In this research paradigm, researchers are considered as part of the data collection instrument, in that researchers use their observational skills, their trust in the participants and their ability to extract trustworthy and quality information (Hussain et al., 2013). For example, Hussain et al. (2013) postulate that interpretive researchers cannot detach themselves from the objects being observed, the subject of the study as well as the methodology of the study. Contrary to positivists, interpretivists accept that there is no objective knowledge that is autonomous of reasoning by humans, so knowledge, thinking, reasoning and meaning-making are acts of interpretation (Hanhela, 2014; Shah & Al-Bargi, 2013).

In each of the positivist, critical and interpretive theories, there are three elements that need consideration: ontology, epistemology, and methodology. Ontology refers to the very nature or core of the social phenomenon being explored. The ontological perspective of interpretive theorists is that the social world is different from the natural world (Denzin & Lincoln, 2018; Guba & Lincoln, 1994). As an example, social phenomena found among children and youth with MI in the basic education settings in Ghana are being demonstrated by preconceived ideas (e.g. disability is a curse). Also, children with disabilities are viewed as children who cannot learn in the mainstream school system, hence children with disabilities are segregated and located in places far from the mainstream society.

Epistemology refers to the nature of knowledge or creation of knowledge and the relationship between “knower and would-be known” (Mertens, 1998, p. 9). Epistemology is made up of the theory of knowledge and learning (Hussain et al., 2013). For example, Shah and Al-Bargi state “the inquirer and the inquired are fused into a single entity and their interaction leads to certain findings" (2013, p. 257). In this study, I took the approach of knowing more about the educational experiences of children and youth with MI through interacting with them and other stakeholders (Guba & Lincoln, 1994).

The methodology specifies how a researcher practically goes about studying whatever he believes can be known or the approaches to systematic inquiry (Babbie, 2008; Merriam & Grenier, 2019). Also, interpretive researchers use methodology to seek the understanding of a phenomenon from the individual's point view and investigates the interaction between individuals within their cultural and historical contexts (Creswell, 2014; Shah & Al-Bargi, 2013). Table 1 below summarises the three elements.

Table 1 Interpretive theoretical paradigm

Theoretical Paradigm	**Ontology**	**Epistemology**	**Methodology**
Interpretive	Reality is multiple. Reality is socially constructed. Understanding the multiple social constructions of meaning and knowledge. Concepts of importance in the study are allowed to emerge as constructed by participants.	There is an interactive link between the researcher and the participants. More personal and interactive mode of data collection. Values are explicitly acknowledged. Multiple research techniques are used in data collection.	Hermeneutical: that is in-depth understanding of a phenomenon. Interviews, observations, and document reviews are commonly used. More interactive between the researcher and the participants.

Adapted from: (Mertens, 1998; Paterson & Higgs, 2005)

As noted earlier, when researchers realize that a research problem cannot be researched by using a single theory, they may synthesise a number of related concepts in an effort to use such integrated concepts to comprehensively understand a research problem (Imenda, 2014; Peta, 2015). For instance, the educational experiences of children and youth with MI involves interaction within the school environment which includes peers, teachers, head teachers, education officers, policy makers and other educational stakeholders. The educational development and trajectories of children with MI further involve the interaction of parents, siblings, the extended family, and the community as a whole. These interactive factors shape the learning process of children with MI. It is important to mention that the adaptation of foreign educational practices in Ghanaian basic schools also influence the educational trajectories of children with MI. For example, use of foreign novels and use of English language as medium of instruction in the Ghanaian schools made the local language more inferior (Connor et al., 2008; McWilliams & Kwamena-Po, 1975).

Against the above background, I was guided by three theoretical frameworks: Disability Studies in Education (DSE), Bronfenbrenner's Ecological Systems Theory (EST) and Post-Colonial Theory (PCT) as discussed in section two below.

3.3 Section two: Theoretical frameworks

In this section, I will discuss the three theories that served as a guide in data generation and analysis, and how these theories support this research. I will begin with disability studies in education.

3.3.1 Disability studies in education

Disability studies in education is a relatively new area in the field of disability research (Connor et al., 2008). It was explicated in the year 2000 in the United States (US) by Susan Gabel through a Special Interest Group (SIG) emanating from the American Education Research Association (AERA) (Connor & Gabel, 2013). The aim of DSE is to promote the understanding of disability from a social model perspective, drawing on social, cultural, historical, discursive, theoretical, literary, aesthetic, artistic, and other traditions to challenge medical, scientific, and psychological models of disability as they relate to education (Connor et al., 2008). Significant to this social model understanding is the distinction between impairments and disabilities, which I will discuss below. After that, I will discuss the medical model and then follow up with the social model.

According to Oliver (2017), impairment is defined as an "injury, illness, or congenital condition that causes or is likely to cause a loss or difference of physiological or psychological function" Whilst disability is the "loss or limitation of opportunities to take part in society on an equal level with others due to social and environmental barriers" (2016, p. 1). This means impairments is the functional limitation (like, sitting, standing or walking) within the individual that is caused by physical, mental or sensory impairments (Oliver & Oliver, 1996). As discussed in Chapter 2, disability may also be seen as the loss or limitation of ability or opportunity to do everyday life activities like any other person in the community (United Nations, 2006). In this context, the distinction between impairment and disability is that they reflect an interaction between the individual with the impairment and the environment.

Education for children with disabilities has, for the most part, been constructed as a "problem requiring the development of a distinct discipline of Special Education in contemporary education system" (Mckenzie, 2009, p. 27). Within this discipline, children with disabilities and those with MI are seen by the community as individuals who require a segregated school with a specialised school curriculum handled by specialised teachers (Opoku, 2016). It is worth noting that, even though children and youth with MI may have impairments, they may not have special educational needs that require a segregated school, a specialised school curriculum and specialised education teachers. What may be necessary is the educational support system and environmental adaptation to serve the needs of children and youth with MI in the Ghanaian basic school settings.

The decision to separate children with disabilities from the mainstream schools may be attributed to the way disability is being viewed by the society. One way of viewing disability is referred to as the medical model of disability as will be discussed in the next section.

3.3.1.1 Medical model of disability

The proponents who adopt the medical model of disability define people with impairments as being 'afflicted' with an illness or medical condition (Barnes & Mercer, 2012). The medical model of disability is also known as the 'clinical–pathological,' 'deficit model' or the 'individual model' (Barnes & Mercer, 2012; Oliver, 1990). From a medical model view, disability can be seen as a result of a physical condition intrinsic to the individual. The focus is on the individual's limitations and, according to Barnes and Mercer (2012), there is an assumption that an individual's disability arises solely from his or her impairment. Disability is viewed in terms of disease, sickness, difference and personal tragedy and assumes that these are intrinsic characteristics of people with disabilities (Elliott et all., 2009).

Hunt (1966, p. 155) stated in his seminal paper 'A Critical Condition' that a medical model views individuals with impairments as "unfortunate, useless, different, oppressed and sick" and that they symbolize everything that the 'normal society' fears the most, namely "tragedy, loss, dark, and the unknown". Hunt's ideas were expanded upon in 1966 in a paper that stated that individuals with severe disabilities are not only viewed as being 'unfortunate' but also unlucky, deprived, and poor, which leads them to have 'cramped lives'. This, in turn, results in people with disabilities as being unable to take pleasure in many of the 'goods' that people without disabilities are familiar with. Within the scope of this model, individuals with disabilities are seen as being unable to learn or study with their peers who are not disabled (Hunt, 1966). This assumption raises questions like: does it mean that people with mobility impairments are academically disabled?

Does it mean people with disabilities who are perceived to be the ‘minority’ group are ‘abnormal’ and ‘different’ from ‘normal society’? (Hunt, 1966).

The emphasis within the medical model tends to be on curative or rehabilitative strategies - changing the individual to fit society - which implicitly regards the environment as “fixed and neutral” (Burchardt, 2004, p. 736). Consequently, within the medical model, medical practitioners diagnose people with disabilities and concentrate on their impairments. Their main focus is on rehabilitating or ‘fixing’ people with disabilities so that they are able to fit into the non-disabled world (Abberley, 1996; Finkelstein, 1993; Hurst, 2005; Oliver, 2013). Accordingly, impairment is seen as being the source of disablement (Barnes, 2015). Those who hold a medical model view towards disability regard non-disabled people as representing ‘the norm’ and people with disabilities are seen as differing from ‘the norm’, having a deficit that needs to be cured or fixed. Within the medical model, decisions affecting people with disabilities are generally undertaken by people without disabilities who have placed themselves in positions of authority (Connor et al., 2008). Subsequently, the scenario arises where people with disabilities are disempowered as those (people without disabilities) making decisions over their lives have little or no understanding of their real needs and experiences. As a result, education for children and youth with MI are not the priority of the family and the community. Rather, the attention is much on the fixing of the impairments.

The medical model promotes the view of a person with a disability as being dependent and needing to be cared for. This, in turn, results in people with mobility impairments being systematically excluded from the mainstream school system and are camped in either special education schools or rehabilitation centres or denied education completely, where they are not able to harness their potentials (Opoku, 2016). In response to the medical model, Barnes (2012) states that people with disabilities stood up and argued against the medical model and, hence, came up with a model called the social model of disability as will be seen in the next section. I argue that the impairment should not be seen as a sickness, with the individual being classified as a 'patient' who needs medical treatment. Further, the impairment should not prevent such people from accessing quality education from the mainstream or inclusive educational settings.

3.3.1.2 Social model of disability

In the 1970s the idea of intrinsic physical or mental disability linked to the medical model of disability was challenged by people with disabilities, disability activists and disability theorists (Barnes, 2012; Hurst, 2005). This led to the social model of disability, which was developed in response to the medical model and the impact it had had on the lives of children with disabilities (Shakespeare, 2006; Watermeyer, 2014). Advocates of the social model viewed disability as a social problem which is perpetuated by society that fails to redesign structures such as classrooms, furniture and bathroom facilities to meet the needs of children and youth with disabilities (Barnes & Mercer, 2012). One of the most notable contributions of the social model was its influence on the various educational settings (Baglieri et al., 2011; Connor, 2013; Shakespeare, 2006). For example, the contribution of the social model has shifted perceptions and attitudes from the person with disability as the problem to the social and the environmental barriers as impediments to the education of these individuals (Shakespeare, 2006; WHO, 2001). Alongside the shift in disability paradigms of the late 1970s and the early 1980s, disability theorists started recognising the medical model related to children with disabilities and their need for special education (Barnes, 2015; Connor, 2013; Connor et al., 2008). Upholding the social understandings of disability, educational policies and conceptualisations moved away from the 'specialness' of the child and 'special' care, to the removal of societal barriers that hindered equal participation within the education milieu

(ACPF, 2011, p. 32). It should be noted that the proponents of the social model do not condemn medical treatment of impairments.

The emphasis on the social model thus helped to shape and restructure basic, secondary and tertiary education (Connor, 2013; Connor et al., 2008), for example, the adoption of education for all children (Aseka, 2003) and the implementation of inclusive education in Ghana (Mohammed, 2014b). Swain et al. (2003) state that from a social model viewpoint "disability ceases to be something that a person has, and instead becomes something that is done to a person" (2003, p. 23). Rather than medical professionals, people with impairments are now seen as being the experts on issues relating to themselves and the shortcomings of society in addressing their needs and their education which prepares them for life (ACPF, 2011).

Comparing the two models of disability discussed above, proponents of the medical model tend to attribute exclusion and disadvantage to a person's biological deficits, while proponents of the social model tend to attribute these issues to social oppression (Elliott et al., 2009; Shakespeare, 2006; Watermeyer, 2014). The proponents of the social model of disability have identified the needs of children with disabilities, without contributing to the negative effects that often have come about in the wake of classification, categorisation and labelling in education (WHO, 2010). In this study, emphasis is placed on the education of children and youth with MI in the context of barriers that prevent them from enjoying their rights to education, and not on the impairments of the individuals as discussed below.

In the perspective of DSE, I argue that we do not have two categories of human beings, (that is, children with disabilities on one side and children without disabilities on the other side) where the emphasis for one group of children is to fix disability and for the other group of children to be in the school. Therefore, children and youth with disabilities should not be segregated from children and youth without disabilities (Connor, 2013). DSE perspectives confine disability to a social and political context, and is concerned with the civil and human rights of children and youth with impairments including issues of equity, access and inclusion in educational settings, curricula and activities (Connor et al., 2008).

As a lens to this research, I was guided to shift focus from a medicalised, psychological and legalised understanding of disability towards a social, cultural and historical understanding (ACPF, 2011). DSE enabled me to examine the influence of the introduction of inclusive education in Ghana as an educational policy on the accessible nature of basic schools for children and youth with MI. For example, did the inclusive school system improve access to education, and did it influence the retention of children and youth with MI in the various basic educational settings in the country? Equally important, proponents of DSE focus on a social conception of disability that identifies barriers, attitudes and actions that serve to systematically exclude individuals with disabilities (Connor & Gabel, 2013). It is a reaction to the dominant medical model of disability which positions children with disabilities as having limitations in the mainstream school settings (Connor, 2013; Connor & Gabel, 2013).

The core feature of DSE as a theory is to reshape the way that society understands people with disabilities and to challenge a series of assumptions in the field of special education for children with disabilities. For example, DSE discourages segregated schools and encourages inclusion of all children with disabilities, thus contributing to the emancipation of persons with disabilities (Goodley, 2011). In a similar way, this study aims at promoting inclusive education by developing strategies that will support inclusion of children and youth with MI and to discourage segregation from their non-disabled peers.

The DSE perspective foregrounds the interest and voices of children and youth with disabilities in their education, rejects deficit models of disabilities and assumes that all children have the right to equitable, full and meaningful access to educational opportunities (Mckenzie & Macleod, 2011; UNCRPD, 2006; UNESCO, 2005). This theory is consistent with the current research because my interest is to understand the educational experiences of children and youth with MI in the basic educational settings in Ghana as a socially constructed phenomenon. The educational experiences of a child with disability cannot be explored without considering the interaction between the child and his or her environment, including the home, the school, and the entire community. The next section explains the second framework that I considered in the analysis of the research data, Bronfenbrenner's Ecological System's Theory.

3.3.2 Bronfenbrenner's ecological systems theory

The second theory to support the conduct of this study can be found in the work of Urie Brofenbrenner's ecology of human growth (Bronfenbrenner, 1989, 2005; Tudge et al., 2016). Exploring the experiences of children and youth with MI should be done in the context of multiple environments. Bronfenbrenner (1989) explains the child's environment in five layers. That is, the microsystem, mesosystem, exosystem, macrosystem and the chronosystem. This theory can be used to understand the context of the basic education system in Ghana. Children with disabilities, at the centre of education, can be seen within the ecological model described in Figure 3 below, which represents the interactions that are likely to occur within a child's ecosystem.

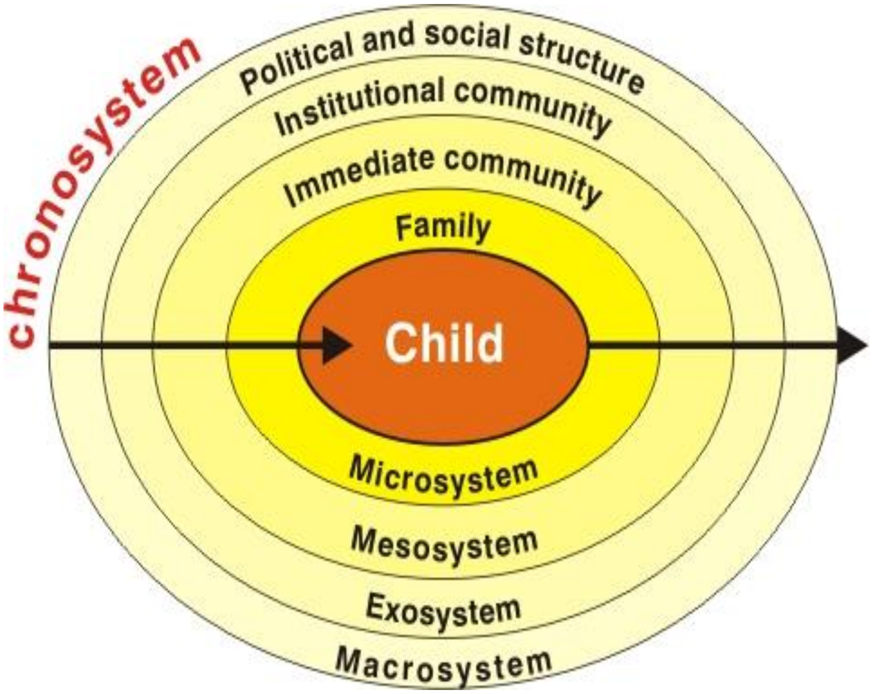

Figure 3 Bronfenbrenner's Ecological System Theory

Source: https://smartysmartypants.wordpress.com/ecological-map-2/

Bronfenbrenner's ecological system theory can be used in general for any child's experience in school, but in this case it will be specifically applied to children with MI. Elements within the various systems - the family, immediate community, institutional community, political and social structure - potentially influence the experiences of children in school, including children with MI. Bronfenbrenner argues that various immediate and distant forces affect an individual's development. The first four systems (microsystem, mesosystem, exosystem and macrosystem) depicted in the circles interact and are linked directly to each other in a system of nested structures ranging from the closest, consisting of immediate face-to-face settings, to the most distant comprising broader social contexts such as classes and culture. The final level (chronosystem) is linked to passage of time that influences the child's development and learning (Bronfenbrenner, 2005). Bronfenbrenner's framework allows for an exploration of educational experiences of children in the mainstream, inclusive, rehabilitation and the special schools in relation to barriers to inclusion such as attitudes of community members, students, and teachers within these systems. For example, Johnson, (2008) argues that EST as a framework allows an understanding of the processes and interactions between students, peers and teachers within an environment that leads to student achievements in school. In this study, identifying the different factors that are operative within and between the ecosystems will facilitate a better understanding of the educational experiences of children and youth with MI. Below is the discussion of the various systems in the framework.

The microsystem is seen as a level which involves activities, roles and interpersonal relationships that are experienced by the developing child (Bronfenbrenner, 1995; Johnson, 2008). Interactions within the microsystem typically involve personal relationships with family members, classmates, teachers and caregivers. How these groups or individuals interact with the children will affect how they grow and learn (Bronfenbrenner, 2005). Within this study, the microsystem as a layer forms a set of relationship where children have direct contact with parents, siblings and other family members, and the influences between the child and the family may impact decisions about education for children with MI. In Figure 3 above, children with MI have been placed at the centre of the ecological system to be seen as priority group because they are to be seen as the most important of the study where the first interaction is with the family as the immediate environment.

At the next level within the ecosystem is the mesosystem. The mesosystem is defined as the linkages between the microsystems (Bronfenbrenner, 1995). This includes the interaction with the classroom teacher, classmates, peers and the linkages within the microsystem which involves parents and the family as a whole (immediate community). These systems directly affect the child and are within the child's immediate environment and are characterised by direct relationships and interactions. For instance, in this study, the teacher in the classroom plays a very important role of awareness and advocacy in the school system, since he or she is one of the key persons who can help with a better education for all children, especially those with MI. The attitude of the teacher towards inclusion determines the success of inclusive education. That is, a negative attitude can lead to an unsuccessful practice of inclusive education, whilst a positive attitude can lead to the successful inclusion of children with disabilities in school (Mprah et al., 2016).

The interactions within the mesosystem can have a notable influence on adopted teaching practices. For example, Berk (2001) stated that in the case of children with disabilities, their self-efficacy and educational outcomes are in the first instance influenced greatly by the family in the home setting as beliefs and practices of these primary people in the child's life have direct bearing on the child's development. In Ghana, like other nations, traditional family beliefs and practices influence the child's upbringing (Opoku et al., 2019). This is because the Ghanaian family is a cohesive unit which defines social and moral norms and safeguards traditions. It also provides social, economic, psychological, and emotional security to the children and the larger society. Thus the family members provide support to the children and the larger family (Opoku et al., 2019). This can suggest that children with disabilities may come from supportive environments, which provide effective care, support, and kind behaviour to them at home. Once the child goes to school, the linkages between home and school for the child, and new interactions with teachers, peers, classmates, workers, and managers will have developmental effects on the child.

Beyond the micro and mesosystem is the exosystem. The exosystem represents the larger social system and encompasses events, decisions and policies over which the child and their families have no influence (Bronfenbrenner, 1995). The exosystem comprises of structures such as state regulations, local economics and local disasters (Johnson, 2008). This means that when there are changes in educational policies, it has an impact on the education of the child. Bronfenbrenner (2005) explains it as consisting of the settings or events that do not directly involve the child, but which still have an influence on the education of children in relation to microsystems. People and places that children may not directly interact with may still have an impact on their lives. Such places and people may include the parents' workplaces, extended family members, and the neighbourhood in which children live. That is the indirect effect which impacts on the child through the other people in the child's life. Within this study, exosystems can be identified as school policies, and interactions between the school, community and other stakeholders such as non-governmental organisations (NGOs), counsellors and other professionals (Johnson, 2008). Even though there is no direct involvement of the child and the teacher, these interactions or decision-making processes have an impact on the children; an example is the implementation of educational policies by governments.

The macrosystem refers to the layer comprising of political, social, economic and cultural patterns, which have great influence throughout the interactions of all other layers (Bronfenbrenner, 2005). This ecological level is comprised of the cultural patterns and values, specifically their dominant beliefs and ideas, as well as political and economic systems of the country as they impact upon the child. This is not restricted to policies themselves but the country as a whole and its environment impact on the child. For example, Ghana is a developing country with limited resources; therefore, if there is political stability, the child's development and peace of mind will enhance his or her education. The features within the macrosystem may be thought of as a societal blueprint for a particular culture, or broader social context (Johnson, 2008). For example, the constitution of Ghana serves as a blueprint and guarantees equal access and non-discriminatory education for all children of school going age (Republic of Ghana, 1992). In the context of this study, the Constitution of the Republic of Ghana influences the operations of all activities in the school. Therefore, if the constitution mandates inclusive practices in all four basic school settings, all other systems within the ecosystems (microsystem, exosystem, mexosystem, macrosystem and chronosystem) will be influenced. This means a broader policy change in the educational system affects other layers in the ecosystem; thus, implication of policies developed will influence the practice and management of the four basic educational settings in Ghana.

The macrosystem may also include a change in family structure, parents’ employment status, as well as immense societal changes such as economic cycles and wars, for example, a change of government where the government tries to implement its manifesto to fulfil its promises made in its political campaign, thereby perhaps neglecting policies and other structures in place or ongoing projects by the previous government. These actions by political parties who are in power may have influence on the education of children with MI.

The last system is the chronosystem and describes the timeframe of development. As such, the chronosystem is described as a developmental timeframe that crosses through and affects interaction between systems and, in turn, influences individual development (Swart et al., 2004). The system encompasses all the four systems together and demonstrates the influence of both change and constancy in the children’s environments. It is through the interaction among any of the above levels that barriers or support may occur at any time. Change in any part of the system affects other systems and individuals and at a later time could be seen as a cause for change (Swart et al., 2004). For example, in Ghana, schools must be adequately prepared for changes which are needed in the education system over time to cope with the transition and implementation of inclusive education.

It is worth noting that all these different layers or systems are highly dynamic and interactive. To understand the activities of a school, one needs to get insight into and knowledge of the interactions that occur amongst the different systems. This is important, especially when one is trying to explore experiences of children and youth with MI in the basic educational settings in Ghana. For example, when there is a change in the school management system, it affects all those who interact within it (Bronfenbrenner, 2005; Johnson, 2008; Swart et al., 2004).

Bronfenbrenner (2005) believes that development is reciprocal and has dynamic relationships between the five systems and, likewise, individual development is affected by interactions between a number of overlapping systems; thus, describing the complexity of the influences, interactions and interrelations between a learner and all the systems in which the child functions. This theory, especially the chronosystem, brings to attention the external influences on the Ghanaian educational system as a result of colonisation and the post-colonial era in Ghana as I will discuss below.

3.3.3 Post-colonial theory

The third theory I used in this research is post-colonial theory (PCT). Post-colonial theory emerged as a theory or critical approach that started with literature that was produced in countries that were once, or are now, colonies of other countries (Young, 2001). Post-colonial theory may deal with literature written on or by citizens of colonising states or countries that take colonies or their peoples as their subject matter (Hall & Gay, 2006; Mongia, 1996). This means PCT focuses particularly on the way in which literature by the colonizing culture distorts the experiences and realities of education, culture, race, language, as well as other forms of social stratification including class and gender in postcolonial contexts. Andreotti (2012) asserts that ‘postcolonial’ was first used in commonwealth literature to refer to cultural interactions within colonial societies in literary spaces and how the colonized were epitomised by colonial writers. Andreotti again postulates that the works of these commonwealth writers were to counter the presentation of culture, history, and language of the colonised in Western writings, which tend to portray the non-European and particularly Africans as unintelligent and without culture (Andreotti, 2005, 2012).

Post-colonial theory is useful as a lens to explore the influence of foreign culture on the Ghanaian educational settings from the pre-colonial era to the start of formal education (mainstream) by the colonial masters. Post-colonial theory can also be used to trace the development of education in Ghana after independence on the 6th of March 1957. In the context of colonization, decolonization and post-colonial debates, education in Ghana and in Africa as a whole has been viewed as a phenomenon located in coloniality, shaped by the hegemony of Western philosophies and forms of knowledge and discourses, and imposed upon countries that were colonized (Walton, 2018). The imposition of the English language as a medium of instruction in Ghanaian schools is an example of Western hegemony. Osseo-Asare (2017) posits that the English language that was inherited from Ghana’s colonial masters (British) did more harm than good because Ghanaian children were alienated from their culture by not being able to use the local language as a medium of instruction in the schools. The effect is that children were not able to effectively interact with teachers during the teaching and learning process.

As noted in Chapter 2, other forms of colonial influences on Ghanaian traditional education were the establishment of educational settings. The first educational setting was the mainstream school which was followed by special schools. The rehabilitation centres were also established, and this was followed by the current educational setting which is inclusive education (see Chapter 2). The special schools and the rehabilitation centres were established to extend formal education to persons with disabilities but turned to further exclude children with disabilities from the mainstream society (Adu-Gyamfi et al., 2017). The curricula of educational systems across all levels of education in Ghana were a copy of the British style and were of limited relevance to the cultural values and local needs, amidst challenges in school infrastructural and educational support systems (Kuyini, 2013). For example, reading materials like novels and poetry were that of the United States and the United Kingdom (Wilton, 2018). Identification and understanding of PCT will help in fighting against the destructive workings of power, privileges and superiority which played a role in the exclusion of children with disabilities from mainstream education (Walton, 2018). Using a PCT lens makes us aware of the influence of western culture on education in Ghana. This may lead to discussion of whether to use the local language as a medium of instruction in all schools and use our local narratives to teach and develop our own textbooks and reading materials. To give further elaborations about the imposition of Western culture on the education in Ghana, I remind readers how education started in Ghana.

The colonial influence of Ghanaian education can be traced to the ‘castle schools’ of European traders from Portugal, the Netherlands, Denmark and Britain. Castle schools were the first schools built in Ghana by the Europeans (McWilliams & Kwamena-Po, 1975). These schools were built purposely for the education of the European children and other children from prominent Ghanaian families (McWilliams & Kwamena-Po, 1975). Mass education and literacy learning started with missionary activities for the training of Catechists of the Roman Catholic Church and training of teachers to instruct students in reading the Bible and to prepare them for life in the missionary field (Osseo-Asare, 2017). This indicates that the establishment of formal schools in Ghana by the colonial masters was not to cater for the culture and the indigenous ideologies.

After independence, Ghana has made significant progress in the provision of education through a number of educational reforms and donor support for both teachers and students (Kuyini,

2013) (see Chapter 2). However, despite the achievements in education, there is a general concern about the imposition of Western dominance especially in terms of the mainstream school, the special education school, and the rehabilitation centres. For example, the use of English language rather than the local language is seen by some indigenes as providing inferior education while, for others, the use of English rather than the local language was perceived as a colonial influence, a form of perpetual domination and a means of eradicating indigenous cultures (Osseo-Asare, 2017; Owu-ewie, 2017). In the context of this study, the postcolonial power may be seen in the prescription of educational guidelines and policies as is being practised in the mainstream, special, rehabilitation and inclusive schools. These educational guidelines and policies have their roots in the Global North through international agencies like UNESCO, USAID, their consultants and funding agencies (McWilliams & Kwamena-Po, 1975). These policies may potentially conflict with the contextual realities of the Ghanaian cultural values and practices. In addition to these cultural disparities, Said's (1978) work on ‘Orientalism’ brings to mind the experiences of the colonised and how the West exaggerates and distorts differences in the culture between the West and the East. Such exaggerations and distortions are intended to point out not only differences in culture but also the superiority of one over the other: the West over the ‘others’ (Said, 1978). Also Spivak's (1988) ‘Can the Subaltern speak’ seeks to question Western knowledge and its construction of the truth, Western representation of others, and Western academic thinking as a means to support their economic interest in the world (Osseo-Asare, 2017; Spivak, 1988). This suggests the questioning of Western ideologies and the recognition of other voices and philosophies. In her study on “Early childhood education, postcolonial theory and teaching practices and policies in India”, Gupta argues that the aim of her study was to:

> Provide space for the voice of the ‘other’ to be heard, the ‘other’ being the marginalised, non-Western early childhood teacher who strives to be the ‘right’ teacher, who feels pressured and compelled to follow the standards of early childhood education that has been articulated within early childhood discourse that is dominant in the West… (Gupta, 2013, p. 2)

Voice of the ‘others’ in the context of the current study represents children and youth with MI in the Ghanaian basic educational settings. With regards to amplifying the voices of children and youth with MI and their parents to be heard, I shared the initial findings of this study at conferences I attended (see Chapter 4).

This study supports the overarching principle of these three theories – DSE – EST - PCT. That is, at the core of the theories is the rejection of all forms of prejudice, oppression and discrimination against persons with disabilities which results in the exclusion of these children from the mainstream schools and the community as a whole (Andreotti, 2005; Connor, 2013; Slee et al., 2019). The three theories guided me to obtain data (through in-depth interviews) and enabled me to understand the influence of overarching environmental factors like the parents, the family, the teachers and the educational policies as well as the western style of education on the basic educational settings in Ghana and their impact on the education of children and youth with MI. This connection between the theories and inclusive education will be discussed in the next section.

3.4 Connecting disability studies in education, ecological systems, and post-colonial theories to inclusive education

There are relationships and interconnectedness between DSE, EST and PCT and inclusive education (Andreotti, 2005; Connor, 2013; Slee et al., 2019). In this study, the three theories place the child with MI at the centre of the theories that relate to the policy and practice of inclusive education. These theories can be applied to help us to understand the three key areas of inclusive education for the learner – presence, participation, and achievement (PPA). Presence in the school and in the classroom refers to the basic human rights for all children (Ainscow & Miles, 2009; Slee, 2020). Participation in quality and equity requires the learner to be actively involved in all aspects of schooling, either academically or socially. Learners must work collaboratively and cooperatively with both peers and their non-disabled colleagues. Children with disabilities in general must be allowed to have opportunity to take part in whatever elements of school life that interest them. Within the third key area, learners must be achieving (Anderson et al., 2014). This dictates access to learning goals that meet individual needs within the bounds of the school curriculum, and assessment that is offered in a meaningful and attainable ways (Anderson et al., 2014; Slee, 2012).

The educational experience of the child with MI is influenced by all layers within the ecosystem and DSE where the child is placed at the middle (also referred to as inclusive education). The educational experience of the child will depend on how the systems or the layers are positioned and interact with each other. These factors are determined by both national and international contexts (see section 3.3.2). Within the PCT, the national and international contexts may include imported Western ideas such as mandatory school curriculum and or political influence like funding and changes in state policies (Anderson et al., 2014). In the ecological systems theory, the level of influence will be determined by those holding account for the meso, exo and microsystems. Factors sitting within these layers are concerned with school rituals, practices and are determined by the school leadership. Decisions that are made at this level influence the microsystem – these are determined mainly by the teacher or head teacher. Factors, such as the school timetabling and resources allocation may also have influence on the child. The chronosystem is positioned outside the layers and represents the constant and consistent movement of time. This layer provides opportunity for reflection, change reform and evolution of the factors that sit within each system. The chronosystem is an essential component of the framework as inclusive education is a dynamic and evolving process (Anderson et al., 2014; Ainscow & Miles, 2009; Slee, 2020). The next section presents chapter summary.

3.4 Chapter summary

In this chapter I discussed the three theories that informed this study: Disability Studies in Education, Bronfenbrenner's Ecological System theory and the Post-colonial Theory. DSE showed how disability as a phenomenon was viewed. For example, the proponents of the medical model view children with disabilities as having a deficit to be corrected, while ignoring other things like education that shape children with disabilities just like non-disabled children. The second view of understanding of disabilities that was discussed in this chapter was the social model. Proponents of the social model see disability as socially constructed, where society imposes disablement on persons with disabilities. Proponents of DSE argue that there are no two different types of human beings where some categories of children are to attend a particular type of school setting, whilst other categories of children are segregated and are usually located in places far from their communities. It was also seen in this chapter that education for children with disabilities cannot be done without interaction with the community and those within the school environment. The chapter discussed how external factors like the educational policies and the general economic conditions within a country can influence the educational experiences of children with disabilities. These external influences also include the Western culture and ideologies that were imposed on the educational practices in Ghana. The discussion in this chapter exposed how Ghanaian cultural belief systems and the local languages were ignored in the school settings. The close relationship embedded in DSE, EST and the PCT that were woven together positioned me to collect and analyse data. Closely linked to the philosophical and theoretical position of this research, which shows the way data were collected, is the methodology which I will discuss in the next chapter.

CHAPTER FOUR: METHODOLOGY

4.1 Introduction

This chapter addresses the overall methodology used for this research study. I outline my philosophical standpoint and introduce the exploratory case study which underpins this research. I begin with the research approach, study design, and then the research settings, study population, sampling and sample size, inclusion and exclusion criteria, recruitment and enrolment techniques, methods of data collection, language used, data management, data analysis, theoretical orientation of analysis and scientific rigor. I conclude the chapter with the ethical protocol in relation to this study which was upheld throughout the research, reflexivity, and a chapter summary.

4.2 Research approach

Research approaches are strategies and techniques for investigation that pass through expansive expositions to nitty-gritty techniques of gathering data and subsequently analysing them to generate collective meaning and understanding (Creswell, 2014). The choice of a research approach must focus on what is most suitable to achieve the research aim. In choosing the research approach, I consider my philosophical standpoint of the research, the research design and specific research methods of data collection, analysis, and interpretation. According to Creswell (2014), there are three major research approaches: qualitative, quantitative and mixed research approaches. In light of the research aim to gain insight, explore the depth, richness, and complexity inherent in the phenomenon of experiences of children and youth with mobility impairments in Ghana, qualitative research was chosen as the applicable approach to help achieve the research objectives.

Qualitative research is concerned with making inferences based on multiple perspectives, making it important to get quality and in-depth data for analysis. Qualitative research is a systematic subjective approach used to explore life experiences and situations to give them meaning (Creswell, 2014). Qualitative research also focuses on the experiences of people and stresses the uniqueness of the individuals involved in the study. Furthermore, qualitative research is seen as a form of social enquiry that focuses on the way people interpret and make sense of their experiences in the world in which they live (Bradshaw, Atkinson, & Doody, 2017). In this research, the focus is on the way children and youth with MI interpret and make sense of their experiences in the basic educational settings in Ghana.

Researchers use the qualitative approach to explore elements like the behaviour, perspectives, experiences and feelings of people and emphasise the understanding of these elements (Cohen et al., 2000). A qualitative approach enables one to evaluate individuals' information, dispositions, convictions and conduct in a school and other settings, making it possible for one to understand why individuals do things the way they do (Creswell, 2013; Creswell & Guetterman, 2018). Additionally, a qualitative approach permits the study participants to give important responses to questions asked by the researcher, and may likewise give substantial bits of knowledge that may have been overlooked by any other strategy (Cohen et al., 2000). Although qualitative research is unable to answer statistical questions and measure elements of strength between relationships, it allows a study to unfold in a natural way to yield more detailed and rich data (Gray, 2009). For example, Mertens (1998) states:

> Qualitative research is multimethod in focus, involving an interpretive, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. Qualitative research involves the studied use and collection of a variety of empirical materials-case study, personal experience, interpretive, life story, interview. (Mertens, 1998 p. 159)

The choice of a research approach is also based on the nature of the research problem or issue being addressed, the researchers' personal experiences, and the audience of the study. In this study, a qualitative approach was appropriate to capture the opinions of children and youth with MI, their parents, and the head teachers of the four basic educational settings in Ghana. Experiences of children and youth with MI is a phenomenon that has not been previously studied, indicating the need for an open-minded, exploratory approach which qualitative research allows for (Creswell, 2014; D. Gray, 2009). In order to gain an in-depth understanding of the real-life educational experiences of children and youth with MI, I agree with Mertens (1998) who states three major roles of a researcher who is conducting qualitative research. These roles are: a researcher acting as a supervisor, acting as a leader and acting as a friend to the participants. As a supervisor, I portrayed myself as an authority seeking the welfare of participants, giving participants training with regards to what is expected from them. That is, viewing participants as insiders who are full participants in the phenomenon (Denzin & Lincoln, 2018). As a leader, I organised recruitment and training. I kept field notes where I recorded personal reactions, and feelings as demonstrated through body language and reflections of all events including focus groups. Further, I acted as the main instrument of data collection. The final role is a role as a friend. In this role, I assumed no specific authority over the participants. Instead, I established a positive relationship with all participants and exercised a high sense of respect for them all. I also tried to make them feel more comfortable. I always sought the views of participants about places where the interviews took place to make sure that participants were relaxed and secure. As a friend, I motivated participants through praise and rewards. However, I was careful not to use the praise and rewards as a tool to coerce participants to take part in the research. Below is a discussion of a research design used in this study.

4.3 Study design

"In the most elementary sense, the design is the logical sequence that connects the empirical data to a study's initial questions and, ultimately, to its conclusions … Colloquially, a research design is a logical plan …". (Yin, 2009, p. 26)

The quote above talks to the research design I used. A study design is seen as the set of methods and procedures used in collecting and analysing the phenomenon specified in the research problem. Study design again refers to the overall plan employed by the researcher to obtain answers to the research questions. According to Denzin & Lincoln (2018), the study design is a pathway of how a researcher intends to conduct the research. Furthermore, a research design is seen as a blueprint for conducting a study with maximum control over factors that may interfere with the validity of the findings (Gray et al., 2016), and a plan for selecting subjects, research sites and data collection procedures to answer the research question (Creswell, 2013). Several researchers use different forms of qualitative research design. Creswell (2013) identified five traditions, namely, biography, phenomenology, grounded theory, ethnography, and the case study. For this thesis, which is qualitative in nature, I used the exploratory case study method.

4.3.1 Exploratory case study

According to Yin (2014), exploratory case study is a research design that attempts to answer questions that are framed by the pronoun "what" (p. 22). In the context of this study, the research question that guided the inquiry was 'what are the experiences of children and youth with MI in education in Ghana?' In trying to further define a case study, it may be expanded to include an in-depth analysis of people, events, and relationships, encompassing factors such as: a school layout, educational support systems, barriers in schools and others that are of interest to the researcher. A case study is regarded as a research method involving an up-close, in-depth, and detailed examination of a subject of study, as well as its related contextual conditions. Case study research can mean single and multiple case studies and can rely on multiple sources of evidence (Creswell, 2014; Yin, 2014).

Contemporary case study research is said to have its origins in qualitative approaches to research in the disciplines of anthropology, history, psychology, and sociology (Merriam & Grenier, 2019). Most scholars attribute the origins of case study research to studies undertaken in anthropology and social sciences in the early twentieth century where detailed ethnographic studies of individuals and cultures were conducted using case study as a research design (Barnard et al., 1999; Flyvbjerg, 2006; Merriam & Grenier, 2019). Anthropologists investigate people's lives, experiences, and how such individuals understand the world in relation to social and cultural context. The reason is to gain insights into how individuals interpret and assign meaning to the world in which they live (Flyvbjerg, 2006). In this research, which explores the experiences of children and youth with MI in four basic educational settings in Ghana, the most important aspects include not only the experiences and behaviours of the children with MI, but also the perceptions of those who interact with them, including their peers, parents and teachers. This is important because educational experiences of children with MI may be influenced by the environmental factors such as the immediate family, the school, and the geographical location of such children.

According to Mertens (1998), a researcher needs to identify a particular unit of analysis and base his or her design on a single or multiple cases and establish the boundaries as clearly as possible in terms of who is included, the geographic area and time for beginning and ending the case. In this research, data was collected from children and youth with MI, parents of children with MI and head teachers who have taught for five or more years. The data was collected within five months from March to July 2018. The research setting was mainstream, inclusive, special schools and a rehabilitation centre. I spent at least one month in each of these educational settings. This helped me to have quality and in-depth data (Creswell, 2014; Yazan, 2015; Yin, 2014). During the one month stay in the sites, I monitored and observed activities such as sports and games, child-play and learning in the classroom. I also observed how children and youth navigate through the physical environment and the school buildings.

This research was conducted in four different educational settings in Ghana (mainstream school, inclusive school, special education school and rehabilitation centre). As a result, I found the study appropriate to use the multiple case studies, using each school setting as a case. A multiple case study was chosen because it enabled me to explore differences within and between cases. The goal was to compare findings across the various cases. Also, because comparisons were to be made, it was important that the cases were selected carefully so that I could describe and interpret similar results across cases, or to compare contrasting results based on a specific research design used (Yin, 2009). Further, multiple case study allowed me to dig in-depth for collecting data pertaining to sensitive areas of the social phenomenon (Stake, 2006). Such sensitive areas included the societal attitudes towards persons with disabilities and school admission for children with MI in the four basic educational settings in Ghana.

4.4 Research settings

The research setting for this study includes mainstream, rehabilitation, special and inclusive schools. These are the four main basic educational settings in Ghana (Ministry of Education, 2015a; National Education Assessment Unit, 2016; Republic of Ghana, 1992).

The decision to limit the study to basic educational settings is that the basic schools give initial training, prepare an individual for livelihood, and can help an individual become a responsible and respectful citizen to contribute towards economic well-being and that of the family and the community as a whole (Su, 2012). It is a common belief that when a child with a disability misses basic education, it is more likely that he or she misses doubly in life compared to his or her non-disabled counterpart. That is to say, if a child with a disability is denied an education at the basic level, later in life they may not be able to do any hard (labourer) work to earn a living that demands physical strength like the activities found within the road and building construction industries, compared to their non-disabled peers who may be willing to do so.

In this study, I used pseudonyms to represent the names of the selected schools as below:

- Kamame School Complex (KSC) – Mainstream school
- Dabokpa Basic School (DBS) – Inclusive Education school
- Akokor Rehabilitation School (ARS) – Rehabilitation centre
- Ohiamankyene Special School (OSS) – Special Education school

I used pseudonyms to protect the identification of the schools that took part in this study (Lankshear & Knobel, 2004).

4.5 Study population

In this study, the three population groups are children and youth with mobility impairments, parents of children and youth with MI and head teachers or their representatives. I selected children and youth with mobility impairments because there is little research on their experiences in the basic educational settings in Ghana (Opoku, 2016; Opoku et al., 2017). Parents of children and youth with MI can give information with regards to the educational trajectories of their children. I chose head teachers because they are the custodians of educational policies and managers of all educational activities in the various basic educational settings in Ghana. The discussion below shows the sample size that was taken from the population.

4.6 Sampling and sample size

In selecting participants for this study, I used a purposive sampling technique (Ofori & Dandy, 2011). Purposive sampling allowed me to intentionally select participants against attributes that are relevant to the research questions (Gray, 2009). I selected 20 children and youth with mobility impairments, 20 parents of children with mobility impairments and four head teachers. Qualitative inquiry does not need large numbers as seen in quantitative research (Creswell, 2014; Patton, 2002; Polit & Beck, 2017). I selected the sample not to generalise the findings to the entire population but mainly because of the relevance of their experiences to answering the research questions. Also, my intention was to gain in-depth knowledge from the participants. Other reasons were financial constraints and time limitations. The sample size has given me quality, rich and in-depth data for the analysis. Table 2 below shows the breakdown of the sample size I used:

Table 2 Sample size

School type	Children and Youth with MI	Parents of Children and Youth with MI	Head Teachers	Total
Mainstream School	5	5	1	11
Inclusive School	5	5	1	11
Special School	5	5	1	11
Rehabilitation Centre	5	5	1	11
Total	**20**	**20**	**4**	**44**

4.7 Inclusion and exclusion criteria

Inclusion and exclusion criteria are a set of predefined characteristics used to identify participants who will be included in a research study (Babbie & Mouton, 2010; Mertens, 1998). Below are the criteria I used for the selection of the study participants.

4.7.1 Inclusion criteria

a. Children and Youth with Mobility Impairments

- Children and youth with mobility impairments between the ages of 12 and 25 were eligible for the study. I am interested in the age range of 12 and 25 because the policies of the Ministry of Education and Ghana Education Service prescribe that students between the ages of 12 and 15 years should be in basic schools, and students between 16 and 25 years should be in either second cycle or tertiary institutions (Ministry of Education, 2015a; National Education Assessment Unit, 2016).
- Children and youth with mobility impairments who were still in school in any of the four educational settings (mainstream, special education, rehabilitation, and inclusive education schools).

b. Parents

- Parents of children and youth with mobility impairments whose children were currently enrolled in any of the educational settings in the Ashanti and Oti regions of Ghana. It was not necessarily a parent whose child had been selected for the study.

c. Head Teachers

  - Head teachers of the selected schools who had at least two years' experience in headship. I assumed that head teachers who have at least two years as heads could tell me much about the education of children with MI, considering the educational policies that govern the activities of the school.

4.7.2 Exclusion criteria

- One exclusion criteria was children and youth with mobility impairments whose impairments were temporal as a result of minor injuries.
- Children and youth who were identified by the functional definition of mobility impairments as described by the International Classification of Functioning (World Health Organization, 2013), like profound cerebral palsy, multiple disability and others who could neither speak nor write (Disabled World, 2015; Euroqol Group, 2009). The focus was on children and youth who only had mobility impairments and not any other additional impairments. I focused on these children and youth because children and youth with MI may not require any special educational need to gain access to quality education. I used the medical report of each individual child which gave a vivid description of the disability as confirmation of the selection (see Appendix 19).

4.8 Recruitment and enrolment of participants

The recruitment and enrolment processes were grouped into three approaches:

a. Head teachers
b. Children and youth with MI who were in any of the four basic educational settings
c. Parents of children and youth with mobility impairments (either the father, mother, a care giver or legal guardian)

The information sheet for parents and children and youth with MI were written in “Twi”, a commonly spoken language in the Ashanti and the Oti regions of Ghana (see Appendices 17 and

22). This enabled the participants to understand what the study was about and what I required from them before they made their decision to participate in the research study.

Participants were recruited after permission was granted by the Health Sciences Human Research Ethics Committee of the University of Cape Town (HREC REF: 339/2017) (see Appendix 1) and the Ashanti Regional Director of Education in Ghana (see Appendix 3). An official letter and the information sheet from me were given to the Ashanti Regional Director of Education for permission to contact head teachers of the various educational settings in the Ashanti Region (see Appendix 2). Permission was also received from the District Director of Education in the Krachi East District (see Appendix 4). The authorisation by the regional director allowed me to interview children and youth with MI who were between 12 and 25 years. When I received the approval from the regional director, I visited the selected schools:

a. I visited the head teachers in the various schools, introducing myself and the aim of the project. I showed the authorisation letter from the regional director and then gave the consent form and the information sheet. I allowed them time to read the consent form and to ask questions about the project. I then asked the head teacher to schedule a separate meeting with students and parents and to assist in the recruitment process.
b. During the meeting with the students, I introduced myself and the purpose of the project. I then took them through the information sheet and the consent forms in Twi and gave them the opportunity to ask any questions they had concerning the research. Children and youth with MI who were above 18 years completed the consent form and those below 18 years who were willing to participate completed the assent forms. I made sure that parents of children who were below 18 years gave their consent before I accepted their children.

c. During the meeting with the parents, I introduced myself and told them why the study was important. I then took them through the information and the consent forms in Twi and gave them time to ask questions about the study. Those who were interested and willing to participate in the study completed the consent form, and I took contact numbers of parents whose children showed interest to participate but had their ages below 18 years. I then followed up with those parents to seek their consent for their children. They all agreed and subsequently filled in the consent form before I conducted the interviews. Participants who were below 18 years of age gave their assent under the auspices of their parents (see Appendices 13 and 18).

Participants were given one take-away 'joloff-rice' each as a lunch and thirty-six Ghana cedis (Gh₵36.00) equivalent to US$8.00 or R120.00 to cover transportation costs after the interviews.

4.9 Methods of data collection

The researchers in a qualitative research, act as the primary instrument for data collection and data analysis (Denzin & Lincoln, 2018). The responsibility of the researcher is to collect and interpret data. Qualitative research that involves fieldwork like this research may require the researcher to go to the people, settings, and institutions in order to observe everyday school life and the behaviour of children and youth with MI in their respective school settings.

In gathering data, I used in-depth, semi-structured interviews for children and youth with MI and head teachers, and focus group discussions for parents of children and youth with MI. Finally, I used my own research observation and field notes. The details of the various ways I gathered data will be seen below.

4.9.1 Interviews

There are different types of interviews including: “structured, semi-structured, in-depth, non-directive, focus group and informal conversational interviews” (Gray, 2009, p. 371).

Qualitative interviews are described as being: “flexible, iterative, and continuous, rather than prepared in advance and locked in stone” (Babbie & Mouton, 2010, p. 289). Interviews are far more personal and help the researcher to work more closely with the participants (Creswell, 2014). Interviews also allow the participants to freely share their opinions and experiences and the researcher can probe for richer information.

Considering the quotes above and the aim of this research, which was to explore the educational experiences of children and youth with MI in Ghana, in-depth, semi-structured interviews were employed. This method of interviewing was appropriate in order to allow a flexible researcher-participant interaction which was necessary to generate relevant information to answer the research objectives and questions (Creswell, 2013).

Tables 3 and 4 below show the interview schedules and a follow-up of the participants in the study, respectively. Follow-up interviews are part of data collection which is aimed at gaining more depth and understanding of the phenomenon under study (Babbie, 2008). The follow-up interview helped me to gather further information that was left out during the first interview session. This follow-up also served as member-check where participants were provided with the opportunity to review the data collected and the researcher’s interpretation (see 4.16 below).

Table 3 ***Interview schedule***

Study Participants	Hours per Participant/Session	Total Number of Hours
20 children and youth with mobility impairments	30 minutes	10 hours
4 teachers	30 minutes	2 hours
4 focus group of 5 parents in each group	60 minutes	4 hours

Table 4 ***Follow-up interview schedule***

Study Participants	Hours per Participant	Total Number of Hours
20 children and youth with mobility impairments	15 minutes	5 hours
4 teachers	15 minutes	1 hour, 10minutes
5 parents in 4 focus group	No follow-up	-

4.9.1.1 In-depth, semi-structured interviews

In-depth, semi-structured interviews were used to collect data from children and youth with MI and head teachers (see Appendices 6 and 7). This method of interviewing allowed for a flexible approach which was appropriate given the high sensitivity of the subjects (Creswell, 2013). I probed the participants where necessary to keep the conversations in line with the objectives of the study, whilst at the same time allowing them to express themselves freely without any interruption. Recognising that children can feel intimidated by adults, I created a good rapport with children and youth with MI. Firstly, my dress code was casual so as to make them feel at ease. Secondly, I gave children and youth with MI three venues from which they selected the venue they liked. The venues were a staff common room of the school, the head teacher's office, and an open space under a tree. Thirdly, I started the interview by reviewing briefly the purpose of the research (Mertens, 1998) and what I expected from them. I then asked questions about their demographics and moved on with the questions with regards to the research questions. This strategy I used increased the confidence levels of the participants and, also allowed them to be at ease and feel relaxed in a safe space for a face-to-face conversation.

4.9.1.2 Focus group interviews

The qualitative researcher can also use focus groups as a useful tool for explorative research in which diverse views are collectively sought. This type of data collection emphasises the value of interaction during group sessions. Femdal and Solbjør (2018) argue that interactions among participants in focus group brings the participants' view of the world, their beliefs, and values as well as co-construction of meaning to the fore. This interaction makes it possible for participants to freely make sense of challenges that they encounter in their daily lives.

Focus group discussions were conducted with four groups of parents of children and youth with MI. Each group discussion was comprised of five participants and took place at a central venue that was arranged and agreed upon by all parents (See Appendix 8). Although there was an interview schedule, I acted as a facilitator where specific areas of interest were to be covered in the process of data gathering. I limited my own contribution to a minimum and introduced general themes on which more information was required.

Participants were encouraged to participate spontaneously, and conversation was stimulated through the use of probing questions. I ensured that the participants followed tactfully directed questions towards the topic when they were found to be going off the topic (Polit & Beck, 2017). I am an experienced interviewer who has previously conducted qualitative research.

A research assistant was recruited for assisting with data collection. He was a Master of Science degree holder in disability studies from the Kwame Nkrumah University of Science and Technology, Kumasi Ghana. He was trained to take charge of duties such as setting up and preparing the venue for the discussions, assisting in transcription and coding of data. The research assistant did not conduct interviews. He coordinated activities during focus group discussions and served as my personal driver. Data was audio recorded, using a digital voice recorder. The research assistant and I met after every focus group session to reflect on the session. The purpose of these meetings was to discuss the observations of what had happened. In this meeting, we discussed participant’s responses and contributions. We also discussed the general emotions of participants that were observed during focus group sessions. These were noted and recorded in the researcher’s field notes. All these interviews were successfully conducted.

4.9.2 Field notes

Field notes are the researcher’s own observations and detailed descriptions of what has been observed. They are records of the researcher’s experience, which includes observations, a reconstruction of dialogue, personal reflections, a physical description of the setting and decisions made that alter or direct the research process. In this research, the notes were written after every event (Creswell, 2013). According to Anderson and Arsenault (1998), notes must be taken in research settings so that the researcher does not miss out important information during data collection process. Written notes included prolonged observations of both verbal and non-verbal behaviours throughout the interview and observation process.

In this research, the research assistant and I took notes during focus group sessions. These were then reviewed. Any blanks or missing information were then filled in, any scribbled information was fixed, and missing details which one might not have had time to note down was added. The field notes revealed what happened during the interview process and provided a vivid description of the four basic educational settings.

Leedy and Ormrod (2001) state that caution should be taken when conducting observations. They argue that the researcher may shift focus as new data comes to light. These authors also urged researchers to be flexible when conducting observations. This was witnessed during some of the focus group sessions. For example, in one instance a parent became emotional when discussing challenges, she was going through after giving birth to a disabled child. I had to draw their attention and refocus on the current discussion in order to give support to the participant. She was, however, referred to the counselling section at the Kwame Nkrumah University of Science and Technology.

4.9.3 Documents

Head teachers willingly gave me school record books that showed the number of students, number of staff and the type of staff in the school (trained and untrained teachers). The head teachers also gave documents that showed the history of the school.

4.9.4 Recording data

According to Patton (2002), data recording is a process that involves the recording of some information using an interview guide or a focus group schedule, which is a list of questions. The researcher may rely on written notes or a digital recorder for recording interview data. In this research, I used field notes and a digital audio recorder to record interview data. Informed consent was obtained from children and youth with MI over 18 years old, parents of children and youth with MI and head teachers. Assent was taken from children and youth with MI who were below 18 years and their parents gave consent. Participants were assured of their right to privacy, fair treatment, anonymity, confidentiality, and protection from discomfort and harm. Examples of the recorded and transcribed interviews are attached to this thesis as Appendix 21.

4.9.5 Interview guide

An interview guide for interviews with all the participants was used. This interview guide contained a list of open-ended questions (see Appendices 6-8). The interview guide began with biographical questions relating to the participant's background. As the interview progressed, the questions were directed to address the more specific objectives of the research in exploring educational experiences of children and youth with MI, and also in identifying barriers and educational support systems in the various educational settings in Ghana. Participants were asked questions relating to their experiences in the following areas:

a. Children and youth with mobility impairments:
    - Understanding of disability
    - Onset of disability
    - Barriers in their educational trajectories
    - Stigma in home and in school
    - Educational support systems
    - Understanding of inclusive education
    - Strategies for implementing inclusive education

b. Parents of children and youth with mobility impairments:
    - Understanding of disability
    - Barriers in the schools of their children
    - Stigma in home and in school
    - Educational support systems
    - Understanding of inclusive education
    - Strategies for implementing inclusive education

c. Head teachers:

- Understanding of disability
- Barriers in the school
- Stigma in the school
- Educational support systems
- Understanding of inclusive education
- Influence of inclusive education on enrolment and retention of children and youth with mobility impairments
- Strategies of implementing inclusive education

The use of an interview guide was necessary, given that “the same basic lines of inquiry were pursued with each person interviewed” but from the different perspectives of the participant group (Patton, 2002, p. 343). The main advantage of using an interview schedule is that it assists in making the interviews with different participants “more systematic and comprehensive by delimiting in advance the issues to be explored” (Patton, 2002, p. 343). It also provided a framework that I used to create a sequence of questions and allowed decisions to be made concerning which information to probe in greater depth.

4.9.6 Transcription of interviews

Transcription of data means transforming the oral interview into a written structure for the purpose of data analysis (Creswell & Guetterman, 2018). The data collected was transcribed verbatim. The field notes were used as back up to the digital audio recorded data and were a very important part of the analysis process. At this stage, it is important for the researcher to see to it that he does not prematurely categorise data (Polit & Beck, 2017). Before I transcribed the interviews, I compared the field notes to the audio recorded version to verify the accuracy of the recorded information. In cases where there was a discrepancy and clarity was needed, I followed up with the participant in the second round of interviews to verify my understanding and interpretation of the issues in question.

4.10 Language used

In order to allow the participants to express themselves freely, one local language called “Twi” was used. This is a common local language used in the whole of the Ashanti and Oti regions of Ghana. Interviews were audio recorded and responses were transcribed in the local language and then translated into the English language immediately after the interview. The interviewer is fluent in the local language and thus could confidently translate the interviews into the English language. However, I engaged a professional teacher in Twi who did all the translations for a fee. The translator and I cross-checked the translations in the English language for the purposes of accuracy. At any point during the interview when a participant decided to use the English language, he/she was allowed to freely express him or herself accordingly.

4.11 Data management

All the audio recordings and soft copies of data were saved on a laptop with a back-up for which only I knew the password, and hard copies were kept in a locked cabinet in my study room. I also kept a list of all types of information gathered as a data tracking system (Creswell, 2013). Furthermore, all transcribed data were stored in Dedoose, a computer-assisted qualitative data analysis software (CAQDAS) as additional back-up and for data analysis which was also protected under a password (Creswell, 2013).

4.12 Data analysis

Data obtained from the teachers and the parents were analysed through thematic analysis, while data received from children and youth with MI were analysed with the aid of Interpretive Phenomenological Analysis (IPA). This is more appropriate because IPA is one of the qualitative approaches to data analysis which is aimed at providing detailed examination of personal educational experiences of children and youth with MI, and it recognizes that this is an interpretive endeavour as humans are sense-making organisms (see Table 5 below) (Smith, 2014). As a requirement of IPA, children and youth with MI have their own personal lived experiences in the various basic educational settings in Ghana, which was essential for this study. As I am a mobility impaired person, I was very careful not to generate themes from my personal point of view but read and re-read the transcribed data and also listen to the voice recorded materials repeatedly to identify themes according to the perspectives of the participants (Creswell, 2013; Patton, 2002).

In this study, data consisted of transcriptions of one-to-one interviews, the researcher's field notes (comprising of reflection sessions about observations of children and youth who are still in school), focus group sessions and documents. The researcher's field notes and observations were used to compare the accuracy of the transcribed data. The reflections on the focus group discussions were done with the research assistant and these were recorded in the researcher's field notes to ensure that no data were left out from the focus group discussions. Documents such as medical reports (see Appendix 20) of children and youth with MI, school records such as school register and staff record book, policy documents like the Ghanaian Education Policy and Disability Act and others were also used as will be discussed below.

4.13 Document analysis

Document analysis (DA) is a systematic procedure for reviewing and evaluating both printed and electronic materials. DA is also a qualitative research approach where the researcher interprets documents to give voice and meaning to a phenomenon under study. It could be public records, personal records or physical evidence such as physical objects found within the study settings (Bowen, 2009).

For document analysis in this study I made use of medical reports from children and youth with MI and the school records that gave information about the enrolment of students and records about the teachers and the history of the school. Ghana Education policy documents (e.g. 2007 Education policy), inclusive education policy documents, the Ghana Disability Act 715 and the Ghanaian 1992 Constitution were also used. The medical reports of children with MI helped me to ascertain that participants did not have multiple disabilities. The focus of this study was on children and youth with MI who did not have any additional impairments. This was important because such children might not need any special care to have quality education. The medical reports of the participants helped me greatly during recruitment of children with MI. The Ghana Education policy documents, the Disability Act 715 and the 1992 Constitution provided a background to the education of persons with disabilities (see Chapter 2). The DA helped me to analyse and to compare the raw data generated during the discussion session (see Chapter 7). Below is the theoretical orientation of data analysis.

4.14 Theoretical orientation of analysis

The table below shows the three theoretical orientations of data analysis that were employed in the research study (Clarke & Braun, 2017; Smith et al., 2009).

Table 5 Theoretical orientation

	Thematic Analysis (TA)	Interpretive Phenomenological Analysis (IPA)	Document Analysis (DA)
Data Source	Individual interview with the head teachers Focus group interviews with parents	In-depth semi-structured interview from children and youth with mobility impairments	Medical report, Admission register, staff record book, 2007 Education Act Disability Act 715 Ghanaians 1992 Constitution
Meaning	Thematic analysis is a method which helps researchers to identify, analyse and report themes or patterns within data	The primary aim of IPA researchers is to investigate how individuals make sense of their experiences. IPA is one of the qualitative approaches which assumes that children and youth with MI are 'self-interpreting beings' who can interpret their world.	The aim of DA is to contextualize this research within the policies and laws with regards to basic education for children with disabilities in Ghana.
Justification	Thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed account of data It offers accessible and theoretically flexible style to analysing data	IPA highlights how individuals make sense of the world, how they experience events and what meaning they attribute to a phenomenon IPA draws upon the fundamental principles of phenomenology,	DA is an efficient and effective way of gathering data. This is so because documents are easily manageable and a practical resource

	This method provides the basic skills useful for conducting many other kinds of analysis It is not tied to a particular epistemological or theoretical perspective	hermeneutics and ideography (see Chapter 2) which is very helpful in this research which is concerned about the phenomenon of children with MI in school settings in Ghana	Using DA is cost efficient and time efficient It can be read and reviewed multiple times and still remain unchanged by researchers' influence or research process

4.15 Dedoose

Data was analysed using Dedoose, a computer-assisted qualitative data analysis software (CAQDAS). Dedoose is an easy-to-use, collaborative web-based application that enhances qualitative research, data management and analysis, developed by Eli Lieber and Thomas Weisner (Lieber et al., 2003).

4.15.1 Self training in Dedoose

Before I delved into the main process of data analysis for this study, I had a series of training sessions in Dedoose. The first training session comprised of two hours of introductory training with my two colleagues in the doctoral studies in the Division of Disability Studies. Then I went online for self-tutorials for one week (https://www.dedoose.com/resources/videos). Finally, I had one-hour training from my supervisor who took me through the process of exporting codes and excerpts from the software.

4.15.2 Using Dedoose

To ensure accuracy and transparency in the data analysis process, I followed the six steps suggested by Clarke and Braun (2017) for the data analysis. These steps are as below:

- Step 1. Become familiar with the data
- Step 2. Generate initial codes
- Step 3. Search for themes
- Step 4. Review themes
- Step 5. Define themes
- Step 6. Writing up the thesis

The first step is familiarisation with the data. That is to say, I involved myself deeply in the data, and became very familiar with it. I did this by reading the data severally and listened to the audio-recorded data at least twice or three times, as well as noting any initial analytic observations. I familiarised myself with the data to the extent that I could hear the voices of each participant during the analysis.

The second step is to generate initial codes. This involves generating categories and giving labels for important features of the data which is relevant to the (broad) research question that is guiding the analysis. I coded every data item and ended this phase by gathering all codes, categories and relevant data extracts. This process was undertaken with the additional input of the study supervisors.

The third step is to search for themes and sub-themes. A theme is a recurring idea that gives a meaningful pattern in the data which relates to the research question. A sub-theme is a specific idea that is under the main theme. A researcher will need codes to build up sub-themes and the main theme. In this research, I used codes to build the theme. As an illustration, if codes are the bricks and tiles in the house, then themes are the walls and roof panels. Themes are to be identified and constructed by researchers. They are not hidden in the data waiting to be discovered by the researcher therefore, I constructed the themes. I then collated all the coded data that relate to each theme.

The fourth step is reviewing of themes. After the themes are identified, the researcher must check that the themes ‘work’ coherently with the coded extracts and the full dataset. I made a crosscheck to reflect on whether the themes tell a good story about the data. I then define the nature of each single theme, and the correlation between the themes. I emerged some themes together, split some other themes into two or more, and rejected the sub-themes that do not relate to the main theme and started the process of theme development again until I got the desired sub-themes. This process was also done with the additional support of my supervisors.

The fifth step is to define and name the themes. I constructed and defined an in-depth analysis of each theme, gave them names, identified the ‘essence’ of each theme, and reconstructed a concise, punchy and a unique name for each theme.

The final step is writing up the thesis. “Writing-up involves weaving together the analytic narrative and (vivid) data extracts to tell the reader a coherent and persuasive story about the data, and contextualizing it in relation to existing literature” (Clarke & Braun, 2013, p. 121). I wove the themes generated from the data together in a manner that gave a coherent and a convincing story about the educational experiences of children with MI in the basic school settings in Ghana.

4.15.3 Within-case analysis

I analysed the interviews of each participant individually within each school setting, using Dedoose in order that the findings would reflect the detailed, deep layers of the experiences of children and youth with MI (Smith et al., 2009). The researcher must immerse himself or herself thoroughly with the data before embarking on a qualitative analysis. Therefore, attentive reading and re-reading of the interview transcript is considered as very important. This step enabled me to become deeply immersed with the content of the interview transcript and enabled me to recognise possible trends and patterns within the text. Also, repeated reading of the transcribed data helped in subduing my voice, exposing the voices of the participants to be heard in each school setting.

When I felt comfortable with the explicit content of the transcript, I began to create excerpts with the aid of Dedoose which was stored in the software. This required paying close attention to the context of each participant and the content of their language. In the course of this process, I identified and recognised common features and differences within the transcripts and informed the development of abstract concepts (Smith et al., 2009). This process continued for every participant within the school setting. By so doing, my familiarity with the text deepened my understanding of the voices of children and youth with MI.

Next, I compared cases that have similar unifying factors (see exploratory case study above). For instance, mainstream and inclusive schools as two separate cases had some similarities, whilst the special school and the rehabilitation centre also had some similarities. By comparison, I used the original transcripts in conjunction with the field notes in order to reflect the data accuracy within the mainstream and the inclusive school settings on one side and the rehabilitation and the special schools on the other side. It is thus evident that the themes reflected not only my interpretation, but also the original words of the research participants.

4.15.4 Cross-case analysis

Cross-case analysis examines themes, similarities and differences across cases (Denzin & Lincoln, 2018). I had the task of looking for patterns across the analysed cases. Here I merged the mainstream and the inclusive schools. I also merged the rehabilitation and the special schools. Merging these schools was important to give a clear understanding of the pattern of the themes from the data. This involved the grouping of similarities and differences across the mainstream and the inclusive school settings on one side and the rehabilitation and the special schools on the other side. The differences and similarities from the school settings were restructured and relabelled in order to get the original individual themes, so that patterns of meaning became clear in a final account of the shared experiences of children and youth with MI.

4.16 Scientific rigor

It is important to every researcher, especially when exploring personal experiences of participants, to produce trustworthy data. In this study, I consider credibility, dependability and reliability (Creswell, 2013; Guba & Lincoln, 1989).

Credibility: Credibility can be achieved when the findings of a study are linked to the reality to demonstrate that findings show the phenomenon that was studied in the field. To ensure credibility, the polished and transcribed data were reviewed by the participants to ensure that they were satisfied with the accuracy of the transcripts. I also phoned the participants to get further clarification about the transcribed data. The other way to ascertain credibility was through reflexivity. By reflexivity, I used the researcher's field notes to record my reflections, feelings, relationships, events, and reactions to participants during the data collection period. These practices are said to improve the credibility of a qualitative study (Creswell & Guetterman, 2018). Credibility was further enhanced through selection of participants from the four basic educational settings (mainstream, inclusive, special and rehabilitation centre) and from four different sources (children and youth with MI, parents, head teachers and documents) to make way for diverse opinions on the phenomenon being investigated (Patton, 2002).

In addition, I used prolonged engagement, persistent observations, triangulation, and member checking. By prolonged engagement and persistent observations, I spent sufficient time in the field - five months - to observe various aspects of school settings and to learn and understand the culture and the phenomenon of interest (Creswell, 2013). Triangulation was accomplished by asking related research questions and collecting data from children and youth with MI, parents, and head teachers. Member checks occur when the researcher asks participants to review both data collected and the researchers' interpretation of that interview data. It does not necessarily mean that the researcher goes to the participants with the transcribed data but the researcher goes to the participants with a polished product such as the themes and the case analysis (Creswell, 2014). Member-checking was done during the follow-up interview sessions to ensure that the researcher's transcribed data reflected everything that transpired during interviews. Reflective periods after the focus group sessions with the research assistant focused on clarifying and ensuring that transcriptions reflected the true meaning of what was meant and said. I also allowed my supervisors to listen to samples of the audio recorded interviewed data and the transcribed version of the same data to verify the quality of the interviews and the questions asked.

Participants were generally appreciative of the member check process. Knowing that they would have a chance to verify their statements caused the study participants to willingly fill in any gaps from the earlier interviews (Denzin & Lincoln, 2018).

Dependability: Dependability was obtained through an explicit and detailed report of the research process that made it possible to repeat the study. In this study, an unambiguous, step-by-step description of the research design and methodology, including data-collection and analysis procedures, was discussed and was followed to ensure trustworthiness of the research (Guba & Lincoln, 1994).

Reliability: Reliability in a qualitative research indicates that the researcher's approach is coherent across different research settings and different participants (Creswell, 2013). The assessment and the credibility of a qualitative research study requires evaluation of reliability of the study's findings. This is to support the soundness and the integrity of the research conclusions (Smith & Noble, 2014). Ensuring reliability, I made sure to check transcripts very well so that they did not contain obvious mistakes during the transcription. I also ensured that there was no deviation in the definition of codes or drift in the meaning of codes during the process of coding. I accomplished this by regularly matching data with codes and by writing drafts about the codes and their definitions that relate to the theme.

4.17 Ethical considerations

I followed basic ethical principles throughout this study. Ethics is referred to as questions of right or wrong (Fraenkel et al., 2012). In research, ethics involves taking a conscious effort to consider the well-being and welfare of all participants to ensure that there are minimal or no harm in the course of the research process (Lankshear & Knobel, 2004). All ethical considerations observed in this study are commensurable with the revised version of the Helsinki Declaration of 2008 which provides ethical principles for research in humans (World Medical Association, 2008). Informed consent implies that participants are made adequately aware of the type of information the researcher wants from them, why the information is being sought, what purpose it will be used for, how they are expected to participate in the study, and how it will directly or indirectly affect them (World Medical Association, 2008).

The University of Cape Town’s ethics form was completed and submitted, and I received the approval with reference number 339/2017 (see Appendix 1). After the approval by the UCT Faculty of Health Sciences Human Research Ethics Committee, I gained an approval from the Regional Director of Education, Ashanti region and the District Director of Education of Krachi East District of Oti region of Ghana to commence the research (see Appendices 3 and 4). I also received an approval from the manager of the rehabilitation centre, since the centre is not under the Ghana Education Service (see Appendix 5).

Each participant’s decision to participate in the study was voluntary; that is, made without any form of pressure, deceit or coercion. Written informed consent was obtained from all participants (Appendices 13-15). Two written consent forms were translated to Twi language for the children with MI and their parents (see Appendices 19 and 22) for a better understanding before they took a decision to take part in the interviews. Consent was sought from participants for the interviews to be digitally audio recorded using a digital audio voice recorder. I also obtained assent from children who were younger than 18 years as well as consent from their legal guardians (Appendix 13). The assent form for the children and youth with MI who were below 18 years was also translated to Twi language (see Appendix 18).

My contact numbers and that of my supervisor were provided so that the participants were able to ask questions, make comments and recommendations or obtain clarification at any point of the research. The name, contact number and email address of the Chairperson of the Human Research Ethics Committee of the Faculty of Health Sciences was made available to participants as well so that concerns or complaints about the manner of how the study was conducted and its staff or about the human rights and welfare of participants could be relayed.

Autonomy: I provided detailed information about the project on the information sheets to inform participants about the purpose of the study and their rights as participants, and to ensure that there were no deceptions about the nature of the study (Appendices 9-12). Participants were given enough time to ask any questions they might have had before the interviews started. For children and youth with mobility impairments who were below 18 years, I read the information sheet to them and, also allowed them to ask questions to ensure that they understood the information given. For all children and youth with MI in the rehabilitation and the special schools, I read the information sheet to them and allowed them enough time to ask questions. Participation in this study was entirely voluntary and participants were allowed to withdraw from the study at any time and this did not result in any form of penalty.

Beneficence: Before taking part in the study, the participants were informed that there would not be any direct benefits for them from participating in the study, but the information they provided had the potential to influence initiation of improved educational support systems in the educational policies which would enhance the education of children and youth with mobility impairments in Ghana. The participants' needs with respect to the timing of and space for the interviews and their views and opinions were respected. There was lunch at the research site (a plate of joloff rice) and each participant was given an amount of thirty-six Ghana cedis (Gh₵36.00) equivalent to US$9.00 or R120.00 for transport.

Risk and referral: The participants were made aware that there were minimal risks associated with participating in this study and the study did not expose them to any form of harm. However, I arranged with the counselling unit of the Kwame Nkrumah University of Science and Technology before commencing data collection so that I could refer for counselling any participant who might be negatively or emotionally affected by the research.

Maleficence: I conducted the interviews at venues that were comfortable for the participants. I was sensitive to the emotional needs of the participants. I avoided issues that raised cues of negative feelings and experiences.

Justice: A researcher must explain to the participants that they have the right to ask questions or to raise any issues or opinions that they might have regarding the study. I ensured justice by allowing participants to ask any question or raise any issue that they do not understand with regards to this research and I responded to their questions to the best of my ability. My contact details and those of the research supervisors and the chair of the UCT Faculty of Health Sciences

Human Research Ethics Committee were included in the information sheet so that anyone with questions or queries was able to contact us (see Appendices 9-12).

To ensure that results of the study were accessible to the participants, I will conduct dissemination talks in the form of workshops to present research findings to the teachers and students in the schools. Dissemination also included conference presentations. For example, I gave a presentation at the African Network for Evidence-to-Action in Disability (AfriNEAD) conference on the 8th August 2017 at the Kwame Nkrumah University of Science and Technology in Ghana. I also shared part of the findings of this current study at the European Society for Disability Research (ALTER) conference on the 5th September 2019 at Cologne, Germany. After this thesis has been examined, I will make known the voices of children with MI through presentations in Ghana during annual forums such as "My First Day at School" organised by the Ghana Education Service (GES) and "New Year School Day" organised by the Ministry of Education (MoE), highlighting findings that may be of use regarding the education of children with MI in Ghana. With the disability organisation (Ghana Federation of the Physically Disabled) of which I am a member, I will get permission from the regional president to present my research findings at their annual general meeting. To reach out to the government and the stakeholders of education as advocacy for social justice, I will publish my findings using the state and private media platforms, for example websites, policy briefings and FM radio and television stations.

Corresponding to good ethical protocols is the need for qualitative researchers to acknowledge their subjectivity in the research process (Creswell, 2016). As a result, I discuss the reflexivity in the next section.

4.18 Reflexivity

Creswell, (2016) describes reflexivity as a continuous process of a reflection about a researcher's values, beliefs and identities, perceptions, behaviour or presence and those of the participants and how these affect the data. This means, in a qualitative research, the researcher is not seen as detached from the research process. The researcher's subjectivity in shaping the construction of knowledge and meaning should therefore be noted in the research process (Kivunja & Kuyini, 2017)

As discussed earlier in Chapter 1, I am a person with MI and a professional teacher in Ghana. My teaching career did not only limit me to the classroom but to a rehabilitation centre where I had the opportunity to interact with not only children and youth with MI but with children with other kinds of disabilities such as hearing and visual impairments. After I worked at the rehabilitation centre for one year, I moved to Kumasi Metropolitan Education Directorate, where I was stationed at Kwadaso sub-metro education office as a special education coordinator and subsequently, became a circuit supervisor within the Kumasi Metropolis. These factors in a way, influenced how I conducted this study. Primarily, the urge to conduct this study is because of my identity as a person with MI who went through similar educational experiences that were found from the data.

To begin with, my identity as a person with MI influenced the recruitment of participants and the data analysis process. Generally, children and youth with MI willingly requested to take part. Their request to participate might be because they saw me as one of them (being a person with MI). In the rehabilitation centre and the special school, the number of participants who requested to take part were more than the expected number of five from each educational setting. I was compelled to interview eight and seven participants from the rehabilitation centre and the special school, respectively. This helped me to further select participants whose data spoke more directly to the research questions. During the interviews with these children and youth with MI, I became very emotional at a point. I became emotional because the stories about their educational experiences were almost the same as what I experienced between the years 1980 and 1990 (when I was in a basic school). Also, I was emotional because all five participants at the rehabilitation centre could have transitioned to a higher level of education if the centre had educational support system like counselling, school, and district base support teams. These participants could have been relocated to the mainstream school where they could progress from one educational level to the other. During data analysis, I was very careful about the bias that might influence the process. I admit, there might be an influence during the data analysis process. This is because I could not completely detach myself from the analysis as a qualitative researcher (Creswell, 2016; Kivunja & Kuyini, 2017).

In addition to my identity as a person with MI was power dynamics. It is applicable to acknowledge my position within three main areas – (1) as a former counsellor in the rehabilitation centre, (2) as a circuit supervisor in the Kumasi Metropolitan Education Directorate and (3) as a PhD researcher from the University of Cape Town (UCT).

As a former counsellor in the rehabilitation centre, I had a good inter-personal relationship with the head of the institution. I also had previous engagement with the students in the centre that enhanced my relationship with the participants. Adding to the good relationship I had with the students, participants in this rehabilitation centre viewed me as someone in a higher office, hence, had confidence that their voices would be heard by the government of Ghana. For example, one participant said: "*They [researchers] always come over here to interview us but we don't see any result or change in this school. I know, as for you, you will make our plight known to the government*" (RSS2).

As a previous circuit supervisor in the metropolis, head teachers gave me easy access to the schools and they readily assisted me when I was recruiting the participants. They organized meetings between the students and me as well as between the parents and me. It is likely that head teachers may understate the true conditions of the school because of my previous affiliation with the education directorate. It may also happen that head teachers will over state issues that needed attention just to have them resolved in the schools.

As an academic researcher from UCT, the prestige of the University was attached to me and I was given an elevated status as an expert in academic research. For example, some head teachers seemed very happy about my academic background and happened to revere it. The head teacher from the special education school shortly after the interview said: "*I am very happy for you to be in this African number one university. I am interested to also do my PhD in this university [UCT]. Kindly give me the website so that I can apply for admission*" (SSHT3). The perception of this head teacher might have led him to respond to the interview questions in a particular way to meet the academic standards he perceived me to have. Other head teachers who may have similar perceptions might have their responses to the interview questions influenced.

My attempt to addressing the foregoing power dynamics was laying emphasis to the participants that they were the experts and knowledgeable than me when it comes to their educational experiences in the schools. I also made the participants aware that my educational background and the fact that I am a researcher from UCT does not guarantee that I know their educational experiences or the resources that were made available to them in the schools.

It is evident from the above discussion that my subjective position in this study played a significant role in shaping the research process (Creswell, 2016). The next session presents the chapter summary.

4.19 Chapter summary

In this chapter I have presented the methodology used in undertaking this study and illuminated my research processes throughout the chapter. I outlined the choice of using an exploratory case study and explained how participants were recruited and enrolled in the study. I explained my choice of data management techniques and the six steps of data analysis with the aid of computer assisted qualitative, data analysis software that structured my approach to data analysis. Furthermore, I outlined my data representation approach and an assessment of the issues of credibility, dependability and reliability that are pertinent to this study. I concluded the chapter with ethical protocols which were upheld throughout the study. The next chapter discusses the first part of the findings of this study.

CHAPTER FIVE: ANALYSIS OF FINDINGS

5.1 Introduction: Kamame School Complex and Dabokpa Basic School

In this chapter, findings from the mainstream school [Kamame School Complex (KSC)] and the inclusive school [Dabokpa Basic School (DBS)] are presented. It is important to note that a researcher may identify school settings as merged units for case studies (Merriam & Grenier, 2019). I have therefore identified these two schools as two separate cases which will be presented in one chapter because they have similar characteristics and the responses are closely related, despite being obtained from different participants and from different school settings. Additionally, both schools follow the general curriculum that is used in the basic schools (Field note; June, 2018). Presenting cases from both schools in one chapter will enhance the cross case analysis (Yazan, 2015). That is, discussions about observations and responses from participants in the schools can be simplified and will be understood more compared to a situation where the findings are presented separately.

In this chapter, I present similarities and differences between the two schools, a brief description of each school in its context, followed by a tabular presentation of the demographics of participants, and a figure showing the theme, sub-themes and categories that emerged from the data. Then, elaboration of findings from the interviews and the researcher's field notes and reflections are discussed.

5.1.1 Similarities and differences between mainstream and inclusive schools

As noted in Chapter 2, the earliest formal education in Ghana before and after independence was known as the mainstream school. In the Ghanaian educational system, the mainstream school is structured to cater for all children of school going age. However, children and youth with disabilities must adapt in order to fit into this school setting (Auberon & Odoom, 2016). This is because the school's layout, the buildings and other educational facilities are not user friendly to children with disabilities.

In the inclusive educational system, the school adapts in order to suit the child with disabilities. The school curriculum, educational support systems, the methods, the school layout and the infrastructural facilities are made to meet the needs of every child, including those with disabilities (Opoku, et al., 2019). This means that in the inclusive school system all children of school going age are placed under one roof (Lamptey et al., 2015) (see Chapter 2).

The similarity between the two school settings is that the management and implementation of educational policies in both school settings are done by Ghana Education Service (GES), under the auspices of the Ministry of Education (MoE) (Ministry of Education, 2015a). In addition, the same basic education curriculum is being used in the mainstream and the inclusive schools and the same examinations are written by pupils when they get to basic school nine (BS9 that is, Grade 9). Children with disabilities may request additional time during examinations conducted by the West African Examinations Council (Ghana Education Service, 2015; Nseibo, 2013). Furthermore, the teachers in both school settings are not specialised to work with children with disabilities. Rather, teachers who have been trained as special education teachers are stationed at the District and Regional Education Offices as Special Education Coordinators (Ghana Education Service, 2015).

5.2 Description of the schools in context

In this section, I will present brief descriptions of KSC and DBS. This is to give a picture of the current standing of the two schools. I will begin with KSC.

5.2.1 Kamame School Complex (mainstream school)

Kamame School Complex is a cluster of schools located in the south-western part of the Ashanti region of Ghana. A cluster of schools means that a number of school streams are concentrated within one geographical location or located within one compound. The school levels start from kindergarten one (KG1) to kindergarten two (KG2) (Pre-school), basic school one (BS1) to basic school six (BS6) (Primary Education) and basic school seven (BS7) to basic school nine (BS9) (Junior High School). These schools are seen in the Ghanaian context as individual school streams. KSC is an urban, basic school. KSC was established with eight students before Ghana gained her independence. The school now has a student population of about 2,630 which comprises of 1,420 females and 1,210 males. Each class size is between 80 and 96 students. KSC has 12 kindergarten classrooms running in six streams. It runs four streams of the basic school section with each stream having 27 classrooms. The school has 126 teachers including a head teacher and six assistant head teachers. As discussed earlier, this mainstream school does not adapt to the needs of its students with disabilities. This means children and youth with MI are expected to adapt in order to fit into the school. The next section discusses DBS in context.

5.2.2 Dabokpa Basic School (inclusive school)

DBS was established in 1958, a year after Ghana gained her independence. It was established as a mainstream school and was changed to an inclusive school on 1 September 2007. As noted in Chapter 2, the change from a mainstream school to an inclusive school was a response to the Disability Act, Act 715, which was enacted by parliament to achieve the right to education for all children with disabilities, including those with MI (Republic of Ghana, 2006). In the case of Dabadabo District (Pseudonym for the political district of the study area), it was observed that all schools at the basic level in the district were used as inclusive practice schools (Field notes; June, 2018).

DBS is located in a semi-urban area, 1km away from the district capital of the Dabodabo district of Oti region of Ghana. It has a student size of 874, comprising of 331 males and 543 females. The school is currently divided into three departments: The kindergarten department (KG1 and KG2) with four classrooms, the primary department (BS1 to BS6) with 12 classrooms and the Junior High School department (BS7 to BS9) which also has nine classrooms. DBS has an average class size of 25 students. The school has 21 teachers, two assistant head teachers, three heads of department and a head teacher. Tables 6 and 7 below provide information about the demographic data of the participants from both the KSC and DBS.

5.3 Demographic data of participants

Tables 6 and 7 below are sub-divided into sections: The first section shows information on children and youth with MI, the second section shows information on the head teacher (HT), whilst the third section shows information on the parents of children and youth with MI. The table also shows name codes which were used in place of names of participants. In addition, the table indicates the class (Grade) of the child with MI, the head teacher’s number of years served as a head in the school, and the age of the child of the parent.

Table 6 Kamame School Complex

Children and Youth with Mobility Impairments				
Name code	**Gender**	**Age**	**Class (Grade)**	**Assistive device used**
MSS 1	Female	13	BS 7	Crutches
MSS 2	Male	14	BS 7	Walking stick
MSS 3	Female	18	BS 9	-
MSS 4	Male	19	BS 7	Crutches
MSS 5	Female	21	BS 9	Wheelchair
Head Teacher				
Name Code	**Gender**	**Age**	**Years of experience**	
MSHT 1	Female	42	7 year	
Parents of Children and Youth with Mobility Impairment				
Name code	**Gender**	**Age**	**Occupation**	**Age of child**
MSFGP 1	Female	53	Trader	16
MSFGP 2	Female	35	Trader	18
MSFGP 3	Male	55	Farmer	15
MSFGP 4	Female	38	Farmer	14
MSFGP 5	Male	52	Trader	19

Table 7 Dabokpa Basic School

<table>
<tr><td colspan="6">Children and Youth with Mobility Impairments</td></tr>
<tr><th>Name code</th><th>Gender</th><th colspan="2">Age</th><th>Class (Grade)</th><th>Assistive device used</th></tr>
<tr><td>ISS 1</td><td>Male</td><td colspan="2">15</td><td>BS 7</td><td>Crutches</td></tr>
<tr><td>ISS 2</td><td>Female</td><td colspan="2">16</td><td>BS 6</td><td>Crutches</td></tr>
<tr><td>ISS 3</td><td>Male</td><td colspan="2">18</td><td>BS 7</td><td>Wheelchair</td></tr>
<tr><td>ISS 4</td><td>Female</td><td colspan="2">15</td><td>BS 6</td><td>-</td></tr>
<tr><td>ISS 5</td><td>Female</td><td colspan="2">19</td><td>BS 9</td><td>-</td></tr>
<tr><td colspan="6">Head Teacher</td></tr>
<tr><th>Name Code</th><th>Gender</th><th colspan="2">Age</th><th colspan="2">Years of experience</th></tr>
<tr><td>ISHT 2</td><td>Male</td><td colspan="2">47</td><td colspan="2">6 year</td></tr>
<tr><td colspan="6">Parents of Children and Youth with Mobility Impairments</td></tr>
<tr><th>Name code</th><th>Gender</th><th>Age</th><th>Occupation</th><th colspan="2">Age of child</th></tr>
<tr><td>ISFGP 1</td><td>Female</td><td>46</td><td>House wife</td><td colspan="2">15</td></tr>
<tr><td>ISFGP 2</td><td>Male</td><td>52</td><td>Trader</td><td colspan="2">18</td></tr>
<tr><td>ISFGP 3</td><td>Male</td><td>49</td><td>Farmer</td><td colspan="2">13</td></tr>
<tr><td>ISFGP 4</td><td>Female</td><td>42</td><td>Trader</td><td colspan="2">14</td></tr>
<tr><td>ISFGP 5</td><td>Female</td><td>39</td><td>Farmer</td><td colspan="2">19</td></tr>
</table>

5.4 Analysis of findings

Introduction

In this section, I present the analysis of findings which have been grouped into one major theme which is analysed across the mainstream school and the inclusive school. The theme was derived from data obtained across the four sources, namely; a) individual in-depth, semi-structured interviews from children and youth with MI and head teachers, b) focus group sessions from parents of children with MI and c) researcher's observation and field notes and d) relevant documents (see Chapter 4).

During data sorting and preliminary analysis, 24 codes emerged from the full corpus of data generated in the course of analysis. For the presentation of findings, I summarized these 24 codes into nine categories, which were further summarised into three sub-themes and finally arrived at a broad theme that kept the focus on the aim of the study as stated in Chapter 1. This theme is the summary of the entire data that was generated from KSC and DBS.

The sub-themes were the product of the categories, and the categories were derived from the codes. These codes were phrases that recurred across the three sources of data, and were thus taken as confirming the prevalence of particular kinds of educational experiences of children with MI in both the KSC and DBS. Findings for the themes, sub-themes and categories are presented in a qualitative format, and are supported by verbatim quotations from the transcribed interview data (Denzin & Lincoln, 2018). The findings are compared and supported by the researcher's field notes. Figure 4 below presents a framework of the categories, sub-themes and the broader theme.

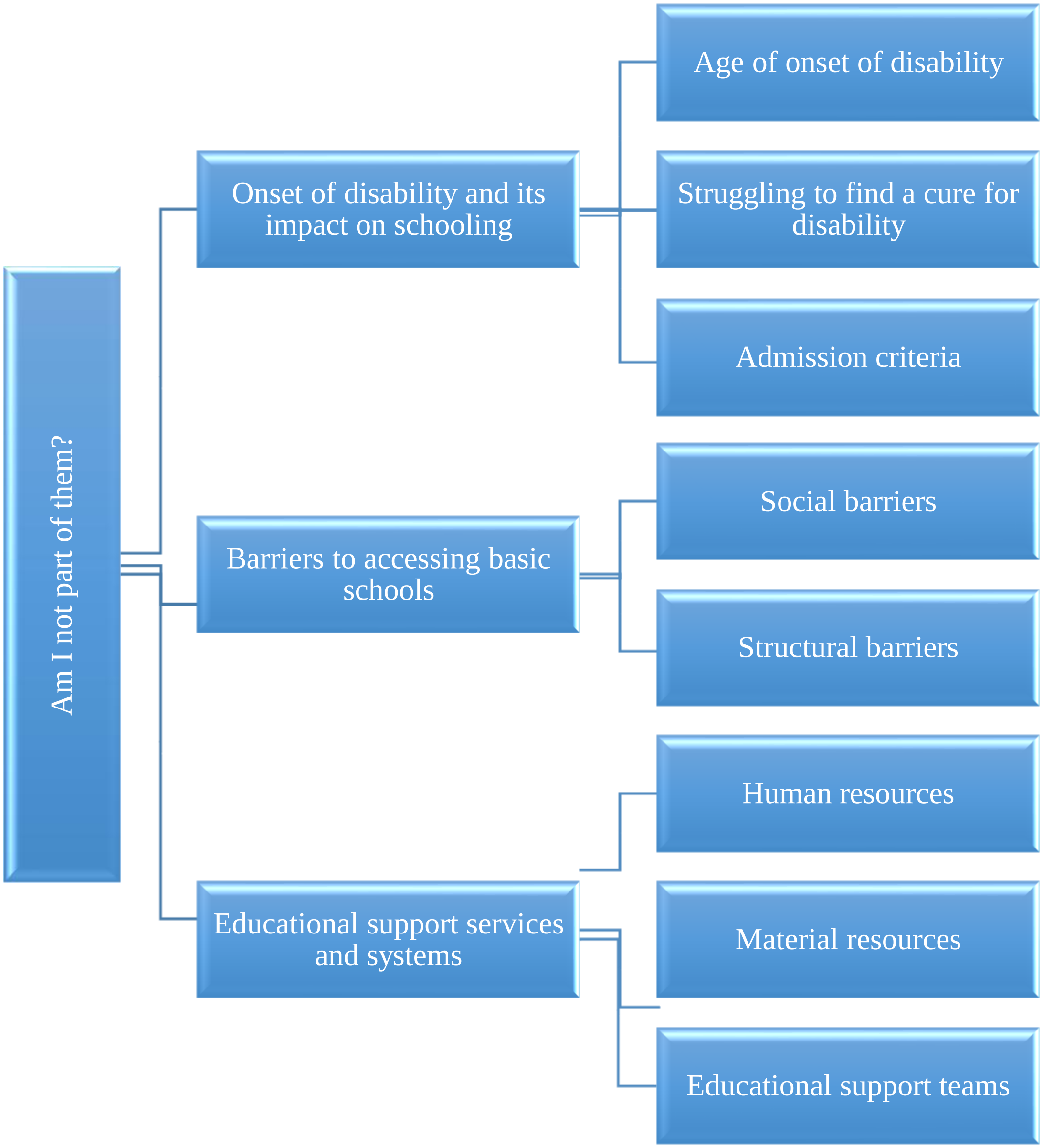

Figure 4 Theme, sub-themes and categories

5.5 Am I not part of them?

The quote “Am I not part of them”? was the overarching theme generated from the data. This theme gives a broad understanding of the experiences of children and youth with MI in KSC and DBS, illustrating how children and youth with MI struggled during their educational trajectories. These children and youth with MI struggled from the onset of their disabilities through to their attempts to gain admission to a school, and the number of barriers they experienced in school. Below is a discussion of the theme, sub-themes and categories between KSC and DBS (mainstream and inclusive schools).

5.5.1 Onset of disability and its impact on schooling

The onset of disability in the lives of children and youth with MI influences the type of educational setting a child may attend. The impact of the onset of disability in children could influence the parents of children with disabilities when selecting educational settings for their children with MI. That is, either they go to the mainstream school or the inclusive school.

In addition to the choice of school setting, it was found in this study that the onset of a child’s disability also influences when to start school and where to have his or her education. The research further discusses findings about the age of onset of disability and its influence on starting school and/or stopping school, especially when the disability occurs in the course of the child’s schooling period.

5.5.1.1 Age of onset of disability

Age of onset of disability of children and youth with MI is important because it gives insight into when and how the child with MI started his or her educational career or how he or she stops schooling after the onset of the disability. Data from this study show that when the disability of the child starts at birth or within the first four years, such a child stays home for a long period of time before the child is sent to school. Conversely, when the disability of the child occurs when such a child is between five and fifteen years (already in school), the child stops school. It was found that out of the ten participants of children and youth with MI in KSC and DBS, six participants were born with their disabilities (congenital) and four developed their disabilities when they were already in school (acquired). The discussions below portray how children and youth with MI either delayed starting school or stopped school when the disabling condition started whilst in school.

Delay in starting school

Children with congenital mobility impairments were delayed in starting school. Some felt that they were kept in the house for a longer period because they could not walk like their non-disabled colleagues. In KSC, this child said:

> I was born with this condition [disability] and was kept in the house whilst my siblings I was older than went to school. I came to realize that it is something that I need to accept and move on in life. Initially I thought it's a situation which could be corrected in the hospital because my parents and I visited many medical centres but all to no avail. I used to stress myself a lot about my condition because all my siblings had no form of deformity and it seemed I was the only odd member of such a great family, I was also worried any time my siblings go to school and I was alone in the house. (MSS1)

Another child said:

"… I was born "abafan" [crippled] so when I was seven years old I started to use the crutches. But before that I was using some sticks to help me to walk. Because I am not able to walk I did not start school early" (MSS4).

In addition to congenital disability, distances from home to school may also be the reason children with MI delay in starting school.

Children became worried and felt rejected when they saw their siblings going to school. This may suggest that children with MI were kept at home against their will. It may also mean that children with MI did not understand why they should be left behind. Children and youth with MI in this study were of the view that members in their communities thought that their brains were affected by their disabling condition. For example, one participant said: “People think that when you are disabled your mind [brain] is also disabled but this is not true” (MSS4). The perception of people in the community that children with MI have their brain affected may be one of the reasons these children with MI were kept at home for a longer period of time.

In addition, participants felt that the disabling condition was a curse from the gods and hence they were not allowed to go to public places like the school. Participants were made to believe that disability emanated from spiritual forces as a result of wrongdoing in the family. One participant said: “… Some people told me that my sickness [disability] was a punishment or curse by the gods in my village so I should not go closer to them [people within community]” (MSS1).

In the focus group discussion, parents felt that children and youth with MI whose disability started within the early years after birth were the category of children that was deprived of starting their educational trajectories at age five as was prescribed in the policy of the Ministry of Education in Ghana (Ministry of Education, 2015a). This means these children were denied their educational rights. One parent said: “Kakra is the only child I have, and she is in a wheelchair. It started from birth [the disability]. Because of her disability, she started school very late at age 12 in BS1 [grade 1]” (MSFGP1).

Another parent said:

> I was rather accused of giving birth to a disabled child. He was like that when I gave birth to him and the family members wanted to take him to the shrine for the "okomfo" [fetish priest] to tell why he was disabled, and I refused. ….. I was stigmatized so I tried my best to make sure that he gets healed. That is why I did not send him to school early. Even though he was not completely healed, I am happy that at least he walks by aid of crutches. (MSFGP4)

Another parent added:

> When my wife give birth to my disabled child, the family said they will not understand so they went for consultation from the ancestors and they said the ancestors were angry because they were not fed during the past ending of the year [Christmas] … And that if they don't sacrifice, serious things will befall the family members, so we moved from the village to another town. There was no disabled school in that town … Well, he did not start school early. He started school when he was eleven years old. (MSFGP5)

The above quotes suggest that children with MI were denied their right to early education because of traditional beliefs and practices like visiting the shrine and staying there for months just to sacrifice and to do consultations. Parents were also accused of being responsible for the disabling conditions found in their disabled children. Others perceived that children with disabilities are "spiritual beings" who should be kept at home.

Participants from DBS gave similar narrations to participants in KSC. For example, one participant said: "I am sure I did not start school early because of my condition [disability]. I am not made like my friends …" (ISS3). Another participant said: "… I started school here from BS1 [grade one] so I am six years old in this school … I started school when I was 10 years because of my condition [disability] hmm, I don't know, I should be in SSS [Senior High School] by now" (ISS2).

These two quotes indicate the impact of the onset of the disabling condition on children and youth with MI. For example, children looked down upon themselves and felt inferior before their non-disabled colleagues. The result was a delay in starting school. It may be assumed that the disabling condition in any child within a family set up was not readily acceptable. The initial struggle to correct the disabling condition further delayed schooling for children and youth with MI.

Onset of disability did not only delay starting of school for children with MI but it compelled children whose disability started while they were already in school to stop schooling for a period of time as will be discussed below.

Stopping school

Four participants had their disabilities during their lifetime (acquired disabilities), and as a result stopped school. One participant said:

> I just woke up one morning and I could not walk. My parents were thinking it was something minor. After some days the pain increased so they rushed me to the hospital. The doctor said the bone in the right leg was broken and said they will do surgery. After first and second attempts there was no improvement. So the doctor did a third surgery and still it was not successful so I was sent to Accra and still it was not successful so I was brought back to the village. I stopped school and was dumped at home and could not go to

> school for three years. Because I could not walk and I had no one to send me to the school. (MSS2)

Another participant said:

> When I was in BS3, that is primary class three I felt sick and my mum rushed me to the clinic and I was given some injections and my buttocks got swollen and the following day I am not able to walk … I was sent back to that clinic and my mum was very angry. So the clinic referred me to … GBB (A Teaching Hospital)]. I was on admission for five weeks and my problem could not be solved. I stopped school and I was dumped at home and could not go to school for three years before I started school again. (MSS3)

Another participant added:

> It [disability] started when I was in primary class three [grade 3]. I got malaria and my Mom sent me to the clinic in the village and the following day I could not walk again. I stayed home for a year before I could walk small, small [little by little]. (MSS2)

Yet another said: “I always asked myself a lot of questions about why me, why I alone in the family I am disabled and have to stop school. Like by now I should be in SHS [Senior High School]*”* (MSS3).

Participants with acquired disabilities experienced feelings of disbelief at their disabilities and asked themselves questions like “why me?” (MSS3). Some of the participants also did not understand why they were disabled, and as a result felt as though they were unable to cope with their disabilities. Data showed that there were no educational support systems like the School Support Team and the District Support Team and others to counsel parents and children with MI when the disability started (Field notes, June 2018). Parents became confused because of the disability which started whilst their children were already in school. Parents and their children with MI did not get any professional advice from either the educational officials or the school authorities. For example, one parent said: “I did not get any help from the teachers not even from the Education Office or the Social Welfare Department” (MSFGP4). Therefore, parents carried the burden of the disabling condition of their children. The impact may be psychological and emotional trauma on the children with MI and their parents. Furthermore, children with MI “felt left behind” as their classmates went ahead to the next educational level, whilst they had stopped school.

Another reason for parents to take children with MI out of school may be because parents wanted to look for a cure for the disabling condition of their children. This is explored in the next section.

5.5.1.2 Struggling to find a cure for disability

Participants in KSC and DBS viewed disability as an illness and tried to look for a cure for the disabilities of their children and youth with MI. The following quotes illustrate how participants struggled to find a cure for the disabilities of their children:

“My Mom said she paid a lot of money to doctors because they said my condition could be corrected, but it did not work” (MSS4). Another participant said:

> Hmmmm, Sir, I had to stop school because my parents took me to the village to see the native doctor to cure my sickness. I spent close to one year in the village. After that, we went to a lot of hospitals. In fact, my Mom did her best to make sure that I was ok, but things did not go as we expected. (MSS2)

One other reason that compelled parents to struggle to find a cure for their children’s disability was stigmatization. For example, one parent said: “… I was stigmatized so I tried my best to make sure that he [her son] gets cured” (MSFGP5). Another parent said:

> My husband ran away from me because of my disabled child. I was stigmatized and was accused of being a bad luck woman and was called a witch. I am suffering too much because I have no one to help me to take care of my disabled daughter. I want my child to be cured! … [Started crying] (MSFGP2)

The story in the DBS was similar to that of KSC. The participants narrated as follows:

> When I was not disabled, I had a lot of friends that always visited me in the house. But when I got sick up to this time, they don’t come to me again. I don’t know why, maybe, they think I am no longer like them or I am no longer strong like them. My dad promised to do all he could to get me cured. (ISS1)

Another said:

> She [mother] sent me to a clinic when I was sick, and I was given an injection and my buttocks got swollen. They referred me to the nearest hospital and conducted surgery on the buttocks and from there I am not able to walk properly. My Mom did her best to make sure that I get healed. (ISS4)

Yet another said: “Because of my disability that is why I stopped school and my Mum was struggling looking for my cure” (ISS5).

Quotes from the two schools suggest that parents struggled to find a cure for the disabling condition of their children. This struggle to find a cure was because of the stigma and pain that is attached to disabilities in the school and the communities. Parents may want to solve the disabling condition of their children before allowing these children to go to school. When parents could not find a solution to the disabling condition of their children, parents sent these children with MI to the school. However, these parents faced challenges because of rigid admission criteria as discussed below.

5.5.1.3 Admission criteria to school

Discussions with participants revealed that there was no laid down procedure or criteria to follow in the KSC and DBS with respect to school admission. The head teacher decides what to do with regards to students' admission. The head teacher looks at the child's disability and either accepts the child or refers him or her to a rehabilitation school. This contributed to children and youth with MI and their parents struggling to gain admission to a school.

Struggle to gain admission for children

It was very difficult to gain admission to the KSC and DBS. For example, the following narrations were taken from KSC:

> Oh, Sir, the problem we faced when we were looking for the admission was that, the head teachers were saying their schools were overcrowded. At least, we went to three schools and the head teachers were saying the same thing. Until we came to this school and I was given the admission. (MSS1)

Another participant said: "Yes, I faced some challenges. The first school we went, the head teacher refused me because of my disability and distance from my house, so I came to this school" (MSS3).

The quotes above indicate that children with MI and their parents struggled with admission because of the overcrowded student population in the mainstream schools. Other participants also felt that children with MI were refused because of their disabilities. The head teacher in the KSC responding to the admission criteria affirmed:

> Well, eem, eeh, we [head teachers] don’t have any criteria we follow. We look at the child, if it is moving difficulties, we manage them. But if the disability is something we cannot manage, we advise the parents to send him or her to either a special school or a rehabilitation school so that more attention will be given to him or her. (MSHT1)

The quote from the head teacher suggests that little attention was given to children and youth with disabilities in the school and the admission of children and youth with MI was solely determined by the head teacher of the school.

The struggle for admission in the DBS was like that of KSC, as can be seen in the below excerpts:

> Hmm Sir, I struggled a lot before coming to this school. When my mother was in Buokrom, she sent me to a lot of schools, and they denied me because of my condition [disability]. The head teacher said my Mum should send me to the rehabilitation school because that place is a boarding school. (ISS2)

Another participant said: “As for this school, the head teacher only asked me if I can walk to school every day, and I said yes I can walk … and he accepted me. There was no admission criteria to follow (ISS3). Other participants added: “I struggled a lot before gaining admission. I will go to this school and the head teacher will say no. I will go to another school and the environment is bad” (ISFGP2). “I also went through the same struggle because of the unfriendly environment of the schools we visited” (ISFGP4).

Children with MI who went to DBS were not subjected to physical health assessment, but the head teacher decided whether to accept or refuse their admission to the school.

> Well, as for physical disabilities, because we can see the disability, we don't restrict them by taking them through any physical assessment. Parents bring them and we give admissions, but we refer those who could not walk at all to the rehabilitation schools because there are boarding facilities to keep them in school. (ISHT2)

Participants in DBS were surprised when they heard from head teachers telling parents to send children with MI to the rehabilitation school. Participants were surprised because DBS is an inclusive school that was supposed to admit children with disabilities. Participants may feel that head teachers used their own discretion for admission because there were no laid down admission criteria from the Ghana Education Service to control admission of children with disabilities. The quote from ISHT2 suggests that head teachers see physical disabilities differently in the schools. This is so because head teachers were able to discern the physical, disabling condition of children who were accepted for admission, whilst others were rejected or referred to the other educational settings.

After parents gained admission for their children with MI there was a struggle in the schools because of barriers that made the schools uncomfortable as will be discussed in the next section.

5.5.2 Barriers in schools

This section focuses on social and structural barriers experienced in KSC and DBS. Social barriers in this context refer to the negative attitudes like stereotypes and prejudices which are created by the culture of societies and the behaviour of people towards persons with disabilities.

The structural barriers refer to physical obstacles (for example, poor school layout and inadequate toilet facilities) that impede the activities of children and youth with MI.

5.5.2.1 Social barriers

Under social barriers, mockery and teasing of and youth and children with MI were mentioned both within the community and in the school. In KSC, participants narrated: “Some of the students in other class always mock me. Sometimes they imitate the way I walk and laugh at me” (MSS1), “I don’t like the way they tease me. I don’t become happy when they tease and mock me” (MSS2). Another participant said:

> But when I got sick up to this time they don’t come to me again. Some think that when they come to me I will transfer my sickness [disability] to them … in the school too some of the students are afraid to come near me. They laugh at me and gossip about me. I wish they will come to me like it was before. (MSS3)

Mockery and teasing as barriers could prevent children with MI from going to school as they feel uncomfortable in the schools. Children with MI also talked about the attitudes of some of their teachers:

> Some of the teachers, particularly two of them, usually show negative attitudes towards me and my fellow disabled peers which has affected a lot of disabled students. These teachers always presume that we are incapable, of low intelligence, and they think we are of no value in the school. (MSS1)

Another participant said:

> I am always not happy about the teachers in this school because they always make fun of me and instruct me to pick litters of rubbish with my crutches claiming I am dirty. Some

> of the teachers told me that I don't belong here in this school. They said I must go to the rehabilitation school. (MSS1)

The above quotes illustrate that children and youth with MI felt rejected by some of the teachers at their school who made a mockery of them and as such they experienced the school as an unpleasant place. School is meant to be place where teachers are welcoming of all children, but this was not the case for these children and youth with MI. Furthermore, children with MI believed that teachers see them as useless and incapable of doing anything in the school. This was seen in the quotes above where teachers were referring to children and youth with MI as being of low intelligence, valueless and using derogatory expressions like "you don't belong here in this school" (MSS1). Children with MI may feel as though they want to stop school because they do not "feel at home" when they are in school. They see the school as not welcoming (that is, children with MI see themselves as not part of the school).

Name calling, mockery and teasing were also noted in DBS. The quotes below illustrate the experiences of children and youth with MI in the school.

"… they mocked me and called me "abafan" [a person who crawls or a cripple]" (ISS1). Elsewhere in her interview she said: "Things that disturb me from learning is the teasing and the mockery from some of the students" (ISS1). Another student said: "They call me names like cripple, meanwhile I am not a cripple …They call my mum 'abafan maame' [cripple's mother], which is not fair" (ISS2).

Children with MI sometimes have tears streaming down their faces when they were being mocked. This means that children see the tone of the school as being very harsh and unconducive for learning. For example, one said:

> I was always feeling bad because my friends sometimes laugh at me. It was like they used to make fun of me or see me as different. I become sad but I will control myself. Sometimes I am not able to control myself and cry. (ISS3)

Children with MI were not only nicknamed, but their parents were also given names. This made children with MI uncomfortable both at home and in the school. One said: “People called my mum names like “yalefo maame” [the sick person’s mother]. I feel bad because my mum has a name and should be called by her name” (ISS1).

Expressions of feelings of pity for children and youth with MI can also be seen as a social barrier in that children and youth with MI saw themselves as not being part of the school community. For example, one participant said: “They [peers and teachers] always feel pity for me which I don’t like at all, does it mean that am I not part of them?” (ISS1).

Exclusion from school activities like sports was also a great concern for children and youth with MI. This was a concern because DBS is an inclusive school where all children are supposed to get involved in all school activities. However, this was not always the case. Children and youth with MI felt rejected, isolated and ignored in the school. This could mean that children with MI have little opportunities to interact with children and youth without disabilities or to experience many of the social, educational and recreational activities that are critical to child development. This is confirmed in the quotes below:

> The school teachers have bad attitudes towards us. They do not involve us in any school activities like football or games ... I am not happy because, I feel uncomfortable. It’s like, they always ignore us. I wish they will allow us to do anything we want to do just like our friends [non-disabled peers]. (ISS3)

"We are not allowed to do sports, only those who are not sick [non-disabled] do the sports… sometimes I cry because I want to also play the game" (ISS3).

"They should allow us to do everything that they do in the school so that we will not feel ignored and bored" (ISS1).

"… I sometimes forced myself to play volleyball with my classmates and somebody will go and tell our mistress [head teacher] and she will come and sack me from the game" (ISS4).

Children and youth with MI felt isolated and ignored because they were not allowed to play games with their non-disabled friends. Children with MI attributed their isolation from sports and games to bad attitudes of teachers towards children with disabilities. The teachers' attitudes and bad teacher-student-relationships become a great challenge as some of the children and youth with MI were not happy about their teachers' behaviour towards children with disabilities, generally. This negative attitude of teachers is also reflected in the communities where the children live. In the focus group discussion, it came out that name calling in the communities was not uncommon. Parents received complaints from their children about how their non-disabled peers sometimes teased them. For example, a parent said: "Even in this community people call me names that I don't like and in the school my daughter complains about some of the students teasing her both in the school and within the community" (ISFGP4). Children and youth with MI did not only experience social barriers but they went through structural barriers as discussed below.

5.5.2.2 Structural barriers

The structural barriers that were most worrisome were inadequate toilet facilities, poor school layout, inaccessible school buildings and overcrowding in classrooms. In most respects, inclusive education in Oti region is just a name. This is because there is no clear difference between an inclusive school and a mainstream school with regards to the provision of school layout and facilities. Below is a discussion of what pertained in the mainstream and inclusive schools. Starting with KSC, participants mentioned the following: “In this school, we don’t have where we urinate, and the toilet is not good. When I go to toilet I suffer too much because I cannot squat on the hole” (MSS2); “Things that disturb me are things like toilet and urinal they are not good especially when you are using a wheelchair” (MSS3); “Any time I feel like going to toilet, I panic because we don’t have a better place. I will have to keep it until I get to the house” (MSS5).

Not being able to use the toilet facilities not only has severe implications for the children’s health, but it also means that the children were ostracized and ignored in terms of basic necessities in the school. The head teacher, confirming the unavailability of toilet facilities as a barrier, said:

> Well, we don’t have proper toilet facilities for children with moving difficulties especially those using wheelchairs. This has been a burden on me but I don’t have the means to put up water closet where these children could sit on when they want to go to toilet. We also don’t have enough classrooms. You can see how crowded the children are in the class. (MSHT1)

Probing further to know how many students were in a class, she said: “averagely, I have about 80 to 96 children in one class” (MSHT1).

Figure 5 KSC showing over-crowded classroom

Apart from the general school layout, the school building itself is a barrier, especially the buildings with multiple floors that did not have lifts and ramps. Children and youth with MI had no option other than to climb the stairs. A participant said: “It has not been easy for me at all, always climbing these stairs with my crutches” (MSS1).

Figure 6 A staircase leading to the classrooms on the top floor in the KSC

In line with climbing stairs to the upper floor, a participant added: "… Sometimes too I have to climb the stairs especially when I am going to pay fees at the accounts office and that is also a problem I face here" (MSS4).

Furthermore, parents showed dissatisfaction about some of the steps leading to the classrooms. For example, one said: "The steps to some of the classrooms are a major issue in the school, as the children always suffer to get to their classroom" (MSFGP3).

Figure 7 A staircase leading to a classroom in Kamame School Complex

Discussions about the school's layout revealed difficulties when children with MI moved around the campus. For example, one participant said:

> I find it difficult walking freely on the campus because of the poor nature of the ground. The ground is not levelled so when I walk with my crutches I find it difficult because some places are higher and some are lower so if you are not careful you will fall down. (MSS4)

Children and youth with MI were hard pressed as they could not move freely on the school compound. This means that children with MI may have to remain in their classrooms during break periods. Below is a story about DBS with regards to structural barriers.

As seen in KSC above, participants in DBS showed a great concern about the school layout. Children and youth with MI were always uncomfortable in school. They were always in pain whenever they arrived at the school. This is so because children and youth with MI sometimes fall down when they move around the school campus. Below are some quotes explaining the predicaments of children and youth with MI:

“You can look at the school compound, full of stones and gravel. One day, I hit a stone with my leg and fell down” (ISS1).

“The compound here is not flat. I struggled moving about, especially when it rains…” (ISS4).

Parents also added their voices about the school layout:

“The layout of the school is bad as you can see erosion all over the campus. My child is here because I don’t have any alternative” (ISFGP4).

“The school environment does not permit one to even send his disabled child to the school-this is why some parents decide not send their disabled children to school” (ISFGP2).

Figure 8 The compound of DBS showing pathways eroded by water

Another barrier expressed by participants at DBS is the distances children and youth with MI had to cover daily before they can get to school. The narratives below show the plight of children with MI: “My other problem is the distance from home to the school. I get tired before getting to the school” (ISS3); “I was not able to go to school always because the school is far from the house” (ISS5).

Parents threw more light on distances their children with MI have to travel daily to school. For example, one said: “Walking from home to the school is very difficult. My child always struggles before he gets to school. In the school, there are no ramps, no pipe born water, no toilet or urinal” (ISFGP5).

When children and youth with MI struggle their way from the house to the school, there are little or no educational support systems in the school to make their schooling easier or convenient. A discussion about educational support systems now follows.

5.5.3 Educational support services and systems

Educational support system is a network of all resources that are taken together to improve teaching and learning (Mariga et al., 2014). Educational support services and systems will be discussed under the following sub-themes: material resources and human resources and educational support teams. Whilst material resources refer to physical material resources that make teaching and learning more meaningful, human resources and educational support teams are about teachers, networks of people and other measures put in place to make teaching and learning more accessible to children and youth with MI (Mariga et al., 2014).

5.5.3.1 Material resources

Children and youth with MI did not see any material resources made available to aid their learning. They felt very frustrated and confused about the situation. In KSC and DBS, most participants experienced a sense of helplessness, sadness and disappointment as they could not see any material resources to enhance their learning. The following quotes were obtained from KSC:

> Hmmm, Sir, I don't see any support service like learning materials in the school … I feel bad, this means that if your parents don't have money to buy things for you, you can't do anything in the school. We are not valued as disabled and we are not supported. (MSS3)
>
> In the focus group, parents shared the following: "No there is nothing like that in the school. We buy everything that the child needs in the school. It means that if a parent does not have money, the child will suffer to learn" (MSFGP2); "Any time I visited the school, I do not see any support service or materials" (MSFGP3) and "There are no support services in the school. We are always levied to pay for any material the child needs in the school" (MSFGP5).

Similar information was gathered in DBS as follows: "I have not seen any support services or materials. We don't grasp what we are learning because it is very difficult as we do only theory and theory, no practical. Our parents will have to buy everything that we need for our studies" (ISS1) and "We don't have any support services here in the school … I feel bad. We don't have computer lab, we don't have library" (ISS4).

The schools did not only lack material resources. Teachers, who are supposed to be the basic human resource, were very few in the schools, as will be seen in the following section.

5.5.3.2 Human resources and educational support teams

Discussions about the human resources in the school with the head teacher of KSC revealed:

> We don't have special education teachers, not even one. Well, as you know, in Ghana, one or two special education teachers are placed in the education offices to take care of all disabled children in the Metropolis. My teachers were not trained for children with disabilities but we are trying (MSHT1); "We don't have any special support services or

> support teams… we sometimes levy the children as Parent-Teacher-Association (PTA) dues. These are the money we used to run the school" (MSHT1) and "To be frank with you, we don't have anything like school support team or district support team or any system to assist us in this school" (ISHT2).

Also, in DBS the following was gathered from the head teacher:

> Well, we have trained teachers, but do not have the special education teachers who are trained to teach children with disabilities. That is to say all our teachers are the ordinary trained teachers. Out of 18 teachers, only one is trained for special children like those with different disabilities. (ISHT2)

Quotes from the two schools showed that special education teachers who are trained specifically to work with children and youth with disabilities were absent in the schools. Inadequate supply of such teachers and the absence of educational support teams in these schools made children and youth with MI see themselves as not being part of the school community. Students, teachers and parents support teams (educational support teams) may bring comfort to children and youth with MI and may feel belonging to the school community.

5.6 Chapter summary

This chapter focused on the educational experiences of children and youth with MI in Kamame School Complex and Dabokpa Basic School. The chapter explored stories about the onset of disabilities and how this impacted on the education of children with MI in the two schools. For some participants, measures to cure the disability were the priority before the education of such children. This action taken by participants delayed the education of children and youth with MI.

Educational experiences of children with MI were characterised by a struggle for school admission, the poor nature of the school layout, mockery and teasing among others. These educational experiences made children with MI feel that they were not part of the school. This chapter also showed that there was an inadequate supply of teachers and an unavailability of educational support systems like student support teams, teacher support teams and education support teams in the two schools. The chapter portrayed that, even though children and youth with MI were in the mainstream and inclusive schools, they did not feel part of the school community.

CHAPTER SIX: ANALYSIS OF FINDINGS

6.1 Introduction: Akokor Rehabilitation School and Ohiamankyene Special School

In this chapter, findings from the rehabilitation school [Akokor Rehabilitation School (ARS)] and the special school [Ohiamankyene Special School (OSS)] are presented. As noted in Chapter 5, a researcher may identify merged units of case studies (Merriam & Grenier, 2019) such as the different types of school settings. In this study, I identified these two schools as two separate cases which will be merged in one chapter. The reason for presenting these two schools in one chapter is because they have similar characteristics and the responses are closely related, even though data was obtained from different participants and from different school settings as noted in Chapter Five. Additionally, both schools do not follow the general curriculum that is used in the mainstream schools (Field note; June, 2018). In addition, ARS and OSS have boarding facilities that house the children and youth with MI in the schools. Presenting cases from both schools in one chapter will enhance cross cases analysis with ease (Yazan, 2015). Here again, as noted in Chapter 5, discussions about observations and responses from participants in the schools can be simplified and are better understood when compared to a situation where the findings are presented separately.

This chapter provides a brief description of each school in its context, followed by the similarities and differences between the two schools. After that, a tabular presentation of the demographics of participants, and a figure showing themes, sub-themes and categories that emerged from the data are presented. Then, analysis and discussions on findings from the interviews and the researcher’s field notes are presented.

6.2 Description of the schools in context

The special and rehabilitation schools were selected because I am interested in the phenomenon of children and youth with MI, which is an important area of inquiry but has very little literature (Auberon & Odoom, 2016). As discussed in Chapter 2, rehabilitation and special schools were established to provide a good education for children and youth with disabilities, considering their educational rights. The findings of this study suggest that children with disabilities in these schools were ignored and excluded from the mainstream society without any care and are failing to receive quality education. According to the findings, children and youth with MI and their parents are often uncertain about an educational setting that will serve the needs of children and youth with MI. Below is a description of these two schools, beginning with ARS.

6.2.1 Akokor Rehabilitation School

As discussed in Chapter 2, ARS was established in 1958, located in the heart of the city of Kumasi. In 1974, the City Council changed the location of ARS to its present location. The school runs courses like carpentry, electronics, woodcarving, soap-making and agriculture. The motivation behind the establishment of ARS was to make children and youth with disabilities more independent and to give them employable skills. The students are children and youth with a range of disabilities. Examples of such disabilities are mobility impairments, hearing and speech disorders, as well as visual impairments (Field notes; June, 2018). It is not clear why some children and youth with disabilities are in specific special schools that use the general basic school curricula whilst others are in other special schools that do not follow the general basic school curricula.

Due to inadequate funding, the courses offered in the ARS were revised to include: needlework, dressmaking, tailoring, shoemaking, hairdressing and beautification and rural craft courses for over 130 male and female students who live in the centre. The revision of the courses was to pave the way for the use of locally made materials which may not require huge amounts of funding for teaching and learning activities. However, parents of children with MI were made to pay for everything the child may need, including teaching and learning materials, a theme which will be explored in more depth later (Field notes; June, 2018).

The school has 16 teaching staff and seven non-teaching staff. It is worth noting that out of the 16-teaching staff none of them are specially trained to teach children and youth with disabilities (special education teachers). ARS is managed by a centre manager and a head teacher. One challenge of the school was that the school was not fenced and hence part of the land was taken by the surrounding community members (Field notes; June, 2018).

6.2.2 Ohiamankyene Special School

OSS was established in the year 2005 with 15 students. It has a current student population of 135, with 15 teaching staff and six non-teaching staff. Out of the 15-teaching staff, five were trained as special education teachers. The school is a boarding institution located on the outskirts of the urban city of Ashanti Region of Ghana. As an urban special school, students come from all over the country. The school admits children with a range of disabilities like cerebral palsy, speech disorders, mobility impairments and intellectual disabilities. As discussed in Chapter 2, the school has no specific number of years for students who are enrolled to graduate hence children and youth with MI feel very bored in the class as they perform the same activity every day (Field notes; June, 2018). Children and youth with MI could stay in the school for 20 years depending on their preference and that of their parents. For example, children with MI remain in the same class for the same programme for the number of years they spend in the school. Programmes in the school include: bead making, candle making, batik tie and dye and vegetable production (Field notes; June, 2018).

Similarities and differences between the schools

ARS and OSS are both boarding institutions located in the urban cities of Ashanti and Oti regions of Ghana. Students in these two schools do not progress from one class level to another. Children and youth with MI are placed in the same class for the number of years that they will spend in the school. There is no stipulated number of years a student could stay in the school, and there is no graduation as is practised in the ARS and OSS (Field notes; June, 2018).

Their differences, however, were as follows: whereas ARS is being managed by the Social Welfare Department of Ghana, OSS is under the auspices of the Ghana Education Service. The differences in management between ARS and OSS is based on political structures of institutions in Ghana (Republic of Ghana, 1996). Whilst ARS had no special education teachers, OSS had five special educators (Field notes; June, 2018). Tables 8 and 9 below provide information about the demographic data of participants in both ARS and OSS.

6.3 Demographic data of participants

Tables 8 and 9 below are sub-divided into sections: The first section shows information on children and youth with MI, the second section shows information on the head teacher (HT), whilst the third section shows information about the parents of children and youth with MI.

Table 8 Ohiamankyene Special School

<table>
<tr><td colspan="6">Children and Youth with Mobility Impairment</td></tr>
<tr><th>Name Code</th><th>Gender</th><th>Age</th><th>Class (Course)</th><th colspan="2">Assistive Device Used</th></tr>
<tr><td>SSS1</td><td>Female</td><td>23</td><td>Bead making</td><td colspan="2">Wheelchair</td></tr>
<tr><td>SSS2</td><td>Male</td><td>23</td><td>Soap making</td><td colspan="2">Wheelchair</td></tr>
<tr><td>SSS3</td><td>Female</td><td>17</td><td>Batik tie and dye</td><td colspan="2">Crutches</td></tr>
<tr><td>SSS4</td><td>Female</td><td>19</td><td>Batik tie and dye</td><td colspan="2">Wheelchair</td></tr>
<tr><td>SSS5</td><td>Male</td><td>23</td><td>Soap making</td><td colspan="2">Callipers</td></tr>
<tr><td colspan="6">Head Teacher</td></tr>
<tr><th>Name Code</th><th>Gender</th><th>Age</th><th>Marital Status</th><th colspan="2">Years of Experience</th></tr>
<tr><td>SSHT3</td><td>Female</td><td>39</td><td>Married</td><td colspan="2">8</td></tr>
<tr><td colspan="6">Parents of Children and Youth with Mobility Impairment</td></tr>
<tr><th>Name Code</th><th>Gender</th><th>Age</th><th>Marital Status</th><th>Occupation</th><th>Age of Child</th></tr>
<tr><td>SSFGP1</td><td>Male</td><td>45</td><td>Single</td><td>Not working</td><td>20</td></tr>
<tr><td>SSFGP2</td><td>Female</td><td>40</td><td>Married</td><td>Table Store</td><td>16</td></tr>
<tr><td>SSFGP3</td><td>Female</td><td>38</td><td>Married</td><td>Trader</td><td>13</td></tr>
<tr><td>SSFGP4</td><td>Male</td><td>39</td><td>Single</td><td>Farmer</td><td>17</td></tr>
<tr><td>SSFGP5</td><td>Female</td><td>35</td><td>Single</td><td>Not Working</td><td>13</td></tr>
</table>

Table 9 Akokor Rehabilitation School

Children and Youth with Mobility Impairment					
Name Code	**Gender**	**Age**	**Class (Course)**	**Assistive Device Used**	
RSS1	Male	16	Shoe making	Wheelchair	
RSS2	Female	22	Beads and needlework	Wheelchair	
RSS3	Female	23	Hair dressing	Crutches	
RSS4	Male	24	Shoe making	Wheelchair	
RSS5	Male	23	Shoe making	- (limping)	
Head Teacher					
Name Code	**Gender**	**Age**	**Marital Status**	**Years of Experience**	
RSHT4	Male	52	Married	9	
Parents of Children and Youth with Mobility Impairment					
Name Code	**Gender**	**Age**	**Marital Status**	**Occupation**	**Age of Child**
RSFGP1	Female	52	Single	Trading	24
RSFGP2	Male	49	Married	Farming	22
RSFGP3	Female	46	Single	Bread Seller	18
RSFGP4	Male	55	Married	Not Working	20
RSFGP5	Female	38	Single	Trader	16

6.4 Analysis of findings

The data were grouped into one major theme analysed across the rehabilitation and the special schools. The theme was derived from data obtained across the three sources, namely; a) children and youth with MI, b) head teachers and c) parents of children with MI (see Chapter 4). The data were supplemented by the researcher’s field notes and observations and documentary analysis. Findings are presented and are supported by verbatim quotations from the transcribed interview data (Denzin & Lincoln, 2018). Figure 9 below presents a framework of the main themes, the sub-themes and the related categories of data from children and youth with MI, head teachers, parents of children and youth with MI, and the researcher's field notes from both schools.

The analysis of findings is thematic, where common quotes are grouped as codes. The codes are then grouped into categories. The categories were regrouped into sub-themes and, finally, the sub-themes were regrouped to form the main theme. In each category, interpretations were given, starting from findings in ARS, and then followed with the findings from OSS. This format was followed under each sub-theme and supported with categories and verbatim quotations from the participants.

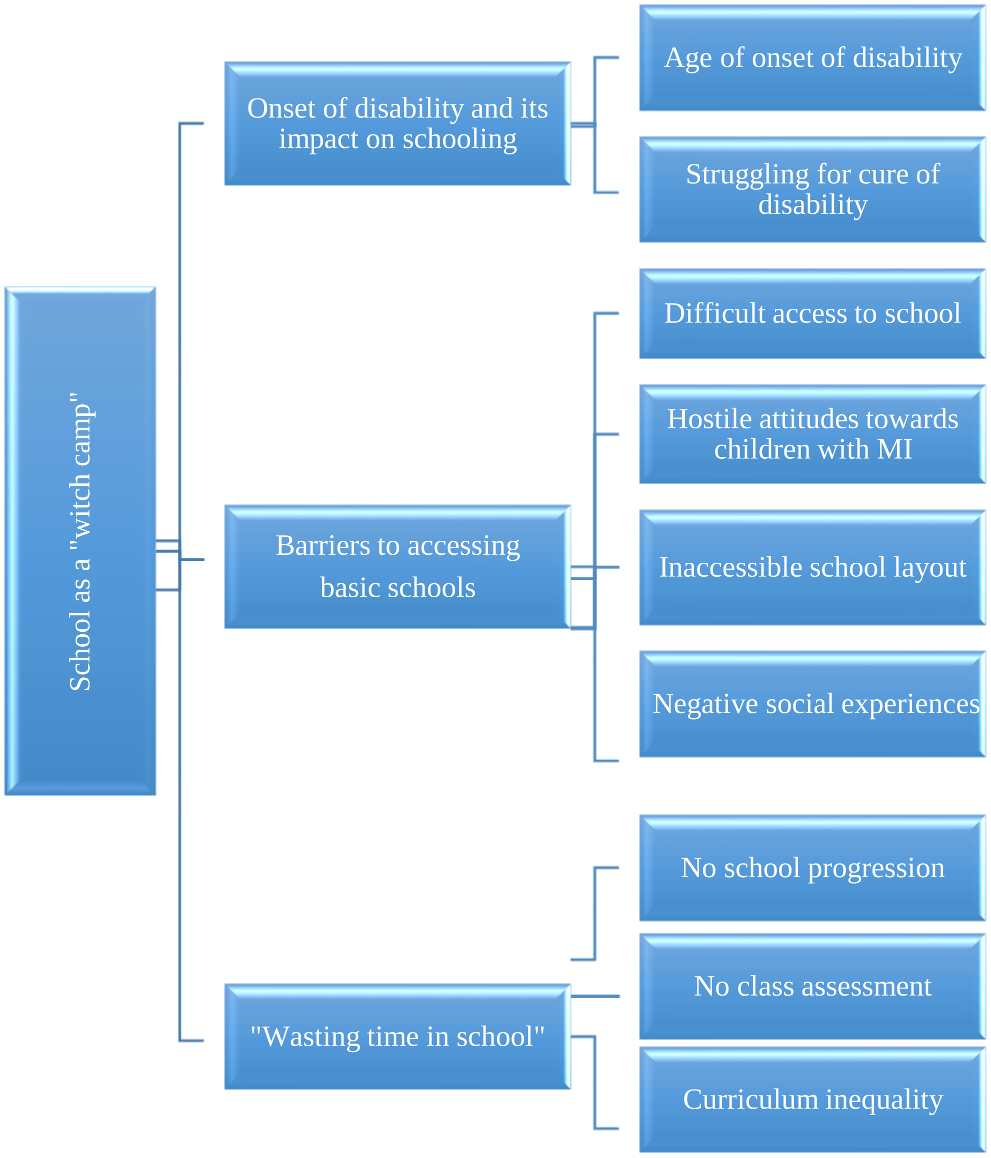

Figure 9 Theme, sub-themes and categories

6.5 School as a "witch camp" for children with mobility impairments

The Collins English Dictionary (2012) defines a "witch" as a woman who professes to practice evil or possess wicked, magical powers. In Northern Ghana, some women are alleged to have such wicked, magical powers. Such alleged women are segregated from their communities and are confined to a camp called a "witch camp". A witch camp in Ghana is a settlement where women suspected to possess evil powers flee for safety. Currently, Ghana has six of such settlements that housed at least 1000 women (Epure, 2016; Muntaru, 2018). The majority of these women are either divorcees or widows who are accused of witchcraft by their own family members, village chiefs and other opinion leaders in the communities (Epure, 2016; Muntaru, 2018). The women are left with no other option for shelter and protection rather than to flee to these settlements. Not only were they left in the these settlements, but they were taken through a process of exorcism by shrine or priest before they were admitted to the camps (Epure, 2016; Munaru, 2018).

I adopted the broad theme "school as a witch camp" for children and youth with MI which emerged from the data obtained from the ARS and OSS. The schools were viewed as witch camps because of the following reasons:

a. Witch camps in Ghana are seen as places where women accused of witch craft seek refuge after escaping from stigma, beating, torture and lynching to live a life in exile (Musah, 2013).
b. Witch camps are places where people who are unwanted and ostracized from their families are left to fend for themselves until the family needs them back (Musah, 2013).
c. Witch camps are also places where women who are suspected to be witches are expelled or banished from their homes to live in segregated camps in the northern part of Ghana (Epure, 2016).

In Ghana, as in other parts of the world, there is a reason for anything that happens (Epure, 2016). For example, in the Northern Ghana, every unpleasant occurrence (e.g. disability, misfortune, death, disease, low crop yield, loss of livestock, bareness, etc.) is attributed to witchcraft. As a result, people, especially women, are accused of such unpleasant occurrences in the family. They are believed to possess evil spirits. These women are isolated from their community and are confined in a witch camp (Epure, 2016; Musah, 2013). These actions of isolating the alleged women (witches) are influenced by the culture and negative belief (Avoke, 2002; Reynolds, 2010). In this study, the focus is on the negative attitudes towards children and youth with MI.

Just like the witches in the witch camp, findings from this study showed that children and youth with MI were segregated, expelled and detached from their families and the community in general. The situation found in the ARS and OSS is likened to a witch camp because the onset of disability in a child, in a Ghanaian context, was seen as a burden where the parents suffer stigma and may like such children to be out of the community (Reynolds, 2010). This stigma brings shame to the family and further results in the denial of educational rights to children and youth with disabilities in general (Avoke, 2002). Apart from the stigma and discrimination faced by children and youth with MI and their parents in the communities, they suffer the same in the mainstream schools. There were instances where parents wanted to send their children with MI to school, but head teachers in the mainstream schools refused to accept them. Children with MI and their parents had no option but to go to the rehabilitation and the special schools. In these two schools, barriers ranging from inaccessible nature of the school and the negative attitudes towards these children with disabilities were observed and recorded in the researcher's journal as children being banished from the mainstream school system and the community as a whole. Details about the experiences of children and youth with MI in the ARS and the OSS will be discussed in the next section.

6.5.1 Onset of disability and its impact on schooling

As was the case with children and youth with MI in the KSC and the DBS, the onset of disability in the lives of children and youth with MI in the ARS and OSS played an important role in parents selecting an educational setting for their children and youth with MI. It was found in this study that the onset of a person's disability has a direct impact on when to start school, and where to have his or her education. The findings about the age of onset of disability and its influence on starting school or stopping school when the disability occurs during the child's schooling period are discussed below.

6.5.1.1 Age of onset of disability

The findings uncovered that age of onset of disability in children determines how long they stay at home before going to school. Where disability occurs at birth or in the early lifetime of the child, parents feel uncomfortable to send children with MI to school early. This may be so because parents felt that their children will be bullied in the school. The Ghanaian basic educational system recommends the age of starting school as six years (Botts & Owusu, 2013; Ministry of Education, 2015a); however, parents would allow their children and youth with MI to stay at home for as long as 12 years.

Delay in starting school

Children whose disabilities started very early in life or from birth (congenital) stayed at home for a longer period of time before they started school than those whose disability started at a later time in their life (acquired). The following quote in ARS illustrates this delay in starting school: “My disability started when I was born and I stayed home until I was 13 years before I went to school” (RSS5). A parent also said:

> My daughter grew to three years before her disability started. It was as a result of convulsion. Because of her condition, she stayed in the house until she was 12 years before she started school. (RSFGP5)

Another parent said:

> My child’s disability was from birth. She couldn’t sit when it was time for her to sit. I sent her to several hospitals, but the situation could not be solved. I sent her to the rehabilitation school when she was 15 years. (RSFGP3)

The above quotes illustrate that children and youth with MI were excluded from schooling up until their teenage years. The inability of children with MI to start school early could partly be because the parents could not get any professional advice from health workers about the education of their children with disabilities. The burden of raising a child with disabilities was solely on the parents, as they moved from hospital to hospital ignoring the early education for children with MI.

Similarly, in OSS most children whose disabilities began in their early life or at birth stayed at home for a longer period of time before they started school. For example, one participant said: “At eight years, I used to crawl on the floor like that at home without going to school until I was 12 years. I was not going out to anywhere because of my disability” (SSS1). This quotation may mean that the dignity of SSS1 was not respected and her right to education was overlooked. Another child thought that his parents delayed his education because of bullying and unfair treatment in the school. He said:

> I did not go to school when I was six years because my parents said it was too early for me to start school. They were thinking that the other students will bully me. I started coming to this school when I was twelve years. (SSS3)

As discussed in the ARS above, parents in the OSS delayed enrolling their children and youth with MI in school. This delay was because parents viewed children and youth with MI as vulnerable as they moved from place to place. For example, a parent said:

> My child's disability started from birth. She was very weak to start school when she was younger. We were so much worried at the beginning, so we tried from place to place ... We finally sent her to school late because of the disability. (SSFGP2)

However, when the onset of disability is at the time when the child is already in school, the parents take their children out of school for a period of time as will be discussed in the next section.

Stopping school

Children and youth with MI were not only delayed in starting their educational trajectories, but some also stopped school completely because the disability started while the child was already in school. Children and youth with MI stayed at home for a period of time before they came back to continue their education. In some cases, the school setting was changed from the mainstream school to the rehabilitation school because of the disability. For instance, in ARS a child with MI said:

> It [disability] started when I was 14 years old and in BS8 [grade 8]. I got some rashes and was taken to a clinic where I was given an injection and since then I am not able to walk, because of this I stopped school for about three years hoping that I could walk again … so I came back to school… no, I came to this rehabilitation school. (RSS3)

Another participant mentioned:

> When I completed primary six (BS6), I stopped schooling… I stopped because there was no Junior High School in that village. I cannot also walk [because of the disability] to the next village where I can attend the school. All my friends who are not disabled walked to that school every day. (RSS5)

This indicates that some children with MI stopped schooling because of the distance from their homes to the location of the mainstream school. Distance to school compelled RSS3 to stop school and finally move from the mainstream school to the rehabilitation school because he could not walk to the nearest village, where there was a mainstream school for grades seven to nine students.

The parents who talked about a similar situation expressed their sentiments about the reason their children with MI had to stop school:

> She grew up to eight years when she was in basic school four [grade 4] where she fell ill …She has to stop school because of her disability. She was in the mainstream school before the illness started. (RSFGP1)

The findings in OSS were not different from that of ARS as will be seen below.

Stopping school impacted greatly on the education of children and youth with MI. This was because children with MI had their disabilities occurring at the time that they were already in school. As a result, children and youth with MI could not keep up with the learning pace of the syllabus that was taught because they stopped school. They feel left behind their classmates. This was found in instances where children and youth with MI had to stop a school because of the disability. For example, one said: “I stopped school and stayed home for about three years before coming to school again” (SSS1). Another said: “I was in the other [mainstream] school when my disability started. Yes, I stopped school for two years. I should be in the SHS [Senior High School] by now (feel left behind)" (SSS3).

Parents felt their children with MI could no longer fit into the mainstream school and would need time to look for alternative basic school settings. For instance, one said:

> My son was in the JHS [Junior High School] when the sickness [disability] started, so I had to let him stay home for him to get well. You know, he cannot go back to the mainstream school I need to get a better school for him … (SSFGP4)

6.5.1.2 Struggling to find a cure for disability

The findings of this study indicate that the parents' struggle to find a cure for the disability made them stop their children with MI from attending school. Parents were worried and moved from one hospital to another with no professional advice either from the education officials or from the health professionals. Parents neglected the education of children and youth with MI and felt that the disabling condition of their children should be first solved before embarking on their education. One parent narrated:

> My child's disability was from birth. She couldn't sit when it was time for her to sit. As a mother, I must make sure that she is healed. I sent her to several hospitals, but the situation could not be solved. (RSFGP3)

Another parent said: "… you know, when you have a child with disability, you will move from hospital to hospital, sometimes to prayer camps for healing before you can think about the school" (RSFGP5). The story is not different in OSS. For example, one parent said:

> My child’s disability started from birth. We were so much worried at the beginning, so we tried from place to place, hospital to hospital, struggling to get him cured. But we could not succeed. We were made to understand that the disability cannot be cured. (SSFGP2)

Despite the struggle of parents looking for a solution for their children’s disability, the children were still eventually sent to school. However, the children experienced numerous challenges at school, both in terms of admission and access.

6.6. Barriers to accessing basic schools

Findings revealed that children and youth with MI went through several hurdles in their attempts to access quality education. These included: difficult access to schools, hostile attitudes towards children with disabilities both at home and at school, inaccessible school layout, unavailability of qualified teachers and educational support systems, and negative social experiences.

6.6.1 Difficult access to schools

Restrictive admission criteria: The educational setting in which a child with MI can be educated is the parents’ choice (Ministry of Education, 2015a). Under the best circumstances, a school setting which is considered to be appropriate to the student's abilities and needs can be agreed upon by both parents and school authorities. However, there are many instances where this issue creates conflict between parents and the head teachers of the school. In particular, the stress and struggles that parents and children with MI go through in order to gain access to the preferred school setting was noted in the study. One such obstacle is the restrictive admission criteria, for example, the financial obligations imposed on parents to buy items such as beds, mattresses and school uniform. Supporting this argument, a parent narrated: “I was asked to bring a medical report, buy a bed, mattress, school uniform, soap, toiletries and materials that she will use in class”

(RSFGP1). Purchasing these school items was a condition before admission was granted. As a result, parents who had no money to buy these school items had no option other than to allow their children with MI to stay at home for some years before their children could gain access to the school. A participant said: “Because of buying the items, my son had to stay home for two more years before I was able to buy the admission requirements and the child started the school” (RSFGP4). This means that the burden on parents in acquiring admission materials could also delay schooling of children and youth with MI.

Apart from parents buying admission materials, another challenge was the denial of admission to children with MI. A child explained:

> Hmm Sir, I struggled a lot before coming to this school. Head teachers were not ready to accept me in the school. When my mother was in Buokrom, she sent me to a lot of schools, and they denied me because of my condition [disability]. The head teacher said my Mum should send me to the rehabilitation school [the current school] because that place is a boarding school. (RSS5)

Additionally, the quote from RSS5 above affirms that head teachers in the mainstream schools were not prepared to admit children with MI (see Chapter 5). This explains the reason RSS5 is found in this ARS.

In OSS, restrictions on gaining admission for children and youth with MI became obstacles as parents were compelled to move from school to school. One parent narrated:

> I struggled a lot before gaining admission. I will go to this school and the head teacher will say no because that school is not a school for the disabled. I will go to another school and the environment is bad. (SSFGP2)

Another parent said:

> The school conducted physical examination on my son and referred me to the mainstream school. But when I sent him to the mainstream school, the head teacher also asked me to re-send my child to either rehabilitation or a special school. So, I brought him back to the special school again. (SSFGP4)

When children and youth with MI finally gained admission to the rehabilitation and special schools as recommended by the head teachers of the mainstream schools, children and youth with MI faced hostile attitudes towards them as is discussed in the following section.

6.6.2 Hostile attitudes towards children with mobility impairments

The findings revealed hostile attitudes towards children and youth with MI. This was reported to be common in both the homes and at schools. Such hostile attitudes included humiliation and verbal abuse.

Humiliation and verbal abuse: Humiliation and verbal abuse have serious effects on the emotional health of all children, including children and youth with MI. In this study, children and youth with MI reported feeling ignored and intimidated. For example, in ARS, a student said:

> One of the challenges I face in the school and the community is telling me things I don't like. Also, stigmatization, especially from the community people. Most people do not want to come close or sit near me they called me names. (RSS1)

Another student, narrating the story behind his name "wane bini korkor" which literally means 'you have produced red faeces', said:

> I had some stomach troubles and because of my disability I was not able to go to where I could go to the toilet and before they could assist me I had already soiled myself, and my friends around that place started calling me ‘wane bini korkor’ [you have produced red faeces] this name followed me to this school, I don’t like it. (RSS4)

Parents raised a concern about bad attitudes of some of the teachers towards children and youth with MI. For example, one said*:* “My daughter said the teachers always insult them. She also said some of the teachers are not friendly. Teachers always forced them to sweep and collect rubbish in the school …” (RSFGP1). This humiliation, teasing and verbal abuse can contribute to children and youth with MI becoming alienated. The insults as seen in the quote above result in children and youth with MI looking down upon themselves and becoming unhappy at school.

A similar situation was found in OSS. A student explaining what she does not like about the attitudes of some of her friends mentioned:

> I feel very sorry when they tease me. I will weep and weep and weep and sometimes I don’t even continue to where I was going. I will quickly get back to the dormitory. Sometimes, they follow me to the dormitory just to tease me. (SSS4)

In addition to the above, one student narrated how he was humiliated and teased since his childhood. He said:

> Hmmm … I was given a name. When I had not come to this school, I did not have this wheelchair, so I used my hands and knees to walk and the children began to call me by that name. Even in this school they call me that name and will laugh at me and will call me “Kwan bolla bolla” [road rubbish collector]. (SSS4)

6.6.3 Inaccessible school layout

In addition to the hostile attitudes towards children and youth with MI, the inaccessible school infrastructure in terms of the school design was a great challenge for children and youth with mobility impairments, as children and youth could not be freely mobile on the school grounds.

Architectural school design: The architectural design of the school building and the layout in ARS and OSS were major concerns raised by children and youth with MI, the head teachers and the parents. Children and youth with MI found it extremely difficult to move from the dormitories to the classrooms. The quote below showed that children and youth with MI felt that they were not regarded as human beings because of the wheelchair they used to be mobile. For instance, a participant in ARS said: *"I find it difficult to move from the dormitory to the classroom because of the bad nature of the compound. Is it my fault to use a wheelchair or are we also not human beings?"* (RSS2) (see Figure 10). Children with MI found it difficult to move from the dormitory to the classroom because of the nature of the compound and the dormitories. For example, the steps leading to the dormitory meant that children with MI who use wheelchairs would have to get off the wheelchair, bring it over to the other side of the steps, crawl over the steps and then climb on the wheelchair again to continue on his or her journey. During each day, such an experience is repeated about ten times depending on the number of times he or she goes to the dormitory (see Figure 10 below).

Findings about school layout indicated that the compound of the ARS is not cemented and not well laid out. As a result, children and youth with MI found it difficult to move about during break or play time. One participant said*:* "hmmm, the school compound is not cemented and so I find it difficult to even go out for break" (RSS4). Another child said:

> Firstly, we find it very difficult to move around freely on this compound due to the big roots of trees that have come out from the soil. Because, I use a wheelchair and I find it difficult to move comfortably … these roots hinder my movements. (RSS2)

Figure 10 below shows what the layout of the compound of the school looks like.

Figure 10 Akokor Rehabilitation School depicting the poor condition of the compound

Parents revealed that children with MI found it very difficult to get friends to assist them in navigating through the school compound. One narrated:

> My son always needs someone to push him [the wheelchair] before he could move around. He sometimes finds it very difficult to get somebody to assist him. The school layout is not friendly meanwhile it is a rehabilitation school. The tree root on the school compound is too much and does not allow students to move freely. (RSFGP5)

Another parent said: “The nature of the school compound is a great barrier to the students, especially, those students using wheelchairs. The protruding roots of the trees on the compound do not facilitate ease movement” (RSFGP3). Rehabilitation schools were mainly established to take care of the educational needs of children and youth with disabilities, and it is therefore very concerning that the school compound at this particular school is not disability friendly, nor adapted to meet the needs of children with disabilities. It highlights that the education for children and youth with disabilities was not well catered for by the community and the government.

In the OSS, children and youth with MI feel depressed and intimidated because of the inaccessible nature of the school. One student narrated: “you see that the compound is not flat, moving around is very difficult for me. I always fall down when I make a least mistake. Sometimes I cry and asked God why he created us like this” (SSS5). Also, children and youth with MI were very careful when they were in school as they easily fell down because of the nature of the school layout: “Sometimes I will fall down and I will shout for help. The compound is not smooth that is why I sometimes fall dawn” (SSS5).

The quote by SSS5 above might also mean that children and youth with MI see themselves as different from their non-disabled peers. This further shows the frustrations and desperations of children and youth with MI in the special school. The situation is thus similar to witches in a camp who go through the frustration and desperation of being ostracized by the community.

There was also a great struggle for children and youth with MI in the dormitories. A participant, talking about her experiences in the dormitory, said:

> We are too many in the room [dormitory] and the place is very congested. Those of us who use crutches or wheelchairs even suffer most. Because you can’t go inside with the wheelchair so you have to pack it [wheelchair] outside and crawl into the room. Sometimes when I am crawling my legs will pick the mat that was laid and they will insult me. Besides, there is always some bad smell in the room, no fresh air, so breathing is difficult. (SSS2)

The narration from SSS2 above illustrates that there was an absence of freedom, dignity and security for children and youth with MI in the school. The quote also suggests that children with MI are not valued in the school.

A parent, discussing this situation, said: “Well, the school layout is not good. It does not look like a school for persons with disabilities. Access to the school, especially to some of the classrooms is very difficult” (SSFGP5), (see Figure 11). In addition, a head teacher said:

> In my school, we have physical barrier that has to do with the design of the place itself, the architectural design has limitations. It does not conform to the international standards and

> the suitability of the categories of person with disabilities that we have here. So, I will refer to that as the structural or physical barriers…The layout and the structures are not in conformity with the basics of universal design. (SSHT3)

The confirmation by the head teacher in the quote above makes the situation in the school more terrible as these schools are supposed to be the best alternatives for children with disabilities, according to the policies of the Ghana education service and the Ministry of Education (Mantey, 2019). Figure 11 below shows the nature of the layout of OSS.

Figure 11 Ohiamankyene Special School depicting inaccessible nature of the compound

Inaccessible toilets and bathrooms: The inaccessible nature of toilet and bathroom facilities coupled with periodic water shortages made the life of children and youth with MI more unbearable, as is depicted by the following excerpts from ARS:

> We don't have showers in the bathroom. Carrying water to go and bath is a problem. So, I find it difficult to bath. Because the school environment is not good, I can't drive the wheelchair myself. I will have to beg my friends to push me always. (RSS1)

> Things that disturb me are things like toilet and urinal they are not good especially when you are using a wheelchair… We don't have showers so I will always need someone to fetch water for me to bath. I suffer a lot when my friend is not in school. (RSS3)

These kinds of experiences are likely to make the children and youth feel inferior and as though their dignity as students was not respected. Children in OSS shared similar experiences:

> Oh! Hmmm, sir that one is very serious. Most at times I sleep without bathing because I will always need someone to assist me to fetch water for me before I can bath. Anytime TBB [a close friend] travels home I had no one to fetch water for me. As for the toilet I always manage to do it without help. (SSS4)

Another child said: "the toilet and bath in this school are very bad. I always struggle before I am able to bath, especially, when the pipe is off [water is not flowing]" (SSS2).

The head teacher talking about barriers and inadequacy of structural materials and resources, said: "The barriers range from inadequacy of physical structures… What I mean by physical structures is computer labs, good bathrooms, toilet and urinal facilities" (SSHT2).

The above quotes reveal that the situation of children and youth with MI in the school makes them more vulnerable to maltreatment and violation of their educational rights as citizens of Ghana. The quote also suggests that the head teacher is very much aware of the situation in the school but seems to be frustrated and powerless to do anything about resolving the issue.

Children and youth with MI did not only suffer from the lack of toilet facilities and the bad nature of the school layout, but they also suffered when they got to their classrooms because of absence of teaching materials, as discussed below.

Absence of teaching materials and educational support systems: Narratives about teaching materials and educational support systems include: tools and equipment, teaching and learning materials, computer laboratories and other general educational support systems like counselling, child support groups, parent support groups, teacher support teams, district based support teams, physiotherapists and other professional bodies. These resources promote and enhance educational trajectories of children and youth with MI (Singal et al., 2015). Unfortunately, the findings revealed inadequate educational support systems or structures (Field notes; June, 2018). Findings from all participants were similar. For example, in ARS, a child with MI said:

> I am in the shoe making class. We don't have tools and machines for our lessons. More often than not our parents need to procure all the necessary materials and equipment to enable lessons to be undertaken due to the inability of government to provide us the required materials for teaching and learning purposes. (RSS1)

Another participant mentioned: "I don't enjoy lessons and feel bad because my parents are farmers and they mostly find it difficult to buy me the needed materials for beads making purposes" (RSS2). Also, a participant expressed her worry over government officials presenting educational materials to the mainstream schools on national television, whilst they do not receive anything from the government:

> I become more worried if I hear or see government providing buses and educational materials to the mainstream schools. Are we [disabled] separated so that they can take good care of us or they want to reject us from the society? (RSS3)

The above quote suggests that children and youth with MI feel they are seen as less important and are discriminated against just like the witches in the camp. It highlights that the promotion and development of children's personality, talent and physical abilities were ignored. Not only were the rights of children ignored, but children and youth with MI were abused. For example, a student revealed that the teachers take them to the street especially during Christmas to solicit money. He said: "the teachers sometimes take us to the street to march, then people will give us money and food stuffs before we can have something to eat in the school" (RSS3).

Parents added their voices to the unavailability of support systems. One said:

> The school does not have any support systems or resources for teaching and learning. The aim of the rehabilitation school is to train children with disabilities to have skills that will support them to earn a living, but when you go to the school, you will not see anything that can prepare these children for life, this is sad. (RSFGP2)

Head teachers were confused and worried about issues around educational support services. They sometimes had no option other than to ask parents to contribute some money to enable them to buy basic resource materials for teaching and learning. For example, the head teacher said: "the pre-requisite tools and equipment that are supposed to be available are also not available … We always levy parents to pay for anything the child needs in the school, especially, for teaching and learning" (RSHT4). He also described the unavailability of qualified teachers in the school as an academic barrier:

> I will say we have academic barrier. To me I classify that as academic barrier because the staffs who are supposed to give training to these children should have certain specified training to be able to give effective training to the children with disabilities who find themselves here but that are not the reality on the ground. Some of the staff who are here do not have the requisite training and for that matter it affects the academic [education of children and youth with MI]. (RSHT4)

There was also a concern about the unavailability of financial resources. The head teacher narrated:

> Then there is the overall constraints which has to do with finances for these mentioned resources to be available, then there should be money available for the acquisition of these materials and once there is financial constraints it affects every aspect of the acquisition that is required for effective learning and training. (RSHT4)

In the OSS, a student said:

> Unavailability of educational materials affect me a lot because it is not always that my mum comes here, so if I need some materials and she has not come to visit me, I will sit down the whole day or a whole week without doing anything. (SSS1)

Another student said: “My mother buys all the materials like the needles, thread and the beads and everything” (SSS2). Also, SSS4 said: “No Sir, there is no support service in the school” (SSS4).

The quotes above suggest that little or no efforts are taken by the head teacher or the education officials in the provision of teaching materials and educational support systems. As a result, children and youth remain idle, helpless and confused in the school when parents are not able to provide teaching and learning materials.

Parents expressed their displeasure at the unavailability of teaching materials and educational support systems. One parent said: “the school is suffering greatly from [lack of] educational resources” (ISFGP3). Another parent narrated: “I have also never seen any teaching materials or support service in the school. We parents will have to buy everything about teaching and learning materials that are necessary for the child” (SSFGP2).

With regards to educational support systems, the head teacher mentioned:

> We don’t have anything like school support team or district support team or any system to assist us in this school … Very few of my teachers are trained professionals and majority are pupil teachers, that is, untrained teachers but because we don’t have the qualified teachers, we use them [untrained teachers] like that. (SSHT3)

He added: “we also lack funding to procure teaching and learning materials to aid the process of knowledge transfer. The government is silent about these basic needs” (SSHT3). Apart from the constraints of the aforementioned educational resources, which impacted greatly on the schooling experiences of children and youth with MI, they also had negative social experiences as will be discussed below.

6.6.4 Negative social experiences

The understanding of disability and social relationships among members of a community are fundamental to human development and are very important in the lives of children and youth with disabilities (Bunning et al., 2017). The findings below show how cultural beliefs and understanding of disability influenced schooling of children and youth with MI in both the ARS and OSS.

Cultural beliefs and understanding of disability: Implicitly, cultural beliefs marginalise children and youth with MI, preventing them from accessing educational opportunities meant to be enjoyed by all persons in the Ghanaian society. Understanding disability in a cultural context is a critically important subject that deserves serious consideration in order to understand how they may influence the education of children with disabilities. The following are quotes from ARS:

> Talking about culture, I was told that during the olden period persons with disabilities are not regarded as human beings, they are killed before they grow up, those who are not killed are not sent to school or not giving the opportunity to grow up with human beings [non-disabled]. Disabled children are seen as “obosom” [lesser gods], demons, witches and wizards. (RSS2)

The above quote indicates that children and youth with MI were not regarded as human beings in the community. Also, children and youth with disabilities were regarded as lesser gods, demons or victims of witchcraft. Another child with MI explained the ordeal he went through:

> They [immediate family] see me as useless because I can’t do anything. My junior brothers talk to me anyhow. I am the elderly in the house but because I cannot do anything and always rely on them, they don’t respect me, not even in school. RSS4

Such cultural beliefs influence society to underestimate the abilities and capabilities of children and youth with MI. This may be as a result of lack of knowledge on the issues of disabilities by teachers, school mates and classmates and by the society. Such cultural beliefs are made known to children and youth with MI in their communities and can negatively influence their educational trajectories. For example, a child with MI may look down on him or herself due to their disabled condition.

The head teacher at ARS expressed that one cannot talk about cultural beliefs without mention of stigma in the communities. He said: "To me … stigma and all negative attitudes cannot be disassociated from persons with disabilities in the communities" (RSHT4). He added that the impact on schooling of children and youth with MI is that: "Any person who believes that crippling condition emanate from evil spirit will not allow his child to sit by a child with that condition, sometimes, they take their children completely from the school" (RSHT4). What brings about the stigma and negative attitudes is the belief that children with disabilities are possessed by an evil spirit. Because of this cultural belief, children with disabilities are denied education. Adding to the traditional beliefs, a parent said: "As I said earlier about convulsion, disability is seen to be evil spirit. The whole community in which I live believe that disability is caused by evil spirit therefore they [children with disabilities] are not allowed to go to school" (RSFGP5). Apart from children with disabilities being seen as evil, others believe that disability is a result of curses and it thus becomes a waste of resources to send a disabled child to school. For example, another parent said:

> Sometimes too disability is seen as curses, witch crafting and "juju" [black powers]. People also think that it is a waste of resources if you send such children to school. Others believe that if you are selling something and a person with disability comes to buy, he or she gives you bad luck, especially, if the disabled person is the first to buy. (RSFGP1)

Like the findings in ARS, parents from OSS revealed:

> Sometimes too they [children with disabilities] are seen as witchcraft, or "obosom" [lesser gods]. This is why we normally hide children who are disabled from the public or the

> schools. What we also see about persons with disabilities is neglect. Because they [children with disabilities] are seen as useless or people who cannot do anything and must not go to school. (SSFGP4)

This means children and youth with disabilities are not recognised in the society. For instance, a parent said:

> The view about disabilities is influenced by our traditional beliefs, where such children [children with disabilities] are killed, where they are not killed, it becomes a great challenge to live within your locality. You are also seen as bad luck and called you all kinds of names. (SSFGP5)

Furthermore, disability is believed to bring disgrace on the family members. Some families may intentionally hide their disabled children from friends and other family members, and a disabled person may find it very difficult to marry. A parent said: “Disability is seen as a disgrace in the family. Marrying even becomes a problem because, people think that if you are disabled, your brain is also affected or you can give birth to a disabled child” (SSFGP1).

The quotes from the two schools seem to justify that children and youth with disabilities have no place in the mainstream schooling system and the society. The quote by SSFGP1 shows that children and youth with MI might have their brains affected by the disability. This means that a camp is the place where children and youth with MI are to be put where they have nothing to do with the non-disabled communities. A series of questions that may be raised are: why are children and youth with disabilities separated from the mainstream schools? Why are children and youth with disabilities not well catered for in the segregated schools? Are they ignored and denied equal and quality education because of their disabilities? These and many other questions point to the

ARS and OSS as witch camps. The denial of educational rights and human dignity of children and youth with disabilities in these school settings made some participants to think of schooling as a waste of time, as will be discussed in the next section.

6.7 Wasting time in school

The findings illustrate that the school curriculum for ARS and OSS were different from the other basic schools like the mainstream schools (Field notes; June, 2018). For example, the focus for the children and youth with MI in these two schools was on skills training, whilst the focus in the mainstream and inclusive schools was on the universal basic school curriculum. However, children and youth with MI did not receive the expected skills that could make them independent in the future upon leaving school, suggesting that they are wasting time at school. Wasting time in school will be discussed under the following categories:

- No school progression of children and youth with MI from one academic level to the next
- No class assessment
- Care centre or dumping ground

6.7.1 No school progression from one class to the next

According to the findings, a child was placed in one class for the number of years he or she remained in the school. This practice where the child is placed in one class for several years was referred to as “class stagnation”. This was seen in both schools. There was no provision for class progression where students could move from one class to the next class. For example, when a child with MI is placed in a shoe making class, he remained in that class for ten years or more, depending on when the student decided to go home (Field notes; June, 2018).

6.7.2 No class assessment

The findings revealed that there was no assessment or examination in the schools which determined progress based on a child's performance. For example, a parent said: "they [children with MI] don't write any exams in the school" *(*RSFGP3*).* A child with MI confirmed that there was no class assessment and examination: "no we don't write any exams in this school" (RSS5).

A student in OSS said: "We don't do any exams. I will like to write BECE [Basic Education Certificate Examination] so that I can go to the university" (SSS3). The quote by this student highlights that children and youth with MI are not given the opportunity to progress in their educational careers, as they are denied the opportunity to write examinations. The head teacher confirmed that there was no formal examination:

> The students here do not write any exams. This was what I came to meet, the intention for students was to gain employable skills, but I believe we can allow those who are capable of writing exams to write. This decision to write exams cannot be taken by me as the head teacher. I take instructions from the GES [Ghana Education Service] office. (SSHT3)

The quote from the head teacher highlights the fact that the children with MI are denied their educational rights to progress in the school.

Also, children with MI in the two schools were denied certificates. For example, a child in ARS said: "No Sir, we don't get any certificate" (RSS5). A parent added: "No, I don't think they will receive any certificate because they don't write any exams in the school" (RSFGP3). The head teacher confirmed that the students do not receive any certificate when exiting from the school. He said: "No, students here do not receive any certificate but those in the special school for the blind and the hearing impairments are given certificates. I actually don't know why" (RHSHT4)

The head teacher in OSS confirmed that the educational rights of children and youth with MI were denied and does not understand why students in the other special schools like those for the visual and hearing impairments received certificates. Expressing his frustrations over the lack of awarding a certificate, he said:

> …they don't write any official exams where they will gain a certificate. No certificate is awarded to our students. It has been a problem especially in most of the special schools and the rehabilitation schools. Yes, this is what I came to meet. This means that we don't graduate them, if there were graduations, they [Education Authority] might think about the certificate. (SSHT3)

6.7.3 Care centre or dumping ground

Unfortunately, students do not graduate from the ARS and OSS. As a result, such schools have been classified by some participants as care centres. The schools were referred to as care centres because these participants believed children and youth with MI do not acquire any skills in those schools and are seen as wasting time in the school. Parents send children and youth with MI to these two schools so that such parents could have time to do other things. To these participants, the ARS and OSS are care centres where their children are sent to be taken care of by the teachers in the schools. For example, a parent said:

> Yes, they don't do any academic work and they don't receive any certificate but it is good for them to be in the school so that the teachers can take care of them. When our disabled children are in the school, we are able to have time to work. We will not be able to do anything when they [children with MI] are with us in the house. (RSFGP4)

It could be deduced from the above quote that parents still wanted their children and youth with MI to be in the school so that they could have time for other things in their homes even though the desired result for their children with MI was not realized. The desired result was that children and youth with MI will acquire employable skills to be independent. To some parents, the schools may be seen as a care facility where they just leave their children and youth with disabilities to be taken care of, instead of being in school to be academically taught. For example, in OSS, a parent said: "I have observed that the special school looks like a place where teachers only take care of the children without any serious academic work" (SSFGP3).

The head teachers, on the other hand, feel that parents view the ARS and the OSS as a dumping ground where children are brought, and parents do not come to collect these children even when schools vacate for the term. For example, one head teacher said: "They [parents] simply come and seek for admission and dump their children here without seeking after their welfare anymore" (RSHT4). Another head teacher said:

> You will be surprised to hear that some of the parents don't come for their children even when the school is on vacation. These students remained on campus till school reopens again, they have nowhere to go and have no one to take care of them. I expect the parents to come for their kids but will not come. Sometimes I will try to call but the numbers will not go through. (RSHT4)

This suggests that the welfare of children and youth with MI is not well catered for and such children are seen as being banned from the mainstream society, as noted earlier. The quote may mean that these children are ignored and rejected by their own families and by the mainstream society. This is like the witches in the witch camp where they are classed as not needed in their own homes and communities. It may also mean that such children with MI are regarded as aliens who need to be separated for their own safety.

The findings further portrayed a similar situation where children with MI are seen as a burden on the family. A head teacher confirmed this assertion by saying:

> Some parents intentionally dump their disabled children on us here because they are burdens on them at home. This is so because when school closes for the term, they do not come for their children. These children remain in the school till school re-opens again. (SSHT3)

The story in the OSS is similar to what occurs in the ARS. The head teacher in this school confirmed the situation. He said: “Some [children with MI] have even been here in this school for over 20 years. Others don’t go to their homes when school vacates for the term” (SSHT3). Children and youth with MI continue to stay in the school because their parents may not need them at home or in the community. This may mean that stigma, verbal abuse, frustration and unnecessary stress are too much to bear in their homes. Hence, children and youth with MI intentionally refuse to go home, even when the schools are on vacation. This could be seen as neglect and abuse of human dignity just like the alleged witches in the camp in Northern Ghana.

6.8 Chapter summary

This chapter focused on the educational experiences of children and youth with MI in Akokor Rehabilitation School and Ohiamankyene Special School. The chapter started with a description of the two schools, followed by the demographic data of participants and a broad theme was developed which described the schools as a witch camp. It was shown that children and youth with MI were either denied education or were segregated from their non-disabled peers to a camp where they suffered stigmatization and neglect, just like the witches in a witch camp. For some participants, stopping school and looking for a cure for disability delayed their schooling and they had to change from the mainstream school system to either a rehabilitation or a special school because of their disabilities.

The chapter also shed light on the struggle, pain and trauma that children and youth with MI experienced as a result of an inaccessible school environment, like the poor school lay out, the poorly constructed buildings and the inadequate bathroom facilities. The stories from the participants also showed that children and youth with MI were expelled or detached from their families and the community in general. Other participants' stories referred to the school as a dumping ground; this was because children and youth with MI were ostracized, where there was no class progression from one level to the next, no class assessment and there was no certificate awarded to children and youth with MI. The next chapter provides a more in-depth discussion of the findings presented in Chapters 5 and 6.

CHAPTER SEVEN: DISCUSSION

7.1 Introduction

All children, including children with disabilities, have a right to education (UNESCO, 2017). However, findings from this study suggest that children and youth with MI are not well catered for within the Ghanaian, basic educational settings. Even though the laws of Ghana's 1992 Constitution and International Conventions were established to protect the rights of children and youth with disabilities, these educational rights of children with MI are not being realized (Mantey, 2017b). This is primarily because there is no coordinated process in place to implement these laws. This results in a gap between policy and practical implementation. For example, recently constructed school buildings do not meet the standard of universal design, which accommodates children with disabilities (Mantey, 2017a; Republic of Ghana, 1996, 2006). Literature reveals several attempts by the government of the Republic of Ghana to make schools more accessible to children with disabilities (Addo, 2014; Avramidis & Kalyva, 2007), yet the current study reveals that there are multiple barriers which have resulted in the denial of the educational rights of children and youth with MI in basic educational settings.

The reason for this study as stated in Chapter 1 was to explore the educational experiences of children and youth with MI in four basic educational settings (mainstream, special, rehabilitation and inclusive schools) in Ghana to identify appropriate educational support services that will enhance equal, accessible and quality education for children and youth with MI. Considering the aim of the study, I specifically wanted to gain a better understanding of the educational experiences of children and youth with MI across basic school settings in the context of inclusive education in Ghana.

Ghana has generally adopted inclusive education (IE) which accommodates children with disabilities (Mantey, 2019), but this study revealed that IE has remained on paper and is not being practically implemented in the Ashanti and Oti regions of Ghana. Therefore, to assess the policy and practice of IE, it is informative to look at children and youth with MI for the implementation of IE in Ghana. This is because the learning abilities of children and youth with MI might not be affected by their impairments. What is important are the environmental changes which may be relatively easier to make, compared to curriculum changes (Opoku, 2016). For example, children with MI may need only an accessible school environment and a change of attitudes towards disabilities in general within the community and in the schools.

This chapter has three sections. The first section consists of a comparison of the educational experiences of children and youth with MI across school settings which is a cross-case analysis. This comparison identifies the common and different experiences among the four schools and helps one gain insight into why these common or different experiences occur. Also, a comparison between the four basic educational settings can inform decisions about the most appropriate educational services that best serve the needs of children and youth with MI. By so doing, I address my second research question which seeks to explore barriers that children and youth with MI have experienced in the basic educational settings in Ghana. This is essential to identify educational support services which are needed to enhance equal, accessible, and quality education in the various school settings.

The second section presents a discussion on two key educational experiences across the four basic school settings. The identified key findings will address the first research question which seeks to explore the educational experiences of children and youth with MI in basic education in Ghana. This is an attempt to address the current knowledge gap in the literature that centres on the lack of insight into the experiences of children and youth with MI in the basic educational settings in Ghana. The knowledge gained may inform policymakers to set proper educational priorities, especially in developing nations like Ghana where there are limited resources.

The third section discusses the theoretical implications of this study. The purpose of this section is to reflect on the theoretical implications of this study as they relate to the educational experiences of children and youth with MI in four basic educational settings in Ghana. I show how the educational experiences of these children and youth can be interpreted using three theoretical frameworks.

7.2 Section one: A comparison of educational experiences across school settings

As noted above, a comparison of educational experiences of children and youth with MI across mainstream, inclusive, rehabilitation and special schools is important to identify educational support services that best serve the needs of children with MI in the basic schools. A comparison of the four basic educational settings will also give an insight into common and different experiences across the school settings. These experiences include; (1) onset of disabilities and its impact on schooling, (2) difficulty with school admission, (3) social barriers, (4) mockery, teasing and bullying, (5) physical and structural barriers, (6) inadequate educational support systems and (7) differences in school curriculum. I will begin with the onset of disability and its impact on schooling.

7.2.1 Onset of disability and its impact on schooling

The findings from the current study show that the onset of their children's disability led parents to begin to look for a cure for the disability. Parents may want to find a cure for the disability before these children are allowed to go to school. Parents may want to concentrate on the cure for the disability just to avoid disgrace from their own family and community members because of the stigma that is associated with the disability. Baffoe (2013), in a study that focused on “Stigma, Discrimination and Marginalization”, notes that parents’ struggle to cure the disability of their children was to avoid pressure from the family and community members. This pressure emanates from stigma and pain that is imposed on them by the family and community members. Parents were of the view that children and youth with MI should not enter formal education unless the impairments are corrected. Therefore, they only began to seek education once they had exhausted all possibilities of a cure. This view is influenced by the parents’ traditional belief system in which impairments are seen as a curse that needs to be reversed by the ancestors/supernatural powers (Baffoe, 2013a; Owusu-Ansah et al., 2018). Other authors like Addo (2014) and Zhou (2015) acknowledge that parents and families who have children with a disability begin to focus on the cure of the disability instead of the education of children with disabilities.

Contrary to the actions by parents of children with MI which aim at curing the disability, Connor and Gabel (2013) state that the focus of DSE is not on curing the disability, but rather on aspects that can enhance the education of children with disabilities within an inclusive environment, as well as efforts that can be made to identify and question issues that make the life of children with disabilities an uncomfortable experience at school. However, the findings of this study indicate that decisions pertaining to impairments and cure are usually taken by parents who choose to focus on the cure of impairments to the detriment of the educational rights of children and youth with MI. I concur with the assertion made by Connor and Gabel (2013) who note that the search for a cure impedes the educational rights of children with disabilities.

The impact on the education of children and youth with MI as a result of parents struggling to find a cure for the disability is that, when disability starts during or soon after birth, children are kept at home for a long period of time. This delay at home tends to prevent children with MI from starting school when they should. This phenomenon was universally narrated by participants from the mainstream, inclusive, rehabilitation and special schools. The children with MI also became worried and felt rejected when they observed their siblings attending school. This situation makes children and youth with MI more dependent on their parents and alienated from the school and the entire community. A case study conducted in the Ntcheu district of Malawi by Banks and Zuurmond (2015) identified common experiences of children with visual, hearing and the mobility impairments in the basic schools. Their study showed that children with disabilities felt worried and rejected because they were not sent to school when they were younger. Banks and Zuurmond (2015) found that students with mobility impairments were kept for a long period of time at home because of the fear of bullying. The findings of this study are in line with this. The current study highlights that children with MI experienced a denial of their educational rights, in particular that they were deprived of starting their educational trajectories at an early age (e.g. five years). Preventing children and youth with MI from attending school at this age conflicts with the policy of Ghana which mandates that children should start school at age five (Ministry of Education, 2015a). For example, the policy of Ghana about schooling at the basic level states that a child must begin school when he or she is five years. The findings of this study revealed that children with MI started school between the ages of 10-12 years.

On the other hand, when disability starts where children and youth with MI are already in school, they stopped schooling. As noted in Chapter 5, in the mainstream and inclusive schools, four participants of the 20 children above began school at the specified age in the education policy i.e. at five years of age (Ministry of Education, 2015a). They had their disabilities in the course of their lifetime (acquired disabilities) and so had to stop school. The effect on the education of children and youth with MI in the mainstream and inclusive schools is that they felt left behind, as their non-disabled peers went ahead to the next level of education. Participants with acquired disabilities experienced feelings of confusion at their disability and asked themselves several questions like “why me?” In a similar way, research conducted in South Africa by McKinney (2013) found that students with acquired disabilities expressed feelings of confusion and could not accept their state of being disabled at the onset of the disability. She contended that students with acquired disabilities went through emotional difficulties before they accepted their disabilities (McKinney, 2013).

The feeling of confusion felt by children and youth with MI in the current study may suggest that there was no psychosocial support available to these children who acquire their disabilities whilst they are already in schools. This study reveals that parents were frustrated because they were uncertain about how to care for and support their children and youth with MI. This indicates that parents and their children with MI did not get any professional advice from either the educational officials or the school authorities. Literature shows that many families of children with disabilities manage the lives of their children with disabilities on their own without any psychosocial support. For example, Opoku et al. (2018) in Ghana and Sagahutu and Struthers (2014) in South Africa found that the families of children with disabilities did not get any adequate support in the form of counselling, physiotherapy and educational support to access services that would improve their lives. As a result, parents and families of children and youth with disabilities in all four school settings became confused as they did not know how to manage their children with disabilities. A study conducted in Ashanti region, Ghana by Edusei et al. (2015) showed that families tend to go to traditional healers for a cure, believing that persons with MI who had their lower or upper limbs affected were cursed by evil spirits. They added that most communities in

Ashanti region in Ghana believed that such disabilities could only be healed through a supernatural power by the traditional healers (Edusei et al., 2015). The possible implication of this is that parents as well as children and youth with MI are unable to break down social barriers due to their inability to access education and other useful services critical to their development. What is surprising is that head teachers who are supposed to ensure inclusion of children with disabilities are not ready to accept children with MI in their schools, as will be discussed below.

7.2.2 Difficulty with school admission

Another common educational experience as narrated by participants in all four educational settings was difficulty with school admission. This study reveals that school admission was a great struggle for parents of children with MI because of rigid admission criteria. One such obstacle is financial obligation. This financial component meant that parents who do not have money to buy items like cumulative report cards, note books, Parent Teacher Association (PTA) levies, writing desk, bed and mattress to mention but a few may be forced to keep their children with MI at home. This implies that the educational rights of children with MI are being overlooked because of the financial obligations attached to school admission. The United Nations (UN) Convention on the Rights of Persons with Disabilities is a legally binding instrument that urges member states to take all appropriate and effective measures, including financial support, to ensure the equal rights of persons with disabilities to a quality education as any other person. This includes provision of basic amenities in the schools (UNCRPD, 2006). The findings from this study, however, contradict this legal mandate where parents are obligated to pay for other school resources for their children's education. The differences in the kinds of financial obligations within school settings are further discussed below.

This financial obligation is common in all the four school settings but has different meaning in the mainstream and inclusive schools compared to the rehabilitation and special schools. For example, whilst children and youth with MI in the mainstream and inclusive schools are required to pay a PTA levy, also known as teachers' motivation levy, children and youth with MI in the rehabilitation and special schools are obliged to pay for beds and mattresses. The reason given for the payment of the PTA levy in the mainstream and inclusive schools was that the official instructional hours as scheduled on the schools' timetable have been extended by one hour for extra tuition (see Appendix 21). Head teachers explained that the extra one hour added will enable teachers to cover several topics that will prepare students for the Basic Education Certificate Examination (BECE) which is written at BS9 (Grade 9). What is worth noting about the extra tuition is that children who are unable to pay for the teachers' motivation levy are either dismissed from the classroom or are punished by teachers. This means that children and youth with MI are more affected than their non-disabled peers because, in addition to the financial obligation in the school, their parents spend extra money on transportation to and from school. For example, children and youth with MI who use wheelchairs are sometimes barred from using "trotro" (a local transport, e.g. minibus). This means that children who use wheelchairs are forced to hire a taxi, which is often very expensive. However, children with MI in the rehabilitation and special schools do not need to take any transport since the schools are residential. Educational materials like school uniform and learning materials are bought by children and youth with MI in all the four school settings. Education is supposed to be free in all schools, but it is not. There is the additional levy that all children pay. If they do not pay, they will be excluded from class. This study found that children and youth with MI are less likely to be able to pay the levy because of the additional costs incurred, and so might be at greater risk of exclusion. Then at the rehabilitation and special schools they have to pay the same costs as other schools, excluding a PTA levy, but will pay for accommodation materials as noted above.

Other common experiences of children with MI in seeking admission into all four basic school settings reported by participants was that head teachers tossed children with MI from one school setting to the other. Whilst teachers in the rehabilitation and special schools felt that children and youth with MI belong in the mainstream and inclusive schools, teachers in the mainstream and inclusive school settings, on the other hand, felt that they are not trained to teach children and youth with MI. This study found that the confusion about identifying the needs of a child with MI was because head teachers lacked understanding of inclusive education practices. From the perspective of DSE, Fleischer and Zames (2001) posit that lack of attention for children with disabilities is attributable to factors such as disability being often misrepresented as a "health, economic, technical, or safety issue" such that "prejudice based on disability frequently remains unrecognized" (p. 218). In a similar vein, Baglieri et al. (2011) assert that:

> If we perceive disability as manifest in interactions among social contexts and bodies and minds— all of them unique—our work in practice is primarily to shape learning environments in ways in which all classroom and school members have access to curriculum and learning opportunities. (p. 272)

These quotations reveal that even though the teachers' position was to shape learning in these students, it is the attitude of teachers which influences the decision of denying students from mainstream schools to access learning opportunities that are prescribed by the general curriculum. Teachers' attitudes towards inclusive education suggest that inadequate training of teachers leads to a misunderstanding of the inclusive education practice, hence contributing to the negative attitude of teachers towards inclusion of children and youth with disabilities in the mainstream schools (Agbenyega & Deku, 2011; Avoke, 2002; Ocloo & Subbey, 2008). As noted in Chapter 5, head teachers in the mainstream and inclusive schools report inadequate knowledge and skills on the part of teachers to practise inclusion due to the fact that they do not have the requisite skills to handle children and youth with MI. It also shows that teachers assume that special skills are always necessary, but this may not be true for children and youth with MI. For example, from the perspective of DSE, a study conducted in Ghana by Opoku (2016) found that a special skill may not be necessary for teachers to include students with mobility impairments. Rather teachers should be trained to understand inclusive practices in the Ghanaian schools. Without adequate training and preparation for teachers and head teachers, it is obvious that teachers would be less knowledgeable and will remain insensitive to the needs of children and youth with MI. This can affect the participation and performance of the children and youth with MI. The unwillingness of head teachers to accept children and youth with MI in schools suggests inadequate preparation on the part of the Ministry of Education and Ghana Education Service towards the implementation of inclusive education as mandated by the inclusive education policy (Awal, 2014). It is important to note that this is not only about special needs of children and youth with MI, but also understanding that all children can learn, and that the curriculum needs to be universal in all basic schools.

In addition, there are several reports showing relatively unfavourable teacher preparedness to accept children with disabilities in their classrooms. For example, Opoku et al., (2019) maintained that both in-service and pre-service teachers revealed their unwillingness to teach students with disabilities in the basic school settings in Ghana. Their study entitled *Mapping the evidence-based research on Ghana's inclusive education to policy and practices: a scoping review* further revealed that teachers in the field had limited knowledge about inclusive education. According to the authors, teachers who are yet to enter the teaching profession but are still in the college claim that they had acquired insufficient knowledge to teach in inclusive classrooms or skills to handle children with disabilities (Opoku et al., 2019). This raises a concern about the nature of the teacher-training curriculum and how it has been designed to equip teachers with relevant skills for inclusive education.

In the context of Ecological System Theory (EST), learning and child development is possible when there is synergistic interaction between the various systems; for example, the learners and the teachers within the school environment (Bronfenbrenner, 1989). This suggests that when teachers are not ready to accept children with disabilities in school it will be very difficult for such children to have a right to equal education. The microsystem in the EST shows that a direct interaction between learners and teachers has a direct impact on the education of the learner. Also, as pointed out by EST, the relationship in the microsystem is bi-directional. This means that the reaction and attitudes of teachers towards learners influence the education of such learners (Bronfenbrenner, 2005; Geldenhuys & Wevers, 2015). For example, a negative community attitude towards children with disabilities could influence the attitude of the teachers towards children with disabilities, and this may further affect the acceptance of children with MI into the schools. This suggests that a change in the attitude of the community toward children with disabilities may have a positive impact on the education of children and youth with MI in the basic schools. In the context of the current study, children and youth with MI in all four school settings feel alienated as head teachers are not prepared to accept them in the school.

Head teachers' refusal to accept children with MI in the schools is in conflict with Article 24 of the UNCRPD which states that children with disabilities cannot be excluded from the mainstream education system on the basis of their disability (UNCRPD, 2006). Article 24 further requires member states to make available the educational support services required within the general education system to facilitate effective teaching and learning. In addition to the provision of UNCRPD, Ghana's Inclusive Education Policy mandates head teachers to make schools child friendly environments. Head teachers are also to make schools "a child seeking school" which means head teachers are to identify excluded children with disabilities and get them enrolled in the school and ensure that such children are involved in all teaching and learning activities (Ministry of Education, 2015b, p. 8). Also, Article 20 of the Persons with Disability Act, Act 715 states that children with disabilities shall not be denied admission to mainstream schools on account of their disabilities (Republic of Ghana, 2006). If Ghana has these legislative instruments to support the inclusion of children with disabilities in the schools, why are children and youth with MI being denied admission to the mainstream schools?

Other reasons accounting for teachers and head teachers' unwillingness to accept children and youth with MI in their schools were that classrooms were always overcrowded, with an inadequate supply of teachers. The education policy on student and teacher ratio in a classroom is stated as: 55:1 for Kindergarten, 38:1 for Primary and 35:1 for Junior High School (Ministry of Education, 2019). In this study, there were 80 or more students in one class in the Junior High School in the mainstream school. This means that children and youth with MI in the overcrowded classrooms find it difficult to find a space to fit their wheelchairs and teachers found it very difficult to manage the class. The large number of students in one class creates poor interactions between teacher and students leading to interruptions and a noisy atmosphere in the class. This finding is consistent with a study in Algeria which posits that large class size is a barrier that does not allow effective class interaction between teachers and students because of the lack of space for their wheelchairs (Bouaghi & Bouaghi, 2015).

Attainment of a high academic record is another barrier for children with MI to gain admission to mainstream schools. This is because schools compete against each other on the grounds of a certain school having the highest examination pass rate at the BECE level. According to findings from this study, the competition for higher examination results is important for head teachers because parents will always send their children to the schools that have high academic achievement. In the pursuit of attaining a high examination pass rate, head teachers refuse admission for children and youth with MI because they view children and youth with disabilities, including those with MI, as 'spoiling'[3] the school's academic records. Head teachers may have limited understanding of what children and youth with MI are and may assume that a person's intellectual ability is affected if they have mobility impairments, which could lead them to believe that children and youth with MI belong in the rehabilitation and special schools. As a result, they will always refer children and youth with MI to these segregated schools. A detailed discussion about attainment of higher academic records will be seen in section two of this chapter.

Contrary to these findings about school admission, a study in England showed that school admission for children with disabilities is controlled by the School Admission Code (SAC) where head teachers have no control over admission of students, especially those with disabilities. SAC provides statutory guidance to be administered by the admission authority (Stobbs, 2015). Ghana can learn from England regarding school admission. That is, Ghana could have a controlled system where basic school admission will not be under the control of teachers and head teachers. This will allow children and youth with MI to have access to any basic school of their choice. The experiences of children and youth with MI with regards to refusal of school admission further isolates them from the mainstream school settings and general society, thus preventing them from

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[3] The poor performance of children with disabilities will downgrade the academic standard of the school on a national BECE league table.

accessing equal educational opportunities which are meant to be enjoyed by all children in Ghana (SAP, 2011).

The unwillingness of teachers to accept children with MI in the school might also be influenced by barriers in the school such as social and structural barriers, as will be discussed below.

7.2.3 Social barriers

Social barriers were reported by participants in all four school settings. Parents and head teachers viewed social barriers such as cultural beliefs as perpetuating negative attitudes, stereotypes and prejudices about children with MI. Social relationships are fundamental to human development and are very important in the lives of children and youth with disabilities (Bunning et al., 2017). Implicitly, cultural beliefs marginalized children and youth with MI, preventing them from accessing educational opportunities which are meant to be enjoyed by all persons in the Ghanaian society (Mantey, 2017b). For instance, in Ghana, there is a general superstition about the causes of disability (Agbenyega, 2003; Avoke, 2001). That is, people in Ghana believe that causes of disability can be attributed to the acts of demons, witchcraft and wizards and that children with disabilities are demon possessed (Agbenyega, 2003). Such beliefs can influence parents to hide children with MI in their homes, thus preventing them from going to school and in some cases, "wo gya won kwan ma wo san ko won akyi [are made to return to where they came from]"[4].

The findings of this study revealed that parents were accused of being responsible for their children's disability. In such cases, parents hid their children with MI to avoid disgrace and blame for being responsible for the cause of the child's disability. Other parents who perceived that

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[4] Direct translation from "Twi" a local language in Ghana which means "to be killed"

children with disabilities are “obosom” [spiritual beings] keep their disabled children at home. The reason is that such parents want to remain obedient to the ancestors. That is, parents would like to take good care of such children with disabilities to avoid further punishment from the ancestors (Agbenyega, 2003). The knowledge of traditional beliefs and practices towards disability is important when considering the education of children and youth with MI. It is necessary to understand such cultural beliefs and how they may influence the education of children with disabilities. From the perspective of EST, a child’s learning and development starts from the interaction with parents at home and these parents are influenced by the community in keeping with the EST model. The decision that is taken about the education of children with MI by such parents will impact the child’s education (Geldenhuys & Wevers, 2015). This suggests that to make inclusive education possible, parents should be involved in its implementation (see Chapter 8).

7.2.4 Mockery, teasing and bullying

There was an overwhelming response from all schools about the high levels of mockery, teasing and bullying of children with MI. Such behaviours from non-disabled peers made the school extremely unpleasant for children and youth with MI. What is surprising is that experiences of bullying and mockery are not only from their peers but from teachers as well. Whilst peers of children with MI may mock, tease or bully children with MI because they are not taught any better, it is not clear why teachers are involved in this unpleasant act. Perhaps teachers’ behaviour may be influenced by superstitious practices that are ingrained in the community, as discussed previously.

Also, teachers think that they are not qualified to handle children with disabilities. It is heart-breaking to hear about the teachers’ involvement in mocking children and youth with MI in the mainstream schools. Ironically, teachers are supposed to show love and care to all students in the school. Such mockery and teasing in some cases can lead to feelings of low self-esteem and isolation among children with MI. This study shows that the behaviour of non-disabled peers and teachers, as reported by participants, might partly be because of an unsupportive educational support system from the schools and the Ghana Education Service, which leads to numerous barriers (see Chapters 5 and 6). This raises the issue about lack of support services like teacher support and parent support teams, as will be discussed later. Such an inadequate support system in the schools may account for the teachers' decision to reject children with MI. Rigby (2004) in South Africa noted that teasing should not be a problem among peers but when "people are picked on over and over again in a one sided way, that causes emotional or physical pain" (2004, p. 8), and it becomes an issue to be addressed. He emphasised that teasing no longer becomes a tease when it causes physical and psychological harm, but, rather, it becomes bullying (Rigby, 2004). In the current study, children with MI experienced physical and psychological harm. In addition, children with MI experienced physical and structural barriers in the four schools, as will be discussed below.

7.2.5 Physical and structural barriers

Physical and structural barriers were reported by the participants in all school settings. The physical environment of every school determines how such a school can provide equal and quality educational opportunities for all students, but especially children and youth with MI. In the current study, children and youth with MI, their parents and the head teachers noted that the most significant structural barriers were inadequate toilet facilities, bad school layout, inaccessible school buildings and unavailability of lifts or ramps to buildings with multiple floors. This was devastating because children with MI who wanted to go to the toilet could not do so. This predicament poses unnecessary stress and panic in the schools. For example, children with MI in the mainstream and inclusive schools who wanted to go to the toilet may have to either go there whilst schools are still in session or wait until school closes for the day to relieve themselves. A study conducted in Ghana by Addo (2014) on barriers to children with MI in basic education found that 73% of 43 participants of children with MI had experienced structural barriers, like the unavailability of good toilet facilities and access to school buildings. The findings of this study revealed inadequacy of toilet facilities, bad school layout, inaccessible school buildings and unavailability of lifts or ramps to buildings with multiple floors as common even in the rehabilitation and special school settings. This deplorable state of the rehabilitation and special schools raises a concern as to why a school, especially established to cater for the needs of children with disabilities, is found to be in such a deplorable state. Addo (2014) notes that existing basic educational facilities in all four school settings should be retrofitted and made physically accessible to children with disabilities, in order to create equal opportunities for all children of school going age. The general setting of the various basic educational environments must be accessible for teaching and learning activities for all students.

The bitter experiences of children and youth with MI with regards to physical and structural barriers as found in this study are not the same as what happens elsewhere. As put forward by Ackah-Jnr and Danso (2019), some developed countries have statutory building instruments like the Building Regulations and Guidelines, Codes of Practice, and others to achieve universal designs and features that can be user friendly to persons with disabilities. In Ghana, there are statutory regulatory bodies that are supposed to ensure universal design of structures and buildings to make learning environments child friendly (Mantey, 2014). However, this study revealed that such statutory and regulatory bodies remain on paper. What is surprising is that, inclusive, rehabilitation and special schools which are supposed to be given special attention also face similar physical and structural challenges, just as reported by participants in the mainstream schools. Other educational support system that are supposed to be available in the basic schools to augment these physical and structural barriers are either inadequate or unavailable, as will be discussed below.

7.2.6 Inadequate educational support system

A comparison of all school settings revealed a common pattern of inadequate educational support systems. An educational support system refers to a network of all resources that are brought together to enhance teaching and learning (Mariga et al., 2014). In this study, an educational support system includes services such as psychosocial support, physiotherapist and counselling. Educational support also includes the child, parents, teacher and district-based support teams (see Chapter 2). In the Republic of South Africa, a policy document entitled “Policy on Screening, Identification, Assessment and Support 2014” described district-based support teams (DBST) and school-based support teams (SBST) as vital to promote inclusive education (Department of Basic Education, 2014). These interventions have promoted coordinated activities which have enhanced inclusive practices in the districts. The DBST enforced training of teachers, distribution of resources in the schools, infrastructure development, and identification and addressing barriers to learning (Department of Basic Education, 2014). Ghana can learn from the Republic of South Africa in terms of the establishment of educational support systems. All participants, including parents and head teachers in all four educational settings of this study, reported that they did not see adequate educational resources or support systems made available to aid teaching and learning in the schools. Among others, participants mentioned unavailability of child support teams, parent support teams, teacher support teams, district-based support teams, physiotherapists and counsellors. A comparison shows that these support systems are not available in all four school settings. So, this once again poses a question as to why the special schools exist if they do not provide the specialised support.

A conscious effort will be necessary to establish a policy that will consider the local beliefs and practices around IE and to establish social and educational support system that will pave way for a collaboration between the indigenous people and the government to promote inclusion in the educational settings. Opoku et al. (2019) noted in their study that the absence of these robust social and educational support systems in the schools was because of lack of political will and commitment on the part of the government of the Republic of Ghana. They added that the government is not committed to advancing the lives of persons with disabilities. From the perspective of EST, the failure to act on the part of the government with regards to education will influence the education of children with MI (Geldenhuys & Wevers, 2015). As noted in Chapter 3, the exosystem within EST represents the larger system which comprises of state regulations. When there is political will and commitment to the education of children with MI, the government may enact policies that will positively influence the education of children with disabilities in general.

A consistent curriculum is another factor that the government could investigate in order to create a positive influence on the education of children and youth with MI, as will be discussed below.

7.2.7 Differences in curriculum

The participants gave a commentary about the disparities that exist in the curriculum that is being used in the rehabilitation and special school settings. As a result of the disparities in the school curriculum, this study found that there seems to be no schooling progress from one level to the next in the rehabilitation and the special schools. For example, within the rehabilitation and special schools, a child and youth with MI was placed in one class for the number of years that he or she remained in the school. Findings from this study suggest that a child or youth with MI who goes to the rehabilitation or special school under the study, will not have the opportunity to progress from one level of education to the next, because there was no opportunity for children and youth with MI to learn how to read and write. This means the potential of children and youth with MI in these schools cannot be harnessed.

The current study refutes the claim by Ocloo and Dogbe (2000) who assert that rehabilitation and special schools aim to provide academic skills to enable all children with disabilities to read, write and continue their education. The implication of children with MI being unable to read and write is that children and youth with disabilities in these schools do not have the opportunity to write exams. This means the schools do not follow the general basic school curriculum and, hence, there is no assessment or examination in the schools which determines the progress of a child's performance. The proponents of DSE argue that all children with disabilities have ability and the potential to learn, but this can only occur when the barriers imposed by the society and institutions are dismantled (Baglieri et al., 2011; Connor & Gabel, 2013). In line with DSE, I agree that children and youth with MI in the rehabilitation and special schools can equally learn, do assessments and progress from one educational level to the next when they are given equal opportunities. This is because children and youth with MI in this study do not have their cognitive ability affected by their impairments and can equally learn like any other child without a disability. Also, reading and writing, that seemed to be left out in the rehabilitation and special schools, might be essential for children and youth with MI, particularly as these children have physical limitations which affect their ability to participate in physical activity. Detailed information about the inequities in the curriculum across the school settings will be discussed in the following section.

7.3 Section two: Key findings

In this section, two key areas from the analysis of the comparison of educational experiences of children and youth with MI within the four basic school settings were identified. The decision to separate this section from the comparison of the educational experiences of children and youth with MI in the school settings is to provide an in-depth analysis and to keep focus on the intricacies, contradictions and unfair educational experiences that were noted in Chapters 5 and 6.

Additionally, I reflect on the key areas of the results in a more analytical way by responding to the first research question which seeks to explore the educational experiences of children and youth with MI in basic school settings in Ghana. By so doing, I address the current knowledge gap in the literature. As noted earlier, the knowledge gained may influence policymakers or raise a concern for further research to meet the needs of all children, including children and youth with MI at all four school settings. Again, the new knowledge may unmask power structures in favour of children and youth with MI, which may not be a comfortable process but a necessary one. This is essential if real change, representation and educational rights are to be considered desirable. The two key areas that were identified are:

1. The inequality of the school curriculum in the rehabilitation and special schools compared to the mainstream schools negatively impacted children and youth with MI in the school and mainstream society.
2. The understanding of disability and societal attitudes towards persons with disabilities creates multiple barriers in the four basic educational settings in Ghana.

Key finding one

The inequality of the school curriculum in the rehabilitation centres and special schools compared to the mainstream schools negatively impacted children and youth with MI, both in the school and in the mainstream society.

> I see, I am wasting my time here. When I stop this school now, I will become somebody out there … He packed his things in a bag and left the school. Indeed, he has been employed as a gate keeper in a house located within one of the townships around here. (SSHT 3)

The above quote is a story about a student in a special school narrated by a head teacher, portraying a student's action taken whilst in the school. The meaning of the quotation was that the student was ignored, not respected and socially isolated from the community and could not gain employment because of his admission to the school. "I will become somebody out there" means he will gain employment, will become useful, respected in the community and live an independent life if he boycotts the school. This suggests that the special school did not support his need to become self-sufficient.

Relating the quote to this study, the questions remain: Why are rehabilitation and special schools which are meant to cater for the needs of children and youth with disabilities being allowed to function as "witch camps"[5] as noted in Chapter 5? Why are children and youth with MI ignored, denied their educational rights and isolated from their communities? Is there something we might have done wrong in the educational curricula and policies? Or perhaps something that ought to be

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[5] Witches in the Ghanaian context are women who are alleged to have possessed evil spirits. Such women are banned from the community and are confined at a place called a witch camp, usually located in Northern Ghana.

done by Ghana Education Service (GES), as a body in-charge of implementation of educational policies? (Ministry of Education, 2019).

In all human endeavours, children are groomed into particular modes of making sense of their experiences in the world around them, and are also born into a set of values, norms, attitudes, knowledge, and skills which are important for the continuance of society (Su, 2012). This set of values, norms, attitudes, knowledge, and skills are often prescribed by a framework called the curriculum. A curriculum can be seen as a plan of teaching and learning activities, or a sort of blueprint for systematically implementing all educational activities (Pratt, 1994). The Ghanaian curriculum is backed by the 1992 Constitution of the Republic of Ghana which defines basic education as the minimal formal education which every Ghanaian child is entitled to in order to be equipped in the right way and to function effectively in society. The Ghanaian basic school curriculum is based largely on the objective model of curriculum, adopted from her colonial masters (Mereku, 2012; National Education Assessment Unit, 2016). From the perspective of post-colonial theory, this objective model is believed to emanate from the beliefs and culture of the global west, and is used in many developed countries in the last half of the 20th century (Mereku, 2012) (see Chapter 3). Even though post-colonial theorists have criticised the current curriculum as a foreign hegemony, it has been accepted as a mandatory framework for all basic educational school settings. However, the current study revealed that rehabilitation and special schools have been deprived of this curriculum, which is supposed to be a general blueprint for teaching and learning in all basic schools, including the rehabilitation and special schools. Thus, my argument is that children and youth with MI at a minimum should have access to this objective curriculum. This is because, when they have the opportunity to be assessed, they will be certified and be similarly qualified just like their non-disabled colleagues in the mainstream schools, thus being able to be self-sufficient and assert their independence.

Additionally, results from a study conducted in Ghana by Kwao (2017) about challenges of curriculum design and its implication for policy showed that examinable school curricula have competitive advantages for students in terms of school progression, placement, career opportunities and the job market. He therefore added that there exists a missing link which is curriculum differentiation, which can be instrumental in breaking down academic barriers. What is surprising is that special schools which are specifically reserved for children with visual or hearing impairments follow a general, basic school curriculum (Opoku, 2016), thus raising a question about why special schools that have children with different types of impairments (for example, children and youth with MI) do not follow the general curriculum. The findings of the current study refute the claim by Opoku (2016) who maintained that activities in rehabilitation and special education schools are closely related to those in the mainstream education in the basic schools.

As noted in the introductory quote of this key finding, the boy with MI referred to himself as “wasting time in the school”. This may be as a result of the different school curriculum that is used at the special school. The expectation of parents of children and youth with MI is to have their children with MI well educated so as to become independent, just like non-disabled children in any basic educational school setting. Yet, the results of this study have showed that there was no teaching and learning in the rehabilitation and special schools, in contrast to the mainstream and inclusive schools. The reason parents sent their children and youth with MI to the different school settings was that they were supposed to be better served at the special and rehabilitation centre environment, just as was revealed in the literature review in Chapter 2 (see e.g. Avoke, 2002; Singal et al., 2017). In addition, parents showed regret, discomfort and disappointment at the fact that rehabilitation and special schools turned into a “witch camp” as noted in Chapter 5, where children and youth with MI were abandoned at the schools.

Literature reveals that the reason for schooling not happening in the rehabilitation and special schools has been the inequalities of the basic school curriculum (Muzata, 2017; Opoku et al., 2017). Meanwhile, rehabilitation and special schools have been established for an intended result (Opoku, 2016). The intended result is that the needs of children and youth with MI should be met in both the rehabilitation and special schools. Opoku (2016) supported this finding when he found that the intended results at the special schools and rehabilitation centres were not realized because the main target group of children and youth with disabilities were children who have visual impairment, hearing impairment, intellectual and behavioural disabilities. This poses a concern as to why children and youth with MI are found in these rehabilitation and special schools. In Zambia, a study entitled *Curriculum Implementation for Learners with Special Education Needs: The Case of Selected Inclusive and Special Schools in Zambia* by Muzata (2017) showed that the curriculum is deleterious to the quality of education delivered. The teacher in the special school becomes non-innovative, non-creative and may give excuses for the failure to yield the results intended by the curriculum. Also, other scholars argue that the main use of the objective curriculum as prescribed by Hitt and Tyler (1991) is an over-emphasis on cognitive learning, rather than on practical aspects of learning (Hitt & Tyler, 1991; Mereku, 2012). While the objective curriculum may have its flaws and needs improvement, it should be extended to the rehabilitation and the special schools. This is because, for children and youth with MI, the problem may not be the curriculum and so they should have access to the general basic school curriculum.

I argue that rehabilitation and special schools may equally use the objective curriculum and educational support systems should be put in place, as discussed earlier. Also, other scholars argue that children and youth with disabilities are not seen by the community as academically capable, where cognitive competencies such as thinking critically, creatively and practically, as well as applying one's skills are assigned to only non-disabled peers (Connor et al., 2008; Connor & Gabel, 2013; Elder & Foley, 2015). The current study shows that the curriculum in the rehabilitation and special schools is not meant for children and youth with MI, which suggests that children and youth with MI are academically incapable, which is not necessarily true. In consequence, children and youth with MI stay in one class for a number of years without progressing to the next level of their academic career. Similarly, Hayford (2013) and Kiyuba and Tuku (2014) found that special schools do not follow the general basic school curriculum and lack good academic programmes for children with disabilities. As a result, the children are kept in the schools as long as the parents will allow. Participants mentioned that the experiences of children and youth with MI are similar to witches who are confined in a camp. This is because children and youth with MI are confined in a school where they are marginalized and prejudiced.

This study found systemic problems in the curriculum used in the rehabilitation and special schools, which included inequity, marginalization and prejudice within the Ghanaian basic educational settings. In consequence, the curriculum does not allow children and youth with MI to progress from one grade to the next, and they do not receive certifications, unlike their counterparts in the mainstream and inclusive schools. This therefore suggests that children and youth with MI do not belong to the rehabilitation and special schools, but due to the understanding of disability and societal attitudes towards persons with disabilities, they were "slipped in" by default. This suggests the next key finding as discussed below.

Key finding two

The understanding of disability and societal attitudes towards persons with disabilities creates multiple barriers in the four basic educational settings in Ghana.

The action of society to avoid whatever is associated with evil affects people's beliefs and attitudes towards children with disabilities. This is because causes of disability are erroneously linked to evil spirits. These misconceptions have produced negative attitudes within the family and the community that emanate from their understanding of disability. Regrettably, these misconceptions by the family, the community and the school have created multiple barriers that impact on the education of children and youth with MI in the basic school settings in Ghana. One such barrier - as noted earlier - is the pain and struggle of children and youth with MI, when seeking school admission.

The findings about the pain and struggle for admission is in conformity with the Ghanaian study by Baffoe (2013) who stated that children with disabilities are "*pitied, at best, and ignored and shunned at worse*" (p. 198). This finding by Baffoe (2013) suggests the segregation of children with disabilities from the mainstream school settings. Negative attitudes towards children and youth with MI include the lack of understanding of disability, cultural beliefs and poor social relationships among members of a community and the school community (Bunning et al., 2017). The negative societal attitudes towards children with disabilities both in school and in the society may be a contributing factor to the unpleasant experiences of children and youth with MI and perhaps leads to separate school settings, which in turn leads to the inequity of school curriculum, as previously discussed.

Disability in general is understood as an unequal relationship within a society in which the needs of children with disabilities are often given little or no consideration (Baffoe, 2013a). As noted in Chapter 2, the WHO defines disability as a big umbrella term to cover impairments, activity limitations, and participation restrictions. Within this definition, impairment is seen as a problem in the body function or structure and also refers to the limitations on physical activity (Baffoe, 2013a; World Health Organisation, 2011). The disability may be regarded as a social construct, resulting from societal structures that are erected (Hurst, 2005). Sometimes, these societal structures that make the school unfriendly to children and youth with MI are unintentional due to entrenched attitudes and assumptions found in the schools and in the communities as a whole (Avoke, 2002; Baffoe, 2013a). Removing such barriers that hinder the day-to-day lives of children and youth with MI in the basic school setting is therefore important to improve their active participation and equal access to quality education (UNESCO, 2014). Notwithstanding the definition of disability by WHO, participants still maintain their beliefs of superstition around children with disabilities and prefer to leave them at home.

The findings of this study showed that cultural beliefs and lack of understanding of disability influenced the schooling of children and youth with MI in the mainstream, inclusive, rehabilitation and the special schools. For example, parents (at least initially) refused to send their children and youth with MI to school because they felt that their main aim was to fix their children’s impairments. Others preferred to leave their children and youth with MI at home to avoid disgrace from the stigma that is attached to disability. Stigma in this context may be described as an attribute possessed by individuals in the school or in the community or by a group of people who are regarded as being discredited (Agbenyega, 2003; Agbenyega & Deku, 2011). Again, stigma against children and youth with MI results in a lowering of status within schools and their communities. Hence, parents will not like to expose their children and youth with disabilities to the public. Sadly, stigma causes feelings of sadness and anxiety among children and youth with MI and their parents.

In addition to stigma, this study uncovered that cultural beliefs and negative societal attitudes have influenced the beliefs of parents towards disability. Due to these strong cultural beliefs, parents and community members felt that disability is a punishment from the ancestors for having committed a sin against the spiritual or moral values of society. As a result, children and youth with disabilities are not allowed to go to school or even go out to any public gathering (Mantey, 2017a). These communities view disability as a stain on the social status of a family, often leading to these children with MI being isolated and hidden away from public places (Agbenyega & Deku, 2011; Obeng, 2012). Cultural beliefs resulting from the negative attitudes towards disability create an unfriendly environment within the society. Meanwhile, this society is where values, norms and other resources are provided for its members through interaction in order to function well. A change in the values and norms of the members within the community impacts on the education of children with MI. Thus, these confusing cultural values regarding disability have dominated the parents' understanding of disability. For example, the message and social interaction that children with MI receive about themselves from their environment determine their feelings about their personality, self-esteem, what they can do and how they behave.

From the perspective of EST, the microsystem shows a pattern of activities like social roles, interpersonal relationships with the immediate families, and beliefs, perception and attitudes (Bronfenbrenner, 1989). The negative attitudes, beliefs, values and norms of the society shown by the current study form the basis of pity, fear, guilt, sympathy, uneasiness and segregation of children with MI and denial of educational rights. The unfair negative attitudes towards children with disabilities arise because of societal beliefs about disability, which are deeply rooted in cultural beliefs (Baffoe, 2013b). As noted by Singal (2014), international policies and programmes which advocate for the social model of disability conflict with the cultural beliefs and understanding about disability which are consistent with the medical model. From the perspective of DSE, I argue that such beliefs about disabilities should be challenged to pave the way for the liberation of parents of children with MI to proudly bring their children with disabilities to schools to enjoy their educational rights just like their non-disabled peers in Ghana.

The findings of this study also indicate that when parents decide to send their children with MI to school, head teachers in the mainstream schools refuse to accept these children with disabilities. As noted in section one above, it was believed that the presence of children with disabilities in the mainstream schools will lower the educational standard of the school. This situation has become a concern to head teachers because schools compete for academic excellence. Mamah (2006) notes that in many countries such as Ghana mainstream schools are under increasing pressure to raise academic standards and are therefore reluctant to admit children with disabilities whose presence, it is thought, would have a negative impact on the overall profile of results. For example, at the end of the Basic Education Certificate Examinations, the results of the entire country are analysed and a “league table” indicating the performance of each school in the district is published. As a result, school heads are concerned about the examination results of their schools. They are therefore not willing to compromise their standards by admitting children with disabilities in general, because of the notion that they are likely to lower their standards (Avoke, 2004; Mamah, 2006). This behaviour of head teachers towards admission of children with MI may be attributed to their limited understanding of disabilities and the influence of negative cultural beliefs around persons with disabilities.

From the perspective of PCT, I argue that the behaviour of head teachers in terms of the admission of children with MI to schools may partly be due to the influence of the western style of education that was inherited from Ghana's colonial masters (see Chapter 3). For example, formal education in Ghana has functioned as a "tool of power", elitist identity and domination across the continent (Tam, 1998). Based on this influence, head teachers, especially those in the mainstream schools, behave as gate keepers by using their authority to refuse children with MI into the school. As noted in Chapter 2, the history of disability in Ghana can be traced to the confining of disabled children to institutions and segregated schools, based on the belief that they required medical attention (McWilliams & Kwamena-Po, 1975; Singal, 2014). Later, schooling for children with disabilities was taken over and expanded by western hegemony (colonial powers) in Ghana (Osseo-Asare, 2017). Colonialism in Ghana has strongly influenced the education system in general about how children grow, learn and develop (Foster, 1965; Tam, 1998). In this light, Osseo-Asare (2017) posits that the English language that was inherited from Ghana's colonial masters (British) did more harm than good because Ghanaian children were alienated from their culture by not using the local language as a medium of instruction in the schools. The effect is that children are not able to effectively interact with teachers during the teaching and learning process. This effect was not only seen in children with MI, but also in their non-disabled counterparts. The neglect of Ghanaian culture and traditional values in the education system further affects the mental and physical development of students (Mfum-Mensah, 2005).

The lackadaisical attitudes of head teachers towards children with MI may be due to the lack of adequate information concerning inclusive practices. For example, in a review of literature regarding 35 articles about inclusive education in Ghana by Opoku et al. (2019), barriers to inclusive practices were found at all levels of education. They reported that teachers and head teachers in particular have not been adequately informed to teach students with disabilities in the mainstream and the inclusive classrooms.

The findings of this study also show physical and structural barriers in all school settings that impacted the educational trajectories of children with MI. Such barriers include poor school layout, inaccessible school buildings, poor toilet facilities and poor access to the dormitories. Despite the enactment of legal frameworks like the National Disability Act 715 of 2006 as noted in Chapter 2, little has been done about the physical and structural accessibility needs of the children with disabilities in the basic school settings. The absence of this enabling environment forces children with MI to assume that they are not part of the school. This is because they see themselves as different as they are unable to fully participate in the school's activities. Studies conducted in Ghana by Addo (2014), Gregorius (2016) and Mantey (2019) found that all basic school infrastructures in Ghana were characterised by some structural barriers. The voices of parents are calling for inclusion for their children and youth with MI in the basic schools, and this therefore challenges the medical model of disability that emphasises segregating children with disabilities for special care. Rather, the voices of the participants embrace the arguments of proponents of DSE that the barriers that hinder inclusion are influenced by society and not by the impairments found in the children (Baglieri et al., 2011). Therefore, there is a need for a holistic understanding of disability, and effective awareness and sensitisation initiatives that will take into consideration the cultural context and the liberalisation of equal rights of education for all in the Ghanaian basic school settings. The next section discusses theoretical implications of this study.

7.4 Section three: Theoretical implications

The purpose of this section is to reflect on the theoretical implications of the study as they relate to the educational experiences of children and youth with MI in four basic educational settings. I show how the educational experiences of these children can be interpreted through the use of three theoretical frameworks: Disability Studies in Education (DSE), Bronfenbrenner's Ecological System Theory (EST) and Post-Colonial Theory (PCT). My decision to adopt the three theories to examine the educational experiences of children and youth with MI in four basic educational settings has been appropriate and highly impactful.

7.4.1 Disability Studies in Education (DSE)

DSE has illuminated the fact that education is not directed at the cure of the impairment, but rather at participation and development. Using the framework of DSE, I was able to discern discriminatory practices and injustices that exist in the rehabilitation and special schools with regards to their school curriculum. The framework assisted me to identify societal barriers (see Chapters 5 and 6) as the main contributory factor to the exclusion of children and youth with MI from the school and the community. Also, the barriers are generated by an uncaring and oppressive society. Furthermore, a key proponent of DSE is that disability is socially constructed by society, which is not accepting human differences (Avoke, 2002; Garland-Thomson, 2005). This proponent helped me to realize that segregation and discrimination were common practices directed against children and youth with MI. The intolerant nature of teachers towards children and youth with MI was very evident. DSE further assisted me to discern that children and youth with MI should not be separated from their non-disabled peers in their educational trajectories. The emphasis on inclusion for all children is an educational right of all children and also is fundamentally moral in nature (Kalyanpur, 2014).

Nevertheless, a gap was identified in that DSE challenges the concept of special education but remains silent about the concept of a rehabilitation centre or school system. Perhaps, a rehabilitation school system is not well known by the proponents of DSE. The rehabilitation centre or school system in Ghana is equally discriminatory and is against the educational rights of children with disabilities as prescribed by Article 24 of the United Nation Convention on the Rights of Persons with Disabilities. As noted in Chapter 2, a rehabilitation school also referred to as 'rehabilitation centre' is a school that is established in Ghana to give training and employable skills to children with all kinds of disabilities so as to enable them to live an independent life (Grischow, 2011; Hayford, 2013). However, this study found that children and youth with MI do not gain any employable skills from the school to make them live an independent life.

In this study, special school and rehabilitation centres used different school curricula compared to the general basic school curriculum that is in use at the mainstream, inclusive and other special school settings. Baglieri and Knopf (2004) argued that inclusive practice will only be realized when stakeholders are encouraged to shape learning environments in ways in which all classrooms and students have access to the curriculum and learning opportunities. This is reflected in the claim arising from the current study that children and youth with MI will gain access to equal and quality education only when the basic school curriculum is made universal and accessible in all the four school settings in Ghana. When the school curriculum is made universal, all children - both disabled and non-disabled - may access education in a school setting within their locality in an inclusive manner. The already existing hostel facilities in the rehabilitation and special schools could also be well resourced to keep children with disabilities in the schools.

7.4.2 Bronfenbrenner's Ecological System Theory (EST)

The EST describes the human development process in terms of complex systemic interactions between children and their environment (Bronfenbrenner, 1989; Bronfenbrenner & Morris, 2006; Johnson, 2008). Through the lens of EST, I became cognizant of the fact that access to equal education for children will be difficult if there is no good interaction and relationship between children and their families, teachers and peers in the school. In line with the proponents of EST, this study showed that the inclusion of every child either with MI or not, at home or in the school, begins with an interaction with family members and in school with fellow students and teachers.

The EST framework has helped me to recognize the interaction of the different levels and the multiple systems involved in inclusive interaction for children and youth with MI. For instance, the micro level depicts where acceptance by the family or into the school begins. Failure to show a sense of acceptance leads to exclusion of children and youth with disabilities in the family or in the school (Geldenhuys & Wevers, 2015). Also, in the layer of EST, the meso level shows an interaction at the school between other students and the larger society. Therefore, when children and youth with MI are well accepted there is a feeling of sense of belonging and being at home. This will potentially lead to a better interaction between them, their family and the school which may lead to a transformed school conducive for inclusive practices.

7.4.3 Post-Colonial Theory (PCT)

I adopted the postcolonial theory to consider the colonial legacy of the current study context. The theory has been effective in giving this study a frame to explore in depth the power structures that have been responsible for influencing the subaltern (see Chapter 3). Using PCT, it was possible to appreciate that precolonial Ghana was not perfect, particularly in terms of understanding disability, thus shaping the attitudes of the society, parents, teachers and the general public towards the basic education system which was characterised by marginalisation, oppression and neglect. Furthermore, insights from the postcolonial theory have enabled a reconstruction of the educational experiences of children and youth with MI, in that post-colonial theory is a theory that aims at advancement of liberation and resistance politics that support decolonisation and engages subaltern experience, which involves the perspectives of dominated, marginalised, oppressed, and subordinated peoples (Spivak, 1988; van der Westhuizen, 2013). PCT enabled me to recognise the establishment of a new research tradition which is aimed at a rediscovery of the voices of children with MI, methods, ways of knowledge development through research, and a re-evaluation of educational policies that relate to education of children with disabilities in general (see Chapter 3).

The findings of this study were better explained using the overarching principle of these three theories in combination [DSE – EST – PCT]. That is, the core of the theories is the understanding of all forms of prejudice, oppression and discrimination against education of persons with disabilities (Andreotti, 2005; Connor, 2013; Slee et al., 2019). The selection of a qualitative research method also enhanced the capture of data and subsequently their analysis through these theoretical frameworks will be discussed below.

The qualitative method was helpful to elucidate educational experiences of children and youth with MI and how such experiences compared from one school setting to the other. The one-on-one interviews with children and youth with MI gave an understanding of the lived experiences of the educational trajectories of these individuals with MI.

The qualitative exploratory case study as an approach was novel in explaining the data comprehensively, which gives the opportunity to propose recommendations for further directions on what needs to be done by stakeholders of education. Based on the data presented in Chapters 5 and 6, the qualitative nature of the approach validated and reinforced the data and the results and explained the reasons children and youth with MI were found in all the four basic school settings. The method also gave room for the voices of children with MI and their parents to be heard on their aspirations and needs in their quest for quality and equal educational opportunities (Babbie & Mouton, 2010; Yin, 2009).

Furthermore, the research methodology in qualitative methods enhanced data collection and analysis which was consistent with an epistemology that views knowledge as constructed through an individual's experiences of the world (Babbie & Mouton, 2010; Barnard et al., 1999; Marton, 1981). The case study approach aimed at "describing, analysing and understanding of experiences" and allowed the researcher to describe and compare differences and similarities in the way that the phenomenon has been experienced by children and youth with MI (Marton, 1981, p. 177; Nand, 2017), which allowed me to explore in-depth the existing phenomenon. The in-depth phenomenon was ascertained through one-on-one in-depth, interviews and focus group discussion (see Chapter 4).

7.5 Chapter summary

This chapter has shown the comparison of educational experiences of children and youth with MI in the four school settings. In this chapter, parents were - at least initially - more concerned about finding a cure to the disability than finding education for children and youth with MI. Also in the chapter, the key findings of this research have shown the complex nature of educational experiences that were greatly influenced by barriers that made the schools unpleasant places for children and youth with MI. This was so because all four school settings lacked an adequate educational support system. The chapter showed that an inadequate educational support system made the basic schools unprepared for inclusive practices. Further, inequity in the basic school curriculum made children and youth with MI alienated from their fundamental educational rights. The disability study in education, Bronfenfrenner's ecological system theory and post-colonial theory in this chapter showed how the theories enhanced the understanding of the educational experiences of children with MI in the four basic educational settings in Ghana.

The next chapter presents the recommendations and conclusion of this study.

CHAPTER 8: SUMMARY, RECOMMENDATIONS AND CONCLUSION

8.1 Introduction

As noted in Chapter 1, the motivation to undertake this research was my personal educational experience as a person with mobility impairments. My initial thought before undertaking this research was to explore the educational experiences of children and youth with MI so that I could make recommendations to the policymakers and the stakeholders of education to abolish rehabilitation and special schools for children and youth with MI in Ghana. However, after I generated data, analysed, and discussed the findings, I realised that the rehabilitation and special schools should not be abolished; rather, they should be transformed to make way for inclusive schooling. The transformation of these rehabilitation and special schools (including interventions such as psychosocial support including counsellors and student, teacher, and parent support teams) are necessary for children and youth with MI to successfully access quality education that is a fundamental right.

In this final chapter, the summary will be a presentation of an inclusive schooling practices framework that will promote inclusive education in Ghana. This will follow with a discussion of the limitations of this study. After that, I will propose some recommendations for the stakeholders of education and provide areas for future research for education researchers. Finally, I will conclude the chapter.

8.2 Summary: Inclusive schooling practices framework

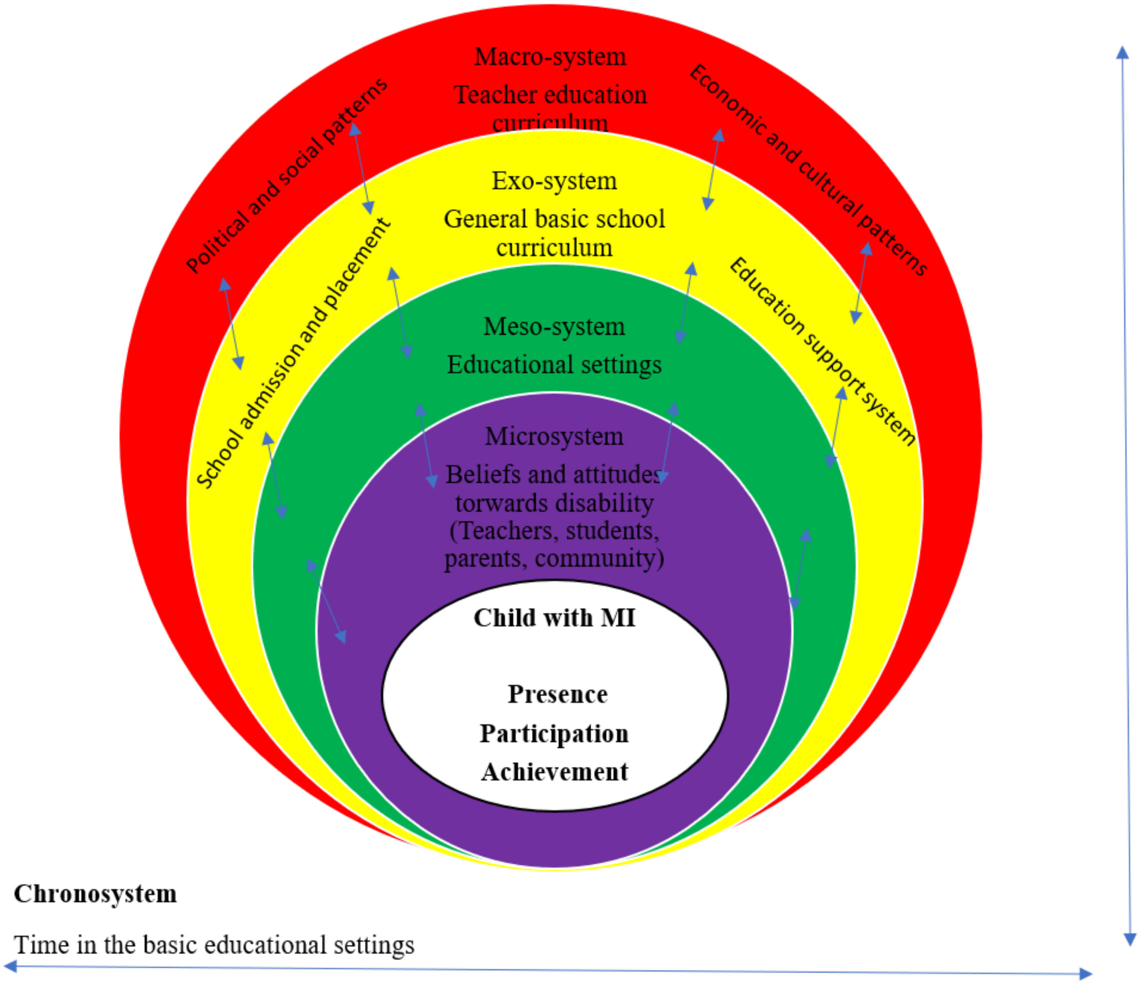


Figure 12 Inclusive schooling practices framework

The discussion of findings and the theoretical implications discussed in Chapter 7 led to the development of a framework that promotes inclusive schooling practices in Ghana. Figure 12 presents a framework that identifies five key areas for inclusive schooling practices (general basic school curriculum, beliefs and attitudes towards disability, education support system, teacher education curriculum and school admission and placement). Inclusive school has been placed at the middle of the framework [child with MI (presence, participation, and achievement)] to indicate a priority for the inclusive schooling practices. This is because the implementation of inclusive education in Ghana has been hampered within the different layers of the ecological system by a lack of structured cohesiveness in areas of preparedness of stakeholders of education at different levels of the education system; that is, inequity of basic school curriculum, difficulties in school admissions and placement, unavailability of support systems, negative beliefs and attitudes towards children with disabilities and inappropriate training at the Colleges of Education in Ghana. These factors are placed around the inclusive school in this inclusive schooling practices framework (ISPF).

Policy initiation to consider an extension of basic school curriculum for the rehabilitation and special schools will empower and adequately resource these schools to ensure that children and youth with MI progress from one level of education to the next. This progression of education is necessary to harness the potential of children and youth with MI to live independently. Also, using a general school curriculum may allow a collaboration between the Department of Social Welfare and the Special Education Division in the GES through the Ministry of Education to evenly assign trained teachers to all four educational settings in Ghana.

Another intervention is the formation of a statutory body. When a statutory body is formed to oversee schools' admission and placement for all children, parents may no longer struggle to gain admission, something that was found to be a barrier in the educational trajectories of children and youth with MI. As noted in Chapter 7, head teachers may not have a chance to refuse admission of children with disabilities in general.

The establishment of an educational support system which is currently unavailable in the basic schools in Ghana may promote inclusive schooling practices. That is, engagement of student groups, teacher groups, parent groups and district support teams will collaborate and complement each other to promote inclusive schooling practices.

Another area of concern are the beliefs and attitudes towards children with disabilities. As noted in Chapter 3, a positive schooling experience of children and youth with MI will not be realised unless there is a good interaction with the child's immediate environment. The factors within the child's immediate environment include the father, mother, siblings, the family, the community and the school community (Bronfenbrenner, 1995). Educational rights of children and youth with MI should be acknowledged in the home and the school community. This is because child development and education begin in the home and the school community. Therefore, measures should be taken to challenge the local beliefs and attitudes towards children with disabilities, as will be discussed later.

The final component of this inclusive schooling practice framework is the curriculum of Colleges of Education in Ghana. Teachers are trained in these Colleges to facilitate teaching and learning in the basic school settings (Owusu, 2016). However, not all teachers are trained in these Colleges to work with children and youth with disabilities and implement inclusive education practices (Opoku et al., 2017; Owusu, 2016). A revision of the curriculum of Colleges of Education by aligning it with the proposed revised general, basic school curriculum will promote inclusive schooling practices in the country.

8.3 Limitations of this study

While this study has several benefits, it is not without limitations. One limitation - as with most qualitative research - is its small sample size and thus the findings may not necessarily be applicable to the entire 16 regions of Ghana (Creswell, 2013). For example, only 20 children and youth with MI from two regions were engaged in the study. The study did not cater for children who could neither speak nor write. Therefore, the experiences shared by these children and youth with MI may not be the same as those from other regions in the country or those with multiple MI. However, a thick description of data was given to consider a comparison of the school settings in the other 14 regions. The findings from this study may not be generalised to the entire population of children and youth with MI in Ghana. However, this research may serve as a wake-up call to inform decisions. Also, the inclusive schooling practices framework that has been developed from this research could be used in all regions in the country to promote inclusive education.

In addition, I acknowledge that some nuances of the data may have been lost in translation. This is because 24 out of the total 28 interviews were conducted in Twi (the local language) and translated into the English language. However, in order to maintain the credibility of this study, I employed a qualified Twi translator who did all the translations and assisted me in the transcriptions.

Furthermore, I admit that there may be interference of personal influence in the generation of themes because I am a mobility impaired person who passed through similar educational experiences. In qualitative research such as this study, I could not completely detach myself from the data process. This is because the researcher becomes a vital instrument in the interpretation, generation of themes and analysis of data (Denzin & Lincoln, 2018). However, I was always conscious of my situation and tried to limit the generation of themes based on my personal perspective but remained loyal to the voices and perspective of the participants throughout this research. The next section discusses recommendations and areas for further research.

8.4 Recommendations and further research

In this section, I will discuss the practical implications of this study. The practical implications are a combination of direct suggestions from the participants and the outcome of this study. The discussions of these practical implications relate to a) policies (macrosystem), b) institutional communities (exosystem) and c) immediate community (micro and mesosystem) and are directed to the government of the Republic of Ghana, policymakers, Ministry of Education, education researchers and other stakeholders.

8.4.1 Policies (Macrosystem)

With regards to school admission and placement policies, a universal basic school curriculum and the review of a curriculum for Colleges of Education are recommended for effective implementation of inclusive education in Ghana. These are the layers in the macrosystem of Bronfenbrenner's ecological system theory that do not involve children and youth with MI directly but which have an impact on their educational trajectories (Bronfenbrenner, 1995).

The barrier with regards to difficulties and frustrations around school admission for children and youth with MI could be solved if attention is given to the process of placement of children with disabilities in the basic schools in Ghana. In the United States, Baglieri and Knopf (2015) in their book entitled *Enduring Issues in Special Education: Personal Perspective* indicated that all decisions with regards to school placement for children with disabilities are done by a team and not by any one individual. The formation of this team was backed by the Individuals with Disabilities Education Act (IDEA) (Baglieri & Knopf, 2015). Such a practice in the US brought increased fairness and ensured an easier transition of learners from home to the basic schools and subsequently to the high schools with less burden on parents. Ghana in a similar way can make a provision in the basic education policy so that a framework could be developed to oversee basic school admission and placement for children with disabilities and their non-disabled counterparts. This body when formed could adopt the computerized school selection and placement system

(CSSPS) to ensure equal access to the basic schools. The CSSPS in Ghana works in a similar way like the body that was formed in the US where school placement of students is not in the control of head teachers. For example, in the year 2005, Ghana adopted CSSPS for school placement of students in the second cycle institutions (Ghana News Agency, 2012). This CSSPS is a system adopted by Ghana Education Service (GES) to place students into Senior High Schools (SHS), Senior High Technical Schools (SHTS) and Vocational Schools (Ghana News Agency, 2012). The CSSPS may have some challenges, yet the team in charge of the placement brought fairness and equity to the admission of students in the second cycle institutions (Ghana News Agency, 2012). A system such as CSSPS is necessary to give equal opportunity to children and youth with MI to attend any school setting that will best serve their needs. Also, the CSSPS when adopted may wipe away all unauthorized financial charges that are made before school admissions are given. Further, the CSSPS may reduce anxiety, frustrations and confusion that parents and children with MI go through when they are looking for school admissions.

To augment the proposed computerized school selection and placement system for students already in the basic schools, Ghana can use the students' cumulative record card as a standard for the school placement. A student cumulative record card gives vivid information of the achievement of a student. The achievement may include, among other things; physical, academic, moral, social and the health aspects of the student (Ansari, 2018). As noted in Chapter 2, students at Grade 9 level write a general national examination before they are placed in the Senior High Schools. The usage of a proposed cumulative record for school placement at the Senior High School means that there may not be a need for Grade 9 students to write the national examinations; that is, basic education certificate examination (BECE). Cancellation of BECE examinations may alleviate unnecessary competition that influences head teachers in the mainstream schools' decision to not accept children with MI. For students who are starting a pre-school or basic school one (grade one), their ages could be used as a standard for placement as prescribed in the education policy (National Education Assessment Unit, 2016).

The policymakers and Ministry of Education (MoE) should revise the education policy in order to address the inequity in the basic school curriculum. At present, the curriculum in the mainstream and inclusive schools is different from the curriculum in the rehabilitation and special schools in the study area, which ultimately denies children and youth with MI in the rehabilitation and the special schools their fundamental education rights. As noted in Chapter 7, I argue that, when the basic school curriculum is extended to the rehabilitation and the special schools, all children whether abled or disabled can access the rehabilitation and the special schools that are closest to them. This will mean that all the four school settings may be accessible to all children, if Ghana takes inclusive education as a priority. The existing hostel facilities in the rehabilitation and special schools may host children with disabilities. This may help parents to spent little money on transporting their children with disabilities to and from the school.

I also recommend a revision of the curriculum of Colleges of Education to align with the universal basic school curriculum. This is necessary to adequately prepare all teachers for all children, irrespective of the children being disabled or not disabled. Teachers may not complain that they were not trained to teach children with disabilities as was observed in Chapter 7. Teachers may be trained to appreciate and welcome all children whether disabled or non-disabled to enforce inclusive education.

Further research is necessary to investigate the applicability of a statutory body to take care of school admission and placement at the basic school level in Ghana. Also, further research is necessary to investigate why a separate school curriculum is being used in the rehabilitation and the special schools. Such investigations may provide reasons for the inequities in the school curriculum and may be beneficial to policymakers. Further research into the universal basic school curriculum and the curriculum of the Colleges of Education is recommended if Ghana takes inclusive education as a priority.

8.4.2 Institutional communities (Exosystem)

By institutional communities, I am referring to the structures of the four basic school settings (mainstream, inclusive, rehabilitation and special schools), including buildings, curriculum, teacher, student and parent bodies. Children and youth with MI encounter physical barriers in accessing educational services in all four school settings, for example, lack of ramps and elevators in multi-level school buildings, inaccessible toilets and lack of school buses to transport students to and from school. I recommend that the Government of the Republic of Ghana through the Ministry of Education make provision in all the schools for children and youth with MI to access the school buildings and the toilet facilities and to supply accessible school buses. The reason is that provision of these facilities will make all basic schools more accessible to children with disabilities in general.

Another concern is the inadequate supply of teachers and those who are available are untrained to teach children with disabilities. To address this situation, the MoE through the GES and Special Education Division should organise inclusive education training through; 1) providing in-service training for all teachers in the basic schools. This training should aim at developing an understanding of diversity and the right of every child to learn in the schools nearer to their homes. The in-service training should also aim at developing teachers' knowledge about various disabilities and how these may influence the learning processes in the school. 2) Extend inclusive education training for all teachers in the Colleges of Education. This type of training may develop empathy and patience in dealing with children with MI and may build confidence in teachers to embrace inclusive practices. This training will empower teachers to have appropriate values and attitudes, skills and competences that will promote inclusion of children with disabilities at all levels of education. It is evident that the training and development of teachers has been a prominent feature of success in Italy (European Agency for Development in Special Needs Education, 2012). The government of Italy believes that effectively trained teachers are teachers for all children, either disabled or non-disabled (European Agency for Development in Special Needs Education, 2012).

Unavailability of structures and systems such as student support teams, teacher support teams and district support teams in schools could be daunting for students, teachers and district education officers. The current study showed that there was no such educational support service in all the four school settings. As a matter of urgency, GES should establish these student support teams, teacher support teams, district support teams and parent support teams in all schools in the country to promote inclusive schooling practices. Ghana can learn from South Africa where the Education White Paper of 2001 captured the establishment of district support teams and the institutional-level support teams (Department of Basic Education, 2010). For example, as noted in Chapter 2, in South Africa, Mariga et al., (2014) stated that district support teams, teacher support teams, student support teams and parent support teams play a vital role in the practice of inclusive education. Some of these vital roles that will be achieved are: 1) good collaboration between students, teachers, parents and education officers which will further reduce negative attitudes towards children with disabilities and subsequently reduce stigma and stereotyping; 2) understanding that each individual is unique and recognise individual differences; and 3) positive school climate for collaboration, team work and life-long inclusive teaching and learning that will make all basic school settings welcoming to all children.

Another area within the exosystem that does not involve children with MI directly, but that has an impact on their education is inadequate financial support in all four school settings. This could be addressed by the government through the fCUBE policy. If the fCUBE policy has made basic schools free (Boahene, 2000), then it is recommended that the government of the Republic of Ghana should demonstrate political will by making a special budget allocation for the rehabilitation and special schools to upgrade them to the level of the mainstream and inclusive schools. When enough funds are allocated to these schools, and they are converted to inclusive schooling centres, all children with and without disabilities may access equal and quality education from these inclusive schooling centres.

Further research is recommended to investigate why all teachers in the Colleges of Education are not trained to teach children with disabilities, as was noted in Chapter 7. Also, I recommend further research to find out why newly built school structures do not make such school buildings accessible to children with disabilities, as was mandated in the Ghanaian Disability Act 715 of 2006.

8.4.3 Immediate community (Micro and mesosystem)

The immediate community of children with MI falls within the micro and mesosystems of Bronfenbranner's ecological system theory and include the home and the school. Within these layers, children and youth with MI have direct interaction with people around them and these relationships were characterised by negative attitudes towards disability among members in the family and the community. In the school, there was mockery, name calling and an unsupportive school environment. It is recommended that the government through the Ministry of Education and the Ghana Education Service conduct a concerted campaign to improve attitudes towards disability at different levels of the community.

Further research is recommended to investigate other ways to create good relationships between children with disabilities and their immediate communities. This is important to make inclusive schooling practices more accessible in the four school settings in Ghana.

8.5 Conclusion

The starting point of this study was the challenge of basic school placement for children and youth with MI in Ghana. Despite the fact that Ghana has followed international frameworks and has taken steps to implement inclusive education (Opoku et al., 2019), parents and children with MI are still uncertain about what educational setting best serves the needs of children and youth with MI. This scenario triggered my interest to explore the educational experiences of children and youth with MI in four basic educational settings in Ghana.

Considering that the topic is rarely researched and that this study is the first of its kind in Ghana, the study has made an original contribution to the body of knowledge. Thus, this study has enhanced the comprehension of educational experiences of children and youth with MI in the basic educational settings in the Ashanti and the Oti regions of Ghana.

Also, the study adopted a combination of three theoretical frameworks – namely: Bronfenbrenner’s ecological system theory, disability studies in education and post-colonial theory. These three theories enhanced the understanding of the views of children and youth with MI, parents, and head teachers regarding the education of children and youth with MI. Again, the theory as a framework showed that the curriculum of Ghanaian basic education was a borrowed one from her colonial masters and does not readily cater for the culture and beliefs of the nation. An example of such a borrowed curriculum is the objective curriculum (Hitt & Tyler, 1991) (see Chapter 3).

Notwithstanding the fact that the Ghanaian basic school curriculum was borrowed from the Western ideologies (objective curriculum), children and youth with MI in the mainstream and the inclusive schools faced barriers, but there can be hope for them to progress from one school level to the next. That is, children and youth with MI in these two school settings could go to the senior high schools and to the universities. On the other hand, children and youth with MI who had their education in the rehabilitation and the special schools could not progress from one level of education to the next (see Chapter 5). This study further showed a scenario where such children and youth with MI in the rehabilitation and special schools saw themselves as being in the witches' camp. This means they were rejected and ostracized from the school system and from the community in general. Thus, it is imperative that interventions that will enhance equal access to quality education for not only children and youth with MI, but all children with disabilities be a priority. As such, this research developed an inclusive schooling practices framework to promote inclusive education in all the four basic educational settings in Ghana. I am confident that the findings of this research will fall on listening ears.

REFERENCES

Abberley, P. (1996). Disabled by numbers. In R. Levitas, & W. Guy (Eds.), *Interpreting Official Statistics*. Routledge, (pp. 166–184).

Ackah-Jnr, F. R., & Danso, J. B. (2019). Examining the physical environment of Ghanaian inclusive schools: How accessible, suitable and appropriate is such environment for inclusive education? *International Journal of Inclusive Education*, *23*(2), 188–208. https://doi.org/10.1080/13603116.2018.1427808

ACPF. (2011). *Educating children with disabilities in Africa: Towards a policy of inclusion*. Addis Ababa. https://www.eenet.org.uk/resources/docs/6519.pdf

Addo, G. (2014). *Analysis of barriers to children with mobility impairment in basic education in Accra Metropolis, Ghana*. Kwame Nkrumah University of Science and Technology. https://doi.org/10.1.1.868.2719

Adu-Gyamfi, S., Donkoh, W. J., & Addo, A. A. (2016). Educational reforms in Ghana: Past and present. *Journal of Education and Human Development*, *5*(3), 158–172. https://doi.org/10.15640/jehd.v5n3a17

Adu-Gyamfi, S., Donkor, W. J., & Addo, A. A. (2017). Educational reforms in Ghana: Past and present. *Journal of Education and Human Development*, *5*(3), 158–172. https://doi.org/10.15640/jehd.v5n3a17

Agbenyega, J. A. (2003). The power of labelling in the construction of disability in Ghana. In *Australian Association for Research in Education* (p. 12). Melbourne. https://www.aare.edu.au/data/publications/2003/agb03245.pdf

Agbenyega, J. A., & Deku, P. K. (2011). Building new identities in teacher preparation for inclusive education in Ghana. *Current Issues in Education*, 14(1), 1-36.

Aheto-tsegah, C. (2011). Education in Ghana – status and challenges. Commonwealth Education Partnership, 27-29

Ahmad, F. K. (2014). Use of assistive technology in inclusive education : Making room for diverse learning needs. *International Journal of Fundamental and Applied Research*, 9(2) 9-16.

Ainscow, M., & Miles, S. (2009). Developing inclusive education systems : How can we move policies forward ? *American Educational Research Journal*, 1–9. Retrieved from http://www.ibe.unesco.org/fileadmin/user_upload/COPs/News_documents/2009/0807Beirut/DevelopingInclusive_Education_Systems.pdf

Albrecht, G. L., Seelman, K. D., & Bury, M. (2001). *Handbook of disability studies*. Sage Publications Limited.

Anderson, G., & Arsenault, N. (1998). *Fundamentals of educational research* (2nd ed.). Routledge.

Anderson, J., Boyle, C., & Deppeler, J. (2014). The ecology of inclusive education. *Equality in education.* 23-34. https://doi.org/10.1007/978-94-6209-692-9_3

Andreotti, V. de O. (2005). The contributions of postcolonial theory to development education. *Journal of Education*. https://doi.org/10.1057/9780230337794

Andreotti, V. de O. (2012). Actionable postcolonial theory in education. *International Journal of Development Education and Global Learning*, *4*(3), 304.

https://doi.org/10.18546/IJDEGL.04.3.05

Ansari, M. (2018). Methods of studying children and adolescents. *Journal of Education and Social Research*, 65–85.

Aseka, W. (2003). Education for all: Right to education for children with disabilities in Kenya, *African Charter on Human Rights and Peoples' Right*, 14(14), 1–28.

Ashigbi, Y. E., Danso, A. K., & Tudzi, E. P. (2014). Mobility Challenges of Persons Living With Disabilities at the University of Ghana. *1st International Conference on Applied Science and Technology (ICAST 2014)*, 47.

Auberon, B., & Odoom, J. (2016). Ghana’s journey towards inclusive education. *Centre for Human Rights Publication*, 12(3), 29-55

Avoke, M. (2001). Some historical perspectives in the developement of special education in Ghana. *European Journal of Special Needs Education*, 16(1), 29–40. http://dx.doi.org/10.1080/08856250150501789. 'Retrieved from' no longer required as I understand it.

Avoke, M. (2002). Models of disability in the labelling and attitudinal discourse in Ghana. C*Disability & Society*, *17*(7). http://dx.doi.org/10.1080/09687590220000039064

Avoke, M. (2004). *Introduction to special educaion for universities and colleges*. City Publishers.

Avramidis, E., & Kalyva, E. (2007). The influence of teaching experience and professional development on Greek teachers’ attitudes towards inclusion. *European Journal of Special Needs Education*, 22(4), 367–389. Retrieved from http://www.seerc.org/refbase/

Awal, M. A. (2014). Implementation of inclusive education in Ghanaian primary schools: A look at teachers` attitudes. *American Journal of Educational Research*, *2*(3), 142–148. https://doi.org/10.12691/education-2-3-5

Babbie, E. (2008). *The basics of social research* (4th ed.). Belmont: Thomson Wadsworth. https://doi.org/-10: 0-495-09468-4

Babbie, E., & Mouton, J. (2010). *The practice of social research.* (10th ed.). Oxford University Press Southern Africa.

Badu, M. (2016). Experiences of parents of children with intellectual disabilities in the Ashanti Region of Ghana. *Journal of Social Inclusion*, *7*(1), 20–30. https://josi.journals.griffith.edu.au/index.phd/inclusion/article/view/796/757

Baffoe, M. (2013a). Stigma, discrimination & marginalization: Gateways to oppression of persons with disabilities in Ghana, West Africa. *Journal of Educational and Social Research*, *3*(January), 187–198. https://doi.org/10.1.1.653.906

Baffoe, M. (2013b). Stigma, discrimination & marginalisation: Gateways to oppression of persons with disabilities in Ghana, West Africa. *Journal of Education and Social Research*, *3*(January), 187–198. https://doi.org/10.5901/jesr.2013.v3n1p187

Baglieri, S., & Knopf, H. J. (2004). Normalizing difference in inclusive teaching. *Journal of Learning Disabilities*, *37*(6), 525–529. https://doi.org/10.1177/00222194040370060701

Baglieri, S., & Knopf, H. J. (2015). *Enduring issues in special education: Personal perspectives* (1st ed.). Routledge.

Baglieri, S., Valle, J. W., Connor, D. J., & Gallagher, D. J. (2011). Disability studies in education: The need for a plurality of perspectives on disability. *Remedial and Special Education*, *32*(4), 267–278. https://doi.org/10.1177/0741932510362200 All journal article items should be just like this one.

Banks, L. M., & Zuurmond, M. (2015). Barriers and enablers to inclusion in education for children with disabilities in Malawi. *International Journal of Science and Research, 1(3),* 1–42.

Barnard, A., McCosker, H., & Gerber, R. (1999). Phenomenography: A qualitative research approach for exploring understanding in health care. *Qualitative Health Research*, *9*(2), 212–226. https://doi.org/10.1177/104973299129121794

Barnes, C. (2012). *Understanding the social model of disability: Past, present and future*. Routledge. https://doi.org/10.4324/9780203144114

Barnes, C. (2015). Understanding the social model of disability. In *Routledge Handbook of Disability Studies*. https://doi.org/10.4324/9780203144114.ch2

Barnes, C., & Mercer, G. (2012). Disability culture: Assimilation or inclusion? In *Handbook of Disability Studies*. https://doi.org/10.4135/9781412976251.n22

Berk, R. A. (2001). The effective teaching is all about the students: Star tech: The net generation! *Journal on Excellence in College Teaching*, 12(1), 97–107. http://www.ronberk.com/articles/2008_star-tech.pdf

Blampied, C., Chattopadhyay, S., Greenhill, R., Aziz, I., Ellison, C., Thompson, R., … Salifu, A. (2018). *Leaving no one behind in the health and education sectors An SDG stocktake in Ghana*. Accra. https://www.odi.org/sites/odi.org.uk/files/resource-documents/12145.pdf

Boahene, A. (2000). Accountability in the education sector: The case of Ghana. *Ministry of Education*, *1*(December), 6. http://unesdoc.unesco.org/images/0025/002595/259537e.pdf%0Ahttp://ir.knust.edu.gh/handle/123456789/8462%0Awww.gra.gov.gh/docs/info/ge_trust_fund_act.pd

Booth, T., Ainscow, M., & Kingston, D. (2006). Index for inclusion: Developing play, learning and participation in early years and childcare. *Centre for Studies on Inclusive Education (CSIE)*, (2006), 1–114.

Botts, B. H., & Owusu, N. A. (2013). The state of inclusive education in Ghana, West Africa. *Preventing School Failure: Alternative Education for Children and Youth*, *57*(3), 135–143. https://doi.org/10.1080/1045988X.2013.798776

Bouaghi, O. El, & Bouaghi, O. El. (2015). Investigating teachers' and students' attitudes towards the effect of overcrowded classes on teacher-students interaction: *Algerian Scientific Journal Platform, 8(2),* 425-438

Bowen, G. A. (2009). Document analysis as a qualitative research method. *Qualitative Research Journal*, *9*(2), 27–40. https://doi.org/10.3316/QRJ0902027

Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research*, *4*. https://doi.org/10.1177/2333393617742282

Briggs, P. (1998). *Guide to Ghana* (First, Vol. 1). Bradt Country Guides. https://www.amazon.com/Guide-Ghana-Bradt-Country-Guides/dp/1898323690

Bronfenbrenner, U. (1989). Ecological systems theory: *Annals of child development*, *6*, 187–249.

https://doi.org/doi …, 1989

Bronfenbrenner, U. (1995). Developmental ecology through space and time: A future perspective. In P. Moen & G. H. Elder, Jr., (Eds.), Examining lives in context: Perspectives on the ecology of human development (pp 619-647). *American Psychological Association*.

Bronfenbrenner, U. (2005). The developing ecology of human development: Paradigm lost or paradigm regained". In *Making human beings human : Bioecological perspectives on human development*, 287-309, Springer

Buah, F. K. (1980). *History of Ghana.* (illustrate). Macmillan Education Group. https://books.google.co.za/books/about/A_History_of_Ghana.html?id=EBl-QgAACAAJ&redir_esc=y

Bunning, K., Gona, J. K., Newton, C. R., & Hartley, S. (2017). The perception of disability by community groups: Stories of local understanding, beliefs and challenges in a rural part of Kenya. *PLoS ONE*, *12*(8). https://doi.org/10.1371/journal.pone.0182214

Burchardt, T. (2004). Capabilities and disability: The capabilities framework and the social model of disability. *Disability & Society*, *19*(7), 735–751. http://dx.doi.org/10.1080/0968759042000284213

Clarke, V., & Braun, V. (2013). Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist*, *26*(2), 120–123.

Clarke, V., & Braun, V. (2017). Thematic analysis. *Journal of Positive Psychology*, *12*(3), 297–298. https://doi.org/10.1080/17439760.2016.1262613

Cohen, L., Manion, L., & Morrison, K. (2000). *Research methods in education* (5th ed.).

Routledge Falmer. https://doi.org/10.4324/97802032

Connor, D. J. (2013). Who “owns” dis/ability? The work of critical special educators as insider outsiders. *Theory and Research in Social Education*, 31(4), 494–513.

Connor, D. J., Gabel, S. L., Gallagher, D. J., & Morton, M. (2008). Disability studies and inclusive education — implications for theory, research, and practice. *International Journal of Inclusive Education*, *12*(5–6), 441–457. https://doi.org/10.1080/13603110802377482

Connor, D. J., & Gabel, S. L. (2013). “Cripping” the curriculum through academic activism: Global exchanges to reframe disability and education. *Equity & Excellence in Education*, 46(1), 100–118.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five traditions* (4th ed.). Sage.

Creswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Sage.

Creswell, J. W. (2016). *30 essential skills for the qualitative researcher*. CA: Thaousand Oaks, SAGE Publications Ltd.

Creswell, J. W., & Guetterman, T. C. (2018). *Educational research: Planning, conducting, and evaluating quantitative and qualitative research* (6th ed.). Pearson.

Crossman, A. (2019). Understanding critical theory. https://www.thoughtco.com/critical-theory-3026623. ThoughtCo

Curtin, M., Clarke, G., Curtin, M., & Clarke, G. (2007). Listening to young people with physical disabilities ’ experiences of education listening to young people with physical disabilities’ experiences of education. https://doi.org/10.1080/10349120500252817

Denzin, & Lincoln, Y. S. (2018). *Qualitative research* (5th ed.). Sage Publications. https://uct.worldcat.org/title/sage-handbook-of-qualitative-research/oclc/975074532

Denzin, N. K., & Lincoln, Y. S. (2000). *Qualitative research (3rd ed.).* Sage Publications. http://xa.yimg.com/kq/groups/22998310/839904994/name/ereserve+1.pdf

Department of Basic Education. (2010). *Guidelines for Full-service/ Inclusive Schools 2010 Education White Paper 6 Special Needs Education: Building an Inclusive Education and Training System*. www.education.gov.za

Disabled World. (2015). Physical & mobility impairments: Information & news. https://www.disabled-world.com/disability/types/mobility/

Djamba, Y. K., & Neuman, W. L. (2002). *Social research methods: Qualitative and quantitative approaches*. *Teaching Sociology* (7th ed. Vol. 30). https://doi.org/10.2307/3211488

Edusei, A. K., Owusu-Ansah, F. E., Dogbe, J. A., Morgan, J., & Sarpong, K. (2015). Perspectives in musculoskeletal injury management by traditional bone setters in Ashanti, Ghana. *African Journal of Disability*, *4*(1). 235-289.

Elder, B. C., & Foley, A. (2015). Working within the tensions of disability and education in post - colonial Kenya: Toward a praxis of critical disability studies. *Disability and the Global South*, *2*(3), 733–751. https://disabilityglobalsouth.files.wordpress.com/2012/06/dgs-02-03-03.pdf

Elliott, R., Utyasheva, L., & Zack, E. (2009). HIV, disability and discrimination: Making the links in international and domestic human rights law. *Journal of the International AIDS*

Society. https://doi.org/10.1186/1758-2652-12-29

Epure, I. (2016). The women of Ghana’s witch camps. https://womenintheworld.com/2016/02/07/ghanian-women-accused-of-witchcraft-banished-to-segregated-camps/

European Agency for Development in Special Needs Education. (2012). Profile of inclusive teachers, Odense, Denmark: European Agency for Development in Special Needs Education. *European Journal of Special Needs Education*, *12*(1), 89–91. https://doi.org/10.1080/0885625970120109

Euroqol Group. (2009). EuroQol Group EQ-5D^{TM} Health Questionnaire. *Http://Www.Euroqol.Org/Eq-5D-Products/How-To-Obtain-Eq-5D.Html*, 3.

Femdal, I., & Solbjør, M. (2018). Equality and differences: Group interaction in mixed focus groups of users and professionals discussing power. *Society, Health & Vulnerability*, *9*(1), 1447193. https://doi.org/10.1080/20021518.2018.1447193

Finkelstein, V. (1993). Representing disability. In J. Swain, V. Finkelstein, S. French, S. & M. Oliver (Eds.). *Disabling barriers: Enabling environments* (pp. 13–20). Sage Publications.

Fleischer, D. Z., & Zames, F. (2001). *The disability rights movement: From charity to confrontation.* University Press.

Fletcher, K. A. (2013). *Perceptions of contemporary effects of colonialism among educational professionals in Ghana*. University of Massachusetts Amherst.

Flyvbjerg, B. (2006). Five misunderstandings about case-study research, 12(2), 219–245. Sage Publications.

Foster, P. (1965). Education and social change in Ghana. Routledge & Kegan Paul. *International Library of Sociology and Social Reconstruction*, *21*(1), 558–559.

Fraenkel, J., Wallen, N., & Hyun, H. (2012). *How to design and evaluate research in education. TT-1* (8th ed.). The McGraw-Hill Companies.

Friesen, N. (2019, June). Critical theory, ideology, critique and the myths of e-learning. *Ubiquity Homepage Archive*, *2008*(June). https://doi.org/10.1145/1403922.1386860

Gadangbui, Y. (2008). Inclusive education in Ghana: Practices, challenges and the future implications for all stakeholders, 53. University of Education, Winneba Press.

Garland-Thomson, R. (2005). Feminist disability studies. *Signs*, 30(2), 1557–1587. https://doi.org/10.1086/423352

Geldenhuys, J. L., & Wevers, N. E. J. (2015). Ecological aspects influencing the implementation of inclusive education in mainstream primary schools in the Eastern Cape, South Africa. *South African Journal of Education*, 33(3), 1–18. https://doi.org/10.15700/201503070804

Ghana Education Service. (2015). The Ghanaian education system described and compared with the Dutch system. Government Publications.

Ghana News Agency. (2012, August). GES Council calls on parents not to interfer in SHS selection. *Education*, p. 3. https://www.ghananewsagency.org/education/ges-council-calls-on-parents-not-to-interfere-in-shs-selection--32855

Ghana News Agency. (2019). Know the 16 regional capitals of Ghana. https://www.businessghana.com/site/news/general/182246/Know-the-16-regional-capitals-of-Ghana

Ghana Statistical Service, Ghana Health Service, I. I. (2015). Ghana Demographic and Health Survey 2014. *International Journal of Health Policy and Management*, *5*(9), 525–533. https://doi.org/10.15171/ijhpm.2016.42

Ghana Statistical Service. (2010). 2010 Population and Housing Census Summary of Final Results, (June 2012), 1–15. http://www.statsghana.gov.gh/censuses.html

Giri-ph, K. (2016). Inclusive education: Stakeholders' perception, (August 2004). https://doi.org/10.13140/2.1.1136.9287

Goodley, D. (2011). Social psychoanalytic disability studies. *Disability and Society*. https://doi.org/10.1080/09687599.2011.602863

Graham, C. K. (1971). The history of education in Ghana: From the earliest time to the declaration of independence, 181–185, Frank Cass.

Gray, D. (2009). *Doing research in the real world* (2nd ed.). Sage Publications. https://books.google.com.ng/books/about/Doing_Research_in_the_Real_World.html?id=l4dEQTQl1NYC&redir_esc=y

Gray, J., Grove, S., & Sutherland, S. (2016). *Burns and Grove's the practice of nursing research* (8th ed.). Saunders.

Gregorius, S. (2014). *Transitions to adulthood: The experiences of youth with disabilities in Accra, Ghana*. Loughborough University.

Gregorius, S. (2016). Exploring narratives: Disabled young people's experiences of educational institutions in Ghana. *Disability & Society*, *31*(3), 322–338. https://doi.org/10.1080/09687599

Grischow, J. D. (2011). Kwame Nkrumah, Disability and Rehabilitation in Ghana, 1957 - 1966. *Journal of African History*, *52,* 179–199. https://doi.org/.1017/S0021853711000260

Guba, E. G., & Lincoln, Y. S. (1989). *Fourth generation evaluation*. Sage Publications.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.). *Handbook of Qualitative Research*. 324-405. Sage Publications

Gupta, A. (2013). *Early childhood education, postcolonial theory, and teaching practices and policies in India: Balancing Vygotsky and the Veda*. Palgrave Macmillan.

Gyimah, E. K., Sugden, D., & Pearson, S. (2008). An investigation into the emotional reactions to inclusion of Ghanaian mainstream teachers. *Support for Learning*, *23*(2), 71–79. https://doi.org/10.1111/j.1467-9604.2008.00373.x

Hall, S., & Gay, D. P. (2006). Questions of cultural identity: Environmental geology: Advances and prospects. *Geological Bulletin of China*, *25*(11), 1247–1256.

Hanhela, T. (2014). Axel Honneth's idea of a drawn-out process of education. *Pedagogy, Culture and Society*, *22*(3), 369–388. https://doi.org/10.1080/14681366.2014.891642

Hayford, S. K. (2013). *Special educational needs and quality education for ALL. University of Education, Winneba*. Winneba: Salt n Light Publications.

Hitt, A. M., & Tyler, B. B. (1991). Strategic decision models: Integrating different perspectives. *Strategic Management Journal*, *12*(5), 327–351. https://doi.org/10.1002/smj.4250120502

Hughes, P. (2010). Paradigms, methods and knowledge. In *Doing Early Childhood Research* (2nd ed., pp. 35–61). Allen & Unwin.

Hunt, P. (1966). A critical condition. In: P. Hunt (Ed.), *Stigma: The experience of disability. Journal of Educational and Social Research* (pp. 1–10). Geoffrey Chapman. https://doi.org/10.4324/9781315560076-5

Hurst, R. (2005). Disabled peoples' international : Europe and the social model of disability. *The Social Model of Disability: Europe and the Majority World*, 65-79. The Disability Press.

Hussain, A. M., Elyas, T., & Nasseef, O. A. (2013). Research paradigms: A slippery slope for fresh researchers. *Life Science Journal*, *4*(10), 2374-2381]. http://www.lifesciencesite.com/lsj/life1004/317_B02518life1004_2374_2381.pdf

IBE-UNESCO. (2016). Training Tools for Curriculum Development - Reaching out to all learners: A resource pack for supporting inclusive education. *Journal of Education,* 108(5), 179. https://doi.org/10.1177/002205742810800506

Imenda, S. (2014). Is there a conceptual difference between theoretical and conceptual frameworks? *Journal of Social Sciences*, *38*(2), 185–195. https://doi.org/10.1080/09718923.2014.11893249

Johnson, E. S. (2008). Ecological systems and complexity theory: Toward an alternative model of accountability in education. *Complicity: An International Journal of Complexity and Education*, *5*(1), 1–10. https://doi.org/10.29173/cmplct8777

Kadingdi, S. A. (2004). *A study of primary teachers' views about their work in the context of the fcube reform in a disadvantaged district of Ghana*. Institute of Education, University of London. http://discovery.ucl.ac.uk/10007397/7/Kadingdi%2C Stanislaus Alu_Redacted.pdf

Kalyanpur, M. (2014). *Equality in education: Fairness and inclusion*. In H. Zhang, P. W. K.

Chan, & C. Boyle, (Eds.). Brill/Sense. https://doi.org/10.1007/978-94-6209-692-9

Kivunja, C., & Kuyini, A. B. (2017). Understanding and Applying Research Paradigms in Educational Contexts. *International Journal of Higher Education*, *6*(5), 26. https://doi.org/10.5430/ijhe.v6n5p26

Kiyuba, J., & Tukur, S. Y. (2014). *Challenges of providing special education to children with disabilities: View of teachers and education officials.* University of Education, Winneba. http://hig.diva-portal.org/smash/get/diva2:764634/FULLTEXT01.pdf

Kojo, E. (2019). Here are the capitals of the newly created regions. https://www.pulse.com.gh/news/local/here-are-the-capitals-of-the-newly-created-regions/y6lxsc5

Kuyini, A. B. (2013). Ghana's education reform 2007: A realistic proposition or a crisis of vision. *International Review of Education, 59*(2), 157–176. https://doi.org/10.1007s/11159-013-93437

Kuyini, A. B., Yeboah, K. A., Das, A. K., Alhassan, A. M., & Mangope, B. (2016). Ghanaian teachers: Competencies perceived as important for inclusive education. *International Journal of Inclusive Education*, *20*(10), 1009–1023. https://doi.org/10.1080/13603116.2016.1145261

Kwao, A. (2017). Challenges of curriculum design and its implications on policy: The case of the Junior High School (JHS) teaching subjects in Ghana. *Journal of Educational and Social Research*, *7*(2), 93–101. https://doi.org/10.5901/jesr.2017.v7n2p93

Lamptey, D. L., Villeneuve, M., Minnes, P., & McColl, M. A. (2015). Republic of Ghana's policy on inclusive education and definitions of disability. *Journal of Policy and Practice in*

Intellectual Disabilities, *12*(2). https://doi.org/10.1111/jppi.12114

Lankshear, C., & Knobel, M. (2004). *A handbook for teacher research: From design to implementation*. Maidenhead: Open University Press.

Leedy, P., & Ormrod, J. (2001). *Practical research: Planning and design.* (7th ed.). Merrill Prentice Hall and Sage Publications.

Lieber, E., Weisner, T. S., & Presley, M. (2003). EthnoNotes: An internet-based field note management tool. *Field Methods*, *15*(4), 405–425.

Lieberman, A. (2018). *Improving schools: Teaching, learning and living*, 81–93. https://doi.org/10.4324/9781315163109-8

Macbeth, J. (2010). *"Living with the colonial legacy: The Ghana story."* Centre for Commonwealth Education.

Mamah, V. (2006). Making inclusion a reality in Ghana. The role of the University of Education, Winneba. *African Journal of Special Education Needs*, 4(2), 299–305.

Mantey, E. E. (2014). *Accessibility to inclusive education for children with disabilities: A case of two selected areas in Ghana*. Siegen, Germany. https://d-nb.info/1068362936/34

Mantey, E. E. (2015). *Accessibility to inclusive education for children with disabilities: A case of two selected areas in Ghana*. University of Siegen. https://d-nb.info/1068362936/34

Mantey, E. E. (2017a). Discrimination against children with disabilities in mainstream schools in Southern Ghana: Challenges and perspectives from stakeholders. *International Journal of Educational Development*, 54, 18–25. https://doi.org/10.1016/j.ijedudev.2017.02.001

Mantey, E. E. (2017b). Discrimination against children with disabilities in mainstream schools in

Southern Ghana: Challenges and perspectives from stakeholders. *International Journal of Educational Development*. https://doi.org/10.1016/j.ijedudev.2017.02.001

Mantey, E. E. (2019). Beyond the politics of inclusion : The policy environment and the fate of children with disability in the Ghanaian educational system Efua Esaaba Mantey. *Mediterranean Journal of Social Sciences, 2117*(1960), 54–61. https://doi.org/10.2478/mjss-2019-0066

Mariga, L., McConkey, R., & Myezwa, H. (2014). *Inclusive education in low-income countries: A resource book for teacher educators, parent trainers and community development workers.* Atlas Alliance and Disability Innovations Africa. http://www.eenet.org.uk/resources/docs/Inclusive_Education_in_Low_Income_Countries.pdf

Marton, F. (1981). Phenomenography - describing conceptions of the world around us. *Instructional Science*, *10*, 177–200. https://doi.org/10.1007/BF00132516

McKay, L. (2016). Beginning teachers and inclusive education: Frustrations, dilemmas and growth. *International Journal of Inclusive Education*, *20*(4). 383-396. https://doi.org/10.1080/13603116.2015.1081635

Mckenzie, J. (2009). *Constructing the intellectually disabled person as a subject of education: A discourse analysis using Q-methodology*. [Doctoral thesis, Rhodes University]. https://www.researchgate.net/publication/43165573_Constructing_the_intellectually_disabled_person_as_a_subject_of_education_a_discourse_analysis_using_Q-methodology/link/02e7e51e791308aa12000000/download

Mckenzie, J., & Macleod, C. I. (2011). Rights discourses in relation to education of people with intellectual disability : Towards an ethics of care that enables participation. *International*

Journal of Inclusive Education, 27(1):15-29. doi.org/10.1080/09687599.2012.631795.

McKinney, E. (2013). *The experiences of people with disabilities during their integration and retention into employment in South Africa*. [Doctoral thesis, University of Cape Town]. https://open.uct.ac.za/bitstream/handle/11427/11266/thesis_com_2013_mckinney_e.pdf?sequence=1&isAllowed=y

McWilliams, H. O. A., & Kwamena-Po, M. A. (1975). The development of education in Ghana. *American Journal of Educational Research*, 1(3), 17. https://www.sciepup.com/reference/228964

Mereku, K. (2012). Curriculum and assessment related factors inhibiting the development of literacy and numeracy in Ghanaian basic schools. *International Journal of Educational Reform*, (October), 24. https://www.academia.edu/22474659/Curriculum_and_assessment_related_factors_inhibiting_the_development_of_literacy_and_numeracy_in_Ghanaian_basic_schools

Merriam, S. B., & Grenier, R. S. (2019). *Qualitative research in practice: Examples for discussion and analysis* (2nd ed.). Jossey-Bass. https://www.wiley.com/en-az/Qualitative+Research+in+Practice%3A+Examples+for+Discussion+and+Analysis%2C+2nd+Edition-p-9781119452027

Mertens, D. M. (1998). *Research methods in education and psychology: Integrating diversity with quantitative & qualitative approaches*. International Educational and Professional Publisher.

Mertens, D. M. (2015). Donna M. Mertens Philosophical assumptions and program evaluation, *Spazio Filosofic, 13*, 75-85. http://spaziofilosofico.it/wp-content/uploads/2015/02/Mertens1.pdf

Mfum-Mensah, O. (2005). The impact of colonial and postcolonial Ghanaian language policies on vernacular use in schools in two northern Ghanaian communities. *Comparative Education*, *41*(1), 71–85. https://doi.org/10.1080/03050060500073256

Ministry of Education. (2019). *Education Strategic plan, Ghana: 2018-2030*. Government of Ghana. https://www.globalpartnership.org/content/education-strategic-plan-2018-2030-ghana

Ministry of Education. (2015b). *Inclusive Education Policy*. Government of Ghana. https://www.unicef.org/ghana/media/1351/file/UN257287.pdf

Mohammed, A. (2014a). Implementation of inclusive education in Ghanaian primary schools: A look at teachers` attitudes. *American Journal of Educational Research*, *2*(3), 142–148. https://doi.org/10.12691/education-2-3-5

Mohammed, A. (2014b). Implementation of inclusive education in Ghanaian primary schools: A look at teachers` attitudes. *American Journal of Educational Research, 2*(3), 142–148. https://doi.org/10.12691/education-2-3-5

Mongia, P. (1996). *Contemporary postcolonial theory : A reader*. St. Martin’s Press.

Mprah, K., Dwomoh, A., Opoku, M. P., Owusu, I., & Ampratwum, J. (2016). Knowledge, attitude and preparedness of teachers towards inclusive education in Ejisu - Juaben Municipality in Ashanti. *Journal of Disability Management and Special Education*, 6(2), 1-15.

Muntaru, S. (2018). An anthropological study of “witch camps” and human rights in northern

Ghana. *Religion, Law and Security in Africa*, *1*(1), 15. https://doi.org/10.18820/9781928314431/17

Musah, I. B. (2013). *Life in a witch camp*: *Experiences of residents in the Gnani witch camp in Ghana*. [Master's thesis, Universitas Bergensis]. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=7&cad=rja&uact=8&ved=2ahUKEwjHvJzmsozjAhVXShUIHbZYAQkQFjAGegQIBBAC&url=https%3A%2F%2Fbora.uib.no%2Fbitstream%2Fhandle%2F1956%2F7465%2F108934115.pdf&usg=AOvVaw08CRiw76vDuN1RmPpZAlzF

Muzata, K. K. (2017). *Curriculum implementation for learners with special education needs: The case of selected inclusive and special schools in Zambia*. [Doctoral thesis, University of South Africa]. https://pdfs.semanticscholar.org/bebe/7b75f15dfa63edabfa6710e33819e5ba366a.pdf

Nand, L. (2017). Applying ecological systems theory to understand the determinants of early school leaving and second-chance education in a socio-economically disadvantaged area in Sydney, Australia, (1985), 52–59. https://researchdirect.westernsydney.edu.au/islandora/object/uws%3A44416/datastream/PDF/view

National Education Assessment Unit. (2016). *Ghana 2016 National Education Assessment Unit Report of Findings*. http://nacca.gov.gh/wp-content/uploads/2019/04/2016-NEA-Findings-Report_17Nov2016_Public-FINAL.pdf.

Nkrumah, K. (1971). *Ghana: The autobiography of Kwame Nkrumah* (Reprint). Ann Arbor: International Publishers.

https://books.google.co.za/books?id=JrbtAAAAMAAJ&source=gbs_similarbooks

Nseibo, J. K. (2013). *A guide in education for pupils and parents* (3rd ed.). Rambat Impression.

Nseibo, J. K. (2017). Transition to a senior high school: Experiences of the physically impaired students of Krachi-Nchumuru District of Volta Region of Ghana. *Innovations in Education and Training International*, 10, 1-10

Nyarkoh, E., & Intsiful, E. (2018). An assessment of the impact of international aid on basic education in Ghana. *American Journal of Educational Research*, 6(1), 43–49. https://doi.org/10.12691/education-6-1-7

Obeng, C. S. (2012). Children with disabilities in early care in Ghana. *International Journal of Early Childhood Special Education*, 4(2), 50–63. https://doi.org/10.20489/intjecse.107939

Ocloo, M. A., & Dogbe, D. S. (2000). Towards inclusive education in Ghana, *AFR 048*, 1–8.

Ocloo, M. A. & Subbey, M. (2008). Perception of basic education school teachers towards inclusive education in the Hohoe District of Ghana. *International Journal of Inclusive Education*. 12(5-6), 639-650. https://doi.org/10.1080/13603110802377680

Ofori, R., & Dandy, D. G. (2011). *Research methods and statistics using SPSS*. Amakom-Kumasi Payless Publication.

Oliver, M. (1990). The Individual and Social Models of Disability. *Paper Presented at Joint Workshop of the Living Options Group and the Research Unit of the Royal College of Physicians*. https://disability-studies.leeds.ac.uk/wp-content/uploads/sites/40/library/Oliver-in-soc-dis.pdf

Oliver, M. (2013). The social model of disability: Thirty years on. *Disability and Society*, *28*(7), 1024–1026. https://doi.org/10.1080/09687599.2013.818773

Oliver, M. (2017). Defining impairment and disability. In E. F. Emens & M. A. Stein (Eds.), *Disability and equality law* (pp. 1-16). Routledge. ttps://doi.org/10.4324/9781315094861

Oliver, M., & Oliver, M. (1996). *Understanding disability: From theory to practice*. Palgrave. https://doi.org/10.1007/978-1-349-24269-6_4

Opoku, M. P. (2016). The state of special schools in Ghana: Perceptions of special educators. *Turkish International Journal of Special Education and Guidance & Counseling*, *5*, 22–38.

Opoku, M. P., Agbenyega, J., Mprah, W. K., Mckenzie, J., & Badu, E. (2017). Decade of inclusive education in Ghana : Perspectives of educators. *Journal of Social Inclusion*, *8*(1), 1–20.

Opoku, M. P., Alupo, A. B., Mprah, W. K., Gyamfi, N., Odame, L., & Badu, E. (2018). The family and disability in Ghana: Highlighting gaps in achieving social inclusion. *International Journal on Disability and Human Development*, *29*(4), 41–59. https://doi.org/10.5463

Opoku, M. P., Rayner, C. S., Pedersen, S. J., & Cuskelly, M. (2019). Mapping the evidence-based research on Ghana's inclusive education to policy and practices: A scoping review. *International Journal of Inclusive Education*, 1–17. DOI: 10.1080/13603116.2019.1600055

Opoku, M. P., Swabey, J.-F. K., Pullen, D., & Dowden, T. (2019). Assisting individuals with disabilities via the United Nations' Sustainable Development Goals: A case study in Ghana. *International Journal of Disability, Education and Development*, *1*(27), 175–182. https://doi.org/10.1002/sd.1899

Osseo-Asare, P. (2017). *Postcolonial theory and early literacy development for 4-8 year-olds: A life history study of Ghanaian teachers*, [Doctoral thesis, The University of Sheffield]. http://etheses.whiterose.ac.uk/18355/1/POAO-PhD%20final%20thesis-%203-10-2017.pdf

Owu-ewie, C. (2017). Language, education and linguistic human rights in Ghana. *Legon Journal of the Humanities, 28*(2), 151–172. https://doi.org/10.4314/ljh.v28i2.7

Owusu-Ansah, J. K., Baisie, A., & Oduro-Ofori, E. (2018). The mobility impaired and the built environment in Kumasi: Structural obstacles and individual experiences. *GeoJournal, 84*, 1003–1020 (2019). https://doi.org/10.1007/s10708-018-9907-y

Owusu, Y. (2016). *Teacher education curriculum: Pre-service teachers' preparation for inclusive education in Ghana pre-service teachers' preparation for inclusive education in Ghana*. [Master's thesis, Universitas Osloensis]. https://www.duo.uio.no/bitstream/handle/10852/54071/Final-Thesis-Autumn-2016-PDF-ready---1-.pdf?sequence=1&isAllowed=y

Paterson, M., & Higgs, J. (2005). Using hermeneutics as a qualitative research approach in professional practice. *The Qualitative Report, 10*(2), 339–357.

Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). SAGE. https://doi.org/10.1177/1473325002001003636

Peta, C. (2015). *Voices from the periphery: A narrative study of the experiences of sexuality of dsabled women in Zimbabwe*. [Doctoral thesis, University of Cape Town]. https://open.uct.ac.za/handle/11427/20354

Peter, M. N., & Nderitu, M. N. (2014). Perceptions of teachers and head teachers on the effectiveness of inclusive education in public primary schools in Yatta Division Machakos County. *Journal of Educational and Social Research*, *4*(1), 91–106. https://doi.org/10.5901/jesr.2014.v4n1p91

Polit, D. F., & Beck, C. T. (2017). *Essentials of nursing research: Methods, appraisal, and utilization* (6th ed.). Lippincott.

Pratt, D. (1994). *Curriculum planning: A handbook for professionals*. Ted Buchholz. https://scholar.google.com.ph/scholar?start=160&q=curriculum&hl=en&as_sdt=0,5#5

Republic of Ghana. (1992). *The constitution of the Republic of Ghana*. https://download-ghana-constitution-1992-pdf.peatix.com/

Republic of Ghana. (1996). *The Constitution of the Republic of Ghana: Amendment Act 527.* https://doi.org/GHA-1996-C-51622

Republic of Ghana. (2006). *Persons with Disability Act*. Retrieved from http://www.inclusion-ghana.org/resources/advocacy-toolkits/Ghana Disability Act.pdf

Republic of South Africa. (2014). *Policy on screening, identification, assessment and support*. https://www.education.gov.za/Portals/0/Documents/Policies/SIAS%20Final%2019%20December%202014.pdf?ver=2015-02-24-131207-203

Reynolds, S. (2010). Disability culture in West Africa: Qualitative research indicating barriers and progress in the greater Accra region of Ghana. *Occupational Therapy International*, *17*(4), 198–207. https://doi.org/10.1002/oti.303

Rigby, K. (2004). Addressing bullying in schools. *School Psychology International*, *25*(3), 287–300. https://doi.org/10.1177/0143034304046902

Sagahutu, J. B., & Struthers, P. (2014). Psychosocial environmental barriers to school attendance among children with disabilities in two community based rehabilitation centres in Rwanda. *Advances in Applied Sociology*, *04*(06), 149–155. https://doi.org/10.4236/aasoci.2014.46019

Said, E. W. (1978). *Orientalism*. Routledge and Kegan Paul Ltd., https://sites.evergreen.edu/politicalshakespeares/wp-content/uploads/sites/33/2014/12/Said_full.pdf

SAP, G. (2011). *Children with learning difficulties in public basic schools in Ghana: A study involving local stakeholders in Greater Accra Region*, 26. http://sapghana.com/data/documents/Schools=20report=202011.pdf

Shah, S. R., & Al-Bargi, A. (2013). Research paradigms: Researchers' worldviews, theoretical frameworks and study designs. *Arab World English Journal*, *4*(4), 252–264.

Shakespeare, T. (2006). The social model of disability. In L.J. Davis (Ed), *The Disability Studies Reader* (pp. 266-73). Routledge. http://thedigitalcommons.org/docs/shakespeare_social-model-of-disability.pdf

Singal, N. (2014). *Disability, poverty and education*. Routledge.

Singal, N., Mahama-Salifu, E., Iddrisu, K., Casely-Hayford, L., & Lundebye, H. (2015). The impact of education in shaping lives: Reflections of young people with disabilities in Ghana. *International Journal of Inclusive Education, 19*(9), 908–925. https://doi.org/10.1080/13603116.2015.1018343

Singal, N., Ware, H., & Bhutani, S. K. (2017). *Inclusive quality education for children with* *disabilities.* University of Cambridge. https://doi.org/10.13140/RG.2.2.14016.23045

Slee, R. (2020). *Inclusion and education: Defining the scope of inclusive education*. UNESCO. https://unesdoc.unesco.org/ark:/48223/pf0000265773

Slee, R., Corcoran, T., & Best, M. (2019). Disability studies in education – Building platforms to reclaim disability and recognise disablement. *Journal of Disability Studies in Education*, 1–11. https://doi.org/10.1163/25888803-00101002

Smith, J. & Noble, H. (2014). Bias in research. *Evidence-Based Nursing, 17*(4), 100-101. https://doi.org/10.1136/eb-2014-101946

Smith, J. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. Psychological Journal, *20*(1), 7-14. DOI: 10.14691/CPPJ.20.1.7

Smith, J., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method, research*. SAGE.

Spivak, G.C. (1988). Can the Subaltern Speak? In C. Nelson & L. Grossberg (Eds.), *Marxism and the Interpretation of Culture* (pp. 271-315). University of Illinois Press. http://jan.ucc.nau.edu/~sj6/Spivak CanTheSubalternSpeak.pdf

Stake, R. E. (2006). *Multiple case study analysis*. The Guilford Press.

Stobbs, P. (2015). Disabled children and the Equality Act 2010 - Council for Disabled hildren , (March).

Su, S.-W. (2012). The various concepts of curriculum and the factors involved in curricula-making. *Journal of Language Teaching and Research*, 3(1), 153–158.

https://doi.org/10.4304/jltr.3.1.153-158

Swain, J., French, S., & Cameron, C. (2003). *Controversial issues in a disabling society*. Open University Press.

Swart, E., Engelbrecht, P., Eloff, I., & Oswald, M. (2004). Developing inclusive school communities: Voices of parents of children with disabilities. *South African Journal of Education*, 8(1), 80–108. https://doi.org/10.1080/16823200409487082

Tam, K. (1998). Postcoloniality, identity and the English language in Hong Kong. *Journal of Asian Pacific*, 8(1), 69–80.

Tudge, J. R. H., Payir, A., Merçon-Vargas, E., Cao, H., Liang, Y., Li, J., & O'Brien, L. (2016). Still misused after all these years? A reevaluation of the uses of Bronfenbrenner's Bioecological Theory of Human Development. *Journal of Family Theory and Review*, 8(4). https://doi.org/10.1111/jftr.12165

UNCRPD. (2006). The unconvention on the rights of persons with disabilities and optional protocol. *Development (Basingstoke)*, *49*(4), 37. https://doi.org/10.1057/palgrave.development.1100310

UNESCO-IBE. (2011). *The IBE Council on the Activities of the International Bureau of Education (IBE) (2010-2011)*. https://doi.org/36 C/REP/1. UNESCO.

UNESCO. (1994). *The Salamanca Statement and the Framework for Action on Special Needs Education*. https://doi.org/E D-94/WS/ 1 8. UNESCO.

UNESCO. (2005). Guidelines for inclusion: Ensuring access to Education for All, 40. https://doi.org/10.1073/pnas.0703993104

UNESCO. (2014). *Education for All (EFA) Global Monitoring Report 2013/4 – Teaching and Learning: Achieving Quality for All*. Paris. http://unesdoc.unesco.org/images/0023/002312/231288e.pdf

UNESCO. (2017). *A guide for ensuring inclusion and equity in education*. *Unesco*. United Nations Educational, Scientific and Cultural Organization. https://doi.org/ED-2009/WS/31

United Nations. (1993). The Standard Rules on the Equalization of Opportunities for Persons with Disabilities. http://www.un.org/esa/socdev/enable/dissre00.htm

United Nations. (2006). United Nations Convention for Persons with Disabilities. *United Nations*, (December), 1–28. https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html

United Nations. (2018a). Realization of the Sustaiable Development Goals By, For, and With Persons with Disabilities, 330. https://www.un.org/development/desa/disabilities/wp-content/uploads/sites/15/2018/12/UN-Flagship-Report-Disability.pdf

United Nations. (2018b). The United Nations and disability: 70 years of the work towards a more inclusive world., (January), 1–26. https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15&chapter=4&clang=_en

United Nations. (2019a). *The 17 Sustainable Development Goals (SDGs) Report*. https://doi.org/10.18356/55eb9109-en

United Nations. (2019b). World Population Prospects 2019. https://population.un.org/wpp/

van der Westhuizen, G. J. (2013). Post colonial perspectives on education policy research. *Africa*

Education Review, 10(4), 689–708. https://doi.org/10.1080/18146627.2013.853562

Walton, E. (2018). Decolonising (through) inclusive education ? Setting the scene : Inclusive education in international and South African contexts. *Educational Research for Social Change*, *7*(June), 31–45. https://doi.org/10.17159/2221-4070/2018/v7i2a3

Watermeyer, B. (2014). Towards a contextual psychology of disablism. Abingdon. *Sociology of Health & Illness*. 36(3), 478-479. Routledge.

Westbrook, J., & Croft, A. (2015). Beginning to teach inclusively: An analysis of newly-qualified teacher pedagogy in lower primary classes in Tanzania. *Teaching and Teacher Education*, *51*. https://doi.org/10.1016/j.tate.2015.05.003

White, B. W. (1996). Talk about school: Eduction and the colonial project in French and British Africa. *Comparative Education*, *32*(1), 9–25.

WHO. (2010). The ICF: An Overview: Functioning and Disability Reference Group, 1–10.

World Health Organisation. (2011). World report on disability 2011. World Health Organisation and The World Bank. *World Health Organization*, *91*, 549. https://doi.org/10.1136/ip.2007.018143

World Health Organization. (2013). How to use the ICF: A practical manual for using the International Classification of Functioning, Disability and Health (ICF). *World Health Organization*, (October), 100.

World Medical Association. Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects (2008). Seoul Korea: The World Medical Association.

Yarfi, C., Ashigbi, E. Y. K., & Nakua, E. K. (2017). Wheelchair accessibility to public buildings in the Kumasi metropolis, Ghana. *African Journal of Disability*, 6(0), 1–8. https://doi.org/10.4102/ajod.v6i0.341

Yazan, B. (2015). The qualitative report - Three approaches to case study methods in education: Yin, Merriam, and Stake. *Teaching and Learning*, 20(2), 134–152. https://doi.org/10.1177/1525822X05279903

Yin, R. K. (2009). *Case study research design and methods* (4th ed.). Sage.

Yin, R. K. (2014). *Case study research design and methods* (5th ed.). Sage.

Yitah, H., & Komasi, M. (2009). Children's literature in Ghana: A survey. *Children's Literature,* 37(1), 236–255.

Young, R. J. C. (2001). Postcolonialism: An historical introduction. *The Cambridge Journal of Postcolonial Literary Inquiry*, 512. https://www.wiley.com/en-us/Postcolonialism%3A+An+Historical+Introduction-p-9781119288954

Zhou, M. C. (2015). *The cultural beliefs of people with physical disabilities in a community rehabilitation centre in Oniipa, Namibia*. University of Pretoria. https://repository.up.ac.za/dspace/bitstream/handle/2263/.../Zhou_Cultural_2016.pdf

Žukauskas, P., Vveinhardt, J., & Andriukaitienė, R. (2018). Philosophy and paradigm of scientific research. *Intech Open.*, 6, 13. https://doi.org/10.1016/j.colsurfa.2011.12.014

APPENDICES

APPENDIX 1: Ethical Clearance from the University of Cape Town

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6492
Email: [illegible]
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

12 February 2018

HREC REF: 339/2017

Dr J McKenzie
Division of Disability Studies
Department of Health & Rehab Sciences
F-45, OMB

Dear Dr McKenzie

PROJECT TITLE: EXPLORING THE EXPERIENCES OF PEOPLE WITH MOBILITY IMPAIRMENT IN FOUR EDUCATIONAL SETTINGS IN GHANA (PhD candidate- Job [illegible] Nseibo)

Thank you for your response letter dated [illegible] February 2018, addressing the issues raised by the Human Research Ethics Committee (HREC).

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 28 February 2019.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

We acknowledge that the student: Job Nseibo will also be involved in this study.

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please note that for all studies approved by the HREC, the principal investigator **must** obtain appropriate institutional approval, where necessary, before the research may occur.

Yours sincerely

Signature Removed

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938

HREC:339/2017

APPENDIX 2: Sample of Authorization Seeking Letter

Department of Health and Rehabilitation Sciences
Faculty of Health Sciences
F45 Old Main Building, Groote Schuur Hospital,
Observatory 7925
Tel: +27 (0) 21 650 5350
Internet: www.dhrs.uct.ac.za

15th February, 2018

The Regional Director
Ghana Education Service
Ashanti Region
Ghana

Dear Madam

RE: REQUEST FOR CONSENT TO RECRUIT PARTICIPANTS IN A RESEARCH PROJECT TITLED

"EXPLORING THE EXPERIENCES OF CHILDREN AND YOUTH WITH MOBILITY IMPAIRMENTS IN FOUR BASIC EDUCATIONAL SETTINGS IN GHANA"

I apply for your permission to recruit participants in your outfit for my research project. I am currently undertaking my PhD in the University of Cape Town, South Africa in the Department of Health and Rehabilitation Sciences. The research entails interviewing children and youth with mobility impairments who are between 12 and 25 years (either in the mainstream school, special education school, rehabilitation school or inclusive education school), parents of children and youth with mobility impairments, head teachers in the four educational settings that would be selected and a representative of Regional Directorate of Education.

The focus of the study is to examine influences of the introduction of an inclusive education system in Ghana on the experiences, enrolment and retention of children and youth with mobility impairments in the various educational settings in the Ashanti Region of Ghana. The study will provide an insight into the barriers and support services that these individuals with mobility impairments experience on a daily basis in accessing quality education. This understanding will enable the researcher to make recommendations and will provide a platform for change initiation that is often omitted in the current policies and legislation in Ghana to enhance the education of children and youth with mobility impairments.

Ethical approval for this study has been granted by the University of Cape Town, Faculty of Health Sciences Human Research Ethics Committee (HREC Ref: 339/2017).

The purpose of the study will be explained to those willing to participate and they will have to voluntarily give their consent and assent.

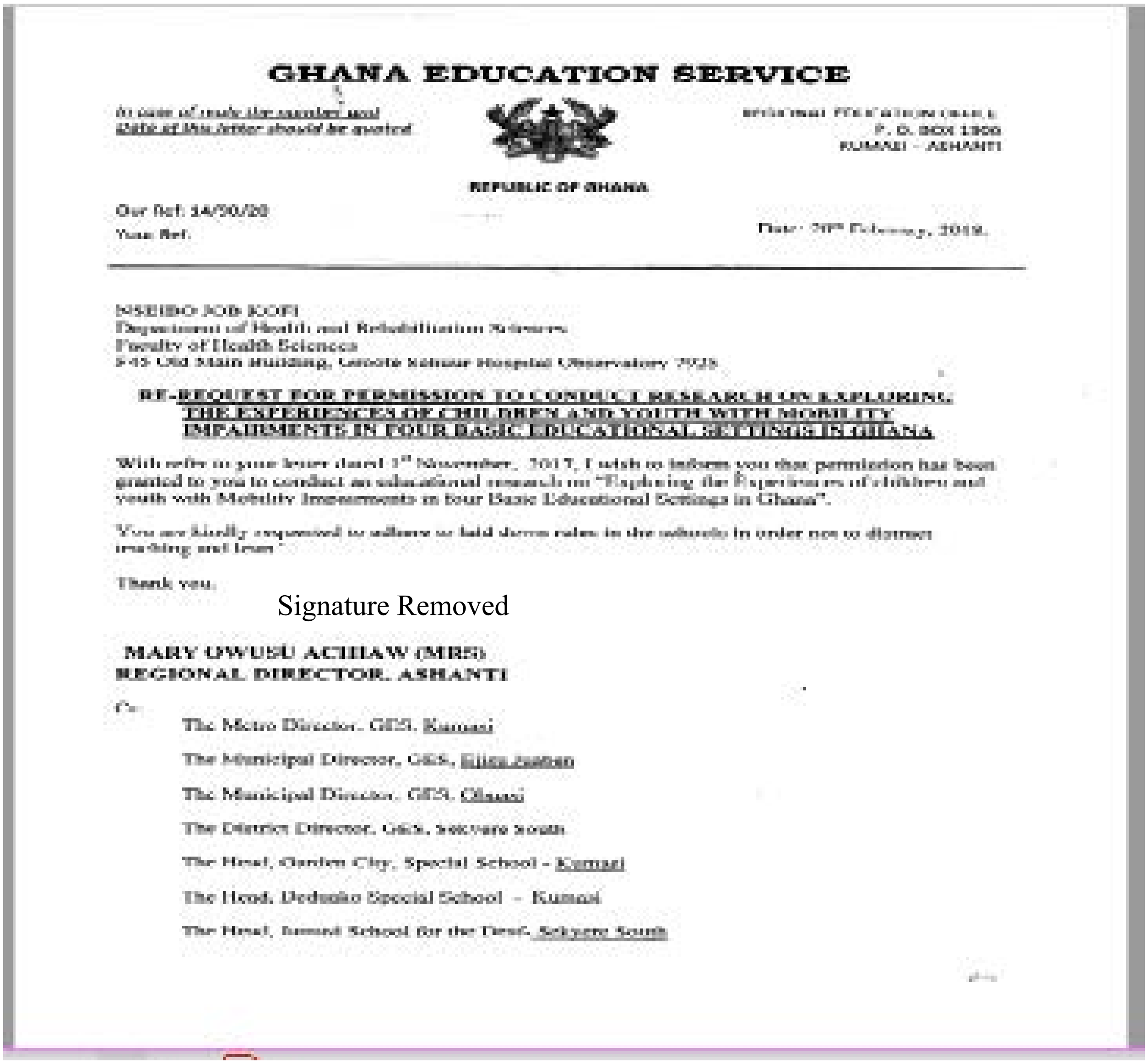
I look forward to hearing favourably from you.

Yours faithfully

Nseibo Job Kofi
(+233 244107056/+27 818316004)
Email: NSBJOB001@myuct.ac.za

Supervisor: A/Prof. Judith Mckenzie (Head of Div)
Disability Studies
Department of Health and Rehabilitation Sciences
University of Cape Town, South Africa
Phone: +27 214066318/+27 835000464
Email: judith.mckenzie@uct.ac.za

APPENDIX 3: Clearance Letter from Ashanti Regional Director of Education, Ghana



GHANA EDUCATION SERVICE

In case of reply the number and date of this letter should be quoted

REGIONAL EDUCATION OFFICE
P. O. BOX 1906
KUMASI - ASHANTI

REPUBLIC OF GHANA

Our Ref: 14/50/20
Your Ref:

Date: 20th February, 2018.

NSEIBO JOB KOFI
Department of Health and Rehabilitation Sciences
Faculty of Health Sciences
545 Old Main Building, Groote Schuur Hospital Observatory 7925

RE-REQUEST FOR PERMISSION TO CONDUCT RESEARCH ON EXPLORING THE EXPERIENCES OF CHILDREN AND YOUTH WITH MOBILITY IMPAIRMENTS IN FOUR BASIC EDUCATIONAL SETTINGS IN GHANA

With refer to your letter dated 1st November, 2017, I wish to inform you that permission has been granted to you to conduct an educational research on "Exploring the Experiences of children and youth with Mobility Impairments in four Basic Educational Settings in Ghana".

You are kindly requested to adhere to laid down rules in the schools in order not to distract teaching and learn.

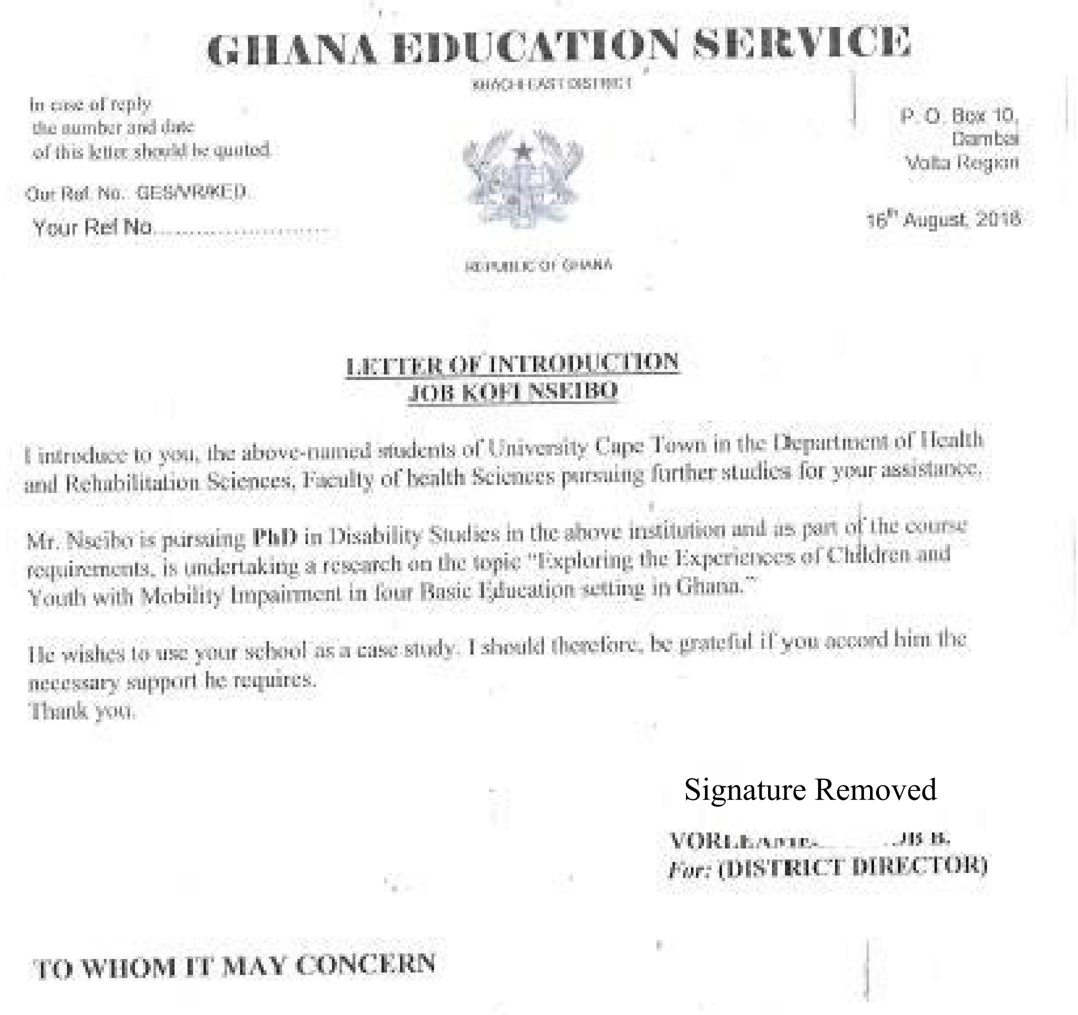
Thank you.

Signature Removed

MARY OWUSU ACHIAW (MRS)
REGIONAL DIRECTOR, ASHANTI

Cc:
The Metro Director, GES, Kumasi
The Municipal Director, GES, Ejisu Juaben
The Municipal Director, GES, Obuasi
The District Director, GES, Sekyere South
The Head, Garden City Special School - Kumasi
The Head, Dedesko Special School - Kumasi
The Head, Jamasi School for the Deaf, Sekyere South

APPENDIX 4: Clearance Letter from District Director of Education, Krachi East District



GHANA EDUCATION SERVICE

KRACHI EAST DISTRICT

In case of reply
the number and date
of this letter should be quoted

Our Ref. No. GES/VR/KED
Your Ref No........................

P. O. Box 10,
Dambai
Volta Region

16th August, 2016

REPUBLIC OF GHANA

LETTER OF INTRODUCTION
JOB KOFI NSEIBO

I introduce to you, the above-named students of University Cape Town in the Department of Health and Rehabilitation Sciences, Faculty of health Sciences pursuing further studies for your assistance.

Mr. Nseibo is pursuing **PhD** in Disability Studies in the above institution and as part of the course requirements, is undertaking a research on the topic "Exploring the Experiences of Children and Youth with Mobility Impairment in four Basic Education setting in Ghana."

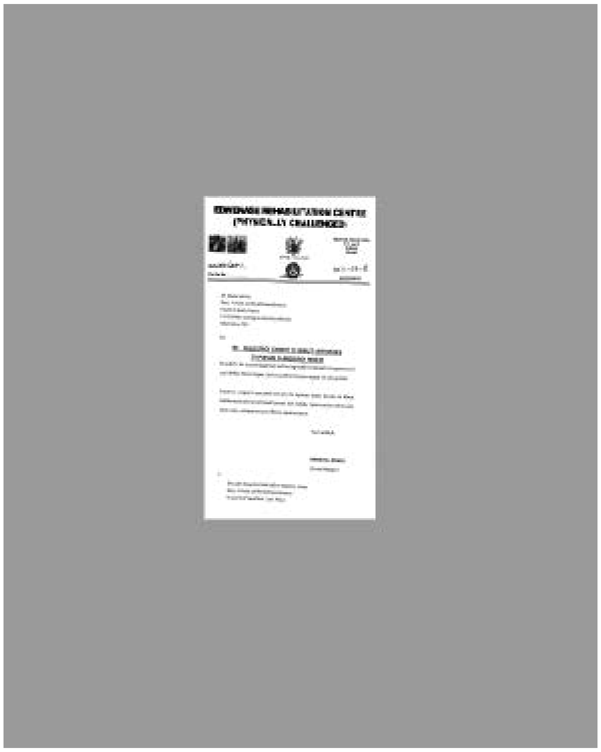
He wishes to use your school as a case study. I should therefore, be grateful if you accord him the necessary support he requires.
Thank you.

Signature Removed

VORLEAVIE.........JB B.
***For:* (DISTRICT DIRECTOR)**

TO WHOM IT MAY CONCERN

APPENDIX 5: Clearance Letter from the Rehabilitation School



APPENDIX 6: Individual in-depth Semi-structured Interview for Children and Youth with Mobility Impairments

Part A: Demographic Data

Please tell me about yourself

a. Name
b. Age
c. Sex
d. Level of Education/Class
e. Type of Education Setting
f. Occupation

Part B:

1. Please tell me about how your disability started

…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

Probe: How disability came about (acquired/congenital), duration of disability.

2. What is your understanding about disability?

…………………………………………………………………………………………
……………………………………… Probe: Perception of disability

3. What challenges did you face as a mobility impaired person in your community?
4. Please tell me how you came by this school

…………………………………………………………………………………………
…………………………………………………………………………………………
…………………………………………………………………………………………

Type of school: Mainstream school, special education school, rehabilitation centre, inclusive education school. Who recommended the school to you?

5. Tell me about your experiences in the school

…………………………………………………………………………………………
……………………………………………………………………………………….....

Probe: feelings,

6. Kindly tell me about things that disturb/hinder you from learning

   ……………………………………………………………………………………………

   ……………………………………………………………………………………………

   Probe: Barriers in accessing quality education, attitude of teachers/peers, and exclusion from activities like sports/recreation, unavailability of ramps/lifts, class size, assistive devise, toilet/urinal facilities, labelling, stigma, myth,

7. Please tell me about support services that enhance your learning

   ……………………………………………………………………………………………

   ……………………………………………………………………………………………

   Probe: Special need educator(s), resource centre, peer support, ramps, lifts, enabling environment
8. Which of the following educational settings would you prefer for accessing quality education? Mainstream school, special education school, rehabilitation school and inclusive education school. Why do you choose it?
9. Tell me what you know about inclusive education. …………………………………

   Probe: Barriers of inclusive education, qualified teachers, support systems
10. What support service will you like to be given/done for you to access quality education for your life?
11. Please suggest some strategies to help to implement inclusive education
12. Is there anything else you want to tell me?

APPENDIX 7: Individual in-depth Semi-structured Interview Guide for Head Teachers

Part A: Demographic Data

Please tell me about yourself

a. Name
b. Age
c. Sex
d. Marital status
e. Number of years in office/position
f. Type of educational setting

Part B:

1. What is your understanding about disability? (Perception about disability, causes, labelling, challenges faced by people with disabilities, etc)
2. Please tell me about how people with mobility impairment are placed in the various educational settings (e.g. mainstream school, special education school, inclusive education school or rehabilitation schools/centres)
3. What do you think are the barriers in the schools faced by people with mobility impairment?
4. What support services are available in the schools for people with mobility impairment?
5. What categories of teachers are currently available in the various schools? (e.g. professional teachers, special education teachers or pupil teachers)
6. What is your view about inclusive education in Ghana? (e.g. Do we have a policy guide to its introduction or implementation?)
7. How has the introduction or implementation of an inclusive education system influenced the enrolment and retention of people with mobility impairment in the various educational settings?
8. Please tell me all you know about Universal Design for Learning (UDL).
9. Please suggest strategies you think will help in the implementation of an inclusive education system in Ghana.
10. What educational setting do you recommend for people with mobility impairment?
11. Is there anything else you would like me to know?

APPENDIX 8: Interview Guide for Focus Group Discussion – Parents of Children and Youth with Mobility Impairments

1. Marking of register and welcoming one another to the meeting
2. Please tell us something about yourself (name, who you are, how long your child has been disabled).
3. What is your view about disability? (e.g. perception, stigma, l …)
4. Please tell me something about the experiences of your child both at home and in school?
5. Please tell us about how you identified the school for your child (e.g. mainstream school, special education school, inclusive education school or rehabilitation schools/centres).
6. What is the criteria for admission when you sent your child to the school? (e.g. medical report, letter from the social welfare department, table and chairs, books, school fees, etc.).
7. What do you think are the barriers to your child's schooling?
8. What are the support services available for people with mobility impairment in the school?
9. Please tell us something about an inclusive education school.
10. What strategies do you suggest for the implementation of inclusive education in Ghana
11. What educational setting do you recommend for people with mobility impairments?
12. Is there anything else you will like us to know?

APPENDIX 9: Information Sheet for Children and Youth with Mobility Impairments

Department of Health and Rehabilitation Sciences
Faculty of Health Sciences
F45 Old Main Building, Groote Schuur Hospital,
Observatory 7925
Tel: +27 (0) 21 650 5350
Internet: www.dhrs.uct.ac.za

Title: **Exploring the Experiences of Children and Youth with Mobility Impairments in four Basic Educational Settings in Ghana**

Dear Participant

My name is Nseibo Job Kofi. I am a PhD student pursuing Disability Studies in the University of Cape Town, Department of Health and Rehabilitation Sciences. This self-initiated study is a requirement for me in order to complete my studies. I am interested to explore experiences of children and youth with mobility impairments in four educational settings in Ghana. The study will examine how the introduction of an inclusive education system in Ghana influenced experiences, enrolment and retention of children and youth with mobility impairments in the various schools. Your input will provide an insight into the barriers and support services that children and youth with mobility impairments experience on a daily basis. The understanding gained will enable the researcher to make recommendations which will provide a platform for change initiation that is often omitted in current policies and legislation in Ghana.

(1) Who is carrying out the study?

I am conducting the study under the supervision of A/Prof Judith McKenzie in the Department of Health and Rehabilitation Sciences at the University of Cape Town.

(2) Who else is participating in the study?

Parents of children and youth with mobility impairments, head teachers in the four basic educational settings and a representative of Ashanti Regional Directorate of Education

(3) What is the study about?

There is little research on the experiences of children and youth with mobility impairments in relation to barriers and support services in the mainstream schools, special education schools, inclusive education schools and the rehabilitation schools in Ghana. This kind of information is crucial in developing support services for this category of people with disabilities. The study therefore seeks to examine how the introduction of inclusive education in Ghana influenced experiences, enrolment and retention of children and youth with mobility impairments in the various basic educational settings in Ghana.

(4) Why have you been chosen for the study?

You have been chosen because you have lived experiences about the educational settings in the Ashanti Region of Ghana with regards to barriers and support services available in the various schools. Your input will enable the researcher to make recommendations to create a platform for change initiatives which might promote quality education for children and youth with mobility impairments in Ghana.

(5) How much of your time will the study take?

Each interview will take between 30 minutes and one hour. I will, however, come back to you for an additional 30 minutes for a cross-check of the information given.

(6) Can you withdraw from the study?

Being in this study is completely voluntary. You are not under any obligation to consent. If you do consent, you can withdraw at any time. Your withdrawal will not affect your relationship with the researcher or the University of Cape Town, South Africa.

You may stop the interview at any time if you do not wish to continue. The audio recording will be erased and the information provided will not be included in the study.

(7) **Will anyone else know the results?**

All aspects of the study, including results, will be strictly confidential. Only researchers (myself, my research assistant and the supervisor) will have access to the information on participants. You will not be identified in the study and your information will be presented under a different name.

A report of the study may be submitted for publication within a Disability Studies Journal, but individual participants will not be identifiable in such a report.

(8) **Will the study benefit you?**

We do not guarantee or promise that you will receive any benefits from the study. However, you will be given Gh36.00 (US$9.00) as your transport cost to the venue of the interview and lunch will be provided. The knowledge gained from the study might help other people in future.

(9) Are there any risks involved in you participating in the study?

There are minimal risks to your participation in this study. If you get affected emotionally and need help I will make arrangements with a qualified counsellor to help you in the Kwame Nkrumah University of Science and Technology.

(10) **Can you tell other people about the study?**

You may talk to other people about the study and the questions asked.

(11) What if you require further information about the study or your involvement in it?

I am willing to discuss with you and provide any further information that you may require regarding the study. You are free to contact me at any time. You can also contact my supervisor on the contact details given below.

(12) **What if you have a complaint or any concerns?**

If you have any concerns or complaints about the research study, you can contact me or my supervisor or the chairperson of UCT Faculty of Health Sciences Human Research Ethics Committee using the contact details given below.

Thank you.

____

Nseibo Job Kofi
Disability Studies
Department of Health and Rehabilitation Sciences
University of Cape Town, South Africa
Phone: +233 244107056 or +27 818316004
Email: NSBJOB001@myuct.ac.za

Supervisor: A/Prof. Judith McKenzie (Head of Division)
Disability Studies
Department of Health and Rehabilitation Sciences
University of Cape Town, South Africa

Phone: +27 214066318
Email: judith.mckenzie@uct.ac.za

If you have any concerns or complaints about the conduct of the study and its staff or about human rights and welfare of participants, you can directly contact;

The Chairperson
Prof Marc Blockman
Faculty of Health Sciences Human Research Ethics Committee
Room E52.24, Old Main Building
Groote Schuur Hospital
TEL: +27 214066496
Email: Marc.blockman@uct.ac.za

This information sheet is to be kept by you.

APPENDIX 10: Information Sheet for Children and youth with Mobility Impairments who are less than 18 years

Department of Health and Rehabilitation Sciences
Faculty of Health Sciences
F45 Old Main Building, Groote Schuur Hospital,
Observatory 7925
Tel: +27 (0) 21 650 5350
Internet: www.dhrs.uct.ac.za

Title: **Exploring the Experiences of Children and Youth with Mobility Impairments in four Basic Educational Settings in Ghana**

Dear Participant,

My name is Nseibo Job Kofi. I am a PhD student pursuing Disability Studies in the University of Cape Town, Department of Health and Rehabilitation Sciences. This self-initiated study is a requirement for me in order to complete my studies. I am interested to explore experiences of children and youth with mobility impairments in four educational settings in Ghana. The study will examine how the introduction of an inclusive education system in Ghana influenced experiences, enrolment and retention of children and youth with mobility impairments in the various schools. Your input will provide an insight into the barriers and support services that children and youth with mobility impairments experience on a daily basis. The understanding gained will enable the researcher to make recommendations which will provide a platform for a change initiation that is often omitted in current policies and legislation in Ghana.

(13) Who is carrying out the study?

I am conducting the study under the supervision of A/Prof Judith McKenzie in the Department of Health and Rehabilitation Sciences at the University of Cape Town

(14) Who else is participating in the study?

Parents of children and youth with mobility impairments, head teachers in the four basic educational settings and a representative of the Ashanti Regional Directorate of Education

(15) What is the study about?

There is little research on the experiences of children and youth with mobility impairments in relation to barriers and support services in the mainstream schools, special education schools, inclusive education schools and the rehabilitation schools in Ghana. This kind of information is crucial in developing support services for this category of people with disabilities. The study therefore seeks to examine how the introduction of inclusive education in Ghana influenced experiences, enrolment and retention of children and youth with mobility impairments in the various basic educational settings in Ghana.

(16) Why have you been chosen for the study?

You have been chosen because you have lived experiences about the educational settings in the Ashanti Region of Ghana with regards to barriers and support services available in the various schools. Your input will enable the researcher to make recommendations to create a platform for change initiatives which might promote quality education for children and youth with mobility impairments in Ghana.

(17) How much of your time will the study take?

Each interview will take between 30 minutes and one hour. I will, however, come back to you for an additional 30 minutes for a cross-check of the information given.

(18) Can you withdraw from the study?

Being in this study is completely voluntary. You are not under any obligation to consent. If you do consent, you can withdraw at any time. Your withdrawal will not affect your relationship with the researcher or the University of Cape Town, South Africa.

You may stop the interview at any time if you do not wish to continue. The audio recording will be erased and the information provided will not be included in the study.

(19) Will anyone else know the results?

All aspects of the study, including results, will be strictly confidential. Only researchers (myself, my research assistant and the supervisor) will have access to the information on participants. You will not be identified in the study and your information will be presented under a different name.

A report of the study may be submitted for publication within a Disability Studies Journal, but individual participants will not be identifiable in such a report.

(20) Will the study benefit you?

We do not guarantee or promise that you will receive any benefits from the study. However, you will be given Gh36.00 (US$9.00) as your transport cost to the venue of the interview and lunch will be provided. The knowledge gained from the study might help other people in future.

(21) Are there any risks involved in you participating in the study?

There are minimal risks to your participation in this study. If you get affected emotionally and need help I will make arrangements with a qualified counsellor to help you in the Kwame Nkrumah University of Science and Technology.

(22) **Can you tell other people about the study?**

You may talk to other people about the study and the questions asked.

(23) What if you require further information about the study or your involvement in it?

I am willing to discuss with you and provide any further information that you may require regarding the study. You are free to contact me at any time. You can also contact my supervisor on the contact details given below.

(24) **What if you have a complaint or any concerns?**

If you have any concerns or complaints about the research study, you can contact me or my supervisor or the chairperson of the UCT Faculty of Health Sciences Human Research Ethics Committee using the contact details given below.

Thank you

____

Nseibo Job Kofi
Disability Studies
Department of Health and Rehabilitation Sciences
University of Cape Town, South Africa
Phone: +233 244107056 or +27 818316004
Email: NSBJOB001@myuct.ac.za

Supervisor: A/Prof. Judith McKenzie (Head of Division)
Disability Studies
Department of Health and Rehabilitation Sciences
University of Cape Town, South Africa

Phone: +27 214066318
Email: judith.mckenzie@uct.ac.za

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Prof Marc Blockman
Faculty of Health Sciences Human Research Ethics Committee
Room E52.24, Old Main Building,
Groote Schuur Hospital
TEL: +27 214066496
Email: Marc.blockman@uct.ac.za

This information sheet is to be kept by you.

APPENDIX 11: Information Sheet for Parents of Children and Youth with mobility Impairments

Department of Health and Rehabilitation Sciences
Faculty of Health Sciences
F45 Old Main Building, Groote Schuur Hospital,
Observatory 7925
Tel: +27 (0) 21 650 5350
Internet: www.dhrs.uct.ac.za

Title: **Exploring the Experiences of Children and Youth with Mobility Impairments in four Basic Educational Settings in Ghana**

Dear Participant

My name is Nseibo Job Kofi. I am a PhD student pursuing Disability Studies in the University of Cape Town, Department of Health and Rehabilitation Sciences. This self-initiated study is a requirement for me in order to complete my studies. I am interested to explore the experiences of children and youth with mobility impairments in four educational settings in Ghana. The study will examine how the introduction of an inclusive education system in Ghana influenced experiences, enrolment and retention of children and youth with mobility impairments in the various schools. Your input will provide an insight into the barriers and support services that children and youth with mobility impairments experience on a daily basis. The understanding gained will enable the researcher to make recommendations which will provide a platform for a change initiation that is often omitted in current policies and legislation in Ghana.

(25) Who is carrying out the study?

I am conducting the study under the supervision of A/Prof Judith Mckenzie in the Department of Health and Rehabilitation Sciences at the University of Cape Town

(26) Who else is participating in the study?

Children and youth with mobility impairments, head teachers in the four basic educational settings and a representative of Ashanti Regional Directorate of Education

(27) What is the study about?

There is little research on the experiences of children and youth with mobility impairments in relation to barriers and support services in the mainstream schools, special education schools, inclusive education schools and the rehabilitation schools in Ghana. This kind of information is crucial in developing support services for this category of people with disabilities. The study therefore seeks to examine how the introduction of inclusive education in Ghana influenced experiences, enrolment and retention of children and youth with mobility impairments in the various basic educational settings in Ghana.

(28) Why have you been chosen for the study?

You have been chosen because you have lived experiences about the educational settings in the Ashanti Region of Ghana with regards to barriers and support services available in the various schools. Your input will enable the researcher to make recommendations to create a platform for change initiatives which might promote quality education for children and youth with mobility impairments in Ghana.

(29) How much of your time will the study take?

Each interview will take between 30 minutes and one hour. I will, however, come back to you for an additional 30 minutes for a cross-check of the information given.

(30) Can you withdraw from the study?

Being in this study is completely voluntary. You are not under any obligation to consent and if you do consent, you can withdraw at any time. Your withdrawal will not affect your relationship with the researcher or the University of Cape Town, South Africa.

You may stop the interview at any time if you do not wish to continue. The audio recording will be erased and the information provided will not be included in the study.

(31) Will anyone else know the results?

All aspects of the study, including results, will be strictly confidential. Only researchers (myself, my research assistant and the supervisor) will have access to the information on participants. You will not be identified in the study and your information will be presented under a different name.

A report of the study may be submitted for publication within a Disability Studies Journal, but individual participants will not be identifiable in such a report.

(32) Will the study benefit you?

We do not guarantee or promise that you will receive any benefits from the study. However, you will be given Gh36.00 (US$9.00) as your transport cost to the venue of the interview and lunch will be provided. The knowledge gained from the study might help other people in future.

(33) Are there any risks involved in you participating in the study?

There are minimal risks to your participation in this study. If you get affected emotionally and need help I will make arrangements with a qualified counsellor to help you in the Kwame Nkrumah University of Science and Technology.

(34) **Can you tell other people about the study?**

You may talk to other people about the study and the questions asked.

(35) What if you require further information about the study or your involvement in it?

I am willing to discuss with you and provide any further information that you may require regarding the study. You are free to contact me at any time. You can also contact my supervisor on the contact details given below.

(36) **What if you have a complaint or any concerns?**

If you have any concerns or complaints about the research study, you can contact me or my supervisor or the chairperson of UCT Faculty of Health Sciences Human Research Ethics Committee using contact details given below.

Thank you

____

Nseibo Job Kofi
Disability Studies
Department of Health and Rehabilitation Sciences
University of Cape Town, South Africa
Phone: +233 244107056 or +27 818316004
Email: NSBJOB001@myuct.ac.za

Supervisor: A/Prof. Judith McKenzie (Head of Division)
Disability Studies
Department of Health and Rehabilitation Sciences
University of Cape Town, South Africa

Phone: +27 214066318
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If you have any concerns or complaints about the conduct of the study and its staff or about human rights and welfare of participants, you can directly contact:

The Chairperson
Prof Marc Blockman
Faculty of Health Sciences Human Research Ethics Committee
Room E52.24, Old Main Building
Groote Schuur Hospital
TEL: +27 214066496
Email: Marc.blockman@uct.ac.za

This information sheet is to be kept by you.

APPENDIX 12: Information Sheet for Head Teachers in the four Educational Settings

Department of Health and Rehabilitation Sciences
Faculty of Health Sciences
F45 Old Main Building, Groote Schuur Hospital,
Observatory 7925
Tel: +27 (0) 21 650 5350
Internet: www.dhrs.uct.ac.za

Title: **Exploring the Experiences of Children and Youth with Mobility Impairments in four Basic Educational Settings in Ghana**

Dear Participant

My name is Nseibo Job Kofi. I am a PhD student pursuing Disability Studies in the University of Cape Town, Department of Health and Rehabilitation Sciences. This self-initiated study is a requirement for me in order to complete my studies. I am interested to explore the experiences of children and youth with mobility impairments in four educational settings in Ghana. The study will examine how the introduction of an inclusive education system in Ghana influenced the experiences, enrolment and retention of children and youth with mobility impairments in the various schools. Your input will provide an insight into the barriers and support services that children and youth with mobility impairments experience on a daily basis. The understanding gained will enable the researcher to make recommendations which will provide a platform for a change initiation that is often omitted in current policies and legislation in Ghana.

(37) Who is carrying out the study?

I am conducting the study under the supervision of A/Prof Judith McKenzie in the Department of Health and Rehabilitation Sciences at the University of Cape Town

(38) Who else is participating in the study?

Children and youth with mobility impairments, parents of children and youth with mobility impairments and a representative of Ashanti Regional Education Directorate

(39) What is the study about?

There is little research on the experiences of children and youth with mobility impairments in relation to barriers and support services in the mainstream schools, special education schools, inclusive education schools and the rehabilitation schools in Ghana. This kind of information is crucial in developing support services for this category of people with disabilities. The study therefore seeks to examine how the introduction of inclusive education in Ghana influenced experiences, enrolment and retention of children and youth with mobility impairments in the various basic educational settings in Ghana.

(40) Why have you been chosen for the study?

You have been chosen because you have lived experiences about the educational settings in the Ashanti Region of Ghana with regards to barriers and support services available in the various schools. Your input will enable the researcher to make recommendations to create a platform for change initiatives which might promote quality education for children and youth with mobility impairments in Ghana.

(41) How much of your time will the study take?

Each interview will take between 30 minutes and one hour. I will, however, come back to you for an additional 30 minutes for a cross-check of the information given.

(42) Can you withdraw from the study?

Being in this study is completely voluntary. You are not under any obligation to consent and if you do consent, you can withdraw at any time. Your withdrawal will not affect your relationship with the researcher or the University of Cape Town, South Africa.

You may stop the interview at any time if you do not wish to continue. The audio recording will be erased and the information provided will not be included in the study.

(43) **Will anyone else know the results?**

All aspects of the study, including results, will be strictly confidential. Only researchers (myself, my research assistant and the supervisor) will have access to the information on participants. You will not be identified in the study and your information will be presented under a different name.

A report of the study may be submitted for publication within a Disability Studies Journal, but individual participants will not be identifiable in such a report.

(44) **Will the study benefit you?**

We do not guarantee or promise that you will receive any benefits from the study. However, you will be given Gh36.00 (US$9.00) as your transport cost to the venue of the interview and lunch will be provided. The knowledge gained from the study might help other people in future.

(45) Are there any risks involved in you participating in the study?

There are minimal risks to your participation in this study. If you get affected emotionally and need help I will make arrangements with a qualified counsellor to help you in the Kwame Nkrumah University of Science and Technology.

(46) **Can you tell other people about the study?**

You may talk to other people about the study and the questions asked.

(47) What if you require further information about the study or your involvement in it?

I am willing to discuss with you and provide any further information that you may require regarding the study. You are free to contact me at any time. You can also contact my supervisor on the contact details given below.

(48) **What if you have a complaint or any concerns?**

If you have any concerns or complaints about the research study you can contact me or my supervisor or the chairperson of UCT Faculty of Health Sciences Human Research Ethics Committee using the contact details given below.

Thank you

____

Nseibo Job Kofi
Disability Studies
Department of Health and Rehabilitation Sciences
University of Cape Town, South Africa
Phone: +233 244107056 or +27 818316004
Email: NSBJOB001@myuct.ac.za

Supervisor: A/Prof. Judith McKenzie (Head of Division)
Disability Studies
Department of Health and Rehabilitation Sciences
University of Cape Town, South Africa

Phone: +27 214066318
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If you have any concerns or complaints about the conduct of the study and its staff or about human rights and welfare of participants, you can directly contact:

The Chairperson
Prof Marc Blockman
Faculty of Health Sciences Human Research Ethics Committee
Room E52.24, Old Main Building
Groote Schuur Hospital
TEL: +27 214066496
Email: Marc.blockman@uct.ac.za

This information sheet is to be kept by you.

APPENDIX 13: Certificate of Assent for Children with Mobility Impairments who are below 18 years

University of Cape Town · iYunivesithi yaseKapa · Universiteit van Kaapstad

Disability Studies
Affirm Advocate Account

Department of Health and Rehabilitation Sciences
Faculty of Health Sciences
F45 Old Main Building, Groote Schuur Hospital,
Observatory 7925
Tel: +27 (0) 21 650 5350
Internet: www.dhrs.uct.ac.za

Title of study: **“Exploring the Experiences of Children and Youth with Mobility Impairments in four Basic Educational Settings in Ghana”.**

I understand the research is about finding out the experiences of children and youth with mobility impairments with regards to barriers and support services available in four basic educational settings in Ghana to promote quality education for people with disabilities. I also understand that I will be asked questions about my experiences with regards to barriers and support services in my school, and that I can choose to answer them.

I have read this information (or had the information read to me). I have had my questions answered and know that I can ask questions later if I have them.

I agree to take part in the research. [ ] (Please tick)

OR

I do not wish to take part in the research [ ] (Please tick)

Only if child assents:

Print name of child ___________________

Signature of child: ____________________

Date:________________

dd/mm/yy

If illiterate:

A literate witness must sign (if possible, this person should be selected by the participant, not be a parent, and should have no connection to the research team). Participants who are illiterate should include their thumb print as well.

I have witnessed the accurate reading of the assent form to the child, and the individual has had the opportunity to ask questions. I confirm that the individual has given assent freely.

Print name of witness (not a parent) ________________ AND thumb print of participant

Signature of witness _____________________

Thumb Print

Date _______________________

Day/month/year

I have accurately read or witnessed the accurate reading of the assent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given assent freely.

Print name of researcher________________

Signature of researcher__________________

Date_________________

Day/month/year

Statement by the researcher/person taking consent

I have accurately read out the information sheet to the potential participant, and to the best of my ability made sure that the child understands that the following will be done:

1. He/she will leave their classroom and go with me to a separate venue based in the school.
2. He/she will be asked questions.
3. He/she will be given a lunch and returned to their classroom once the interview has finished.

I confirm that the child was given an opportunity to ask questions about the study, and all the questions asked by him/her have been answered correctly and to the best of my ability. I confirm that the individual has not been coerced into giving consent, and the consent has been given freely and voluntarily.

A copy of this assent form has been provided to the participant**.**

Print name of researcher/person taking the assent________________________

Signature of researcher/person taking the assent __________________________

Date ___________________________

Day/month/year

Copy provided to the participant ________ (initialled by researcher/assistant)

Parent/Guardian has signed an informed consent ___Yes ___ No ____(initialled by researcher/assistant)

Contact details:
Nseibo Job Kofi
Disability Studies
Department of Health and Rehabilitation Sciences
University of Cape Town, South Africa
Phone: +233 244107056 or +27 818316004
Email: NSBJOB001@myuct.ac.za

Supervisor: A/Prof. Judith McKenzie (Head of Division)
Disability Studies
Department of Health and Rehabilitation Sciences
University of Cape Town, South Africa
Phone: +27 214066318

Email: Judith.mckenzie@uct.ac.za

If you have any concerns or complaints about the conduct of the study and its staff or about human rights and welfare of participants, you can directly contact:

The Chairperson
Prof Marc Blockman
Faculty of Health Sciences Human Research Ethics Committee
Room E52.24, Old Main Building
Groote Schuur Hospital
TEL: +27 214066496
Email: Marc.blockman@uct.ac.za

APPENDIX 14: Consent form for Individual Interviews

Department of Health and Rehabilitation Sciences
Faculty of Health Sciences
F45 Old Main Building, Groote Schuur Hospital,
Observatory 7925
Tel: +27 (0) 21 650 5350
Internet: www.dhrs.uct.ac.za

Title of study: **"Exploring the Experiences of Children and Youth with Mobility Impairments in four Basic Educational Settings in Ghana".**

I.. [PRINT NAME], give consent to my participation in the individual interview.

In giving my consent I acknowledge that: **(Please tick)**

1. The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction [ ].
2. I have read the Participant Information Letter and have been given the opportunity to discuss the information and my involvement in the project with the researcher [ ].
3. I understand that being in this study is completely voluntary – I am not under any obligation to consent [ ].
4. I understand that my involvement is strictly confidential. I understand that any research data gathered from the results of the study may be published; however, no information about me will be used in any way that is identifiable [ ].
5. I understand that I can withdraw from the study at any time without affecting my relationship with the researcher(s) or the University of Cape Town now or in the future [ ].

6. I understand that I can stop the interview at any time if I do not wish to continue, the audio recording will be erased and the information provided will not be included in the study [ ].
7. I consent to audio-recording YES ☐ NO ☐ (Please tick one)

Signature (participant)..
Date and place...
Signature (researcher)…………………………………………………………..
Date and place…………………………………………………………………..

APPENDIX 15: Consent Form for Parents of Children and Youth with Mobility Impairments in Focus Group Interview

Disability Studies
Affirm Advocate Account

Department of Health and Rehabilitation Sciences
Faculty of Health Sciences
F45 Old Main Building, Groote Schuur Hospital,
Observatory 7925
Tel: +27 (0) 21 650 5350
Internet: www.dhrs.uct.ac.za

Title of study: **"Exploring the Experiences of Children and Youth with Mobility Impairments in four Basic Educational Settings in Ghana".**

I.. [PRINT NAME], give consent to my participation in the focus group interview.

In giving my consent I acknowledge that: **(Please tick)**

1. The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction [ ].
2. I have read the Participant Information Letter and have been given the opportunity to discuss the information and my involvement in the project with the researcher [ ].
3. I understand that being in this study is completely voluntary – I am not under any obligation to consent [ ].
4. I understand that my involvement is strictly anonymous. I understand that any research data gathered from the results of the study may be published; however, no information about me will be used in any way that is identifiable [ ].
5. I understand that I must keep confidential information about others to myself in the course of focus group discussions and after the groups [ ].
6. I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher(s) or the University of Cape Town, now or in the future [ ].

7. I understand that I can stop the interview at any time if I do not wish to continue, the audio recording will not be erased but the information provided by me will not be included in the study [ ].
8. I consent to audio-recording YES ☐ NO ☐ (Please tick one)

Signature (participant)..

Date and place..

Signature (researcher)…………………………………………………………..

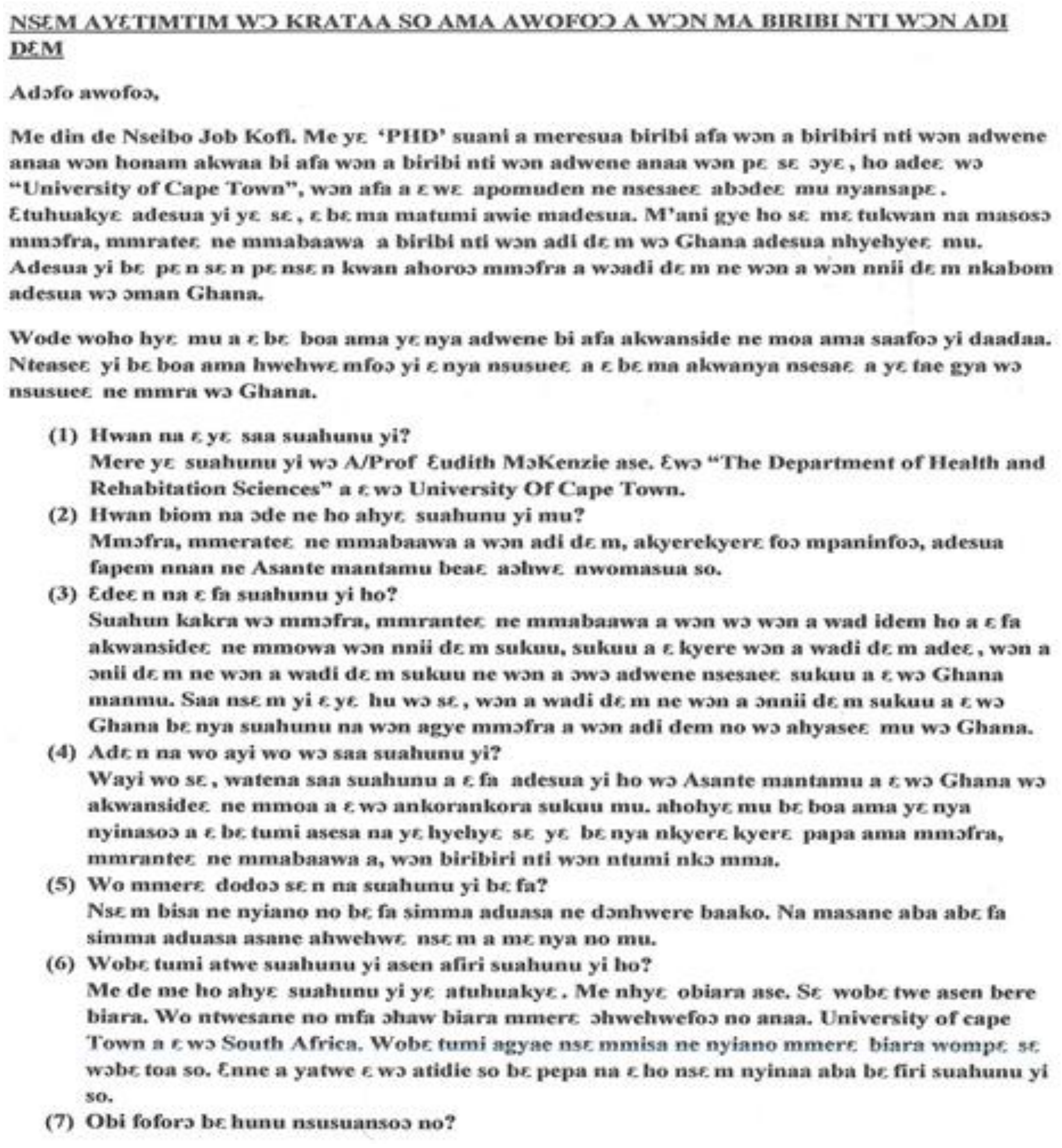
Date and place…………………………………………………………………..

APPENDIX 16: Attendance Register

Date …………………………….. Venue …………………………. Time…………………….

NO	First name(s)	Surname	National Registration card number (NRC)	Cell number	Signature

APPENDIX 17: Twi Version of the Information Sheet for Parents of Children and Youth with Mobility Impairments



NSƐM AYƐTIMTIM WƆ KRATAA SO AMA AWOFOƆ A WƆN MA BIRIBI NTI WƆN ADI DƐM

Adɔfo awofoɔ,

Me din de Nseibo Job Kofi. Me yɛ 'PHD' suani a meresua biribi afa wɔn a biribiri nti wɔn adwene anaa wɔn honam akwaa bi afa wɔn a biribi nti wɔn adwene anaa wɔn pɛ sɛ ɔyɛ, ho adeɛ wɔ "University of Cape Town", wɔn afa a ɛ wɛ apomuden ne nsesaeɛ abɔdeɛ mu nyansapɛ. Ɛtuhuakyɛ adesua yi yɛ sɛ, ɛ bɛ ma matumi awie madesua. M'ani gye ho sɛ mɛ tukwan na masosɔ mmɔfra, mmrateɛ ne mmabaawa a biribi nti wɔn adi dɛ m wɔ Ghana adesua nhyehyeɛ mu. Adesua yi bɛ pɛ n sɛ n pɛ nsɛ n kwan ahoroɔ mmɔfra a wɔadi dɛ m ne wɔn a wɔn nnii dɛ m nkabom adesua wɔ ɔman Ghana.

Wode woho hyɛ mu a ɛ bɛ boa ama yɛ nya adwene bi afa akwanside ne moa ama saafoɔ yi daadaa. Nteaseɛ yi bɛ boa ama hwehwɛ mfoɔ yi ɛ nya nsusueɛ a ɛ bɛ ma akwanya nsesaɛ a yɛ fae gya wɔ nsusueɛ ne mmra wɔ Ghana.

(1) Hwan na ɛ yɛ saa suahunu yi?
Mere yɛ suahunu yi wɔ A/Prof Ɛudith MɔKenzie ase. Ɛwɔ "The Department of Health and Rehabitation Sciences" a ɛ wɔ University Of Cape Town.

(2) Hwan biom na ɔde ne ho ahyɛ suahunu yi mu?
Mmɔfra, mmerateɛ ne mmabaawa a wɔn adi dɛ m, akyerekyerɛ foɔ mpaninfoɔ, adesua fapem nnan ne Asante mantamu beaɛ aɔhwɛ nwomasua so.

(3) Ɛdeɛ n na ɛ fa suahunu yi ho?
Suahun kakra wɔ mmɔfra, mmranteɛ ne mmabaawa a wɔn wɔ wɔn a wad idem ho a ɛ fa akwansideɛ ne mmowa wɔn nnii dɛ m sukuu, sukuu a ɛ kyere wɔn a wadi dɛ m adeɛ, wɔn a ɔnii dɛ m ne wɔn a wadi dɛ m sukuu ne wɔn a ɔwɔ adwene nsesaeɛ sukuu a ɛ wɔ Ghana manmu. Saa nsɛ m yi ɛ yɛ hu wɔ sɛ, wɔn a wadi dɛ m ne wɔn a ɔnnii dɛ m sukuu a ɛ wɔ Ghana bɛ nya suahunu na wɔn agye mmɔfra a wɔn adi dem no wɔ ahyaseɛ mu wɔ Ghana.

(4) Adɛ n na wo ayi wo wɔ saa suahunu yi?
Wayi wo sɛ, watena saa suahunu a ɛ fa adesua yi ho wɔ Asante mantamu a ɛ wɔ Ghana wɔ akwansideɛ ne mmoa a ɛ wɔ ankorankora sukuu mu. ahohyɛ mu bɛ boa ama yɛ nya nyinasoɔ a ɛ bɛ tumi asesa na yɛ hyehyɛ sɛ yɛ bɛ nya nkyerɛ kyerɛ papa ama mmɔfra, mmranteɛ ne mmabaawa a, wɔn biribiri nti wɔn ntumi nkɔ mma.

(5) Wo mmerɛ dodoɔ sɛ n na suahunu yi bɛ fa?
Nsɛ m bisa ne nyiano no bɛ fa simma aduasa ne dɔnhwere baako. Na masane aba abɛ fa simma aduasa asane ahwehwɛ nsɛ m a mɛ nya no mu.

(6) Wobɛ tumi atwe suahunu yi asen afiri suahunu yi ho?
Me de me ho ahyɛ suahunu yi yɛ atuhuakyɛ. Me nhyɛ obiara ase. Sɛ wobɛ twe asen bere biara. Wo ntwesane no mfa ɔhaw biara mmerɛ ɔhwehwefoɔ no anaa. University of cape Town a ɛ wɔ South Africa. Wobɛ tumi agyae nsɛ mmisa ne nyiano mmerɛ biara wompɛ sɛ wɔbɛ toa so. Ɛnne a yatwe ɛ wɔ atidie so bɛ pepa na ɛ ho nsɛ m nyinaa aba bɛ firi suahunu yi so.

(7) Obi foforɔ bɛ hunu nsusuansoɔ no?

Bribiara nni hɔ a obi bɛ hunu afa suahunu yi mu. hwɛ hwefoɔ no ne nanamu sinii ne nea ɔtenetene no no, pɛ na wɔwɔ kwan wɔ nsɛ m biara wɔn a ɔde wɔn ho ahyɛ mu de ama. Obiara nhu wo ho nsem biara wɔ suahunu yi mu na nsɛ m biara fa wo ho no yɛ de obi din na ɛ bɛ hyɛ hɔ.

Nsɛ m a ɛ fa suahunu yi mu no yɛ de bɛ gu wɔn a wadi dɛ m ho nsɛ m a yahwehwɛ asua mu no nwoma na ɛ mom wɔn a ɔka ho no obiara nhu wɔn.

(8) Suahunu no bɛ ma wo mfasoɔ?

Yɛ ntumi nyianso nsi no pi anaa nhyɛ bɔ sɛ wobɛ nya biribi afa suahunu yi mu. na ɛ mom yɛ bɛ ma wo sika a ne dodoɔ yɛ Gh¢3600 (US$900) sɛ ɔnfa mfa lɔre mmra faako ɔreyɛ nsɛ mmisa ne nyiano no, ne wɔn awie aduane. Nnoɔma pa a yɛ bɛ nya afiri suahunu yi mu bɛ boa afoforɔ nso daakye.

(9) Nnoɔma bi ɛ hu wɔ sɛ wode woho ahyɛ suahunu yi mu?

Nnoɔma kakra bi ɛ hu wɔ suadeɛ yi mu. Sɛ woboto na wo hia mmoa bi a mɛ hyehyɛ na moakɔ hu wɔn a ɔtu fa wɔ Kwame Nkrumah University of Sɔienɔe and teɔhnology suapɔn mu.

(10) Wobɛ tumi aka suahunu yi mu asɛ m akyerɛ obi?

Wobɛ tumi aka suahunu yi ho asɛ m ne nsɛ mmisa.

(11) Sɛ ebi wohia nsɛ m bi fa suahunu yi ho anaa wahohyɛ mu?

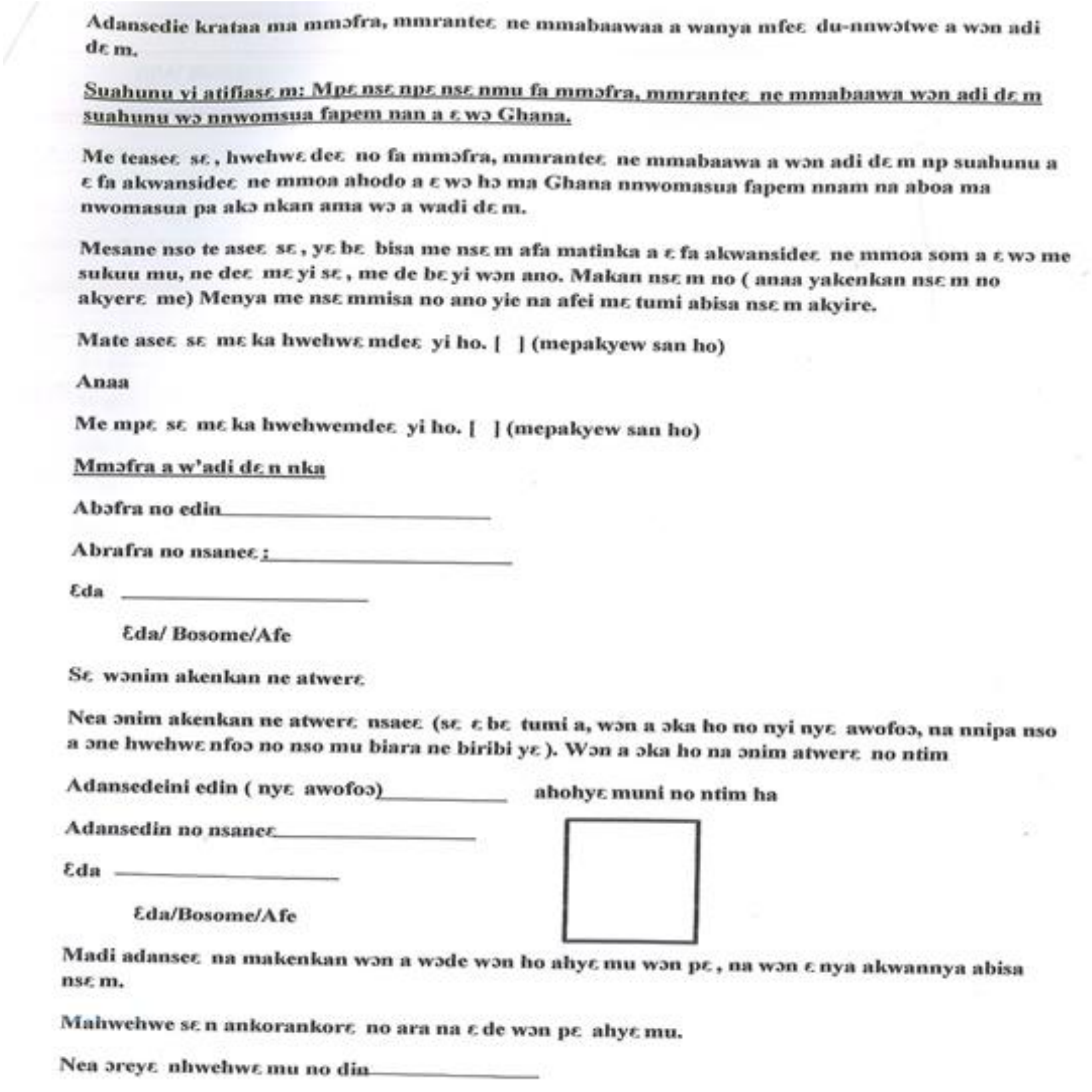
Mayɛ madwene sɛ , me ne mo pɛ n sɛ pɛ nsɛ n na ma ma mo nsɛ m biara a ɛ fa suahunu yi ho. Mo bɛ tumi afrɛ me abrɛ biara. Mobɛ tumi nso afrɛ me hwɛ sofoɔ yi wɔ ahomatrofoɔ yi a ɛ wɔ aseɛ yi a ɛ wɔ aseɛ yi so.

(12) Sɛ ebia wo wɔ nsɛ mmisa nso a anaa ɔhaw bi a nso?

Sɛ wo wɔ ɔhaw anaa Nsɛ mmisa bi nso a frɛ me. Anaa me hwe sofoɔ anaa dwamtenani a ɔwɔ 'UCT'' Faculty of Health Sciences Human Research Ethics Committee' so wɔ ahomatrofoɔ yɛ de ama wɔ aseɛ ho.

Me daase.

APPENDIX 18: Twi Version of the Consent and Assent Forms



Adansedie krataa ma mmɔfra, mmranteɛ ne mmabaawaa a wanya mfeɛ du-nnwɔtwe a wɔn adi dɛ m.

<u>Suahunu yi atifiasɛ m: Mpɛ nsɛ npɛ nsɛ nmu fa mmɔfra, mmranteɛ ne mmabaawa wɔn adi dɛ m suahunu wɔ nnwomsua fapem nan a ɛ wɔ Ghana.</u>

Me teaseɛ sɛ , hwehwɛ deɛ no fa mmɔfra, mmranteɛ ne mmabaawa a wɔn adi dɛ m np suahunu a ɛ fa akwansideɛ ne mmoa ahodo a ɛ wɔ hɔ ma Ghana nnwomasua fapem nnam na aboa ma nwomasua pa akɔ nkan ama wɔ a wadi dɛ m.

Mesane nso te aseɛ sɛ , yɛ bɛ bisa me nsɛ m afa matinka a ɛ fa akwansideɛ ne mmoa som a ɛ wɔ me sukuu mu, ne deɛ mɛ yi sɛ , me de bɛ yi wɔn ano. Makan nsɛ m no (anaa yakenkan nsɛ m no akyerɛ me) Menya me nsɛ mmisa no ano yie na afei mɛ tumi abisa nsɛ m akyire.

Mate aseɛ sɛ mɛ ka hwehwɛ mdeɛ yi ho. [ ] (mepakyew san ho)

Anaa

Me mpɛ sɛ mɛ ka hwehwemdeɛ yi ho. [ ] (mepakyew san ho)

<u>Mmɔfra a w'adi dɛ n nka</u>

Abɔfra no edin____________________________

Abrafra no nsaneɛ :____________________________

Ɛda __________________________

Ɛda/ Bosome/Afe

Sɛ wɔnim akenkan ne atwerɛ

Nea ɔnim akenkan ne atwerɛ nsaeɛ (sɛ ɛ bɛ tumi a, wɔn a ɔka ho no nyi nyɛ awofoɔ, na nnipa nso a ɔne hwehwɛ nfoɔ no nso mu biara ne biribi yɛ). Wɔn a ɔka ho na ɔnim atwerɛ no ntim

Adansedeini edin (nyɛ awofoɔ)______________ ahohyɛ muni no ntim ha

Adansedin no nsaneɛ______________________

Ɛda __________________________

Ɛda/Bosome/Afe

☐

Madi adanseɛ na makenkan wɔn a wɔde wɔn ho ahyɛ mu wɔn pɛ , na wɔn ɛ nya akwannya abisa nsɛ m.

Mahwehwe sɛ n ankorankorɛ no ara na ɛ de wɔn pɛ ahyɛ mu.

Nea ɔreyɛ nhwehwɛ mu no din____________________

Ne nsaeɛ ____________________

Ɛda ____________________

Ɛda/ Bosome/ Afe

Hwehɛ mufoɔ no anodisɛm

Makenkan nsɛm a ɛ wɔ krataa yi so akyerɛ wɔn a ɔka ho nyinara na mɛ tumi ama mo ateaseɛ sɛ, mmɔfra nsteaseɛ sɛ, yɛ bɛ yɛ yie nom:

1. Wɔn bɛ firi wɔn adesua dan mu adi makyi ne me akɔ baabi wɔ sukuu no mu.
2. Yɛ bɛ bisa wɔ nsɛm
3. Yɛ bɛ ma wɔn awia aduane na sɛ, yɛ wie wɔ nsɛmmisa ne anoyie na wɔn bɛ sane akɔ wɔ adesua dan mu.

Megyina so sɛ, yɛ maa kwan ma bɔfra biara bisa nsɛmmisa faa suahunu yi ho na anoyie no yɛ pɛ pɛ ɛ pɛ. Megyina so sɛ, yɛ n sii kwan sɛ obiara mfa ne pɛ. Ya firi wɔn ankasa pɛ mu.

Wɔn a ɔde wɔn ho ahyɛ mu no ɛ nya ɔpɛ krataa no bi.

Hwehwɛ mfoɔ no din ____________________

Nsaeɛ ____________________

Ɛda ____________________

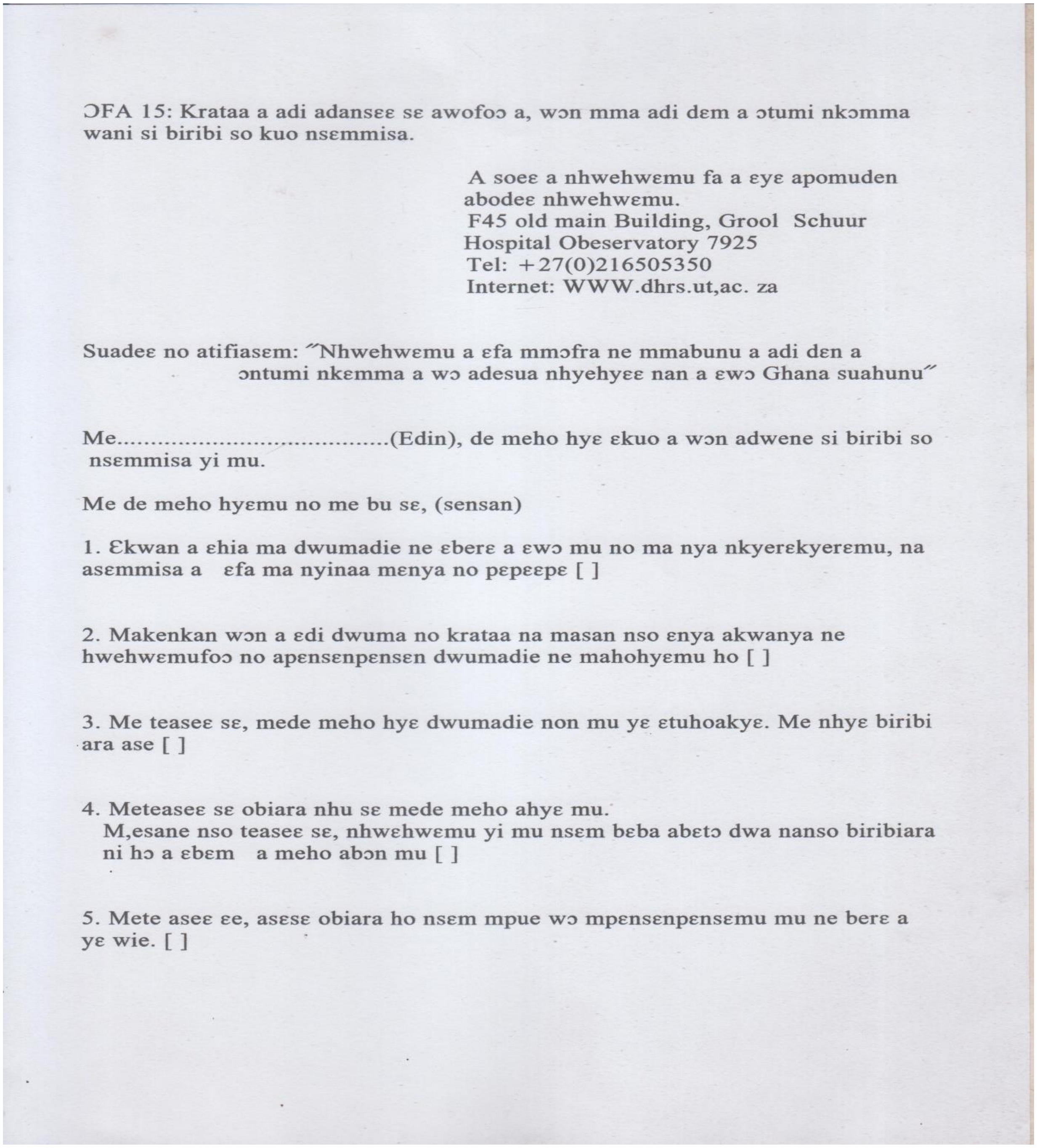
Ɛda/Bosome/Afe

Yɛ de krataa no bi bɛ ma wɔn a ɔka ho no ____________________

Awofoɔ/ɔhwɛ foɔ asensan adwenkyerɛ ____________________ aane___ daabi___

Ahomatorofo ho nsɛm:

APPENDIX 19: Twi Version of the Consent Form for Parents of Children and Youth with Mobility Impairments



ƆFA 15: Krataa a adi adansɛɛ sɛ awofoɔ a, wɔn mma adi dɛm a ɔtumi nkɔmma wani si biribi so kuo nsɛmmisa.

A soeɛ a nhwehwɛmu fa a ɛyɛ apomuden
abodeɛ nhwehwɛmu.
F45 old main Building, Grool Schuur
Hospital Obeservatory 7925
Tel: +27(0)216505350
Internet: WWW.dhrs.ut,ac. za

Suadeɛ no atifiasɛm: ˝Nhwehwɛmu a ɛfa mmɔfra ne mmabunu a adi dɛn a ɔntumi nkɛmma a wɔ adesua nhyehyɛɛ nan a ɛwɔ Ghana suahunu˝

Me..(Edin), de meho hyɛ ɛkuo a wɔn adwene si biribi so nsɛmmisa yi mu.

Me de meho hyɛmu no me bu sɛ, (sensan)

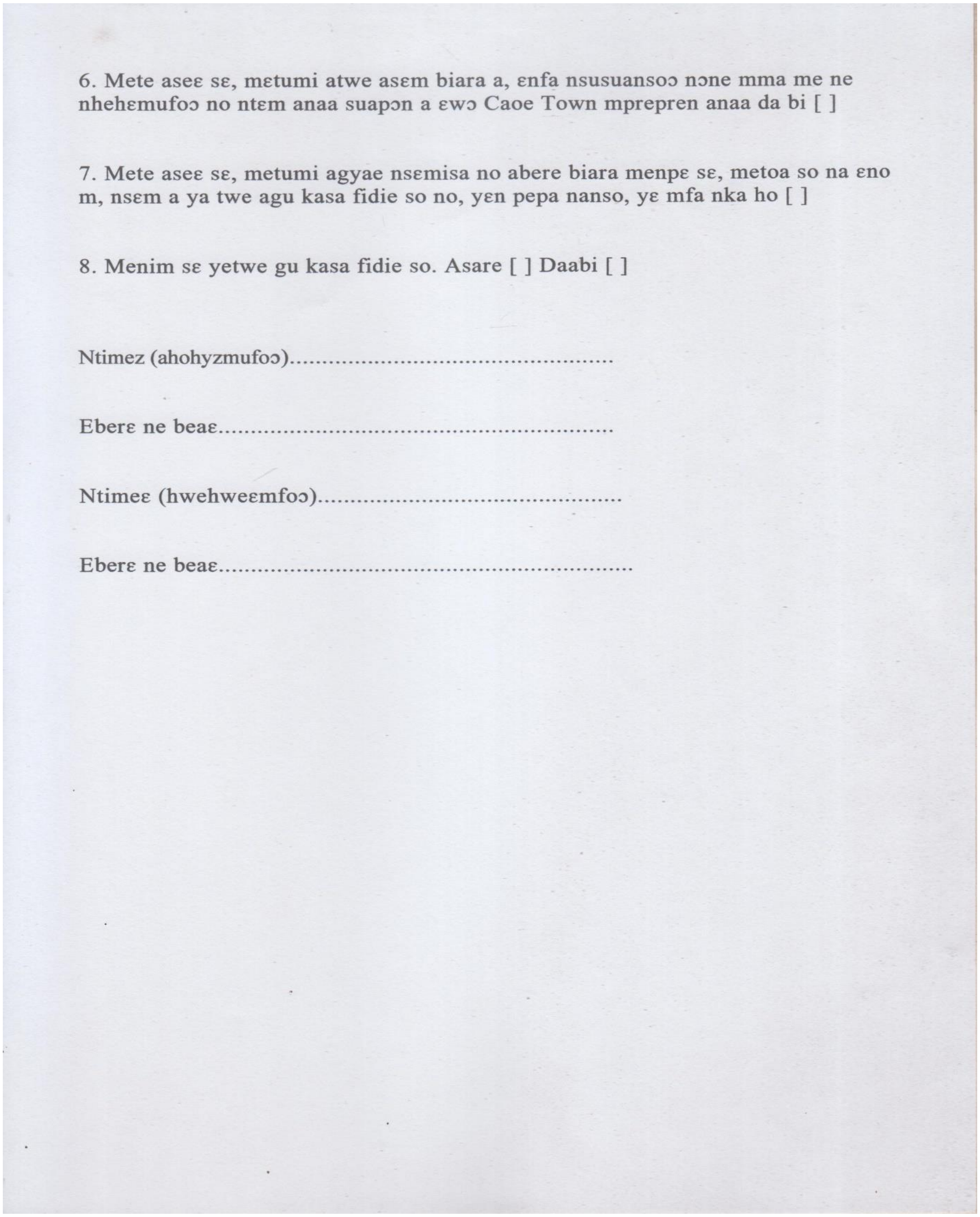
1. Ɛkwan a ɛhia ma dwumadie ne ɛberɛ a ɛwɔ mu no ma nya nkyerɛkyerɛmu, na asɛmmisa a ɛfa ma nyinaa mɛnya no pɛpɛɛpɛ [ ]

2. Makenkan wɔn a ɛdi dwuma no krataa na masan nso ɛnya akwanya ne hwehwɛmufoɔ no apɛnsɛnpɛnsɛn dwumadie ne mahohyɛmu ho [ ]

3. Me teaseɛ sɛ, mede meho hyɛ dwumadie non mu yɛ ɛtuhoakyɛ. Me nhyɛ biribi ara ase [ ]

4. Meteaseɛ sɛ obiara nhu sɛ mede meho ahyɛ mu.
M,esane nso teaseɛ sɛ, nhwɛhwɛmu yi mu nsɛm bɛba abɛtɔ dwa nanso biribiara ni hɔ a ɛbɛm a meho abɔn mu [ ]

5. Mete aseɛ ɛe, asɛsɛ obiara ho nsɛm mpue wɔ mpɛnsɛnpɛnsɛmu mu ne berɛ a yɛ wie. [ ]



6. Mete aseɛ sɛ, mɛtumi atwe asɛm biara a, ɛnfa nsusuansoɔ nɔne mma me ne nhehɛmufoɔ no ntɛm anaa suapɔn a ɛwɔ Caoe Town mprepren anaa da bi [ ]

7. Mete aseɛ sɛ, metumi agyae nsɛmisa no abere biara menpɛ sɛ, metoa so na ɛno m, nsɛm a ya twe agu kasa fidie so no, yɛn pepa nanso, yɛ mfa nka ho [ ]

8. Menim sɛ yetwe gu kasa fidie so. Asare [ ] Daabi [ ]

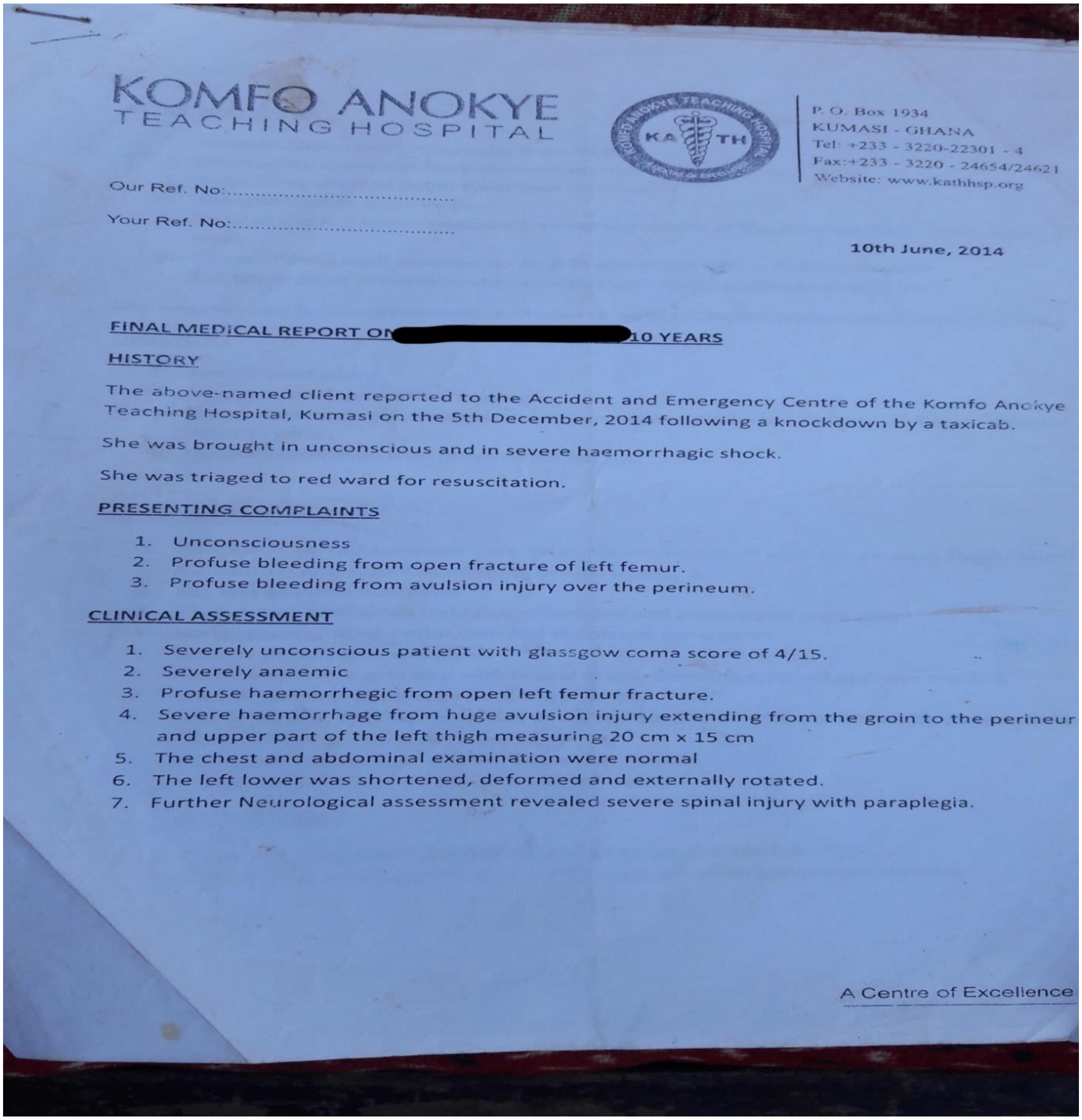
Ntimez (ahohyzmufoɔ)..

Eberɛ ne beaɛ...

Ntimeɛ (hwehweɛmfoɔ)..

Eberɛ ne beaɛ..

APPENDIX 20: Sample of Medical Report from Children and Youth with Mobility Impairments



KOMFO ANOKYE
TEACHING HOSPITAL

P. O. Box 1934
KUMASI - GHANA
Tel: +233 - 3220-22301 - 4
Fax:+233 - 3220 - 24654/24621
Website: www.kathhsp.org

Our Ref. No:......................................

Your Ref. No:......................................

10th June, 2014

FINAL MEDICAL REPORT ON [redacted] 10 YEARS

HISTORY

The above-named client reported to the Accident and Emergency Centre of the Komfo Anokye Teaching Hospital, Kumasi on the 5th December, 2014 following a knockdown by a taxicab.

She was brought in unconscious and in severe haemorrhagic shock.

She was triaged to red ward for resuscitation.

PRESENTING COMPLAINTS

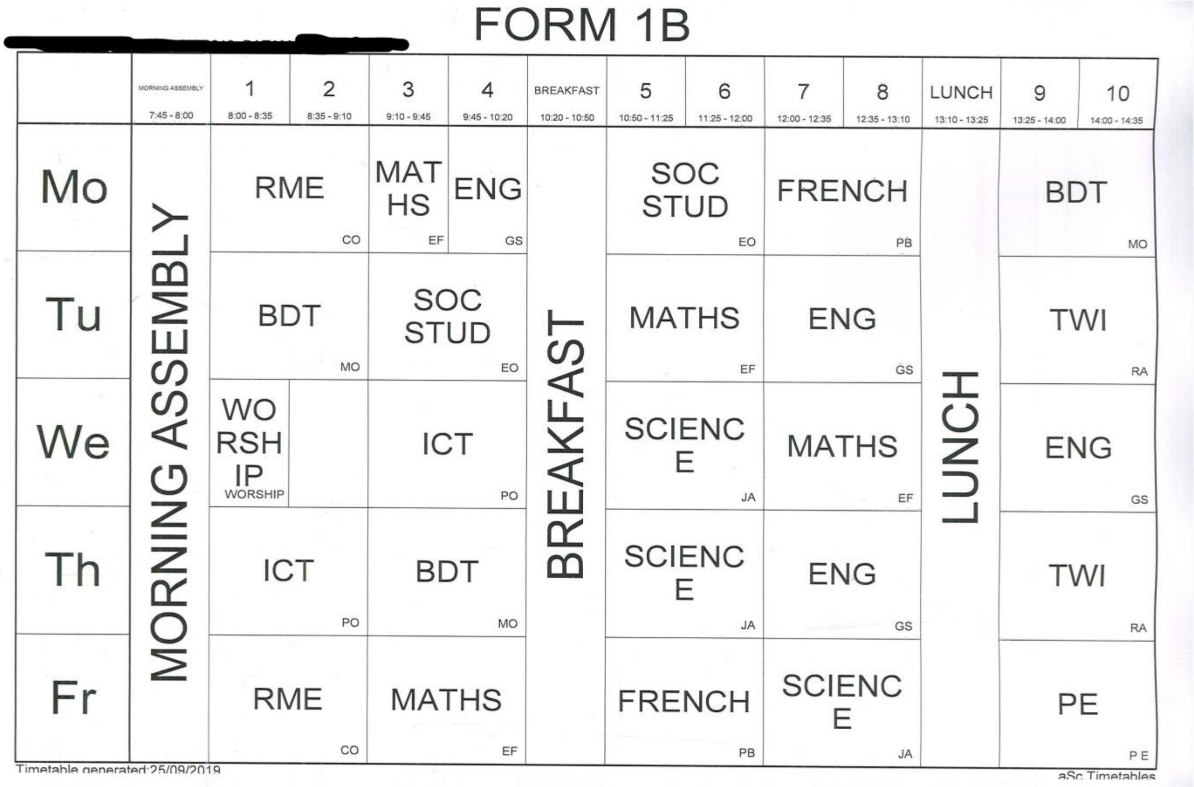
1. Unconsciousness
2. Profuse bleeding from open fracture of left femur.
3. Profuse bleeding from avulsion injury over the perineum.

CLINICAL ASSESSMENT

1. Severely unconscious patient with glassgow coma score of 4/15.
2. Severely anaemic
3. Profuse haemorrhegic from open left femur fracture.
4. Severe haemorrhage from huge avulsion injury extending from the groin to the perineur and upper part of the left thigh measuring 20 cm x 15 cm
5. The chest and abdominal examination were normal
6. The left lower was shortened, deformed and externally rotated.
7. Further Neurological assessment revealed severe spinal injury with paraplegia.

A Centre of Excellence

APPENDIX 21: Sample of a Timetable of a Mainstream School



[redacted]

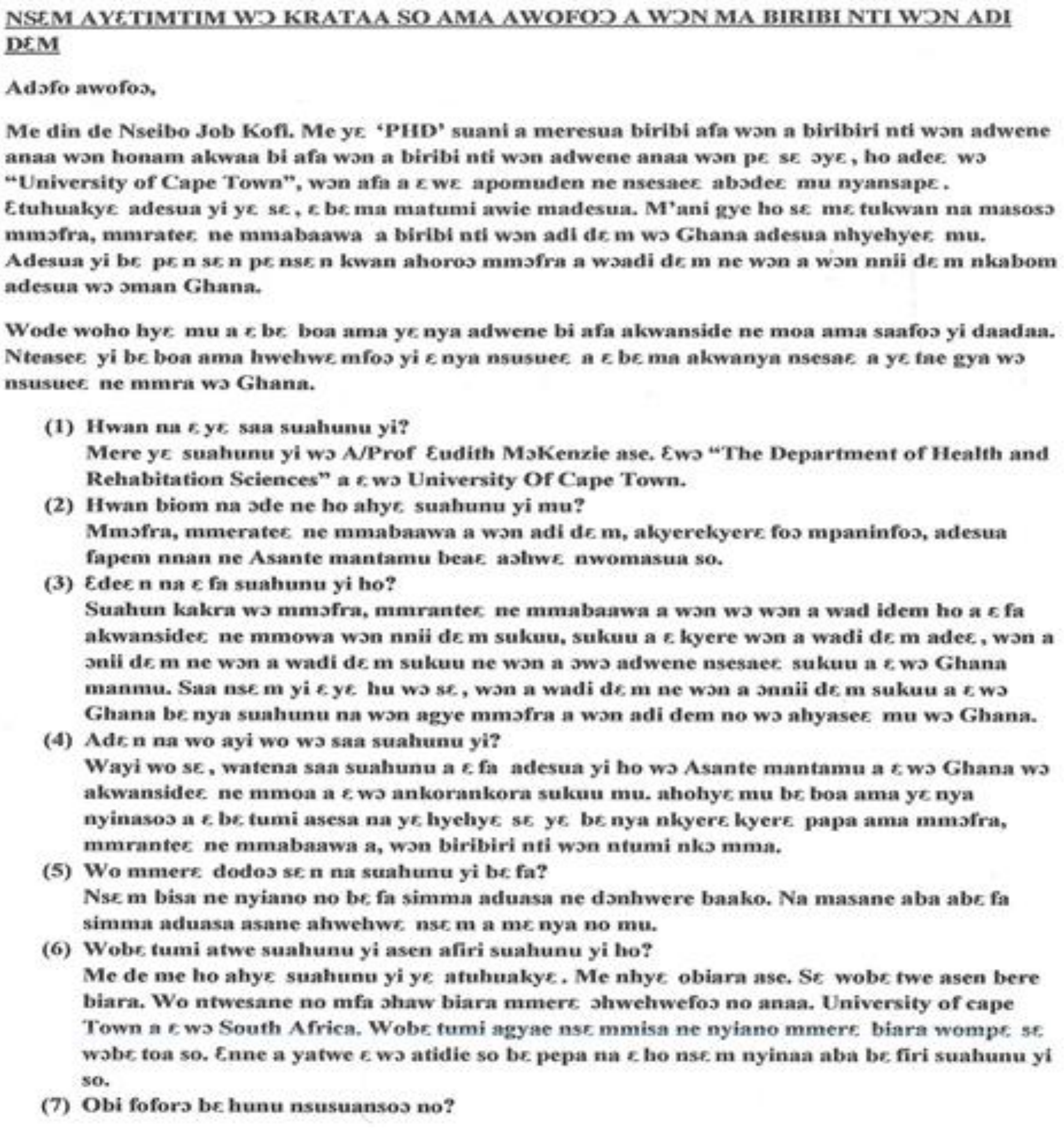
FORM 1B

	MORNING ASSEMBLY 7:45 - 8:00	1 8:00 - 8:35	2 8:35 - 9:10	3 9:10 - 9:45	4 9:45 - 10:20	BREAKFAST 10:20 - 10:50	5 10:50 - 11:25	6 11:25 - 12:00	7 12:00 - 12:35	8 12:35 - 13:10	LUNCH 13:10 - 13:25	9 13:25 - 14:00	10 14:00 - 14:35
Mo	MORNING ASSEMBLY	RME CO		MATHS EF	ENG GS	BREAKFAST	SOC STUD EO		FRENCH PB		LUNCH	BDT MO	
Tu		BDT MO		SOC STUD EO			MATHS EF		ENG GS			TWI RA	
We		WORSHIP WORSHIP		ICT PO			SCIENCE JA		MATHS EF			ENG GS	
Th		ICT PO		BDT MO			SCIENCE JA		ENG GS			TWI RA	
Fr		RME CO		MATHS EF			FRENCH PB		SCIENCE JA			PE P E	

Timetable generated:25/09/2019

aSc Timetables

APPENDIX 22: Twi Version of the Information Sheet for Children and Youth with Mobility Impairments



NSƐM AYƐTIMTIM WƆ KRATAA SO AMA AWOFOƆ A WƆN MA BIRIBI NTI WƆN ADI DƐM

Adɔfo awofoɔ,

Me din de Nseibo Job Kofi. Me yɛ 'PHD' suani a meresua biribi afa wɔn a biribiri nti wɔn adwene anaa wɔn honam akwaa bi afa wɔn a biribi nti wɔn adwene anaa wɔn pɛ sɛ ɔyɛ, ho adeɛ wɔ "University of Cape Town", wɔn afa a ɛ wɛ apomuden ne nsesaeɛ abɔdeɛ mu nyansapɛ. Ɛtuhuakyɛ adesua yi yɛ sɛ, ɛ bɛ ma matumi awie madesua. M'ani gye ho sɛ mɛ tukwan na masosɔ mmɔfra, mmrateɛ ne mmabaawa a biribi nti wɔn adi dɛm wɔ Ghana adesua nhyehyeɛ mu. Adesua yi bɛ pɛn sɛn pɛnsɛn kwan ahoroɔ mmɔfra a wɔadi dɛm ne wɔn a wɔn nnii dɛm nkabom adesua wɔ ɔman Ghana.

Wode woho hyɛ mu a ɛ bɛ boa ama yɛ nya adwene bi afa akwanside ne moa ama saafoɔ yi daadaa. Nteaseɛ yi bɛ boa ama hwehwɛ mfoɔ yi ɛ nya nsusueɛ a ɛ bɛ ma akwanya nsesaɛ a yɛ fae gya wɔ nsusueɛ ne mmra wɔ Ghana.

(1) Hwan na ɛ yɛ saa suahunu yi?
Mere yɛ suahunu yi wɔ A/Prof Ɛudith MɔKenzie ase. Ɛwɔ "The Department of Health and Rehabitation Sciences" a ɛ wɔ University Of Cape Town.

(2) Hwan biom na ɔde ne ho ahyɛ suahunu yi mu?
Mmɔfra, mmerateɛ ne mmabaawa a wɔn adi dɛm, akyerekyerɛ foɔ mpaninfoɔ, adesua fapem nnan ne Asante mantamu beaɛ aɔhwɛ nwomasua so.

(3) Ɛdeɛn na ɛ fa suahunu yi ho?
Suahun kakra wɔ mmɔfra, mmranteɛ ne mmabaawa a wɔn wɔ wɔn a wad idem ho a ɛ fa akwansideɛ ne mmowa wɔn nnii dɛm sukuu, sukuu a ɛ kyere wɔn a wadi dɛm adeɛ, wɔn a ɔnii dɛm ne wɔn a wadi dɛm sukuu ne wɔn a ɔwɔ adwene nsesaeɛ sukuu a ɛ wɔ Ghana manmu. Saa nsɛm yi ɛ yɛ hu wɔ sɛ, wɔn a wadi dɛm ne wɔn a ɔnnii dɛm sukuu a ɛ wɔ Ghana bɛ nya suahunu na wɔn agye mmɔfra a wɔn adi dem no wɔ ahyaseɛ mu wɔ Ghana.

(4) Adɛn na wo ayi wo wɔ saa suahunu yi?
Wayi wo sɛ, watena saa suahunu a ɛ fa adesua yi ho wɔ Asante mantamu a ɛ wɔ Ghana wɔ akwansideɛ ne mmoa a ɛ wɔ ankorankora sukuu mu. ahohyɛ mu bɛ boa ama yɛ nya nyinasoɔ a ɛ bɛ tumi asesa na yɛ hyehyɛ sɛ yɛ bɛ nya nkyerɛ kyerɛ papa ama mmɔfra, mmranteɛ ne mmabaawa a, wɔn biribiri nti wɔn ntumi nkɔ mma.

(5) Wo mmerɛ dodoɔ sɛn na suahunu yi bɛ fa?
Nsɛm bisa ne nyiano no bɛ fa simma aduasa ne dɔnhwere baako. Na masane aba abɛ fa simma aduasa asane ahwehwɛ nsɛm a mɛ nya no mu.

(6) Wobɛ tumi atwe suahunu yi asen afiri suahunu yi ho?
Me de me ho ahyɛ suahunu yi yɛ atuhuakyɛ. Me nhyɛ obiara ase. Sɛ wobɛ twe asen bere biara. Wo ntwesane no mfa ɔhaw biara mmerɛ ɔhwehwefoɔ no anaa. University of cape Town a ɛ wɔ South Africa. Wobɛ tumi agyae nsɛ mmisa ne nyiano mmerɛ biara wompɛ sɛ wɔbɛ toa so. Ɛnne a yatwe ɛ wɔ atidie so bɛ pepa na ɛ ho nsɛm nyinaa aba bɛ firi suahunu yi so.

(7) Obi foforɔ bɛ hunu nsusuansoɔ no?

Bribiara nni hɔ a obi bɛ hunu afa suahunu yi mu. hwɛ hwefoɔ no ne nanamu sinii ne nea ɔtenetene no no, pɛ na wɔwɔ kwan wɔ nsɛ m biara wɔn a ɔde wɔn ho ahyɛ mu de ama. Obiara nhu wo ho nsem biara wɔ suahunu yi mu na nsɛ m biara fa wo ho no yɛ de obi din na ɛ bɛ hyɛ hɔ.

Nsɛ m a ɛ fa suahunu yi mu no yɛ de bɛ gu wɔn a wadi dɛ m ho nsɛ m a yahwehwɛ asua mu no nwoma na ɛ mom wɔn a ɔka ho no obiara nhu wɔn.

(8) Suahunu no bɛ ma wo mfasoɔ?

Yɛ ntumi nyianso nsi no pi anaa nhyɛ bɔ sɛ wobɛ nya biribi afa suahunu yi mu. na ɛ mom yɛ bɛ ma wo sika a ne dodoɔ yɛ Gh¢3600 (US$900) sɛ ɔnfa mfa lɔre mmra faako ɔreyɛ nsɛ mmisa ne nyiano no, ne wɔn awie aduane. Nnoɔma pa a yɛ bɛ nya afiri suahunu yi mu bɛ boa afoforɔ nso daakye.

(9) Nnoɔma bi ɛ hu wɔ sɛ wode woho ahyɛ suahunu yi mu?

Nnoɔma kakra bi ɛ hu wɔ suadeɛ yi mu. Sɛ woboto na wo hia mmoa bi a mɛ hyehyɛ na moakɔ hu wɔn a ɔtu fa wɔ Kwame Nkrumah University of Sɔienɔe and teɔhnology suapɔn mu.

(10) Wobɛ tumi aka suahunu yi mu asɛ m akyerɛ obi?

Wobɛ tumi aka suahunu yi ho asɛ m ne nsɛ mmisa.

(11) Sɛ ebi wohia nsɛ m bi fa suahunu yi ho anaa wahohyɛ mu?

Mayɛ madwene sɛ , me ne mo pɛ n sɛ pɛ nsɛ n na ma ma mo nsɛ m biara a ɛ fa suahunu yi ho. Mo bɛ tumi afrɛ me abrɛ biara. Mobɛ tumi nso afrɛ me hwɛ sofoɔ yi wɔ ahomatrofoɔ yi a ɛ wɔ aseɛ yi a ɛ wɔ aseɛ yi so.

(12) Sɛ ebia wo wɔ nsɛ mmisa nso a anaa ɔhaw bi a nso?

Sɛ wo wɔ ɔhaw anaa Nsɛ mmisa bi nso a frɛ me. Anaa me hwe sofoɔ anaa dwamtenani a ɔwɔ 'UCT'' Faculty of Health Sciences Human Research Ethics Committee' so wɔ ahomatrofoɔ yɛ de ama wɔ aseɛ ho.

Me daase.

APPENDIX 23: Sample of a Transcribed Interview

Rehabilitation School Student 1 (RSS 1)

JKN Good afternoon

RSS1 Good afternoon Sir

JKN How are you doing today?

RSS1 By the grace of God I am fine

JKN Can you please mention your name, age and your class to me?

RSS1 Ok sir, my name is Kay

a. Name: Kay
b. Age: 16
c. Sex: Male
d. Level of Education/Class: Shoe making class
e. Description of disability: **wheelchair user**

JKN Please tell me about how your disability started?

RSS1 I was born mobility impaired and my parents did not treat me bad, they accepted my disability and treat me well. They have always been very supportive in all endeavours. I was first enrolled in a mainstream school before I came to this rehabilitation centre. I came here because the teachers said I don’t fit in the mainstream school.

JKN Who do you think the teachers said you don’t fit in the mainstream school?

RSS1 Hmmm, they said there is no disabled person there apart from me. He also said my friends will laugh at me and bully me.

JKN What is your understanding about disability?

RSS1 Disability is when an individual is not able to walk well or see well or someone who cannot do anything as a result of the disability.

JKN You said someone who cannot do anything. Does it mean you cannot do anything?

RSS1 Oh no, as for me I can do something because mine [disability] is not serious

JKN So what challenge did you face as mobility impaired person in your community?

RSS1 One of the challenges I face in the community is stigmatization from the community people. Most people do not want to come close or sit near me. Another challenge is the uncomfortable nature of transport services.

JKN So how do you feel when people do not want to come close or sit near you?

RSS1 I feel very bad because I too I am a human being.

JKN Sorry for that. Please tell me how you came by this school?

RSS1 My parents sought for admission here on my behalf and when I came I was assessed and placed in the shoe making class and I am enjoying the training very well. I have a lot of people to talk to and have fun with unlike home when I'm somehow confined to my immediate family and my wonderful wheelchair. I stayed in the house for 2 years before coming to this school.

JKN Can you tell me why you stayed in the house for 2 years?

RSS1 As for that, I don't know Sir.

JKN Please tell me about your experiences in this school.

RSS1 Hmmmmm, I have more experiences. We don't have showers in the bathroom. Carrying water to go and bath is a problem. So I find it difficult to bath. Because the school environment is not good I can't drive the wheelchair myself. I will have to beg my friends to push me always. Sometimes the blind student, sometimes too I beg those students who cannot talk, the day I did not get anyone and I tried to drive the wheelchair myself and I fell down.

JKN Sorry for that. Can you tell me about what happens in class?

RSS1 In the class, we don't have materials to work with. Our teacher said we must always buy the materials to be used to learn but my parents don't have money to buy these materials. When we get to the class, we will sit and sit until evening then we will go and eat and sleep. The food we eat too do not satisfy us. When we talk, our teachers said government has not given them money to buy food for us so we should keep quiet.

JKN Can you also tell me about things you like in the school?

RSS1 I like my friends in this school. Because when I beg them to push me they do it willingly. They don’t mock people or laugh at me when I fall down.

JKN Is that all you like in this school?

RSS1 No I like the church service also. We will sing and dance when we have church service.

JKN Kindly tell me about things that disturb/hinder you from learning?

RSS1 These are plenty, but I will mention only a few. We lack a lot of things here which impacts on our learning processes. I am in the shoe making class and more often than not our parents need to procure all the necessary materials and equipment to enable lessons to be undertaken due to the inability of government to provide us the required materials for teaching and learning purposes. Due to the inability of government to support us financially and materially, we lack a lot of things here ranging from feeding to toiletries and unfavourable school environment. Support services here are very low, government cares little about how we fare here. Our parents need to buy everything and help in raising funds for our support services else no lessons will go on here. Me, I like sports but we don’t do any sports here. People look down upon us even some of our teachers think we cannot do anything.

JKN You said you are in the shoe making class, then when you graduate, you will produce more shoes for sale.

RSS1 No sir, I cannot produce shoes, we don’t have the machines to produce shoes.

JKN So what work will you do when you graduate from this school?

RSS1 I don’t have any work to do when I graduate from this school.

JKN Tell me what you know about inclusive education.

RSS1 Inclusive education is where by children and youth without impairment are put together in the same school environment under the same teaching and learning activities. This is a laudable idea because it will help us to be very social and will minimize the huge stigma associated with disability.

JKN Please suggest strategies for the implementation of inclusive education.

RSS1 Government must provide good environment in the school and learning materials. We can help each other in the inclusive school.

JKN How can you help each other in the inclusive school?

RSS1 Like pushing me around during break time or when we are given homework and I don't understand they can teach me.

JKN What support service will you like to be given/done for you to access quality education for your life?

RSS1 The government should immediately come to our aid and help to provide the necessary materials and equipment needed in all classes to help enhance teaching and learning in this center. There should also be more support for the implementation of inclusive education system in Ghana so that we can enjoy the benefits associated with it.

JKN How will this help you?

RSS1 I am sure we will get a school bus so that when we have sports we can all go and watch it.

JKN Is that all you want government to do?

RSS1 No, I also want government to provide food, showers in the bathrooms, nice environment and teachers who will love us.

JKN I am so grateful to you for your time and assistance. This is your lunch and money for transport.

RSS1 Thank you master, and God bless you.