Reflections of a Ghanaian Support Worker in Canada: My Experience in Disability Studies

By

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A Thesis submitted to the Faculty of Graduate Studies of

The University of Manitoba

in partial fulfillment of the requirements of the degree of

MASTER OF ARTS

Department of Disability Studies

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Abstract

Ghana is a multilingual and cosmopolitan country with diverse set of values, customs, and cultural practices. Disparities in disability, attitudes and practices may result from differing belief systems. Disability is both a societal and a biological issue. People are only as impaired as their culture permits. Improving our understanding of the social issues that impact the disabled will help in full participation in societal activities. My work experience in social services motivated me to employ an auto ethnography approach to study the viewpoints of a Ghanaian support worker in Canada. In this study, I investigated my beliefs and thoughts, demonstrating how culture influences our perception of disability and disabled people. I also recall of events from my interactions with disabled people, participant observation field notes, and study diaries as data gathering techniques. I highlight how disability studies has changed my understanding of disability and disabled people. In addition, I document the similarities and differences in disability experiences between Ghana and Canada and how they help me become a better ally, and I provided readers with alternative methods and recommendations that may address and explore the perspectives of a Ghanaian support worker in Canada, my understanding of disability studies. I recommended that Priority should be given to removing cultural barriers that prevent people with disabilities from participating in society. The Ghanaian government's main priorities should be the construction and support of lobbying and information distribution campaigns. This will make it easier to apply inclusive practices and contribute to a reduction in community discrimination towards people with disabilities. The government must collaborate with local and political leaders to counteract the growing stigmatization of disabled people.

Acknowledgements

I would like to thank my Thesis Advisor, Professor Nancy Hansen, for her words of encouragement, mentorship, and teaching.

I would also like to thank Dr Sid Frankel and Dr. Diane Driedger my committee members for your contributions to this work. Your insights, time, conversations, and guidance have steered this work to its end.

I am grateful to Dr. Seidu Jamatutu and Mr. Boateng Ampratwum Kwadwo for your consistent support throughout the lengthy period of this research.

I wish to express my greatest appreciation and sincere thanks to my colleagues and family whose motivation and belief in me was unprecedented.

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CHAPTER ONE - Background

According to a 2018 World Bank report, disability is a global problem (world bank 2018). Again, as further indicated by the World Health Organization (WHO, 2020), 15% of the global population, or more than 1 billion people, are anticipated to be disabled. Many aspects of their lives have not given them enough attention, even though the number of disabled people is still rising, in part because of the high incidence of chronic disease (WHO, 2018).

The Global Disability Action Plan 2014–2021 report from the WHO states that "disability is a global public health issue, human rights issue, and developmental issue" (WHO, 2015, p. 1). According to the report, persons with disabilities still encounter prejudice while sharing the same rights as able-bodied persons since they cannot complete some jobs that able-bodied people can, owing to the constrictive features of society (spaces). The suggests that they remain impoverished and rely on handouts, while others seek assistance from various institutions (Naami, 2015). Discrimination against the disabled is more widespread in developing countries, particularly in Sub-Saharan Africa, where some people believe disability is caused by witchcraft (WHO, 2018).

People with disabilities are frequently viewed as social outcasts in many parts of the world, particularly in the third world and developing countries. Africa sub-Saharan makes no exception. (WHO, 2018). Individuals with impairments, according to Groce (1999), face social, cultural, and financial challenges rather than physical, psychological, or intellectual limitations. “People with disabilities are usually seen as burdens in the family and community in most sub-Saharan African countries”, which leads to many disabled people winding up on the streets asking for food (Kassah, 2008).

When it comes to education, employment and healthcare, people with disabilities are frequently not accepted according to their own country’s discriminatory attitudes, abuse, and violence. Access barriers lead to segregation and exclusion in the family context, at work, school, and in society, where disability is frequently regarded as a burden and a source of shame (African Union of the Blind, 2007).

The treatment of people with disabilities is frequently a reflection of social views and knowledge that are connected to existing beliefs and attitudes (Munyi, 2012; White et al., 2003). Again, a variety of explanations have been put forth as to why disabled people in Africa cannot get the assistance and care they require (Munyi, 2012). This happens through the belief systems that exclude people with disabilities from society at large, poverty, a lack of understanding of impairments, and inadequate legal protections (McKenzie et al, 2012) are a few examples. People with impairments, according to Avoke (2002), were thought to be possessed by evil spirits and cursed by the gods as a punishment of their family's or parents' disobedience.

How people are treated is also impacted by the prevalent religious and spiritual beliefs. For instance, Covey (2005) said that Christians in 16th-century Europe widely believed that those with intellectual disabilities or other disabilities, such epilepsy, were possessed by evil spirits, and that they were routinely beaten to force these spirits out. The way that persons with disabilities are perceived and treated in African nations has varied historically and continues to do so today (Munyi, 2012). For instance, people in Benin thought that children who seemed unusual were shielded by supernatural or spiritual forces and thus brought luck (Munyi, 2012). How people with disabilities are handled in Ghana is influenced by cultural prejudices and a variety of spiritual and paranormal beliefs (Grischow, 2019). According to Munyi (2012), views toward people with disabilities can range from appreciation and celebration to confinement, abuse, and infanticide, depending on the region.

Infanticide or social rejection has occurred in some communities in Ghana because of beliefs about the spiritual causes of a child's birth with a disability (Munyi, 2012). According to Avoke (2002) in Baffoe (2013), children with intellectual disabilities are also seen as the descendants of rivers and forests, and historically, these children have been sent back to the forest or rivers to assist them reclaim their natural habitat. According to a different study (Baffoe, 2013), people with mental health disorders are denied opportunities for a respectable life and meaningful interaction with their family, friends, and the greater community. In some parts of Ghana, having a malformed child is a sign that the gods are displeased.

Ghana has made progress in recognizing the rights of individuals with disabilities through several pieces of legislation and adherence to international conventions (Anthony, 2011), even though stigma around disability is entrenched in the country. Governments and important political think tanks are therefore giving more attention to the global concerns of poverty, inequality, and unemployment (Fellin et al., 2013). On a global scale, these urgent issues have drawn a lot of attention. Human rights groups have become more vocal in recent years in support of equality for all people, including those with disabilities (United Nations Human Rights of Persons with Disabilities, 2017). As a result, certain nations such as Ghana is leading the charge for greater services and recognition for people with disabilities.

To improve the inclusion of individuals with disabilities in society and lessen stigmatization and prejudice against persons with disabilities, several governments have put into place several new laws and policies since Ghana's 4th Republic dispensation. These human rights policies have been designed and implemented to fulfil the needs of Ghana's most vulnerable inhabitants, including the Domestic Violence Act, the Mental Health Bill, and the Disability Act (Yazbeck et al., 2004). According to Strogilos and Avramidis (2017), more research is needed to better understand the sociocultural factors that influence inclusion programs and the process of developing support services for people with disabilities that promote inclusion, which explains why such policies and laws have had varying degrees of success.

The Republic of Ghana's Constitution, the Persons with Disabilities Act, 2006 Act 715, and the Ghana National Disability Policy (Oye-Lithur, Stickney & Nathan, 2007) are all in effect. “Discrimination of disabled people must not be tolerated” (Oye -Lithur et al 2017) according to each of these documents, educational institutions are not allowed to discriminate against or disadvantage impaired students who have just graduated from high school and are enrolled in postsecondary programs (Taneja-Johansson, Singal, & Samson, 2021). Little is known about how Ghanaian persons with disabilities access education despite advancements in educational policy (Braun & Naami, 2021).

1.1 Motivation for the Study

In Ghana, where I come from, education has always been seen as the cornerstone of growth. Ghana's education system has made significant progress because of various legislative and community-led reforms, pupils continue to confront numerous challenges in acquiring a decent education. Some children do not even have classrooms, preferring to learn under a tree. Existing classrooms are frequently inaccessible to disabled children, and even when they are, teachers are ill-equipped to fulfil their needs. Growing up in a family of six boys where both of my parents were teachers and education played a significant role in my upbringing. The final three children were fortunate to have access to one of the greatest basic educations (private schools) in our area while the first three were encouraged to pursue careers as teachers. My school hired a man who had a visual impairment to teach us songs about our nation's independence. He was such a charming young man, and his son went to my school. In the neighborhood, we refused to play with children who had disabilities and simply referred to those who were homeless or on the streets as ‘mad’ or beggars. Disability-related persons who were unable to care for themselves were abandoned on the streets without access to food, shelter, or protection. He was so talented that no one noticed he was blind and needed his son to guide him while he sang.

Disabled people were not a part of my life until a few years later, my brother and his wife welcomed a lovely baby girl into the family, who was adored by everyone. After numerous attempts to improve her circumstances through a doctor and different local medications to assist her talk, we found that she was unable to speak and was therefore 'deaf.' Nobody in the family knew what to do at that time. Disability-related institutions, organizations, and societal or governmental support are lacking. My brother learned about special schools as Anna was old enough to attend school. She was eligible for the deaf school. For my brother, having his daughter attend school alongside him was a challenge. Some of the experiences he had in school Anna would not have. Within Ghana's education system (basic school system), special schools met standards and were accepted.

As circuit supervisor, my father is responsible for making sure teachers carry out their duties. He spends his day visiting different schools to check on the wellbeing of the pupils and the effectiveness of the instructors. When he got home, he would tell us tales about the classroom and how the teachers taught. According to him, most impaired students in special schools end up learning trades since they are unable to continue their education. My niece is currently enrolled in a sewing training program as I finish this thesis because the special schools are unable to accommodate her in other professions. To better understand disability and develop as an ally, I enrolled in the Master's in Disability Studies. I gained so much knowledge and looked at many problems through a disability lens.

Because of the program, I chose to work as a support worker to gain practical experience and deepen my awareness of disability. I chose this subject for my thesis because of my experiences working as a support worker.

1.2 Job Hunting

Interestingly in a discussion of where to find care jobs to get in-person experiences of the program (Disability Studies) and to provide the support where necessary, some of my colleagues where already employed with one of the third-party organizations in Winnipeg, with my little working knowledge in contracts, I had the impression that things would be better working for the companies that start and own these programs. I further discussed with other friends and my interest was to work with a company that accommodates all the various disabilities to give me a full understanding of disability.

My friends talked about this program that was unique to the other places they have worked and as I enquired more, this program was also operated through the same third-party organization that my friends worked for. I was also informed by friends of the frustration in applying to work with the regional health or non- profit organization, the bureaucratic process in hiring and timing. Initially, I applied at the Winnipeg Regional Health Authority but was turned down due to my study hours. International students by law are allowed to work a total of 20 hours a week and this organization usually needed someone to work more hours. This I believe was one of the reasons I was not selected; maybe there were more qualified applicants than myself.

1.2.1 Hiring Process

I applied to a third-party company which my friends recommended and was invited for an interview two (2) weeks after my application.

1.2.2 Interview

This was an in-person activity, and I went into the organization’s main office to meet with one of the mangers of the company, we had a casual conversation and he asked me practical questions about the job and possible scenarios were presented to me which I was asked to respond. An example of the questions is found below:

What will I do when I first meet a client, how will I act if I am in the community with a client and the client becomes aggressive or anxious?

How would I ensure the safety of myself and the client on a daily basis?

How would I approach a person with disability without provocation?

1.2.3 Training

I was taken through a three- day training that mandated eight (8) hours a day. The areas of training were about the policies and procedures of the company, residential and transitional care, safety, safety in action, performance and professional development, diversity, and inclusion in the workplace and how to administer medication. Followed by an inhouse training of two (2) days of eight hours each of training for me to familiarize myself with the procedures of the house.

1.2.4 Presentation of Documents

The company requires some documents to get you started, for example: bank information, identifications, CPR and First Aid certificate, child and adult abuse checks and vulnerable/criminal checks. The CPR and first aid certificate also require an eight (8) hour training and a final exam. This constituted a total of thirty- two (32) hours plus in-house sixteen (16) hours of training for me to work as support staff in specialized community services.

1.2.5 My Day

According to procedure we are required to do hourly checks on clients, prepare breakfast, routine cleaning of rooms and accompany clients on outings or appointments (if necessary). The day usually starts at 7am and ends at 3pm, since there is a 24hr staff present we have a handing over which is supposed to be organized and detailed, but I sometimes meet my colleagues by the door ready to exit and all they say is, “Everyone is around and well.” After, I go around the rooms of clients to see for myself because I have learned throughout my three (3) years of working at this job that staff usually do not do their checks. If you are not diligent you, encounter situations that you cannot explain. There was a situation where a client was taken to the hospital in the middle of the night, but the staff was asleep. Come morning time, we were told that client was sleeping so we relaxed. During breakfast we could not find the client. We enquired and were told by a tenant who lives by his room that the client was taken to the hospital in the middle of the night. This makes it evident that staff do not do their checks.

We start to prepare breakfast for clients and during their breakfast I will prepare the scheduled medication for the individual clients and administer. I would scan the rooms that needs cleaning. After serving breakfast, I inform my colleagues for us to do it together. Some of the workers usually find excuses to exclude themselves from these activities, so I and any other person will do it to avoid conflict. I would check for upcoming appointments or outings and arrange taxis for this activity. Lunch is ‘heat and serve’ so it takes one person to perform this duty while I administer medication for the second time. At around 2pm, I document the activities of clients and the duties I performed in a binder for reference. Every day presents itself in a different way since we accommodate various disabilities. This is my typical daily routine.

1.3 Disability in Global Socio-Cultural Context

According to the WHO (2015), ‘disability’ is defined as a state or function that is significantly diminished from the norm for a certain person or group. The largest minority group in the world is made up of people with disabilities. One billion people, or 15% of the world's population, are estimated to have some form of disability. As a result, 2.2% to 3.8% of adults over the age of 15 deal with significant functional issues (WHO, 2015).

Importantly, as indicated by the Disabled Women's Network (DAWN, 2007), three instances of discrimination against people with disabilities have occurred in emerging nations. Disabled people experience prejudice based on gender, disability, and location, making their situation worse than that of persons in developed countries who may or may not encounter any of these forms of bigotry. People with disabilities are subjected to a variety of types of discrimination, which reinforce one another and limit their chances (DAWN, 2007). Gladys Charowa, who was injured in a vehicle accident in 2001 and is a founding member of the Disabled Women Support Organization, stated: "Society views disabled people as useless liabilities that have no role to play in society." (P.14)

Most communities in underdeveloped nations are hostile to people with disabilities, “there is no financial estimation and funding for implementation of rehabilitation and treatment of persons with disabilities” (Hasanzada, 2012, p. 17). When people with various disabilities ask the public for assistance in starting a business, such as a dressmaking or music enterprise, they sometimes receive a negative response. It is a common misconception in less developed nations that a person with a disability can only ply their trade on the sidewalk or in front of a church. In rural places, where the issue is more severe, disabled children are usually kept indoors because of deeply ingrained cultural beliefs that persons with disabilities are God's curses (Slikker, 2009).

The difficulties that people with disabilities face in society are numerous and usually unique to the individual with the impairment. The bulk of issues that people with disabilities face are related to public services, instruction, and information. As was previously stated, people with disabilities including walking impairment and sight impairment find it extremely difficult to use public transportation, buildings, and public gatherings. In many developing nations, disabled persons face significant obstacles while attempting to enter public buildings and facilities like schools, hospitals, bus stations, public restrooms, and many more (Hasanzada, 2012).

According to Hasanzada (2012), the government and development authorities' lack of interest in and attention to the physical and mobility needs of the disabled can be blamed for the inability of people with disabilities to access public places and amenities. In many rural places, this disregard for the needs of the disabled has contributed to their isolation and a loss of their fundamental human rights (Hasanzada, 2012).

The three biggest obstacles for people with disabilities worldwide are stigma, prejudice, and preconceptions. These factors contribute to the marginalization and discrimination that disabled people and their families experience in every aspect of their life. Hasanzada (2012) contributed to the conversation by arguing that the lack of attention given to people with disabilities frequently results in their exclusion from routine services. Persons with disabilities experienced worse health outcomes, lower educational attainment, less economic involvement, and higher rates of poverty than persons without impairments, according to a study by Dassah et al. (2018). Unfair employment opportunities, such as being paid less for accomplishing the same amount of work, are a common occurrence for people with disabilities (United Nations Enable [UNE], 2008).

The UN General Assembly passed the Convention on the Rights of Persons with Disabilities in December 2006 to uphold disability rights. The goal of the convention and an additional optional protocol is to ensure that all people with disabilities can fully and equally enjoy all fundamental freedoms and human rights. The general guidelines for the convention's application are outlined in Article 3. Among these are the freedom to pursue one's own goals, full engagement in society, acceptance of individuals with disabilities as a part of human diversity, respect for each person's innate dignity, and equality of opportunity.

Persons with disabilities still encounter prejudice while sharing the same rights as able-bodied persons since they cannot complete some jobs that able-bodied people can owing to the constrictive features of society (spaces). This occurs more commonly in developing nations where people with impairments receive harsh treatment. Slikker (2009) discovered that people in developing nations like Ghana have negative views of people with disabilities because they believe that impairments are curses and that, as such, they are most often brought on by an individual's wrongdoing in society.

According to Lau (2003), "the able-bodies' principle embedded in vast social systems disenfranchises them" (p.16). Worldwide, minorities with a variety of disabilities are frequently underrepresented (Lau, 2003). Disabled people frequently do not have the same access to shared resources. It can be challenging to comprehend the needs of people with physical disabilities since doing so requires understanding the person, the society in which they live, and their relationships. Governments, humanitarian groups, and the international community are concerned about the status of individuals with disabilities in emerging nations.

According to Nhiwatia et al (2001), the UN has long served as a forum for discussion of the rights of people with disabilities. However, according to Hihambo and Lightfoot (2010), for policies and programs to be effective, they must consider the cultural perspectives on disability that exist among their respective populations. The authors go on to say that although it is obvious that a developing nation lacks the resources required to completely enforce all enacted regulations, sociocultural factors may also have an impact on these policies. They advise considering cultural prejudices and preconceptions towards impairments (Hihambo & Lightfoot, 2010).

1.4 Disability and Ghana’s Socio-Cultural Perspective

Culture is one of the foundations upon which discrimination against people with disabilities is built, claims Khupe (2010). Persons frequently invoke culture to defend their egregious discrimination towards disabled persons. Disability is viewed in Africa in a number of different ways (Berghs, 2017). or instance, some individuals believe that disabilities are brought on by witchcraft (Berghs, 2017).

In communities like the Ghanaian setting, stigma and prejudice increase the plight of people with disabilities (Ametepee & Anastasiou, 2015; Mantey, 2014). To fully understand the circumstances that people with disabilities face in Ghana, it is essential to look at the historical dynamics of impairments within families. According to Avoke (2002), there is a proverb among the many tribes of Ghana's Logba-speaking people that reads, "People with disabilities, especially those of a physical nature, do not sing war songs" (p. 771). These ideas are founded on the idea that people with physical disabilities and people who experience a variety of other disabilities should not engage in battle. Communities in Ghana used to see healthy people as assets due to conflict and military needs, but because disabled people were not seen as normal and healthy, many of them were slaughtered.

As posited by Ametepee and Anastasios (2015), people with disabilities are thought to be especially susceptible to the harmful impacts of sociocultural and religious practices that are prevalent in society, such as superstitious beliefs, habits, and neglect. Further research indicated that in Ghana's Northern Region, some deformed children are abandoned by the riverbed to die, while those who were fortunate enough to avoid being murdered at birth were concealed to prevent anybody from learning about them (Kassah et al., 2012).. Most of these children eventually die because of neglect and a lack of medical care.

Ghanaians' views and beliefs regarding disability influence how disabled people are treated in society. To further clarify, Naami et al. (2012) note that Ghanaian society discriminates against and impoverishes people with disabilities. Due to low societal expectations of their talents, physical obstacles, limited access to transportation, a lack of information, subpar medical systems, and a lack of social welfare benefits, people with disabilities are more likely to live in poverty. In their research, Opoku et al. (2019) identified barriers to employment, education, training, and the physical environment. According to Opoku et al. (2018), it is often the case that individuals with impairments do not acquire the type of education that would enable them to pursue productive occupations. One participant, for example, asserted that the primary barriers preventing people with disabilities from attending school were physical limitations that were not altered to meet the handicap and a lack of financial support for pursuing higher education (Opoku et al., 2018, p. 16). The findings show the need for additional research on people with disabilities as well as the introduction and effectiveness of effective.

1.5 Aim/Purpose of the Study

I experienced so many different ways of doing things and the cultural differences between Ghana, my country of birth, and Winnipeg, Manitoba made this possible. I study and work as an African Support Worker in Winnipeg. I believe it is essential to understand more about how people with disabilities live in different societies after giving the opportunity to study Disability Studies in Canada. This study examines how I came to serve as a support worker for the Specialized Community Service Program (SCSP) in Canada as an African student. This program will improve my ability to support and advocate for people with disabilities. I try to consider the extended family system, culture, and the education I received to carry out my responsibilities as an African support worker. To better myself and others as allies and advocates for disabled people, using my experiences as an African support worker in Canada.

1.6 Research Questions

The following broad and focused questions will be addressed in this study:

1. What is culture and its impact on the understanding of disability and disabled people?
2. How does Disability Studies impact my understanding of disability?
3. What are the similarities and differences in experiences of disability from Ghana and Canada and how will this make me a better ally?

1.7 Research Objectives

The research objective is to examine the reflections of a Ghanaian support worker in Canada and my experience in Disability Studies through autoethnography. Specifically, this study seeks to:

1. examine culture and its impact on the understanding of disability and disabled people.
2. determine how Disability Studies is impacting my understanding of disability.
3. document the similarities and difference in experiences of disability from Ghana and Canada and how it will make me a better ally.

1.8 Significance of the Study

It is impossible to overestimate the impact of this study on society, academia, and culture. The study is especially important since it tries to investigate and document cultural perspectives of people working with people with disabilities and how such perspectives affect or influence the lives of people with disabilities. The results of this study should be useful to policymakers and other professionals who oversee providing services and treatments for people with disabilities. The study gives disabled people in Winnipeg, Manitoba the chance to talk about what it is like to live with disabilities. The results will help us better understand people with disabilities and their lives. The study will offer suggestions for including people with disabilities and suggestions for different strategies to inform families, communities, and other organizations about how to support and protect persons with disabilities. The study will promote additional investigation into the problem and recommendations for reform in Canada, Ghana, and other nations.

CHAPTER TWO - Conceptual Review

2.1 The Concept of Disability

According to recent projections, there are 1 billion or 15% of the world's population who are disabled (World Health Organization [WHO], 2020). Disabled persons have not received adequate attention in many areas of life, even though their number is still rising (WHO, 2018), in part due to the rising incidence of chronic diseases (WHO, 2011). A considerable percentage of persons with disability (PWD) experience marginalization, discrimination, and stigmatization within educational institutions, according to several studies and publications (Haihambo & Lightfoot, 2010).

According to the World Health Organization (2017), disability is a complicated condition that includes impairment, activity restriction, and participation restrictions. The ability of a person to perform an act, as well as their ability to do so and engage in activities, is limited. Impairment is linked to physical flaws or faults with how their bodies work. According to Kisanji (1995), societal and environmental factors can also cause damage. This is supported by the United Nations' definition of disability which states.

A person is deemed to have a disability if they consistently struggle with one or more of the following: physical, mental, intellectual, or sensory impairments. They could find it challenging to participate fully and fairly in society because of these disabilities (United Nations, 2008, p. 5)

In the definition above, various barriers can be interpreted to include environmental, infrastructural, cultural barriers (Baglieri et al., 2011). Therefore, disability has multiple conceptualizations. According to Finkelstein (2001), disability is either conceptualized as a personal tragedy or a social oppression. Disability is viewed differently by various cultures and from several different perspectives by individuals and societies. Thus, its general concept and approach are determined by the perspectives from which one looks at them, whether from a medical perspective or from a social perspective. Florin and McLaughlin (2008) and Duguay (2010) indicate that the way disability is conceptualized and classified is what determines the provisions, services, and recognized responses it receives in a social setting.

Physical, technological, and cultural impediments are included in the definition of a barrier provided above (Baglieri et al., 2011). There are numerous ways to conceptualize disability. According to Finkelstein (2001), a handicap might be seen as a social wrong or as a personal tool. Diverse societies, people, and cultures all have different viewpoints on disability. Therefore, how they are perceived, whether from a medical or social aspect, determines their essential notion and technique. According to Florin and McLaughlin (2008) and Duguay (2010), how a disability is viewed and treated in a social setting depends on how it is perceived and comprehended.

According to Article 1 of the UN Convention on the Rights of Persons with Disabilities (n.d.), a disability is "including all persons with long-term physical, mental, intellectual, or sensory impairments which, in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others" (p. 24). A more thorough definition of disability is provided by the World Health Organization (2013), which characterizes it as a normal human condition that can develop at any time, be temporary or permanent. Three separate groups of people with disabilities were also highlighted.

a. A physical handicap that restricts one's ability to move around, perform daily activities, or attend school;
b. Those with long-term diseases, advanced age, or mental problems that make it difficult for them to function;
c. Those with physical disabilities, such as the blind, the deaf, amputees, and others.

It suggests that disabilities can present in several ways and to varying degrees of severity, some of which may not show any obvious physical symptoms. As a result, the

World Health Organization (1980) established four types of disability: communication; the kind that makes it difficult for people to easily exchange thoughts; difficulties with behavior and mobility. Stigmatization, discrimination, vulnerability, poverty, and illiteracy are among the common experiences of people with disabilities (Groce, 1999). Studies on impairments have pinpointed a few key common factors. According to Albrecht et al. (1982), experts in the area claim that the following characteristics of the disability experience are common to all people:

1. According to Barnes and Mercer (2010), being impaired means having limitations on one's physical, social, economic, medical, or political capacities.
2. Being perceived as different and being socially excluded are examples of differentiation and marginalization (Albrech et al, 1982; Sahin-Dikmen, 2003).
3. When individuals are aware of a person's disability, stigmatization and prejudice may occur.
4. In addition to the threat to one's independence, privacy, and security listed two additional threats: being alone and the possibility of poverty.
5. The negotiation of a disability label or the erasure of such designations by concealing indicators of a handicap are identity considerations (Linton, 2005).

Disability, then, is a complex phenomenon that demonstrates how a person's personal traits interact with those of his or her social and physical environment, as well as a health condition. As a result, the interaction between a person and his or her physical surroundings, general health, and other external elements that represent the circumstances of the person's life are considered as contributing factors to impairment (WHO, 2001).

Due to the emphasis on physical health, the external environment, and other factors, it is believed that everyone has or could have a disability. According to this statement, disability is seen as a common human experience that can affect everyone, regardless of age, colour, sex, ethnicity, or social class (Baffoe, 2013; WHO/World Bank, 2011). The focus on interaction demonstrates how limitations caused by both internal and external causes play a role in some disabilities. This demonstrates how enhancing PWDs' social participation may aid them in overcoming the difficulties they encounter daily. Therefore, a person's surroundings affect how they perceive their disability and the extent to which they engage in social activities (Opoku et al., 2017).)

2.2 Disability Prevalence and Incidence

As Muir et al. (2019) posit, “disability may occur at any time during the lifespan” (p. 1). According to Dokumaci (2019), in the past, people determined the quality of life of an individual based on the physical or visible body structure of that individual. One was considered to have a quality life when they have a ‘normal body.’ Today, the individual (with or without a disability) is the best or sole candidate to determine their quality of life. Disability is not only about the visible elements. Some disabilities or conditions are invisible.

The authors Muir et al. (2019) write that "disability can happen at any point in a person's life" (p. 1). According to Dokumaci (2019), people once judged a person's quality of life based on their external physical characteristics or bodily type. It is considered that if a person has a ‘normal body,’ they are living a happy life. The person (with or without a disability) is the best or the only candidate to assess one's current quality of life. The reality of disability is more nuanced than its symptoms. By this, unseen illnesses and disabilities exist.

According to Muir et al. (2019), for the most part, disabilities are "invisible...or not immediately parent to an outsider" (p. 1). Disability, in the words of Dokumaci (2019), is "a category that is defined not through its reduction to mere pathology, but through its dispersal into everyday life" (p. 72). According to Haegele and Hodge (2016), "The language people use to describe individuals with disabilities influences their expectations and interactions with them" (p. 6). The definition of disability is significant because it affects how we use language and engage with people who are impaired. The main models in the field of impairments, the medical and social models as well as the pertinent terms used in these models are underlined.

Ignorance, neglect, and superstition are social factors that can differ throughout cultures, nations, and groups and have an impact on how people view impairments (Munyi, 2012). Cultural beliefs and attitudes toward disability may be related directly or indirectly, according to the United Nations Division for Social Policy Development (2012). Beliefs on the cause or origin of impairment reflect this relationship (Butera, 2014). Teachers may have negative views toward these children if they believe that their impairment is the result of a curse because they are afraid of the unknown (Bunning et al., 2017). For instance, a student in Ghana might not be allowed to go to class if epilepsy is thought to be the result of a curse. Alms begging is typical of the "*Almajiri culture"* in northern Nigeria, where parents and guardians have no problem sending their kids out to beg for money (Etieyibo & Omiegbe, 2016). They assert that this is comparable to children selling items on the sidewalk.

Outsiders may see attitudes toward people with impairments as unfavorable, although they may be "altruistically motivated" (Bunning et al., 2017, p. 4). For instance, some African nations imprison those who have epilepsy to protect them from danger or abuse. Outsiders might interpret these activities negatively, but the locals view them favorably. The construction of social amenities deviates from the norm, claim Yarfi et al. (2017). Access to public services, healthcare, work, and education is therefore limited to nonexistent for people with impairments (Gibilisco & Tudzi, 2014). According to Tudzi et al. (2017), accessibility to public buildings continues to be a significant obstacle for individuals with disabilities.

Access to high-quality healthcare has proven to be a significant difficulty in many Sub-Saharan African nations. People with impairments face major barriers to accessing healthcare. Medical professionals avoid and do not give priority to medications for persons with disabilities. Facilities for the care of persons with disabilities are available in Ghana and Nigeria. However, there have been reports of neglect and abuse in these facilities.

People with impairments who are HIV-positive have difficulty receiving HIV services in Ghana, Uganda, and Zambia, according to Tun et al. (2016). Because of a lack of money or a refusal to go to a hospital, treatments may occasionally be postponed until the situation gets worse. Despite the poor accessibility, the traditional setting remains the main issue. The traditional setting allows for people to treated by native doctors (doctors without formal education) by using local medications like herbs, most families would rather send disabled people to spiritual healing facilities than to hospitals. for things have significantly become worse, hospitals are commonly sought for.

Despite being a worldwide issue, the frequency of unemployment among people with disabilities cannot be overstated. According to Naami (2015), many disabled individuals in Ghana do not have jobs. In Africa, there are barriers preventing persons with impairments from acquiring an education. Many countries have invested in education for people with disabilities. While some have separate special schools for children with disabilities from the regular schools, others have found that this strategy just serves to entrench social marginalization and discrimination. In some places, inclusive education is used, enabling students with impairments to take classes alongside those who do not. Several higher education institutions, according to Hamzat and Dada (2005), have accessibility issues. Emong and Eron (2016) discovered that prejudice still exists in higher education institutions despite Uganda's extensive disability legislation and policy framework. In their investigations from, Hibel et 2012 and Hibel et al 2016 found that immigrants are not the only ones that experience delayed schooling for individuals with impairments.

2.3 Disability and Concept of Culture

A general definition of culture is the way of life of a certain group of people. Culture was described by Etieyibo and Omiegbe (2016) as an individual's point of view on a particular issue or occasion. According to Uwagie-Ero et al. (1998), culture is the set of common attitudes, beliefs, customs, goals, and behaviors that constitute a particular group or association. The researchers claim that when the word ‘belief’ is used in this context, it does not necessarily relate to religion but rather to the affirmation or acceptance of a reality or an unverified position as authentic or true, without taking into consideration relevant comparisons or studies.

People with disabilities may nevertheless feel physical, psychological, or intellectual limitations despite Groce (1999) finding that they are more socio-ecologically constrained than people without impairments. Therefore, the constraints imposed by cultural standards are more onerous than their physical restraints. The African community, which is more rooted in traditional beliefs, has several barriers that disadvantage persons with disabilities, according to Blakely et al. (1994), Magesa (2014), and Sackey (2015). Socio-ecological barriers are more challenging for persons with impairments, say Abosi and Ozoji (1985), Shoko (2007), Makhubu (2009), and Ndlovu (2016).

Due to cultural preconceptions and ideas about people with disabilities that are frequently founded in fear and ignorance, these individuals are subject to prejudice and discrimination. Due to this, citizens' rights and resources are denied, and individuals with disabilities are subjected to prejudice and discrimination. Understanding the diverse perspectives on disability is crucial since cultures approach issues related to it in accordance with how they understand it. Many Ghanaian communities, according to Avoke (2002), view children with intellectual disabilities as "children of the rivers and forest," and in the past, these children have been returned to the forest or the rivers under the guise of assisting them in "going back to where they came from" (p. 773).

According to Fefoame (2009), crocodiles and snakes are examples of creatures having magical properties in some traditional cultures, and under certain situations, people can change into these animals as well. As a result, any abuse of these animals could cause a mother to give birth to a child that is disabled. These concepts undoubtedly have an impact on societal attitudes and perspectives of disability in Ghana's traditional civilization. Even though some of the expressions may not be as frequently used in modern Ghanaian culture, they nonetheless help to illustrate the views that are generally held about those who have intellectual disability. As posited by Avoke (2002), individuals with disabilities were subjected to cruel treatment and torture in some Ghanaian communities. The fervent idea that disabilities were divine retribution for sins committed against the gods, the community, or the gods themselves served as the justification for these therapies.

Fefoame (2009) claims that when a mother gives birth to a child that is ‘crippled,’ there is only one possible explanation: the gods are angry. She goes on to say that, in addition to other things like the woman's nutritional health and prenatal care alternatives, society does not take diseases like Rubella and German measles into account. The emphasis is instead placed on the alleged family's culpability, which restricts the promotion and defense of the rights of those with disabilities (Fefoame, 2009). These attitudes toward people with disabilities in Ghana have led to circumstances that have increased their feelings of isolation and stigma. This study's foundation was the stigmatization and marginalization of people with disabilities and its effects.

2.4 Current Debates and Studies on Culture, Beliefs and Physical Disabilities

“Beliefs are thought of as psychologically held understandings, premises or propositions about the world that are true” (Richardson, 1996, p. 104). In same vein, Cultural

Beliefs or narratives can be interpreted as psychologically held local understandings about the world that are true. They exist as means of explaining causes or sources of disability. It varies between regions and across cultures (United Nations Division for Social Policy Development, 2012). "Psychically held truthful understandings, premises, or propositions about the world are referred to as beliefs”. According to Richardson (1996, p. 104), Similar to this, cultural beliefs or narratives can be seen as exact localized interpretations of reality that are psychologically held. They may be able to explain the origins or causes of impairment. Regional and cultural differences exist, according to the United Nations Division for Social Policy Development (2012).

Modernization may have led to a "monocultural understanding of disability" (Lamorey, 2002, p. 68), even though there were cultural ideas in the West regarding the causes of disability (Ingstad, 1990). For instance, compared to their American counterparts, preservice students from Asia, Africa, and South America demonstrated a greater diversity of viewpoints. The medical model could not support a disability order as well as the students could. Combining disability theories has become required due to shifts in beliefs and attitudes (Stone-MacDonald, 2012). Cultural norms influence how people view, relate to, and instruct students with disabilities (Bunning et al., 2017). The attitudes, beliefs, and treatment of people with disabilities are reflected in African cultural notions (Stone-MacDonald, 2012). The self, others, fate, and biological are the four main narratives that can be utilized to understand handicap.

‘Oneself’ relates disability to the results of transgressing social norms or cultural taboos, such as having improper familial relationships, showing disdain for those with disabilities, or losing household belongings. It is said that having improper relationships will curse the offender's ancestors. In these cases, the impairment typically reflects the gender of the negligent parent. a case analysis. If the father acted inappropriately, the right leg is bent;

if the mother, the left leg is bent. A woman was cursed by a dwarf for laughing at him, and as a result, three dwarfs were born (Bunning et al., 2017).

It is also possible for supernatural or extraterrestrial forces to render a youngster incapable. Witchcraft, demons and evil spirits, the natural world, and God's purpose are subcategories of this theme. Infractions are subject to a witchcraft ‘wrongdoer curse,’ and handicap is considered as a ‘negative consequence.’ A disabled person is thought to be under the control of a ghost or demon. This can occasionally be viewed as a mixed blessing. There are times when such demonic possession helps parents financially. For instance, a child drooling will bring the parents financial success (p. 9). The least frequent type of disability is those caused by natural occurrences. The moon and the sea are associated with epileptic convulsions.

The final attribution is based on the fate, nature, or will of God theme and sees impairment as a quality of God's creation. It necessitates acknowledging and accepting the fact that some events are uncontrollable and, as a result, have an impact on one's destiny or nature. Accepting one's beliefs might also encourage future optimism. For instance, after exhausting all other options, the mother of a ‘crippled’ kid ultimately turned to faith, and the child was later healed. Other tales, though, have dark overtones.

Pre-natal (during pregnancy), peri-natal (during labor), and post-natal (after delivery) are the three parts of the biological third tale. It is thought that a mother's diet, lifestyle, and attention to her antennae throughout pregnancy may influence the unborn child's health. Additionally, it has been suggested that a disability might be caused by a parent's DNA. Issues with delivery could have caused a child's handicap. For instance, breathing issues, bleeding, or additional birth issues. Stories are sometimes spoken after birth because of accidents, unsuccessful abortions, or illness. One story does not preclude the possibility of another in this setting; rather, there are "plurality of beliefs" (Bunning et al., 2017, p. 11).

Numerous continuous stories are consequently feasible. For instance, a child with polio may be considered a victim of witchcraft, God's will, or another ailment.

Practically all acts in traditional African society are explained in terms of their cultural context. Similar concepts about how to react to natural disasters exist across cultural boundaries (Groce, 1999). To comprehend African behavioral patterns and worldviews, it is crucial to grasp cultural concepts and practices. It is crucial to remember that African culture always analyzes phenomena in terms of the widely practiced national religion that existed before encounter with Western Culture. According to Olkin et al. (1994), the central tenet of traditional African religion was the belief in a supreme deity who was worshipped through subordinate gods known as idols. These idols may be created out of rocks, trees, rivers, distinctive sceneries, or the remains of a deceased ancestor.

In the perspective of old mythology, people with disabilities are considered as outcasts making up for the wrongdoings of their ancestors, according to a Nigerian author Munyi (2012). In this respect, Ghanaian society is akin to other societies (Oduro, 2009). The attribution of impairments and disabilities to spiritual beliefs is reportedly strongly ingrained in Ghanaian society, so much so that the arrival of the Christian and Islamic religions did not totally erase traditional beliefs, according to (Otti-Boadi 2017). According to a 2002 study by Avoke, there is a perception in Ghanaian society that a child's intellectual handicap is a punishment meted out by the gods. They claim that a family in such a setting would not have a child with an intellectual disability if it were not for the atonement for sins. A family may exploit a child's intellectual disability as a sacrifice in a different Ghanaian culture to obtain money (Inclusion Ghana, 2011; Otti-Boadi, 2017). Anum (2011) and Aldersey (2012) claimed that because of the negative sentiments upheld by the family, infants born with disabilities are frequently abandoned at riverbanks or killed at birth.

Several authors, including Abosi and Ozoji (1985), Desta (1995), Makhubu (2009), and Magesa (2014), have outlined and investigated the primary causes of prejudice against individuals with disabilities. Among these are God, the supernatural, curses, witchcraft, and sex. According to Abang (1988), the idea that such disabled persons could be employed in rituals to generate income is a dangerous development. In many civilizations, it is common practice to sacrifice people with impairments to achieve prosperity, success, the favor of supernatural deities, and children, according to Etieyibo and Omiegbe (2016). Such a perspective is based on the idea that people with impairments don't constitute whole human beings. According to Magesa (2014), disability is seen as a flaw in African cultural contexts that results from a spiritual degeneration or annihilation of the power of life and necessitates an attempt to restore the initial good.

CHAPTER THREE - Theoretical Review

This chapter explains the social model of disabilities, medical model of disabilities, the disability justice theory as reported by researchers. Scholars' methods for examining and studying topics related to disability are influenced by the theories.

3.1 Social Model of Disability

The social model of disability is one of the earliest theories on disabilities. To minimize the barriers that come along with various disabilities, the social model of disability contends that reducing societal obstacles is preferable to attempting to ‘cure’ those who have impairments. Marxist social theories regarding how the unemployed are oppressed in capitalist society gave rise to the idea of the social model of disability (Oliver, 1990; Shakespeare, 2014). The Union of Physically Impaired Against Segregation (UPIAS), one of its leading proponents, was among those with disabilities who thought it was important to make a distinction between what they called ‘impairments’ (medical conditions) and ‘disability’ (unfavorable societal responses to impairments) (UPIAS, 1970).

The personal tragedy hypothesis, according to Oliver (1996), asserts that disability is some terrible incident that inevitably befalls sad people. Oliver claims that people with disabilities conceived, produced, and articulated the social model of disability, which means that the idea is false. Oliver (1996) asserts that this approach openly addresses the problem of disability in society rather than evading it. While the WHO and OPCS programs acknowledge the social components of disability, according to Oliver (1996), they do not think that social factors are the cause of the issue. Shakespeare (2014) claims that the Social Model's goals are to recognize the need for barrier removal, get rid of social mechanisms that place the blame for social exclusion on individuals, and change the conversation about disability away from medical sociology and toward an examination of social and cultural mechanisms (Oliver, 1996).

Owens (2014) is one of many academics that oppose the social model of disability. Even though it has received criticism, neglecting the physical and psychological aspects of impairment has aided the disability activist movement. A person with a disability could use the social model to filter how they perceive the world or their immediate environment. According to Owens (2014), the "social model of disability has demonstrated political success for disabled people in society" (p. 12). Disability is seen as a societal issue in accordance with the social model of disability (Shakespeare, 2021). The social model "identifies disability as a culturally and historically specific phenomenon," according to Shakespeare (2021, p. 1). It is believed that impairment results from society's incapacity to accept difference. For instance, a blind person who cannot read is not unable to do so because their eyes cannot see; rather, it is due to society's lack of accessibility to Braille. According to the social model of disability, this is correct.

According to the social model of disability, a person's handicap or difference does not directly contribute to their disability; rather, it is the structure of society. It examines strategies for reducing obstacles that limit the choices accessible to people with disabilities. Disabled persons can become autonomous, equal members of society with freedom of choice and control over their own lives when barriers are removed. By seeing disability as a social construct, the social model of disability distinguishes between impairment and disability. According to Goering (2015), the social model of disability makes a distinction between impairment and disability, characterizing the latter as a disadvantage brought on by a body's failure to fit into its social environment.

It appears that advocates for the social model of disability hold distinct opinions from those who support the medical model. Some academics have emphasized the 'person-centered' component of the medical paradigm by highlighting how it focuses on the person with a handicap. The medical approach, according to Guevara (2021), "treats inadequacies as flaws that need to be rectified. This maintains prejudice and stigma against those who have disabilities and emphasizes the able body as the standard (p. 1). According to the medical model of disability, a person's physical restrictions are what produce their condition. Any disability intervention that focuses on a specific disabled person will be impacted by this concept.

Mallett and Runswick-Cole (2014) examine how national and international attitudes, policies, culture, and history can be used to study disability. They placed a lot of emphasis on the social model of disability, which holds that society, not the person with an impairment, is what is causing the issue. It attributes disability to the environment rather than the person. According to the social model theory, disabilities are caused by obstructive social, environmental, and attitude barriers rather than by a lack of ability (Crow, 1996; Oliver, 1996; Shakespeare, 2014). This asks for the removal of institutional, physical, emotional, and legal barriers that prevent persons with disabilities from participating in society because people with the same impairments may not experience the same hurdles in various countries (Oliver, 1990).

According to the United Nations Convention on the Rights of Persons with Disabilities (CRPD), people with disabilities of all kinds include those who interact with various barriers, which may prevent their full and effective participation in society, and who have long-term physical, mental, intellectual, or sensory impairments. According to the understanding just given, ‘barriers’ are the difficulties that prohibit persons with disabilities from participating in society issues. It appears that people with disabilities also battle an uncaring society.

A social model of disability was designed to address social issues and hurdles preventing people with impairments from advancing. Our limitations, which originate from our unjust exclusion from and denial of our legitimate involvement in society, exacerbate our impairments. This is what we mean when we talk about the social model, which is also referred to as the phenomena known as "Society Disables Physically Impaired People." As a result, the population of people with impairments is underrepresented (UPIAS, 1975). The number of disabled people who struggle with housing and ultimately end up homeless has grown over time (NCH, 2007). As a result, many people are now homeless, engaging in criminal activity, and possibly doing jail time.

The earlier assertion that the social model of disability reflects a fresh perspective on persons with impairments was made by Oliver (1990). Disability advocates have fiercely maintained the concept and refuted the historical presumption that they are less deserving. According to Avoke (2005) in his contribution, this idea of disability argues that persons with impairments are made more impaired by a social structure that places obstacles in their way of participating. Therefore, through boosting their self-esteem and independence, disabled people are expected to inspire society to remove any obstacles stopping them from taking part in developmental concerns like the education of the challenged child.

3.2 The Medical Model of Disability

The medical model was one of the first models applied to disability studies (Retief & Letsosa, 2018). The development of medical research necessitated a shift in how individuals regard impairment from a moral or religious standpoint. Therefore, in accordance with the medical model of disability, an individual's impairment must be viewed as a medical condition. Disability is defined by the medical paradigm as "a defect in or failure of a bodily system and, as such, is inherently abnormal and pathological" (Olkin 199, p. 26). Given this, the goal of any intervention should always be "cure, maximal physical condition improvement, and rehabilitation (i.e., the individual with the disability's adjustment to the condition and to the environment)" (Olkin 1999, p. 26). People with disabilities must make use of the wide range of resources available to them and spend some time acting as patients or students who need the assistance of skilled experts (Olkin 1999)

According to Thomas and Woods (2003, p. 15), the medical model of disability is also referred to as the "Personal tragedy model" because it regards disability as a negative event that has happened to the person. Similar remarks were made by Carlson (2010, p. 5), who asserted that having a disability is inherently terrible, depressing, and "a personal tragedy for not just the individual, but for the entire family of the person." It should be noted that a large portion of those who work in the medical field feel that impairment should be prevented and, if possible, cured (Carlson, 2010). According to Thomas and Woods (2003) and Carlson (2010), the unfavorable perception of disability influences the often-provided care for the disabled that is occasionally questioned. According to the medical model of disability, having an impairment deviate from the norm, supporting the idea that those who have them cannot be compared to those who do not (Retief & Letsosa, 2018).

According to the medical paradigm, human functioning must adhere to a set of standards or norms to be considered acceptable. The term ‘disabled’ is used to describe people who have impairments and who cannot be made functional in accordance with the standard using aids, medical interventions, medications, or other therapies, according to Rothman (2010). For instance, there is what is regarded as normal eyesight, and any deterioration in that vision that could result in complete blindness or loss of vision is considered an abnormal condition that requires medical care. These criteria are founded on an understanding of what makes ‘normal’ vision. Who is eligible for assistance and programs for those who meet medical criteria for being declared ‘disabled’ – as well as who is outside the norm – is determined by the medical model. As stated by Michailakis (2003, p. 212), "[I]n the medical model observations concern the body, its functions and malfunctions, observations about health conditions and deviations from health conditions."

Disability has been medicalized (Barnes et al., 1999), thus individuals with impairments must rely on the knowledge of experts to get support services. According to Brisenden (1986):

> Other professionals and persons with disabilities have been subjected to the restrictive limits of the medical paradigm, which has led to unimaginative service providers' answers and low expectations on the part of those with impairments. People with disabilities continue to suffer because the medical paradigm is still used to define and view them, which indicates that someone will and should constantly be in and out of the hospital. This perspective ignores the sociological and psychological dimensions of disability. It disregards the fact that one of the most incapacitating aspects of disability is the requirement for repeated hospitalization and medical treatment. Rather, we should take a holistic approach to life and empower those who are disabled to make their own decisions based on a variety of criteria, not only medical ones. (p. 5)

As a result, people with disabilities only use healthcare services in a passive manner (Rothman, 2010). Additionally, Michailakis (2003) demonstrates:

> According to the medical paradigm, a person's ability to be disabled can be overcome via therapy. The medical paradigm has come under scrutiny because it downplays the significance of social, political, and economic variables. The individual's physical, intellectual, or mental state is selected as the key component and the only point of departure in a somewhat reductionist approach. (p. 210)

According to the medical paradigm, a person with a disability is incompetent and needs care and support (Barnes et al., 1999). This viewpoint contends that a person's disability is a result of their own tragic life experience rather than social circumstances or personal responsibility (Areheart, 2008). With this information in mind, the medical model has the potential to stigmatize the disability community by emphasizing that for those who have a disability, their impairment is a personal concern that makes them feel cut off from society (Brzuzy, 1997).

Negative perceptions regarding individuals with disabilities have historically included the idea that they are pathetic and disagreeable, according to previous research (Payne, 2006). The medical model also claims that the disability limits the disabled person's agency. If medical personnel are unable to treat or rehabilitate the patient, it will be assumed that they have a limited ability to participate in society. the medical paradigm assumes that doctors can either prevent or treat inability. In actuality, the medical concept or paradigm has kept us isolated from society in ghettos and special facilities. We choose where we belong in society and how we will participate as equals with something to say and a life to lead. We are advocating for the freedom to accept the same risks and pursue the same objectives. We become incapacitated when society takes away our ability to choose for ourselves. As a result, our desire for equality is motivated by our need for control and our need for independence (Brisenden, 1986, p. 7).

Although the medical model is helpful for understanding disability, it has come under fire for emphasizing the impairment at the expense of the disabled person and claiming that people with disabilities have little ability to change their impairment. In 2010, Scullion claimed that the "medical model has contributed towards an environment that promotes the devaluation of the worth and citizenship of people on the basis of their disability status" (p. 6). The author persevered in making the claim that the medical paradigm of disability, which is predicated on classifying and naming impairments and the impaired person, does not provide equitable possibilities disabled people.

According to Rothman (2010), the medical model's definition of a disability is constrained by a person's capacity to compensate for their impairment. This notion, according to Rothman (2010), holds a person exclusively accountable for their inability to go above a physical disability. In accordance with the medical paradigm, "obstacles to participation on equal terms are situated, accordingly, in the individual, since it is the individual who lacks certain capacities that are necessary to attain autonomy" (Michailakis, 2003, p. 210). The medical paradigm places greater emphasis on the physiological characteristics that distinguish people with disabilities than it does on the socioeconomic challenges that all people with disabilities experience.

The medical paradigm, according to Rothman (2010), emphasizes physical difference: people whose bodies do not work or behave differently. It does this by using a definition of ‘normal’ that some people stray from. Despite this, it is frequent for individuals with impairments to be perceived as slightly outside of society's norms and incapable of performing the tasks that are required of them. This idea of ‘normal’ leads, according to Shyman (2016), to an apparent axiomatic idea of what a person ‘ought to be,’ which is intelligent and physically fit. Because any deviation from this ideal is to be viewed as abnormal and detrimental, treatment and rehabilitation are of the utmost importance. As stated by authors Retief and Letosa (2018), "people with disabilities should assume the ‘sick role’ for medical personnel who follow the medical model of disability if they want to continue receiving assistance and support. " (p. 3).

According to the medical paradigm, both physical and mental diseases are distinct issues that require attention. The medical approach puts the onus of cure and appropriate functioning back on each individual disabled person, ignoring the circumstances, histories, identities, and societal forces that have given rise to the category of disability. The medical paradigm also has the flaw that "disabled people should play the 'sick role' properly if they desire to receive continued help" (Areheart, 2008, p. 3). According to the author, undergoing disability treatment is not always detrimental. However, it will be detrimental if the search for a cure is overemphasized, and the social aspect of disability is overlooked.

Disability experts claim that rather than assisting in changing societal perspectives, the medical approach just serves to reinforce the idea that disability is a personal problem requiring medical intervention (Terzi, 2004).

As stated by Brzuzy (1997),

> From a medical standpoint, disability is understood in terms of functional restrictions. In our culture, this point of view is generally accepted. This approach makes the assumption that a person's ability to interact "normally" with others in society is limited by a mental, emotional, or physical disability. The definition of handicap is the inability to carry out daily tasks like eating, bathing, and clothing because of a disability. A person's handicap is defined as their social disadvantage as a result of a disability. (p. 86)

If a person's incapacity significantly adds to inequality, it is likely that their ability to engage in society will be challenging at best and impossible at worst. Disability activists and detractors have criticized the medical model using the social model to alter how others regard individuals with disabilities and assert that it is the answer to the issues they confront.

3.3 Disability Justice Theory

A notion of social change called disability justice seeks to end ableism and other forms of prejudice. Sins Invalid claims that since 2005, disabled, homosexual, and trans ethnic minorities have joined and supported the development of the disability equality system in a booklet titled Skin, Tooth, and Bone - The Basis of Movement is Our People: A Disability Justice Primer (Sins Invalid, 2016, p. 5, 12). The idea eventually matured into an "attractive conceptual framework of reference for describing the range of struggles for the inclusion of people with disabilities in countries across the world" (Onazi, 2020, p. 9).

The expansion of disability equality contrasts with the growth of disability rights, which is focused on social liberties within liberal practice. This new approach is based on ten criteria, each of which has room for growth in the future: The first, known as intersectionality, asserts that we are all impacted by the various identities that people hold. They are not just disabled. Each of them also has unique experiences connected to their ethnicity, class, sexual orientation, age, rigid foundation, geographic region, and immigrant status, and this is only the tip of the iceberg.

The political movement ‘disability justice,’ which is made up of several interconnected groups, does not define ‘disability’ in terms of race, gender, or sexual orientation. "Disability justice centers disabled people of color and everyone who is marginalized in mainstream disability organizing" (Piepzna-Samarasinha, 2018, p. 45).

A disability justice plan informs society on the following, claims Onazi (2020):

> A person's capacity for agency, freedom, self-help, self-discipline, personal responsibility, and the ability to exercise a variety of lifestyle options available to a person with a disability, including what services such people would require to fully integrate and participate in community life, are all part of what is meant by independence, according to the definition of independence given on. (p. 10)

Another definition of independence is to be in good physical health.

In 1989, women's activist academic Kimberle Crenshaw coined the term ‘intersectionality’ to describe the experiences of Black women who encounter racism and sexism in particular ways. This implies that everyone has a variety of traits and that everybody can be exploited for good or harmful purposes. Incapacity itself is influenced by race, sex, class, sexual orientation articulation, authenticity, relationship to colonization, and that's just the beginning. The mechanisms of abuse and the outcomes they produce depend on some unidentified institutional or relational collaboration. Constituency administration is the second. We elevate, tune into, read, follow, and feature the voices of those who are typically impacted by the systems we fight against when we discuss issues like ableism, bigotry, sexism and transphobia, colonization, police brutality, and other such topics. We keep our footing and devise fresh ways to thwart development by focusing on the initiative of people who are typically touched. We understand that to genuinely enjoy freedom, we must pay attention to the advice of those who are most familiar with these organizations and their workings.

To reach its full potential as a development, disability equality must be combined with racial equity, trans-freedom, jail cancellation, natural equity, against police fear, deaf activism, fat liberation, and other movements promoting equity and freedom. Competition is encouraged as a survival strategy in capitalism since it depends on the rise of wealth for some (the white ruling class) at the expense of others. A system that defines labor using non-disabled, white supremacist, and gender normative standards typically ignores our labor since our damaged bodies and minds make it impossible for us to produce at ‘normative’ levels in a capitalist culture. Disability justice-driven thinkers "allowed us to approach accessibility in a plural, critical way that resists a one-size-fits-all approach" (Jones et al., 2022, p. 2).

Cross-disability solidarity promotes and honors community engagement from all members, including those who are typically excluded from political discourse. We are creating a movement that breaks down isolation among those who experience ableism, including those who have chronic illnesses, physical impairments, mental health disabilities, neurodiversity, intellectual or developmental disabilities, deafness, blindness, environmental injuries, and chemical sensitivities (Jones et al., 2022).

Our countries just realized how intertwined they are because of the vast colonial expansion of Western Europe. As a result of this link, the emphasis is placed on each person's independence, and the environment is seen as essential to this process. Accessibility needs may be adequately met in a cooperative or in the community, depending on the demands of the individual and the group's capabilities. This point of view emphasizes shared accountability for allowing access while upholding the individual's integrity (Jones et al., 2022).

Individuals from various social classes, racial backgrounds, and gender identities freely migrate over the sexual spectrum in concert, leaving no one behind. This point of view strongly emphasizes the need to end prejudiced institutional and societal practices that keep people with disabilities out of society. People with disabilities should not be wholly dependent on others for existence without having their own autonomy recognized, say those who support this position.

According to Annamma (2017), this is the central concept of the disability justice theory:

> Since each of these institutions contributes to a normative standard and penalizes those who do not meet it, they should be fought alongside disability justice rather than in place of it. Examples of these institutions include colonialism, white supremacy, cisgender heteropatriarchy, and capitalism. An integrated disability justice paradigm argues that it is insufficient to only voice complaints to persons who speak indecent language or are illiterate. As a result, it is a deliberate choice to include disability-related concerns into our resistance operations by selecting a diverse group of disabled people as movement leaders. By committing to disability justice, we may advance this intersectional strategy for eradicating persistent disadvantages. (p. 1050)

The disability rights movement has recently come under fire for focusing mostly on white people with physical disabilities while ignoring others. Grue (2016) made a similar case indicating, In terms of power relations, the generic category of disability, which specifically entails marginalization, oppression, and exclusion, is particularly pertinent. I am not aware of any definitions of disability by the disability movement or disability scholars that imply a favorable appraisal of a particular handicap. (p. 959)

Annamma (2017) then issued a caution:

A growing number of academics have started to recognize that people with disabilities are marginalized as critical voices have emerged. Simply including disability on a list of targeted identities is insufficient. Not to be confused with recognition, solidarity is not the same thing. The goal is not to comprehend how racism and disabilities are socially formed and how these ideas of being "less than" lead to unequal outcomes, despite their importance. (p. 1048)

CHAPTER FOUR - Methodology

The stories of an individual or a group of individuals with diverse cultures, languages, or beliefs are introduced through autoethnography. Autoethnography is defined as witnessing the lives of others while actively participating in the process (Thurova, 2009). Writing about my experiences and views working as a home care worker with an agency and people (staff and residents) is the method I will employ in this research. I learnt more about the various disabilities and how to become a better ally to disabled people, therefore I decided to tell my story as a home support worker using autoethnography.

4.1 Autoethnography

By exploring a person's extraordinary educational relationships in relation to their social roots, auto ethnography is defined by Custer (2014) as a type of subjective analysis and self-portrait writing. Jones (2013) asserts that auto ethnography has developed into a way of life that encourages us to live intentionally, reflect on our surroundings, and live inside ourselves. It causes us to pause and consider our life and the causes of our actions, words, and emotions. It forces us to reevaluate and change how we live while carefully choosing who and how we should be. Additionally, it looks for stories with self-assurance and authors who at the very least keep the protagonists in the story as overcomers. Autoethnography is a literary subgenre, according to Reed-Danahay (1997), that situates the author and the scientist's self in a social setting.

According to Ellis et al. (2011), autoethnography is a field that combines elements of ethnography with personal history. They argue that ethnographies typically attempt to understand a community, whereas autobiographies frequently focus on revelations or events that had a significant impact on the essayist's life. According to Ellis et al. (2011), experts "ponder and go into detail on discoveries that come about or are made feasible by possessing a specific social personality and being noteworthy for a society" (p. 276) when performing autoethnography. According to this perspective, writing involves both contemplation and thought. It is a significant autoethnographic piece.

Writing is a method for learning more about an experience or learning about it in an unexpected way (Adams et al., 2015). Broadkey (1996) urges researchers to "think of themselves and other individuals as human subjects who have been shaped by auto-ethnographers in a variety of historical, social, and cultural contexts and interactions" (p. 29). Custer (2014) defines autoethnography as a type of subjective writing, self-portraiture, and analysis that examines a person's extraordinarily illuminating encounters in relation to social and cultural circumstances. Jones (2013) asserts that autoethnography has developed into a way of life that promotes deliberate, thoughtful living. It causes us to pause and consider our life and the motivations behind our actions, words, and emotions.

Autoethnography is a type of writing that, according to Reed-Danahay (2017), places the inner story of the scientist within a social framework. "Auto-ethnographers challenged conventional ideas of silent authorship, in which the researcher's voice is not incorporated in the presentation of findings by including themselves in their own works as significant characters" (Holt, 2003, p. 2). Delgado (1989) emphasized the value of using stories as a strategy for autoethnographic research. He further posited that:

> Stories help us become more human. They highlight our differences in a way that might someday bring us together. They allow us to see the world from the perspective of another person. We are required to remove our own contact lenses. People who have been taught to repress their emotions now have a voice thanks to storytelling, which also gives writing emotion. By eradicating prejudices, upsetting complacency, boosting spirits, and eroding defenses, a narrative motivates the audience to join. Because they urge the audience to put aside their personal opinions, concentrate on

> the story's premise, and compare it to how they see the world, stories are effective tools for the underdog. In a pluralist society like ours, this process is crucial. (p. 2440)

One of the course's key benefits of autoethnography, according to Bochner and Ellis (2016) and Chang et al. (2013), is that it helps students to consider their own interactions and decontextualize them in the context of the 'other's' life and culture. It might also be claimed that the analyst is employing autoethnography to comprehend ‘oneself’ more fully in order to comprehend ‘the other.’ They only look to speak; they do not truly do it (Ellis, 1999). Making a person's lived experience understandable to others through autoethnographic writing might increase comprehension of a certain issue or mystery (Blalock & Akehi, 2018; Johnstone, 1999).

Hegelund (2005), for instance, examined her personal recollections of childhood harm, disgrace, rejection, and fatherly sexual assault via exam writing. This was carried out following her parent's divorce. In this regard, autoethnography, for instance, can be seen as undermining the analyst's objectivity and ‘authority.’ It emphasizes the specialist's role as a topic in the book and in the larger social, political, and historical contexts in which they are set. This demonstrates how some theories hold that the knowledge an analyst uses comprises knowledge gained from interactions and environments in which they operate in addition to information that reflects how they see themselves (Okely, 1992).

Since reality is dynamic, Teachout & White (1985) urged members of the "abled bodied" to pay attention to stories to enhance their own realities (Delgado, 1989, p. 2439). According to Delgado (1989), “intellectual apartheid can be ended by learning about the experiences of oppressed people. Shared words can serve to break up monotony, stiffness, and sameness while hearing different voices for the first time” (p. 2441). Recognizing one's own limitations is important when striving to comprehend the ‘other.’ As a form of translation, it restricts our capacity to fully know another person's innermost essence

Inexperienced researchers may find employing autoethnography as a research method to be new and difficult, yet it enables them to analyze and explain the culture in which a phenomenon is being experienced. This cultural knowledge can make it easier to interpret participant accounts and the "reality" discovered via this style of study (Méndez, 2014, p. 285).

4.1.1 Consistently High-Quality Autoethnography

Significant contribution, aesthetic merit, reflexivity, and expression of reality were put forth by Patton (2015) as standards for measuring the caliber of an autoethnographic study. For instance, Patton (2015) contends that the following queries must be addressed in relation to reflexivity: “How has the author’s subjectivity been both a producer and a product of this text? Because the author has a sufficient level of self-awareness and self-exposure, can the reader evaluate the points of view?” (p. 232). Richardson (2000) asks, "Do authors hold themselves accountable to the standards of knowing and telling the people what they have studied?" (p. 254).

Throughout my supporter for the Specialized Community Service Program (SCSP) in Canada as an African student, I have had the chance to spend a lot of time reflecting not on a specific event, but rather on a dynamic process. I critically examined my own assumptions and engaged in reflective practice to make sure that more ethical behaviors were taken throughout this research. Again, as an African student who is a support worker the in Canada, I still struggle with how to relate to persons who are disabled and the many other forms of discrimination.

Méndez (2013) also highlighted the evaluation of subjective interpretation in addition to reflexivity by indicating:

> Personal narratives that defy positivist research's aim to produce an objective explanation of reality may give birth to subjective interpretations. In contrast to the

> researcher's goals, which, from a positivist perspective, play a remote and impersonal role, autoethnography places the researcher in a more intimate and emotional position. Because of this, it is difficult to evaluate autoethnography, and it appears that there is no recognized standard. (p. 284)

A researcher's ‘substantive contribution’ is defined by Patton (2015) as how it "contribute[s] to our understanding of social life" (p. 232). Richardson (2000) provides the following considerations for auto ethnographers to consider when determining subjective contribution: ‘Does the author demonstrate a solidly anchored (if embedded) understanding of the human-world? And how does this viewpoint impact the text's structure’? (p. 254).

In my research, I employed an autoethnographic approach to examine the reflections of a Ghanaian support worker in Canada and my experience in disability studies. The goal of this study is to understand more about how people with disabilities live in different societies after having the chance to connect with them in Canada. This study examined how I came to serve as a supporter for the Specialized Community Service Program (SCSP) in Canada as an African student. To that end, it employs a range of autoethnographic methodologies.

The study's potential advantages are consistent with Méndez's (2014) assertion:

> By making readers reflect on and relate to the situations portrayed, autoethnography has the potential to enhance the lives of others. By reading a cultural or social story of an experience, autoethnography is a useful form of research since it enables readers to grasp realities they may not have previously considered. (p. 282)
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4.2 Research Data Organization

This study incorporated observations I collected while working as an African Support Worker and a student in Disability Studies in Winnipeg, Manitoba, Canada, and Ghana, where I was born, learning about, and interacting with persons with disabilities. To compose my autoethnography, I drew on my personal recollections of the situations in my interactions with people I supported. I once more drew on a variety of experiences from recollections, learning diaries, and document analysis to connect with the greater social context.

The anthropological method has long recognized the use of memory, study diaries, and participant observation field notes. In their research, auto ethnographers have used participant observation notes, interviews, document analysis, and research diaries (Ettorre, 2005). For instance, Sparkes (1996) used information about himself that was taken from his medical records, journal extracts, and press stories to discuss his sporting career and the chronic sickness that ended it.

Ettorre (2005) used a diary, a letter, literature, and lab test data to understand her illness. She understood the significance of memory to the analytical process. Holt (2003) discussed his teaching methodology using information from his reflective notebook. Duncan (2004) evaluated her professional performance using a thorough reflective notebook, emails, notes, and sketches. The renowned anthropologist Margaret Mead, for instance, emphasized the importance of her footnotes and claimed that due to her in-depth understanding of her subject and singular consciousness, she was able to observe and document aspects of daily life that no one else could (Mead, 1977, cited in Sanjek, 1990). historical data, data from her own memories, and data from self-reflection to analyze her previous professional work at the American Psychological Association (APA). She also looked into the role that ableism played in the discriminatory actions that APA professionals took, actions that eventually led to pain and harm.

According to Doloriert and Sambrook (2012), autoethnographers may write on their experiences outside of higher education, notably their work experiences prior to enrolling in higher education. According to Sparkes (2000), when his published autoethnography was utilized in a lecture for undergraduates, his pupils did not see it as academic material. He gave one illustration. When asked if it would count as research if someone else had spoken with Sparkes, obtained his medical records, diary excerpts, and news stories, evaluated the information, and wrote it up, the students answered in the affirmative.

Coffey (1999) asserts that during an ethnographic inquiry, memories of being there and knowledge about the local social actors are gathered. The headnotes, which are on-the-spot recollections, are included in autoethnographies together with interview transcripts, field notes, and, if they are accessible, diaries and journals (Coffey, 1999). Similar to this, the case that an ethnographer working alone must recall a staggering amount of emotions, memories, and experiences from the field of research may be true.

4.3 Ethical Deliberations

The researcher and the other study participants are shielded by ethical issues, according to Mills and Morton (2016). Additionally, every facet of research has an ethical component. As a result, the ethical principles that guide research should be taken into mind at every stage of the process, including planning, designing, acquiring access, reporting, and even the act of reciprocating. As a result, when deciding how to address difficulties that arise at any point during the study process, the researcher is driven by ethical considerations (Mill & Morton, 2016).

Chang (2008) warned against the following pitfalls when structuring autoethnographic writing: a lack of ethical standards when it comes to others in self-narratives, an excessive emphasis on narration over analysis and cultural interpretation, segregation of the self from others, misuse of the term ‘autoethnography,’ and segregation of the self from others. I actively engaged in the creation, reconstruction, and selection of the title and the themes for this study to highlight the links between my experiences and the circumstances in which they relate to the reflections of a Ghanaian support worker in Canada, my experience in disability studies.

Doloriert and Sambrook (2012) assert that different autoethnographic self/other combinations necessitate different ethical considerations while writing, assessing, publishing, presenting, and examining autoethnography. The first is safeguarding the subjects of the ethnographic study. Relational ethics is the second in the list of friends, family, and coworkers. The third topic is autoethnographic ethics, which addresses the issue of disclosing the author's identity both for publication and throughout the review process.

I enrolled in the Master of Disability Studies degree to increase my understanding of disabilities and my abilities as an ally. I gained a lot of knowledge and changed my perspective on many subjects. I made the decision to look for a job as a support worker in order to refine my practical skills and extend my perspective on disabilities. When writing autoethnography, it may occasionally feel important or even appropriate to simplify, modify, or make other changes to our personal experiences.

According to Méndez (2013), "being ethical and truthful regarding the events portrayed as well as the sentiments conveyed by each participant in these events is a requirement for writing autoethnographically" (p. 283). I was open and honest in presenting the research methodologies I used to develop a responsible research process in order to achieve honesty and responsibility. I articulated my positionality and took thoughtful notes during the investigation.

4.4 Limitation of the Study

While autoethnography can offer valuable insights, it comes with certain limitations. One challenge is the potential for bias, as I write down the stories my personal experience may be subjective and not fully representative of the entire situation. This way of research will not permit generalizing the findings to other individuals and communities. This autobiographical research may have provided a thorough insight of my experiences as a Ghanaian support worker in Canada working in the field of disability studies.

Additionally, there may be ethical considerations, especially when exploring sensitive or personal topics. Balancing transparency with the need to protect privacy can be a delicate matter. Furthermore, the depth of analysis in autoethnography might vary, and there is a risk of overlooking broader social structures and systemic issues. Critics also argue that autoethnography can sometimes lack the rigor associated with more traditional research methods, potentially affecting the credibility and reliability of the findings. It is important to approach autoethnography with a crucial awareness of these limitation and to compliment it with other methods for a more comprehensive understanding.

CHAPTRT FIVE - My Experiences of Disability

Culture and My Understanding of Disability

I mentioned early one of the motivations of this topic and enrolling into disability studies is my niece who happened to be hearing impaired. This story saddens my heart and whenever I reflect on it tears run through my eyes. It was a difficult time for my family, but we went through it believing we were doing our best.

When my niece was born everyone in the family was very happy because she was the first female of the family. My parents gave birth to six male children and the family desperately needed a girl to have some mixture. As my niece developed over the years, we discovered she was not able to follow instructions. Due to lack of technical know-how and medical equipment's, the doctors were unable to inform us in the early stages of her birth. My family tried to get help by visiting the hospital and local medicine men within the community but none of them could change her situation, we initially believed it was a sickness that needed to be cured and this was a way of reaction for many people within the community. My niece would come home crying after playing outside with other kids and when we go outside to see what happened we would find the kids hooting at her calling her 'Sonya' – meaning 'witch' – and this behaviour was learnt from their parents as they referred to her as a 'witch' within the community mainly because she was very smart.

I was very close to my brother growing up, so my niece was like a sister to me and I decided to be her protector. I would take her with me everywhere I went, and I realised that most of my friends were not inviting me to places that we used to go together. This I believe was a form of discrimination since it only started when I begun travelling with my niece. One day I had a physical fight with one of my friends who called her 'Moo.' This is a sound cattle make. Within my society, it refers to people who do not listen and therefore follow the crowd. Upon reflecting I see that I rather pitied her as I decided to be her protector instead of showing her some sympathy.

Cultural norms, beliefs and societal values shapes the perceptions and attitudes of individuals in our various communities, this can be assessed by discussing the following: language and terminology; stigma and stereotypes; traditional beliefs and superstitions; inclusion and accessibility; family and community support; legislation and policy; and media and representation.

At many family gatherings or places where there are many people, we avoid taking my niece because people do not understand her, and they become afraid of her and treat her as someone who is ‘dangerous.’ I remember we once visited the village for a funeral and the people who organized the funeral were trying to kidnap her and use her as part of the funeral rites. My Dad decided that day to always keep her home and to ensure her safety, this also defies the rules of inclusion as my niece was not able to be part of most societal activities that occurred within the community.

My niece gained admission into a special school called WA SCHOOL FOR DEAF, we were so happy she was finally going to a place where people would understand her and treat her with the respect that she deserved, but this was the most unfavorable place to have put her as she always came back home with so many complaints but was not taken seriously. She mentioned the fact that all their teachers were able bodied and did not fully understand her and her colleagues. She described how the conditions in the school were very poor. She sometimes came home and hid so she would not be sent back. When I was at boarding school, I also hated it, but we failed to listen to her thinking she was just being dramatic until one day she was caned and harmed. My father went to the school and threatened to take the school on for such practices as he is a circuit supervisor. Little did he know there was nothing he could do. He reported it to the district director, and nothing happened.

The story of my niece discusses the cultural practices of my community, and the way disabled people are treated in such communities – name calling, discrimination, exclusion, and ignorance/misinformation. Within my community we did not understand disability. Now I feel my niece had so many dreams and much potential that she stopped believing in because of the way society treated her. She was smart because she developed ways of communicating with us in the family that we never imagined. She would make certain sounds depicting certain actions and use emotions a lot in her communication.

This situation has been revealing for my family and I believe we will do things differently in a similar situation going forward. I decided to get more information by enrolling in Disability Studies. After retiring, my father volunteered at one of the schools in the region to help change some things. Today, some persons with physical disabilities do attend that school. These cultural norms in my community have not changed much, though attitudes towards disabled people have changed general ideas. This is significant.

Language and Terminology

I grew up in an environment where our way of life was determined largely by the norms and values of the various religious affiliations: Christianity, Muslim, and traditional religions. All the three religions had similar beliefs when it came to disability. Disability was seen as demonic, and the words people used to describe persons with disability were 'witches' and 'wizards.' Persons with disability were seen as people with certain dark powers and were meant to bring bad luck to families that they were born into. People with disabilities were referred to as sick people who can transfer their disability to other people. This was the understanding of people within the community I grew up in and this made us very afraid of people with disabilities.

A friend of mine, Kwaku, once told me that he lived across a street where a disabled person lived. One day, the entire family left the house and locked all their doors. When they returned from their outing, they found a big snake on one of their beds. His family attributed this scene to the actions of the disabled person living across their house who magically sent the snake to harm the family and therefore she had to vacate the premises. Later that day the lady was hooted after, pursued out of the compound yelled at as ‘Baifou’ which is translated as ‘witch.’

Living in Canada, I have yet to hear one person call a disabled person a ‘witch’ or a ‘wizard.’ As a matter of fact, it is the other way round. On a lighter note, I work in a transitional care home where one of the clients’ labels staff who do not treat her well as ‘witches.’ Whenever that staff person enters her room, she calls her ‘that witch.’ People learn to refer to persons with disabilities by their names or sir/madam which means the persons with disabilities are seen to be a human being and not someone less than a human. This I believe is because of the language and terms that people use on people with disabilities in the community.

Traditional Beliefs and Superstition

The community I grew in is a firm believer of traditional norms and practices. The introduction of the other modern religions all respects the traditional religion. This was the first belief system of the African people (Ghana), persons with disabilities were referred to as ‘abominations,’ ’unworldly creatures,’ and were seen to not belong to this world and must be returned to the creator by sacrificing them as babies. People with disabilities were not given the chance to even grow as babies to experience the world as it is today, this was the norm in the community and people do not question this activity.

In Ghana, people believe that some disabled people can use dark powers to harm other people. Therefore, people with disabilities are feared and non-disabled people do not want to associate with them. This is not the case in Canada as many people are educated enough to know that disability is not inability. The understanding of disability is different in both environments and working as a support worker both cultures can affect my work.

In Wa, my city of birth, a mentally impaired person used to live at the city center and the story I was told was that she killed an animal that she was not supposed to kill and was punished by the gods. She now cannot be supported by her family or any other person within the society. She lived in the city center scavenging and finally died of hunger and some infections.

Living in Canada and working as a support worker, I have worked with various persons with disabilities. Sometimes thinking back to where I lived, I see how persons with disabilities are denied basic amenities and blamed for non-performance. One can say this has a very big impact on how disability is perceived in different environments.

Stigma and Stereotypes

In Ghana's major regions, many disabled women make out a life on the streets. I have seen several homes for children with disabilities. Due to the shame attached to disabilities, those children were never permitted to leave their homes. According to Agbenyengan (2003), parents of children born with disabilities and becoming victims of isolation and mockery in some situations. My grandparents instilled in me the notion that people with disabilities are not of this world, are evil, portend horrible omens, or could infect me. These same grandparents later regretted it when they learned that infants with disabilities were killed for ceremonial purification. This happened because of the stigma around disability.

A blind person with a walking stick approached a car I was traveling into the city center in Ghana's public transport called ‘trotro’ and began pleading with me for money. As a result, one passenger became enraged and used the code phrase "ayarefo wei nso ha adwen dodo," which means "these sick people can disturb our peace." Once the signal allowing the car to drive turned green, the passenger then hurled one Ghana cedi at the person who was unable to defend themselves. I tried to convince the passenger that people with disabilities are not sick or a problem as he thought, but he would not listen. Homeless individuals are regularly mocked, called foul names, and subjected to harsh treatment.

This passenger was being impolite by giving money to the blind man who was begging, and as a result, the recipient would have felt uncomfortable. Even if one chooses to disregard the disagreeable opinions of other Ghanaians, street peace is not promoted. Homeless individuals, in the words of Abekah-Carter and Oti (2020), "have no access to good food, shelter, and health care" (p. 46).

Working in Canada as a support worker, I realized that many disabled people are empowered by education and exposure to speak out for themselves, but this is not evident in care homes. The transitional care home I worked in is no different. Persons with disabilities are treated by the support workers as worthless because they feel they are not able to help themselves. I have witnessed support workers refuse to clean certain rooms in the program simply because they have some diagnosis in their file. There was a client who lived in the program who almost all the staff labelled as ‘mad’ simply because she will not stop advocating for herself. They believe that he does not know what she is talking about and therefore people refused to go help with her care.

I worked with an individual for about two years who took a long time when eating. Staff consider him as someone who cannot eat and usually try to feed him, resulting in many issues during their shift. He would challenge them to eat by himself. However, he wouldl also allow you to feed him if you ask him, ‘Can I help you eat?’ I believe this is staff classifying him as someone who cannot eat and therefore try to force feed him.

Family and Community Support

In my town Wa, Upper West Region, there is a young man who decided to help the mentally disabled in the community, people who end up being homeless. He established an organization called ‘Bahass Foundation’ and started by organizing young men within the community to go around the street and find people with mental illness and perform basic activities like shaving of hair, shower and proving of clean clothes. The process is literally kidnapping persons with mental deficiencies of the streets to help them. When I first saw this, through my education in Disability Studies, I found everything wrong with his approach. I decided to engage this young man and he told me his reasons: ‘They will not come with me if I ask politely. I get consent from some of their families to help them. I am doing this to help them.’ These activities of his are applauded in the community, so I decided to educate him on the rights of persons with disabilities. I acknowledge him seeking consent for some of them, but what about those whose families you do not know? Going forward he has come up with a full program which starts with housing persons with disabilities on the streets. People who will be part of this program can receive the help that he offers.

The process of taking people from the streets is clearly a violation of human rights, but it is the norm within the Waala tradition in Ghana. He explained that some of the people do not have parents/family and are therefore regarded as orphans. That is why these decisions to help them die do not conflict with anyone. A few months ago, there were some killings going on within the Waala community where people who experienced mental illnesses and are homeless were being abducted and killed for rituals in 2023. It took the entire community to get the government to provide some security. Interestingly the cry of the people was not to save the disabled people that were being abducted, but the fear that after all of the disabled people are taken from the streets the killers will turn to other persons in the community. In fact, some people mentioned that ‘at least we do not see mad people on the streets anymore.’ This shows a complete disregard for disabled people lives.

Acquired disability refers to an impairment that develops after birth as opposed to one that is present at birth. It can result from illness, injury or other factors that affect physical or mental health later in life. Some examples may include disabilities caused by accidents, diseases or medical conditions that develop overtime. In the wa community, many people acquire mental illness due their involvement with narcotic drugs. This is against the culture of the community and therefore people who found themselves in such situation are usually abandoned or left alone by their families and friends. This is the situation of the waala community as most of the young men engage in drug abuse because of unemployment and end up with mental illnesses. They are then left on the streets to fend for themselves without any help.

Living in Ghana, the only support for children, the old and persons with disabilities is the extended family system. We rely heavily on this system to be able to help one another. The physical structures are built in such a way that the whole family – parents, children, adults, and grandparents – all live in the same environment. This allows for easy accessibility to one another. People who have children allow the whole family to help groom them for the future, disciplinary actions are performed by all members of the family, and therefore the rules and regulations of the family applies to all that live in that environment.

The old and, most importantly, people with disabilities that live in these extended family systems are well taken care of by their brothers, sisters, grandchildren, and parents as they live together. People who are not able to move around are helped by running errands for them by the children, the adults who are capable go to work in the farms and other sources of food for the entire family. Peri care is performed for the old and the disabled who are not able to perform these tasks. This system is governed by our believes and cultural norms.

One of Ghana's traditional cultural values, particularly in the context of extended families, is support for those with disabilities. Respondents to a study conducted by Naami (2015) stated that among other things, their family, friends, non-governmental organizations, churches, mosques, and the government had provided them with food, shelter, clothing, and emotional support. Participants in the study, however, asserted that they do not get any help from their relatives. Subsequently, begging is a survival tactic. According to Sayibu (2016), there has been a decrease in family support. Most disabled persons now have to scavenge for food on the streets as a result of this problem. People with disabilities frequently endure rejection from family members, particularly siblings. Disabled individuals are excluded from social gatherings and meetings where decisions are made in society (Sayibu, 2016). This interferes with their entitlement to be treated with respect and without bias and limits their capacity to participate fully and effectively in Ghana and be accepted by it (Sayibu, 2016).

In Canada I lived with a man who was in his 70's. One time we were eating dinner with his one and only daughter and he jokingly said to her 'I do not think I can live in this house by myself.' She replied, 'I suggest we start looking for assisted living for you to move into.' His daughter has a full house where she lives with only her boyfriend. This should have been an opportunity for them to live together, but I believe because of the way of life of Canadians, putting your parents in an old age home is considered ideal.

Many persons with disabilities I support have their families come visit them and some of them never receive even one visit, not because they do not have family, but because the way of life in Canada does not necessarily make you visit your family. One might be busy with work or other extra activities, but in the environment that I grew up in, one must visit family wherever they find themselves. All this shapes the understanding of disability.

Inclusion and Accessibility

In Ghana the Disability Act mandates that all parents, guardians, providers, or custodians of disabled children in Ghana enroll them in school as soon as they reach school age. Asante and Sasu (2015) state that "any custodian, parent, or guardian who refuses to enroll a child with disability in school commits an offense and is liable to pay a fine or serve a term of imprisonment" (p. 63). The Ministry of Education was tasked with providing the required teaching aids, a setting that was accessible to people with disabilities, and a regionally adjusted curriculum that considered students with impairments. Any specific disabled individuals who were unable to continue higher education owing to their impairment were required to be provided with options for skill development by the Ministry of Education. This was designed to provide them with the possibility to become contributing members of society who could sustain themselves despite their inability to continue their schooling.

According to Ocran (2019), there are many anti-discrimination legislations in place to protect the rights of individuals with disabilities. If these rules had been in place, Ghana's progress toward becoming a developed nation would have been greatly accelerated. Education improves a person's quality of life by empowering them with knowledge of their rights and responsibilities and making it easier for them to find respectable job.

Due to stark discrepancies and difficult restrictions, children with disabilities are unable to fully participate in academic, social, and community activities. These discriminatory actions may deter their parents from actively contributing to their children's schooling. Discrimination against a disabled person, their family, or anyone connected to them can result from stigmatization. People with disabilities may experience exclusion and unjust treatment in various facets of their lives, including educational institutions, as a result of stigma and discrimination. According to Baffoe (2013), negative preconceptions, superstitions, and beliefs about disability have a substantial impact on the social marginalization of individuals with disabilities in Ghana. Because of this exclusion, they find it difficult or impossible to engage in social activities that will help them maintain or ensure a high quality of life. Since it deprives them of necessities for survival, poverty has a significant negative impact on people with disabilities (Mukobe, 2013). According to the research, many people with disabilities and their families lack or have limited access to necessities of life such clean water, food, and clothing as well as medical care, job opportunities, and education. To enroll their children in school, parents might need to pay tuition fees as well as extra expenses such books, uniforms, transportation, and school dinners (Mukobe, 2013).

Families with impaired members typically have limited incomes, especially those who live in isolated rural areas. Because so many parents feel suffocated by the cycle of poverty, it frequently takes a lot of convincing to get them to take part in activities connected to their child's special education. Parents of children with disabilities may need to drive their children to school every day and pick them up at the end of the school day due to the distance between their houses and schools. Because they find this to be so annoying, some parents have opted to keep their child at home rather than putting them in daycare (Mwangi & Orodho, 2014).

According to people with disabilities and their families, one of the main obstacles to accessing services is a lack of access to pertinent and helpful information. The programs that are accessible to them or how to seek assistance aren't even known by some parents of disabled children (Kiarie, 2007). Some parents and families can feel intimidated by the educational system and think there is nothing they can do to assist their children with learning difficulties. In general, parents of disabled children lack the means to communicate with and support one another, especially those who live in rural areas.

When a child is born, parents could not have obtained a formal education, or they might lack the skills to help the youngster get through challenges. Additionally, parents might not know how to get outside assistance to get past these obstacles. As a result of not bringing their child to the neighborhood evaluation and placement services, it has been demonstrated that some parents are unaware of the health or special needs of their children (Mwangi & Orodho, 2014). When they discover their child is not developing as it should, many parents of disabled children are unsure of what to do or who to contact (Bii & Taylor, 2013). For instance, many families are only vaguely familiar with autism spectrum disorder. Many parents lack adequate knowledge of autism and its symptoms. This inability reduces the effectiveness of intervention services because the parents do not follow up.

From my point of view, parents occasionally do not know what to look for that might imply an impairment when a child is developing. As a result, limitations or impairments are only discovered when the children become adults. Parents are hesitant to report their child's impairment and ask for assistance because of the stigma associated with disabilities in the community. Because there is a lack of information about identification and rehabilitation programs, parents are unable to learn about the services that are offered, what services are offered, and how to get them for their children. There are times when interactions between parents, teachers, and the disabled child are not good.

I lived in Wa, Upper west region of Ghana, and I had an uncle who was old and had no children, so he was living with us. My Dad entrusted myself and my brothers with his care. Any time he came home, and my uncle was not in a good condition, we would all be punished. We were kids and only interested in going out to play, forgetting my uncle is unable to perform certain duties for himself. We would provide him with a commode for toileting, feed him and change his clothes when necessary. This was reflective of the extended family system in Ghana, but after a few years of living in Winnipeg, I realized that parents are sent to care homes when they become unable to take care of themselves. This is not to say that the extended family system is perfect in Africa.

The People with Disabilities Act 2006 (Act 715) was adopted by Parliament. Architectural limitations, a lack of access to transportation, information, and medical services, as well as social welfare benefits, have all had a substantial negative influence on the well-being of people with disabilities (Naami et al., 2019). Since the Ghana Disability Act of 2006 was established, it appears that there are numerous significant physical barriers, including steps, that limit the movement of wheelchair users. Even though the Persons with Disability Act, 2006 (Act 715) mandates that all structures to which the public has access be equipped with disabled-accessible features. Critics of the Ghana Disability Act of 2006, Asante and Sasu (2015) acknowledge that many public facilities constructed after 2006 are still not compliant, making it appear as though the law does not even exist.

Many scholars have mentioned health care restrictions as issues with the research on disability in Ghana. Due to their incapacity to access formats like Braille for the blind or technologies to access this information, people with disabilities, for instance, would not be informed about medical issues like HIV/AIDS and other infectious diseases (Evans et al., 2016). Low-income households who are unable to afford appropriate medical treatment typically raise children with disabilities (Anwar, 2017).

Act 715's approval gave rise to expectations that, by 2016, all parts of Ghanaian life (the built environment, attitudes, and educational system) will be accessible to people with disabilities. This was ten years after the Ghana Disability Act went into effect. As opposed to this, according to Ansah-Owusu and Danso (2012), "most designers and contractors in Ghana fail to factor the disabled people in the design and construction of infrastructure" (p. 448). Even while many companies and organizations are already operational, they do not go above and beyond in terms of inclusivity when planning and building their physical facilities.

The Act mandates that the Ministry explore opportunities for people with disabilities through public employment centers to improve their employment. Employers who hire persons with disabilities are required to receive a tax credit from the government every year on their taxable income. Furthermore, government incentives were to be offered as a form of support for disabled people starting their own enterprises (Asante & Sasu, 2015). The likelihood of seeing certain people with disabilities without work, begging, or sleeping on the streets may decrease if these promising elements of the Ghana Disability Act were put into practice.

Media and Representation

The cultural norm is not seeing disabled people within the mainstream media. The media almost never talks about people with disabilities in Ghana; journalists usually shy away from topics that includes people with disabilities. The few times that I have seen persons with disabilities on television was on the grounds of begging for funds. People and journalists will take pictures of persons with disabilities in deplorable states and appeal to the public for funds to help provide for people who are unable to work and earn a living. This creates an impression that people with disabilities are not important in society, or they are people needing pity and handouts for survival.

Throughout my stay in Canada people with disabilities are seen in television giving speeches almost daily advertising programs. The media will listen to anyone whether with or without a disability. A client that lived in my place of work once told me that she lived in a group home which had a broken elevator for a week. She is a wheelchair user so she could not move freely. She invited the media to come and witness her situation as a disabled person. The media showed up and offered her an interview and surprisingly the elevator was repaired very quickly. This meant that she was ignored because she was a person with disability, but after so many people heard about the situation, the authorities knew there could be consequences and hurriedly repaired the elevator.

People listened to her story, and she got the problem fixed. Working as a support worker, I would not have listened because of the environment I grew up in which was accustomed to not paying attention to the cries of people with disabilities.

Within the Ghanaian environment, some cultural norms perpetuate discrimination and stigmatization towards disabled individuals. Negative attitudes may lead to exclusion, limited opportunities and unequal treatment. We must therefore strive to improve the system by reforming some of the harmful cultural norms like promoting awareness, education and advocating for inclusive policies to create a more accepting and accessible society for persons with disabilities. There must exist respect and understanding of the rights and dignity of individuals with disabilities across diverse cultural contexts.

Disability Studies and Understanding Disability

Disability Studies has had a significant impact on my understanding of disability. It encourages me to see disability as a social construct rather than just a medical condition, as distinguished by the two models in disability basically the social and medical model. The social model emphasizes the importance of societal attitudes, accessibility and the empowerment of individuals in shaping the experiences of individual with disabilities. It also helps in developing an inclusive way of thinking and moving beyond stereotypes. On the other hand, the medical model views disability primarily as a medical issue or a result of an individual's impairments or health condition. Some of the focuses of the medical model incudes individual deficits, diagnoses and treatment and dependence on experts.

Coming into class to meet a disabled teacher was a game changer for me. She had a title of Doctor and now Professor. She portrays knowledge and understanding of disability. I am tempted to say she is the Master of Disability, the way she carried herself with her physical impairment. I believed more of her teachings because she told stories from a disabled person's perspective and related to everyday life, from how she wakes up to how she transports to school for our classes to take place. I employed the teachings I received from Disability Studies, observed, and employed these teachings to my interaction with disabled people and my life as a whole. Among the many things that changed throughout my studies are social attitudes, accessibility, and empowerment.

Societal Attitudes

I have personally had a change of attitude as a Disability Studies student. This change came about as a result of the education and exposure I received by studying and working as a support worker in Canada. Through empathy and inclusion, stigmatization and pity, ignorance, and misunderstanding, advocating and allyship, and person first language.

I was very ignorant about disability. I misunderstood almost everything about disabled people as I enrolled into Disability Studies and started learning from courses like History of Disability, Global Disability, Disability and the Media. I learned that among all the disabling factors affecting persons with disabilities, the behaviours of people in the society affects disabled people the most. It is a fact that with all the accessible infrastructure, persons with disabilities will not feel welcomed to places where people are looking at them like they are from space and are not welcomed. I remember my first time seeing a disabled person using a customed motorized wheelchair, I was amazed, and I kept looking at him until he passed. I have shared meals with persons with disabilities that I support. This is something I have never done felt was the right thing but with my studies I was able to understand and overcome this type of attitude.

I remember vividly one of my teachers showed a video in class at the beginning of the course to let us understand what we are learning. She showed a video of the institutionalisation of disabled people. It was a very sad video but educative. In this video there were establishments called residential schools and these schools were created to separate disabled children from their families. This was done to separate disabled people from the rest of the population (segregationWithin these institutions, disabled people were maltreated and mostly unattended to. This was also because people did not understand how to support persons with disabilities.

Empathy and inclusion are about people having positive feelings towards persons with disabilities and wanting persons with disabilities to be part of life activities. This is a general display of positive attitudes. During one of our sessions in Disability Studies, a classmate who had a physical disability mentioned that when she first arrived at the university campus, she found it difficult to locate the department of Disability Studies which at that time was recognised under the department of education. She therefore visited the secretary of the department of education and asked for directions to the department of Disability Studies. To her surprise the secretary had never heard of our department and did not know where it was located. She explained how excluded she felt at that point, and the secretary did not show much concern as to helping her find her destination. This displays the kind of exclusion that disabled people experience within the society.

Stigmatization and pity, this is an attitude that is very common from where I grew up, persons with disabilities were seen as witches and wizards and therefore many people are afraid of them and do not want to go close to them. People will offer some of those who are on the streets clothes and food because they feel pity, but through the studies of disability I learnt that people, even if given charity, need dignity and respect. The fact that someone is diagnosed with some kind of condition does not mean that person is less of a human. I was in the same class with a visually impaired person. With all the materials and opportunities for all of us, he was one of the best students in the class. He excelled in most of the assignments given to us and I would sometimes go to him to explain certain concepts to me. When I got a job as a support worker, he told me his struggles of finding a job. He said, ‘I was not getting interviews and decided to remove the information of me being blind and just identified as a person with a disability. When I go for interviews and they realise I am blind, they sometimes do not grant me the interview, or sometimes out of pity will interview me and not call me back.’ This was a clear instance of stigmatization and pity.

With Person-First Language, Disability Studies has taught me to see each person as a human being and not the disability first. Disability is a characteristic of a person and not who the person is. One must see people as who they are and not what they can do. With the right environment and resources persons with disability can equally perform to the very best of their abilities.

One individual I supported I called ‘madam’ when we first met. I saw her as an elderly person and, partly because of my culture and how I grew up, cannot call her by her name. I grew up learning to only call elderly people sir/madam and not by their names. She became furious and asked that I call her by her first name. A colleague of mine who is from Nigeria remained adamant and said, ‘In my culture I cannot call you by your name.’ This has remained a quarrel between the two even though I tried to explain to my colleague that she has the right to choose how she can be referred to. This issue was reported to the authorities, and nothing has happened yet. But through my education in Disability Studies, I understood the rights of persons with disabilities and the differences in cultural values.

I have always said that my ultimate goal is to become an ally and advocate with persons with disability. I encountered a supported person who indicated he had family outside of the city and that he wanted to visit for Christmas. He had not met with his family for some time. There is a bureaucratic process in things like this, but I made it a point to follow through with his request and he has been approved financially to visit his family this December. This happened by sending numerous emails and meetings with my supervisors explaining and assuring them that this is very important for this individual and I will personally ensure his safe visit to his family.

Accessibility

Accessibility is a fundamental aspect of addressing disability. By prioritizing accessibility, we promote a more inclusive and equitable society where everyone can participate fully and contribute to their maximum potential. Physical, digital, communication, information, universal design, inclusion, and empowerment.

Physical accessibility is ensuring the accessibility of physical locations, buildings, and transportation. Accessible public transit, lifts, wider entrances, and ramps allow those with mobility impairments to fully engage in society. I have lived in a society that did not have accessible buildings even until today. As I enrolled in Disability Studies, I learned about laws that mandate public buildings to follow universal design. Canada is doing a good job with making most of the buildings accessible but there is still more to do. Most of the buildings are recently upgraded to become accessible buildings which is a good sign of inclusivity.

Digital accessibility is crucial with technology becoming more and more important. Websites, applications, and software should be made to work with people who have different kinds of disabilities. For example, screen readers may be used by the blind and people with motor impairments can use keyboard navigation. When I was growing up computers were very scarce, and people usually resorted to traditional media for information and other ways for information. These days without a phone or computer one will not be able to be up to date with current happenings. I was amazed at the extend to which a classmate of mine who was visually impaired used his cellphone. He was able to do everything an abled person with full vision could with their phone. This is an example of a person who have had the opportunity to access digital items, but many are those who have no idea of such and should be made available to all disabled people to be able to unearth numerous potentials.

Communication access ensures people with hearing or speech impairments can engage, access information, and express themselves with the help of sign language interpreters, captioning, and other alternative communication methods. Effective communication is essential for the growth of society. I know about ‘special’ schools in my country of origin, but I have never seen communication tools like braille used. During my studies in Disability Studies, I learned about such tools and have seen them used in several circumstances. This education and exposure add to my knowledge for a better understanding of disability.

It is important to offer information in a variety of accessible formats. For those who are blind or visually impaired, Braille materials, large print, and accessible documents are necessary. Having access to knowledge enables people to engage in jobs and education and make educated decisions. Many disabled people are unemployed due to the lack of basic education, and this may be because they have no information about where to go or how to start. In this developing world, people need to access information all the time to keep updated with current understanding.

The university had some accessible spaces that enabled disabled people to use in search of knowledge such as the library. The library had accessible computers that were friendly to disabled people and therefore disabled people could learn just like the able-bodied students.

Regardless of a person's ability, universal design aims to create environments, goods, and services that are accessible to all. Equitable use lessens the need for retrofits and is advantageous to all parties. The world would be very simple and accommodating if all environments adapt the universal design strategy. I leant about universal design in Disability Studies and got to understand that universal design is not limited to physical design but extends to digital design, communication, and policy as well. I remember I had to get a different doctor for one of the individuals I support since clinic was not accessible to the client. This happened in 2023 in Winnipeg, Canada. There were no ramps at the clinic, and this is a person who uses a power wheelchair. After I explained to the secretary, all she said was ‘I am sorry we will not be able to help you today at this location.’

Inclusion and empowerment are achieved when people with disabilities are treated with the same dignity, respect, and opportunities as everyone else. This encompasses full participation of all individuals with disabilities in all aspects of the society, the integration of students, providing equal opportunities for individuals with disabilities, and providing an accessible environment for persons with disabilities to make their own choices and decisions. Within my Disability Studies class, there was a mixture of persons with disabilities and persons without disabilities. We were all educated at the same level, and I believe inclusivity is one of the values of Disability Studies and therefore persons without disabilities were not left out. One other thing within the department is a visually impaired secretary. She has been employed in the department and she does her job very well. She uses Braille to write our names on our assignment papers. This was my first time actually seeing Braille being used.

Empowerment

Embracing one's identity, questioning the status quo, and actively working to remove obstacles that prevent people with disabilities from fully participating in society are all ways of empowering oneself. It works to create a more just and equitable society in which people with disabilities are treated with the same respect, opportunities, and rights as everyone else. Challenging the medical model, self-determination, advocacy and activism and intersectionality are all ways of empowering people with disabilities.

The medical model is challenged when persons with disabilities define their own experiences and encourage individuals to reject the idea that they are primarily defined by their impairments or medical condition. This includes occupying spaces that are meant to disable people, showing up, speaking up and informing people that the impairments are not the limitation, it is the societal barriers. Doctors and other medical professionals need to know that societal barriers are more disabling than the medical conditions that they seek to ‘cure.’ I experienced a situation where a supported person expressed dislike for one particular individual and this individual was a person of authority. I supported this individual for three years in a row and was very familiar with him, but because of his behaviours, he would ask the person of authority to go away and use foul words. Measures were taken to use some medication to help this person conform, but I was able to put myself into the situation and explain to this person in authority that I do not think medication is the way to go as he does not been behave this way in all our interactions. I made some other workers talk about their experiences with him. He reacted this way when this person was around. Therefore, I suggested TRYI other approaches to see the outcome. The person in authority started using words like ‘please’ and ‘thank you’ to him and he stopped shouting at her. This simple act avoided the use of medication with would make him moody.

Encouraging self-determination by providing them the autonomy to make decisions about their own lives is a crucial strategy for empowering people with disabilities. It acknowledges that they are the experts of their own experiences. People expect persons with disabilities to act a certain way in public spaces, so the idea of exploring the personal ideas and needs of oneself no matter the barriers depict empowerment.

I support a person who reported to me that he hates it when his support workers do not ask him but go ahead and perform certain tasks for him. He stated that whenever it is supper time, staff will bring the food and start to feed him. He usually rejects it and creates a lot of confusion between the worker and the staff. He stated, ‘I wouldn’t mind them feeding me but sometimes I want to feed myself, and therefore if they ask me before I will be fine with it.’ He believes he can feed himself, however there are some kinds of food that are very difficult to eat. He is determined to try and if he cannot, he will then ask for help.

Advocacy and activism involve persons with disabilities working closely with their allies to help change societal attitudes, policies and practices that perpetuate discrimination and exclusion. Persons with disabilities embark on peaceful walks to create awareness for able bodied persons to know disability is not inability, but the numerous social barriers that are hindering development and productivity of persons with disabilities. I have since understood this through disability lenses and admit that advocacy is an essential part of my duty as an ally to help create enabling environments for persons with disabilities.

The provincial election that happened recently in Winnipeg was highly patronised by disabled people and I was part of this campaign. I wore Disability Vote Matters T-shirts and marched some streets of Winnipeg with my association to create awareness and encourage disabled people to go out and vote.

Disability Studies taught me that race, gender, sexual orientation, and class are all facets of identity that are intertwined with disability, known as ‘intersectionality.’ Empowerment takes into account the difficulties and experiences faced by disabled people who are members of several marginalised groups. Through Disability Studies I realised the difference in treatment of a black disabled person and a white disabled person (race). Persons with disabilities are met with different attitudes due to who they are or what they believe in. A rich person with disabilities will be treated better than a poor person with disabilities because of the social class that one belongs to. I never really thought about this until I took courses in Disability Studies.

Working in a transitional environment, I see a lot of turn over with the clients we support. Sometimes, people who are supported newly arrive in the home and either run away or cause damage to the home that may involve the police removing the person from the premises or transferring the person to the right placement. An individual was brought to the home, and they made it clear they was not going to stay and after they was dropped off, in about an hour, running away from staff. They were found downtown and brought back but she stated it clearly, she will not stay and therefore she left again before the nightfall.

authorities finally understood there was nothing they could do so they packed belongings and met the person downtown and they went to one of the shelter homes.

In conclusion, I would not become a support worker if I had not enrolled in Disability Studies. The information and education I received helped me observe certain aspects of disability. Through my work I was able to apply the knowledge and understanding by calling people by names they prefer, identifying the need for accessibility and being able to help fight for the rights of persons with disabilities.

Documenting my Experiences as a Support Worker

My experiences working as a home care worker are included in this chapter. It examines my employment process, my training, and my interactions with coworkers and the individuals I support while working as a support worker. It also examines the trends in the provision of services as well as the procedures used by my agency.

My journey as a support worker in Canada

It has been and continues to be an interesting and joyous journey as a support worker in Canada. I will look at some of the interesting and difficult aspects of the job as I lived and worked with an organization and people for providing care and support to persons with disabilities in Winnipeg.

How I became a support worker

Growing up in Ghana, most people automatically perform certain duties in the household as we do not have a good social system that houses people requiring support. This process occurs to almost everyone in this community as we grow. When I was 18 years old, I was tasked to help with showers and preparing my nephews for school.

I arrived in Canada for my studies starting in September 2019. I immediately found a job as I needed money to sustain myself. I had saved money for my tuition but prepared myself to work as I study to sustain myself in school. During the first month of my arrival, I found a recruitment agency that recruited me for construction work in a shop called Walmart. I started working with them for minimum wage. This was hard work because the work had to take place in the night when business is over. I would go in and come home around 7am and sometimes attend classes at 9am. This was really hard combining that kind of work schedule with school.

We started classes and I met other colleagues of mine. One day they were talking about jobs after class, so I joined the conversation. I had planned to find a job related to my course of study to gain more knowledge and experiences to become a better ally to disabled people. I listened to them as they gave stories of the jobs they do. I asked some questions and I realized they were working for an organization that outsources its contracts from the government in the health care sector (home care). I have some experience with contracts back in Ghana and I do not like the way things are handled when contracted to other companies. When contracts are awarded, people create their own ways of doing things without reference to the initial objectives and aims of the project.

I therefore decided to apply to the regional health authority (home care) but unfortunately, I was not offered the job partly because of the number of hours I was allowed to work. International students by law were allowed to work a total of 20 hours a week but the jobs demanded more (40) hours for a week. After I could not find jobs with the regional health authority, I asked my friends about another program they mentioned which was a little different from the traditional home care. This program provides housing transition to disabled people who do not have a place to live. Unfortunately, this type of home care was operated by a company that had a contract from the government to provide staffing.

The program involved people with various disabilities on a temporary/transitional basis. This was the type setting I wanted to work in; it had all types of disabled people so I could get real experiences to become a better ally. I applied to the company and was called in for an interview within two weeks of my application.

I was nervous because it was my first interview for a job related to my course of study. This was an in-person activity, and I went into the organization’s main office to meet one of the managers of the company. We had a casual conversation and he asked me practical questions about the job. Possible scenarios were presented to me, to which I was asked to respond. Example of the questions are:

1. What will I do when I first meet a client? How will I act if I am in the community with a client and the client becomes aggressive or anxious?
2. How would I ensure the safety of myself and the client daily?
3. How would I approach a person with disability without provoking them?

I was taken through a three- day training that mandated eight hours a day. The areas of training were about the policies and procedures of the company, residential and transitional care, safety, safety in action, performance and professional development, diversity, and inclusion in the workplace and how to administer medication

The company requires some documents to get you started. For example, bank information, identifications, CPR and First Aid certificate, child and adult abuse checks, and vulnerable/criminal checks. The CPR and First Aid Certificate also require an eight-hour training and a final exam.

This entire process to become a support worker in Winnipeg constituted a total of 32 hours plus 16 hours of in-house training for me to work as a support staff in specialized community services for this company.

The Location I Worked as a Support Worker

In Ghana, my working location was the house because my siblings and uncle lived with us in the same house. I did not have a paid working job; this was more like a volunteer job by providing services to your family.

In Canada, I worked at a location within the organization that operates differently from the typical group home locations run by the company. It was a temporary/transitional service program where people come into the homes temporarily while the case coordinator helps in securing suitable, safe, and affordable homes for the individuals to move into. I joined a total of nine staff – four in the morning, three in the afternoon and two at night – and I worked the afternoon shift (3pm to 11pm) when I started in 2019 and moved to 7am to 3pm when I became the team leader. It took me one year to take the leadership position as I was reluctant to take the responsibility knowing how difficult it is working with people who are merely in the job for the money and not to provide support. Many of the staff will rotate with many homes but within these three years I worked with this company, I only worked at this location. Some of the units were disability friendly and others were not. The program acquired ten rooms within this building at different sections in the building to encourage community living experiences.

Observations as a Support Worker in Canada

I travelled from Ghana to Canada and listed my experiences in my resume as someone who has had some experience in home care. Little did I know that the differences with regards to the environment and culture would cause me some challenges. In Ghana we rely on the extended family system for caring for the young, disabled, and old. After my initial training I was assigned to the program and as soon as I started my shifts, I began to learn from the people I worked with on a daily basis. This became difficult when after a week I started working with different people every shift.

Different staff came with different approaches. Some operated with passion, others by rules. I believe that the employer recruits staff and expects them to operate under the rules and aspirations of the company. Home care attendants are faced with numerous challenging situations and are left to use their own judgment. I remember when I started, the team leader confiscated a walker from one of the clients because he left it at different places within the building. I respectfully questioned if taking the walker away was the right decision, instead of encouraging the client to keep using his walker. The team leader was mad at me for challenging her decision and I was very new at the job, so I kept quiet. As she continued, the client himself reported her to the authorities. She got suspended and never returned to the workplace. Because of the scattered nature of the rooms around the building, many staff were very lazy to go around all rooms to administer medication or perform other duties. One day a particular staff took the medications of all ten clients and administered them as he moved from room to room. In our training we are only to administer one medication per person at a time. This was ignored because of laziness, and he eventually mixed the medication and exchanged two people's medication. When something like this happens there is a protocol to be followed, but this staff wanted to skip some of these steps. The client brought this to my knowledge, and I insisted the staff went through the required process to make sure the client is safe. This created a war between myself and the staff simply because I listened to the disabled person and insisted the right thing be done.

Challenges I faced as a support worker

Home support work must always be done with professionalism and some compassion as we work with different people with different behaviors. The job comes with its own challenges. One must first decide that one is coming to work to help and not to be idle and get paid at the end of the day. I will talk about a few of the challenges I faced while working at this transitional care home.

I believe support work has been disorganized by these organizations because when I started working, I had in mind I am there to support, which meant I will do activities with the person and not doing everything for the person. It was interesting to note that after I met so many people with various disabilities, persons who were capable of doing laundry or getting a shower waited for a worker to do it for them. This culture I believe is partly the fault of the workers and the organization because the managers blame the workers when certain tasks are not completed, the authorities do not look at why certain things are happening in the homes but blame the staff for not completing tasks in the home. A gentleman once shouted at me, 'Hey, come and clean my room!' I walked away and later went back to him and had a conversation with him. He understood it as support workers are his workers and are there to do all his work for him. This has been his understanding for many years and there was no way I could make him understand by talking to him one time. I decided to educate my fellow staff .

It is very important to protect yourself and create boundaries as a support worker when working with people in general because behaviors can be learnt as you work with people every day and end up learning some of the things they do daily. I found myself at one point using bad words when I came home because most of the people I supported always used the ‘F’ word. It took me a while to realize this behavior with the help of my family. The other way is also important; protecting the individuals supported so that they will not learn the bad behaviors of some staff, like lazing about or postponing household chores. There was a client who was allowed to used medical marijuana. He was very close to one staff member and the staff person would support him making the purchases, but we did not know that the staff person was encouraging this client to buy more so they both could smoke. The staff would make him use all his money to buy marijuana and he would take some of it home to smoke. We suspected this, and when we asked the client, he said no to the allegations. We kept an eye on them, and I believe he stopped.

The location where I worked was comprised of people with various disabilities. The idea for the location is to provide temporary help to people with disabilities until more permanent housing is secured. I have been called all sorts of names and sometimes asked to go back to my country mainly because I am implementing rules of the program. The people I support sometimes believe I am giving some of the rules myself because when they were brought to the program they were not properly orientated by the authorities. An intake has a process but is mostly ignored. People are just brought and dumped into the program to learn as we go. There are so many instances where I have to call on the social worker to come and explain some of the rules of the program to the participants. Some of the rules are no smoking in the rooms, no visitors after 10pm, and no drugs/alcohol in the premises. I am therefore tasked to confiscate all these substances when found in the rooms and ask all visitors to leave when it is 10pm.

Left over responsibilities happen when staff ignore their responsibilities because they are lazy and do not want to do anything or they had other incidents in their shift which prevent them from completing their responsibilities. This puts the group into a situation where people blame each other for not doing their job. I had an instance where staff did not complete laundry for an individual. The next morning, I was to take this individual for an appointment and at the time of dressing we found out he had no clothes; they were all left in the laundry yet to be put in the dryer, but no one had informed us of such an uncompleted task. This led to a whole issue because the individual missed his appointment and the authorities had to be informed.

I am expected to go and help with social outings with the individuals we support, but this has always been a challenge due to the limited number of staff at this particular transitional home – ten individuals supported by three to four staff. It is not possible to coordinate social activities. We hardly make it for doctors’ appointments by scheduling these appointments in the morning where there are four staff. Also, doctors’ appointments usually do not last long, so they usually come back in time. Social activities might take the whole shift, and this would put a lot of pressure on the remaining staff as so many things happen within the day shift like showers, cleaning scheduling and attending appointments. I asked for more staff, but the organization declined saying the government only pays for this number of staff to be at this location. Meanwhile other locations with three supported individuals have the same number of staff.

The workplace culture

I can conveniently say that 95% of support workers in Winnipeg are immigrants. This seems to be the easiest job to get when you arrive in Winnipeg. People will encourage you to apply even if you do not have the passion to help people with personal care. People come into the profession for the money and not necessarily to support the people as they are supposed to. This creates a very bad working environment as the duties are neglected. Others who care for the support of the individuals are left to either deal with it or become the enemy. You are labeled the enemy when you report people to the authorities for not performing their duties. People feel because we are all immigrants one should not make reports to the authorities, forgetting that others will have to perform their duties on their behalf. I remember we had a staff who would come sit at the location and play with her phone all day. We later had another staff that was paired with her on the evening shift and due to her laziness, most of the work was on one staff and she reported to the authorities about the situation in the house. We had several conversations with the manager about this staff, but the managers were reluctant to discipline her. We later pleaded with the manager to at least transfer her out of our location, and they finally transferred her. This staff person still works at other locations in the organization. Due to what happened, she is no longer friends with all the other staff of our location. She felt we should have protected her and allowed her to stay at our location.

The Dependence on Casual Staff

Many health care organizations in Winnipeg rely heavily on casual staff which is usually composed of international students. In my organization, out of every two staff, one is casual and usually a student. This affects the work in two ways sometimes want to complete their assignments at work, thereby neglecting the duties assigned at work. This is evident at my workplace as I have witnessed many people come to work with their laptops and start to work on their assignments forgetting the schedules for some clients. Other staff will have to remind them to perform certain tasks, and this puts more pressure on other staff. On a good note, students like me who are interested in the job and welfare of the people we support pay more attention to the job responsibilities. I believe my interest in the job led me to becoming the leader of the team at this location.

Transportation

The movement of people whether disabled or not depends on transportation. The location I work at did not have any vehicle for transport like other originations. Rather, the people we supported had either Employment Insurance support in paying for taxi rides or the parent and guardian trustee pays for the rides, but they only pay for rides that are medical, they do not pay for social activity rides like going to the mall or visiting the park. This limits the movement of the people we support, and they eventually stay at the location almost every day unless they have an appointment because they cannot afford taxi rides themselves. This breeds exclusion of disabled people from societal activities.

Weekly Allowances

Weekly allowances are provided for some of the people I support, and it is distributed with the direction of the social worker. I provide this money on a weekly basis. This money is so small that it is not enough to buy anything for oneself. I am allowed to provide each person under the parent and guardian trustee system an amount of $20 a week. It should be noted that meals and laundry and all basic needs are provided at the location. The only question is: Are the individuals happy with the basic needs that are provided? Over the years that I have worked at this location, the individuals have expressed their concerns about the food that is provided in the congregate meal program. Some of them prefer to eat other foods. Therefore, the congregate food provided mostly ends up in the garbage. Some of the people supported get some income occasionally from First Nations if they are members. This helps them to afford certain needs that they are not able to get with the little money from EIA and PGT.

Location Specific Training (Refresher Training)

The company I work for has about 15 homes with people living in them for care. My location has the highest number of people and with different needs and expectations. I expected the organization to at least make this location stand out by providing additional training for staff and maintain some refresher training sessions from time to time to maintain good working practices. Recruitment should be done specifically for this location due to lack of staff sent to the house from the casual pool or other locations every day. This puts pressure on the existing staff as every little thing will have to be explained to the new staff. Here, there are more clients than staff, so the time you will use to train the staff is not providing care for the individuals. I was recruited for this location but received the same basic training as a home care worker. I learned the processes and was able to provide the necessary care. Other staff who are scheduled at my location expressed the pressure on staff according to the demands of the supported individuals. They usually say they will not work at this location again when they can go to a location that houses three clients and three staff.

The Persistence of the Medical Approach

. Working at this location, all the occupants take their medications on a regular basis. A person who does not take medication is quite uncommon in group homes. Persons with disabilities are assumed to be unwell and in need of treatment. Pharmacies provide weekly medicine deliveries following the patient's evaluation and admittance into the residence. When it comes to staff onboarding and in-house training, medication administration and documentation play a critical role. Medication mistakes and missed doses are taken very seriously indeed. If an employee made mistakes in administering medication, training is organized for them, but if it occurs again, depending on the situation the employee may lose them. Immediately upon discovering an error, the protocol is to inform poison control and follow their instruction after you inform the pharmacist, clinical case worker, and on-call supervisor. There was an admission of an individual into the program and this individual was diagnosed with dementia. When he was moved he was very confused, which was to be expected considering it was a new environment, but the staff on the ground had no experience in supporting someone with dementia. Therefore, staff reported several difficulties they faced, and the authorities immediately involved the medical professionals and medications were immediately provided to the client. These medications I observed were making the client sleepy and unable to walk. I reported to the authorities and a reassessment was done. The medication was adjusted, yet the client had some side effects whenever he took that medication. I reported what I observed until the medication was removed. The client became very lively and became familiar to the environment, but because the staff was not trained to support such persons, he was transferred again to another care facility.

Documentation

Every document within my workplace is considered a legal document and must be treated as such. Organizations use documentation as their reference point since the authorities are not usually present at the homes. An incident I earlier mentioned where an individual was not found in his room is a typical example. Documentation was reviewed and the staff indicated that the individual ‘slept through the night,’ but the reality was that the individual had an emergency and was taken to the hospital. This was found the next day when the day staff could not find that client. An investigation was initiated and the staff were found to have neglected their duty by not checking on the client and not knowing their whereabouts, but most importantly, writing down that the client slept all night. Employees are expected to record everything that happens from the start of each shift to the finish. Furthermore, incident reports are created if something unusual occurs. When referring to small behaviors like skipping dinner, taking medication an hour early or late, going to bed early, or waking up late, it is considered out of the norm when it comes to home care. Every shift, they are all noted and either forwarded to the office or stored at home so that the proper action can be taken.

Variation in Salary and Care Deliveries

The pay rates for support workers in Winnipeg is hard to determine. Recently the minimum wage has been raised to about 15 dollars per hour. When I started working, I was paid 13 dollars per hour whilst other companies were paying 15 dollars at that time. Currently the range is from 15 to 20 dollars an hour and companies are allowed to decide this for their employees. This brings about competition in the industry and makes staff who find themselves working two jobs work hard in one and become lazy when they go to the company that pays less. Due to the rising cost of living, many support workers rely on two jobs to make ends meet. I recently noticed that some organizations are offering a pension and life insurance for their employees. This is not evident in my organization. This would be a good incentive for workers and would make staff feel secure in working in home care. When staff is not properly motivated or paid it results in poor output. Those who are already in such situations are looking for other jobs. A friend of mine who recently got hurt in a long-term care home regrets working with them. She says the risk is not worth the remuneration.

Staffing Needs

Until recently, staffing was handled by a group of people hired to schedule and send staff to the various houses. These schedulers have never been to the houses, nor have they seen the employees at their workstations. All they know is that you are staff, and you are needed at this location, therefore you will have to go and work. The location I work at is slightly different from the typical group home because it houses ten individuals. The authorities should have at least informed these schedulers of this, but the authorities themselves do not see this location as needing more resources. There are instances where all the people in a shift have never been to that location. When they work, they omit most of the tasks that are required. I expressed this as a concern, and I was trained to make the schedules for this location. This is further incorporated in the organization and all team leaders are now scheduling the staff that are to work for their various homes.

Better Ally

The experiences talked about above during my working time as a support worker in Canada is slightly different from the support I offered in Ghana. In Ghana I was part of the family support system where I helped take care of my siblings, elderly and the disabled. A few home care facilities operate in Ghana, and this is located at the capital city, Accra, but I never had the opportunity to work in that environment.

I believe I have become a better ally based on the experiences from both environments through increased empathy, cultural sensitivity, advocacy, and community engagement. Learning and working in Canada, adding to my disability knowledge from Ghana, will help in my future endeavors in disability issues around the world.

Learning about the unique challenges and cultural context in each country helps me empathize with individuals living with disability in both places. I have since learnt a lot from my studies in Disability Studies. I engaged in active listing to the people I supported as a support worker, putting myself in their shoes, trying to imagine how I would have lived with a disability. I have engaged in meaningful and respectful conversation and volunteered to do activities with persons with disabilities that are not outlined in my job responsibilities.

Experiencing both cultures has equipped me with the sensitivity to interact with persons with disabilities from different cultures; there are a lot of differences in how people live in different places. I learnt that the people of Canada are more informed and accept disability. In Ghana, people in certain areas still believe that disability is a curse. I have become open to learning more as I do each day from people I interact with and avoid making assumptions. One very important thing I learned both in Disability Studies and from the lives of people with disabilities in Canada is the use of inclusive language. This is an aspect that has been ignored by people in Ghana towards people with disability. For example, person first language calls people by the names they desire.

In Ghana, very few people discuss matters of disability, therefore the government does not do much for the community of disabled people. I have equipped myself with enough information to engage in meaningful and productive discussion that will ignite the conversation in disability matters. I intend to carry this message wherever I go in order to lobby for better policies and services for persons with disabilities.

Community engagement and first-hand interaction has been the best way by which most of my information was collected. I interacted with professors in Disability Studies, persons with disabilities that I am supporting, and the community in general. Getting to know people and the situation they find themselves in helps you better understand how to help. I have learnt that what you see from afar may not be the case. Seeing someone with one of his legs does not mean he needs a wheelchair or that a wheelchair is his primary need. I have seen politicians in Ghana donate wheelchairs to persons with disabilities but forget that person may not have some food to eat the whole day. By talking with people, one can identify initial and pressing needs.

Complexities of Allyship

There exists some bureaucracy in the system to get things done, and therefore I must confess that there are situations I win and some requests I lose. Recently there have been some changes at the Department of Families where case workers were reshuffled. One case worker has been allocated to one organization each within Winnipeg. This change disrupted a lot of processes where so many requests were submitted but never approved or responded to.

People were not able to achieve their goals within this period and there was nothing anyone could do about it.

Effective allyship requires continued education and commitment to challenging discrimination. This becomes difficult when people do not listen to you. Manitoba Housing has a nonphysical rule and therefore if a tenant reports another tenant for hitting them, there is no investigation needed, but outright termination of tenancy. The program I supervised is located within the Manitoba Housing, I encountered a situation where three white people ganged up and consistently provoked a client of ours who was nonverbal. He is Aboriginal and there has been cases with the housing where people have expressed dislike for the Aboriginal people. They asked him not to come to the common area. I realized this was going on and I made a report to the authorities, but nothing was done. One day, they provoked him and he took a swing at one of them. A report was put in and immediately we were asked to evict this tenant or the whole program will suffer it. This was a clear case of discrimination from the three gentlemen and the housing staff for not acting when I reported because I am also a person of visible minority.

Chapter Six - Conclusion

My exploration into Disability Studies has profoundly shaped my perspective by challenging prevailing societal norms. It prompted a critical examination of language and terminology, urging me to discard stigmatizing words and embrace inclusive language. The study dismantled stereotypes associated with disabilities, emphasizing the uniqueness of each individual’s experience.

Traditional beliefs and superstitions surrounding disabilities paved he way for more enlightened and empathetic understanding. The concept of inclusion and accessibility emerged as a key pillar for environments that empower individuals of all disabilities. Recognizing the pivotal role of support within the family or in the community amplifies the importance of fostering inclusive communities.

Moreover, a closer examination of legislation and policy revealed the necessity for comprehensive frameworks that safeguard the rights and dignity of individuals with disabilities. Media and its representation are powerful agents in shaping societal perceptions, emphasizing the need for accurate and diverse portrayals to combat stereotypes.

Reshaping societal attitudes towards disability is paramount for fostering a truly inclusive and compassionate community. By promoting awareness, understanding and empathy, we can break down stereotypes, reduce stigma and create an environment that celebrates the unique contributions of individuals with diverse abilities, fostering a society where everyone is valued and included.

Prioritizing accessibility is pivotal for values diversity and inclusion. By ensuring physical, digital, and social spaces are accessible to everyone, we dismantle barriers and create environments where individuals of all abilities can participate fully. Embracing universal design principles not only enhances the quality of life for those with disabilities, but enriches the collective experience, leading to a more equitable and harmonious society.

Empowerment is the key to unlocking the full potential of individuals with diverse abilities. By providing equal opportunities, fostering self-determination and dismantling systemic obstacles, we empower people with disabilities to actively engage in society, pursue their aspirations and contribute meaningfully. A society that embraces and nurtures the empowerment of every individual regardless of their abilities is one that thrives on inclusivity, resilience, and shared accomplishment.

Ultimately, Disability Studies has been transformative, instilling commitment to social change, accessibility, and empowerment. It has not only altered my individual attitudes but also motivated advocacy for a more inclusive and equitable society.

Recommendations

Priority should be given to removing cultural barriers that prevent people with disabilities from participating in society. The development and support of programs for lobbying and information distribution should be the government’s top goals. This will facilitate the adoption of inclusive practices and contribute to a decrease in the community's prejudice against people with disabilities be it in Ghana or Canada.

Cultural differences should not be forgotten when discussing immigrant/African support workers. The difference in culture affects people’s views of disability. The way the people of Ghana view some persons with disabilities and associated beliefs may influence their behavior or quality of care provided. The only way to break cultural barriers is through education. People fear what they do not know. When they get the right information and understand they will appreciate disabled people and acknowledge persons with disability as valuable members of the society.

I recommend that more students should be given the opportunity to study Disability Studies to totally understand disability and how to support disabled people. When I enrolled, we were about 14 students, and that number was said to be the highest number at that time. I know there has been lesser numbers since our year of entrance into the course. This course is designed to encompass both professionals and fresh students from undergraduate levels to come and learn about disability and how to make the lives of disabled people easier within the society in their original professions, for example championing disability courses in engineering by making accessible spaces or working with disabled people directly.

Parental and family involvement in the care of their loved ones and the involvement of parent in the lives of people living in care home will go a long way to help identify the needs and focused care of the individual. Individuals that get visits from their parents and other family members tend to be happier than others. Family members visit with gifts and make the individuals feel loved; we all live as one. I recommend the practice of both systems (extended family system and home care system) as I believe it will help to support disabled people to the highest level.

I recommend regular visits by the authorities to the location at least once a month. This would allow them to evaluate the decisions and rules that are posted for us to follow. Currently, the authorities usually sit in their offices and make the rules based on the whatever documents are put before them, forgetting that we are dealing with human behaviors which usually change from time to time. This requires flexible and immediate redress to help in the development of the individuals. Obsolete rules of these programs are still in place and we are expected to operate with them.

The diverse groups accepted into the same program, I believe, is a positive decision. However, I also think if the people are well assessed and all the necessary procedures are followed, we will not have situations where someone moves in one day and moves out the next. This causes people to become unstable and can cause other issues for a person who is trying to pull their life together. The view of a person is very important to providing help. The fact that a person needs a home does not mean they will agree to live with you and follow instructions. The participants in the program should be informed about the goals and expectations of the program before and after intake is completed.

The organizations should ensure that new staff scheduled to work in this program are trained in specifics.. Regular training (refreshers) must be provided for staff to remind them of their responsibilities and the expectation of the program. With well trained staff, the people supported will receive quality care.

Social outings must be organized, and staff must be provided if needed at least once a week. This would allow all individuals in the program some social interaction. People enjoy interacting with other human beings, not just seeing some common face every day who comes to administer medication and forces you to take a shower. This activity should be scheduled to make sure that it happens. The managers of the program should make sure they follow up with the staff to ensure the persons supported involve themselves with the community.

I believe that considering the medical and social models of disability, it is recommended to adopt an integrated approach. The medical aspects of individuals with disabilities should be addressed, but the focus must be on creating an inclusive society, reducing barriers, and promoting equal opportunities for persons with disabilities. This approach I believe will bring about individual well-being and societal inclusivity.

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