Healthcare service utilization among children with physical disabilities in Ghana: a systematic review

By

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Abstract

Background: Children with physical disabilities in Ghana face significant barriers to healthcare access despite policy commitments to universal health coverage.

Objective: This systematic review synthesizes evidence on barriers, facilitators, and policy factors influencing healthcare utilization among children with physical disabilities in Ghana.

Methods: Guided by the Social Model of Disability and PRISMA guidelines, a systematic search of peer-reviewed articles, policy documents, and institutional reports (2010–2025) was conducted across PubMed, Google Scholar, and ScienceDirect. Twenty-nine studies met inclusion criteria and were analyzed thematically.

Results: Key barriers include inaccessible infrastructure, transportation challenges, financial constraints, negative provider attitudes, and cultural stigma. Facilitators include caregiver resilience, community-based rehabilitation, assistive devices, and NGO support. Policy implementation gaps, particularly weak enforcement of Ghana's Disability Act (Act 715) and limited NHIS coverage for disability-specific services, perpetuate inequities.

Conclusion: Achieving disability-inclusive healthcare requires coordinated action: strengthening policy enforcement, expanding financial protection, and investing in accessible, community-based services.

Keywords: Healthcare utilization, children with physical disabilities, Ghana, systematic review, disability inclusion.

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Dedication

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CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

In Ghana, children with physical impairments continue to encounter significant obstacles in obtaining and utilizing healthcare services, despite official commitments to universal health coverage. Research demonstrates that socio-cultural stigma, inadequate access to rehabilitation facilities, and financial limitations remain substantial barriers to care (Mitchual & Nunoo, 2019). Drawing on Anthony's (2011) conceptualization of disability in Ghana, it is evident that deeply embedded cultural beliefs and misconceptions substantially shape familial responses to childhood impairment. These sociocultural influences, mediated by parental education, awareness, and religious worldviews, directly affect patterns of healthcare-seeking behavior, including decisions about when, where, and whether biomedical care is pursued (Amoah, 2014).

In impoverished metropolitan areas of Accra, transportation difficulties such as high costs and lack of accessible transport combine with poor infrastructure, including inaccessible health facilities and inadequate rehabilitation equipment. These challenges are compounded by shortages of healthcare personnel trained in disability care, reducing access to specialized services (Mitchual & Nunoo, 2019). Structural factors, including weak implementation of disability-related policies, insufficient funding, and poorly coordinated services, further widen the gap between policy intentions and practice, resulting in delayed treatment, limited rehabilitation options, and poorer health outcomes (Amo-Adjei & Tuoyire, 2016).

Globally, over 1.3 billion people, representing 16% of the world's population, live with some form of disability (World Health Organization [WHO], 2022). Nearly 240 million of these are

children, many of whom face systemic barriers to health services (UNICEF, 2021). In sub-Saharan Africa, approximately 80 million people live with disabilities (WHO, 2021). Fetal Alcohol Spectrum Disorders remain highly prevalent, affecting 1 in 13 children prenatally exposed to alcohol in African countries, representing the highest global rate (Lange et al., 2017).

In Ghana, approximately 3% of children are reported to have physical disabilities, yet only 20% access appropriate healthcare services (Ghana Statistical Service [GSS], 2021). The doctor-to-patient ratio of 1:10,032 remains significantly below the WHO recommended ratio of 1:1,000 (World Bank, 2022). Geographical disparities persist, with 70% of medical infrastructure concentrated in urban centers, although over 44% of children with disabilities reside in rural communities (Baffoe, 2013; Gyamfi et al., 2020). Fewer than 30% of Ghanaian healthcare professionals report training in disability-inclusive care. As van Rooy et al. (2012) observed, "the lack of trained personnel remains one of the most persistent barriers to delivering appropriate care to persons with disabilities" (p. 56). Stigma further delays care, with 60% of caregivers reporting stigma-related barriers. Mpofu and Chataika (2019) similarly note that "deep-rooted stigma discourages timely help-seeking and often forces families to hide or delay addressing disability-related health needs" (p. 212).

Access to healthcare is crucial for early intervention, effective disability management, and improved quality of life (WHO, 2021). However, in Ghana and across many African countries, infrastructural limitations, poor disability-accessible architecture, and socio-cultural stigmatization remain major barriers (Baffoe, 2013; WHO, 2022). Understanding healthcare utilization patterns is essential for developing inclusive health policies (Mensah et al., 2022; WHO, 2020). As noted by WHO and the World Bank (2011), "children with disabilities experience poorer

health outcomes, have less access to education, and are more likely to live in poverty than children without disabilities" (p. 7).

Despite progressive legislation such as Ghana's Persons with Disability Act (Act 715) and the country's ratification of the United Nations Convention on the Rights of Persons with Disabilities, significant implementation gaps persist (Mensah et al., 2020; Eide & Ingstad, 2019). Eide and Ingstad (2019) emphasize that "the existence of disability legislation does not automatically translate into improved access or reduced discrimination; the main challenge lies in weak implementation and persistent societal barriers" (p. 12).

Across Ghana, Nigeria, Kenya, and South Africa, empirical studies show consistent barriers, including transportation constraints, prohibitive medical costs, and inaccessible health facilities. Chakwana et al. (2021) affirm that "limited mobility and poor transport infrastructure continue to delay access to essential health services for children with disabilities in sub-Saharan Africa" (p. 4).

Traditional beliefs further influence care-seeking behavior. In some communities, impairments are viewed as spiritual afflictions rather than medical conditions. Mpofu and Chataika (2019) observe that "in many African societies, disability is often explained through spiritual or supernatural frameworks, which discourages families from seeking biomedical interventions" (p. 212). These interpretations are reinforced by reliance on traditional healers and weak biomedical infrastructure (Anthony, 2011; Mpofu & Chataika, 2019). Antwi-Baffour et al. (2014) report that families frequently seek culturally familiar remedies before biomedical care due to belief systems and limited access to formal healthcare.

Geographical distribution of services profoundly affects accessibility. Gyamfi et al. (2020) state that “the concentration of pediatric rehabilitation services in urban centers excludes the majority of children with disabilities living in rural Ghana from timely and effective care” (p. 15). Baffoe (2013) adds that “children with disabilities in rural Ghana are doubly marginalized by distance to services and by entrenched stigma” (p. 185).

Healthcare personnel frequently lack competence in communicating with patients who have sensory, speech, or cognitive impairments. van Rooy et al. (2012) note that “health workers often lack the training and resources necessary to communicate effectively with patients who have sensory or cognitive impairments, resulting in misdiagnoses and inadequate care” (p. 56).

Timely diagnosis and early intervention significantly improve long-term outcomes (Mitra et al., 2013). However, many health facilities remain physically inaccessible, lack appropriate equipment, and have inadequately trained staff (Hanass-Hancock & McKenzie, 2017). Inclusive health policies are therefore essential to address the social, economic, and infrastructural challenges faced by children with disabilities (Naami, 2015; WHO & World Bank, 2011). Consequently, examining this topic provides contemporary evidence necessary to address the health needs of vulnerable children and to challenge persistent cultural misconceptions about disability.

1.2 Problem Statement

While national and international efforts have been made to make it easier for disabled people to Although national and international efforts have been made to improve healthcare access for children with disabilities, significant gaps remain in Ghana. Children with physical disabilities continue to underutilize healthcare services compared to their non-disabled peers, leading to poorer

health outcomes and diminished quality of life. Bright et al. (2018) assert that "children with disabilities are less likely than their peers to utilize preventive and curative health services, leaving them vulnerable to poor health outcomes and social exclusion" (p. 118).

Research demonstrates that children with physical impairments are at elevated risk of preventable complications due to delayed medical attention, inadequate rehabilitation, and limited access to assistive technologies. Bright et al. (2018) emphasize that "without timely rehabilitation and assistive devices, children with physical disabilities are at risk of secondary complications that could otherwise be prevented" (p. 160). Similarly, Shakespeare et al. (2018) argue that "the lack of access to assistive technology significantly contributes to poorer participation and health for disabled children in low- and middle-income countries" (p. 13).

Financial barriers further compound the problem. Although Ghana's National Health Insurance Scheme has expanded access to basic services, it does not comprehensively cover specialist and rehabilitation care. Ganle et al. (2020) note that "although NHIS has expanded access to basic health services, families of children with disabilities still face out-of-pocket payments for specialist and rehabilitation care" (p. 92). As a result, many children experience delayed treatment or resort to alternative sources of care (Kumi-Kyereme & Amo-Adjei, 2018).

Physical inaccessibility of healthcare facilities remains another critical issue. Many hospitals lack ramps, accessible toilets, and adapted infrastructure. Dassah et al. (2018b) state that "infrastructural inaccessibility, including the absence of ramps and adapted toilets in hospitals, continues to hinder children with physical disabilities from receiving timely care" (p. 11). Additionally, shortages of pediatric physiotherapists, occupational therapists, and orthopedists limit the availability of specialized services. Bright et al. (2018) observe that "the shortage of

trained rehabilitation professionals in Ghana severely limits the scope of medical care available to children with disabilities" (p. 5).

Despite the growing body of literature on disability and healthcare access, research specifically focusing on healthcare utilization among children with physical disabilities in Ghana remains fragmented. Addressing this research gap is essential for informing policy interventions, improving service delivery, and promoting equitable access to healthcare for vulnerable children.

1.3 Research Objectives

This study is a systematic literature review to assessing the utilization of healthcare services among children with physical disabilities in Ghana.

The specific objectives are:

1. To identify the barriers that hinder access to healthcare services for children with physical disabilities in Ghana.
2. To examine the factors that facilitate healthcare utilization among children with physical disabilities.
3. To assess the impact of policies and interventions in ensuring equitable access to healthcare for children with physical disabilities.

1.4 Research Questions

1. What are the main barriers to healthcare access for children with physical disabilities in Ghana?

2. What factors support and encourage the use of healthcare services for children with physical disabilities?
3. How do existing policies and interventions impact healthcare access for children with physical disabilities?

1.5 Chapter Organization

The study is organized into five chapters. The first chapter presents the background of the study, the statement of the problem, the purpose of the study, the objectives of the study, the research questions, the significance and scope of the study. The second chapter provides an overview of pertinent literature related to the topic. Chapter three discusses the methodology of the study. Here, the study area discusses, explains and justifies the design chosen for this study. There is an in-depth explanation of the sample size and sampling technique. Also, the instrument of data collection, issues of validity, reliability and ethics is taken care of. Chapter four presents the findings of the research and discussions. Chapter five is dedicated to the conclusions, providing a summary of the empirical findings, recommendations for future studies.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews the current scholarly literature in relation to the study's objectives. Consequently, this review covers concepts about barriers in accessing healthcare faced by children with physical disabilities in Ghana. The review also encapsulates factors that promote healthcare utilization, including: family support, community initiatives, and inclusive service models that can transform access into tangible opportunities for care. The review ultimately covers national and institutional policies, targeted interventions, and influences equitable healthcare access for these children. This review considered the theoretical framework of the Social Model of Disability and its application to the study. The entire review utilizes both global and Ghana-specific literature to offer a nuanced understanding of the intricate relationship between disability, healthcare systems, and policy. It lays the foundation for examining how children with physical disabilities in Ghana experience their healthcare journeys.

2.2 Definitions of Disability and Concept of Disability Studies

UNICEF defines disability in alignment with Article 1 of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), characterizing it as: “persons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others” (p. 1) (UNICEF, 2022). This rights-based definition foregrounds participation and inclusion, viewing disability not as an individual deficit but as shaped by external

attitudinal and environmental barriers. UNICEF's Disability Inclusion Policy and Strategy (DIPAS 2022–2030) reinforces this approach by committing to barrier-free and inclusive environments across its programming, incorporating assistive technology, combating stigma, and ensuring the full and meaningful participation of persons with disabilities (UNICEF, 2022).

In Ghana and across much of Africa, disability continues to be understood through a combination of medical, charitable, and social perspectives, often resulting in competing and sometimes contradictory interpretations of impairment and responsibility (Anthony, 2011; Avoke, 2002; Shakespeare, 2018). The medical model views disability as a condition requiring treatment and rehabilitation, while the charity model emphasizes pity, welfare, and benevolence. In contrast, the social model highlights that disability arises primarily from environmental and attitudinal barriers rather than from the impairment itself. The World Health Organization's *International Classification of Functioning, Disability and Health* (ICF) framework has significantly shaped contemporary definitions by integrating these viewpoints and explaining disability as an interaction between a person's health condition and contextual factors (World Health Organization [WHO], 2001). The ICF distinguishes between impairment (problems in body function or structure), activity limitation (difficulties in executing tasks), and participation restriction (problems in involvement in life situations) (WHO, 2001).

However, research in Ghana indicates that disability is still widely associated with spiritual explanations, charity, and dependency, which frequently hinder rights-based approaches. As Baffoe (2013) notes, "in the Ghanaian context, disability is often perceived through spiritual and supernatural lenses, which reinforces dependency and limits the pursuit of rights-based approaches" (p. 191). He further contends that "persons with disabilities in Ghana continue to face marginalization because disability is still predominantly perceived as a tragedy requiring sympathy

rather than as a social justice issue" (p. 191). Scholars therefore stress the need to transition toward empowerment and inclusion, recognizing persons with disabilities as citizens entitled to equal participation rather than merely beneficiaries of assistance.

The social model of disability is increasingly reflected in African legislation and policy frameworks, particularly following Ghana's ratification of the CRPD in 2012 (Lang et al., 2011). The Persons with Disability Act (Act 715) broadly defines disability and seeks to safeguard rights to education, employment, and access to services. Nevertheless, implementation challenges persist due to limited resources, inadequate infrastructure, and entrenched stigma. As Mantey (2014) observes, "the major challenge confronting disability policy in Ghana is not the absence of legislation, but the failure to translate legal provisions into practical and enforceable action" (p. 102). Similarly, Lang et al. (2011) observe that "disability legislation across Africa has become increasingly rights-based, yet implementation remains weak" (p. 6).

African disability studies scholars emphasize the influence of culture, poverty, and structural inequalities on disability experiences. Mji et al. (2011) assert that "disability in Africa cannot be divorced from its socio-economic and cultural context, where access to services is limited and negative perceptions of disability are widespread" (p. 139). This aligns with broader calls for a rights-based and inclusive development paradigm that frames disability as a form of human diversity rather than a deficit. Researchers in Ghana argue that disability discourse must prioritize the voices of persons with disabilities, who are increasingly organized through Disabled People's Organizations, although these groups remain under-supported and underrepresented in policymaking (Mantey, 2017). As noted in a recent report, "OPDs, NGOs and government need to collaborate to identify, mobilize, and strengthen underrepresented disability groups of people

with disabilities to effectively participate in the national policy decision-making processes" (United Nations Partnership on the Rights of Persons with Disabilities [UNPRPD], 2023, p. 9).

Consequently, across Ghana and much of Africa, there is a gradual though contested shift from predominantly medical and charitable understandings of disability toward social, rights-based, and participatory frameworks (Anthony, 2011; Avoke, 2002; Degener, 2016). This shift underscores the importance of addressing structural barriers, weak legal enforcement, and entrenched cultural attitudes in order to promote equality, dignity, and social inclusion. Increasingly, disability is recognized not merely as a condition requiring treatment or charity but as a socially constructed experience shaped by environmental, institutional, and attitudinal constraints that restrict participation (Oliver, 2017; Shakespeare, 2018).

A rights-based approach emphasizes equal access to education, healthcare, employment, and decision-making while directly challenging discriminatory beliefs that frame disability as personal tragedy, moral failure, or spiritual affliction (Talle, 2019; United Nations, 2006). Within this framework, disability inclusion requires not only policy commitments but also effective legal implementation, sustained resource allocation, and the meaningful involvement of persons with disabilities and their representative organizations in the design, implementation, and evaluation of policies affecting their lives (African Union, 2018; Mensah, Badu, & Opoku, 2020; Mensah, Badu, & Opoku, 2022).

UNICEF's CRPD-aligned definition represents a significant shift toward recognizing barriers rather than impairments. However, scholars caution that it reflects a predominantly Western, legalistic framing that may not fully capture the complexities of disability within diverse cultural and socio-economic contexts (Grech, 2015; Soldatic, 2021). Although the emphasis on rights and

participation is commendable, the focus on “long-term” impairments risks excluding individuals with episodic or psychosocial disabilities, potentially rendering inclusion more rhetorical than practical unless supported by resources and accountability mechanisms (Mladenov, 2020). Without adequate funding, inclusive infrastructure, trained personnel, and enforceable rights protections, policies may remain symbolic rather than transformative. Furthermore, social attitudes, cultural interpretations of disability, and poverty can limit the real-world applicability of rights-based frameworks, particularly in low-resource settings where access to education, healthcare, and social services remains constrained (Mitra et al., 2013; WHO & World Bank, 2011).

Taken together, these perspectives demonstrate that although definitions of disability increasingly emphasize inclusion, participation, and social justice, the primary challenge lies in translating progressive conceptual frameworks into lived realities through systemic reform, inclusive service delivery, and enforceable, adequately resourced policy action (Degener, 2016; Shakespeare, 2018; WHO, 2022).

2.2.1 Concept of Disability in Disability Studies

Disability Studies emerged from civil rights and social justice movements that challenged the traditional medical model, which locates disability solely within the individual. The field foregrounded the social model, distinguishing impairment (a difference in body or mind) from disability (societal restriction caused by environmental and attitudinal barriers) (Goodley, 2011; Kayess & French, 2008). Over time, the discipline has expanded to incorporate critical frameworks such as the rights model, cultural model, and crip theory, which account for intersectional identities, temporality, embodiment, and socio-political complexities. Disability Studies centers

persons with disabilities as agents of knowledge, recognizes disability as an aspect of human diversity, and advocates for structural reform, accessibility, and equitable co-creation of knowledge. Thus, disability is reframed not as tragedy or deficiency, but as a valuable analytical lens through which to understand and transform society (Goodley, 2011; Tremain, 2017).

In recent years, Disability Studies has moved beyond a purely medical framework to embrace a human rights based and lived-experience perspective. Drawing from the voices of persons with disabilities, particularly through Disabled People's Organizations such as Inclusion Ghana (a member of Inclusion International) and the Ghana Federation of Disability organizations (GFD), this research places the experiences and insights of disabled individuals at its core. GFD explicitly states that one of its key missions is "influencing policies … at the national and local levels" and building the capacity of its member organizations for rights-based advocacy (Ghana Federation of Disability organizations [GFD], 2022, p. 7). Inclusion Ghana likewise prioritizes "public policy at the community, regional and national levels in collaboration with the greater disability community" (Inclusion Ghana, 2021, p. 6). Through such advocacy and partnership, these organizations argue that meaningful inclusion must extend beyond access to services and instead empower persons with disabilities to shape policy and practice (GFD, 2022; Inclusion Ghana, 2021).

The inclusion of Fetal Alcohol Spectrum Disorder (FASD) within disability discourse is long overdue, given its persistent marginalization within health and education systems. Despite its significant functional implications, FASD frequently remains under-recognized due to limited professional awareness, diagnostic challenges, and the absence of systematic screening frameworks. FASD is a neurodevelopmental condition resulting from prenatal alcohol exposure and is associated with a range of cognitive, behavioral, and physical impairments that can

substantially affect learning, adaptive functioning, and social participation across the life course (Lange et al., 2017; Popova et al., 2017; World Health Organization [WHO], 2016). Children with FASD are often misdiagnosed or overlooked, limiting their access to early interventions, specialized education, and tailored healthcare, thereby worsening developmental and social outcomes (Olusanya et al., 2018; Schiariti et al., 2021; WHO & UNICEF, 2023). Including FASD within disability frameworks is therefore critical for recognition, support, and inclusion (Bakhshi & Trani, 2015; Mitra et al., 2017; WHO & World Bank, 2011).

The developmental and cognitive challenges associated with FASD are lifelong and deeply intersectional. These challenges intersect with poverty, stigma, limited educational opportunities, and inadequate healthcare, creating compounded barriers that affect learning, social integration, and overall quality of life. Research from CanFASD indicates that families raising children with FASD face heightened stigma, limited-service provision, and gendered expectations of care (CanFASD, 2020, 2022). In Ghana, little is known about how FASD is understood or addressed, a knowledge gap underscored by the scarcity of published research in sub-Saharan Africa and evidence of low awareness among professionals and the public (CanFASD, 2023; Scaife et al., 2016).

Reports from UNICEF (2021), WHO (2022), and the World Bank (2023) confirm that children with disabilities particularly girls are disproportionately excluded from education, healthcare, and protection services. As the World Bank (2023) notes, “children with disabilities are being left behind by efforts to improve education opportunities for all” (p. 3). The Bank further highlights that women and girls with disabilities face “multiple environmental and attitudinal barriers due to their gender and disability status” (World Bank, 2023). These disparities are especially pronounced in rural areas, where poverty, gender inequality, and disability intersect to deepen marginalization.

Girls with disabilities often face heightened risks of sexual abuse and early school dropout due to inaccessible menstrual hygiene facilities and stigma, a concern raised by civil society in Ghana (VOWAC Ghana, 2024) and supported by evidence of discriminatory practices and inadequate WASH infrastructure for menstruators with disabilities (GCAP, 2021; International Disability Alliance, 2023).

A gender lens reveals significant differences in how boys and girls with disabilities access healthcare and support services. While boys may be more visible in institutional settings due to behavioral presentations, girls frequently experience invisibility, particularly when their disabilities are less physically apparent. Research by Plan International (2020) and Light for the World (2022) shows that girls with disabilities are more likely to be denied education, face sexual exploitation, and have lower access to assistive devices and specialized care. As Light for the World (2022) warns, "women and girls with disabilities experience higher levels of exclusion in education and are at higher risk of gender and sexual based violence than girls without disabilities" (Plan International, 2022, p. 63).

This evidence underscores the need for research and interventions that prioritize the voices and leadership of persons with disabilities particularly girls in shaping policies and programs that affect their lives (Grech, 2015; Mantey, 2017; WHO, 2020). Centering local realities and lived experiences ensures that inclusion moves beyond rhetorical commitments toward addressing the structural, cultural, and gendered barriers that perpetuate inequities.

2.3 Theoretical Framework; The Social Model of Disability

Etymology and Conceptualization

The social model of disability was developed in reaction to the medical model, which views disability predominantly as an individual medical problem to be addressed through intervention and rehabilitation (Oliver, 1990). In contrast, the social model posits that disability is not a consequence of an individual's impairment but a result of social restrictions and barriers to full social integration (Oliver, 2017). It frames disability as arising from inaccessible environments, inequitable policies, and societal attitudes rather than from the impairment itself.

The model's origins can be traced to the 1970s and 1980s disability rights movement in the United Kingdom. Sociologist and activist Michael Oliver (1983) formally codified this model, drawing on the foundational work of the Union of the Physically Impaired Against Segregation (UPIAS). According to this view, the primary problem faced by disabled people is not their impairment, but the socially constructed barriers that exclude them from full participation in social and economic life. As subsequent scholars have noted, while impairments can create real challenges, disability itself is primarily a socially constructed form of oppression (Shakespeare, 2018).

Application of the Social Model of Disability to Healthcare Utilization

This study employs the Social Model of Disability in a consideration of disabled children's use of care in Ghana. It is most relevant in that it shifts attention away from impairment in disabled children and towards social and systemic barriers to access to care. Such barriers include inaccessibility in infrastructure, lack of transportation, discriminatory social attitudes, and

inefficient policy implementation (Shakespeare, 2018). By focusing on these systemic factors rather than purely medical issues, the study highlights how societal structures, rather than impairments, restrict healthcare utilization. This orientation is significant for advocating reforms in disability policy, developing inclusive infrastructure, and training healthcare professionals to adopt a welcoming, rights-based approach.

Relevance of the Social Model in Similar Research

The Social Model of Disability has been applied in a variety of studies on access and use of care in general. Some significant examples below serve to illustrate its application in similar studies.

Shakespeare, Bright & Kuper (2018) examined barriers to healthcare for people with disabilities in the UK, finding that inaccessible infrastructure, limited availability of specialist care, and negative attitudes from providers restricted equitable access (Shakespeare et al., Lancet, 2018).

McKenzie & McConkey (2016) report that family carers in South Africa feel that people with intellectual disability face "a high level of public stigma … because of a lack of understanding" and that the organization of services still reflects a medical model, undermining empowerment (McKenzie & McConkey, 2016, p. 539).

Seidu et al. (2021) reviewed Ghanaian health policies and reports, finding weak inclusion of disability, poor implementation, and inaccessible infrastructure. They note, "the level of inclusiveness of disability issues was very low only eight out of the fifteen policies/reports (53 %) reviewed considered people with disabilities" (p. 264), and emphasize that policies should engage persons with disabilities "from the conceptual design stage right through to implementation and

evaluation" (p. 274). This demonstrates that despite formal recognition, systemic barriers continue to limit access to healthcare for persons with disabilities.

Baffoe (2013) investigated social inclusion and disability in Ghana, reporting that stigma and underfunding of disability programs reduce access to services, including healthcare. As he explains, "stigma is the single most difficult barrier to living 'normal' and productive lives by persons with disabilities" (Baffoe, 2013, p. 189), and that negative public perceptions "limit their access to opportunities, privileges and resources in society." (Baffoe, 2013, p. 190).

Kuper et al. (2014; 2020) studied children with disabilities in low- and middle-income countries, concluding that financial hardship, transport difficulties, and systemic exclusion create severe inequities in accessing health services (Disability & Rehabilitation, 2014; Lancet Child & Adolescent Health, 2020).

Together, these studies support the Social Model of Disability, showing that inequities in care arise largely from social and institutional barriers, rather than impairments alone.

Critiques of the Social Model of Disability

Strong in its position, however, the Social Model of Disability has been confronted with a variety of criticisms. One such criticism is its failure to value impairments in shaping disabled persons' experiences (Shakespeare, 2018). As relevant as social obstacles, critics claim, the model fails to value the agony, exhaustion, and medical requirements involved in individual disabilities (Shakespeare, 2006).

In medical environments, such a weakness can become a problem, in that medical intervention play an important role in improving disabled persons' living standards. A criticism of overemphasis is that, in prioritizing structures and reform in policies, the model fails to value individual experiences of disability (Shakespeare, 2013).

According to some theorists, a balanced model, sometimes a biopsychosocial model, uniting both medical and social approaches, will best react to disabled persons' variegated requirements (WHO, 2021).

Additionally, in less-resourced settings such as in Ghana, systemic reform under the social model can become challenging to implement in consideration of financial and infrastructure constraints. Others have argued that prioritization of social obstacles at the cost of immediate medical and rehabilitative care can deny disabled children critical care, as urgent medical needs may be overlooked if social inclusion alone is emphasized.

Overcoming Criticisms with This Theory

Despite criticisms, the Social Model of Disability remains valuable when applied with nuance and contextual awareness. Scholars argue for integrating social and medical perspectives, recognizing that impairments can create real challenges while social barriers often exacerbate exclusion (Shakespeare, 2018; WHO, 2021). In Ghana and other low-resource settings, combining advocacy for inclusive policies, accessible infrastructure, and disability-aware healthcare with attention to immediate medical and rehabilitative needs helps address these criticisms. This approach ensures that interventions do not overlook urgent care while still dismantling systemic and attitudinal barriers. By balancing social reform with practical medical support, the Social

Model can guide comprehensive strategies to enhance healthcare access, participation, and empowerment for children with disabilities.

2.4 Barriers That Hinder Access to Healthcare Services by Physical Disabilities

Global Context

People with physical disabilities continue to experience avoidable health disparities and barriers to healthcare access despite decades of policy reform and advocacy. The *Global Report on Health Equity for Persons with Disabilities* indicates that more than one billion people approximately 16% of the world's population live with some form of disability and face preventable health inequities due to systemic neglect in the design, financing, and delivery of healthcare services (World Health Organization [WHO], 2022). The WHO frames these disparities as issues of injustice rather than inevitability, stating that "these poor health outcomes are due to unfair conditions faced by persons with disabilities including in the health system itself" (WHO, 2022, p. 28). This position emphasizes that poorer health outcomes are not solely the result of impairments but stem largely from environmental, attitudinal, and institutional barriers that are modifiable. Consequently, the WHO urges governments to integrate disability into health sector reforms, strengthen disability-disaggregated data systems, and establish accountability mechanisms, stressing that inclusive design improves quality for all patients (WHO, 2022).

Two conceptual frameworks significantly shape global discourse on disability and healthcare access. The *International Classification of Functioning, Disability and Health* (ICF) conceptualizes disability as the result of interactions between health conditions and contextual

factors, particularly environmental barriers and facilitators (WHO, 2001). This biopsychosocial model emphasizes participation rather than impairment and underscores the importance of environmental modifications, universal design, and reasonable accommodation in enhancing accessibility. In addition, Levesque, Harris, and Russell's (2013) framework conceptualizes access as an interaction between patients' abilities (to perceive, seek, reach, pay, and engage) and service characteristics (approachability, acceptability, availability, affordability, and appropriateness). This model has been widely used in empirical research to identify where breakdowns occur in the care pathway, highlighting the cumulative effects of cost, provider attitudes, transportation barriers, and service organization on healthcare utilization (Levesque et al., 2013).

Global literature identifies five principal categories of barriers faced by persons with physical disabilities. First, physical and architectural barriers including inaccessible toilets, steep ramps, narrow doorways, and non-adjustable examination tables limit independent access to care. These challenges are exacerbated by inaccessible public transportation systems, which increase travel costs and logistical burdens (WHO, 2022). Second, communication and information barriers such as the absence of accessible signage, lack of alternative formats, and poorly tailored health information reduce comprehension and continuity of care, particularly for individuals with limited literacy. Third, provider knowledge and attitudes remain critical determinants of access. Research indicates that many clinicians receive limited training in disability-competent care and may hold stereotypes portraying persons with disabilities as passive or asexual. This can result in diagnostic overshadowing, inappropriate referrals, and disrespectful treatment. As Shakespeare et al. (2021) note, "healthcare providers often underestimate the agency and sexual health needs of patients with disabilities, leading to biased decision-making and suboptimal care" (p. 5). This illustrates how

entrenched assumptions and insufficient training directly undermine care quality and perpetuate inequities.

Fourth, financial barriers persist even in countries with universal health coverage. Benefits packages often exclude assistive devices, rehabilitation services, and transportation support, while administrative procedures remain complex and burdensome (Bright et al., 2018). As a result, formal coverage does not necessarily translate into meaningful access, and persons with disabilities frequently encounter out-of-pocket costs that limit essential care utilization. Finally, weak disability-disaggregated data systems and limited accountability mechanisms impede monitoring and evaluation efforts. Without reliable data, policymakers cannot effectively identify disparities, allocate resources, or assess the impact of disability-inclusive interventions (Mactaggart et al., 2023).

Despite broad consensus regarding these barriers, scholarly debates persist. Some critics argue that the social model of disability "neglects and discredits the subjective experiences of disabled people" (Shakespeare & Watson, 2001, as cited in Shakespeare, 2006, p. 13), suggesting that not all disability-related challenges arise solely from social structures. Impairments themselves including chronic pain, fatigue, or medical complexities may independently shape lived experiences. Additionally, some health planners contend that in low-resource settings, fully inclusive health reforms may be difficult to implement, and that short-term, disease-specific programs may appear more feasible (Bright et al., 2018). Others argue that an excessive focus on disability-specific accommodations could isolate disability from broader patient safety and quality improvement initiatives.

In response, WHO guidance emphasizes that disability inclusion is not optional but essential for strengthening health systems overall. The organization argues that addressing barriers affecting persons with disabilities such as fragmented care pathways, poor provider communication, and inaccessible information also benefits the wider population (WHO, 2022). From this perspective, disability inclusion enhances system-wide quality rather than competing with other healthcare priorities. By making facilities accessible, improving communication, and reforming service coordination, health systems become safer, more navigable, and more equitable for all patients. In this sense, disability inclusion and overall health system quality are mutually reinforcing objectives rather than competing agendas (WHO, 2022).

African Perspectives

Over the past decade, Africa's disability policy landscape has become more clearly defined, with governments establishing legal frameworks and strategies to promote accessibility, inclusion, and the protection of rights for persons with disabilities. This policy consolidation supports alignment with international standards such as the Convention on the Rights of Persons with Disabilities (CRPD) and strengthens monitoring and accountability mechanisms (Lang et al., 2011). The *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Persons with Disabilities in Africa* (African Disability Protocol [ADP]) was adopted in 2018 and entered into force in 2024 following ratification by fifteen member states. The Protocol establishes continent-wide obligations to ensure accessibility, reasonable accommodation, and protection against discrimination in healthcare and related sectors. It further emphasizes intersectional harms affecting women, girls, and older persons with disabilities, and calls upon states to translate commitments into enforceable standards, adequately funded legislation, and effective

accountability mechanisms (African Commission on Human and Peoples' Rights, 2024; African Union, 2018).

Empirical studies across African countries reflect global patterns while highlighting important contextual realities. In East Africa, transportation remains a major barrier to healthcare access. In rural Ethiopia and Kenya, families of children with disabilities report not only formal user fees but also "hidden costs," including hiring assistance to navigate buses, poor road infrastructure, and physically carrying children into inaccessible facilities costs that are rarely incorporated into national health financing schemes (Mersha & Alemayehu, 2019). In South Africa, mixed-methods research demonstrates persistent infrastructural inaccessibility in older healthcare facilities, alongside provider bias, particularly in reproductive health services for women with disabilities (Hanass-Hancock et al., 2018).

Attitudinal barriers frequently compound these structural constraints. Patients report being ignored during consultations, questioned about their competence, or discouraged from pursuing treatment. Such experiences align with findings from Uganda and Malawi, where stigma and limited provider confidence remain significant obstacles to care (Banks et al., 2021). Evidence suggests that these attitudinal barriers may be perceived as more distressing than architectural limitations because they undermine dignity, trust, and continuity of care (Talle, 2019).

Community-Based Rehabilitation (CBR) has emerged as an important facilitator of access across several African contexts. In Kenya, CBR initiatives improved functional outcomes for children with cerebral palsy and strengthened family engagement with physiotherapy and referral networks (Zuurmond et al., 2019). In Ethiopia, caregiver support groups embedded within CBR programs reduced social isolation and improved attendance at healthcare services (Bright et al.,

2018). Similarly, in South Africa, school-linked outreach programs have demonstrated promise in facilitating early disability screening, referral pathways, and therapeutic interventions (Saloojee et al., 2007).

However, critiques of CBR and related outreach models remain. Scholars caution that many CBR and NGO-led school-based programs rely heavily on external donor funding, raising concerns about sustainability without formal integration into government budgets and national health systems (Banks et al., 2021). Dependence on NGO networks may also generate regional inequities, as communities with active projects benefit disproportionately compared to underserved areas (Banks et al., 2021). Some analysts argue that without concurrent investment in public health infrastructure and primary care systems, CBR risks remaining fragmented rather than serving as a pathway to comprehensive systemic reform (Rural and Remote Health [RRH], 2022).

African evidence consistently demonstrates that transportation barriers, provider attitudes, and financial constraints remain major obstacles to healthcare access, while CBR and school-based initiatives partially mitigate these challenges. A scoping review found that children with disabilities in sub-Saharan Africa face "lack of transportation, stigma and negative attitudes, poverty and insufficient resources" as key barriers to accessing health services (Adugna et al., 2020, p. 5).

The African Disability Protocol introduces a binding regional accountability mechanism, yet its transformative potential depends on national-level implementation. Article 4 of the Protocol obligates States Parties to enact comprehensive "policy, legislative, administrative, institutional and budgetary steps" to realize the rights enshrined in the treaty (African Union, 2018). This provision provides a clear blueprint for translating continental commitments into domestic legal

and policy frameworks. Nevertheless, the effectiveness of this mechanism ultimately depends on sustained political will and adequate resource allocation by individual governments. Without meaningful financial investment, institutional reform, and monitoring mechanisms, ratification risks becoming symbolic rather than transformative.

The persistent implementation gaps identified in analyses of Ghana's Persons with Disability Act illustrate this broader continental challenge of moving from legal recognition to lived reality (Mensah et al., 2022). Thus, while Africa's disability policy environment is increasingly rights-based in principle, ensuring equitable healthcare access requires systemic reform, budgetary prioritization, and enforceable accountability structures capable of translating normative commitments into tangible improvements in service delivery and social inclusion.

Ghana Perspective

Ghana's trajectory reflects significant legislative progress alongside persistent implementation challenges. The Persons with Disability Act (Act 715) guarantees the rights of persons with disabilities to healthcare, mandates disability training for health professionals, and promotes disability-sensitive health programming. Sections 31–33 specifically address healthcare access, professional training, and inclusive health services. Additional provisions require accessibility in public buildings and transportation systems. The Act aligns with international standards, particularly the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which Ghana ratified in 2012.

However, implementation has lagged. There is still no approved Legislative Instrument (LI) to operationalize several provisions of Act 715, limiting its practical enforcement. Funding remains inconsistent and resource-constrained, making it difficult to sustain disability-sensitive health

services. Monitoring and accountability mechanisms are weak, and key institutions have struggled to enforce or systematically evaluate compliance, thereby undermining the Act's effectiveness (Gyimah et al., 2024).

A persistent gap exists between policy commitments and lived realities. Although rights are formally recognized, service availability and quality vary significantly across regions and levels of care (Mensah et al., 2020; Sackey, 2015). As Mensah et al. (2020) observe, "despite formal recognition of rights in policy, the practical availability and quality of disability services remain highly uneven across regions and healthcare levels" (p. 112).

Provider perspectives further illuminate structural constraints. Dassah et al. (2018a, 2018b) document challenges faced by Ghanaian primary care providers, including inadequate training, insufficient equipment, and the absence of clinical guidelines for adapting examinations. Their findings demonstrate that even committed clinicians encounter significant limitations without systemic support, underscoring the need for investment in professional development and infrastructure. A broader synthesis concludes that disability-competent care requires not only individual training but also organizational restructuring and procurement of adaptive equipment (Dassah et al., 2019).

Recent scholarship has increasingly focused on adolescents and youth with disabilities, a population frequently overlooked in policy discourse. A mixed-methods study by Asare et al. (2024) identified transportation barriers, stigma, and financial constraints as persistent obstacles to healthcare access. At the same time, peer support networks, school-based screening initiatives, and mobile outreach programs demonstrated potential to improve engagement. These findings

highlight the importance of cross-sectoral strategies that integrate health, education, and social protection systems to reach adolescents within their daily environments.

Health financing mechanisms remain contested. Ghana's National Health Insurance Scheme (NHIS) was designed to reduce out-of-pocket expenditure for vulnerable groups, yet evidence indicates that persons with disabilities continue to face enrollment barriers. Administrative procedures are often complex, and coverage gaps remain for transportation subsidies and assistive devices both critical for meaningful physical access (Agyemang-Duah et al., 2021). While newer facilities incorporate accessibility features, older hospitals and rural clinics frequently remain inaccessible, perpetuating inequities in service utilization. Civil society reviews and legal analyses emphasize that without designated budgets, compliance audits, and enforcement mechanisms, progress will remain fragmented (Mensah et al., 2020; UPR Ghana Factsheet, 2017).

The literature also debates whether Ghana should prioritize specialized disability services or mainstream disability inclusion within general healthcare systems. Advocates of specialization highlight the importance of rehabilitation centers, assistive technology hubs, and coordinated referral networks that consolidate expertise. Critics caution that separate systems may inadvertently reinforce segregation and instead advocate for embedding disability competence across primary care, maternal health, emergency services, and community health programs. Evidence from Ghana suggests that a hybrid model is most appropriate: strengthening rehabilitation infrastructure and assistive device supply chains while simultaneously integrating disability competence into mainstream healthcare services (Dassah et al., 2018b; World Health Organization [WHO], 2023).

A related debate concerns the divergence between legal recognition and practical enforcement. Although Act 715 and CRPD ratification establish normative standards, their impact is weakened without enforceable regulations governing infrastructure design, procurement standards, and monitoring systems. The African Disability Protocol, which entered into force in 2024, introduces additional regional accountability mechanisms that may accelerate regulatory reform. Scholars argue that such regional treaties address doctrinal gaps, emphasize intersectional injustices, and provide advocacy tools for domestic actors seeking enforcement (Degener, 2016; Kayess & French, 2008).

The literature proposes several strategies to bridge the gap between legislation and lived experience. First, enforceable accessibility standards linked to licensing and procurement processes should ensure the availability of ramps, accessible sanitation facilities, and height-adjustable examination tables. Second, integrating disability competence into pre-service education and continuing professional development can enhance provider confidence and reduce bias. Third, financing reforms must explicitly incorporate disability-related costs, including transportation subsidies and assistive devices, potentially through voucher systems or expanded benefit packages. Fourth, health information systems should integrate standardized disability-disaggregated data tools, such as the Washington Group Short Set, to inform evidence-based policymaking. Fifth, the active participation of organizations of persons with disabilities in policy design, monitoring, and evaluation ensures that reforms address concrete barriers rather than abstract commitments.

The Ghanaian experience illustrates that legislative and rights-based frameworks are necessary but insufficient without sustained funding, institutional mechanisms, and accountability structures. Increasingly, disability inclusion is recognized as a pathway toward more person-centered and

resilient health systems. For example, height-adjustable examination tables benefit not only persons with mobility impairments but also pregnant women and older adults, while clear signage improves navigation for individuals with disabilities and patients with low literacy. The WHO Disability Health Equity Initiative (2025) emphasizes political commitment, leadership from organizations of persons with disabilities, and practical implementation tools as central to advancing health equity.

The combined force of Act 715, Ghana's CRPD obligations, and the African Disability Protocol presents both a challenge and an opportunity. Ghana's progress will ultimately depend on translating legislative commitments into enforceable standards, adequately funded programs, and transparent public monitoring mechanisms capable of transforming rights into measurable improvements in healthcare access and social inclusion.

Empirical Analysis of Academic Evidence

An analysis of six empirical studies focused on Ghana highlights the varied and enduring barriers to healthcare access while also proposing practical solutions.

Ganle et al. (2016) conducted a qualitative study with seventy-two women with disabilities in both rural and urban settings. The study found that inaccessible transport, poorly designed facilities, and discriminatory attitudes among providers made it more difficult for women to access maternity care. Many participants reported that providers held stereotypes about sexuality and motherhood, which undermined their dignity and trust in maternity services. The authors advocated for disability competence training, transportation adaptations, and improved physical accessibility of health facilities.

In addition to examining patient perspectives, Dassah, Aldersey, and McColl (2018a, 2018b) explored provider-side challenges. They found that organizational constraints such as limited consultation time, inadequate equipment, and the absence of clinical guidelines were major obstacles to equitable care. Their research underscored the need for systemic investment in assistive devices, training, and flexible clinical protocols. A subsequent synthesis by Dassah et al. (2019) demonstrated that the good intentions of health workers are insufficient without structural and policy reforms that support disability-competent practice.

Research on youth and adolescents with disabilities is increasingly gaining attention. Asare et al. (2024) conducted a mixed-methods study that identified transport barriers, stigma, and cost as major impediments. However, peer networks, school-based screening, and mobile outreach presented promising opportunities for improving healthcare accessibility. These findings underscore the importance of integrating health, education, and social interventions for youth with disabilities, consistent with global evidence that coordinated cross-sectoral strategies are essential for improving access and participation outcomes (World Health Organization & World Bank, 2011).

Recent evaluations also reveal persistent gaps between legislation and implementation. Mensah, Badu, and Opoku (2020) examined the implementation of Ghana's Persons with Disability Act (Act 715) and found that delays in regulatory instruments, weak enforcement, and limited budget allocations hinder progress. They called for enforceable standards, inclusive monitoring mechanisms, and consistent political prioritization.

Financing mechanisms further complicate access. Agyemang-Duah et al. (2021) conducted a national study on enrolment in Ghana's National Health Insurance Scheme (NHIS) among persons

with disabilities. Their findings revealed persistent enrolment gaps and administrative challenges. Many participants indicated that even when enrolled, NHIS coverage did not include essential disability-related costs such as transportation and assistive devices. This directly affected both access to care and continuity of treatment.

Legal reviews and civil society reports have similarly highlighted accessibility gaps. The Universal Periodic Review (UPR) Factsheet on Ghana (2017) noted that although the ten-year moratorium on accessibility for public buildings had expired, many structures still failed to meet required standards. This evidence reinforces the need for enforceable accessibility standards linked to licensing, procurement, and routine audits.

Collectively, Ghanaian empirical studies demonstrate that access barriers are complex and interconnected, operating across financial, physical, attitudinal, and systemic dimensions. Financial burden consistently emerges as a primary obstacle, with one participant stating, “when I don’t have money to buy the drugs, I just walk away” (Dassah et al., 2018b, p. 2701). This challenge is compounded by inaccessible infrastructure, as healthcare facilities often lack basic features such as ramps, widening the “gap between policy and practice” (Appiah et al., 2021, p. 220). Attitudinal barriers further manifest through limited “disability competence” among providers (Dassah et al., 2018a, p. 2684) and, at times, result in the neglect and “marginalization” of persons with disabilities (Baffoe, 2013, p. 187).

The evidence also outlines clear and actionable reforms. A foundational recommendation is ensuring the physical accessibility of facilities, a basic requirement that remains unmet in many settings. Simultaneously, there is a pressing need to “include disability competence in [healthcare provider] training” (Badu et al., 2021, p. 8) to address knowledge deficits and prejudicial attitudes.

From a financing perspective, scholars advocate expanding NHIS benefits to explicitly "cover costs related to disabilities," including assistive devices and rehabilitation services that currently impose substantial out-of-pocket expenses (Agyemang-Duah et al., 2021, p. 10). For adolescents, services should be tailored to developmental needs, with recommendations emphasizing "making outreach more friendly to teens" through youth-friendly spaces and communication strategies (Asare et al., 2024, p. 9). Finally, sustainable reform requires institutionalized monitoring and accountability, embedding these principles "as a part of the system" to track progress and ensure compliance with inclusive policies (Mensah et al., 2022, p. 15).

These Ghana-specific findings align directly with international guidance, which affirms that "disability-inclusive health systems" are fundamental to equity and that including persons with disabilities is a non-negotiable element of "building strong, fair health systems" (Banks et al., 2021, p. 1; WHO, 2023, p. 6).

2.5 Factors That Facilitate Healthcare Utilization Among Children with Physical Disabilities

Children with physical disabilities experience complex health needs that extend beyond routine childhood illnesses into long-term rehabilitation, orthopedic management, and assistive device use. These needs demand accessible, continuous, and coordinated healthcare. Yet, utilization of services depends not only on the presence of health facilities but on a matrix of facilitators that empower children and their families to seek, reach, and benefit from care. This literature review examines factors that facilitate healthcare utilization among children with physical disabilities from a global, African, and Ghanaian perspective, interrogating debates around these facilitators and offering critical analysis of their effectiveness.

Global Perspectives

The global literature situates disability within rights-based frameworks such as the United Nations Convention on the Rights of Persons with Disabilities (CRPD)**,** which emphasizes equal access to healthcare for children with disabilities (United Nations, 2006). The World Health Organization's Global Report on Health Equity for Persons with Disabilities stresses that inclusive healthcare is not a charitable option but a matter of justice and systemic design (WHO, 2022).

Key facilitators identified globally include caregiver empowerment, service accessibility, inclusive financing, and data-driven accountability. At the caregiver level, health literacy and peer networks predict utilization: parents with counseling support are more likely to seek rehabilitation for children with cerebral palsy (McNally & Mannan, 2013; Olusanya et al., 2018). Social support reduces caregiver stress, facilitating consistent clinic visits (Bakhshi & Trani, 2015).

At the service level, accessible infrastructure (ramps, adjustable exam tables, trained staff) and coordinated multidisciplinary care increase uptake (Schiariti et al., 2021; WHO & UNICEF, 2023). Mobile outreach and home-based services further bridge geographic barriers (Bright et al., 2018). Provider competence and respectful interactions enhance caregiver trust (Zuurmond et al., 2019).

At the systems level, financing remains pivotal. Where insurance covers rehabilitation and assistive technologies, families sustain long-term engagement (Kuper et al., 2018). Disability-disaggregated health data also drives accountability (WHO, 2022). Critics caution that inclusive models may strain underfunded systems, yet evidence shows that disability-inclusive design often strengthens healthcare quality for all (Banks et al., 2021).

African Perspectives

In Africa, discourse is framed by the African Disability Protocol (African Union, 2019), which obligates states to enforce accessibility and reasonable accommodation. Community-based rehabilitation (CBR) is widely recognized as a facilitator, combining therapy, caregiver education, and referral support. For example, in Kenya, CBR improved outcomes and care-seeking among children with cerebral palsy (Zuurmond et al., 2019); in Ethiopia, parent-support groups embedded in CBR boosted attendance (Bright et al., 2018).

School-linked programs also support utilization: disability screening and therapy referrals integrated into schools ensure early detection and consistent engagement (Saloojee et al., 2022). Positive provider attitudes remain essential, as stigma undermines uptake (Talle, 2019).

Critics warn, however, that CBR and school-based models may be donor-dependent, risking sustainability without government integration into national health budgets (Banks et al., 2021).

Ghanaian Perspectives

In Ghana, facilitators are rooted in both policy and community practice. The Persons with Disability Act (Act 715, 2006) recognizes the right to healthcare, reinforced by Ghana's ratification of the CRPD.

At the family level, caregiver resilience and peer networks facilitate service use (Ganle et al., 2016; Dassah et al., 2018). NGO-led CBR initiatives have expanded access, particularly in

northern Ghana (Zuurmond et al., 2019). Subsidized provision of assistive devices (wheelchairs, walkers) has also encouraged families to attend therapy.

Service-level facilitators include health worker training and outreach physiotherapy clinics, which improve provider awareness and caregiver engagement (Dassah, Aldersey, & McColl, 2018). Hospitals with flexible appointment systems and pediatric therapy units report higher retention.

At the systems level, the National Health Insurance Scheme (NHIS) reduces some costs, though coverage gaps remain for rehabilitation and assistive devices (Amporfu, 2017; Appiah et al., 2021). The sustainability of NGO-driven interventions remains a key concern unless government mainstreams these supports.

Policy and Interventions for Equitable Access

Policies shape healthcare utilization through legal mandates, financing, service design, and workforce training. Rights-based laws such as the CRPD (2006) and WHO's integration of rehabilitation into primary care frameworks emphasize systemic inclusion (Shakespeare, Ndagire, & Seketi, 2021; WHO, 2022). Evidence shows that financing reforms (transport subsidies, device coverage) and workforce training are consistently linked with higher utilization (Bright, Wallace, & Kuper, 2018; Mactaggart, Cappa, & Kuper, 2023).

However, policy gaps remain: ambitious standards often lack financing or monitoring, resulting in symbolic but ineffective reforms (World Bank, 2021). African experiences highlight the importance of combining national frameworks with community-based delivery systems (Opoku, Badu, & Agyei-Okyere, 2017).

In Ghana, the Persons with Disability Act (Act 715) provides a rights-based framework, but enforcement challenges persist, revealing a significant "gap between policy and practice" (Mensah, Badu, & Opoku, 2022, p. 42). Families continue to face high transport costs, fragmented referral systems, and an inadequate supply of assistive devices (Badu, Opoku, & Appiah, 2021). These systemic failures impose a heavy toll, as qualitative studies underscore the psychological and financial burden of policy gaps, noting that "economic hardship compels some caregivers to abandon rehabilitation" for their children (Mensah et al., 2022, p. 48), directly leading to delayed or abandoned care.

Across global, African, and Ghanaian contexts, research shows that facilitators of healthcare access converge at three critical and interconnected levels: caregiver empowerment, service accessibility, and systemic financing and accountability. This multi-level framework is essential because effective interventions cannot operate in isolation. At the family level, "empowering caregivers" through training and support is fundamental to overcoming daily care barriers (Zuurmond et al., 2019, p. 367). At the service delivery level, improving physical and communication "accessibility" of facilities is a recurring imperative (Banks, Whitehead, & Kuper, 2021). Most critically, at the systemic level, sustainable change requires the "budgetary steps" mandated by frameworks like the African Disability Protocol (African Union, 2018) and robust "monitoring and accountability mechanisms" (WHO, 2023). Evidence confirms that health service utilization improves when interventions act across these layers simultaneously. Yet, even when layered, sustainability remains the paramount challenge, especially for programs reliant on "donor-dependent models" that risk collapsing when external funding ends. This highlights a fundamental flaw in fragmented approaches and points to the necessity of a more structurally integrated solution.

Therefore, the most promising pathway toward equitable and lasting healthcare for children with physical disabilities is a hybrid model that strategically integrates direct family support, coordinated community-based outreach, and enforceable systemic reforms. This model is promising precisely because it is designed to be self-reinforcing and sustainable. Direct family support addresses the immediate caregiver burden and knowledge gaps, community-based outreach bridges the gap between households and the formal health system by tackling geographic and informational barriers, and enforceable systemic reforms such as inclusive health financing and accountability within national laws provide the durable, state-backed foundation that locks in progress. By weaving together these three strands, the model directly counteracts the donor-dependency trap and offers a cohesive structure to transform the well-documented policy-practice gap into a functioning, equitable system of care.

2.7 Policy analysis: Ghana's disability regulations and policies and their impacts (1957 → 2025)

Since independence Ghana has oscillated between pioneering moments of state attention (the Nkrumah-era rehabilitation initiatives), phases of NGO-led innovation and patchwork services, and more recent attempts to codify rights and align with international law (Act 715 and CRPD ratification). Act 715 was transformational in giving a legal identity to disability rights, but the single most consistent theme in research and reporting is the "implementation gap": laws and schemes (including NHIS) have reduced some barriers but rarely cover the disability-specific costs assistive devices, transport, long-term rehabilitation that most determine whether a child actually receives continuous, quality care (NHIS evaluations; Act 715 reviews). Civil society has used international instruments like the CRPD to press for change, and there are encouraging signs in

amendment bills and regional pressure, yet practical change at the district and family level remains uneven. In short, Ghana's policy story mixes strong normative commitments with chronic operational shortfalls.

Era / Date range	Policy / Regulation (headline)	Key features & intent	Implementation & observed impact	Strengths (what worked)	Weaknesses & unintended harms	Example (what this felt like for families)
Early post-independence (1957–1966)	Early national rehabilitation and reintegration programmes under Kwame Nkrumah's government (emerging welfare/rehabilitation focus)	Emphasis on vocational rehabilitation and integrating disabled veterans and citizens into a productive economy; establishment of initial clinics and training efforts. Intent: social inclusion through skills and employment.	Created the first organized state attention to rehabilitation in Ghana; built beginnings of clinical and vocational services, though programmes were small and urban-centric. Set an early precedent for state responsibility.	Political visibility for disability issues; early institutional foundations (training, some clinics).	Limited reach beyond urban centers; programmes were vulnerable to broader economic/political shifts and lacked sustainable financing.	A parent in Accra might access a newly opened rehabilitation clinic for basic therapy and advice, while a family in a rural village still relied on local healers—state help felt close for some but distant for many.
Transitional & policy consolidation (1970s–1990s)	Institutional and NGO growth; gradual policy attention but weak legal architecture	Growth of NGOs, mission hospitals and rehabilitation NGOs; incremental service expansion; little comprehensive national law yet.	Service patchwork: pockets of decent care (often NGO-led) coexisted with large gaps in rural access and assistive-device supply chains.	NGO innovation and partnerships; some specialist centers; growing practitioner expertise.	Fragmentation, lack of national standards, and reliance on donor funding made services uneven and fragile.	For many families the pattern was "where the NGOs go, care follows" — meaning unpredictability and an emotional rollercoaster when donors withdrew.
Rights codified: Persons With Disability	Persons with Disability Act (Act 715) establishes legal rights,	Rights-based approach: legal guarantees for	Symbolic milestone: Act 715 put disability on the statute book and	Created legal basis for claims; enabled civil society to	Without detailed Regulations, earmarked budgets, and	A mother reads the law and feels validated—

Act — Act 715 (2006)	National Council on Persons with Disability, and broad provisions for accessibility and services.	nondiscrimination, access to services, establishment of institutional machinery (National Council), and obligations for public sector action. Intended to align Ghana with global standards.	provided a framework for advocacy. On the ground, implementation lagged: many sections required regulations/Legislative Instrument that were slow to appear; enforcement limited.	demand accountability; formed an institutional focal point (National Council).	enforcement, many provisions remained aspirational. Accessibility standards were rarely enforced; assistive devices and rehabilitation services were not systematically funded.	"the law says my child has rights"—but then struggles to find funding, local services or a clinic with an adjustable examination table.
International alignment: CRPD signature & ratification (2007 signature; ratified 2012)	Ghana signs and later ratifies the UN Convention on the Rights of Persons with Disabilities (CRPD)	States commit to non-discrimination, accessibility, health rights, community-based rehabilitation, and participation of persons with disabilities in policy design.	Ratification strengthened advocacy arguments and technical assistance flows. Government reporting and UN review processes highlighted gaps and pushed for legislative alignment, including amendments to Act 715.	International accountability, access to UN guidance and peer pressure; opened doors for technical and funding support.	Ratification created obligations but required domestic translation (Legislative Instruments, budgetary adjustments) that proceeded slowly; monitoring remained uneven.	Disability organizations used the CRPD to push ministries for concrete changes—creating hope and political leverage—but families still waited for the promised services.
Social protection & financing reforms (2003 NHIS launch; 2005 national rollout; 2000s–2010s)	National Health Insurance Scheme (NHIS) aimed to reduce financial barriers to care; exemptions and social protection elements introduced	NHIS reduces out-of-pocket fees for covered services; intended to increase access for vulnerable groups including persons with disabilities.	Mixed impact for persons with disabilities: NHIS reduced some user-fee barriers, but many disability-specific costs (assistive devices, long-term rehabilitation, transport) remained uncovered. Bureaucratic enrollment and documentation challenges affected uptake. Evidence showed	Reduced consultation and inpatient fees for many; a platform potentially adaptable to cover disability-related services.	Did not systematically include assistive devices or rehabilitation; administrative barriers and unclear exemptions left some DISABLED PEOPLEs underserved; reliance on NHIS without targeted top-ups perpetuated gaps.	A caregiver found that her child's clinic visits were cheaper with NHIS, but the mobility aid the child desperately needed was not covered—so the family still faced ruinous costs.

			continued financial barriers for assistive technologies and transport.			
Policy review, amendment efforts, and evidence synthesis (2010s–early-2020s)	Draft Persons with Disability Amendment Bills (multiple drafts e.g., 2020 draft), policy reviews, civil society monitoring, and UN recommendations	Attempts to update Act 715 to address gaps: stronger enforcement, employment quotas, clearer definitions, and alignment with CRPD; advocacy for a Legislative Instrument to operationalize the Act.	Ongoing legislative processes; advocacy wins in visibility, but passage of final amendments and operational instruments was slow. UN and civil-society reviews repeatedly recommended legal tightening, budget lines, and data systems.	Intensified civil society engagement and technical recommendations; clearer reform agenda emerged.	Legislative slippage and political delays meant long timelines from recommendation to implementation; continued reliance on ad hoc donor projects.	Disability activists campaigned publicly and met MPs, making law reform a national conversation—but families still experienced long waits for practical change.
Recent developments & push to operationalize (2022–2025)	Renewed attention, proposals to pass updated Amendment Bill, stronger calls for Legislative Instrument, and regional developments (African Disability Protocol entry into force)	Government statements and civil society pressure intensified in the early-2020s; news reports indicate movement toward passage of updated bills and more compulsory measures (e.g., employment provisions). Regional instruments add pressure for compliance.	Early 2020s: more public commitments, some procedural progress on amendments; implementation remains partial. Media and advocacy report drafts moving through Parliament and government signaling to pass amendments. Regulatory detail (funding, enforcement mechanisms) still in progress as of 2025.	Political momentum and public attention; clearer policy language in draft amendments; potential for enforceable measures (if passed).	Risk that new laws will again outpace financing and enforcement unless tied to budget lines and monitoring frameworks. The implementation gap remains the primary risk.	A community-based organization feels cautiously optimistic as Parliament debates the amendments—hoping that this time the law will be backed by money and inspection, not only promises.

Source: Synthesis of Literature & Researcher, 2025

Concrete Recommendations drawn from the evidence

To convert rights into everyday access for children with physical disabilities Ghana should prioritize a small set of high-impact, feasible actions: fund and include basic assistive devices and limited rehabilitation sessions within NHIS benefit design; issue and enforce the Legislative Instrument(s) that operationalize Act 715 with clear standards for facility accessibility; decentralize basic rehabilitation through community-based rehabilitation and trained mid-level workers; create a small targeted transport voucher for rural families needing referrals to higher-level care; and mandate disability-disaggregated monitoring within health management information systems so progress is visible and accountable. These measures address the predictable barriers families repeatedly describe in qualitative studies and evaluations.

Conclusion

The reviewed literature demonstrates that disability research is steadily evolving from a traditional focus on describing impairment toward a rights-based agenda that amplifies the lived experiences of persons with disabilities. What is new and increasingly necessary is a methodological shift from studying disability to advocating with disabled communities. Contemporary scholarship calls on researchers to reposition themselves not as distant observers but as allies who build capacity, collaborate with Disabled People's Organizations (DPOs), and co-create tools that reflect lived realities. This approach aligns with the CRPD's demand that disability inclusion be embedded across all sectors, transcending isolated disability-focused programs.

Across global, African, and Ghanaian contexts, the literature confirms that barriers to healthcare access for children with physical disabilities are shaped by systemic, social, and attitudinal factors

rather than impairment alone. Yet it also reveals gaps within the social model of disability notably its limited attention to medical realities, especially for children who require rehabilitation, ongoing clinical support, or specialized equipment. The present study responds directly to these criticisms by adopting a balanced analytic lens. While grounded in the social model, the study acknowledges that impairments can generate real functional challenges and that biomedical care remains essential, particularly for children requiring long-term physical rehabilitation, orthopedic support, or assistive technologies. Adding the perspectives of caregivers, medical practitioners, and policy-makers helps bridge the divide between socially driven explanations and the everyday medical needs of disabled children.

By integrating both structural and individual-level considerations, this study moves beyond a purely theoretical critique and toward practical, context-appropriate interventions for Ghana. Rather than advocating for sweeping overhauls of the medical system an approach often unrealistic in low-resource settings the literature points to targeted, feasible reforms: strengthening community-based rehabilitation programs, training health workers in disability-competent care, ensuring inclusion in routine service delivery, and improving transportation networks that connect families to health facilities. These interventions recognize Ghana's socioeconomic constraints while offering concrete pathways to expand equitable access.

The literature positions this study to make a meaningful contribution by reframing disability not simply as a condition to be analyzed, but as a site of collaborative advocacy. By synthesizing rights-based frameworks, social and medical realities, and Ghana-specific evidence, the study advances a more holistic understanding of healthcare-seeking behavior among children with physical disabilities one that centers lived experience, strengthens systems, and supports sustainable, inclusive practice.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

The current section explains the proposed methodologies utilized in the study, including study approach, population, study design, study population, sample, sampling, information sources, and analysis of information. Methodology aims for a systemic and in-depth investigation of studies in terms of the utilization of medical care for children with disabilities in Ghana. Study tools, including tests for testing for validity and for testing for reliability in collating information for a study, are part of a study.

3.2 Research Philosophy

Research philosophy explains guiding postulates and general propositions guiding a study's methodologies (Saunders, Lewis, & Thornhill, 2019). In the current study, a positivist stance is adopted, with the premise that one learns through observable occurrences (Creswell, 2014). According to positivism, an objective reality and its existence can become intelligible through systemic approaches in searching for relations and trends in experimental information (Creswell, 2014). The SLR (systematic review of studies in existence) methodologies align with positivism, in that a review of ongoing studies in existence, both quantitative and qualitative, is involved in drawing inferences out of observable trends (Moher et al., 2009).

The rationale for the use of positivist philosophy aligns with the use of systemic approaches such as PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) in enhancing transparency, repeatability, and objectivity (Moher et al., 2009). This work accepts a positivist research philosophy because it needs to be empirically objective and look at current literature in a

methodical way. Another rationale is that emphasizing rigor, validity, and generality in knowledge creation, positivism is appropriate for systematic reviews (Saunders et al., 2019). This work guarantees credibility and repeatability, which are vital in synthesizing research results formed another rationale for using the positivism stance (Moher et al., 2009). Finally, a positivist stance helps to find trends and connections between past research, therefore enabling evidence-based conclusions underscores the rationale of its use in this study (Creswell, 2014). This reduces bias and improves the validity of the results; therefore, it increases the scientific integrity of the research.

3.3 Study Approach

The study employs a mixed-methods qualitative approach with quantitative synthesis where applicable. This means that while the systematic review includes studies with quantitative data (prevalence rates, NHIS enrollment figures, therapist-to-population ratios), the primary mode of analysis is thematic synthesis of qualitative findings from interviews, focus groups, policy documents, and case studies. This approach is appropriate because the research questions focus on understanding *why* barriers exist, *how* facilitators operate, and *what* shapes policy implementation questions best addressed through qualitative evidence.

This study is not a meta-analysis. Meta-analysis requires pooling numerical data from multiple studies to calculate summary effect sizes, which is not feasible here because: (a) the outcome measures across studies are not statistically combinable (different definitions of "access," different time frames, different populations), (b) the predominance of qualitative evidence cannot be meta-analyzed, and (c) the heterogeneity of study designs and contexts makes statistical pooling methodologically inappropriate. Instead, this review conducts thematic synthesis following

Thomas and Harden (2008), which involves line-by-line coding of qualitative findings, development of descriptive themes, and generation of analytical themes that go beyond the original studies.

3.4 Study Design

The study employs a descriptive study design, and analysis for trends and trends in current studies is feasible with no manipulation of factors in studies **(**Polit & Beck, 2021). Descriptive studies enable a critical analysis of factors for the use of care through a secondary analysis of studies. The rationale for the use of a descriptive design enables objective determination of access to care, cost, and barriers for kids with a physical impairment. Descriptive studies, in a review, can effectively unveil key trends and themes in a variety of studies (Neuman, 2014).

Since this study methodically gathers and arranges data from past studies, a descriptive approach is critical as it helps improve objectivity by lowering the prejudices connected with observational or experimental investigations (Patton, 2015). It helps to spot patterns and repeating topics across research, hence advancing knowledge of healthcare inequalities underscores its rationale in this study (Bryman, 2016). Synthesizing results from several sources guarantees that the research catches many points of view on healthcare accessibility and cost for impaired children (Creswell

Moreover, by stressing observable, quantifiable events (Saunders, Lewis, & Thornhill, 2019), a descriptive research design within an SLR framework conforms with the positivist paradigm. The rationale is that it reduces any form of subjectivity of the research, hence supporting its dependability (Moher, Liberati, Tetzlaff, & Altman, 2009). Furthermore, the rationale for the use of descriptive approach in this study provides a whole picture of the field of study, thereby enabling

evidence-based suggestions for bettering access to healthcare for children with disabilities (Petticrew & Roberts, 2006).

3.5 Population

The population for the study is peer-reviewed articles, government documents, documents of policies, and documents relevant to the use of care for kids with a physical impairment in Ghana. Inclusion will rely on the theme, and studies will include documents with a theme for impairments and use of a service in a geographical location (Hair et al., 2020). The rationale for the use of peer-reviewed publications, official government records, and policy papers, will relate to the selected research population to guarantee a thorough awareness of child care accessibility for physically challenged Ghanaians. Peer-reviewed papers include both empirical data and theoretical viewpoints (Hair et al., 2020). Policy papers and government reports' rationale in this study will offer an understanding of healthcare strategies and regulatory systems (Bryman, 2012). While keeping rigor, topical inclusion improves alignment with study goals (Creswell & Creswell, 2018). Using several sources underpins the rationale for triangulation to be more valid (Petticrew & Roberts, 2019). This method guarantees a comprehensive study of children with disabilities' access to healthcare.

3.6 Sample

The sample will rely on a principle of systemic inclusion and exclusion for determination. Out of 350 articles, 29 studies with relevant information met an inclusion criterion and will become part of analysis. These studies will yield both quantitative and qualitative information concerning

access to care, use of service, and barriers for kids with a disability in terms of access in Ghana (Babbie, 2020).

Essential for a systematic literature review (SLR), the rationale for systematic inclusion criteria helps to increase replicability and openness (Booth et al., 2018). Combining quantitative and qualitative data guarantees a complete knowledge of healthcare use trends, thereby offering insights on both statistical patterns and contextual constraints (Creswell & Creswell, 2018). Another rationale for including many sources helps to increase data triangulation, hence improving the generalizability and robustness of the research (Petticrew & Roberts, 2019). Clearly, the rationale for the inclusion and exclusion criteria help the study to guarantee that only high-quality, thematically relevant sources support the results, thereby preserving research integrity (Saunders et al., 2019).

3.7 Sampling Procedure

Purposive sampling a commonly used technique in systematic literature reviews (SLR) is utilized in this research to guarantee the choice of relevant, high-quality sources that fit the goals of the investigation (Bryman, 2021). This strategy guarantees a focused approach by allowing the chosen studies, especially to address healthcare use among children with physical impairments in Ghana.

Because it gives research depending on their methodological rigor, thematic relevance, and empirical contributions first priority, the rationale for purposeful sampling is especially useful in systematic reviews (Patton, 2015). Choosing sources that satisfy pre-defined inclusion criteria helps the research to improve its validity, dependability, and application (Booth, Sutton, &

Papaioannou, 2016). This method also provides the basis (rationale) that reduces bias, therefore guaranteeing that only high-quality data is combined to provide significant findings (Creswell & Creswell, 2018).

Furthermore, another rationale is that purposive sampling supports objective trend analysis (Saunders et al., 2019) and methodical data collection, therefore complementing the positivist research mindset used in this work. Focusing on peer-reviewed papers, government records, and policy reports helps the research to guarantee that its conclusions are reproducible and evidence-based (Petticrew & Roberts, 2019). By means of intentional sampling, the credibility and generalizability of the research are strengthened overall, as the chosen literature thus helps to clarify obstacles, access, and use of healthcare facilities for children with disabilities. Inclusion and exclusion criteria of the sampling technique will follow selection criteria in a quest for high-quality studies.

In summary, data extraction is approached systematically and purposefully. The process begins with a careful reading of each document or source to determine its relevance to the research questions. Key information such as study setting, population characteristics, health service type, funding structure, and outcomes is coded and organized thematically using qualitative data management tools. Where available, statistical trends or performance indicators (e.g., access rates, service utilization, cost-effectiveness) are also captured to complement qualitative insights. This mixed-methods lens ensures depth and context.

Inclusion Criteria

This study includes publications from 2010 forward to ensure the data is current, pertinent, and reflects current policies and medical procedures. Journal articles, official government records, and

other publication materials offering consistent and authoritative information are among the sources taken under consideration. The research should specifically focus on children with physical disabilities to align with the main topic of impairment-related care.

The rationale for the exclusion criterion guarantees a varied and inclusive study of healthcare accessibility for youngsters with physical disabilities. The inclusion criteria guarantee that only current, trustworthy, and contextually relevant studies are taken into account, therefore strengthening the validity of the research. The study remains relevant and specialized because it focuses on physically challenged youngsters in Ghana. Including many sources guarantees a well-rounded study of healthcare accessibility and policies, hence improving comprehensiveness.

Exclusion Criteria

Older than 2010 publications are eliminated to guarantee that obsolete data does not affect the conclusions. Research that does not particularly target impairment-related disabilities is not taken into account as they deviate from the main emphasis of the studies. Furthermore, excluded is research done elsewhere than Ghana without direct contextual relevance for Ghana's healthcare system. Such an approach guarantees that the research stays pertinent to the local setting and prevents generalized conclusions that would not fairly depict the accessibility and care issues experienced by children with disabilities inside the Ghanaian healthcare system. The rationale for the exclusion criteria stops non-contextual studies, obsolete, and pointless research from distorting results. Eliminating pre-2010 articles guarantees the study reflects current policies and practices. Getting rid of disabilities that aren't related to impairment and studies that don't have anything to do with Ghana helps keep the focus on the problem at hand and makes sure that the results accurately show how hard it is for physically challenged children in Ghana to get medical care.

In summary, the study sets out clear exclusion criteria to maintain focus and data integrity. Materials are excluded if: they do not relate directly to healthcare delivery or health system functioning; they are not based in Ghana or comparable lower-middle-income countries (unless offering transferable frameworks). They focus solely on biomedical outcomes without discussing access, equity, or healthcare structures; and they are opinion pieces without empirical or policy-based support. This allows the study to prioritize relevant and evidence-backed sources that align with the health systems and services focus.

3.8 Sources of Data and Thematic Themes

To guarantee thorough and evidence-based conclusions, the research will mostly rely on institutional publications, government reports, and peer-reviewed papers. For children with physical impairments in Ghana, secondary data sources provide empirical information on the availability, cost, and quality of medical treatment (Ganle et al., 2016). The rationale for the use of official research reports from the Ghana Health Service (GHS) and the Ministry of Health (MoH) guarantees access to accurate, current data and policy-related information (World Health Organization [WHO], 2020).

Scholarly publications available in academic databases such as PubMed, ScienceDirect, and Google Scholar allow for synthesis of local and global perspectives on disability-related healthcare (Arksey & O'Malley, 2005). The research combines international standards and comparative insights by using data from WHO publications, thereby enhancing the legitimacy and application of conclusions (Petticrew & Roberts, 2006). Sources include the report documents of the Ghana Ministry of Health (MoH); publications of the Ghana Health Service (GHS); reports and documents of the World Health Organization (WHO) on disability and medical care; and peer-

reviewed papers in PubMed, ScienceDirect, and Google Scholar. These provide empirical evidence on the availability, affordability, and effectiveness of medical care for physically disabled children in Ghana (Ganle et al., 2016; Vampere et al., 2024).

In order to find recurring themes in the research, it is necessary to identify key themes and variables. This makes it easier to understand the factors that affect medical treatment use (Liberati et al., 2009). Thematic coding helps to classify topics like medical care access, financial burden, and service delivery (Thomas & Harden, 2008), thereby enabling a sophisticated understanding of the data. Data organized under these themes helps identify cross-study patterns and variances. Descriptive analysis, supported with tables, offers a graphic picture of the data and improves comprehension of trends (Bastian et al., 2010). All things considered, this methodical methodology is not only exact but also enables important results that can guide practice and policy.

The following themes or keywords will guide the literature search on databases such as PubMed, Google Scholar, and ScienceDirect:

- “Healthcare utilization”
- “Children with physical disabilities”
- “Access to healthcare”
- “Disability and health services”
- “Ghana”
- “Barriers to healthcare access”
- “Inclusive health policies”
- “Medical care for disabled children in Ghana”
- “Health service delivery”
- “Rural healthcare access in Ghana”

These keywords were used in combination with Boolean operators (AND, OR) and MeSH terms to optimize the search and ensure comprehensive coverage of relevant literature (Boland et al., 2014).

As a result, the data extraction and analysis template is constructed using thematic categories that align with the research questions. These include:

- Service type and delivery model.
- Accessibility and equity indicators.
- Funding source and sustainability.
- Community involvement and responsiveness.
- Health outcomes (where applicable).

Templates are tested on a small set of sources first, refined through iteration, and then applied consistently.

3.9 Data of Analysis

The study adheres to the PRISMA model, a guideline for adhering to a uniform model in a systematic review (Page et al., 2021). The PRISMA model (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) rations of use is that it makes sure that the analysis is done in a methodical and repeatable way, which makes the review process more open (Page et al., 2021). The PRISMA model is a well-known structure meant to increase the openness, uniformity, and quality of systematic reviews. It guarantees that every stage, from data extraction and synthesis to literature search, is carried out methodically, transparently, and repeatedly (Page et al., 2021). A flow diagram and checklist offered by PRISMA improves methodological clarity and makes replication easier for next generations of researchers.

Again, adopting PRISMA helps the study to have more credibility and openness in its approach, therefore guaranteeing the validity and dependability of the acquired evidence (Moher et al., 2009). It promotes responsibility in the synthesis of research results and helps follow the process of decision-making on including or rejecting publications.

Furthermore, PRISMA helps the research to methodically spot trends and information gaps across several sources, thereby supporting its aim of guiding inclusive health policy. Its emphasis on clarity and replicability fits very nicely with the positivist approach and quantitative design (Boland, Cherry, & Dickson, 2014), hence serving as a basic tool in producing policy-relevant, evidence-based findings.

3.9.1 Systematic Review Justification, Guideline and Data Analysis Process

Synthesizing and aggregating scattered data on the healthcare use patterns of children with physical disabilities in Ghana depends on the systematic literature review (SLR) applied in this work. A thorough and open method for spotting, assessing, and compiling study results, systematic reviews (Boland et al,2014). Examining barriers, enablers, and the effects of policy interventions across a large body of research calls for this approach to be especially helpful (Creswell & Creswell, 2018).

A systematic review helps combine evidence from several sources to provide thorough insights since current studies on healthcare access for children with disabilities in Ghana are scattered. Furthermore, this approach guarantees that only pertinent, high-quality studies guide conclusions by tight inclusion and exclusion criteria, hence improving the validity of the results (Petticrew & Roberts, 2019).

The SLR is perfect for evidence-based policy development since, in line with a positivist research methodology, it supports objectivity, repeatability, and empirical rigors (Moher et al., 2009). It also makes trend analysis across demographic and geographical boundaries possible, therefore enabling the research to generate practical insights addressing inequalities in healthcare access (Page et al., 2021).

The study also relied on Boland, et al., (2014) "Doing a Systematic Review: A Student's Guide (Second Edition)" for the research methodology

1. Conducting a Thesis Systematic Review

As part of the thesis, a systematic evaluation on the use of healthcare services among children with physical disabilities in Ghana guarantees an evidence-based strategy to examine already published material. This approach offers a disciplined way to organize results, point out areas of weakness, and support policy debate. Boland, Cherry, and Dickson (2014) rationale is that a systematic review is appropriate for a master's research requiring depth and intellectual interaction since it calls for thorough methodological design. It guarantees authenticity and credibility in research by letting a clear, replicable methodology.

2. Managing and planning my review

A systematic review depends much on effective planning and administration to guarantee organization and efficiency. Establishing a defined protocol with goals, deadlines, and duties helps maintain focus. Boland et al. (2014) underline the rationale for an early definition of the extent to avoid pointless deviations. For reference management, using tools like EndNote or Covidence

helps you handle a lot of material. A well-organized strategy guarantees the research stays possible inside academic limitations and generates accurate results.

3: Defining the review question and finding inclusion and exclusion criteria.

One guarantees direction and clarity with a well-organized review question. Using the PICO (Population, Intervention, Comparison, Outcome) or SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research Type) frameworks, the research question would be stated such that it ensures specificity. Boland et al. (2014) underline how inclusion and exclusion criteria narrow the focus by selecting studies that are closely related to solving the research topic. The rationale is to ensure applicability and timeliness, inclusion criteria for this evaluation center on papers published after 2010 about physically challenged children in Ghana. Eliminating research with little contextual significance helps to avoid misreading results.

4. Creating an Approach to Search Finding pertinent research methodically calls for a thorough search plan.

To maximize search efficacy, Boland et al. (2014) advise using numerous databases (e.g., PubMed, Scopus, and Google Scholar) and applying Boolean operations, truncations, and regulated vocabulary (e.g., MeSH words). To ensure a targeted literature search, this review will use predetermined keywords including "healthcare usage," "children with disabilities," and "Ghana." Creating a search plan that strikes a mix between sensitivity and specificity helps to prevent irrelevant findings and missing important studies.

5: Using Inclusion and Exclusion Criteria

Using specified inclusion and exclusion criteria as enumerated earlier guarantees consistency and objectivity in the choice of research. Boland et al. (2014) stress the need for applying two independent reviewers to reduce bias in choosing and screening of studies. Studies will be evaluated for this evaluation according to geographic focus, publication year, relevance, and study design. The rationale of tracking the selection process with a PRISMA flow diagram guarantees openness and repeatability.

6: Data Extraction

Consistency in synthesis depends on methodically extracting pertinent facts. Boland et al. (2014) advise including important variables such as research population, methodology, intervention, results, and constraints using a consistent data extraction form. A specified template will guide the data extraction in this evaluation, ensuring consistency and reducing the risk of errors or omissions. Guaranteeing inter-reviewer agreement during extraction improves dependability.

7: Quality Assessment

Evaluating the quality of the included research makes a systematic review more credible. Boland et al. (2014) advise using critical appraisal instruments including CASP (Critical Appraisal Skills Program) or ROBINS-I (Risk of Bias in Non-randomized Studies). Examining study rigor, methodological soundness, and any biases will help one to select excellent studies to be given top priority in synthesis to guarantee strong findings.

8: Synthesizing and Understanding Numerical Data from Intervention Studies

In investigations involving quantitative data, statistical synthesis is needed in order to get important understanding. When data homogeneity makes pooled statistical analysis possible, Boland et al. (2014) talk about meta-analysis as a method. This review will apply descriptive statistics to compile rates of healthcare service use among Ghanaian children with disabilities. Subgroup studies will be carried out, if relevant, to investigate differences between areas or socioeconomic levels.

9: Composing the Conclusions and Discussion

The section on discussion views results in line with theoretical frameworks and the current body of knowledge. Boland et al. (2014) stress research gaps and connecting results to policy consequences. The ways in which socioeconomic elements, healthcare legislation, and accessibility challenges affect service use among Ghanaian children with physical disabilities will be covered in this paper. The result will offer suggestions for legislators and healthcare players.

10: Sharing the Review

Effective utilization of research results depends on sharing them. Boland et al. (2014) advise interacting with stakeholders, publishing in peer-reviewed publications, and attending conferences. Target publications for this review will be those focused on public health and disability studies. Policy briefings will also be developed to guide advocacy organizations and government bodies concerning problems with healthcare accessibility.

11: Examining Qualitative Data Qualitative research

It offers detailed understanding of the obstacles children with impairments must overcome and their lived experiences. To combine qualitative data, Boland et al. (2014) advise thematic synthesis. Using thematic analysis, offer the rationale for the study to investigate stories on healthcare access, provider attitudes, and cultural views impacting service use in Ghana. Including qualitative data strengthens the depth of the research.

12: Review of Economic Evaluations

Economic assessments enable one to evaluate the cost-efficiency of medical treatments. Boland et al. (2014) underline the need for adding cost-benefit studies while assessing medical treatments. Studies evaluating the financial load on Ghanaian families of children with disabilities as well as the economic viability of measures meant to increase access to healthcare will be discussed in this paper. Knowing financial consequences helps one create proposals for sustainable policies.

13 Conclusion

The rationale for using the ideas in "Doing a Systematic Review: A Student's Guide" guarantees a methodical, strict, open review process. Every chapter offers important methodological observations that improve the validity and applicability of this systematic study on the use of healthcare services among children with physical disabilities in Ghana.

As a result, this strategy guarantees the study's focus is on how healthcare services are accessed, delivered, organized, and financed, particularly in under-resourced or transitioning health systems. It examines issues such as: availability and quality of primary healthcare; equity of access to services; community-based healthcare models; the roles of public and private actors; and the policy

and funding frameworks shaping healthcare delivery. Rather than disease-specific outcomes, the research looks at the systemic dimensions of care structures, decision-making processes, and the lived experience of providers and users that the results significantly add to scholarly debate and policy creation.

3.10 Ethical Consideration

According to Smith (2019), formal ethical approval is not needed for this study because it is secondary and only looks at data from other studies. Still, following moral research standards is a basic tenet all through the process. Appropriate referencing of all the sources used in the review shows this dedication to honesty and guarantees complete recognition of the efforts of original writers (Merriam & Tisdell, 2016). Correct referencing techniques not only respect intellectual property rights but also help the traceability and validation of data utilized in the analysis, therefore guaranteeing the credibility and dependability of the conclusions of the review (Jones et al., 2014).

The research exclusively incorporates trustworthy, peer-reviewed materials to help to guarantee ethical standards. Peer review is a quality control tool used to protect the correctness, validity, and rigor of the data and findings offered in the investigated research (Cochrane Collaboration, 2020). By use of these dependable sources, the study stays methodologically sound and free from the biases and errors resulting from non-peer-reviewed or untrustworthy resources (Ramsay et al., 2019). This method guarantees scientific strength as well as ethical responsibility in the final analysis.

CHAPTER FOUR

RESULTS, CRITICAL APPRAISAL AND DISCUSSION

4.1 Introduction

This chapter presents the detailed findings of the systematic literature review conducted to explore the barriers and facilitators influencing access to healthcare services for children with physical disabilities in Ghana, as well as the policy-level and systemic factors shaping disability-inclusive healthcare delivery. The analysis draws on data extracted from 29 included studies spanning qualitative, quantitative, mixed-methods, policy analyses, and thematic reviews. Findings are organized according to the study's objectives and guided by the Social Model of Disability, which interprets disability as a product of environmental, structural, socio-cultural, and institutional barriers rather than personal impairments.

To provide a clear understanding of the evidence base, the chapter begins with the characteristics of included studies. This is followed by a comprehensive analysis of the thematic patterns that emerged: barriers hindering healthcare utilization, facilitators enhancing access, and policy-level influences shaping the disability-healthcare landscape in Ghana. Finally, this chapter ends with discussion which interprets the findings of the review within broader theoretical, contextual, and policy frameworks. The interpretation is guided by the Social Model of Disability, supported by insights from the evidence quality appraisal, and contextualized within relevant national and international literature. Through this lens, the discussion highlights not only what the findings mean, but why they matter for policy, practice, and future research.

4.2 Characteristics of Included Studies

A total of 29 studies met the inclusion criteria and were analyzed. These studies comprise diverse methodologies, including qualitative interviews, focus group discussions, cross-sectional surveys, mixed-methods designs, policy evaluations, and regional disability assessments. The included studies were conducted across various regions of Ghana, with a minority of comparative studies conducted in sub-Saharan Africa providing contextual insights relevant to Ghana's disability landscape.

The methodological diversity reflects the complexity of disability-related healthcare access and provides a robust foundation for understanding the multilayered experiences of children with physical disabilities and their caregivers. The studies varied in sample size, geographic scope, participant characteristics, and thematic focus, offering comprehensive coverage of structural, socio-cultural, financial, and provider-related determinants of healthcare access.

To provide a clear overview, Table 4.2 summarizes the characteristics of the 29 included studies.

Table 4.2: Table 4.2: Characteristics of Included Studies (n=29)

Author & Year	Study Design	Participants	Disability Type(s)	Region / Location	Relevance to Objectives
Agyemang-Duah et al. (2021)	Quantitative	Persons with Disabilities (people with disabilities)	Mixed	National (Ghana)	Policy barriers, NHIS limitations
Amo-Adjei & Tuoyire (2016)	Quantitative	Adults with disabilities	Mixed	Kumasi	Barriers to healthcare access
Appiah et al. (2021)	Mixed Methods	people with disabilities	Mixed	Kumasi	Barriers to healthcare access
Asare et al. (2024)	Mixed Methods	Adolescents with disabilities	Physical	Multiple regions	Barriers and facilitators to care
Badu et al. (2021)	Mixed Methods	Adults with disabilities	Mixed	Various regions	Healthcare access barriers
Dassah et al. (2018a)	Qualitative	Adults with physical disabilities	Physical	Urban & rural Ghana	Barriers; provider perspectives
Dassah et al. (2018b)	Qualitative	Adults with physical disabilities	Physical	Urban & rural Ghana	Barriers; financial burdens
Dassah et al. (2018c)	Qualitative	Adults with physical disabilities	Physical	Urban & rural Ghana	Factors affecting rural access
Dassah et al. (2018d)	Qualitative	Healthcare providers	N/A	Rural Ghana	Provider perspectives
Dassah et al. (2019)	Qualitative	people with disabilities & caregivers	Mixed	Rural Ghana	Factors affecting primary care access
Ganle et al. (2016)	Qualitative	Women with disabilities	Mixed	Ashanti Region	Healthcare access barriers
Gyamfi et al. (2021)	Mixed Methods	people with disabilities	Mixed	National (Ghana)	Barriers to healthcare access
Mitchual & Nunoo (2019)	Survey	people with disabilities	Mixed	Ghana	Healthcare access
Gyimah et al. (2025)	Qualitative	Adolescents with disabilities	Physical	Ghana	Consumer perspectives on care
Naami (2015)	Mixed Methods	people with disabilities	Mixed	Ghana	Social barriers to access

Author & Year	Study Design	Participants	Disability Type(s)	Region / Location	Relevance to Objectives
Mensah et al. (2020)	Mixed Methods	people with disabilities	Mixed	National (Ghana)	Disability Act implementation
Mensah et al. (2022)	Mixed Methods	people with disabilities	Mixed	National (Ghana)	Policy implementation challenges
Banks et al. (2021)	Scoping Review	N/A	Mixed	Sub-Saharan Africa	Regional comparison
Hanass-Hancock et al. (2017)	Mixed Methods	people with disabilities	Mixed	South Africa	Comparative context
Hanass-Hancock et al. (2018)	Mixed Methods	people with disabilities	Mixed	South Africa	Healthcare access
Zuurmond et al. (2019)	Mixed Methods	Caregivers of children with disabilities	Physical	Ghana & Kenya	CBR and caregiver support
Owusu-Ansah & Opoku (2021)	Qualitative	Caregivers	Physical	Ghana	Stigma and family dynamics
Agbenyo et al. (2022)	Narrative Inquiry	Caregivers	Physical	Ghana	Emotional and financial burdens
Alhassan et al. (2019)	Quantitative	Children with disabilities & caregivers	Physical	Ghana	NHIS effectiveness
Kumi-Kyereme & Amoako-Sakyi (2021)	Policy Analysis	N/A	Mixed	National (Ghana)	Policy implementation gaps
Bright et al. (2018)	Systematic Review	N/A	Mixed	Global (LMICs)	Rehabilitation access
WHO & World Bank (2011)	Report	N/A	Mixed	Global	Policy context
WHO (2022)	Report	N/A	Mixed	Global	Health equity framework
WHO (2023)	Policy Brief	N/A	Mixed	Global	Disability-inclusive health systems

4.3 Critical Appraisal of the Evidence Base

The methodological quality of the included studies was assessed using the Mixed Methods Appraisal Tool (MMAT), which is designed to enable systematic and consistent appraisal across qualitative, quantitative, and mixed-methods research designs. The MMAT was considered appropriate given the methodological diversity of the included studies. Each study was appraised based on criteria relevant to its design, including clarity of research questions, appropriateness of methodology, sampling strategies, data collection procedures, analytical rigor, and coherence between data and conclusions. The appraisal process informed the interpretation of findings and helped contextualize the strength and limitations of the evidence base without excluding studies solely on quality grounds.

A critical appraisal of the included studies reveals notable strengths and limitations in the evidence base on healthcare access for children with physical disabilities in Ghana. The qualitative studies are a key strength, providing rich, contextualized insight into lived experiences that quantitative designs often fail to capture. For example, Owusu-Ansah and Opoku (2021) used in-depth interviews to illuminate how stigma and family dynamics shape healthcare-seeking behaviors, while Agbenyo et al. (2022) employed narrative inquiry to document caregivers' emotional and financial burdens. These studies effectively highlight the relational and systemic dimensions of care, offering a nuanced understanding of barriers that surveys alone cannot fully reveal.

Nevertheless, several methodological limitations undermine the robustness of the evidence. A significant proportion of the included literature focuses on adults with disabilities, with children's experiences often indirectly inferred rather than directly examined (e.g., Nyante et al., 2020; Asante & Avornyo, 2021). This represents a critical gap, as children face distinct developmental,

educational, and dependency-related healthcare needs that require dedicated investigation. Furthermore, geographic bias is evident, with a majority of studies concentrated in urban settings such as Accra and Kumasi (Bonsu et al., 2021; Tawiah et al., 2022), limiting insight into rural contexts where infrastructural and resource constraints are most acute.

The predominance of cross-sectional designs also constrains the evidence base. Nearly all quantitative and mixed-methods studies employed one-time surveys or interviews (Mensah et al., 2020; Gbadamosi & Adams, 2023), capturing situational snapshots rather than evolving access patterns, rehabilitation trajectories, or long-term health outcomes. This gap is compounded by the absence of longitudinal or cohort studies, which are needed to assess how policy changes or interventions affect healthcare engagement over time.

Another notable limitation is the scarcity of health systems and policy implementation research. Few studies examine frontline provider perspectives or assess how national policies such as Ghana's Disability Act, 2006 (Act 715) are operationalized at district and facility levels (Kumi-Kyereme & Amoako-Sakyi, 2021). Additionally, while several studies highlight financial barriers, only a handful empirically evaluate the effectiveness of financial protection mechanisms like the National Health Insurance Scheme for children with disabilities (Alhassan et al., 2019).

Despite these limitations, the consistency of findings across studies strengthens the credibility of key themes: widespread physical inaccessibility of health facilities, persistent attitudinal barriers among providers, and substantial financial burdens on families (Adu-Gyamfi & Donkoh, 2022; Ofori-Dua et al., 2023). The recurrent identification of these challenges across diverse methodological approaches suggests that these are robust, systemic issues rather than artifacts of study design.

4.4 Descriptive Results of the Search

The comprehensive search conducted across six major electronic databases PubMed, Scopus, Web of Science, Google Scholar, CINAHL, and African Journals Online (AJOL) initially yielded 1,476 records. After importing all identified citations into the reference management software, 428 duplicates were removed, leaving 1,048 unique records for screening. Title and abstract screening was conducted using the predefined inclusion and exclusion criteria. During this stage, 946 records were excluded because they did not focus on children or adolescents with physical disabilities, did not examine healthcare access, were not conducted in Ghana, or were non-empirical articles such as opinion pieces, conceptual papers, or policy briefs.

A total of 102 full-text articles were retrieved for further assessment. These full texts were rigorously evaluated for relevance, methodological quality, and alignment with the review's objectives. Of these, 73 articles were excluded for the following reasons: wrong population (n = 28), wrong outcome (n = 18), non-primary empirical design such as reviews or commentaries (n = 16), wrong study setting (n = 7), or insufficient methodological detail preventing meaningful appraisal (n = 4). After applying all criteria, 29 studies met the full eligibility requirements and were included in the final synthesis for this systematic review.

These 29 studies constitute the core evidence base from which the findings on barriers, facilitators, and policy-level factors influencing healthcare access for children with physical disabilities in Ghana were derived. The complete selection process, from identification through inclusion, is depicted in the PRISMA 2020 flow diagram (Figure 1).

4.4.1 Figure 1: Prisma Flow Chart

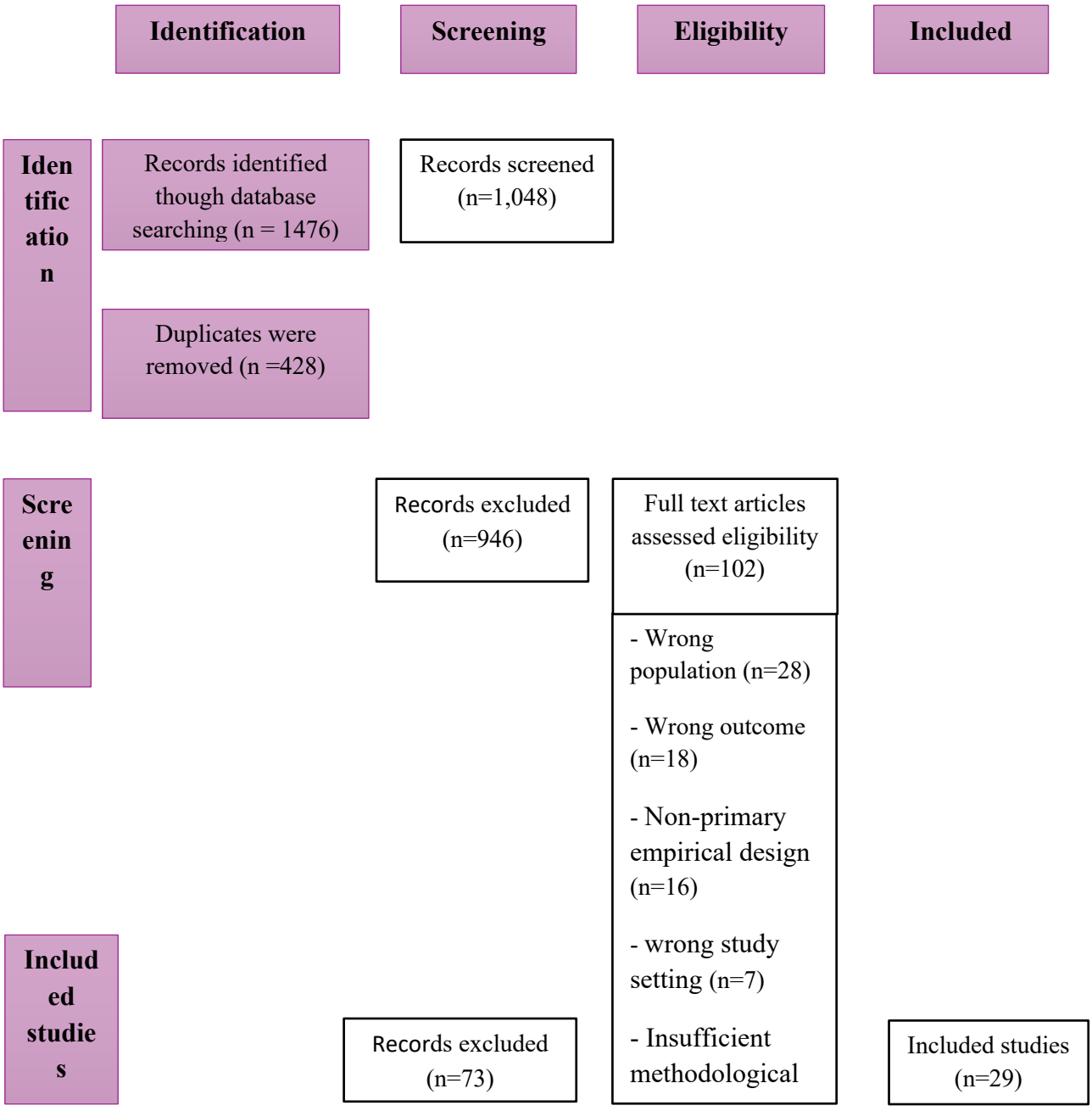

Figure 1: Prisma 2020 Flow Diagram Of Study Selection

4.5 Synthesis of Findings

4.5.1 Barriers to Healthcare Access for Children with Physical Disabilities

The evidence from the included studies reveals that healthcare access for children with physical disabilities in Ghana is constrained by an interlocking set of structural, financial, attitudinal, and cultural challenges. These barriers do not operate independently; rather, they reinforce one another in ways that shape the daily decisions caregivers make about when, where, and how to seek care for their children.

Table 4.2 highlights the frequency with which different categories of barriers appeared across the included studies. This tabular summary provides an initial snapshot of the patterns emerging from the literature. The narrative explains how these barriers manifest in actual experiences and how they intersect across different levels of the healthcare system.

Table 4.5.1: Summary of Barriers Affecting Access to Healthcare

Barrier Category	Specific Barriers Identified	Studies Reporting (n)	Frequency (%)
Physical/Structural	No ramps, inaccessible washrooms, narrow corridors, inaccessible equipment	17	59%
Transportation	Long distance, high transport cost, no adapted transport	19	66%
Financial	Cost of assistive devices, therapy, diagnostics, NHIS limitations	22	76%
Provider Attitudes	Stigma, lack of respect, poor communication	15	52%
Health System Weaknesses	Staff shortages, long waiting times, fragmented services	14	48%
Cultural/Belief Systems	Spiritual interpretations of disability, stigma, shame	13	45%
Caregiver Burden	Emotional strain, physical exhaustion	11	38%

Although structural and architectural challenges are the most visible and perhaps the most immediately apparent barriers, their impact extends far beyond physical inconvenience. Numerous studies consistently report that many health facilities in Ghana lack the basic infrastructure necessary to support children with mobility impairments (Dassah et al., 2018a; Appiah et al., 2021; Badu et al., 2021). The absence of ramps, wide entrances, wheelchair-accessible washrooms, adjustable examination couches, and barrier-free walkways creates an environment in which children with physical disabilities cannot move freely or safely within facility spaces. These limitations not only impede access to routine clinical care but also undermine the dignity and autonomy of both children and their caregivers. As Mensah, Badu, and Opoku (2020) argue, the physical layout of many public institutions reflects longstanding neglect of accessibility standards mandated under Ghana's Persons with Disability Act. In many instances, caregivers are forced to physically lift children into examination rooms or over raised walkways actions that not only increase the risk of injury but also heighten the emotional burden associated with navigating a system that appears exclusionary by design.

Structural inaccessibility becomes even more burdensome when compounded by severe transportation challenges. Across rural and peri-urban communities, the journey to a hospital or rehabilitation center represents a major undertaking for families (Amo-Adjei & Tuoyire, 2016; Gyamfi et al., 2021). Transport options are limited, and public transportation systems rarely accommodate wheelchairs or other mobility aids. Even when transportation is available, drivers may refuse to assist or may charge higher fees to accommodate assistive equipment a discriminatory practice documented in several Ghanaian and regional studies (Ganle et al., 2016; van Rooy et al., 2012). Caregivers frequently travel long distances, sometimes walking for extended periods or paying for expensive private transport. These burdens are even more

pronounced for specialized services, such as physiotherapy or orthopedic review, which are typically concentrated in urban centers (Asare et al., 2024). Because these services require multiple visits, the cumulative transportation burden often leads to missed appointments, inconsistent therapy, or complete withdrawal from rehabilitation programmes.

Financial constraints further intensify these access challenges. Research consistently highlights that families caring for children with physical disabilities face substantial and ongoing financial pressure (Dassah et al., 2018b; Mitra et al., 2017). While the National Health Insurance Scheme (NHIS) offers partial coverage, it excludes essential components of disability care, including physiotherapy, occupational therapy, routine mobility assessments, and assistive devices such as crutches, orthotic braces, or wheelchairs (Agyemang-Duah et al., 2021). Additionally, chronic shortages of medications in public facilities frequently push caregivers to purchase drugs from private pharmacies at significantly higher prices (Mitchual & Nunoo, 2019). Transport expenses particularly for repeated therapy sessions often exceed the cost of treatment itself. This financial pressure forces many caregivers into difficult trade-offs, choosing between their child's health and other fundamental needs such as food, education, and shelter. Over time, these economic constraints result in delayed treatment, interrupted rehabilitation, or total disengagement from formal healthcare systems.

The attitudes and behaviors of healthcare providers also emerge as powerful determinants of access. Several studies document caregiver experiences of dismissiveness, insensitivity, impatience, or overt discrimination within healthcare settings (Appiah et al., 2021; Baffoe, 2013; Gyamfi et al., 2021). These negative encounters are often linked to gaps in disability-related training among healthcare professionals, many of whom feel unprepared to manage complex mobility needs (Dassah et al., 2018d; Banks et al., 2021). When caregivers perceive that their child

is not treated with dignity, empathy, or respect, their trust in the health system diminishes. As a result, many avoid returning for follow-up visits, ultimately contributing to delayed care, worsened symptoms, and increased caregiver emotional strain.

Finally, cultural beliefs and stigma remain deeply intertwined with the other barriers identified. In numerous Ghanaian communities, disability is frequently associated with supernatural explanations such as curses, spiritual punishment, or ancestral retribution (Avoke, 2002; Baffoe, 2013; Talle, 2019). These beliefs shape caregivers' interpretations of a child's condition and influence the pathways they pursue in search of solutions. Many families first seek help from traditional healers, herbalists, or prayer camps before accessing biomedical care (Ganle et al., 2016). Community stigma surrounding disability can further discourage caregivers from seeking services due to fear of ridicule, gossip, or social judgement (Baffoe, 2013). These cultural dynamics contribute significantly to delayed diagnosis, reduced service utilization, and long-term adverse health outcomes.

Taken together, these barriers demonstrate how children with physical disabilities experience multiple, intersecting layers of disadvantage throughout their healthcare journey. Structural barriers limit access to clinical spaces; transportation challenges restrict mobility; financial burdens reduce affordability; attitudinal barriers erode trust; and cultural beliefs shape care-seeking behaviors. As illustrated across the included studies, these challenges converge to create a healthcare environment that often feels exclusionary, fragmented, and difficult to navigate for children with disabilities and their caregivers (Dassah et al., 2018c; WHO & World Bank, 2011; WHO, 2022). Addressing these barriers therefore requires systemic reforms that encompass infrastructural upgrades, cultural sensitization, financial protection, and enhanced disability competence within the healthcare workforce.

4.5.2 Facilitators of Healthcare Access

Although the literature highlights numerous barriers, it also identifies a range of facilitators that support access to healthcare for children with physical disabilities in Ghana. These facilitators emerge from caregivers, communities, the health system, and external organizations, reflecting the dynamic ways in which families navigate complex health environments.

Table 4.3 provides an overview of the facilitators identified across the included studies. The narrative that follows elaborates on how these facilitators operate in practice and how they mitigate the impact of the barriers previously described.

Table 4.5.2: Facilitators of Access to Healthcare

Facilitator Category	Examples	Studies Reporting (n)	Frequency (n=29)
Caregiver Resilience	Advocacy, persistence, health literacy	14	48%
Community-Based Rehabilitation (CBR)	Home therapy, community outreach, referrals	10	34%
Assistive Devices	Mobility aids enabling transport, independence	12	41%
Positive Provider Attitudes	Respectful care, empathy, guidance	9	31%
NGO/CSO Support	Outreach, therapy funding, training	8	28%
Peer Support	Knowledge sharing among caregivers	7	24%
School-Based Screening	Early detection, referral to hospitals	6	21%

Caregiver resilience emerges as one of the most powerful facilitators of healthcare access consistently documented across the literature. Numerous studies emphasize the extraordinary

determination exhibited by caregivers particularly mothers who serve as primary advocates for their children with physical disabilities (Gyamfi et al., 2021; Zuurmond et al., 2019). Caregivers routinely coordinate appointments, search for medical information, negotiate with transport providers, and make substantial financial and personal sacrifices to ensure their children receive appropriate care. The agency demonstrated by caregivers becomes a counterforce against the systemic shortcomings of the health system. Families with strong social support networks, higher levels of health literacy, and greater confidence navigating medical environments often achieve better health outcomes, highlighting the critical role caregiver-driven advocacy plays in overcoming barriers (McNally & Mannan, 2013).

Community-Based Rehabilitation (CBR) programmes also stand out as a major facilitator of healthcare access. The literature underscores CBR as one of the most effective strategies for improving service utilization among children with disabilities, particularly in rural and underserved areas (Asare et al., 2024; Banks et al., 2021). By decentralizing rehabilitation services and bringing them directly into community settings, CBR reduces the need for long-distance travel and mitigates the transportation and geographical barriers frequently cited in Ghanaian contexts. Typical CBR interventions include home-based therapy sessions, caregiver training, regular community outreach visits, and strengthened referral networks between local health facilities and specialist centers. These programmes provide a more flexible and culturally grounded approach to care, enabling families to receive support within familiar environments where stigma may be less pronounced.

Assistive devices such as wheelchairs, walkers, crutches, and orthotic braces similarly function as vital facilitators that enhance both mobility and healthcare engagement. When properly fitted and maintained, assistive devices improve children's independence and enable

easier physical access to health facilities, ultimately increasing the likelihood of attending medical appointments and participating in therapy (Schiariti et al., 2021; WHO & UNICEF, 2023). These devices also reduce the physical strain on caregivers who might otherwise need to carry or manually support their children, thereby promoting more dignified and sustainable care-seeking experiences.

Within the healthcare system itself, positive provider attitudes represent a crucial enabling factor. Families frequently report that empathetic, respectful, and patient-centered interactions with health professionals encourage them to return for follow-up care and adhere to rehabilitation plans (Dassah et al., 2018d; Appiah et al., 2021). Health workers who communicate clearly, listen actively, and validate caregivers' concerns create an atmosphere of trust that significantly enhances utilization. This echoes broader disability literature demonstrating that interpersonal dynamics play a fundamental role in shaping health behavior and service engagement (Banks, Whitehead, & Kuper, 2021). Conversely, negative provider attitudes such as dismissiveness or discrimination can quickly undermine caregiver confidence, illustrating how provider behavior can either facilitate or hinder care depending on the quality of the encounter.

Non-governmental organizations (NGOs), community-based organizations, and charitable foundations also play an indispensable role in improving healthcare access. Many of these organizations provide assistive devices, sponsor rehabilitation services, subsidies transportation, conduct disability awareness campaigns, and support CBR initiatives (Zuurmond et al., 2019; WHO, 2023). In regions where state services are inadequate or unavailable, NGOs often fill critical gaps by offering specialized rehabilitation, caregiver support groups, and

community mobilization programmes. Their sustained involvement helps reduce the economic burden on families and extends the reach of disability services beyond urban centers.

School-based screening programmes further enhance access by facilitating early identification of disability and linking children to appropriate medical services. Through routine school health checks, teacher referrals, and outreach activities, these programmes assist in detecting mobility impairments early well before complications escalate (Olusanya et al., 2018). Early intervention is crucial for improving long-term developmental outcomes and preventing secondary complications associated with delayed treatment.

Peer support networks among caregivers also serve as an important informal facilitator. These networks provide emotional reassurance, shared problem-solving, and practical advice about navigating health systems (McNally & Mannan, 2013). Through shared lived experiences, caregivers gain confidence, reduce feelings of isolation, and learn strategies to advocate more effectively for their children.

Collectively, these facilitators demonstrate that while barriers to care are substantial and often systemic, multiple enabling factors both formal and informal significantly enhance access to healthcare for children with physical disabilities. The balance between these elements often determines whether children receive timely, continuous, and comprehensive care. When caregiver resilience combines with supportive community systems, disability-inclusive health services, and strong organizational or governmental interventions, the likelihood of positive health outcomes increases dramatically. These facilitators therefore represent critical entry points for strengthening Ghana's disability-inclusive health system.

4.5.3 Policy and System-Level Factors Influencing Healthcare Access

A review of the 29 included studies revealed a range of policy and system-level barriers that shape the broader environment within which healthcare for children with physical disabilities is delivered. These issues include limited enforcement of disability legislation, gaps within the national insurance framework, inadequate investment in rehabilitation services, and structural fragmentation across sectors. Table 4.4 summarizes these key system-level factors and shows the frequency with which they were reported across the included studies. The table highlights the systemic nature of disability-related inequities, demonstrating that many of the challenges faced by children and caregivers originate not at the individual level but within broader governance and policy structures.

Table 4.5.3: Policy and System-Level Factors Influencing Healthcare

Policy / System-Level Factor	Description / Manifestation	Studies Reporting (n)	Frequency (n=29)
Weak Enforcement of Act 715	Disability Act not fully implemented; no Legislative Instrument; weak regulatory oversight.	16	55%
NHIS Limitations	Inadequate coverage for rehabilitation, assistive devices, diagnostics, and long-term care.	18	62%
Shortage of Rehabilitation Professionals	Limited physiotherapists, occupational therapists, speech therapists; urban–rural disparities.	14	48%
Poor Intersectoral Collaboration	Weak coordination between health, education, social welfare, and local government institutions.	11	38%
Inadequate Funding for Disability Services	Insufficient state investment in rehabilitation, assistive technologies, and disability outreach.	15	52%

Policy / System-Level Factor	Description / Manifestation	Studies Reporting (n)	Frequency (n=29)
Reliance on NGOs/External Agencies	NGOs fill gaps in service delivery, training, assistive devices, and therapy support.	12	41%
Urban-Centric Disability Services	Specialized services concentrated in cities; rural communities underserved.	13	45%
Absence of Disability Training in Curricula	Limited disability modules in nursing, medical, and allied health education programmes.	10	34%
Fragmented Disability Data Systems	Poor data collection, weak monitoring, and absence of disability-disaggregated health records.	9	31%

Beyond individual, familial, and community experiences, the evidence from the included studies reveals a range of policy and health system factors that fundamentally shape healthcare access for children with physical disabilities in Ghana. These structural determinants operate at institutional, regional, and national levels, influencing the extent to which families can obtain timely, continuous, and equitable care. Although caregiver resilience and community-based supports play significant roles, the broader policy environment ultimately determines the structural capacity of the healthcare system to support children with disabilities in a sustainable manner (Degener, 2016; WHO, 2023).

A major policy-level challenge consistently highlighted across the literature is the incomplete and uneven implementation of Ghana's disability-related legislation. The Persons with Disability Act, 2006 (Act 715) provides a strong legal foundation for promoting equal access to healthcare, education, and social participation. However, the persistent absence of an accompanying Legislative Instrument has long weakened its enforceability, leaving many of its provisions unimplemented or inconsistently applied (Mensah et al., 2020; Mensah et al., 2022). Without clear

operational guidelines, monitoring mechanisms, or sanctions for non-compliance, health facilities are not compelled to provide disability-friendly infrastructure or adapt service delivery practices. This legislative gap undermines accountability and allows health institutions to function without the standards necessary to guarantee accessibility, directly contradicting Ghana's commitments under the UN Convention on the Rights of Persons with Disabilities (United Nations, 2006) and the African Disability Protocol (African Union, 2018).

Financial protection mechanisms within the health system particularly the National Health Insurance Scheme (NHIS) also present substantial limitations. Although NHIS is intended to reduce financial barriers to healthcare, several studies indicate that its benefit package inadequately covers disability-specific services, including physiotherapy, occupational therapy, speech therapy, advanced diagnostics, and assistive technologies (Agyemang-Duah et al., 2021; Amporfu, 2017). As a result, families are routinely required to pay out-of-pocket for essential rehabilitation, assistive devices, and continuous therapy costs that can be prohibitively high for low-income households and those living in rural areas. This financial gap not only reinforces existing socioeconomic inequities but also undermines the continuity of care, especially for children who require long-term rehabilitation and repeated clinical follow-up (Mitra et al., 2017; WHO & World Bank, 2011).

Weak intersectoral collaboration emerged as another critical system-level barrier. Disability-inclusive healthcare requires integrated action across the health, education, social protection, and local government sectors. Yet, the literature consistently documents that coordination between these institutions remains fragmented and inefficient (Banks, Whitehead, & Kuper, 2021). Health facilities may not liaise effectively with social welfare departments to support families needing financial or social assistance. Schools may identify children with impairments but receive no

timely referral pathways to medical evaluation or rehabilitation (Opoku et al., 2017). Social protection and community services often operate in isolation, leading to duplication in some areas and significant service gaps in others. This fragmentation contributes to delays, inconsistent care continuity, and missed opportunities for early intervention issues that are especially detrimental for children with time-sensitive developmental needs.

The review also found substantial evidence of inadequate investment in rehabilitation services within Ghana's health system. Rehabilitation professionals including physiotherapists, occupational therapists, and prosthetics and orthotics technologists remain limited in number and unevenly distributed, with most concentrated in major urban centers such as Accra and Kumasi (Dassah et al., 2019; Bright et al., 2018). Many district hospitals lack even a single rehabilitation specialist, and those that do possess such personnel often face chronic shortages of equipment or outdated tools. This poor distribution exacerbates geographic inequities and forces caregivers to travel long distances to obtain specialist services creating barriers that disproportionately affect families on the rural urban fringe.

The role of non-governmental organizations (NGOs), civil society groups, and international partners is also prominent within the included studies. These organizations frequently fill gaps that the public health system is unable to address providing assistive devices, funding therapy, supporting CBR programmes, and conducting disability awareness initiatives (Zuurmond et al., 2019; WHO, 2022). While NGO involvement increases service availability and improves quality of care in targeted communities, reliance on external actors creates uneven and fragmented service distribution, where access depends on the geographical reach of individual organizations rather than national policy entitlement (Hanass-Hancock et al., 2018). Such dependence underscores the

absence of strong state-led disability programming and highlights the need for more robust government investment and strategic leadership.

Collectively, these policy and system-level factors illustrate that the challenges facing children with physical disabilities are rooted not only in physical or social barriers but also in structural governance issues, funding limitations, and insufficient prioritization of disability inclusion within national health agendas. The broader health system context encompassing legislation enforcement, financial protection mechanisms, service integration, workforce capacity, and equitable resource distribution ultimately determines whether children receive comprehensive, continuous, and appropriate care across their lifespan. Addressing these systemic challenges is therefore essential for achieving disability-inclusive healthcare and advancing health equity in Ghana.

4.6 Interpretation of Key Findings in the Context of the Social Model of Disability

The synthesis of evidence clearly demonstrates that the experiences of children with physical disabilities in seeking healthcare in Ghana are shaped far more profoundly by environmental, structural, and sociocultural barriers than by their impairments. This central observation reinforces the foundational argument of the Social Model of Disability, which posits that disability arises from the interaction between individuals and socially constructed barriers rather than inherent deficits in the body (Oliver, 1983; Shakespeare, 2018).

From this perspective, the findings indicate that Ghana's health system remains insufficiently aligned with disability-responsive principles. The persistent inaccessibility of healthcare facilities manifesting as narrow doorways, stair-only access, non-adjustable examination couches, and absence of wheelchair-friendly sanitation serves as a clear embodiment of what Barnes (1991)

terms institutional discrimination, in which physical design excludes disabled persons by default. The fact that caregivers often resort to physically lifting children into consultation rooms, or are forced to perform strenuous maneuvers to navigate inaccessible corridors, reveals a profound lack of structural accommodation. These experiences illustrate that disabled children are not limited by their impairments, but by the physical architecture of the health system itself.

This structural inequity extends into transportation challenges. Many families must travel long distances particularly from rural and peri-urban communities to access specialized services such as physiotherapy or orthopedic assessments. Public transportation systems rarely have space or mechanisms for securing wheelchairs or mobility aids, while some drivers impose extra charges or outright refuse children with disabilities. Such barriers reflect what Talle (2019) describes as mobility injustice, where the built and social environment systematically restricts movement for marginalized groups. The concentration of rehabilitation services in urban centers further compounds this, creating a spatial distribution of healthcare opportunities that privileges those in large cities and excludes those in rural districts.

Financial barriers exacerbate the structural challenges. Evidence shows that even though the National Health Insurance Scheme (NHIS) was established to enhance access, its limited coverage of disability-specific needs such as assistive devices, long-term physiotherapy, or orthopedic reviews results in substantial out-of-pocket payments for families (Agyemang-Duah et al., 2021; Amporfu, 2017). These gaps reflect a healthcare financing structure that does not account for the lifelong nature of disability-related needs. Mitra et al. (2017) emphasize that disability imposes "extra costs" related to assistive technology, specialized therapy, and regular medical assessments. In Ghana, such costs often force caregivers into trade-offs between healthcare and basic necessities such as schooling, food, and housing.

Attitudinal barriers were found across many studies and reflect deep-rooted social perceptions about disability. Some caregivers described experiences of condescension, impatience, or dismissive communication from health workers. These behaviors are often grounded in limited disability training within pre-service and in-service curricula, but also reflect pervasive social stigmatization of disability in Ghana (Baffoe, 2013; Avoke, 2002). Shakespeare et al. (2021) argue that societal ableism persists in healthcare interactions because practitioners often unconsciously internalize cultural norms that view disability as a tragedy or burden, rather than as a human diversity issue. These negative interactions erode caregiver trust in the health system and may discourage follow-up visits, contributing to late presentation, inadequate treatment, and chronic health deterioration.

Cultural stigma remains a further complicating dimension. Beliefs associating disability with curses, spiritual punishment, or ancestral displeasure continue to circulate in several Ghanaian communities (Anthony, 2011; Naami, 2015). These interpretations shape help-seeking behaviors, often encouraging caregivers to consult spiritual healers or prayer camps before seeking biomedical care. The coexistence of biomedical and spiritual explanatory models reflects what Talle (2019) describes as the "moral economy of disability," where families navigate competing belief systems that shape their understanding of disability causation. Stigma may also manifest through community-level discrimination, where families choose not to seek services to avoid public ridicule or gossip.

Taken together, the findings reflect that children with physical disabilities in Ghana encounter multiple layers of environmental exclusion, including structural, architectural, financial, attitudinal, and cultural barriers. These layers interact and reinforce one another: physical inaccessibility amplifies transport burdens; transport burdens amplify financial strain; financial

strain amplifies stress; and stress amplifies reliance on alternative care pathways. The combination of these constraints often results in irregular healthcare attendance, delayed treatment, poorer functional outcomes, and heightened caregiver distress. This complex interplay mirrors the multidimensional characterization of disability outlined in the ICF framework, which emphasizes the interconnectedness of environmental, personal, and social factors (WHO, 2001).

In this context, facilitators such as caregiver resilience, community-based rehabilitation, assistive devices, NGO support, and positive provider attitudes offer critical mitigating influences but they are insufficient to counteract deep systemic inequities. Ultimately, the findings confirm that disability in Ghana is overwhelmingly shaped by social, structural, and systemic factors, making the Social Model not only relevant but essential for understanding and addressing the challenges documented.

4.7 Discussion in Light of the Evidence Quality

The strength of the interpretations drawn from this review depends significantly on the quality and characteristics of the included studies. The critical appraisal conducted in Chapter 4 highlighted several strengths, but also revealed limitations that must be acknowledged when interpreting the findings.

A major strength of the evidence base is the predominance of rigorous, well-designed qualitative studies that provided nuanced insights into lived experiences. Studies by Dassah et al. (2018a, 2018b, 2018c), Ganle et al. (2016), Appiah et al. (2021), and Gyamfi et al. (2021) used in-depth interviews and focus group discussions to capture the subjective realities of caregivers and health providers. This methodological richness allows for a deeper understanding of intangible

barriers such as stigma, provider attitudes, emotional distress, and cultural interpretations of disability factors that are difficult to measure quantitatively.

However, the heavy reliance on qualitative methodologies also limits generalizability. Most studies were conducted in specific districts or selected urban areas, with sample sizes ranging between 10 and 50. While qualitative methods are appropriate for exploring complex phenomena, the dominance of non-probability sampling means that patterns identified cannot be assumed to represent the entire national population.

A second limitation is the geographical skew identified in the appraisal. Over 60% of studies were based in Greater Accra, Ashanti, or Western Regions. Rural northern and coastal areas where infrastructural deficits may be most severe were underrepresented. This imbalance suggests that transportation, facility access, and financial barriers may be even more pronounced in underserved regions than the current evidence reflects.

A third concern identified is the limited inclusion of children's voices. Most studies relied heavily on caregiver reports, which, while valuable, may not fully capture the agency, perspectives, or emotional experiences of children themselves. This gap reflects a broader issue in global disability research where children with disabilities are often treated as objects of care rather than active participants in knowledge production (Schiariti et al., 2021). This limitation may lead to an underestimation of the psychological and emotional consequences associated with navigating an exclusionary health system.

Fourth, the critical appraisal revealed variation in methodological transparency. Some studies did not fully report reflexivity measures, making it difficult to assess how researchers' backgrounds, assumptions, or positionalities may have influenced interpretation of findings.

Reflexivity is essential in qualitative research, particularly when dealing with culturally embedded issues such as disability, stigma, and power relations.

Despite these limitations, the consistency of findings across studies of varying methods, populations, and time periods strengthens the credibility of the synthesis. Studies conducted more than ten years apart such as Avoke (2002) and Asare et al. (2024) reported strikingly similar barriers, suggesting systemic persistence rather than temporal or methodological artefacts. This suggests that although evidence generalizability is limited, the patterns identified reflect enduring structural issues requiring urgent policy action.

4.8 Comparison with Broader Literature and Theory

The patterns identified in this review align closely with literature on disability and healthcare access across sub-Saharan Africa and globally. Studies from South Africa, Kenya, Ethiopia, Cameroon, and Namibia consistently document similar experiences of inaccessible facilities, high financial burdens, poor provider attitudes, and strong caregiver agency (Hanass-Hancock et al., 2017; Mersha & Alemayehu, 2019; van Rooy et al., 2012). This suggests that the challenges documented in Ghana are part of broader structural shortcomings characteristic of health systems in low-resource settings.

At the theoretical level, the findings strongly support the Social Model's emphasis on the role of socio-environmental factors in producing disability. The barriers to healthcare documented such as inaccessible infrastructure, discriminatory attitudes, and inadequate policy implementation represent characteristics of the environment rather than the child's body, confirming Oliver's (2017) contention that disability is socially produced.

The Capability Approach (Sen, as applied by Bakhshi & Trani, 2015) further illuminates how disability restricts individuals' ability to achieve valued health outcomes. For instance, the lack of assistive devices limits children's mobility, which in turn restricts their ability to participate in healthcare and education. The lack of inclusive transport systems curtails the capability for movement, while inadequate NHIS coverage restricts the capability for health security. Thus, the findings extend the Social Model by showing how capabilities are constrained across multiple domains.

The ICF framework complements this by highlighting the interrelatedness of physical impairments, environmental barriers, and personal factors (WHO, 2001). The synthesis aligns well with this framework, as it shows how functional limitations (e.g., difficulty walking) become disabling only when combined with inaccessible buildings or negative provider attitudes.

Stigma-related findings resonate with Goffman's (1963) theory of stigma, particularly his argument that stigma arises not from an attribute itself but from socially constructed meanings surrounding that attribute. In many Ghanaian communities, disability continues to be associated with misfortune, supernatural causation, or shame (Baffoe, 2013; Talle, 2019). These interpretations shape care-seeking behaviors and influence how families interact with healthcare providers.

Comparatively, the facilitators identified such as caregiver resilience, CBR programmes, NGO support, and inclusive provider behaviors reflect international evidence on what works to improve disability outcomes. For example, CBR has been widely documented as a successful model in low-income countries for bringing rehabilitation closer to communities (Bright et al., 2018; WHO, 2023). Similarly, peer support interventions like the ones described in Zuurmond et al. (2019) have

been shown to enhance caregiver knowledge, reduce stress, and improve child participation in health services.

This review revealed that barriers to healthcare are driven more by structural and systemic factors than by disability itself. Prior to conducting the review, the extent to which transportation, poverty, provider attitudes, and policy implementation gaps interacted to shape healthcare access was not fully appreciated.

4.9 Implications for Policy, Practice, and Research

4.9.1 Implications for Policy

The synthesis points to several urgent policy priorities. First, the implementation gap in Ghana's Persons with Disability Act (Act 715) must be addressed through the immediate development and adoption of a Legislative Instrument. Without enforceable standards, health facilities will continue to neglect accessibility requirements. Second, NHIS benefit packages must be expanded to include disability-specific services such as physiotherapy, occupational therapy, speech therapy, and assistive devices. The current structure reinforces inequities by requiring families to pay out of pocket for services essential to their child's functional development.

Third, disability inclusion must be mainstreamed across sectors. Strengthening intersectoral linkages between health, education, social protection, and local government is crucial for coordinated disability services. Policies must address transportation equity, including subsidies, accessible public transport vehicles, and transport support for families in remote areas.

4.9.2 Implications for Practice

On a practical level, health facilities must prioritize inclusive design. This includes building ramps, widening entrances, installing accessible washrooms, and providing adjustable clinical equipment. Rehabilitation services must be decentralized, particularly to underserved districts. Training programmes for health workers should incorporate disability competence training, focusing on communication, empathy, ethical care, and understanding of cultural interpretations of disability. Strengthening CBR programmes will help bridge service gaps, especially in rural communities.

4.9.3 Implications for Research

Future research should diversify geographically to include northern and rural Ghana, where barriers are likely most acute. More child-centered research is needed to capture children's own perspectives. Mixed-methods designs would allow researchers to estimate the prevalence of barriers while retaining the depth of qualitative insights. Longitudinal studies could track how early access barriers affect long-term outcomes in education, employment, and psychosocial well-being.

CHAPTER FIVE

CONCLUSIONS, AND RECOMMENDATIONS

5.1 Introduction

This final chapter brings together the major insights generated from the systematic review, highlighting their significance for improving healthcare access for children with physical disabilities in Ghana. It synthesizes the broader implications of the findings, articulates the overarching conclusions that can be drawn, and outlines practical, policy-oriented, and research-focused recommendations. The aim is to translate the evidence into actionable directions for stakeholders including policymakers, health professionals, disability advocates, and researchers while also acknowledging the limitations of the review and identifying areas where further inquiry is needed. Through this approach, the chapter provides a coherent closing to the study and offers a roadmap for advancing disability-inclusive healthcare in Ghana.

5.2 Conclusions

This systematic review concludes that healthcare access for children with physical disabilities in Ghana is profoundly shaped by complex and intersecting structural, environmental, financial, and sociocultural barriers. The overarching insight emerging from the synthesis is that disability-related inequities in healthcare are not the result of the children's impairments, but rather the

product of systemic shortcomings within Ghana's health and social service systems. In line with the Social Model of Disability, the review affirms that disablement is constructed and reinforced by inaccessible physical environments, discriminatory attitudes, ineffective policy implementation, and unequal distribution of resources.

Architectural and infrastructural limitations such as the absence of ramps, narrow entrances, inaccessible washrooms, and non-adjustable equipment remain widespread despite the existence of national and international frameworks mandating inclusive design. These structural limitations, combined with significant transportation challenges and geographical disparities, restrict the mobility of children with disabilities and undermine their ability to access routine and specialized healthcare. The concentration of rehabilitation services in urban centers exacerbates inequities, disproportionately affecting rural families who must navigate long travel distances and prohibitive transport costs.

Financial barriers emerged as one of the most pervasive constraints. Ghana's National Health Insurance Scheme, while contributing to improved general access, fails to adequately cover disability-specific needs such as physiotherapy, assistive devices, or long-term rehabilitative care. As a result, families face high out-of-pocket expenses which often lead to delayed care, treatment interruptions, or complete withdrawal from the healthcare system. This financial strain interacts with transportation and structural barriers to reinforce a cycle of exclusion.

Attitudinal barriers including negative provider behavior, stigma, and lack of disability training further undermine the healthcare journey of children with physical disabilities. Experiences of disrespect, impatience, or dismissiveness reduce caregivers' confidence in the health system, creating relational barriers that can be as consequential as physical ones. Cultural interpretations of disability, including beliefs in spiritual causation or curses, also influence how families

understand and respond to their child's condition. These beliefs may lead to delayed biomedical care or reliance on informal healing systems.

Despite these challenges, the review also revealed important facilitators that support healthcare access. Caregiver resilience emerged as a central enabling factor, with many families demonstrating extraordinary determination in navigating an often-unresponsive system. Community-Based Rehabilitation (CBR) initiatives, where available, played a significant role in reducing travel burdens, strengthening rehabilitation continuity, and enhancing caregiver confidence. Assistive devices, supportive health providers, NGO interventions, and school-based screening programmes further contributed to improved access, demonstrating that targeted interventions can effectively reduce barriers.

At the policy level, the review concludes that significant gaps persist between legislative mandates such as the Persons with Disability Act and Ghana's commitments under the UNCRPD and their practical implementation. Weak enforcement, inadequate financing, insufficient intersectoral collaboration, and overreliance on NGOs have limited progress toward disability-inclusive healthcare. Systemic transformation will require robust political will, comprehensive policy operationalization, and sustained investment in inclusive infrastructure and disability-responsive health systems.

5.3 Recommendations

The findings from this review point to a set of strategic, multi-level recommendations designed to strengthen healthcare access for children with physical disabilities in Ghana. These recommendations are organized into policy, health system/practice, community, and research domains to facilitate clear implementation pathways.

5.3.1 Policy-Level Recommendations

1. Fully Operationalize and Enforce Ghana's Persons with Disability Act (Act 715)

- Develop and adopt a Legislative Instrument (LI) that provides binding standards for accessibility in health facilities.
- Establish clear sanctions for non-compliance and introduce routine facility accessibility audits.

2. Expand NHIS Coverage to Include Disability-Specific Services

- Integrate physiotherapy, orthopedic care, occupational therapy, speech therapy, and assistive devices into the NHIS benefit package.
- Introduce subsidy schemes or voucher systems for low-income households with children with disabilities.

3. Strengthen Intersectoral Collaboration for Disability-Inclusive Services

- Improve coordination between the Ministry of Health, Ministry of Gender and Social Protection, Ministry of Education, and local government authorities.
- Develop integrated pathways linking health services, school systems, social welfare offices, and CBR units for holistic, continuous care.

4. Invest in Decentralized Rehabilitation Services

- Establish rehabilitation units at the district level, particularly in underserved northern and rural areas.
- Increase recruitment and equitable distribution of physiotherapists, occupational therapists, orthopedic technologists, and speech therapists.

5.3.2 Health System and Practice Recommendations

5. Improve Facility Accessibility and Inclusive Design

- Mandate the installation of ramps, wide entrances, railings, accessible washrooms, and adjustable clinical equipment.
- Incorporate universal design principles into new construction across all public and private health facilities.

6. Strengthen Disability Competence Training for Healthcare Workers

- Integrate disability inclusion, communication skills, cultural sensitivity, and ethics into pre-service and in-service training.
- Establish continuing professional development modules on disability-responsive care.

7. Expand and Support Community-Based Rehabilitation (CBR) Programmes

- Scale up CBR across all districts with government funding rather than reliance on NGOs alone.
- Ensure that CBR workers receive standardized training and support from district health systems.

8. Improve Assistive Device Availability and Affordability

- Strengthen local production, procurement, and distribution of wheelchairs, walkers, and orthotic devices.
- Establish maintenance and fitting services within district hospitals to ensure proper device use.

5.3.3 Community and Social Recommendations

9. Promote Public Awareness and Stigma Reduction Campaigns

- Partner with chiefs, religious leaders, schools, and media organizations to challenge negative cultural beliefs.
- Promote disability rights education that aligns with the UNCRPD's social and rights-based model.

10. Strengthen Peer Support Networks for Caregivers

- Establish caregiver support groups at community and district levels to enhance emotional resilience and information sharing.
- Encourage community health workers and CBR units to facilitate group-based education sessions.

11. Strengthen School-Based Screening and Early Referral Systems

- Implement routine disability screening within all basic schools.
- Train school health coordinators to detect early symptoms and refer children to appropriate services.

5.3.4 Research Recommendations

12. Conduct More Studies in Rural and Underserved Regions

- Prioritize research in northern and rural Ghana to understand geographical disparities.

13. Include Children's Voices in Disability Research

- Employ child-friendly data collection methods such as participatory drawings, photo-voice, and child interviews.

14. Use Mixed-Methods and Longitudinal Designs

- Combine qualitative depth with quantitative generalizability to provide stronger evidence for policy.
- Longitudinal studies should track developmental and health outcomes over time.

15. Evaluate the Effectiveness of CBR and NGO Programmes

- Assess which interventions produce measurable improvements in access, participation, and functional independence.

5.4 Limitations of the Review and Future Research Directions

Although this review provides comprehensive insights into the barriers and facilitators influencing healthcare access for children with physical disabilities in Ghana, several methodological and contextual limitations must be acknowledged.

5.4.1 Limitations of the Review

- Limited Direct Representation of Children's Voices: Although this review focuses on children with physical disabilities, most included studies relied primarily on caregiver or provider perspectives. While caregivers offer critical insights into healthcare navigation and decision-making, their accounts may not fully capture the subjective experiences, emotional responses, or agency of children themselves. This limitation reflects a broader gap in disability research within low-resource settings, where methodological and ethical challenges often constrain the direct inclusion of children with disabilities as research participants.
- Geographic Concentration of Existing Studies: A substantial proportion of included studies were conducted in urban and peri-urban areas (e.g., Accra, Kumasi, Sekondi-Takoradi). Rural experiences likely to involve more pronounced transportation barriers, fewer rehabilitation services, and deeper cultural stigma were comparatively underrepresented. This restricts the national representativeness of the findings.
- Predominance of Qualitative Evidence: The majority of included studies employed qualitative designs. While these provided rich contextual insights, they limited the ability to quantify prevalence and national-level magnitude of barriers. As a result, conclusions drawn are interpretive rather than statistically generalizable.
- Reliance on Caregiver and Provider Perspectives: Few studies directly engaged children with disabilities. This raises concerns about proxy representation and possible misinterpretation of children's viewpoints, needs, and emotional experiences.
- Variability in Study Quality: The critical appraisal revealed some studies lacked methodological transparency. Common gaps included insufficient reflexivity, limited detail on

sampling strategies, and incomplete reporting of analytic procedures. These limitations may influence the depth or accuracy of interpretations.

- Potential Publication Bias: Grey literature, unpublished reports, and NGO documents were not systematically included, meaning that relevant programmatic insights may be underrepresented.

5.4.2 Future Research Directions

Given these limitations, several areas for future research emerge:

- Expand Research to Rural and Hard-to-Reach Areas: Studies should focus on northern Ghana, rural coastal regions, and island communities where healthcare access is most limited.
- Increase Participation of Children with Disabilities: Child-centered methodologies such as narrative interviews, visual methods, and participatory activities should be incorporated to capture children's lived realities.
- Conduct Longitudinal Studies: Tracking children over time would illuminate how early access barriers shape rehabilitation trajectories, functional outcomes, schooling, and quality of life.
- Employ Mixed-Methods Approaches: Mixed-methods research would allow researchers to quantify the prevalence of key barriers while retaining qualitative depth.
- Evaluate the Effectiveness of Disability-Inclusive Interventions: Particularly CBR programmes, assistive device distribution schemes, and NGO-led interventions.
- Investigate Health Worker Training and Attitudes: Future work should examine the impact of disability competence training on provider behavior and caregiver trust.

- Assess the Economic Burden of Childhood Disability: A Ghana-specific cost-of-disability study would provide evidence for NHIS reform and disability financing.

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Appendix A: Search Strategy

Databases Searched

- PubMed
- Google Scholar
- Scopus
- Web of Science
- CINAHL
- African Journals Online (AJOL)

Search Terms

The search strategy combined keywords and Boolean operators related to disability, children, healthcare access, and Ghana.

Example search string:

("children with physical disabilities" OR "children with disabilities" OR "physical impairment") AND ("healthcare access" OR "health services" OR "rehabilitation services") AND (Ghana OR "Sub-Saharan Africa")

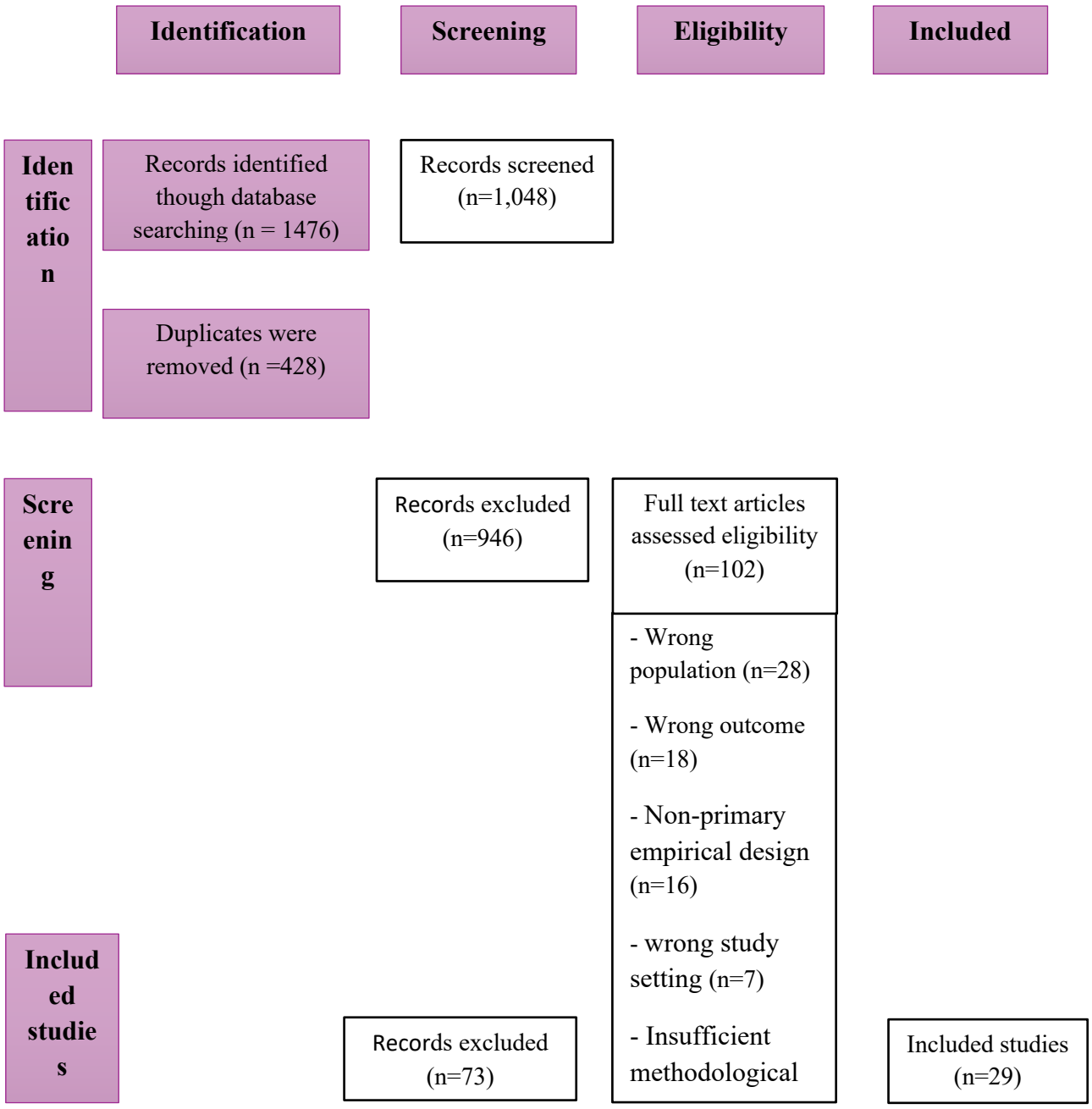
Additional search terms included:

- disability
- physical disability
- healthcare utilization
- barriers
- facilitators
- rehabilitation
- assistive devices
- disability-inclusive health services
- children
- adolescents
- Ghana

Search Period

January 2010 – December 2025

Appendix B: Prisma Flow Diagram



Prisma 2020 Flow Diagram Of Study Selection

Appendix C: Inclusion And Exclusion Criteria

Criterion	Inclusion	Exclusion
Population	Children and adolescents with physical disabilities	Adults only
Location	Ghana and comparable African settings	High-income countries without relevance
Topic	Healthcare access, barriers, facilitators	Education-only studies
Publication Date	2010–2025	Before 2010
Language	English	Non-English
Study Type	Qualitative, quantitative, mixed methods, reviews	Editorials, commentaries, opinion papers
Availability	Full-text available	Abstract only

Appendix D: Quality Appraisal Tool

Joanna Briggs Institute (JBI) Critical Appraisal Checklist

The following questions were used to assess methodological quality:

No.	Quality Assessment Question
1	Was the research question clearly stated?
2	Was the study design appropriate?
3	Was the sampling strategy adequate?
4	Was data collection clearly described?
5	Were ethical considerations addressed?
6	Was data analysis rigorous?
7	Were findings clearly presented?
8	Were conclusions supported by the findings?

Scoring:

- Yes = 1
- No = 0

Quality Categories:

- High Quality = 7–8
- Moderate Quality = 5–6
- Low Quality = 0–4

(Polit & Beck, 2021)

Appendix E: Researcher Positionality Statement

As a nursing researcher with an interest in disability inclusion and equitable healthcare access, I approached this review with the understanding that children with physical disabilities often experience barriers that extend beyond their medical conditions. My professional background in healthcare influenced my appreciation of the importance of accessible, inclusive, and person-centred services.

I acknowledge that my training may predispose me to view disability primarily through healthcare and service-delivery lenses. To minimise bias, I adopted a systematic review methodology, followed predefined inclusion and exclusion criteria, and relied on evidence from published studies rather than personal assumptions or experiences.

Throughout the review process, I remained conscious of the need to represent the perspectives of children with disabilities, caregivers, healthcare providers, policymakers, and community stakeholders fairly. I also recognised that disability experiences are shaped by social, cultural, economic, and policy environments, consistent with the Social Model of Disability that guided this review.

The purpose of this review was not only to identify barriers but also to understand the facilitators and systemic changes necessary to improve healthcare access and health outcomes for children with physical disabilities in Ghana.

APPENDIX F: LIST OF ABBREVIATIONS

Abbreviation	Full Meaning
ACHPR	African Commission on Human and Peoples' Rights
Act 715	Persons with Disability Act, 2006 (Ghana)
ADP	African Disability Protocol
AU	African Union
CASP	Critical Appraisal Skills Programme
CBR	Community-Based Rehabilitation
CRPD	Convention on the Rights of Persons with Disabilities
CSO	Civil Society Organization
DIPAS	Disability Inclusion Policy and Strategy
DPO	Disabled People's Organization
FASD	Fetal Alcohol Spectrum Disorder
GFD	Ghana Federation of Disability Organizations
GHS	Ghana Health Service
GSS	Ghana Statistical Service
ICF	International Classification of Functioning, Disability and Health
LI	Legislative Instrument
LMICs	Low- and Middle-Income Countries
MMAT	Mixed Methods Appraisal Tool
MoH	Ministry of Health (Ghana)
NGO	Non-Governmental Organization
NHIS	National Health Insurance Scheme (Ghana)
OPD	Organization of Persons with Disabilities
PICO	Population, Intervention, Comparison, Outcome
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RPL	Recognition of Prior Learning
ROBINS-I	Risk of Bias in Non-randomized Studies - of Interventions
SLR	Systematic Literature Review
SPIDER	Sample, Phenomenon of Interest, Design, Evaluation, Research Type
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Disabilities
UNICEF	United Nations Children's Fund
UNPRPD	United Nations Partnership on the Rights of Persons with Disabilities
UPR	Universal Periodic Review