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**Community Based Rehabilitation and
Stigma Management by Physically
Disabled People in Ghana**

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HiH Skriftserie 1998/1 - Harstad College



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Sammendrag/Abstract Community Based Rehabilitation (CBR) has been recommended by the World Health Organisation as an approach to the care of people with disabilities. Facilities in the developing countries are scarce and it is not always possible for disabled people to receive the help they need. In addition, people with disabilities are often stigmatised by their families and the community. Research has however indicated that many disabled people do not perceive themselves as disabled. Many who give up have resigned. Most of the disabled people with severe disabilities do not go to help. Many reasons including economic and cultural constraints which centre on the costs, have been assigned for this trend of failure. The major reasons are the problem of stigma by disabled people and their families, the lack of knowledge and the lack of role models. It is also remarkable stigma. The main aim of the study was to describe the experiences of community based rehabilitation, to identify the barriers and to propose ways to overcome them. The study was conducted in a rural area, and the findings will be used as the basis for a pilot study to reduce stigma and to improve rehabilitation services.	
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Community Based Rehabilitation and stigma management by physically disabled people in Ghana.

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Keywords Community Based Rehabilitation, Ghana, stigma.

Summary

Community Based Rehabilitation (CBR) has been recommended by the World Health Organisation, as an antidote to the poor coverage of rehabilitation facilities in the developing countries. This attempt is to make it possible for disabled people to receive the help they need to be able to go about their daily activities aided by trained personnel from their own communities. Research has however indicated that many disabled people do not patronise rehabilitation programs. Many who give it a try leave dissatisfied. Most of the disabled people will rather migrate to the cities to beg. Many reasons including economic and location of rehabilitation centres in the cities, have been assigned for this trend of affairs. This paper however see the problem as attempts by disabled people and their families to manage what Scambler and Hopkins (1986) refer to as «felt» and «enacted» stigma. The paper seeks to question the importance of Community Based Rehabilitation, since experienced and perceived stigma seem to be more pronounced in the rural areas, and begging is often seen as the fastest way to gain some independence, reduce stigma and avoid stigmatised environments.

Introduction

In Africa, outh of the Sahara, out of the 524 million people, about 36 million of them are disabled. According to Helander,¹ in about the year 2025, the region will be

populated by about 435million handicapped people who will need to be rehabilitated. In response to the alarming statistics above, member countries of the World Health Organisation (WHO) decided to include Community Based Rehabilitation as an integral part of the Primary Health Care programme.

Rehabilitation involves three processes, medical treatment, training or compensating for the disability and total integration into the society.² The main focus to date has been on the first two, while much is left to be done on the last. Community Based Rehabilitation, which seeks to overtid resolve the problem of integration by direct involvement of disabled persons, their families, and the entire community in which they live, has become very important especially in the developing countries.

Earlier studies have however indicated that many disabled persons and their families do not patronise rehabilitation services. Many who did use them left dissatisfied.^{4,5} A draft progress report presented to the United Nations Development Program(UNDP), Norwegian Association of Disabled (NAD), Swedish Organisation of the Handicapped International Aid Foundation (SHIA) mission to Accra, also points to the fact that

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it is not easy to get disabled people involved in CBR activities.⁶ What rather seems to be the case is a drift of disabled persons to the cities where they parade the principal streets of the city begging for food and money. The main questions to be addressed are; "Why this trend"? What makes begging in the city more attractive than getting involved in Community Based Rehabilitation? Is it an attempt by disabled people to manage what Goffman refers to as the experience and perception of stigma?⁷ Do disabled people feel less stigmatised by substituting their "roleless roles" in the village with begging, another stigmatised role? How then can Community Based Rehabilitation be organised to cater for needs of the disabled?

This paper seeks to lay emphasis on the importance of the "stigma argument" and "stigma management" in Community Based Rehabilitation. It is limited to persons with disabilities pertaining to moving, even though others for example those with seeing, hearing and learning disabilities also fall within the same category. Discussions are based on available literature data, information from friends and observations in the field.

PHYSICALLY DISABLED PEOPLE IN GHANA

There are over one million disabled people in Ghana. The majority of them live in the rural areas, where there are scarcely groups or associations that defend the interests of disabled people.

They have generally lower incomes and mostly suffer from poverty. The majority live at the mercy of their family throughout their life. Since the management group are themselves poor, disabled persons are often underfed. Many of them have little or no medical care. They are therefore victims of high mortality.

Disabled persons have little or no rights in the society. They are often excluded from positions of leadership in their communities. This implies their exclusion from planning and decision making in their societies. Their needs are therefore more often than not, neglected.

The quality of life of disabled persons is very low. They are often unemployed, poorly housed, and few receive education and vocational training. Only few of them marry and form a family. Society often considers them as burdens and not people who have a lot to offer to society. While some people support them, others look down upon them.

Many Ghanaians are Christians. Traditional religion and Islam are but two of the other religious groups in the country. Many citizens however combine Christianity with traditional religion. It is therefore not strange to uncover, that a person who is a Christian in the city visits the home town to perform the traditional religious rites. Belief in ancestral spirits of the dead and in their influence over the living is found among Ghanaians. This

is to say, that they believe that the ancestors are in their midst, and have the power of rewarding those who do good and punishing the evil ones.⁸

Disability is thus seen as a punishment from God, the smaller gods and ancestors, for sins committed either presently or in their earlier lives or by their families. Many are hidden and are not welcome at public places or meetings. This practice is not limited to the rural areas, but occasionally crops up in the cities. Before the last International conference of Non-Alliance countries, for example, all disabled persons were carried out of the city centres much against their will and settled outside the city. They were only allowed to show their faces on the streets after the conference. This points to the fact, that even though parading of the city streets by disabled persons is normally not reacted to by city dwellers, situations reconfirm the tendency of regarding disability as shameful.

COMMUNITY BASED REHABILITATION (CBR) DEFINED.

Successful rehabilitation, according to Ben-Sira is readjustment in the wake of a traumatic irrevocable, eventually stigmatising, impairment.⁹ Rehabilitation includes all measures aimed at reducing the impact of disability and handicapping conditions and at enabling disabled/handicapped

/impaired people to achieve social integration.¹⁰

The concept of Community Based Rehabilitation (CBR) was developed by the World Health Organisation (WHO) as one of the components of Primary Health Care (PHC). The PHC services identified at the Alma-Ata conference in 1978 include, promotive, preventive, curative and rehabilitative services.

Community Based Rehabilitation was designed to meet the needs of populations that are largely rural and without access to rehabilitation facilities.¹⁰ The primary goal of community-based rehabilitation is to make it possible for disabled persons to live as «normalised» a life as possible: in other words, an improved quality of life. Following Rashid et al.(1988), a disabled person should be able to look after him or herself, move around the house and village, attend school, do a job and carry out household activities, enjoy family life and take part in community activities.

The CBR model according to Hoeman incorporates a person's social network and the community. It also reassigns roles by encouraging and equipping clients and their families with knowledge and lifelong coping plans.¹¹ Hoeman pointed out, that when clients and families become co-partners with professionals, they contract mutual agreeable goals, foster empowerment, educate for self-care, and enhance positive

coping behaviours.¹¹ Peat listed four essential components in the design of any CBR Programme; the disabled person, health personnel, the family, and the community. He pointed out, that all must be involved in planning and provision of services if such plans would be appropriate and achievable.¹¹

COMMUNITY BASED REHABILITATION PROGRAMME (CBRP) IN GHANA

The Ministry of Employment and Social Welfare (MESW), in collaboration with the Ministry of Health, Ministry of Education/Ghana Education Service, the Ministry of Local Government, Non Governmental Organisations (NGOs) and Organisations of disabled people, initiated the Community Based Rehabilitation Program (CBRP) in Ghana. The programme is aimed at improving the quality of life of children, youth and adults with disabilities, through the mobilisation of community resources, provision of services, and the creation of educational, vocational and social opportunities. The MESW requested assistance from international NGOs (the Norwegian Association of the Disabled and the Swedish Organisation of the Handicapped International Aid Foundation), World Health Organisation, United Nations Educational, and Scientific, and Cultural Organisation (UNESCO) and International Labour Organisation (ILO), in order to strengthen the

capacity of the CBRP. The world organisations are to strengthen the CBRP through technical guidance, training of personnel, and the establishment of a training capacity.

Eight regions, **twenty** districts, and **eighty-six** communities are engaged in the CBR Programme in Ghana. The operational areas were grouped into three belts; the South Belt, the Middle Belt, and the Northern Belt.

TABLE 1. DISTRIBUTION OF DISABILITY TYPES IN GHANA

Disability types	Number	Percentage %
Seeing difficulties	587	21,7
Hearing /speaking difficulties	430	12,2
Moving difficulties	1158	42,9
Learning difficulties	101	3,7
No feeling	92	3,4
Epilepsy	152	5,6
Strange behaviour	110	3,7
Others	71	2,6
TOTAL	2170	100

The Southern Belt comprises of eight districts, 32 communities and registered 938 disabled persons; the Middle Belt comprises of six districts, 28 communities, and has 709 people with disabilities; while the Northern Belt consists of six districts, 26 communities and

registered 1054 PWDs. These are broken down in Table 1.

The personnel involved in the CBR Programme are shown in Table 2.

1. CBR programme/Project Director	- 1
2. CBR Management Team	- 5
3. CBR Agents (Social Welfare Officer)	- 24
4. Peripatetic teachers (Spec. educ.)	- 28
5. Local Supervisors	- 172
6. Family Trainers	----
7. Community Rehab. Committee	- 860

The CBRP of the Ministry of Employment and Social Welfare has identified the following goals:

- creating awareness and mobilising resources at village level to enable families to better help their disabled infants, and disabled children and youth to attend school, learn skills, and to contribute productively to the needs of the family and community;
- training village volunteers in simple rehabilitation approaches and basic knowledge about disability;
- establishing linkages between service providers in health, education, community development and social welfare at District level, to better meet the needs of disabled individuals;
- strengthening associations of disabled people to play a role in the mobilisation of the community, the implementation of village-level activities, and the management of the CBR Programme;
- promoting the human rights of persons with disabilities.

As previously stated, Community Based Rehabilitation is built on mutual trust and rapport among health workers, disabled persons, the family and the community. The full support of elders and opinion leaders in the communities need to be secured if CBRPs are to develop a meaningful strategy to help disabled people in the rural areas. In developing rehabilitation plans, it is important to know each client, his/her preferences and cultural values, medical status, and unique strengths and weaknesses. Where mutual trust, respect and good social relations are absent or functioning poorly, the goals of Community-Based Rehabilitation may be difficult to realise.

What is stigma?

The Greeks used the concept "stigma" to refer to bodily signs, usually inflicted cuts or burns, designed to expose the unfortunate bearers as a slave or criminal, or a social outcast (Goffman, 1963). Persons who were marked this way were avoided especially in public places and ritualistically excluded from normal social relations. According to Goffman the term today, is widely applied more to the disgrace itself than the bodily evidence of it.*

Included in the disorders that are considered as stigmatising are epilepsy (Schneider and Conrad, 1980), (Scambler and Hopkins, 1986), (West, 1986); deafness (Becker, 1981), mental retardation (Birenbaum, 1970), rheumatoid arthritis (Bury, 1982);

alcoholism (Albrecht, Walker and Levy 1982); diabetes (Hopper 1981); cancer (MacDonald, 1988); Machado-Joseph disease (Boutte 1987), and mental illness (Goffman, 1963).

Goffman (1963) defines stigma as "an attribute that is deeply discrediting...". An individual who is stigmatised possesses «a trait that can obstrude itself upon attention and turn those of us whom he meets away from him, breaking the claim his other attributes have on us» (Goffman, 1963). Becker and Goffman see stigma as deriving from how "differentness" or deviance is conceptualised and how social rules and sanctions are applied against an individual who has the stigma label. Following Anspach (1979), Schneider et al. (1981) and Del (1986) agree that stigma is not solely the outcome of societal devaluation of differentness. It has been pointed out that in order for stigma to exist, individuals possessing such differences must accept this devaluation. Stigma is thus a relational concept.

Scambler and Hopkins (1986), are of the view that stigma applies more generally to any condition, attribute or trait which marks an individual as culturally unacceptable or 'inferior'. They proposed two distinct forms of Stigma: enacted and felt stigma. According to Scambler and Hopkins (ibid., 1986) enacted stigma refers to episodes of discrimination against disabled people, solely on the grounds of their social unacceptability, while

felt stigma, refers to the shame associated with having a disability and the fear of enacted stigma. Scambler and Hopkins (1986) conclude that:

«...felt stigma, and especially the fear of enacted stigma, was typically the source of more personal anguish and unhappiness than was enacted stigma... felt stigma was in its own right a profound and lasting, if intermittent, source of unease, self-doubt and disruption in people's lives».* (Scambler & Hopkins 1986).

Friedson (1970) and Albrecht et al. (1982) pointed out that stigma is ineradicable and irreversible, so that even when deviant behaviour occurred in the past or when an individual appears no longer to possess a particular characteristic, he or she may continue to be perceived as a disruption to interaction. Given the alternative people do all they can to avoid the company of the labelled persons. Scambler (1986) draws attention to this permanent quality of stigma in relation to epilepsy, a condition which is self-limiting in a majority of cases. He made it clear that, the majority of people whose epilepsy goes into remission continue to live with a «spoiled identity» and the label «epileptic». The same applies to people who are labelled as thieves or have been patients of mental institutions. Such persons are often referred to by «outsiders», borrowing Beckers terminology, as the man/woman «who has been

to prison or has just returned from the mental hospital».

Stigma is not limited to the person who wears the deviant label but also those who are in close contact with the stigmatised person. Goffman called this type of stigma, «courtesy stigma». This includes the feeling of people close to the stigmatised person, that they will be discriminated against. Some even experience direct discrimination. Courtesy stigma may take the two forms of stigma described by Scambler and Hopkins; enacted and felt stigma.

The work of Ryan (1980) et al. opposes the view that there exists a widespread felt stigma. He pointed out that felt stigma may not be as all-embracing as Scambler suggests. It seems that felt stigma is the case, when the person involved accepts the stigma or is aware that he has to live with it. Arntson et al. (1986) on the other hand, reported a significant relationships between patients' feelings of stigma and a number of measures of psychopathology.* (Arntson, 1986). Dell (1986) argues that stigma is serious and real and limits the quality of life of people with epilepsy.

Disabled persons in Ghana are also victims of both types of stigma described by Scambler and Hopkins. While they are at times directly discriminated against, many often go with the strong feeling that they will be discriminated against. They are also often in doubt about how the

«normal» will receive or categorise them. My observation of a disabled man emphasises the limiting effect of stigma. Remarks like «whatever I do or say is interpreted as wrong; no one wants to be with me; nothing I ask for is granted; why do people stare at me whenever I happen to be outdoors?; why should children follow me any time they see me?; I have nothing to live for» give an indication of the problems persons who bear the stigma label face. The management of stigma can be seen as two processes; the first has to do with the stigmatising process and the second, the stigma managing process.

The stigmatising process

Many disabled and «normal» people have different expectations as far as roles of disability in society are concerned. Some «normals» expect for example, that disabled persons are treated differently in terms of the right to go to school, work etc., remain dependants do and not take active part in public activities. Many disabled persons on the other hand, expect that they are treated as equals, be as independent as possible, be given the right to education, work and the chance to take part in public activities.

When disabled persons and «normal» persons interact, socialisation takes place and norms, rules and regulations for behaviour are internalised. This is to say, that even though disabled

persons have their expectations as to how they want to be treated by the «normal», their situation as dependants make it difficult for them to challenge the «imposed» norms. They therefore have to accept and conform to the expectations of the «normals». By accepting and assuming the roles confirmed on them, they become victims of enacted and felt stigma.

The stigma managing process

Both those who accept and oppose stigma find ways of coping with the situation they find themselves in. Those who accept stigma and do nothing to reduce it become the «free riders». This is to say that they may give up all hopes and only wait for death, they lose all their rights and are often isolated. Those who do not accept the stigma, but due to their dependency on others, have to play the roles confirmed on them, do all they can when they have the chance, to escape from the roles that make them stigmatised members of society. Some of them fight for their rights by for example, breaking some of the norms (migrating to cities to become performers and beggars); try to correct their conditions indirectly by mastering activities that the «normals» value (some learn to ride horses, fly planes, swim, skiing, climbing etc.); some who can afford do attempt to correct what is seen as an objective basis of their failing (the physically deformed for example undergo plastic surgery,

a blind person takes eye treatment, the illiterate takes remedial courses, a homosexual and the mentally sick visit the psychotherapist).

In Ghana, the shrines of traditional healers and spiritual churches become the abodes of the stigmatised. The stigma management model is based on the assumptions that many disabled persons, like «normals» constantly avoid activities that make them feel different from others (e.g. public places, people, things or artefacts), and adopt activities that make them feel less stigmatised.

Why physically disabled persons move to the bigger towns and cities?

Disabled people in Ghana, like all others in the developing countries migrate to the cities when they have the chance, because of economic, social and personal reasons. In Ghana, disabled people who have relatives in the cities are the ones who mostly make such trips. In the cities, they cease to be totally dependent on others both economically and socially. Following Hoeman (1992) persons with chronic disabling conditions expect to live as independently as possible. The allegations that begging in the cities is a lucrative business, and could at the same time make them independent, strengthens or reinforces the drift of disabled persons to the cities.

Apart from the communities in Ghana, which are populated predominantly by Muslims, most rural dwellers view begging as unacceptable, shameful and devaluing. Most disabled people however see it also as a way of gaining not only their economic independence but also their social independence. In the cities, they have the chance to beg for money, determine what they will eat and where to go. Associations that fight for the rights of disabled people are also mostly found in the cities. Such meetings also make it possible for them to meet and discuss matters of common interest. The problems of isolation and loneliness are also often resolved as a result.

Disabled people also migrate to cities as a means of minimising their felt and enacted stigma. The understanding of this phenomenon can be derived from Tönnies' (1957) hypothetical Gemeinschaft and Gessellschaft typology. According to Tönnies in the rural communities where everybody knows everybody else, the bonds of social relations are tight. Deviation from the norms is thus easily visible and strictly sanctioned. This is to say that disabled persons easily become targets of societal sanctions when they engage in activities not acceptable in their community or bring shame on their families, for example begging.

In the Gemeinschaft society where disabled people are considered as «outsiders», feelings of helplessness,

loneliness, self pity, reject and desires to end ones life, cannot be overruled. The fighting spirit necessary to go against the established order is dampened in the Gemeinschaft society.

Parents of disabled persons in the Gemeinschaft society can also promote migration of their disabled members of the family to the cities. Parents, relatives and friends of disabled persons experience, what Goffman calls «courtesy stigma». This is to say, that members of such families are stigmatised only because of their affiliation with the stigmatised individual, rather than through a characteristics of their own. Following Birenbaum (1976), they are regarded as «normal yet different». Such families often experience discrimination, are ridiculed, looked down upon and even insulted, when they find themselves quarrelling with people who do not bear the stigma label. «It is because of your bad character you have a cripple in your family» is but an example of the painful insults hurled at people who are related or close to disabled persons in Ghana. The point being raised here is, that disabled persons may find themselves in the cities as a result of the need of their relatives to manage «courtesy stigma».

In the Gessellschaft society, where people from different cultures meet, social relations are less tight. People in these societies acquire new rules for behaviour that differ from the ones they carry with them from the rural areas. Most of the old norms and

ways of doing things are thus either suppressed or abandoned. The cities thus serve as «meeting points» of all norms, and people become less concerned about what the others do or say, provided their action do not encroach on others rights.

Behaviour that is considered in the rural societies as deviant, becomes an accepted way of life. Disabled persons arrive in the cities to find out, that what has been considered in the villages as unacceptable and shameful, is generally not shunned in the cities. This is to say that they could easily find their way to the city streets, visit public places and also beg for money, without thinking of the shame it could bring to their families. It does not take a long time before disabled persons from the rural areas, discover also that some societies accept and even encourage all their poor to beg, and the rich to give alms to the poor. The Muslims have the right, according to the Koran, to give and accept alms. Changes in perception reduces felt stigma and makes disabled persons feel they do no wrong by behaving the way many other disabled persons do in the cities.

In Ghana, the non-Muslim disabled people, who still feel the guilt of doing something wrong by begging, find it relieving to identify with people who are not stigmatised for begging. It is therefore not strange to discover, that many disabled persons in Ghana put on dresses that the Muslims often wear, whenever

they are out begging. This makes it easier for them to accept their new roles as beggars.

Favourable conditions in the city, as can be seen in the discussion above, seem to constitute the «magnet» that pulls disabled people to the city.

Why begging instead of Community-based rehabilitation?

As already stated, begging in the cities seems to deliver disabled people from their dependency roles in the villages. This is because they no longer have to stay at home waiting to be fed. They have the opportunity to come by food and money, which they themselves can determine how to spend. In Ghana some disabled persons are said to have made enough money from begging and have been able to put up buildings. It is not only the disabled person who benefit from what is earned, some of the relatives, especially the ones who take care of him/her, depend on this income to survive in the city.

On the other hand it seems that the skills that many of disabled persons acquire at rehabilitation centres do not help them overcome their poverty. In Ghana, some disabled persons who have been able to acquire skills like, shoe making for example, abandon them, migrate from the village to the cities to beg. Making the disabled take part in Community Based Rehabilitation is therefore not attractive. Taking part in CBR

activities can therefore be seen as efforts to train them to continue life in their stigma laden environments, playing stigmatised roles.

CBR programmes seems to be perceived by disabled people in Ghana, as programmes that can prolong or hinder their dreams of becoming «independent» and doing away with feelings and experience of stigma. It is therefore not strange that the CBR programme in Ghana is facing the problem of involvement from disabled persons and their organisations. Lack of involvement in CBR programs might be a signal that they do not want to be tied to any other group of people. This is to say, people who do not understand how they feel and what their actual needs are.

Taking part in CBR activities also implies binding themselves up for some time. They will thus have to be steered by the rules and regulations that govern such programmes. If there is anything that many physically disabled people value, it is the right to live as independently as possible. This is often because most of them spend a greater part of their lives as dependants. For disabled persons who do not accept stigma, activities that demand that they continue in dependency roles, are unacceptable. They will rather choose begging.

Can disabled persons live a «normal» life in the midst of those who stigmatise them? Normal life, for the disabled means not only control over

money and food, but the right to live a life devoid of feeling and experiencing stigma. Disabled persons seem to consider begging in the cities as less stigmatising and rehabilitation activities in the rural areas, as stigma perpetuating. Disabled persons do all they can to avoid environments and artefacts that are associated with their stigma. They seem to hate the idea of being placed under people who have previously been their suppressers. After all it is the members of community who confirmed stigmatised roles on them. How can they be expected to join hands with them?

It is not yet clear whether it is an advantage to initiate Community Based Rehabilitation, or if it only worsens the situations of disabled persons. The point here is, that in the rural areas, stigma due to disability may be felt to a greater degree, than when the disabled migrate to the cities to beg. Left with the choice between taking part in Community Based Rehabilitation and remaining in environments where one has been a victim of stigma, and migrating in order to have the opportunity to beg without feeling stigmatised, the natural choice for a stigmatised disabled person is begging. Planners of community rehabilitation may have to go back and find out more about what stigma and the desire by disabled people to manage stigma can cost CBRPs.

Peat (1991) and other researchers pointed out, that many problems crop up during the

implementation of CBR programmes. They made it clear that health professionals do not accept the principle of involving the disabled persons and their management groups directly in rehabilitation. The professionals foresee a situation of lowered standards. This means, they do not see community members as people capable of taking care of their own disabled relatives. There has been reports of conflicts between health professionals and community workers. Some of the community workers feel and experience discrimination, and are looked down upon by professional health workers. Disabled persons who are witness to such conflicts, may become insecure and lose their interest in CBR activities. The desire to participate in such programmes may be killed. CBR programmes may therefore not be an easy option. Disabled persons and their families will rather adapt other ways of helping themselves, for example moving their disabled members of family to the cities to perform or beg for money, than to be part of programmes that make them feel inferior.

The argument here is, that it takes more than technical equipment and professionals to make rehabilitation efforts appealing and acceptable to persons who experience and perceive enacted and felt stigma. This is to say that, for Community Based Rehabilitation to take place successfully, something must be done to help disabled persons to feel less stigmatised in the

company of those who are not. The point is, stigma is perpetuating and not only reflects on the individual who bears it, but extends to the relatives and other artefacts or things associated with the stigmatised person. Perhaps, the move by the Norwegian Association of Disabled (NAD) and the Swedish Organisation of Handicapped International Aid Foundation (SHIA), to direct their future support to strengthen the Disabled Peoples Organisation in Ghana, may be a way of winning the confidence of disabled people and entice them to participate in Community Based Rehabilitation.

SUMMARY

Stigma is a very important concept, especially when one is considering help to disabled persons to be able to take control over their lives. Many reasons can be assigned for the unwillingness of many disabled persons to take part in CBR. Apart from the fact that begging in the cities grant them the fastest possibility of minimising their overdependence on others, actions to avoid stigmatising conditions seem to a large extent to guide their choice between being part of CBR programmes or moving to the cities to beg for a living. This desire is further strengthened when the management group see them not only as a potential income earners but also as a very convenient way of avoiding courtesy stigma.

The Gemeinschaft community seems more favourable for the «normals» and seems less favourable for those who bear the stigma label. The stigmatised become tied up in roles that demand that they remain dependants for life. It is also not wrong to say, that the feelings of stigma is likely to be more intensive in the rural communities, where deviants are not tolerated, and deviant behaviour is easily detected and punished, than in the cities, where behaviour classified as deviant in the rural areas, becomes an acceptable way of life.

In some rural areas of Ghana some family members who are scared of courtesy stigma, keep their disabled relatives out of public places. How then can they be instruments for Community Based Rehabilitation? It has also been pointed out that professionals who are supposed to guide and train community workers, who also happen to be relatives of the disabled persons, have often been at loggerheads. Simply, most of the professionals do not appreciate the idea of sharing their knowledge with the community workers, as they do not want to sacrifice quality for quantity. Spoiled interaction thus leads to ill feelings and consequently avoidance of rehabilitation services and activities.

For the disabled, the Gessellschaft communities, where individualism reigns supreme, may be a less stigmatising environment for them.

It is this environment that provide disabled persons the right atmosphere for the pursuance of things they value in society without the fear of sanctions.

Disabled persons who do not accept the stigma try to do things that are regarded as valuable in the eyes of the "outsiders" (this time the normals) as a means of stigma management. Some however choose to beg for alms with the intent of becoming rich, a well cherished value of all «normals».

The teachings of Koran provide the necessary cushioning mechanism, since giving and receiving of alms is encouraged. Disable persons find out that begging or receiving alms is after all no crime. Their feelings of stigma reduce as a result. Begging for alms is thus not only a means of achieving economic independence but it also provide them with the arena where they can resolve their felt and enacted stigma. It is therefore not easy for disabled persons to choose Community Based Rehabilitation which restricts them to environments where conservative norms, societal pressure, feeling and experiencing stigma reigns supreme.

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