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Insights into the lived experiences of persons with vision impairment in Ghana: A Phenomenological Study

Deborah Annan

deborah.annan@umontreal.ca

University of Montreal

Soutongnoma Safiata Kabore

University of Montreal

Prajjol Raj Puri

University of Montreal

Joseph Paul Nemargut

University of Montreal

Research Article

Keywords: vision rehabilitation, vision impairment, lived experience, accessibility

Posted Date: June 3rd, 2026

DOI: https://doi.org/10.21203/rs.3.rs-9726998/v1

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Additional Declarations: No competing interests reported.

Abstract

Background

Approximately 90% of blind persons worldwide reside in developing countries, including Ghana. While access to vision rehabilitation, education, assistive devices, eye care services and government-supported programs can improve independence and social inclusion of persons with vision impairment (PVI), research seldom documents how these individuals navigate such supports in real life. This study explored the perspectives of medical professionals, educators and persons with vision impairment on the lived experiences of visually impaired individuals in Ghana with particular attention to vision rehabilitation services.

Methods

Using a phenomenological research design, inductive interviews were conducted with 10 participants, namely, 4 persons with a visual impairment (PVI), 3 rehabilitators/educators, and 3 optometrists who were purposively recruited through the Ghana Blind Union (GBU) and snowball sampled through professional networks between November 2024 and March 2025. A semi-structured interview guide was adapted from prior research. All interviews were conducted via Zoom, transcribed verbatim, and analyzed thematically in MaxQDA.

Results

Seven themes emerged namely: resources as a pathway to independence, living with fragmented support, knowledge barriers in accessing support, compromised safety, financial and structural burden of visual disability, stigma and social exclusion, and a call for reform. From participants' responses, government-funded programs, peer networks, inclusive education, and assistive devices were perceived as beneficial, whereas barriers including inconsistent service provision, environmental inaccessibility, poor public awareness, and ineffective disability policies remained.

Conclusion

Government should prioritise integrating vision rehabilitation, increasing public awareness, expanding support systems, and reinforcing disability policies in close collaboration with persons with visual impairment and the professionals who support them to promote the well-being of persons with vision impairment (PVIs).

1.0 Introduction

Background

An estimated 2.2 billion individuals worldwide have a visual impairment, a number projected to rise significantly by 2050 due to demographic shifts including population growth and ageing [1]. As a leading cause of disability, visual impairment has been associated with a negative impact across multiple domains of life often limiting social participation and quality of life[1]. People in low-and middle-income countries (LMICs) bear a disproportionate burden, accounting for approximately 90% of all moderate to severe cases [2, 3]. Ghana is no exception, with most cases of visual impairment attributable to preventable causes such as uncorrected refractive errors[4, 5].

Visual Impairment in Ghana

A pressing public health challenge in Ghana is the high number of people living with sight loss, much of which cannot be reversed with current available treatments, affecting approximately 40.1% of the 737,743 persons living with disabilities[6]. Vision loss is commonly classified as either low vision or blindness and may occur as a result of hereditary disorders [7], congenital causes [8] or acquired degenerative conditions [9]. According to the World Health Organization (WHO), low vision is defined as visual acuity worse than 6/18 to light perception with optimal correction, or a visual field restricted to less than 10 degrees from the point of fixation, and blindness is defined as visual acuity of less than 3/60 in the better eye with the best possible correction, or a visual field of 10 degrees or less [10, 11]. For persons with vision impairment (PVI), the most pervasive challenges they face do not stem from the impairment itself, but from its impact across multiple life domains, including education, employment, transportation, accessibility, social inclusion, emotional well-being, and access to services [1, 12–14]. While these far-reaching ramifications can certainly be challenging, vision rehabilitation services have demonstrated a supporting role in improving participation across these domains in daily life[14, 15].

Vision Rehabilitation Services

Vision rehabilitation refers to a set of support and training aimed at helping people with vision loss enjoy a safe, independent, and productive life in their homes and communities. A large-scale international initiative on global eye health has defined visual rehabilitation to be an essential component of an ideal eye care package within the framework of universal health coverage[15]. As part of the eye-care continuum, its services extend from clinical assessment to treatment and long-term support, device prescription and purchase to address the extensive functional, emotional, and social impact of vision loss on patients' lives [16].Although vision rehabilitation does not restore lost sight, it is considered the standard of care for maximizing remaining vision, restoring autonomy, and improving quality of life. Services are adapted to the specific needs and circumstances of each visually disabled individual, regardless of their underlying pathology [17]. McCabe and colleagues also reported that the preponderance of people living with significant vision loss benefit from vision rehabilitation interventions including enhancement of adaptive skills, mobility training, training in the use of assistive devices and rehabilitation counselling [18]. Scholarly research also describes visual rehabilitation as involving multidisciplinary workforce and training including visual strategies, occupational therapy and adaptation of optic and non-optic delivered by professionals such as medical doctors, optometrists, orientation and

mobility instructors, daily living activities instructors, social workers, counsellors and psychologists [17]. As such, an individual should typically be able to carry out many everyday tasks with greater physical independence and efficiency following these interventions.

Beneficiaries of vision rehabilitation services often report expanded educational and professional opportunities, attributed to improved functional skills and adaptive strategies gained through training [19]. They also describe becoming more socially visible, which reinforces their sense of identity and community belonging [20], driving more inclusive policies and societal awareness [21]. However, vision rehabilitation varies across countries, reflecting differences in service models, availability, coverage and benefits [22]. While these services are well established in regions such as North America and Australia, known for complementing optometric, surgical, medical and other preventive-focused initiatives[19], current knowledge is less abundant when it comes to vision rehabilitation services in Ghana.

In the West African sub-region, where Ghana is situated, scholarly reports of rehabilitation service differences are discernible in the range of programmes available for persons with visual impairment including segregated residential rehabilitation facilities, mobile projects, and community-driven rehabilitation initiatives. Additional efforts to expand access include offering low-cost devices through organisations such as the Hong Kong Society for the Blind's Low Vision Resource Centre alongside training of health workers to deliver low vision care via task-shifting approaches [23]. Despite being a low-resource country, Ghana has established policy commitments and legislative frameworks that reflects an intent to strengthen rehabilitation and ensure equitable access for PVIs The nation ratified the United Nations Convention on the Rights of Persons with Disabilities in 2012, becoming the 119th country to do so, creating a legal obligation for the country to improve services for persons with disabilities including vision rehabilitation[24, 25]. More specifically, Article 26 of the United Nations Convention on the Rights of Persons with Disabilities [24] enshrines the right to rehabilitation services. Similarly, Section 14 of Ghana's Persons with Disability Act (Act 715) calls for the establishment of rehabilitation centres in every region, ensuring people with disabilities including those with vision impairment have access to training, guidance, and counselling.[26, 27]. This is consistent with global disability-inclusive development frameworks which positions rehabilitation as essential for promoting functional ability, self-reliance, and inclusion of persons with visual impairment [28].

While these structures are necessary, they do not fully illuminate vision rehabilitation interventions in Ghana and how related support shape the everyday experiences of persons with vision impairment. Although reports suggest people with sub-optimal vision may resort to available treatment through low vision services[4], less is known about how PVIs navigate vision rehabilitation services, physical accessibility, education, and government supported programs daily [29]. In light of this gap, this study explores the lived experiences of persons with visual impairment in Ghana, with particular attention to how experiences are shaped by vision rehabilitation, accessibility, education, assistive devices and government supported programs. Drawing inspiration from similar research conducted in our research laboratory [30], the ultimate goal is to develop recommendations to promote the well-being of PVIs. By engaging deeply with the narratives of medical, educational and rehabilitation professionals as well as

persons with visual impairment, this study addresses the dearth of research on the lived realities of the visually disabled in Ghana.

Research Questions:

(a) What are their perspectives on vision rehabilitation services in Ghana?

(b) How do persons with visual impairment experience accessibility in relation to transportation, physical environment and independent mobility?
(c) What are their perspectives on eye care services, education, assistive devices and government supported programs for persons with visual impairment in Ghana?

2.0 Methodology

2.1 Study Design

A descriptive phenomenological design was selected to explore the lived experience of PVIs in Ghana. This approach was appropriate because it enabled different participants' reflections to be coalesced into a rich description of "what" and "how" living with vision impairment is experienced[31]. Descriptive phenomenology, grounded in the Husserlian tradition focused on the structures of lived experience as reported by participants themselves, was therefore the most epistemologically coherent choice for this study's aims[32]. Consistent with this approach, researchers aimed to set aside preconceptions and remain open to participants' perspectives while capturing the humanness of their predicament[33]. To reduce generalization, they gleaned insights from participants' streams of consciousness that is, their thoughts, feelings and memories of how PVIs cope in the Ghanaian society.

2.2 Ethical considerations

Ethical approval

was obtained through the University of Montreal's Comité d'Éthique de la Recherche Clinique (CERC) (# 2024–5924). All methods followed the tenants of Declaration of Helsinki. The reporting of study methods and research findings conformed explicitly and comprehensively to the Consolidated Criteria for Reporting Qualitative Research (COREQ) Checklist[34]. Researchers' professional background informed the sensitivity to the contextual realities of vision loss while necessitating ongoing reflexive awareness to minimise interpretative bias. All four authors actively hold research experience in vision rehabilitation.

2.3 Eligibility Criteria

A diverse group of participants were required for this exploration based on their profession and personal experiences. This study sought to include PVIs (blind and low vision), educators or rehabilitation professionals (R&E) and medical professionals. For PVI, eligibility criteria stipulated that participants

must be over 18 years of age, self-identify as having a visual impairment diagnosed at least one year prior, English-speaking and facing limitations in daily life activities. Inclusion criteria for professionals working with PVI in medical and educational fields was a minimum of one year of professional experience and at least monthly contact with PVIs. These criteria were intended to ensure respondents had sufficient acquaintance with the human experience of living with sight loss to produce rich responses required for phenomenological study. Initial email-based screening questions were used to confirm eligibility, report demographic information and schedule online interviews.

2.4 Recruitment and Sampling

DA initiated recruitment by contacting the Ghana Blind Union (GBU) through email correspondence detailing study information and requesting their circulation of a call for participants. In response, seven participants directly contacted DA, expressing their willingness to participate. All participants were recruited between November 2024 and March 2025.

A purposive sampling technique directed recruitment by selecting from individuals who responded to the call and met the inclusion criteria [35]. In addition,three(3) participants were recruited through snowball sampling, as initial participants referred other eligible candidates within their networks, maximizing the breadth of the datasets [36]. In total, ten (10) participants were included in this study and each received CAD 30 remuneration for their time.

2.5 Procedure

All interviews were conducted over a secure online connection via Zoom, in a confidential setting with only the researcher (DA) and the participant present. There was no relationship between the researchers and participants prior to the study. Interviews started with a background introduction of the researcher, participant(s) and a brief explanation of the study's purpose and discussion focus. Formal written consent was obtained, and verbal consent was reconfirmed immediately before starting the audio recording and questioning. Participants were assured that all data would be kept confidential and that their identities would not be disclosed. They were also reminded of their right to withdraw at any time.

Following these protocols, interviews began and lasted a total of 60–90 minutes. Data collection was guided by an in-depth, semi-structured guide(Appendix A) adapted from the existing literature [30]. Each interview followed the guide addressing five domains, namely, assistive technologies, vision rehabilitation services, government support programs, accessibility, and eye care services [30]. The questions further delved into service availability, procurement pathways, and payment structures for PVIs, consistent with barriers outlined in the World Health Organization's Action Plan [37]. Drawing on this semi-structured guide of open-ended questions was well-suited for this study, as it enhanced memory recall by beginning with broad prompts before culminating in more specific lines of inquiry, enabling the researcher to garner respondents' views in a natural way [34]. Data saturation was defined by three consecutive interviews in each participant group that generated no new themes, a criterion met after ten (10) interviews. Upon completion, participant names and institutional affiliations were anonymized. All recordings were transcribed verbatim using Zoom [38],verified for accuracy and then

imported into MAXQDA Analytics Pro 24 for analysis [39]. Participants' consent forms, video recordings, and transcript files were stored on a secure, password-protected OneDrive server managed by the Université de Montréal, with restricted access to the research team.

2.6 Data analysis

Data analysis was informed by qualitative thematic analysis grounded in the descriptive phenomenology framework [40]. Analysis began by the first author (DA) immersing herself in the data through repeated reading and reviewing of each transcript paired with corresponding audio recordings whilst bracketing out presuppositions to minimize interpretation bias. Using an inductive approach, significant statements relating to interviewees' experiences were identified and iteratively grouped into initial patterns that captured emerging meanings in the data. This was followed by an open and collaborative discussion with a co-author (JPN) through which patterns and their initial meanings were refined and reviewed. These patterns of statements were then clustered to form initial themes, which were subsequently reorganised and defined to form a comprehensive description of participants' perspectives. Final themes were agreed upon following several meetings and discussions with the research team. These meaning-oriented themes strengthened the robustness of qualitative research findings by grounding interpretations in participants' own expressions of lived experiences[40]. The final phase involved writing an analytic narrative that wove the themes together to clearly and fully convey their story. Member checking and peer debriefing were undertaken to ensure analytical rigor. Trustworthiness was strengthened by maintaining credibility and accountability throughout the research process, including prolonged engagement with transcripts, member checking, detailed documentation and rigorous peer review.

2.7 Reflexivity

Reflexivity was maintained across the entire research process. The researchers acknowledged their position and reflected on how their personal experience, thoughts, beliefs, opinions, and interpretations could shape the study process (i.e., from data collection to analysis) consciously suspending potential bias. DA maintained bracketing journals by documenting assumptions, interpretations, and moments of uncertainty which was reviewed by JPN at each phase of the analysis. Importantly, we adhered to the inclusion and exclusion criteria laid out for participant recruitment and data collection. During interviews, the researcher used an open-ended interview guide adapted from previous studies, with follow-up prompts, allowing participants to express their experiences without any time constraint. JPN independently reviewed the interview transcripts to further prevent biases from entering the data analysis process. Discussions were held regularly between authors to clarify any discrepancies in interpretation. Furthermore, sharing preliminary findings at a local conference helped understand the lens through which the study data were interpreted. While full objectivity is unattainable in the research process, we approached our data collection and analysis by making conscious efforts to set prior assumptions aside.

3.0 Results

3.1. Sociodemographic Characteristics of Participants

In total, ten participants (N = 10) were recruited from various regions in Ghana. The sample included three optometrists, one of whom also specialised in low vision rehabilitation, and three educators, with all but one working in inclusive education settings for students with visual impairments. The remaining four (n = 4) were persons with visual impairment, two with low vision and two who identified as functionally blind. This sample size aligns with phenomenological research principles where smaller cohorts are considered analytically advantageous to illuminate in-depth accounts of lived experience along with the aim of maintaining idiographic focus [41, 42].

Additional demographic details are presented in Table 1.

Table 1
Sociodemographic information of participants (N = 10)

Visual status	Participant ID	Gender	Residential Region	Occupation
	Person with vision impairment			
Low vision	PVI1	M	Volta	Financial Consultant
Blind	pvi2	F	Greater Accra	Undergraduate Student
Blind	pvi3	m	ashanti	Graduate Student
Low vision	pvi4	m	Central	Undergraduate Student
	Rehabilitator and education personnel			
	R&E1	M	Ashanti	Teacher of Students with Visual Impairments (TVI)
	r&E2	f	Greater Accra	Teacher of Students with Visual Impairments (TVI)
	r&E3	m	Central	Disability Education Resource Personnel
	Optometrist (OD)			
	OD1	m	Central	Low Vision Specialist / Optometrist
	od2	f	Greater Accra	Low Vision Specialist/ Optometrist
	od3	f	western	Low Vision Specialist/ Optometrist

M: Male; F: Female; OD: Optometrist; PVI: Persons with visual impairment; R&E: Rehabilitation practitioners/educators; TVI: Teachers of Students with Visual Impairment

3.2. Themes

Thematic analysis yielded seven themes: (1) Resources as a pathway to independence, (2) Living with fragmented support, (3) Knowledge barriers in accessing supports, (4) Compromised safety, (5) Financial and structural burden of visual disability, (6) Stigma and social exclusion, and (7) Call for reform. Each is supported by verbatim quotes with participant identification numbers (IDs).

3.2.1 Resources as a pathway to independence

Nearly all participants shared accounts of the transformative role of resources in promoting the independence and participation of PVIs. Some participants spoke of government support programs such as the Disability Common Fund and vocational training as a stepping stone for turning dreams into

reality. They described other government measures such as the National Health Insurance Scheme (NHIS), and free inclusive primary education promote the welfare of PVIs.

PVI2 mentioned, *"Government has some support they give to people who want to start a business. It comes from the government's District Disability Common Fund. A percentage of this fund is set aside to support us to start a business".* Another opined that, *"The vocational facility in inclusive schools has been helpful in training blind students. We have a sewing unit that trains them how to sew, a carpentry unit that teaches woodwork, and a leather unit where students can learn to make shoes, slippers, and other leather items" (R&E1).*

Participant PVI4 reported, *"Eye care services are free, depending on the type of hospital you visit. In government hospitals, the services are free because we are enrolled in the National Health Insurance Scheme (NHIS), so there is no cost".*

Again, R&E2 noted, *"We have free residential inclusive schools for the visually impaired at the basic level like the Akropong School for the Blind and Wa School for the Blind. These are boarding institutions and students do not pay tuition, as the government caters for them…..the government provides funding, infrastructure, and basic services such as feeding"*.

Moreover, they described support as a relational process, where independence blossomed through moments of peer connection and shared problem solving. A participant echoed, *"My colleagues who are perfect at using assistive devices, helped me. When I went to school, I learned Braille from my colleagues or my friends. They taught me how to read and write Braille. They also taught me how to use the white cane" (PVI 2).*

Another participant explained, *"There wasn't any session where we were introduced to mobility training or taught how to move around the school. We had to rely on our friends in our class or in the same house or dormitory. They were the ones we depended on for mobility support until we became familiar with the environment" (PVI3).*

Participants also highlighted the role of assistive devices as a resource in enabling daily independence by compensating for the decline in functionality. The white cane was the most frequently mentioned assistive device, with magnifiers coming in as a close second. One participant explained, "*Here in Ghana, there are not many assistive devices available. For mobility, it is the white cane. There are locally made white canes, which are less expensive, and the imported ones, which tend to cost more. You mostly see them using the foreign ones" (OD1)*.

Another respondent mentioned, "*We use magnifiers in the classroom and to write exams"* (PVI4).

3.2.2 Living with Fragmented Support

Participants highlighted present support systems including vision rehabilitation professionals such as low vision therapists, resource personnel, occupational therapists, psychologists and teachers of

students with visual impairment, but described services as inconsistent, unevenly distributed, often dependent on location, conditions or organizational affiliation. Similar concerns were raised about eye care services, the educational system, government-supported programmes and access to assistive devices. One participant commented, *"People in the rural areas usually have access to low-vision specialists by travelling to regional hospitals in the major cities" (OD2).*

Moreover, they portrayed support and services as something that must be searched for, negotiated, or accessed sporadically through limited channels.

This fragmentation was especially evident in comments such as *"Apart from seeing the low-vision specialist for vision rehabilitation, it's difficult to get additional support. There are some psychologists and maybe occupational therapists, but I haven't met one. Children in blind schools benefit the most from their teachers, but for adults, services are very limited. The university resource center helps students, but not for the public. Outside that, it's a very minimal service" (OD1)*.

Another participant echoed, "*Support is mostly available only when we are in school. Outside school, in the community or at home, you don't receive that kind of assistance. Even in school, you often have to push teachers, resource personnel or management to help for example, to guide you with a white cane if you don't know your way around. And even then, the support usually lasts only a short time, maybe a week or two" (PVI1).*

Experiences related to provision of assistive devices revealed inconsistency and informality. One participant noted, *"Braille paper, the frame and stylus are provided for free by the government only the first time, together with the white cane. After that, you have to buy these materials yourself whenever you need them" (R&E3). Another participant described*, "*New white cane users usually learn from experienced students…. they teach them how to use it" (PVI2).*

3.2.3 Knowledge barriers in accessing supports

Knowledge of available services varied widely, often leaving persons with no or partial vision unsure about what support they could realistically expect. One participant remarked, *"I've never heard of vision rehabilitation services... I do not even know what they do" (PVI2).* Another added, *"I grew up and taught in the Ashanti Region. I didn't even know there was a school for the deaf and blind in that area" (R&E1).*

Communication gaps within systems added to this uncertainty. Without clear and consistent information, PVIs often found it increasingly difficult to understand available support. These experiences were captured in comments such as *"If a doctor is telling me that my [optic] nerves are weak, the doctor should be able to say it in its simplest way so that I can understand… if you tell me that my [optic] nerves are weak and you just end the day, and I go home, I wouldn't know what you're trying to tell me" (PVI2).*

As a result, PVIs were left unsure of their next steps. In the words of one participant, *"Because there isn't a nationwide eye screening program and many services are miscommunicated, some people find alternative ways of dealing with their conditions and may never end up going to the hospital" (OD2).*

Another participant shared, "*When I first began seeking eye care for my sight problem, I didn't understand what the doctors were doing. I was desperate, so I went anywhere I was directed. A pastor then introduced me to a traditional medicine which I believe damaged my eye"* (PVI1).

3.2.4 Compromised Safety

Participants highlighted how environmental inaccessibility directly curtailed their autonomy and made reliance on others unavoidable. One participant explained, *"There are a lot of open gutters around. If you are not careful, you can fall into them. I usually go out with the guidance of a friend, so I do not get hurt in new environments"* (PVI4).

Concerns extended beyond physical inaccessibility to infrastructural gaps as one noted, "*In some of these spaces, the lighting conditions are very poor and create glare… They need stronger lighting to be able to see clearly"* (OD2).

In addition, participants drew attention to the lack of enforcement of accessibility policies. One respondent mentioned, "*The Disability Act of 2006 includes provisions for transportation, like reserving seats for persons with disabilities, but it has not been enforced. With the commercial cars, we fight before we even get a place to sit. Transport is tough here for visually impaired people" (PVI3)*.

Non-inclusive traffic environment shaped their daily experiences, as participants explained "*Our sidewalks, even though meant for pedestrians, sometimes have cars overtaking on them. There's a possibility that if a blind person is walking alone, they could even be hit by a car or a vehicle" (R&E3*) and another recounted, *"Most drivers don't know what the white cane means. They don't understand what raising up white cane means, so they ignore it and disobey. Even when the traffic light is on and cars are supposed to stop, motorbikes still pass through without stopping. They continue moving and can easily knock you down. So, when you go out, you really need someone to assist you"* (PVI1). These narrations collectively reinforce their reliance on sighted assistance for safe mobility in Ghana.

3.2.5 Financial and structural burden

Financial aid, institutional connections, or reliance on free programmes were reported as means by which participants obtained assistive devices, education and vision care service, however, they were deemed untimely and unreliable. A visually impaired participant shared "*For the Ghana Secretariat scholarship, you have to apply every year and they pay your fees. But they never pay at the appropriate time. You end up paying the fees yourself first, and only later do they pay into the school's account, after which you apply for a refund. The process takes a very long time. Since I entered Level 100, I haven't received anything. I'm now moving from Level 200 to Level 300, and I still haven't received it" (PVI3).* Another participant added *"Assistive devices are very expensive, so they are not readily available. You have to wait till the next restock or free donation by an NGO" (PVI4).*

For many, the cost of eyecare was a constant worry. This was elucidated through comment such as "*I have the National Health Insurance, but when I go to the hospital and they check the coverage and say 'Oh,*

this medicine is not covered.' When it happens like this, you have to pay it yourself, which is expensive for us" (PVI1). As their quotes reflect, surviving under-resourced systems in Ghana comes at a direct and indirect cost.Furthermore, procuring assistive devices was a hurdle for most. As quoted by R&E2 "*The cost of assistive devices is very high. Those provided by the government do not reach all regions in Ghana, and many parents cannot afford them for their children. This has become a major problem. For some time now, these devices provided by the Government have been out of stock at Ghana Education Service (GES) so many individuals who are blind are forced to live and learn without them.*" And OD3 shared "*In Ghana, only a few can afford white canes on their own. Even assistive devices such as telescopes are typically imported because they are not readily available in the country. This makes them very expensive, and hard to afford when importation costs are included*"

3.2.6 Stigma and Social Exclusion

The theme of stigmatization and social exclusion naturally emerged as personal disclosures unfolded. Participants reflected on how societal reactions to disability often left them feeling misunderstood, neglected or seen through cultural prejudice. Some recounted instances where visual disability was interpreted as a curse or something contagious. One participant disclosed, *"They do not assist us because of the mindset that some of these disability challenges are contagious"* (PVI1). This stigma extended into the family home, as participant reflected, "*The moment the child has visual impairment, it's as if their child is useless"* (R&E2).

Further reflection touched on the ineffectiveness of disability laws, where one participant mentioned, "*Although we have the disability Act 715, it is like a toothless bulldog. It exists but it is not working.*" (PVI4).

Employment also unfolded another stark form of exclusion. One participant described, "*Employment is one of the most difficult experiences for persons with disabilities... You can present all your qualifications, yet someone will still tell you, 'Because you cannot see, you cannot do this job*" (R&E2).

Furthermore, OD1 noted how non-inclusive environments deepened their sense of isolation, expressing that, *"Most buildings are not disability friendly. The blind struggle to move about because floors do not have tactile pavement. Because of this, they cannot tell exactly where they are. We have poor street designs with no raised edges or detectable warning surfaces."*

3.2.7 Call for reform

Participants emphasized the need for infrastructural improvements to support safe and independent mobility. As one optometrist (OD1) shared, *"We need to improve Ghana's infrastructure. The government should install tactile paving along pedestrian walkways, build ramps that are disability-friendly, and remove all obstacles from sidewalks so that people with visual impairments can move safely without bumping into them."* They also highlighted the need for shifting societal perceptions through sustained public education. Another participant stressed, *"We need much stronger education and advocacy, so people understand that people who are visually impaired are also human beings and not supernatural beings. As*

healthcare professionals, we should be educating the public and advocating the society about these people, so they are not being discriminated against." (OD3)

Again, respondents stressed the need to challenge pre-existing assumptions about the work capabilities of PVI, advocating for equitable access to employment opportunities. They described how graduates frequently struggle to secure employment, calling on government and stakeholder support. One participant pleaded, "*The government should reserve a percentage of jobs in workplaces for persons with special needs. Many visually impaired people complete school but still cannot find employment, which leaves them dependent on their families. I am pleading with the government to ensure that when people are being hired, they should reserve some positions for persons with special needs*." (R&E1)

In the words of another participant: "*I would call on the government, NGOs, and all those concerned to recognize that they have a role to play. The fact that someone cannot see, or has an eye condition, does not mean that the person cannot do anything, especially with regard to employment. All of us have special abilities and capabilities, and we can also contribute to the growth of the nation and society. At the very least, we should be given the opportunity to demonstrate what we can do, rather than having others assume or predetermine that because of a disability, we are unable to do certain things. We should all be given an equal chance, an equal opportunity, so that we can build a better place and a better society for all of us to live in.*" (PVI4)

4.0 Discussion

In this discussion, we examine the realities of individuals living with visual impairment in the Ghanaian society, focusing on perspectives on vision rehabilitation services, eyecare services, education, government supported programs and physical accessibility. Previous studies have identified challenges and facilitators to various specific services available to persons with visual impairment in Ghana. To the best of our knowledge, this is the only study to comprehensively synthesize the lived realities of people with vision impairment in Ghana across multiple domains, informed by perspectives of professionals who work closely with visually impaired individuals (R&E, OD) as well as PVIs.

4.1 Integration of Vision Rehabilitation

Providing vision rehabilitation services remains paramount to maximizing functional ability, through the learning of adaptive strategies, mobility training, physical approaches and the effective use of assistive devices. With regard to the experiences shared in this study, participants described limited knowledge as well as weak visibility of vision rehabilitation services. Given that optometrists in Ghana are well positioned to provide vision rehabilitation services, particularly low vision services due to their widespread distribution across urban and rural areas [43], it was surprising to find that service awareness remains low. Beyond not knowing what these services entail, participants indicated that outside professionals frequently found in inclusive educational settings, they were unsure of who provides these services. This may be due to the limited integration of vision rehabilitation within the eye

care continuum, which has been associated with constraints in equipment and high cost of assistive devices[4, 44]. Another study reports that eye care professionals remain uninvolved in low vision services due to low interest, heavy ophthalmology workload, the view of time-intensive and financially unrewarding care [23]. Rather than reflecting PVI disengagement, these findings reflect a system uptake failure as PVIs navigate a reality where services are opaque, geographically concentrated, and siloed, making access practically impossible. Our findings also shows that knowledge barrier, not only service availability, critically shape access. A structured national effort to integrate vision rehabilitation into routine eye-care delivery through targeted practitioner training and awareness campaigns can enhance service delivery, visibility and uptake.

4.2 Expanding access to resources, support and pathways to independence

Resources have been widely published to have a transformational impact on the lives of persons with visual impairment [15, 23, 45]. Like in our present data, resources such as assistive devices promote personal development, self-empowerment, and life satisfaction. Also, government-funded programs like the National Health Insurance Scheme (NHIS) and the Disability Common Fund provide equitable opportunities for persons with vision impairment alongside sighted individuals concurring with other studies [46–48].It also contributes to the reduction of poverty among persons with disabilities, especially those without employment.

Our study shows that relational anchoring is a form of support, particularly for learning and adaptation, as participants described them as a pathway to independence, with peer-guided strategies enabling long-term functional proficiency. Likewise, participants described they could move outdoors with confidence only when a trusted companion was by their side, making guided mobility central to their physical safety. This concurs with a study by Odame and colleagues who stated that peer guidance aided PVIs in navigating both academic studies and the environment with confidence.[48]. Hence, independence among PVIs in Ghana is not achieved through individual effort alone, but through a combination of formal support systems, informal relationships, and opportunities. While this may appear beneficial, it often reflects the functional absence of formal rehabilitation training and risks fostering over-reliance on informal support, which may mask the unmet need to provide the right interventions that increase functional ability. Strengthening assistive device provisions, expanding government-funded programs, integrating mobility training and formalizing community support structures can promote sustainable independence of PVIs.

4.3 Providing equitable, reliable and accessible services delivery

Despite the importance of resource deployment and support systems to promote the quality of life of PVIs [49, 50], participants deemed resources such as government funded programs and vision services as unreliable, inconsistent and inequitable. This observation is similar to previous findings from other contexts showing that persons with visual impairment encounter difficulties with government supported

funds such as delays in disbursement and insufficient funds [51]. As such, many continue to find necessary support elusive. Conversely, our study revealed compounding difficulties such as challenges in locating appropriate care and poor communication from service providers sometimes delaying help-seeking and pushing individuals toward unsafe alternatives. This is unsurprising, given evidence that eyecare facilities are concentrated in major cities, with limited attention to marginalized areas [4, 52]. This is further reflected in our findings, where urban residents appeared to be the most reached population. This patchwork of support was also reported to extend beyond eyecare, seeping into educational systems. To address these challenges, policymakers and stakeholders can adopt accountability mechanisms including regular audits of fund disbursements, monitoring of service reliability and regional coverage to identify gaps and make necessary adjustments to ensure services are accessible, timely, and responsive.

4.4 Closing gaps between disability policy and practice

Our findings revealed that written disability laws were often ‘at odds’ with their realities, creating a gap between policy intent and lived experiences. Accordingly, the Ghana Disability Act 2006 (Act 715) was enshrined to protect the rights of persons with disability and promote their social integration. The Act also mandates accessible environments and public transportation [53], yet it is perceived as practically ineffective. This finding substantiates previous evidence on the incompatibility between physical buildings and disability legislation [54]. Ghana's ratification of the UNCRPD and enactment of Act 715 represent genuine commitments, yet participants' description of the Disability Act as a "toothless bulldog" reflects what literature calls paper compliance where law substitutes for enforcement. More concerning, PVIs had internalised this absence as a signal that their rights are more symbolic than real, which may prevent PVIs from seeking the protections they are entitled to. Routine evaluation of the implementation of Act 715, identification of non-compliant institutions, and enforcing corrective actions can ensure legal protections translate into meaningful improvements in accessibility and inclusion for persons with visual impairment.

4.5. Prioritizing accessible environments and safe mobility

The theme of compromised safety indicates how environments in Ghana limit the autonomy of people with visual impairments. Participants’ accounts of open gutters, poor lighting, dangerous driver behaviour and unpredictable traffic conditions show how daily mobility is shaped by unforeseen risk rather than choice. Built environments do not support their safety, leading to social exclusion and isolation [55]. Scholarly studies similarly point to various difficulties this population faces when navigating unsafe traffic and transport conditions in Ghana. For instance, research conducted by Abraham et al. found shortcomings in drivers’ knowledge and practices, including limited understanding of how to identify and appropriately respond to pedestrians with visual disability, which may compromise safe and independent mobility [56]. When PVIs are unable to navigate public space safely without sighted assistance, their capacity to access employment, education, healthcare, and social participation is conditioned on the availability of another person. This enforced dependency has consequences beyond the immediate safety risks described, as it erodes self-efficacy, self-worth and functional ability.

These findings reinforce the need to enforce the Ghana Disability Act 2006 alongside road-safety sensitization, including driver education on disability awareness. Future research should examine functional and psychosocial outcomes of PVIs who have lived longer in inaccessible built environments, an underexplored area in the Ghanaian literature.

4.6 Addressing socio-cultural attitude and stigma

Beyond structural barriers, reported socio-cultural attitudes, including deep-rooted cultural beliefs, parental disengagement, and deficit-based views of visual impairment further contributed to their experiences. Such negative misconceptions unfortunately distort people's understanding of vision impairment and hinder their livelihood participation [57]. Research suggests that these value-laden biases undermine psychological resilience, increase feeling of isolation, diminish emotional wellbeing and erode self-worth[58]. These stereotypes and attitudes often exclude people with visual impairments from employment, educational, and social opportunities, reinforcing systemic inequalities[59, 60]. Disability awareness training and public sensitization campaigns can address such beliefs, but changing minds without changing structures will only go so far. Enforceable anti-discrimination provisions, disability-inclusive hiring mandates, and compulsory accessibility standards are equally necessary to create lasting change.

4.7 Strengthening public awareness, support and societal sensitization

Equally important was participants' call for increased public awareness of available services, stronger government support, and societal sensitization toward visual disability. Despite the implementation of policies and services intended to assert the rights of persons with disabilities and to tackle barriers to inclusion, their effectiveness is often undermined in contexts where a lack of awareness and stigmatizing beliefs prevail [61]. As such, efforts toward inclusion may be met with resistance, highlighting the critical role of greater state involvement, public consciousness and positive attitude in driving the success of policy implementation, societal acceptance, expanded knowledge and practical effectiveness of policies. Greater allocation of funds and material resources remains crucial in addressing these barriers [62, 63],a responsibility the Government of Ghana must take on. Concretely, the state should prioritize integrating vision rehabilitation into routine eye care, enforce the Ghana Disability Act 2006 with clear accountability mechanisms, expand and reliably disburse disability funding, and mandate disability awareness training across public institutions. Together, these steps would begin to close the gap between what the law promises and what persons with visual impairment experience, moving Ghana closer to a society where sight loss does not determine the boundaries of a person's life.

5.0 Limitations

Although participants were recruited from multiple regions in Ghana, not all regions were represented. While this study provides valuable insights, the sample size of this phenomenological research limits the transferability and generalization of findings to all educators, medical professionals and PVIs across

Ghana. Additionally, recruitment through the Ghana Blind Union and professional networks may have introduced selection bias, as participants were more likely to be organizationally connected, potentially underrepresenting the experiences of marginalized PVIs and those without organizational affiliations.

6.0 Conclusion

In this phenomenological study, we discovered that the lived experiences of persons with visual impairment are shaped by both enabling supports and barriers. Given the prevailing evidence, coordinated action from policymakers and stakeholders is required to alleviate difficulties and promote autonomy. The Government of Ghana must make an active effort to integrate vision rehabilitation into eye care delivery, increase public sensitization to counter cultural stigma and strengthen accountability for support programs and disability-related policies, in partnership with PVIs and professionals working with the visually impaired. Advancing these efforts also requires legislative enforcement and policy revisions. Further research should prioritize marginalized PVI populations to build equity-driven change.

Abbreviations

GBU
Ghana Blind Union
GES
Ghana Education Service
LMICs
Low- and middle-income countries
NHIS
National Health Insurance Scheme
OD
Optometrist
PVI
Persons with visual impairment /People with vision impairment
R&E
Rehabilitation practitioners/educators
TVIs
Teachers of students with visual impairment
WHO
World Health Organization

Declarations

1. Ethics approval and consent to participate

Ethical approval was obtained through the University of Montreal's Comité d'Éthique de la Recherche Clinique (CERC) (# 2024-5924). Informed consent was obtained from all study participants electronically.

2. Consent for publication

All authors approved the manuscript.

3. Availability of data and materials

All the data required are already in the manuscript. Additional data will be available upon request.

4. Competing interests

The authors declare that they have no competing interests.

5. Funding

The work was supported by a funding from the Fonds de recherche Québec—Santé-Vision Sciences Research Network (PP 2324-02#; J.P.N.).

6. Authors' contributions

DA (female) and JPN (male) collaborated in designing the study. DA conducted data collection, data analysis, writing, reviewing and editing of manuscript. JPN, SSK (female), and PRP (male) carried out data analysis, reviewing and editing. All authors critically reviewed and approved the final version of the manuscript and gave consent for its publication.

7. Acknowledgements

We acknowledge the support of the research team and the Ghana Blind Union (GBU) for their support in the execution of this study. We also acknowledge all participants for their openness and generosity to share their livelihood stories which generated information that will hopefully raise awareness about the lived experience of persons with vision impairments in Ghana.

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