CHILD REARING PRACTICES BY PARENTS OF CHILDREN WITH PHYSICAL DISABILITIES IN *WOREDA* 20 AND 25 ADDIS ABABA

SELAMAWIT TADESSE

A thesis submitted to the School of Graduate Studies of Addis Ababa University in partial fulfilment of the requirements for the Degree of Master of Arts in Special Education

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GLOSSARY

Words in *italics* are Amharic words or names and they are presented based on the participants' translations:

Abish: greenish cereal turned into flour and made as porridge, usually fed to children and women

Akerkari: spinal cord

Awakie: People who are believed to have extra power in spirit and can foretell or know the problems of other people and give prescriptions for cure.

Balageroch: people living in the countryside

Balewukabi: a person who is also called *awakie* sometimes that has a spirit in him, this person can be a woman or a man and goes to a trance when the spirit apparently appears on her/him

Behitsanent: Childhood period referred by participants from 0-4 years old

Beliginet: Childhood period referred by participants from 4-18 years old

Betilikinet: Adulthood referred by participants above 18 years old

Buda: evil eye believed to possess mind of others and cause them unconsciousness or paroxysm behaviour.

Debtera: person who has church education sometime called priest and can make witchcraft

Gundish: a cut-off body or disabled (derogatory word for physical disability)

Injera and *wot*: Ethiopian National food made of *teff* and any kind of sauce

Kalicha: A person who has spirit power interchangeably named as *bale-wukabi (see balewukabi)*

Ke-goremese: it indicates the child's age in adolescence

Likift: possession by devil spirit

Nefsun-yaweke: a person who becomes an adolescent or an adult

Shiba: physical disability (derogatory word)

Silet: vow made to sacred entities like the saints

Tebel: Holy water used to treat people in Christina churches such as orthodox and Catholic

Tebel-tsadik: feast made on any one of the saint's days such as 'St. Michael day/St. Gabriel's day'.

Wegesha: person who knows to treat physical anomalies such as splinted bones, dislocation of bones

Yemitil beshita: name referred to epilepsy

Yesemayu: name referred to cerebral palsy

ABSTRACT

The study investigated child-rearing practices by parents of children with physical disabilities. The rearing practices considered in the study include *feeding, health care, disciplinary methods, informal sex-role skill training, formal schooling and parent-child relationship.*

In collecting data for the study, thirty mothers/guardians, thirty children with physical disability and their twenty-tree non-disabled siblings were contacted. The children with physical disability were selected from among those who get some support from two Addis Ababa non-government organizations namely Cheshire Community Based Rehabilitation Project and Voluntary Council for Handicap Project. In addition to the above mentioned, data were collected from the two projects' offices records.

The data obtained in the study were analysed using both quantitative and qualitative approaches. Accordingly the major findings were: a reasonably long period of breast-feeding, inadequate body washing, an emphasis on non-corporal punishment, de-emphasis on informal skill training and formal schooling and general positive relationship between mothers/guardians and their children with physical disabilities. Also, substantial influence of traditional and religious outlook on childrearing practices was observed particularly in relation to health care, informal sex role skill training and schooling. Discrepancies in rearing of children with and without physical were observed particularly in disciplinary methods, informal sex role skills training and formal schooling while similarities were on feeding, health care and parent-child relationships. *Awareness creation and education* to the families on physical disability and its intervention is recommended for more positive rearing practices among families of children with physical disabilities.

CHAPTER ONE

1. INTRODUCTION

1.1. GENERAL BACKGROUND

This study was conducted in two *Woredas* of Addis Ababa City Administration, namely, *Woreda* 20 and *Woreda* 25. In *Woreda* 20, a survey made by a local NGO Voluntary Council for Handicap (VCH) in seven of the *kebeles* shows that there are a total of 264 people with disabilities. This NGO works on community based rehabilitation of people with disability (VCH, 2000). In *Woreda* 25, a survey made in the year 2000 by Cheshire Community Based Rehabilitation (CCBR) shows that there are 179 people with disabilities (CCBR, 2000). The surveys of the two *woredas* indicated that children are about half of the population with disability (VCH, 2000; CCBR, 2000). The study included only those with physical disability.

The types of disabilities of the two projects' participants in *Woreda* 20 and 25 generally include hearing impairment, visual impairment, mental retardation, physical disorder such as polio, epilepsy, rickets, cerebral palsy and speech problems (VCH, 2000; CCBR, 2000).

The people in the two *woredas* are similar in religion, language and economic background. The mainstay of the people is petty trade and daily menial jobs with an average income of 150 -200 Birr (VCH, 2000; CCBR, 2000).

Two main religions, Muslim and Orthodox Christianity are practised and the dominant language the people use is Amharic. The ethnic background of the people is heterogeneous and the dominant ones includes *Oromo, Amhara, Gurage, Wolaita* and *Tigray*. (VCH, 2000; CCBR, 2000).

The two organizations indicate that polio, cerebral palsy, poor personal hygiene and environmental sanitation; lack of knowledge of the health service available in the area and harmful traditional practices and beliefs are the major causes of health problems or disabilities in the two sites. Children with disabilities highly depend on their families for mobility, self-care and communication. On the other hand, parents of children with disabilities are said to have low level of caring skills for children with disabilities particularly for children with cerebral palsy (VCH, 2000; CCBR, 2000). Other problems faced by families of the children with disabilities are lack of information on medical services for early detection and intervention, little access to health service, appliances and aids, and lack of awareness on the causes of and means of preventing disability. Many of the parents believe that the causes of disability are curse from God for the wrong deeds of the parents, devil's possession, and pregnant woman's exposure to deformed and/or 'ugly and frightening' events or persons, and heredity (CCBR & VCH, 2000). The parents use traditional and scientific methods of treatments for the children with disabilities. Traditional treatments include holy water, sorcery *'tenquay/awakie',* and traditional medicines. The parents also take their children to hospitals (VCH & CCBR, 2000).

The attitude of parents and the community toward disability is that children with disability are incapable of establishing their own independent future life. The general social and attitudinal problems of children with disabilities in the two *woredas* as indicated by VCH and CCBR (2000) is that parents feel ashamed of their children with disabilities because of the social stigma. Neighbours sometimes are heard *saying "God gave these parents cripple children because of their sin"* Therefore, the parents, in attempting to avoid such social stigmas, usually hide their children with disabilities behind doors thus inhibiting them from exercising mobility, education and social interaction. Many children, particularly with cerebral palsy, are neglected. They are usually left alone on the floor drooling and without care of sanitation and feeding (VCH; 2000; CCBR, 2000).

In general, the above information suggests that children with disabilities in *Woredas* 20 and 25 lack the desired care and attention for many different reasons. One of these concerns the child rearing practices (by their parents) and/or their parents' beliefs about disabilities.

This is the general issue to be investigated in the present study. The specific research questions are indicated below.

1.2. STATEMENT OF THE PROBLEM

A. What are the prevailing child rearing practices or malpractice of parents or guardians with regard to their *physically disabled* children? Child rearing practices will include;

- Feeding
- Health care
- Disciplinary methods
- Informal sex role skill training
- Formal schooling
- Parent-child Relationship

B. What are the prevailing conceptions and beliefs of parents or guardians regarding the causes, prevention and remedies/cure of physical disabilities and rearing practices? How are they related to scientific explanations of the same and the actual rearing practices?

C. In what major ways do child-rearing practices on children with disabilities differ from methods used to rear their non-disabled children?

D. What types of support would parents like to have in rearing their children with physical disability?

1.2.1. OPERATIONAL DEFINITION

1.2.1.1. Parents

Parent (s) is a father or a mother or both who provide care to their biological child or children by living together in one home.

1.2.1.2. Guardian

Guardian (s) is any caregiver other than a father or mother who provides care to a child or children who are not their biological children and live together in one home.

1.2.1.3. Physical Disability

Physical disability is defined in terms of a child who has any kind of motor disorder including, polio, clubfoot, epilepsy and cerebral palsy.

1.2.1.4. Child rearing

Child rearing is regular methods used by parents or guardians to care for children interact with them, train and deal with them on various day-to-day life activities. The provision of parental care will include a) *feeding, b) health care, c) disciplinary methods, d) informal sex role skill training, e) formal schooling, and f) parent-child relationship.*

1.2.1.5. Belief

For the purpose of this study, *belief* is defined as parents' feeling, trust, or confidence in something or the things they accept as true or real. Belief in this study includes religious, traditional values, perceptions, and knowledge of the parents.

CHAPTER TWO

2. REVIEW OF RELATED LITERATURE

2.1. CHILD REARING METHODS: GENERAL FEATURES, MAJOR ASPECTSAND ASSESSMENT PROCEDURES

Child rearing is a process whereby an individual's standards, skills, motives, attitudes, and behaviours are influenced or guided by caregivers. Parents, siblings, peers, and teachers are communicators of values and directing and modifying children's behaviour toward shaping their personal and environmental view. They influence the child through direct tuition, that is, by putting forth rules or standards of behaviour and trying to maintain them through rewards and punishments. Hetherington & Parke (1986) pointed out that these group also have impact on the development of morality and self-control, on the inhibition of aggression and encouragement of positive social behaviour, on achievement and on behaviours regarded as appropriate for males and females within a specific culture. Mussen *et.al.* (1990) pointed out that each child is reared within a particular cultural context, and that most children in each generation grow up to function well in their culture. Therefore, all theories about infant's social development and the child rearing practices associated with healthy development must be considered within a cultural context.

Thus, Mussen and associates (1990) and Hetherington & Parke (1986)) pointed out that the standards, goals and methods of child rearing vary among societies, within subgroups in the same society, and within a society over time. And that different culture has different conceptions of the ideal child and these beliefs determine how parents rear their children. For example, Hetherington & Parke (1986) pointed out that Guatemalan mothers confine their infants to a small, dark, windowless, toy-less hut for the first year of life because of the belief that outside fresh air, sunlight, and dirt are harmful whereas American mothers surround their children with educational toys, festoon cribs with spinning mobiles and busy boxes, and involve their children in a routine of daily sunbathes and walks in the parks.

Besides, American mothers conceive of their mission as moulding their children into active, independent beings by stimulating them and teaching them self-reliance and social skills. By contrast, Japanese mothers remain very close to their young children; they respond quickly to crying by soothing and quieting more often than stimulating their babies. (Mussen *et.al.*, 1990).

In the years between 1910 and 1930, which was the heyday of American behaviourism led by John B. Watson, child-rearing experts regarded the infant as an object for systematic shaping and conditioning. Little attention was paid to the needs and feelings of the child or the parent, or possible variations in genetic predisposition or temperamental characteristics of the child. Behaviourists of this era maintained an extreme environmentalist position and believed that desirable social behaviour could be shaped in almost any child. Desirable social behaviour could be attained if the child's antisocial behaviours were always punished and never indulged, and if positive behaviours were carefully conditioned and rewarded in a highly controlled and structured child-rearing regime. The goal of the parents was to "shape in" good habits and avoid the development of, or "stamp out", bad habits (Hetherington & Parke, 1986).

From the early 1930s until the mid-1960s, a more permissive attitude in which the parent was advised to be concerned with the feelings and capacities of the child emerged. This shift was due to in part to the influence of Freudian psychology and its focus on the role of early deprivation and restrictions in the development of inhibitions that could serve as the foundation of many emotional problems. Psychologists of the time stressed the importance of the "readiness" of the child in socialization. When the child was maturationally ready and at the appropriate stage for training, then weaning, toilet training, and other forms of self-control would proceed with greater ease and less stress for both mother and child. When the child was biologically ready, she would almost train herself with a little encouragement from the parent if there were a positive relationship between parent and child (Hetherington & Parke, 1986).

According to these scholars, this more relaxed attitude toward child-rearing was given added force by the continuing influence of progressive educators, such as John Dewey, and the writings of humanistic psychologists, such as A.H. Maslow and Carl Rogers, which began to appear in the 1940s. Both of these groups believed that individuals have an innate capacity to learn and develop in a constructive and creative way and to realise their potential abilities if they are free to explore and develop in open, accepting environment. Since the mid-1960s there has been a continued emphasis on the role of parental love in the socialization of the child; however, experts now advise the parents to play a less permissive and more active role in shaping the child's behaviour (Hetherington & Parke, 1986).

2.1.1. PARENTAL BEHAVIOR IN CHILD REARING

All parents have desire and hopes for their children. The way parents achieve these ends can differ greatly from family to family. Dworetzky (1995) noted that researchers do not agree on which one of the many child-rearing practices is best. However, parents provide role models for their children and that children rely on heir parents to teach them about the world.

Hetherington & Parke (1986) noted three main parenting styles and they are *authoritative, authoritarian,* and *permissive.* The *authoritative* parents are warm and supportive toward their children. They give the child consistent standards to abide by but they are at the same time willing to grant her sufficient authority. They are flexible, often even willing to learn from the child. Children whose parents are authoritative are socially active and responsible, they have high self-esteem and they evaluate their life possibilities, committing themselves to certain values and goals. The *authoritarian* parents are controlling in their interactions with the child. They expect the child to abide by numerous rules, and they are unwilling to adjust to the child's needs for independence. The interaction between the authoritarian parents and the adolescent child, for example, are likely to be conflict-ridden. Children of authoritarian parents have problems developing their own identity in adolescence often prematurely withdrawing from attempts to evaluate their life choices and make commitments. The *permissive* parents understand their children. They expect the child to be sufficiently mature which will help her to make major life decisions on her own, and they provide her with inconsistent or no rules, standards, and expectations. For example, permissive parents often attempt to interact with the adolescent as though they were friends, and they resent the adolescent's attempt to form attachments with peers. Children of permissive parents feels rejected and confused from the lack of direction in the home and resentful of their parents' attempts to be friendly. They often develop emotional and behavioural problems as result of inadequate guidance they receive and the inconsistencies and lenience in their parents' stand toward them. Generally girls of permissive parents evidence emotional problems including alienation and an attitude of helplessness, whereas boys of such parents evidence behavioural problems Hetherington & Parke (1986). Watson (1973) found out that research is consistent in stating that there is direct relationship between parental attitude and children behaviour. He noted as example that authoritative parents who were themselves non-conforming tend to have boys who were more independent, purposive, and dominant.

2.1.2. FACTORS AFFECTING CHILD REARING

Research indicates that among several other factors, social class as defined by the economic capacity of families, ethnicity, and family size affect child-rearing practices.

With regard to social class, for example, lower class parents are said to have placed more emphasis on respectability and obedience to authority; middle class parents put more emphasis on the development of curiosity, internal control, the ability to delay gratification and work for distant goals, and sensitivity in relations with others (Hetherington & Parke, 1986). Working – class men whose jobs typically require compliance with authority stress obedience and conformity in socializing their children. Middle class men whose work involves greater initiative, competitiveness, and risk-taking attempt to train their children to be independent and self –directing (Mussen *et al.*, 1990).

Ethnicity also influences childrearing. The behavior of parents and children is understood in the context of the meanings and values of the individual's particular socio-culture. For example, Hetherington & Parke (1986) indicate that child rearing within subcultures is oriented toward the development of competencies required for adult political, economic, and social roles. Considering the American society, these competencies and the child rearing practices necessary to develop them differ for the white middle class and for minority groups such as urban ghetto blacks (Hetherington & Parke 1986).

Another factor affecting child rearing is family size. As family size increases, opportunities, for extensive contact between the parents and the individual child decrease, but opportunities for a variety of interactions with siblings expand (Mussen *et.al.*, 1990).

The same scholars pointed out that a parent's attitude towards child rearing and the circumstances under which a child is reared would change as more children are added to the family. With a large number of children, particularly in families with over six children, family roles tend to become more precisely defined, chores are assigned, and discipline is more authoritarian and severe. Parents cannot afford to be indulgent with a large number of children or chaos will result. There is little time for reasoning and extended explanations. In addition, as family size increases, the mother exhibits not only less attention but also less warmth toward individual children. Frequently older siblings are assigned the supervisory and disciplinary roles maintained by parents in smaller families (Mussen *et.al.*, 1990).

Because the parents in large families cannot interact as closely with their children as those in smaller families, there is less opportunity for overprotection, infantalization, constant harassing, or close supervision of children. The results of this relationship are reflected in the greater independence but lower academic achievement of children from large families (Hetherington & Parke, 1986).

Economic limitation is another factor affecting child rearing. According to Luthar (1999), when socioeconomic resources of parents are unremittingly scant, the challenges of daily living can substantially erode parents' tolerance and mental health.

Psychological condition such as depressive feelings could also adversely affect various aspects of parenting behaviour. Luthar (1999) found out that depressive mothers tend to be less attentive than others to their children; make more negative attribution about their children; and are at risk for hostile, coercive parenting as well as child maltreatment. Another factor for child abuse is that parents of children with disabilities often expect their children to perform in an impossibly developmentally advanced way or to exhibit levels of independence and self – control. (Hetherington & Parke, 1986). Mussen (1990) also noted that poor parenting and child abuse is associated with inability to handle stress adequately. Furthermore, Hetherington & Parke (1986) indicated that inappropriate parenting styles sometimes also lead to the abuse and neglect of children

2.1.3. SEX ROLE TRAINING IN CHILD REARING

Considerable consistency in standards of appropriate sex-role behavior exists within and between cultures. Some behaviors viewed as more characteristics of males or females in the American culture as cited by Hetherington & Parke (1986): the male role is oriented toward controlling and manipulating the environment. Males are expected to be independent, assertive, dominant, and competitive in social and sexual relations. Females are expected to more passive, loving, sensitive, and supportive in social relationships, especially in their family role as a wife and mother. Expression of warmth in personal relationships, anxiety under pressure and suppression of overt aggression and sexuality are regarded as more appropriate for women than for men. Although this may appear to be a rather outdated presentation of sex-role standards, studies have indicated that females are expected to be higher in affection, nurturance, and passivity than males while males are expected to be higher in aggression, independence, competence, and dominance than females. Even before their child is born, fathers show a strong preference to have a son. After birth, especially with first-born children, they are more likely to stimulate and talk to their sons.

2.1.4. PARENTS AS MEDIATORS IN CHILD-REARING

Supporting measures which focus on the child's individual strengths is today becoming more and more prevalent, also for children with mental and physical disabilities. The caregivers or parents play crucial role in providing such support. Rye (1997) indicated that an early positive child-parent or caregiver relationship and interaction brings about quality of development in the child. And lack of opportunity to form attachment early in life may interfere with children's later psychosocial development. Rye (1997) further indicated that adults' natural tendency to hold, talk, smile, and respond to the infant cry as complementary to the infant's own biologically determined behaviour, would build attachment.

Studies (Darge, 1997; Rye, 1997; Klein, 1996) stress that it is crucial that the caregiver should guide and support the child's own initiative towards the surrounding world as he or she grows up. Darge (1997) noted that responding to children's need readily and adequately, providing explanations about desirable and undesirable actions, rewarding desirable behaviours, and expressing love and concern foster the development of self-management in the children. Crucial to these developments is the mother's and the father's unconditional acceptance of the child.

Rye (1997) and Klein (1996) suggested eight guidelines that are simple and universal and present in care-giver-child communication in all cultures, though there are great differences between cultures, in the way they are expressed. The eight guidelines for good interactions are: Emotional – (1) showing positive feelings of love, (2) following and responding to the initiative of the child, (3) establishing a positive personal dialogue, verbal or non-verbal, (4) praising and giving confirmations to the child; and Mediational - (5) helping the child to focus on things, situations in the environment, (6) conveying meaning and enthusiasm to the child's experiences, (7) expanding and enriching the child's experience by explanations and comparisons, and (8) regulating and guiding the child's actions and projects, setting limits for what is allowed in a positive way, giving alternative for action (Haywood, 1993; Klein, 1996; Rye, 1997).

2.1.5. CHILD REARING AMONG THE ETHIOPIAN COMMUNITY (BIRDS-EYE VIEW)

Describing the Ethiopian methods of child rearing, particularly of the rural area, (Ringness & Gander 1974; Levine, 1965; Kebebew, 1986; Molvaer 1995) wrote that a child is considered to be a "gift of God" and children are the "wealth of family". These authors indicate that in the Ethiopian community, it is desirable to have as many children as possible for economic reasons and because infant mortality is high. They further stated that many children are needed to help their parents with their work, to be sure there will be married children to take care of the parents in their old age, and to insure that the family lineage will be carried on. For example, a man who has several surviving sons is said to be "not dead" when deceased. Barrenness often leads to divorce or the rearing of someone else's children as one's own.

In addition, the same authors (Ringness & Gander 1974; Levine, 1965; Molvaer 1995; Kebebew, 1986.) indicate that communities in Ethiopia do not provide their children with sufficient stimulation in early childhood, and as a result children are said to be lacking verbal interaction with adults throughout childhood. Children in Ethiopia as stated by Ringness & Gander (1974) are considered inferior to adults; respect for parents and other adults is essential, and children who displease their parents may be harshly punished. Fear is also used a means of control. Superstition is used for treatment of the ill, and care in the supervision, cleanliness, and nutrition of young children is not adequate. (Levine, 1965; Ringness & Gander 1974; Kebebew 1986; Molvaer 1995).

Furthermore, Ringness & Gander (1974) after comparing child rearing methods of the Ethiopians to that of impoverished Americans, found out that both countries have similar child rearing methods which emanates from families characterized by poverty, and that such child rearing practices contribute to the perpetuation of low socio-economic status, and they recommend that information in areas such as birth control, preventive health care (nutrition, sex education, sanitation, health facilities etc.), prenatal care, and child care should be given to rural Ethiopians and the poverty stricken Americans.

2.2. MAJOR PROBLEMS OF PARENTS THAT HAVE CHILDREN WITH DISABILITIES

2.2.1. ATTITUDE OF SOCIETY TOWARD DISABILITY: HISTORICAL PERSPECTIVE

The historical attitudes to disability within different culture affects how children with special needs or disabilities are being valued and how this influences the ways in which their parents may treat them (Corbett, 1998).

As extensively described by Hewett & Forness (1977), the attitude of society toward people with disabilities has its roots in the early history of human being. They stated that in the earliest societies, physical abnormalities were not common beyond infancy because most tribes permitted the killing of a new-born if they are sickly or if the mother had died during the birth process. However, children born blind may not have been destroyed since visual disability may not be recognisable at birth. Infants born under unlucky circumstances might also be killed.

Early writings of Chinese, Egyptians, and Greeks reflect a belief that mental disorders were the result of demons that have taken possession of an individual. Among the ancient Hebrews, such disorders were thought to represent the wrath and punishment of God. The primary treatment consisted of exorcism, an attempt to drive the spirit from the possessed through prayer, incantations, noisemaking, flogging, or starving. Giants, dwarfs, cripples, and particularly women were believed that sometimes they had the power to turn "the evil eye" who often partially protected themselves with magic amulets, talismans, and charms.

In general early peoples accepted, rejected, and even worshipped the individual who was different in appearance or behavior and developed elaborate demonological systems to explain as well as to treat such differences. In Greece, infants who appeared defective were thrown from a cliff on Mount Taygetus and left to die on the jagged rocks below (Hewett & Forness, 1977).

The Romans' attitude and practices permitted the father to expose to death any child who was deformed or female. Abandonment of children was a wide-spread practice; professional beggars collected such deformed children, even deliberately mimed them, and then used them to solicit alms from charitable passer-by. Most of the sightless in Rome were rejected and lived in extreme poverty. Blind boys were often trained to beg or sold as galley slaves, while blind girls were frequently forced into prostitution.

By the close of the eighteenth century, schools for blind and deaf had appeared, but little was done for the child with a physical or mental handicap. Public sympathy was more readily aroused by blindness and deafness than by physical deformity, mental retardation or deviant behaviour. Children with physical handicap were often repulsive to look at and, along with retarded and disturbed children, were sometimes considered examples of divine displeasure and chastisement of the parents (Hewett & Forness, 1977).

During the nineteenth and twentieth centuries, changes of attitude towards people with disabilities occurred due to the development of research and practices. The nineteenth century was the beginning of special education. Building on fragments of knowledge and understanding accumulated over thousands of years and further dismantling centuries of cruelty, superstitions, and neglect of the handicapped, this century has established care treatment, and education as the mandate for the twentieth century. The twentieth century has seen improved and increased services to the handicapped. Freudian psychology for example contributed to the understanding of the psychological basis for mental illness and to the emphasis on early experience in the development of the child. In the early 1900s, Binet's testing movement revealed thousands of mildly retarded persons who had previously been overlooked, and state institutions that had isolated individuals were modified to include other community members (Hewett & Forness, 1977).

2.2.2. ATTITUDES AND PROBLEMS OF PARENTS WHO HAVE CHILDREN WITH DISABILITIES

The emergence of the social model of disability has equipped us with a different conceptual framework for understanding that difficulties for disabled children stem not from their impairment but from the attitudes towards it and towards disabled people which are adopted by society (Middleton, 1996).

Many parents are reluctant to have their child identified as exceptional due to various reasons, of which one is fear of being stigmatised. Parents' reactions to having a handicapped child vary and include loss of self-esteem, shame, ambivalence, depression, self-sacrifice, and defensiveness. Parents may anticipate social rejection, pity, or ridicule and related loss of prestige. Social withdrawal may be a common consequence (Hallahan & Kauffman, 1988).

As cited by Tirusew and his associates (1995), there are three sorts of parental attitudes toward physically children, and they are, (1) inconsistent behavior involving careful provision for necessary physical care, together with resentment at the burden entails; (2) outright rejection of the child; and (3) overprotection of the child. Morgan (1986) also indicated that infants who suffer from a failure to thrive, show apathy, lack of normal social interest, and stunted growth, often face rearing situations where they are neglected, abused, or poorly stimulated by their parents. One reason cited by this author was the stresses involved in coping with an infant's problems; disorders such as mental retardation make parents feel inadequate or even angry at the baby.

Undoubtedly, children with disabilities benefit from early secure attachment in a caregiver – child relationship in childhood. However, parents or caregivers of children with disabilities face some problems in this early interaction with their children. Some of the interactive problems related to motor disabilities as cited by Rye (1997) are, for example, infants with hampered or delayed motor skills may not be able to respond with synchronised motor movements to parents' voice and contact. Abnormal muscle tones may influence a child's activity level and control of facial movements are important as they guide the caregiver's behaviour and emotional responses. Children with, for example, cerebral palsy often have delayed expressive language, which may decrease the child's potential for interacting and eliciting positive responses from the caregivers. And when caregivers are not able to help the child to compensate for these problems, the child does not get the important experience of a good meaningful interaction, the caregivers may feel rejected, and the child may become emotionally vulnerable and his/her psycho-social experience and learning may seriously be hampered (Rye, 1997). Therefore, it is vital that the care-giver has an understanding of the child as a person with wishes and needs because this is in turn, the cornerstone in delivering secure, stable relationship, which is important for development of personal experiences, inner security, positive self-respect, trust in oneself, mastery and autonomy (Klein, 1996).

Hallahan & Kauffman (1988) pointed out that the potential for psychological havoc in the family because of a physically disabled child is great. Such a child almost invariably demands a disproportionate amount of the family's financial resources, energy, and time. The parents may blame one another, neglect each other or their children, or try to deny that their child is disabled. Siblings may resent the child and extra care and attention he or she must have. The child may be overprotected and infantilized, or neglected and denied normal experiences, or even tormented and abused by the family. Families with disabled children also face enormous financial burdens and naturally this financial burden adds to their psychological stress.

Moreover, parents who have children with disabilities in their families often have conflicts with each other and are socially isolated. They seem to have fewer friends, relatives, or neighbors they can turn to in times of stress. The isolation may contribute in part to blame the child rather than themselves for what is occurring. Mothers are often thought to be the persons that are locked into a stressful family situation and spend more time with the child than do other family members (Hetherington & Parke, 1986).

2.2.3. CHILD REARING OF CHILDREN WITH DISABILITIES

In addition to understanding the child's and the family's feelings about disability, managing the consequences of the child's behavior is crucial aspect of education and rehabilitation. The *child rearing* mechanisms of parents with disabled children has important place in enabling the disabled child learn to accept his or her disability and its personal and social implications, and finally become well-adjusted person with good self-concept (Hallahan & Kauffman, 1988).

Middleton (1996) states that disability is a learning state and the upbringing of disabled children is a process of inferiority; people teach disabled children that they are problems, of less value, and that they are not expected to fulfil the same gender roles as are non-disabled children. One ignores their childhood in giving emphasis on making them function as disabled, rather than allowing them to enjoy themselves as children. A disabled adult is viewed as less than a full citizen and as dependent and as occupying a permanent childlike status. A disabled child is likely to experience neither a normal childhood, nor adolescence, and is conditioned into an adulthood of dependency. Whereas most children are envisaged as growing up to take the place of their parents, a disabled child is expected to remain a child.

The same author states that when a child born with disability is reported, society makes a common remark, such as 'If it was mine, I'd put a pillow over its head'. Furthermore, the reaction to the death of a disabled child is also often different and equally devaluing. Parents may well feel denied full permission to grieve by comments such as 'well, it was a blessing, really'. Furthermore, as society does not want to include disabled children, the best way to prevent them is to prevent the birth. If this fails, society seeks to normalize them during childhood upbringing; and if this fails segregation and invisible service is provided to them.

Tigabu (1997, p192 –193) in his survey of rehabilitation of persons with disabilities in Ethiopia interviewed a 78-year-old woman on community care of a child born with disabilities and reported the following:

> *In our days all births were attended at home, ... when an abnormal baby is born, the traditional birth attendant, in consultation with some of the elderly women, will decide to suffocate the infant, and we will declare to everyone a stillbirth. ... but what actually happens is that the secret leaks to the neighbourhood and spreads rapidly. Then the gossip becomes an issue in the community and the elders will inform prominent respected traditional leaders that an "abomination' was born to a particular family in the community. This is assumed to be a sign of anger and of disciplinary punishment from God towards the whole community. So the community, excluding youth and children, will convene and pray to God not to punish them any further. For the future, each person will make an oath to himself and to his inmates, not to commit mistakes that may anger God and bring such punishments on him or on the community. Disability is a sign of bad luck in the family. The family keeps the disabled hidden as much as possible ... gradually the parents become subjects of pity. Everyone offers suggestions saying, 'had it been only water in her uterus* (meaning a false pregnancy) *they would not have been ashamed as they are now.*

Tigabu (1997, p 194) further reported the belief of a rural community in Ethiopia on the causes of disability as follows:

> *Children can acquire a disability through the possession of an evil spirit when they play alone under a hot sun; while they are swimming far from their friends; when they herd cattle in the forest, alone; or when they play where ashes and garbage are dumped. Disabilities caused through possession of an evil spirit may include paralysis or leprosy depending how powerful and angry the evil spirit is towards the parents and the child.*

> *After the failure of many different trials to cure these acquired disabilities, the disabled will be segregated by the community and the person with disability will seek shelter around churches. Blind persons, especially, will benefit from church education and become teachers for the deacons. The leper and the epileptic are the most ostracised and will migrate away from their home community to an area where they are not known to live by begging,*

Research also indicates that there is a connection between maltreatment and disability. As noted by Heward & Orlansky (1988), although the incidence of parental abuse and neglect of children with disabilities is unknown, there is growing evidence that establishes a convincing connection between child maltreatment and handicapped children. Children with disabilities are more likely to be abused for a longer period of time. For example, the infant with colic may increase family stress for a limited period, the child with cerebral palsy, or any other long-term or permanent handicap, presents a potential long-term family crisis. As a result, children with handicaps are not only at greater risk for abuse, but for longer periods of time. Morgan (1987) indicates that some children are abused because they are disabled, and some children are disabled because they are abused.

However, Heward & Orlansky (1988) stressed that in most instances it would be a mistake to say simply that a child's disability caused the abuse and neglect. They indicate that child abuse and neglect has no single cause but is the product of the complex interactions of numerous variables, only one of which concerns the child's characteristics.

To overcome problems of children with disabilities in Ethiopia Tirusew (1998) stated that parental childrearing with regard to their children with disabilities should include understanding that their disabled children can learn like any other child; avoid negative feelings, rejection and overprotection; see them with equal eyes like the non-disabled siblings, talk to the child, encourage the child to mix with the neighbourhood children, go to school and learn function as any child in the society.

2.2.4. FACTORS AFFECTING ATTITUDES TOWARD PERSONS WITH DISABILITIES

Cultural and social factors have effect on attitudes of parents and the public toward persons with disabilities. Research indicates that the American society holds strongly to the view that to be a parent is a good thing, but, inconsistently enough, to be the parent of a child with disability is bad thing (Tirusew *et.al.*, 1995). In New York City as cited by Tirusew *et.al* (1995), families in which Italian cultural influences are strong, children are expected to mature behaviorally at a young age. These families look upon physical impairment as a sign of evil. For an African woman, as pointed out by Ingstad and Whyte (1995), pregnant women must observe the food prescription and sex taboos; the non-observance of some of these taboos is believed to lead to disability.

Religion is another factor affecting attitude of people towards disability. Tirusew (1995) citing Zuk (1962), stated that religious background can powerfully determine the degree of family acceptance of handicap in the child. Hebrews consider that physical defect marks the person as a sinner; illness was considered both a punishment and a means of atonement. A spiritual crisis would exist when the family faces the cultural dilemma. However, the devotion people have to religion may, however, determine the degree of acceptance and/or rejection these people show toward persons with disabilities. In the African community in Songye the cause of spasticity in a child was sought in the quarrels between the mother and her brother-in-law when the mother was pregnant. In the course of the quarrel, the brother-in-law has told the pregnant mother that she would vomit her child instead of delivering it in the normal way. Disrespecting ancestral rules are also factor for causing disability; adultery and theft might cause the ancestors to be angry and manifest their anger towards members of the family through the birth of a child with a disability, or through abortion. Disability is considered as punishment for bad behavior (Ingstad & Whyte, 1995).

The cultural and religion beliefs could also highly influence the self-concept of the persons with disabilities. Negative, superstitious, and culture-bound attitudes prevailed specially in rural areas of Ethiopia. (Savolainen, 1995). For example, in a survey conducted on disability in Ethiopia by Tirusew, *et al*, (1995), it was found that persons with disabilities have both negative and positive feelings toward themselves. The positive feelings include: have self-confidence in themselves; have full trust in their surroundings; do not have hatred towards others; are satisfied in their way of living; and have a feeling that others accept and like them. And the following were reported as the negative feelings of the persons with disabilities: Consider themselves inferior to non-disabled person; have a feeling of loneliness; hate themselves sometimes; are not satisfied in their way of living; cannot lead an independent life like any other person; do not have the potential to learn like other person; have no full trust in their surroundings; have a feeling that others do not accept and like them; are not satisfied in their way of lives; and have no confidence in their competence (Tirusew *et.al*, 1995).

2.3. CAUSES, PREVENTION AND CURE OF PHYSICAL DISABILITY

Hallhan & Kauffman (1988) indicate that people with physical disabilities have to fight two battles – the battle to overcome the limitations imposed by their physical condition and the battle to be accepted by others. Many people show insensitivity and non-acceptance towards children whose bodies are distorted by disease or accident.

There is tremendous range and variety of physical disabilities. Children may have congenital anomalies (defects they are born with), or they may acquire disabilities through accident or disease after birth. Neurological impairments, musculoskeletal conditions, congenital malformation, accidents and other physical conditions, and child abuse and neglect are the major causes of physical disabilities (Hallahan & Kauffman, 1988). The same authors describe that *Neurological Impairments* include Cerebral Palsy, Epilepsy (Seizure Disorder), Spina Bifida, Poliomyelitis, Multiple sclerosis and other neurological impairments; *Accidents and Other Physical Conditions* include falling, burning, poisoning and mishaps involving bicycles, motorcycles, and automobiles are some of the ways children and youths acquire disabilities. Neurological impairments as well as disfigurement or amputation may result form such accidents.

According to Kashani (1997), maltreatment also has impact in causing disability and certain characteristics of the child and the family is associated with maltreatment of children. This author stated that head injuries caused by parents are the most common cause of physical disabilities and death, mostly triggered by toileting accident, messy diapers, or unending crying. Middleton (1996) also stated that neglect, ignorance, violence, drug abuse and poor health care all serve to create physical disability.

Hallahan and Kauffman (1988) defined child abuse and neglect as: "physical or mental injury, sexual abuse, negligent treatment of a child under the age of 18 by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened." Hallahan & Kauffman (1988) further indicate that many thousands children ranging from new-borns to adolescents in the United States are beaten, burned, sexually molested, starved, or otherwise neglected or brutalised by their parents or other older persons.

Some indications of child neglect are abandonment, totally or for a long period of time; lack of supervision, children left unattended at home or in the care of others too young to protect themselves; lack of adequate clothing and poor personal hygiene, children who are dirty, un-bathed, or lice ridden; lack of adequate nutrition, insufficient quantity and/ or quality of food resulting in severe developmental lags or "failure-to-thrive"; lack of emotional stimulation, and lack of education. Some indications of abuse are: child being afraid of others; child is kept confined; child shows repeated skin injury or other injuries; appears undernourished; given inappropriate food, drink or medicine; shows evidence of overall poor care (Hallahan & Kauffman, 1988).

2.4. OBJECTIVES OF THE STUDY

2.4.1. GENERAL OBJECTIVES

The general objectives of this research were:

1. To identify parents'/ guardians' *rearing practices* with regard to their children with physical disabilities, and explore if there are indications of maltreatment in relation to their children with disabilities,

2. To identify the prevailing understanding or *belief* of parents or guardians regarding the causes, prevention and remedies/cure of physical disabilities, in relation to the scientific explanations of the same,

3. To identify outstanding *similarities* and *differences* between parental ways of child rearing concerning their children *with* and *without* physical disabilities,

4. To explore parents' *belief* on rearing practices related to their children *with* and *without* physical disability.

5. To identify the needs of parents and their children with physical disabilities with regard to supporting/rehabilitating their children with physical disabilities.

2.4.2. SPECIFIC OBJECTIVES

The specific focuses of the study in relation to parental rearing practices are:

A) The general socio-economic characteristics of parents that have children with physical disabilities, by sex, income, education, family size, religion, and ethnic group; and type of physical disabilities of their children, their age, sex, and education.

B) The most prevailing types of child rearing practices by parents of children with physical disabilities, and indications of maltreatment in their practices,

C) The most prevailing conceptions or belief of parents on the, causes, prevention and remedies of physical disabilities and the differences between parental conceptions and the scientific explanations,

D) Discrepancies and consistencies of parents' rearing practices of their children *with* and *without* physical disabilities,

E) Discrepancy and similarity on the belief of parents with regard to rearing practices related to their children *with* and *without* physical disabilities,

F) Views of parents and their children *with and without* physical disabilities, on requirements of types of support or arrangements at family level, to up bring children with physical disabilities in a desirable way,

2.5. SIGNIFICANCE OF THE STUDY

Child rearing plays crucial role in the development of children and is mainly carried out by a family, which is the most sustained source of social contact for the child. The beliefs, values, and attitudes of the culture are filtered through the parents and presented to the child in a highly personalised, selective fashion (Hetherington & Parke, 1986). In addition, Ezewu (1998) noted that the type and quality of child rearing practised by parents is critical because it allows children to learn and view themselves positively as competent, effective individuals able to influence events and people in the world around them. To achieve such competence Ezewu further noted that parents must permit children to take the initiative and assume responsibilities appropriate to their age - children need the support and freedom to apply, test, and practice social rules and skills, and they must learn by doing (Ezewu, 1998).

While a task of child rearing is a great responsibility for parents, the challenge even lies when they have children with disabilities. Because of the nature of the problem disability brings into the family, parents and other members of the family tend to react in different ways.

In a base line survey conducted in Ethiopia, Tirusew *et.al.* (1995) state that the experience of parents with disabled children is different. Their reaction when they know that their child is disabled varies, they may experience disappointment, anger, or guilt. He further indicates that these reactions are likely to occur soon after the discovery of the problem. Disappointment arises from awareness that the child will not be able to fulfil all the fond hopes and expectations that have been built up even prior to his birth. Anger is initially directed at the child as the obvious source of frustration of those expectations. In addition, guilt feelings arise from the need of parents to deny that they are angry at the child. One way parents may deny this is by turning the anger inward at themselves. In the most extreme form, it has been found that anger toward the child for failing to fulfil ambitions can generate the desire to do away with the child (Tirusew, 1995).

Tirusew *et.al.* (1995) further indicated that physical disability is the largest group among disability population in Ethiopia that requires attention directed on the alleviating the prevalence of the problem in the country.

In light of the above notion, addressing the issue of child rearing of children with physical disabilities would contribute to the promotion of knowledge on prevailing rearing practices concerning children with physical disabilities, its implications on their well being, and possible intervention mechanisms.

2.6. DELIMITATION

The scope of the study is de-limited to an urban area and one type of disability, i.e. *physical disability*. The study focuses on physical disability due to its high prevalence in Ethiopia. In a baseline survey conducted on disabilities in Ethiopia, Tirusew *et al.* (1995) indicated that out of 1, 345, 000 people with disabilities that include people with motor, sensory, mental, language, behavioural and multiple disabilities, physical disability stood out as the major disability group in Ethiopia. Moreover, a preliminary assessment in the projects of CCBR and VCH indicated that the majority groups of project participants are people with physical disabilities. The study is conducted in urban area due to the accessibility of the NGOs involved in the study.

CHAPTER THREE

3. METHOD OF THE STUDY

3.1. OVERALL APPROACH

The study is *descriptive* and *analytic.* It is descriptive since it describes the prevailing child rearing practices by parents or guardians of children with physical disabilities using primary data; and their needs in improving their child rearing practices with respect to their children with disabilities. The description included parents or guardian's belief on causes, prevention and cure of disability as well as their belief on rearing practices related to both their children with and without physical disability. In addition, the views of the children with and without physical disability on parental rearing were looked into. It also uses proportional analysis on the relationships between parents' belief and their rearing practices, and the differences that exist between child rearing practices of parents on their non-disabled children and disabled children.

3.2. PROCEDURE

3.2.1. PILOT STUDY AND RESULTS

A pilot study was carried out in November – December 2000 in Woreda 8 in a project area of the Cheshire CBR program. The participants of the pilot study include: a) six mothers, b) six children with physical disability, c) their six non-disabled siblings, and d) women group with seven members. Respondents were selected in consultation with the Cheshire CBR project social workers because only mothers who are willing to participate in the study were considered. The researcher and three social workers of the CCBR Project have conducted the pilot study.

The pilot study was conducted in November - December 2000 in Woreda 8, Addis Ababa. 320 items on open-ended questionnaires regarding rearing practices were tested, and the following were achieved: *nine* items were rephrased, *fifteen* items were added, and *six* items were deleted on the questionnaire of the parents, resulting with 329 questions/items for the main study; while minor phrasing were adjusted on children's questionnaires that include 125 questions. In addition, it was possible to test an anticipated bias among the participants when they respond about their children with and without physical disability, which was found to be otherwise. Also, anticipated bias that mothers/guardians might not allow their children to be interviewed was refuted - all children interviewed were also cooperative and open in the discussion. Moreover, the time for interviewing one participant was identified, which is approximately 2:25 minutes with 25 minutes of interruption included.

The time spent to interview siblings (non-disabled children) was shorter by 30 minutes than the time used with the disabled ones. The latter, took time before they gave answers; they tended to be shy, emotional and quiet. All factors were taken into consideration, and the time of the interview in the main study was scheduled accordingly.

Focus group discussions were also held with seven women in the neighborhood (*Woreda* 8) on prevention, causes and remedy of physical disability in the community. In addition, based on the pilot findings, and using techniques by Edwards (1957), scales for measuring belief also employed concerning the rearing practices of children with physical disability and the non-disabled children. Ambiguity and double statements were corrected and *three* belief statements were discarded for being repetition. Each mother was interviewed two times for five minutes each - one about her CWPD, another about her non-disabled child.

A difference in belief was indicated in the answers obtained from the mothers regarding their children *with and without* disabilities. For example, regarding feeding, out of the fifteen participants, seven said that feeding is not important to physical growth of child with physical disability. One mother said, *"Since she (the physically disabled child) does not have* *appetite, feeding would not bring any change"*. These seven mothers on the other hand, said that feeding is important for the physical growth of child *without* disability.

Discussion was held with a women neighborhood group in one of the member's house who has one girl with physical disability. This group was organized by the CCBR project in Woreda 8. Members of the group were eleven and the topic of discussion was on cause and remedy of physical disabilities and attitude of people on physically disabled children. They pointed out that children with physical disabilities are seen by the neighborhood as the *"devil's work"* on the family. The women also said that the neighborhood has sympathy towards the children with physical disability; but they also mentioned that many children with physical disability are discriminated in the family; they are made to look after the house and are not allowed to go to school, some are not even fed well. Regarding remedial measures, the women said that many mothers treat their children with physical disability by both traditional such as *tebel* (holy water) and *Tenquay bet* (sorcerer's house) and medical services, they further indicated that some parents even leave the children with the sorcerer, hoping their child's disability would be cured if they stay with him (the sorcerer). The women indicated that mothers that have children with physical disabilities need social support such as talking about their children's disability, its causes and what they could do to help out such children and their mothers. One woman (the host) said, *"I have began checking in my neighborhood if there is a disabled child that is maltreated by parents, and I know that there are some parents who beat their children with disabilities losing their patience, and once I have reported to the Kebele against a mother who tied up her "cripple" child with a bed the whole day while she was away from home."*

3.2.2. MAIN STUDY

3.2.2.1. Area and Respondent Sampling

Two sites in Addis Ababa were selected for the study. The sites were *Woreda* 20 and 25. These two sites were selected because of the availability of children with physical disabilities in the programs of non-government organizations functioning in the sites and because of the relatively easy access the researcher had to the two non government organizations. The two organizations are Cheshire Community Based Rehabilitation (CBR) Project in *Woreda* 25, and Voluntary Council for Handicap (VCH) CBR Project in *Woreda* 20 Addis Ababa.

All the thirty children with physical disability (i.e. below 19 years of age) that were being supported by the two rehabilitation projects were involved in the study. Their parents i.e., thirty mothers/guardians and twenty-three non-disabled siblings of the children with physical disability were also included in the study.

Data was collected in January - March 2001 using a *triangulation method* and it included, *interview, focus group discussions and project records.*

The instruments were closed, fixed response interview, open-ended interview, three-point scaled choices on belief related to rearing practices, and focus group discussions.

The interviews were designed in English, and were translated into and administered in Amharic. The researcher and other ten social workers of the CCBR and VCH have conducted the interview in the homes of the participants. The date and time of administration of the instruments was decided in consultation with the participants of the study. The CCBR and the VCH projects have facilitated such technical arrangements. Despite the lengthy hours in the interview, participants were highly cooperative and open during the interview.

3.2.2.2. Methods of Data Collection

Data were organized using SPSS computer programmes. Variables for analysis were selected based on the most outstanding results observed in the findings. The number of variables organized and included in the study include the following:

A total of 329 variables were organized regarding the interview questions on rearing practices of parents, out of which 118 variables were selected and included in the analysis.

Out of the *one-hundred-eighteen* variables, *seventy-four* variables were the parents' responses regarding their children with disabilities while *thirty-one* variables were the responses of the parents regarding their non-disabled children, which are used for comparison purposes.

A total of *fifteen* variables were organized regarding belief on causes, prevention and remedy of physical disability and *all* of them were included in the analysis.

A total of *thirty* belief statements on rearing practices were organized and *eighteen* of them were selected and analyzed in the study.

A total of 125 variables were organized regarding the interview made with children with and without physical disability about rearing practices of their parents, and the data were used for elaboration purposes.

The closed, fixed response interview and the open-ended interview was administered in 2:30 minutes per participant.

Examples of questions about child *with and without* physical disability included in the interview are:

Question on **'Feeding practice'**

At what age did you stop breast-feeding for your child?

Question on **'Health care'**

What do you do when your child is sick?

Question on **'Discipline'**

What kinds of misconduct does your child display at home?

Question on **'Work skill and sex-roles training'**

What type of informal sex role skill training do you provide to your child?

Question on **'Formal schooling'**

If you send your children to school, do you support them in their education?
Probe: If yes, what kinds of support?
If no, why?

Question on **'Parent-child relationship**

How do you and your child spend the day?

The interview on three-point scaled choices on belief was conducted in five minutes per questionnaire with options (1) agree, (2) not certain, (3) disagree. The scaled choices were constructed based on illustration by Edward, (1957) under each theme/sub heading of child rearing practices considered in the study. Each sub heading of the rearing theme consists of the following number of questions a) feeding (4), b) health care (5), c) discipline (7), d) informal work skill and sex-roles training (5), e) formal schooling (4), and f) parent-child interaction (5).

Examples of belief statements that were administered to the participants were:

Feeding: *The appetite of a child is limited*

Health care: *Health problems of child has to be treated through traditional/ spiritual methods only*

Disciplinary method: *Parents could manage their children's misbehavior through corporal punishment only*

Informal Sex role skill training: *Child cannot manage activities of daily living*

Formal Education: *Child cannot achieve good grade results in formal education*

Parent-child Relationship: *Child is intractable by nature and difficult to communicate with*

Documented information such as project follow-up records and reports, personal files of the participants of this research were also referred.

To minimise problems of validity and reliability of instruments, the interview questions were constructed based on the illustrations by Patton, (1990). And the construct validity of the interview questions was established using expert advisory supports in Addis Ababa University.

3.2.2.3. Methods of Data Analysis

Descriptive statistics was applied using SPSS for Windows Programme, and the analysis procedure include the following:

The primary data on child rearing practices were analysed using descriptive and qualitative approaches that include frequency, average and the most commonly observed child rearing practices of parents. Interview data were also sued for illustration.

Concerning information on maltreatment of children with disabilities, qualitative description were used by comparing profile of social and individual background of the maltreated child with and without physical disabilities with background factors for maltreatment of child. Information concerning beliefs on disability were described in frequency; also the parents' belief on rearing practices regarding their children *with* and *without* physical disability.

Parents' methods of rearing of their children *with* and *without* physical disabilities were analysed using comparative analysis of proportion of responses;

CHAPTER FOUR

4. FINDINGS

The findings of the study are presented in the following order: a) the socio-economic characteristics of the participants and their children with physical disabilities, b) the child rearing practices of mothers/guardians with regard to their CWPD, c) the participants' belief regarding the causes, prevention, and remedy of physical disability, d) similarities and discrepancies in parental rearing of children *with* and *without* physical disability, and e) similarities and discrepancies in parental belief regarding rearing practices of children *with* and *without* physical disability

4.1. GENERAL SOCIO-ECONOMIC CHARACTERISTICS OF PARTICIPANTS

4.1.1. CHARACTERISTICS OF MOTHERS/GUARDIANS

The parent participants of the study are twenty-eight mothers and two grandmothers hereafter referred to as [*participants*, or *parents*, or *mothers/guardians*], each one parent having one child with physical disability.

The average age of the mothers/guardians is 37.8. The mode is 50 with a standard deviation of 11.7. The youngest mother is sixteen years old while the eldest is seventy-nine.

The marital status of the parent respondents is as follows (Table 1).

Table 1

Martial Status of Parents

Marital status of mothers/guardians	No. & % of the parents having the status	
	F	%
Single	1	3. 3
Married	20	66. 7
Divorced	3	10. 0
Widowed	6	20. 0
Total	30	100. 0

As shown in Table 1, 66.7% of the participants are married, and the rest (33.3%) are only the household heads of their respective families. The proportion of parent respondents who are single (and never married) is very small (3.3%).

In terms of educational level of the parent respondents, the findings indicate that the majority of them are illiterate or below grade 5. (Table 2)

Table 2

Education Status of Mothers/Guardians

Educational status of mothers/guardians	No. & % of mothers/guardians citing the education status	
	F	%
Illiterate	9	30.0
Read and write	4	13.3
Grade 1-4 grade	5	16.7
Grade 5-8 grade	8	26.7
Grade 9-12 grade	3	10.0
Above grade 12 grade	1	3.3
Total	30	100

The data about the mothers'/guardians' educational status further shows that the proportion of the mothers/guardians with higher education is almost nil.

Concerning the religious affiliation of the mothers/guardians 73.3% are Orthodox Christians, 16.7% Muslims, and 10% Protestants. So the majority are Orthodox Christians.

Regarding their ethnicity, the mothers/guardians come from four different ethnic groups: Amhara (60%), Gurage (23%), Oromo (13.3%) and Tigre (3.3%), with the majority being Amhara.

The income sources of the parent respondents are varied as shown in Table 3.

Table 3

Income Source of Mothers/Guardians

Income source	No. & % of mothers/guardians indicating the income source	
	F	%
Petty Trade	11	36.7
Daily Menial Jobs (Labour)	6	20.0
House renting	1	3.3
Salary & petty trade	4	13.3
Pension	1	3.3
Pension & house renting	1	3.3
Salary	6	20.0
Total	30	100

According to Table 3, most of the mothers/guardians gain their livelihood through petty trade or manual (daily) labour. Even those who earn a salary use petty trade to supplement their income.

The monthly income of participants, as reported by mothers/guardians is limited. The mean income is 194.60 Birr (SD = 95.60; range = 30-450). The proportion of mothers/guardians whose monthly income is 100 or below is 79.8%. The result also indicates that more than half of the participants (60%) lives in rented house.

The family size is also considerable with an average of 6.8 and a range of 3-11. The percentage of the mothers/guardians with a family size of 7 or above is 50%.

4.1.2. CHARACTERISTICS OF CHILDREN WITH PHYSICAL DISABILITY (CWPD)

The majority of the CWPD are females (63.3%). As reported by mothers/guardians, the average age of the CWPD is 9.7 years (SD = 4.6; range = 2-17), and the proportion of children of age 6 or below is 23.3%.

The types of physical disability of CWPD, as reported by mothers/guardians, are summarised below (Table 4). The terms for types of the disability of the CWPD was referred from project documents of the two non-government organisations involved in the study. Otherwise, the mothers refer to their children's disability as ' *yesemayu'* (cerebral palsy), *'shiba' (polio), 'gundish' (clubfoot), 'yemitil beshita or likift beshita' (epilepsy or cerebral palsy).* It is noted that the words used by the mothers/guardians are derogatory.

Table 4

Types of Physical Disability of Children Participants

Types of physical disabilities	No. & % of CWPD cited by mothers/guardians	
	F	%
Cerebral Palsy	17	56.7
Poliomyelitis	3	10.0
Club foot	3	10.0
Cerebral Palsy with Mental retardation	2	6.7
Epilepsy	2	6.7
Bone deformity on one leg	2	6.7
Locked knee	1	3.3
Total	30	100

Among the children, the majority (63.4%), are victims of cerebral palsy, poliomyelitis and clubfoot each account for 10% of the disabilities.

The mothers/guardians reported that they have observed various signs of disability in the children. The information is reported in Table 5.

Table 5

Signs of Physical Disability observed by Mothers/Guardians

Signs of physical disability	No. & % of mothers/guardians citing the signs	
	F	%
Inability to walk	13	43.3
Inability of child to do 'normal' developmental activities (suck, sit, grasp, walk)	8	26.7
Hands spastic (floppy)	4	13.3
Convulsion seizure	2	6.7
Hands and legs spastic (floppy)	2	6.7
Legs spastic (floppy)	1	3.3
Total	30	100

As might be expected, the sign of physical disability that is relatively more evident for the mothers/guardians is the gross motor skill - inability to suck or grasp or sit or walk. During the interview in the parents' home, it was also observed that their children with disabilities were lying on the floor unable to talk, or sit or walk and some children were seen while walking using frames. The mothers/guardians have also apparently used information or observation about developmental retardation to define their children's disabilities.

Participants have also described the time at which they identified their children's physical disability. Following is the data (Table 6).

Table 6

The Time Mothers/Guardians Identified their Children's Disability

Time of identification	No. & % of mothers/guardians citing the time of identification	
	F	%
From birth – 6 months	12	40.0
From 7 -11 months	3	10.0
From12 – 23 months	2	6.7
From 24 - 35 months	6	20.0
After the child was three years old	7	23.3
Total	30	100

Most of the mothers/guardians (40%) identified their children's physical disability as early as the time of birth and within 6 months after birth. But in general, most of them detected the disability of their children within the first three years of the child's life.

Overall, the mothers/guardians of the children with physical disabilities are mostly adults of age 38, married and are below grade 5 level, with low income derived from petty trade and manual daily labour. Regarding the children themselves, they largely consist of females (i.e. 63.3%) and most of them suffered from cerebral palsy, poliomyelitis and clubfoot.

4.2. CHILD REARING PRACTICES OF PARENTS REGARDING THEIR CHILDREN WITH PHYSICAL DISABILITY (CWPD)

The findings on the child rearing practice of mothers/guardians are described in terms of each of the rearing practice themes considered in the study, and are presented in the following sequence - a) *feeding*, b) *health care*, c) *disciplinary methods*, d) *informal sex role skill training*, e) *formal schooling*, and f) *parent-child relationship.*

4.2.1. FEEDING PRACTICES

Breast-feeding is an important part of nutrition in postnatal care. Twenty-four (80%) of the participants said that they have breast-fed their CWPD while six (20%) said they have not.

The six (20%) mothers/guardians who said that the CWPD were not breastfed indicated that the failure was because it was taboo to practice it with the disabled, the concerned CWPD were unable to suck, or they were abandoned by their mothers. For those who were breastfed, the duration were as follows (Table7).

Table 7.

Duration of Breast Feeding, as Reported by Mothers/Guardians

Duration	No. & % of mothers/guardians reporting the duration	
	F	%
1-6 months	3	12.5
7-12 months	8	33.3
13-18 months	9	37. 5
19-24 months	3	12.5
Above 24 months	1	4.2
Total	24	100

As shown in Table 7, eleven (36.7%) of the mothers/guardians said that the CWPD under their care were breastfed for one year or less. A good proportion of the children, (54.2%) were provided with the diet for over one year. It can be seen from the table, thirteen (54.2%) mothers/guardians said that they have had breastfed their CWPD for over one year.

Regarding the difficulties the CWPD face during eating, more than half (56.7%) of the mothers said that their CWPD do not have such difficulties. However, a considerable percentage of the participants, i.e. thirteen or 43% said that their CWPD do face the problems. In these latter cases, the caregivers reported that they tried to tackle the problem in the following ways: changing the type of food (2 parents or 15.3%), making the child drink and bath with holy water (6 parents or 41.1%), taking child to hospital, and to the *awakie* (2 parents or 15.3%). Only one mother (7.6%) sought medical help *without* mixing traditional or other means but two (15.3%) of them made no effort at all.

Moreover, these thirteen mothers/guardians provided their CWPD additional help to improve the eating problem of their CWPD. More than half of them seven (53.8%) prepared mashed food, and the rest four mothers/guardians (30.7%) tried to encourage child to eat whatever food available at home, and also to learn how to eat by himself/herself with little help.

Regarding the type of food preferred by the CWPD, the finding is shown in Table 8 below.

Table 8.

Types of Preferred Food by CWPD as Reported by Mothers/Guardians

Types of preferred food	No. & % of mothers/guardians citing the preferred food	
	F	%
Whatever is available at home	7	23.3
Egg, meat	6	20.0
Spaghetti/Macaroni, bread	4	13.3
Meat, bread	4	13.3
Injera with *wot*	4	13.3
Fruits, vegetables and sweets	4	13.3
No response	1	3.3
Total	30	100

The preferences (as shown in Table 8) are a broad variety. Some (20%) of the mothers/guardians said that their CWPD like to eat meat and egg. Others reported that their CWPD enjoy fruits and vegetables.

Evidently, however, the mothers/guardians have difficulty in offering the type of food their CWPD prefer, as reflected below (Table 9).

Table 9

Response of Mothers/Guardians on whether They Fulfil Food Preference of CWPD

Response	No. & % of mothers/guardians giving the response	
	F	%
Yes, if food is available	15	50.0
Yes, sometimes	4	13.3
No	10	33.3
	1	3.3
Total	30	100

As indicated in Table 9, half of the participants said that they fulfil food preference as long as they could afford to do so while about one third said they do not at all fulfil the food preference of their CWPD.

In addition to providing quality food, frequency of feeding is also an important factor in the overall development of CWPD. Thus, the following table (Table10) shows the frequency of meal service to the CWPD per day.

Table 10

Frequency of Feeding by CWPD Per Day as Reported by Mothers/Guardians

Frequency	No. & % of mothers/guardians citing the frequency	
	F	%
Four times	10	33.3
Three times	14	46.7
Two times	2	6.7
As the child likes	4	13.3
Total	30	100

Table 10 indicates that except few of the mothers/guardians (6.7%), the majority (93.3%) of the mothers/guardians feed their CWPD three or more times in a day.

The study has also looked into social aspect of feeding. Seventeen (56.7%) participants said that their CWPD eat with their non-disabled siblings. A considerable number of participants, i.e. eleven (36.7%), on the other hand, said that their CWPD do not eat with their non-disabled siblings. Two (6.7%) of the participants said that their CWPD sometimes eat with their non-disabled siblings sometimes.

The reasons given by the eleven mothers/ guardians as to why their CWPD do not eat with their non-disabled siblings include: the non-disabled siblings do not like to eat with CWPD, saying he/she would mess up food (reported by 5 mothers/guardians), and the CWPD could not eat at the same pace like his/her non-disabled siblings (reported by 6 mothers/guardians).

4.2.2. HEALTH CARE PRACTICES BY MOTHERS/GUARDIANS OF CWPD

Washing is one of the means to up keep primary health care. Thus, participants were asked on the frequency of washing habit of their CWPD. Their answers are shown in Table 11 (below).

Table 11

Mothers/Guardian's Report on the Washing Practices of CWPD

Washing practice	No. & % of mothers/guardians citing the frequency	
	F	%
Face only (daily)	6	20.0
Face (daily) and hair (once a week)	2	6.7
Face (daily), hair (once a week) and body (once a week, or twice a month)	15	50.0
Washes rarely	7	23.3
Total	30	100

Apparently, many of the CWPD wash their hair once a week and their body at least once a month. The responses of eight (26.7%) mothers/guardians however, indicate that their CWPD neglect *body* washing, while seven (23.3%) said that their CWPD wash rarely.

With regard to the person who makes the health follow up of the CWPD in the family, more than half of the participants (60%) said that mothers are the main persons attending to the CWPD's health complaints or situation. From the remaining participants, twelve (33.3%) mentioned that others such as the CWPD himself/herself, his/her siblings and aunt are the persons in the family who make follow up on the health of CWPD, while two (6.7%) participants did not give response.

When participants were asked if their CWPD have complaints regarding their health, eighteen (60%) said that their CWPD are sometimes sick while five (16.7. %) said their CWPD have continuous health complaints. The types of health complaints of CWPD reported by the mothers/guardians are the following.

Table 12

Types of Health Problems of CWPD as Reported by Mothers/Guardians

Types of Problems	No. & % of mothers/guardians Reporting the problem	
	F	%
Diarrhoea, vomiting	3	13.0
Fever and vomiting	6	26.0
Flue, draught and fever	6	26.0
Spirit induced ailments	7	30.4
Unidentified complaints	1	4.3
Total	23	100

Among the twenty-three participants who said that their CWPD have ailments, seven (30.4%) responded that their children have spirit induced ailments such as attacks by *buda* (evil eye) and evil spirit; while fifteen (65%) said that their children's ailment is related to viral and parasitic infections, and draught.

Investigation of the participants' view regarding the specific causes of the ailments of their CWPD has produced the following result shown in Table 13.

Table 13

Mothers'/Guardians' View on the Specific Causes of the Health Problems of their CWPD

Perceived causes	No. & % of mothers/guardians citing the causes	
	F	%
Devil's spirit possession at birth	2	8.6
Devil's spirit possession after baptism	2	8.6
Devil's spirit possession when falling causing meningitis	7	30.4
God's curse/anger	3	13.0
Shortage of food	2	8.6
Spoiled food	2	8.6
Eating with dirty hands;	4	17.4
Staying in the sun	1	4.3
Total	23	100

Out of the twenty-three participants, fourteen (60.8 %) associated the causes of the ailments of their CWPD to spiritual sources, while seven mothers/guardians (39.1%) ascribe their children's cause of health problem to shortage of food, spoiled food, lack of hygiene, and staying in the sun.

In order to improve the health problems of their CWPD, out of the twenty-three mothers/guardians, twelve mothers/guardians (52.1%) used *tebel* (holy water) making their CWPD drink and take bath in it, six mothers/guardians (46.1%) consulted medical doctors in hospitals, and five (38.4%) used the assistance of the *Wegesha* (local physiotherapist).

In addition, all the thirty mothers/guardians were asked if their CWPD have special psychological health complaints. The responses of participants are shown below (Table 14).

Table 14

Special Psychological Health Complaints by CWPD, as Reported by Mothers/Guardians

Complaint	No. & % of mothers/guardians mentioning the complaint	
	F	%
CWPD is unhappy due to his/her disability	6	20.0
CWPD gets easily irritated	1	3.3
CWPD shows anger and/or withdrawals any time	3	10.0
CWPD show fear to mix with persons	3	10.0
CWPD does not have special health complaints	16	53.3
No response	1	3.3
Total	30	100

As shown above, sixteen mothers/guardians (53.3%) said that their CWPD do not have any special psychological health complaints. But noteworthy is also the fact that thirteen of the participants (43.3%) determined that their CWPD have special health complaints. Prominent among the reported psychological problems is the unhappiness or depression of the CWPD due to their disability.

Furthermore the thirteen participants who reported psychological problems among their CWPD have said that they have made some efforts to improve the special psychological health complaints of their CWPD. The types of effort they have made are described in the following manner.

Some of them (3 out of 13 parents) used only holy water drinking and bathing, and prayers. Others (2 out of 13 parents) approached the *Awakie* (sorcerer) and also used herbs (*one* parent). But *five* mothers/guardians sought both *tebel and* medical/psychological assistance, and the remaining *two* parents simply used cajoling.

The story of a mother who has an eight-year-old girl with cerebral palsy is exemplary to mothers'/guardians' traditional practices in general health intervention. Explaining how this mother got assistance from the *Awakie*, she said,

> *"... I had to find and bring a special rope, which a deceased man had used to hang himself, from a far place called Lalo-midir, Menz. The Awakie told me to go to this specific place giving me some address to contact people who live there ...arriving at the place, ... I contacted some 'balageroch' [people living in countryside] using his reference. These people fetched me the rope ... and when I get back home, I tied it around my daughter's neck. The Awakie advised me not to wash it until I see my girl become a person like any human being ... but here I am not seeing any change ... losing hope, I have put away the rope from my daughter's neck but kept it still ... "*

Among the thirteen participants who made the psychological health follow up, eight (61.5%) said that the holy water drinking and bathing treatment has brought positive change in the special health problem of their CWPD while five (38.4%) of them said that they did not see any change at all.

Moreover participants have cited *silet* (vow made to sacred entities like the saints) as another means of their seeking 'health' solution for their CWPD. Twenty (66.7%) of the total participants have said that they have made *silet* to one or more Saints, for the cure of the disability of their children. A mother expressing her *silet* experience said, *" I made silet to Saint Gabriel, so that He heals my girl and stops her suffering; every year for Tahsas Gabriel, I make His tebel-tsadik (feast), I know he would not fail me..."*

Furthermore the mothers/guardians have reported that providing health care to their CWPD is difficult. Except eight of the participants (26.6%) who saw no problem in providing care for health of their CWPD, and one (3.3%) who did not give response, twenty-one mothers/guardians (70%) have said that caring for CWPD is generally challenging. The types of challenges the twenty-one mothers/guardians face when providing health care for their CWPD, as reported by them, are the following – refer to Table 15 below.

Table 15

<u>Types of Difficulties Perceived by Mothers/Guardians in Providing Healthcare for CWPD</u>

Types of difficulties	No. & % of mothers/guardians citing the difficulties	
	F	%
Moving child from place to place	1	4.7
Washing child whenever he/she soils herself/himself	1	4.7
Lack of energy in providing attention to CWPD	12	57.1
Watch over child against danger	2	9.5
Stubbornness & incessant complaints by CWPD	5	23.8
Total	21	100

What emerges very clearly from Table 15 is that twelve of the participants (57.1%) face challenge during providing health care for their CWPD, in terms of lacking the energy to attend to child's health complaints. Moreover, some find it difficult to manage the children's behaviour, which includes stubbornness and persisting complaints.

The mothers/guardians also provided information regarding the developmental period at which the CWPD pose the most serious challenges. The mothers/guardians classified the period in their own terms such as *behitsaninet'* (0-3 years old) *'beliginet'* (4-18 years old), and *betilikinet* (above 18 years old). (Table 16).

Table 16

The Most Challenging Development Period in Caring for the Health of CWPD

Period	No. & % of mothers/guardians citing the challenging period	
	F	%
Behitsaninet (Infancy)	5	16.7
Beliginet (Childhood)	19	63.3
Betilikinet (Adulthood)	1	3.3
Infancy, childhood and adulthood	5	16.7
Total	30	100

Evidently, childhood is a specially challenging period in the health care of the CWPD. Nineteen of the participants (63.3%) have indicated this point.

Some of the mothers/guardians who found childhood as the most challenging period in the health care of the CWPD, mentioned the following reasons: child cannot take care of his/her personal hygiene due to his/her disability (8 out of the 19 parents), child does not listen to parents warnings because he/she is simply a child (3 parents out of nineteen), and child does not discern the good and bad things that could expose him to sickness and danger (8 parents out of 19),

Expressing how it is difficult to take care of her child, one mother said,

> *" ... my life is debilitating because I am cursed by God to have such a child on top of my being destitute ... the caring of this child is nearly putting me to death, if only I know what*

> *to do with her ... her uncleanness tires me out ... every time even if I warn her, she soils her body because she does not control her bowl, ... to be created to simply put up with such a life is a real curse ..."*

The story refers to a cerebral palsied girl of seven years old, who cannot sit and eat independently, as well as not able to talk. The mother earns by working as a housemaid in the neighbourhood on part-time basis. During the interview with the mother, this girl was sitting smiling on the lap of her older sister whose age is eleven. But on the second day interview with the sister, it was observed that the girl with the cerebral palsy had bruises on her face. The explanation by her mother was that she has fallen from a bed while she (the mother) was away from home.

4.2.3. DISCIPLINARY PRACTICES

All mothers/guardians reported that their CWPD have behaviour problems, which include the following (Table 1).

Table 17

Behaviour Problems of CWPD as Reported by Mothers/Guardians

Behaviour problems	No. & % of mothers/guardians Indicating the problem	
	F	%
CWPD is irritable and cries constantly	4	13.3
CWPD insults members of his/her family	6	20.0
CWPD disobeys parents	2	6.7
CWPD talks to self like Satan	2	6.7
CWPD is nervous, irritable, and non-responsive	9	30.0
CWPD does not show peculiar behaviour problems	7	23.3
Total	30	100

Table 17 shows that irritability and verbal aggressiveness are major forms of the behaviour problems of the CWPD. Interesting, however, is some of the mothers/guardians (23.3%) have vouched that the CWPD do not show special behaviour.

Information from the mothers/guardians further indicated that in the eyes of these mothers/guardians, CWPD are generally more misbehaving than non-disabled children are. The majority i.e. 76.7% of the thirty mothers/guardians expressed this view.

Moreover, out of the twenty-three mothers/guardians who said that CWPD is more misbehaving than their non disabled children, twenty-one noted that the CWPD are aggressive that they are disliked by family members, and also have spoiled character in the sense that they get easily irritated by reprimand or disapproval from family members for their mistakes.

In fact, among the twenty-three (76.7%) participants, almost all of them said that the behaviour problems of their CWPD are related to their disability, (One mother/guardian did not give response).

Participants further were asked to indicate the type of disciplinary actions they take on their CWPD, and the following answers were obtained.

Table 18

Disciplinary Actions Taken by Parents on their CWPD, as Reported by Mothers/Guardians

Types of disciplinary actions	No. & % of mothers/guardians citing the type of disciplinary action	
	F	%
Scolding	1	3.3
Advising	11	36.7
Charming child	7	23.3
Beating	1	3.3
Advising, beating and pinching	9	30.0
Scolding, beating, advising & cajoling	1	3.3
Total	30	100

In general, nineteen (63.3%) of the participants said that they use non-corporal punishment which includes scolding, advising, and charming while eleven (36.6%) admitted that they use both corporal and non-corporal punishment to correct the misbehaviour of their CWPD. The mothers/guardians further indicated the types of disciplinary actions that brought positive change in the behaviour of the CWPD (Table 19).

Table 19

The Most Effective Disciplinary Action as Reported by Mothers/Guardians

Most effective disciplinary actions	No. & % of mothers/guardians citing the effective disciplinary action	
	F	%
Advise	20	66.7
Beating	2	6.7
Advising and mild pinching	4	13.3
Pinching	1	3.3
Cajoling	1	3.3
Advising, beating, pinching and cajoling	1	3.3
No response	1	3.3
Total	30	100

As indicated in the table above, participants have found mild corporal and non corporal punishment to be the most effective way of disciplining their CWPD. Twenty of the participants (66.7%) actually found *advise* alone as the most effective disciplinary action that brought positive change in the behavior of their CWPD.

Asked how they found out *advise* to be the most effective way of disciplining CWPD, out of the twenty participants, sixteen have said that their attempts in beating CWPD made the CWPD more stubborn and aggressive, and they got better results when they used *advise* instead.

Regarding disciplinarians, twenty-two mothers/guardians (73.3%) have pointed out that mothers are the main persons in the family who administer the disciplinary action on their CWPD. Specifics appear in the Table 20 below. Among the CWPD, one girl who has epilepsy said that her father does not beat or reprimand her because he sympathises her. In explaining the situation, she said, " ... *My father always gets mad when my mother punishes* *me. He tells her to leave me alone, ... even if he gets angry at me he never picked up a stick to beat me..."*

Table 20

Person Administering the Disciplinary Action on CWPD

Person administering disciplinary action	No. & % of mothers/guardians citing the person taking disciplinary action	
	F	%
Mother	22	73.3
Mother and father	4	13.3
Mother and sibling	1	3.3
Sibling	1	3.3
Aunt	1	3.3
No response	1	3.3
Total	30	100

The mothers/guardians further gave their reasons for taking disciplinary action on their CWPD, and it is shown in the table below (Table 21)

Table 21

Reasons Mothers/Guardians gave for Taking Disciplinary Action

Reason for disciplinary action	No. & % of mothers/guardians indicating the reason	
	F	%
So that child's future life becomes 'good' (secure and stable)	12	40.0
So that child is able to help family when grown up	2	6.7
So that child live harmoniously with family members & others	12	40.0
So that child does not become rude	4	13.3
Total	30	100

Obviously, the two justifications that a good number of the mothers/guardians gave for taking disciplinary action are to help their child have good future life, and to help their CWPD live harmoniously with family. According to the participants 'good life' means when child has secure and stable life.

As the following table shows, the views of mothers/guardians about the appropriateness of corporal punishment for handling disciplinary problems of CWPD of different ages show wide variance.

Table 22

Views of Mothers/Guardians about the Use of Corporal Punishment in Relation to Child's Age

Views of Mothers/Guardians	No. & % of mothers/guardians citing the reason	
	F	%
Corporal punishment should increase as the child grows up	11	36.7
Corporal punishment should decrease as child grows up	14	46.7
Corporal punishment should be applied depending on the type and degree of misbehaviour regardless of age and disability	4	10.0
No response	1	3.3
No response	30	100

As reported in Table 22, fourteen of the mothers/guardians (46.7%) said that corporal punishment on CWPD should *decrease* as the child grows up while eleven (36.7%) said that corporal punishment should *increase* with the child's age.

The mothers/guardians, who said that corporal punishment should *decrease*, indicated their reasons. Out of the fourteen mothers/guardians eight said they think the CWPD might get hurt and even die. The remaining six mothers/guardians said that as the child grows he would "know" more about himself/herself, and would become more responsive to parents' orders and reprimands, so there would be no need for punishing him. A typical example here is the explanation of a mother who supports this reason and said " *... I could punish my child until he knows his "soul" ... but once he became a young child (nefsun ke-aweke) he would control himself and do things as he is told ... then I do not have to beat him ...*"

Among the latter group of mothers/guardians who support increment of corporal punishment, eight said that it should increase because, it would be difficult to handle child's behaviour when he/she becomes adolescent (in their expression *ke-goremese*) The rest of the group (3 mothers/guardians) ascribe their reasons in relation to child's disability, saying that the CWPD by nature are incorrigible, and it increases from time to time so punishing is the way of solution. One of the mothers/guardians belonging to this group, and who has a ten year old boy with club foot, justified her reason of increasing corporal punishment on CWPD by saying:

> *... Even now it is difficult to make my child behave in good mannerisms, and eat and dress whatever is available at home. His demands are increasing from time to time. He always wants to look better than his friends at school do. For instance, yesterday he came from school and asked me to buy him a pair of leather shoes that could fit to his feet ...This one, I could not tolerate because as you can see I live in distress... the way to make him shut his mouth is when I slap him on the face right there and then...*

Furthermore, the mothers/guardians, have expressed their view regarding the intensity corporal punishment should have when applied to the CWPD (Table 23).

Table 23

Views of Mothers/Guardians about the 'Appropriate' Intensity of Corporal Punishment

Degree of corporal punishment	No. & % of mothers/guardians citing the degree of punishment	
	F	%
Corporal punishment should be lenient	4	13.3
Corporal punishment should be moderate	14	46.7
Corporal punishment should be severe	3	10.0
Different degrees of corporal punishment should be applied depending on the seriousness of misbehaviour	6	20.0
CWPD should not be punished at all	3	10.0
Total	30	100

According to Table 23, although a few of the mothers/guardians advocated severe corporal punishment, relatively large number felt that a moderate degree of corporal punishment is appropriate. Only three mothers/guardians said such punishment should be avoided altogether.

In spite of their avowal of different degrees of corporal punishment, nineteen of the mothers/guardians (63.3%) said that using corporal punishment to discipline their CWPD is difficult. Eleven of the mothers/guardians (36.6%) said that they punish their CWPD physically just as they punish their other children.

The participants have indicated a number of reasons as to why administering corporal punishment on CWPD is difficult.

Out of the nineteen mothers/guardians, ten or 52.6% said that it is difficult to apply corporal punishment on CWPD because it would make CWPD more disabled and unhappy. The remaining nine mothers/guardians (47.3%) mentioned other reasons which include *"CWPD is already cursed by God, so does not need additional punishment", "Disability is a punishment by itself, so additional punishment is not necessary," and "CWPD are frail and cannot withstand punishment".*

4.2.4. INFORMAL SEX-ROLE SKILL (ISRS) TRAINING PRACTICES

Concerning the expectations of mothers/guardians with regard to skills that their female CWPD should develop, most of the mothers/guardians said that these children should try to perform all domestic female skills like general cooking and housekeeping. A few other mothers/guardians also indicated that the CWPD should know how the skills are executed but they should not be expected to actually perform the skills. The detail information is in Table 24.

Table 24

Mothers'/Guardians' Expectations Regarding Informal Sex role Skill Training of *Female* CWPD

Expectation of mothers/guardians	No. & % of mothers/guardians disclosing the expectation	
	F	%
CWPD can learn skills such as repairing utensils, keeping garden, fencing, and housekeeping by heart, but cannot perform them	5	16.7
CWPD must try everything in domestic works	20	66.7
CWPD cannot learn informal skills due to disability	3	10.0
CWPD should only play and not learn any informal skill	1	3.3
No response	1	3.3
Total	30	100

In the case of male CWPD, about one third of the mothers/guardians said that they should perform tasks normally associated with males as long as they are physically capable of doing them. Some others felt that the male CWPD should focus on getting academic and vocational training. Still others thought the male CWPD should have the know- how for different skills to be able to teach them. A summary table follows (Table 25)

Table 25

Mothers'/Guardians' Expectation on Informal Sex-role Skill Training *Male* CWPD

Expectation of mothers/guardians	No. & % of mothers/guardians Expressing expectation	
	F	%
CWPD must only do things within his capacity	10	33.3
CWPD should have education and vocational skill training	5	16.7
CWPD should learn handcraft	2	6.7
CWPD should know different skills to teach others	5	16.7
CWPD preferably should not do anything	7	23.3
No response	1	3.3
Total	30	100

One interesting response of the mothers/guardians, which was not evident in their response pertaining to the sex-role expectation of the female CWPD, is that some of the mothers/guardians believe that preferably male CWPD should not "do anything".

Mothers/Guardians were also asked if they have taught ISRS to their CWPD. In this regard, sixteen mothers/guardians (53.4%) said that they have given such skills to their CWPD while a considerable number of participants, i.e. thirteen or 43.3% said that they do not teach their CWPD such skills. Furthermore, those participants who said that they do not teach their CWPD informal sex role skills have argued that their CWPD couldn't be trained due to their disabilities.

In those cases where the family provides ISRS training it is apparently the mother who is largely responsible. Fourteen of the sixteen mothers/guardians who said they give training on ISRS further declared that it is the mothers who give the training. Only one mother/guardian said a father trains the CWPD.

Some of the mothers (13 or 43.3%) have disclosed that in training their CWPD about sex roles they use methods that are different from those they use in training their non-disabled children. The reasons the mothers/guardians gave for using different methods include: the need to use special instructions due to the disability of the children, the inability of the CWPD to perform equally with the non-disabled, and the fact that the CWPD need more time (than the non-disabled) to do or finish a specific task. The last reason is apparently weighty because 10 out of the 13 mothers/guardians have expressed it. In this respect, a grandmother of an eight-year-old cerebral palsied girl (hemiplegic) said, " ... *After school she [the girl] sometimes brew coffee for us, but it takes long time before we have the coffee, ... With the others (siblings) I wouldn't have patience. As she has a 'shiba' [derogatory word for physical disability] hand I do not expect her to do and finish the task quickly...*"

Asked why they teach their CWPD informal sex role skills, out of the thirteen mothers/guardians who said they teach informal sex role skills to their CWPD, eleven said that they want their CWPD to know domestic skills and help their families in daily life.

4.2.5. FORMAL SCHOOLING PRACTICES

Formal schooling is another aspect investigated in the participants' rearing practices. In this respect half of the mothers/guardians said that they send their CWPD to school while the other half said they do not. Among those who reported that they do not send their CWPD to school, seven explained their decision by saying that the CWPD have mobility problem. A few mothers/guardians (4) were afraid that the CWPD should fall and get hurt, and a similar number (3) revealed that the CWPD stopped going to school because of insults by students. (One parent did not give response)

In addition to the above reasons given by mothers/guardians, in the discussion made with women groups, some information were obtained pertaining to the reason why children with physical disability are not going to school. Some of the dialogue includes the following:

> *... Majority families in our neighbourhood who have children with physical disability do not send them [children with physical disability] to school ...because they [parents] want to 'keep' their names. They are afraid that people would know that they have 'shiba' [derogatory word for physical disability] children and afterwards would point their fingers at them saying 'yeshiba welaj' [parents' of disabled child]*

Another participant of the group continued:

> *For example, it is common to see mothers and fathers keeping out their children with physical disabilities from being registered at the 'kebele' family registration form. We hear them saying 'we do not have children' when the 'kebele' clerk asks them to register their children. The reason they do this is because they think the child with disability does not have any use anyway ...*

Concerning the types of schools the CWPD attend, among the fifteen mothers/guardians who said that they send their children to school, fourteen of them said that they send their CWPD to formal government schools, and one said that she sends her CWPD to public kindergarten.

An important aspect of family activity that can have an impact on the educational progress of the CWPD is the kind and amount of support they get from mothers/guardians.

Pertaining to this point out of the fifteen mothers/guardians who said that the CWPD go to school, six indicated that they provide verbal and moral encouragement and three said that they help the CWPD in their studies as tutors. The rest could only provide educational materials, uniform or study place.

In addition to the support they provide to their CWPD, fifteen mothers who send their CWPD to school also indicated that they give reward to their CWPD when they get "good" grades/marks in their education.

The types of rewards the fifteen mothers give to their CWPD when they have "good" performance in their education, include: verbal appreciation, purchasing some material the child asks for, and buying clothes, shoes, or books. However, the reward that was mentioned most frequently was verbal appreciation, which was cited by seven mothers/guardians.

When their CWPD get poor grades in school, six of the mothers/guardians said that they feel sorry and angry, and another six said that they feel sorry but still encourage child to improve. Three others reprimand the child.

Still, except one parent who prioritise her non-disabled child, almost all of the mothers/guardians (96.7%) said that they would give educational priority to their CWPD, rather than to their non-disabled siblings if they have the necessary support and means to do so, and they gave the reasons indicated below (Table 26) for their bias in favour of the education of the CWPD.

Table 26

Reasons Mothers/Guardians Advanced in Favour of Giving Priority to the Education of the CWPD

Reasons	No. & % of mothers/guardians citing the reason	
	F	%
To ensure the future life of CWPD	4	13.7
Unless educated, CWPD does not have chance of becoming self-reliant	9	31.0
CWPD should be protected against the feeling of discrimination in the family	10	34.4
CWPD should be compensated for God's punishment	6	20.6
Total	29	100

As shown in Table 26, the three most frequently mentioned reasons for assigning priority to the education of the CWPD are: to protect the CWPD from feeling of discrimination, to help them become self-reliant, and to make amends for what the mothers/guardians regard as God's punishment (which incapacitated the CWPD)

The one mother/guardian, who does not prioritize the CWPD said, "... *my daughter is 'beshitegna' [ill-ridden]. Even if she goes to school she would not make it up to the 'final' ...*"

Interesting to know on the same topic is also the view of the non-disabled child of this mother (a sister to a CWPD who is twelve-year-old and has cerebral palsy). She said, " *As far as I know my mother would give me the educational priority than to my sister. Because I know that I am not disabled and can understand better lessons at school than her [CWPD] ...*"

In addition to giving priority to the education of the CWPD, twenty-four of the thirty mothers/guardians have also indicated that continuous education up to the advanced levels is useful for their CWPD while five said it is not. Those who assigned value to the continuous education of their CWPD identified the following advantages of such education: the CWPD can have equal status with his/her siblings; they would be self-reliant; they would be considered as a human being by society, and they can get a job and help their family. Eight mothers/guardians identified each of the first two reasons, and five identified the third.

Those who give no value to continuous education for their CWPD have reasoned out by saying that CWPD could not understand lessons due to their disability.

The twenty-four mothers/guardians also indicated the educational level they wish their CWPD to attain (Table 27).

Table 27

Mothers'/Guardians' Wish Concerning the Level of Education the CWPD should Attain

Level	No. & % of mothers/guardians citing the level of education	
	F	%
Up to the "final" level (Terminal degree)	12	50.0
Up to College	5	20.8
Up to grade 12	4	16.6
It depends on child's ability to learn	2	8.3
No response	1	4.2
Total	24	100

As Table 27 shows, half of the mothers/guardians who wanted their CWPD to continue their education would like them to do so until the children secure their terminal degrees. The majority of these mothers/guardians actually feel that the CWPD should receive college education.

4.2.6. PARENT-CHILD RELATIONSHIP

Parent-child relationship plays an important role in the emotional and cognitive development of children. The child rearing practices were also studied in terms of this relationship.

Mothers'/Guardians' report on how they pass their time with their CWPD during the day was as follows (Table 28).

Table 28

Ways in which Mothers/Guardians pass their Time with CWPD

Activity/Interaction	No. & % of mothers/guardians reporting the interaction	
	F	%
Talking to CWPD about different things in life	10	33.3
Looking after CWPD - feeding, washing	8	26.7
Watching over CWPD against any possible danger	3	10.0
CWPD and mother do not have any encounter during the day (mother is out the whole day an meets the child in the evening)	9	30.0
Total	30	100

According to Table 28, the most frequently mentioned form of parent –child interaction is talking to each other, but a good number of the mothers/guardians have also indicated that their interaction relates to attending to the physical welfare of the CWPD. But nine mothers/guardians also said that they do not have any encounter with their CWPD once they are out of home to work, they said they meet their CWPD in the evening time.

The mothers/guardians have further identified the person/s with whom CWPD mostly talks to. (Table 29).

Table 29

CWPD Most Frequent Companion for Conversation/Interaction

Interlocutor	No. & % of mothers/guardians Mentioning the Interlocutor	
	F	%
Mother	15	50.0
Father	2	6.7
Sister	3	10.0
Mother and friends	2	6.7
Aunt	1	3.3
Any member of the family	7	23.3
Total	30	100

Evidently, the CWPD mostly talk to their mothers rather than to the others in the family. Only two of the mothers/guardians said that the CWPD talk mostly to their fathers.

The fifteen mothers/guardians have also indicated that the CWPD talk more with their mothers rather than with other members of the family, because mothers are more intimate to their CWPD, and because the CWPD love their mother the most and feel comfortable with her.

The subjects of conversation between the CWPD and the mothers/guardians are summarized below in Table 30.

Table 30

Subjects of Talk between the Mothers and the CWPD

Subject	No. & % of mothers/guardians citing the subject	
	F	%
About child's disability and education	10	33.3
About life, sharing the anxiety they have about ensuring food in the family	9	30.0
Advising CWPD not to disturb the family	7	23.3
About the country's peace and future life of the family	3	10.0
Reprimanding CWPD's misbehavior	1	3.3
Total	30	100

About one third of the mothers/guardians have thus revealed that their talk with the CWPD deals with the child's disability and education. A similar proportion of the mothers/guardians talks about ensuring food in the family.

To understand the smoothness of communication between child and his/her parents, participants were asked if talking to CWPD is difficult. Twenty-three mothers/guardians (76.7%) have said that talking to their CWPD is *not* difficult while seven said otherwise. Four of these seven mothers/guardians said the CWPD do not like to talk to their mothers and the other three said that the CWPD are either aggressive or always complain and/or do not listen to others.

In addition, the advice that mothers/guardians give to the CWPD takes various forms, which relate to their physical, emotional, and academic security. Generally, a focal concern seems to be on the ability of the CWPD on feeling of inferiority. Table 31 provides more specific information.

Table 31

Types of Advice by Mothers/Guardians to their CWPD

Type of Advice	No. & % of Mothers/Guardians Providing the Advice	
	F	%
Advice child not to feel inferior	11	36.7
Advise child to be clever student and glad	8	26.7
Advise child against possible danger	7	23.3
Advise child not to quarrel	3	10.0
No response	1	3.3
Total	30	100

Regarding general care for the CWPD, once gain the mothers/guardians singled out the *mother* as the main caregiver (Table 32).

Table 32

Caregiver to the CWPD as Reported by Mothers/Guardians

Caregiver	No. & % of mothers/guardians identifying the caregiver	
	F	%
Mother	17	56.7
Father, mother, siblings	7	23.3
Mother and sister	3	10.0
Aunt	1	3.3
No response	2	6.7
Total	30	100

Play is another important means of physical, emotional, social and intellectual development. This particular point is specifically valid during the early years of the child's life in the home. In this study, twenty-eight of the mothers/guardians (93.3%) said that they play with their CWPD while one mother/guardian said that she does not play with her CWPD due to lack of time. The twenty-eight participants who said that they play with their CWPD have described the type of play they perform with their CWPD as follows (Table 33). (One mother/guardian did not respond).

Table 33

Types of Play Mothers/Guardians Engage in with CWPD, as Reported by Mothers/Guardians

Type of Play	No. & % of mothers/guardians reporting the play	
	F	%
Playing with ball	4	14.2
Talking, telling stories and jokes	15	53.5
Inducing laughter on CWPD by tickling, and teasing	9	32.1
Total	28	100

As indicated in Table 33, the majority of the mothers/guardians spend time talking to the CWPD - which involves story telling and joking. There is obviously an element of entertainment in all the play activities.

Interestingly also the majority of the mothers/guardians (93.3%) have indicated that CWPD play with their non-disabled siblings.

Asked if participants have any sort of conflict with their CWPD, eighteen mothers/guardians i.e. (60%) said that they do not have any, while ten (33.3%) participants said they have conflicts with their CWPD. Two (6.7%) participants did not give response. In the case of those who said they have conflicts with the CWPD, the main reasons for the conflicts (according to eight of the mothers/guardians) was the children's misbehavior or refusal to obey orders. Two of the mothers/guardians also pinpointed the children's over demandingness as a source of conflict.

In resolving the conflict, five mothers/guardians used *advice* three engaged in playing and cajoling, while the remaining two resorted to beating.

4.2.7. SUMMARY OF MAJOR REARING PRACTICES OF PARENTS WITH REGARD TO THEIR CHILDREN WITH PHYSICAL DISABILITY (CWPD)

With regard to breastfeeding, twenty-four (80%) of the mothers/guardians have breast fed their CWPD. Out of the twenty-four mothers/guardians, thirteen said that they breastfed their CWPD for over one year. Thirteen mothers/guardians, (out of thirteen mothers/guardians) have also disclosed that the CWPD gave difficulties in eating.

Among the thirteen mothers/guardians, six mothers said that they have sought spiritual cures or solutions i.e. holy water, to improve the eating difficulties of their CWPD, with five mothers/guardians reporting that they did not see any improvement.

CWPD are also said to have food preference by almost all of the mothers/guardians, but above one-third of these mothers/guardians have pointed out that they have limitations in fulfilling the CWPD's desires mainly because of economic problems.

More than half of the mothers/guardians also indicated that their CWPD eat with their non-disabled siblings, while eleven said they do not do that because the CWPD cannot eat at the same pace with non-disabled ones.

Pertaining to health care eight of the thirty mothers reported that their CWPD neglect *body* washing, while seven said that their CWPD wash rarely.

Mothers are said to be the main persons in the family who make the health follow up on CWPD.

Twenty-three of the thirty mothers/guardians (76.6%) said that their CWPD have health problems and among them, seven have said that the health problem of their CWPD is spiritually induced while fifteen of them said that their children's ailment is related to viral, parasitic, and draught causes.

Thirteen of the mothers/guardians (43.3%) mentioned unhappiness, irritability, anger, withdrawal, and fear to mix with people to be the special psychological health complaints of CWPD.

To treat the psychological health problems of their CWPD, out of the thirteen mothers/guardians, seven mothers/guardians said that they have used different means such as holy water, local herbs, and have consulted medical doctor and *Awakie. Silet* (as a solution) has also been reported by twenty mothers/guardians (66.7%).

Nineteen of the total mothers/guardians (63.3%) have further said that they found the childhood period of their CWPD to be the most challenging time during health care of the CWPD.

Concerning discipline, twenty-three of the mothers/guardians (76.7%) have said that the behaviour problems of the CWPD include crying, irritability, insulting and disobedience. The same proportion of the participants said that their CWPD are more "misbehaving" than their non-disabled siblings.

Nineteen of the mothers/guardians (63.3%) use non-corporal punishment to correct the misbehaviour of the CWPD while the rest (eleven mothers/guardians) use both corporal and non corporal punishment. But most of those who use corporal punishment have observed their attempts in beating CWPD have had made the CWPD more stubborn and aggressive. The main disciplinarian has been reported to be the *mother.*

About one-third of the mothers/guardians further said that corporal punishment should increase with the child's age.

Overall, the majority of the mothers/guardians have found out that it is difficult to discipline their CWPD by corporal punishment. In fact, most of them think that corporal punishment would make their CWPD more disabled.

In relation to informal sex role skill training, the majority of the mothers/guardians said that they expect their female CWPD to learn all skills in domestic skills associated with females. Regarding their male CWPD, 33.3% participants said that they must only do things within their capacity.

About half of the mothers/guardians (sixteen mothers/guardians) said that they have trained their male and female CWPD sex role skills. The major trainers are mothers. Those who said that they did not teach their CWPD have indicated that their CWPD could not be trained due to their disability.

Concerning formal schooling, half of the respondents said that they do not send their CWPD to school primarily because of the mobility problems of the CWPD

Those who send their CWPD to school give educational support to their CWPD in various ways – both materially and morally.

In addition, almost all of the mothers/guardians said that they would give priority for the education of the CWPD instead of to their non-disabled children.

Most of the mothers/guardians (80%) that continuous education (up to the terminal degree) is useful for their CWPD because it helps them to get equal status in family, recognition by society, self reliance and job security.

Regarding parent-child rearing practices the main caregiver and the person (in the family) with whom the CWPD talk to was found to be the mother.

Mothers/guardians often talk about education, food supply and discipline while conversing with the CWPD, but in some cases they find it difficult to engage in the conversation because of negative predisposition on the part of the CWPD.

Mothers/guardians also assume the role of counselor and companion by providing advice to the CWPD and by entertaining and educating them through stories and jokes.

Some mothers/guardians face conflicts with CWPD personally due to the children's misbehavior and overdemandingness, and *advice* is one major means the mothers/guardians use to resolve the conflict.

About half of the mothers/guardians have indicated that the CWPD request for both material and social provisions – including clothing and education.

4.3. BELIEF OF PARENTS ON CAUSES, PREVENTION AND REMEDIES OF PHYSICAL DISABILITY

Half of the thirty mothers/guardians said that physical disability is not preventable either because it is the result of God's wrath or because it is beyond man's control. Fourteen mothers/guardians said it is preventable through careful attention by birth attendants (seven), hospital medication and *tebel* treatment during pregnancy (four), mothers' good care and attention to their babies (two), and placing pieces of metal under the pillow in post natal period (one).

According to the mothers/guardians, the causes of physical disability are as follows. (Table 34).

Table 34

Causes of Physical Disability as reported by Mothers/Guardians

Causes	No. & % of mothers/guardians identifying the causes	
	F	%
Child falls and attacked by evil spirit	10	33.3
Neglect and *buda* (the 'evil eye' spirit) possession	7	23.3
Spiritual possession	3	10.0
Congenital	4	13.3.
Cause is unknown	6	20.0
Total	30	100

Evidently, spiritual sources, including the evil eye (which is commonly referred by participants as *buda* – a spiritually powerful person, who can control the psyche of another person and believed to cause on the possessed a stance of unconsciousness or paroxysm) dominate the views of the mothers/guardians about the causes of physical disability.

A focussed group discussion with women neighborhood groups also revealed additional information on community's belief regarding the causes of physical disability. Some of the remarks made during the discussions were:

> *...Most of the time children are born with physical disability due to the curse of God on the parents. Because of this many [the parents] hide them [children with physical disability] from the sight of other people ... because they feel ashamed of it [the disability]. Usually the curse is on the mother. For example, one of our neighbors laughed at a child whose lips are splinted in to two [cleft lip] while she was pregnant with her son who was born with the same kinds of lips. But apart from that, God had mercy on her child, He created the boy very beautiful...*

Regarding the rehabilitation or cure of physical disability, twenty-four mothers/guardians (80%) said that it could be achieved with God's or Allah's permission. In this connection, the mothers/guardians have made various efforts to alleviate the problem of the CWPD (Table 35).

Table 35

Types of Effort made by Mothers/Guardians to Alleviate Problem of CWPD

Type of Effort	No. & % of mothers/guardians Reporting the Effort	
	F	%
Take child to hospital, consult *awakie* (sorcerer), and administer rituals	6	20.0
Take child to hospital, massage child's waist with *Aabish*	4	13.3
Make child to inhale special incense to exorcise the *buda* (evil eye) spirit	1	3.3
Provide education and moral support to child	2	6.7
Make child drink and bath in *tebel* (holy water)	14	46.7
No response	3	10.0
Total	30	100

Except three (10%) of the participants, the rest have tried different ways in order to improve or cure their children's physical disability. A method which was reported relatively more frequently is the use of holy water.

To gain a broader understanding of societal beliefs about the care and cure of physical disability, the mothers/guardians were asked to indicate what, at societal level, people use for the purpose. Following are the methods, which the mothers/guardians said are commonly used among the general community (Table 36).

Table 36

Mothers'/Guardians' Account of Measures Society Takes to Alleviate Physical Disability

Types of Measures	No. & % of Mothers/guardians citing Medicines	
	F	%
Use *tebel,* local herbs	4	13.3
Use local herbs for drinking, tie amulets around neck of child	3	10.0
Tie amulets, sacred charms, and silver crosses around neck of child	4	13.3
Treat child with *yesemayu* (the sky's)	5	16.7
Make child drink and bath in *tebel* and apply hospital medication	14	46.7
Total	30	100

The *tebel* again comes out to be a commonly accepted means of curing physical disability. Others include *yesemayu* [traditional treatment used for cerebral palsy] and local herbs as remedial medicines for physical disability.

Healers of physical disability are mentioned by mothers/guardians with one mother/guardian mentioning one or more than one healers (Table 37).

The group discussions have also elaborated on some of the responses made by the mothers/guardians regarding the traditional treatment by community members for 'healing' physical disability. One of a specific curiosity is the practice of *'yesemayu'*, which was expressed by the women as follows: [*'yesemayu'* is apparently associated with the cause and treatment of children that have cerebral palsy, and the treatment is cited as common practice by the families in the study as well as among the women in the group discussion]

'Yesemayu' is devil's possession from the sky on a fetus that happens if the mother spins cotton while she was pregnant with her child. While she does that the devil spirit enters to her womb and uses the cotton thread to entangle the fetus's spinal cord. Then, when the child is born he/she would have weak damaged backbone ...

To evict the devil's spirit, the child that is affected by 'yesemayu' is made to stand or sit naked on a metal pan under a burning sun and some one usually the mother would splash a solution of Abish, on the back of the child's waist an pats it (the back). The patting has to be done slowly but strong enough that it could evict the bad spirit that has contorted the child's 'akerkari' [spinal cord] once and for all. When the devil leaves the body it gives a sign of tiny cotton-like particles flowing out of the child's body.

Table 37

Healers of Physical Disability

Healers	No. & % of Mothers/Guardians Citing the Healers	
	F	%
Medical doctors and *Wegeshas (local physiotherapist)*	10	33.3
Sheiks, *Awakies, Wegesaha*	8	26.7
Priests, A*wakies,*	5	16.7
Family and social workers	4	13.3
Debtera, kalicha bale wukabi	2	6.7
Medical doctors	1	3.3
Total	30	100

Respondents cited one or more than one healers

As indicated in Table 37, the healers cited by mothers/guardians include medical doctors and *awakies*, (ten), sheiks, *awakies*, *wegesahs* (eight), priests, *awakies*, (five), family and social workers (four) and *debtera, kalicha, bale-wukabi* (two).

The above result indicates that people, who are non-medical doctors, like a*wakies*. *sheiks, debteras, kalicha, bale-wukabi* are frequently mentioned by the mothers/guardians as capable of treating physical disability.

Regarding self-sufficiency, seventeen or 56.7% mothers/guardians said that their CWPD could become self-sufficient while eleven (36.7%) said that their CWPD cannot become self-sufficient. According to the former, the CWPD can achieve self-sufficiency, if they are provided with educational opportunity, support and patience, tasks/jobs within their capacity or with vocational training, and if parents of CWPD get financial support.

Pertaining to beliefs of mothers/guardians about physical disability, fifteen or 50% of the mothers/guardians said that it is not preventable.

With regard to the causes of physical disability over half of the mothers/guardians said that it is caused by spiritual sources.

About three-fourth of the mothers/guardians further said that physical disability could be corrected with God's/Allah's will.

All except three of the mothers/guardians have made some effort to overcome the physical disability of their children mainly through *tebel* treatment.

The persons who can treat children with physical disability are said to be the medical and non-medical personnel, with the latter mentioned frequently by mothers/guardians.

Over half of the mothers/guardians said that CWPD could become self-sufficient and most of them underscored the importance of education and vocational skill training for such self-sufficiency.

4.4. SIMILARITIES AND DESCREPANCIES OF RESPONSES OF MOTHERS/GUARDIANS IN THEIR REARING PRACTICES OF CHILDREN WITH AND WITHOUT PHYSICAL DISABILITY

The study has investigated if there is a difference and/or similarity in the parents' child rearing practices of their children with and without physical disability concerning *feeding, health care, disciplinary methods, informal sex role skill training, formal schooling, and parent-child relationship.*

4.4.1. FEEDING PRACTICES

The data on breastfeeding are as follows.

Table 38

Breastfeeding of CWPD and their Non - disabled Siblings as Reported by their Mothers/Guardians

Practice	No & % of Mothers/Guardians Mentioning the Practice as it relates to			
	child with physical disability		Child without physical disability	
	F	%	F	%
Child is breastfed	24	80.0	30	100.0
Child is not breastfed	6	20.0	0	0.0
Total	30	100	30	100

It appears from Table 38 that in breastfeeding, some mothers/guardians are biased towards those who have no physical disability.

Regarding the duration of the breast-feeding, there is a difference on mothers'/guardians' practice. A greater percentage of the mothers/guardians i.e. twenty out of 30 or 66.6% have breastfed their non-disabled children for over one year while thirteen out of twenty-four or 54.1% of them did the same for their CWPD.

However, when it comes to fulfilling the food preferences of the two groups, the discrepancy is not so noticeable, although once again it favors the non-disabled. In this respect, nineteen mothers/guardians (63.3%) fulfil their CWPD's food preference sometimes or if they can afford buying the food while twenty-two of them (73.3%) said they do the same regarding their non-disabled children.

The mothers'/guardians' practice concerning frequency of feeding also shows a slight difference with twenty-four or 80% of the mothers/guardians feeding their CWPD three and more times a day, and with twenty-nine mothers/guardians (96.7%) saying they do the same for their non-disabled children.

4.4.2. HEALTH-CARE PRACTICE

Concerning personal hygiene, as shown in Table 39, similar practices are observed among the children with and without physical disability in both washing pattern and neglect of body washing between the two groups (Table 39).

Table 39

Bathing Practice of CWPD and their Non-disabled Siblings as Reported by their Mothers/Guardians

Bathing	No & % of mothers/guardians giving the response regarding			
	child with physical disability		child with out physical disability	
	F	%	F	%
Face only (daily)	6	20.0	12	40.0
Face (daily) & hair (once a week)	2	6.7	0	0.0
Face (daily), hair (once a week) & body (as needed)	15	50.0	18	60.0
Washes rarely	7	23.3	0	0.0
Total	30	100	30	100

Concerning independent bathing, the CWPD need more assistance by others in washing when compared to their non-disabled siblings. Eighteen or 60% of the mothers/guardians said that their CWPD depend on their *mothers* in washing while the corresponding proportion in the case of non-disabled children was 26.7%. It is noted that a larger number of non-disabled children wash themselves than CWPD do. (i.e. 20 out of 30 mothers/guardians or 66.7% ascribe independent washing to their non-disabled children while only 6 out of 30 or 20% of the mothers/guardians mentioned the same for their CWPD).

In terms of attending to the health problems of the CWPD and their non-disabled siblings, mothers/guardians indicated the following (Table 40).

Table 40

Treatment sought by Mothers/Guardians for the CWPD and their Non-disabled Siblings

Treatments	No & % of mothers/guardians giving the response regarding			
	child with physical disability		child without physical disability	
	F	%	F	%
Tebel (holy water) drinking and bathing, prayer	13	43.3	8	26.7
Hospital medication	11	36.7	9	30.0
Wegesha (local physical therapy)	1	3.3	0	0.0
Local medicines/herbs	0	0.0	4	13.3
Holy water and hospital medication	0	0.0	2	6.7
Others	5	16.7	3	10.0
No response	0	0.0	4	13.3
Total	30	100	30	100

As shown in Table 40, more mothers/guardians i.e. thirteen or 43.3% use *tebel* and prayer as means to improve the health problem of their CWPD while eight mothers/guardians (26.7%) use the same treatment for their non-disabled ones. On the other hand, similarities are observed in the mothers'/guardians' practice regarding consulting medical doctors to improve the health problems of both groups of children.

Interview results with the children with and without physical disability also indicate similarity with that of the mothers'/guardians' responses regarding their remedial actions to the health problems of their children. Most of the non-disabled children (47.8% out of 23) said that their parents take them to hospital or treat them with herbs and *tebel* (17.4% out of 23) when they get sick. Similarly, 55.6% of the CWPD (out of 18 CWPD) said that their mothers/guardians take them to *tebel* or pray or give them herbs when they get sick while 17.8% of them (out of 18) said their mothers/guardians take them to hospital.

4.4.3. DISCIPLINARY METHODS

With regard to disciplining their children, mothers/guardians show a difference in their practice that Nineteen (63.3%) of them use non-corporal punishment such as scolding, charming, and advising, on their CWPD while only fifteen or 50% of them use the same type of punishment on their children who have no physical disability. However, a similar percentage of the mothers/guardians said that they use *advice* with the CWPD and the non-disabled ones with a respectively put proportion of their responses i.e. eleven or 36.7% (for CWPD) and ten or 33.3% (for non-disabled ones).

The children's responses on parental use of corporal punishment have also some similarities with the mothers'/guardians' responses. Out of 23 non-disabled sibling eleven or 47.8% of them said their parents advice them while six or 26.1% said their parents beat them. Out of the eighteen CWPD, sixteen or 88.2% of them said their parents advice them with only two (11.8%) saying that they are punished by beating.

Regarding the use of corporal punishment in relation to the age of the child, the views of the mothers/guardians in relation to the two groups are similar. That is, eleven or 36.7% of the mothers/guardians said their corporal punishment with CWPD grows with the age of child with the same response by twelve or 40% of the mothers/guardians regarding their non-disabled children. Like wise, the reverse practice was advocated for CWPD and the non-disabled children by fourteen or 46.7% and thirteen or 43.3% of the mothers/guardians respectively. Moreover, four mothers/guardians (10%) advocate that both groups of children should be punished with corporal punishment depending on the degree of their misbehaving.

The comparison regarding the disciplinary actions, which the mothers/guardians found to be effective with the CWPD and their non-disabled siblings, shows that two mothers/guardians (6.7%) said that *beating* has been effective in changing the behaviour of CWPD while twelve mothers/guardians (40%) said so with respect to their children without disability. Conversely, *advice* was reported to be more effective with the CWPD than with non-disabled children, with the proportion of responses of the mothers/guardians being 66.7% (twenty mothers/guardians) and 43.3% (thirteen mothers/guardians) respectively.

4.4.4. INFORMAL SEX ROLE SKILL (ISRS) TRAINING

In terms of ISRS training, the data show that mothers and siblings are more involved in the instruction of the CWPD than in the instruction of the non-disabled siblings (Table 41)

Table 41

Trainers in Sex Role Skills of the CWPD and their Non-disabled Siblings

Trainer	No & % of mothers/guardians giving the response regarding			
	Child with physical disability		Child with out physical disability	
	F	%	F	%
Mother	14	46.7	20	66.7
Father	1	3.3	0	0.0
Mother and father	4	13.3	3	10.0
Mother and siblings	10	33.3	0	0.0
Others	1	3.3	6	20.0
No response	0	0.0	1	3.3
Total	30	100	30	100

In teaching their CWPD informal sex role skills, twenty-two mothers/guardians (73.3%) said that they use ways that are different from ways they use to teach their children without physical disability. Main reasons mentioned by mothers/guardians for using different ways are that CWPD have limited capacity to perform and complete tasks in equal time with that of their non-disabled siblings. It was also noted that more non-disabled children (76.6%) have got ISRS training than their siblings with physical disability i.e. 53.4%.

4.4.5. FORMAL SCHOOLING

In terms of formal schooling, the data indicate that the CWPD are at a disadvantage. While twenty-six of the mothers/guardians (86.7%) send their non-disabled children to school, only fifteen of them (50%) do give the educational opportunity to their CWPD.

In the case of educational support, the CWPD have a marginal advantage over their non-disabled siblings in getting school materials and uniforms but not in getting tutorial. In this respect, out of those mothers/guardians who send their children to school, six mothers/guardians (out of 15 or 36.9%) provide the former type of support to their CWPD while fifteen mothers/guardians (out of 26 or 57.7%) of them did the same to the latter group. However, both groups are apparently were provided with a similar degree of moral support, i.e. six mothers/guardians (out 15 or 40%) provide this support to their CWPD with ten of them (out of 26 or 38.5%) doing the same to their non-disabled children. With regard to the tutorial support, (three mothers/guardians out of 15, or 20% of them provide tutorial to CWPD while *none* of the children who do not have physical disability get this support).

The mothers/guardians also give rewards to their children with and without physical disability for their good performance at school.

Their practice in this aspect indicates that when their CWPD get good grade results at school, seven mothers (out of 15 or 46.6%) said that they reward them verbal appreciation. Almost the same proportion of mothers/guardians (12 out of 26, or 46.1%) said they do the same in the case of their non-disabled children. In addition, in the case of poor performance, greater proportions of the mothers/guardians (8 out of 26 or 30.7% versus 3 out of 15 or 20%) reprimand their non-disabled children.

The views of mothers/guardians regarding the priority level that they give to the CWPD and their non-disabled siblings indicated that twenty-nine mothers/guardians (96.7%) said they would give educational priority to their CWPD than to their non-disabled children provided they get the necessary support.

With regard to the wishes of the mothers/guardians concerning the education of the CWPD and the non-disabled siblings, the results show that the wishes of mothers/guardians concerning the target educational level of the CWPD is generally lower than their wishes for their non-disabled children. Advanced educational level (college and above) was mentioned by nine mothers/guardians (30%) for the CWPD while twenty-four (80%) mentioned the same level for their non-disabled ones. Secondary high school as a level of attainment was mentioned for the CWPD by seventeen or 56.7% and for the non-disabled by only two or 6.7% of the mothers/guardians. The same number of mothers/guardians, i.e. 4 out of 30 or 13.3% on the other hand perceived the educational attainment of their children with and without physical disability depends on the children's ability to learn.

4.4.6. PARENT-CHILD RELATIONSHIP

Out of the total participants in the study, eighteen of the mothers/guardians (60%) said that *mothers* are the most caring persons for CWPD in the family. Similarly, seventeen mothers/guardians (56.7%) said the same thing in relation to the care for non disabled children.

The interview with both groups of children also show similar responses to that of their mothers/guardians - while ten out of eighteen CWPD or 55.5% indicate *mothers* as the person who give the most care to them, eleven out of 23 non-disabled children (47.8%) said the same thing. This was reasoned out by one of the non-disabled female child with age of fifteen, who has a twelve-year-old cerebral palsied sister, she said, " *...I always talk with and get comfort from my mother, she listens to my worries and above all we share secrets ... but with my father it is different, he only advice and reprimands me not to become a bad girl...*"

Moreover, twenty-five of the mothers/guardians (out of 30 or 83.3%) said that their CWPD talks mostly to *mothers,* when compared to other family members while only ten mothers/guardians (out of 30 or 33.3%) said that non disabled children talk mostly to *mothers.* The father's role in relation to the CWPD was mentioned only by two mothers/guardians (out of 30 or 6.7%) while none of the mothers/guardians mentioned the father as having the same role regarding their non-disabled sibling; rather twelve mothers/guardians (out of 30 or 40%) mentioned that non-disabled talk mostly to each other.

With regard to the type of interaction they have with their CWPD and non-disabled children, mothers/guardians have answered the following (Table 42).

Table 42

Type of Interaction between Mothers/Guardians and the CWPD and their Non-disabled Siblings as Reported by Mothers/Guardians

Interaction	No & % of mothers/guardians indicating the type of interaction in relation to			
	Child with physical disability		Child without physical disability	
	F	%	F	%
Talking and playing when suitable during the day	10	33.3	5	16.7
Parent giving care (washing, feeding)	8	26.7	3	10.0
Watching over child against any danger	3	10.0	2	6.7
Parent and child usually have encounter during the evening hours	9	30.0	20	66.7
Total	30	100	30	100

From Table 42, generally it appears that mothers/guardians interact more (in terms of playing and caring) with the CWPD than with their non-disabled children.

The length of time mothers talk to the CWPD and the non-disabled children was also investigated (Table 43).

Table 43

The Times at which Mothers/Guardians talk to their CWPD and their Non-disabled Ones

Talking Time	No & % of Mothers/Guardians giving the Response regarding			
	Child with physical disability		Child without physical disability	
	F	%	F	%
When mothers are not working	4	13.3	5	16.7
Many times in day	11	36.7	9	30.0
During dinner time	7	23.3	13	43.3
As found suitable	8	26.7	3	10.0
Total	30	100	30	100

It appears from Table 43 that the talking time in the case of the CWPD spreads out more evenly across day and evening in the case of the CWPD. For the non-disabled children however, it seems that they talk with their mothers/guardians more during the evening hours. One example for the latter situation is the response of a brother of a girl with cerebral palsy. In explaining his communication with his mother he said,

> *... I do not have much time during the day, I go to school and when I come back I eat some food and leave the house to play with my friends, but even if I stay at home my mother talks and gives care more to my little sister. Rather my mother and I talk for a good length of time in the evening hour. We talk about our life while we eat and listen to the radio...*

Pertaining to the subjects of conversation between the CWPD and the non-disabled ones ten or 33.3% of the mothers/guardians chat about the children's disability and education in the case of the CWPD while eighteen or 60% of the mothers/guardians said they talk about life and education with their non-disabled children.

Children also get different types of advice from mothers/guardians. In this respect, the following data were obtained.

Table 44

Type of Advice Given to CWPD and their Non-disabled Siblings as reported by their Mothers/Guardians

Type of Advice	No & % of mothers/guardians giving the response regarding			
	Child with Physical Disability		Child without Physical Disability	
	F	%	F	%
Advise child not to feel inferior	11	36.7	0	0.0
Advise child not to quarrel	3	10.0	4	13.3
Advise child to be clever student	8	26.7	17	56.7
Advise child against danger	7	23.3	0	0.0
Advise child not misbehave	0	0.0	8	26.7
Total	29*	100	29*	100

** One participant did not give response.*

As Table 44 shows, more mothers/guardians offer advice about avoidance of inferiority feeling and accidents to the CWPD than to the non-disabled. The reverse is true in the case of advice on improving achievement and conduct.

Concerning play activities, twenty-eight of the mothers/guardians (93.3%) said that they play with their CWPD, while only twenty-two (73.3%) said they play with their non-disabled children. During the play activities, both in the case of the CWPD and the non-disabled children, a little over half of the mothers/guardians engage in telling stories or jokes.

4.5. SIMILARITIES AND DISCREPANCIES IN THE *BELIEFS* OF PARENTS ABOUT REARING PRACTICES REGARDING CHILDREN WITH AND WITHOUT PHYSICAL DISABILTY

The comparison on the beliefs of mothers/guardians on rearing practices is made based on variables on beliefs concerning each of the rearing practice themes discussed in this study. The rearing practice themes are a) *feeding*, b) *health care*, c) *disciplinary method*, d) *informal sex role skills training*, e) *formal schooling*, and f) *parent-child relationship.*

The description is made based on the thirty mothers'/guardians' choice of responses from three options a) *'agree'* b) *'uncertain'* c) *'disagree'.*

The responses are of the comparative view/belief of the thirty mothers/guardians with regard to their CWPD as well as of their non-disabled children.

4.5.1. COMPARISON OF THE BELIEF OF MOTHERS/GUARDIANS ON FEEDING

Belief 1. *Feeding does not bring any change in the life of child*

A greater percentage of the mothers/guardians said the statement is *true* in the case of the CWPD. (i.e. 36.7% agreed in the case of CWPD while only 6.7% did so in the case of the non-disabled).

Belief 2. *The appetite of a child is limited*

A greater proportion of mothers/guardians (i.e. 63.3%) *agreed* with the belief statement in relation to their CWPD with only 10% of the mothers/guardians giving their consent on the same when it applies to their non-disabled children.

Belief 3. *Parents of low –income family should give priority to child in feeding*

While twenty mothers/guardians (66.6%) *agreed* to the belief statement in the case of their CWPD only four mothers/guardians (13.3%) did the same in the case of their non-disabled children.

4.5.2. COMPARISON OF THE BELIEF OF MOTHERS/GUARDIANS ON HEALTH CARE

Belief 1. *Health care does not bring any change in the life of child*

While eight (26.6%) of the participants *agreed* on this belief in relation to their CWPD, their belief on the statement is the reverse (i.e. none of them show agreement) regarding their children without physical disability.

Belief 2. *Health problems of child has to be treated through traditional/spiritual methods only*

Mothers/guardians *agreed* to the above belief statement in the case of the CWPD by a half-greater proportion of responses (19 mothers/guardians or 63.3%) while only nine (30%) of them have the same reaction on the belief regarding their non-disabled children.

Belief 3. *Religious people and sorcerers (awakies) can solve the health problem of child*

Fifteen mothers/guardians (50%) said the statement is *true* in the case of their CWPD while only one mother/guardian (3.3%) agreed in relation to her non-disabled child.

4.5.3. COMPARISON OF THE BELIEF OF MOTHERS/GUARDIANS ON DISCIPLINARY METHODS

Belief 1. *Corporal punishment should be applied on child*

A smaller percentage of the mothers/guardians *agreed* on the statement in the case of their CWPD. (i.e. three mothers/guardians or 10%) while fifteen or 50% did so in the case of the non-disabled ones.

Belief 2. *Parents could manage their children's misbehavior through corporal punishment only*

Proportionally, less mothers/guardians (3 out of 30 or 10%) said the statement is *true* in the case of CWPD while greater number of mothers/guardians (10 out 30 or 33.3%) gave the same response in relation to their non-disabled children.

Belief 3. *Corporal punishment should be applied on child only when he/she is small child*

Fourteen mothers/guardians (46.7%) *agreed* to the statement by relating it to their CWPD while twenty mothers/guardians (68.9%) said the statement holds *true* for their non-disabled children too.

4.5.4. Comparison of the Belief of Mothers/guardians on Informal Sex role Skill Training

Belief 1. *Child cannot be trained on informal sex role skill*

Mothers/guardian believe that the statement holds *true* for their CWPD while they said it *does not* in the case of their non-disabled children. (i.e. the proportion of responses of mothers/guardians is 5 out of 30 or 16.7% for their CWPD while *none* said the same applies for their non-disabled children).

Belief 2. *Child cannot manage activities of daily living*

A greater percentage of the mothers/guardians (i.e. 20 out of 30 or 80%) *agreed* with the statement regarding their CWPD while only few mothers/guardians (4 out of 30 or 13.3%) did the same in the case of their non-disabled children.

Belief 3. *Child cannot contribute to the social life of family and community*

Greater percentage of mothers/guardians (36.7%) *agreed* with the statement by referring it to their CWPD while only one mother/guardian (3.3%) said the statement holds *true* for her non-disabled child too.

4.5.5. COMPARISON OF THE BELIEF OF MOTHERS/GUARDIANS ON FORMAL SCHOOLING

Belief 1. *Parents must educate their children*

Equal number of mothers/guardians (96.6%) *agreed* to the statement when it refers to their children with and without physical disability.

Belief 2. *Child does not benefit from formal education*

Four mothers/guardians (13.3%) *agreed* to the belief statement when it is related to their CWPD, with only one mother/guardian (3.3%) saying the belief is also *true* for her non-disabled child.

Belief 3. *Child cannot achieve good grade results in formal education*

The majority of the mothers/guardians (80%) *agreed* on the statement when it applies to their CWPD while only nine mothers/guardians (30%) said the belief is also *true* for their non-disabled children.

4.5.6. COMPARISON OF THE BELIEF OF MOTHERS/GUARDIANS ON PARENT-CHILD RELATIONSHIP

Belief 1. *Child is intractable by nature and difficult to communicate with*

Proportionally, a greater majority of the mothers/guardians (i.e. twelve out of 30, or 40%) *agreed* on the belief statement when it refers to their CWPD while only two mothers/guardians (two out of 30, or 6.7%) did the same pertaining to their children without physical disability.

Belief 2. *It is difficult for parents to play with child*

Some of the mothers/guardians (i.e. 6 out of 30 or 20%) *believed* that the above belief is *true* for their CWPD, with *none* of them supporting it when it refers to their non-disabled children.

Belief 3. *Children feel good and comfortable when parents do not talk to them*

Twenty-one mothers/guardians (70%) *agreed* with the statement in the case of their CWPD, while only eight of them (26.7%) said it also applies to their non-disabled children. Also small number of the mothers/guardians (4 out of 30 or 13.3%) said they are uncertain with regard to the CWPD.

4.6. INTERVENTION AT FAMILY LEVEL: PARENTS' AND CHILDREN'S PERSPECTIVE

In the study, the views of the mothers/guardians and their children with and without physical disability on possible interventions regarding the physical disability of the children was explored.

In the results, all three groups indicated that *social* and *emotional* supports and *formal education* and *vocational skill* training are fundamental requirements for the rehabilitation of the CWPD.

Out of the total mothers/guardians thirteen or 43.3% of them suggested that their CWPD would need emotional and social support for their rehabilitation such as love and moral support by parents and siblings and making CWPD feel accepted by others. Furthermore (6 out of 30 or 20%) of the mothers/guardians believe that advice and patience have important roles in the life of the CWPD. Other suggestions include educating parents on disability (4 out of 30 or 13.3%), food, clothing, medical care, and education for CWPD (7 out of 30 or 23.4%).

The mothers/guardians focus on the social and emotional needs of their children might partly be due to influences by the community around them. Most of the mothers/guardians said that the community around them is unfriendly. According to the mothers/guardians: community considers CWPD as the last creatures in the human race and burden to their families (9 out 30 or 30%), friends look down upon CWPD and sometimes call them names (3 out of 30 or10%), other children do not come near CWPD in fear of "contamination" (1 out of 30 or 3.3%), neighbors tell mothers to give away CWPD to government (5 out of 30 or 16.7%) or neighborhood children mock at CWPD (3 out of 30 or 10%). Only nine out of the thirty mothers/guardians (30%) said that people express sympathy towards CWPD and wish them good. A mother's expression on some of the community reaction towards her is, " *...my neighbors behaviour sometimes make me feel ashamed of my own child. They speak in low voices when they pass by me. Some even tells me to give away my child to the government...*"

Compared to the parents' view, the CWPD seem to give more weight to their educational and vocational training needs, having a similar focus with that of their parents regarding their social and emotional needs. Out of the total of the eighteen CWPD included in the interview, seven CWPD (38.8%) suggested formal and vocational education and training, six CWPD (33.3%) suggested provision of love and acceptance by others, while five of them (27.7%)

indicated basic services such as food, clothing, and medical care as requirements for their rehabilitation.

There is a similarity of views between the CWPD and their non-disabled siblings about the needs for the rehabilitation of CWPD. Like their siblings with physical disability, the majority of the non-disabled children interviewed in the study i.e. (19 out of 23 or 82.6%) felt that the CWPD need special attention in developing their abilities through vocational skill training as well as skills on activities of daily living. In this respect, among the interviewed non-disabled siblings, one of them has said, " ... *After all what my brother needs is things that would make him equal to us. He needs vocational skills to comfortably lead his future life...*" The rest of the non-disabled children suggested dietary food, medical care (3 out of 23 or 4.3%) and formal education and participation in social activities (one out of 23 or 4.3%).

CHAPTER FIVE

5. GENERAL DISCUSSION

5.1. STATUS OF MOTHERS/GUARDIANS (PARTICIPANTS)

The study involves thirty mothers/guardians who have children with physical disabilities. These parents live in *Woreda* 20 and 25 in Addis Ababa. They are involved in community programmes for rehabilitation of children with disabilities run by two separate non-government organizations - Cheshire Community Based Rehabilitation (*Woreda* 25) and Voluntary Council for Handicap (*Woreda 20*).

The mothers/guardians are young adults having an average age of 38 and non-formal education or none. Most of them are married and have religion and ethnic background of Christianity and Amhara respectively. The mothers'/guardians' average family size is seven and the large majority earn their income mainly from petty trade and daily manual labor, getting an average monthly income of 195 Birr with more than half of them living in *Kebele* owned houses.

5.2. STATUS OF CHILDREN WITH PHYSICAL DISABILITY (CWPD) AND TIME OF DISABILITY IDENTIFICATION

With regard to children participants, thirty CWPD and their twenty-three non-disabled siblings are involved in the study. Most of the CWPD (63.3%) are females. The average age of the CWPD is ten and they have physical disabilities of cerebral palsy, cerebral palsy with mental retardation, poliomyelitis, clubfoot, epilepsy, locked knee and other deformities. The onset of their disabilities were identified by their mothers/guardians within the first three years of the children' life, with mothers/guardians having observed unusual anomalies of gross motor abilities on children such as inability to suck breast, grasp feeding-bottle, sit or walk.

The rehabilitation programmes of the NGOs cited earlier provide the CWPD with physical, health and social supports through their social workers at household level. The supports include physical exercises for muscle tone strengthening for cerebral palsied children, surgical correction for children with clubfoot, medical follow up for epileptic children, provision of appliances and special needs (disability) education for the family members.

As indicated above, most of the children with physical disability are affected by cerebral palsy. The high prevalence could be attributed to possible damage to the spinal cord and/or brain of the children. Studies (Hewett and Forness, 1977; Heward & Orlansky, 1988; Tirusew, 1996) indicated that cerebral palsy results from damage to the central nervous system, before, during or after birth; it could be caused by several factors that include birth injury, congenital cerebral defect, postnatal head injury, infection and unidentified or other causes. A few mothers/guardians have also suggested that cerebral palsy (in their terms – '*yesemayu*') comes at birth or its causes are unknown.

5.3. PARENTS BELIEF ON CAUSES, PREVENTION, AND REMEDY OF PHYSICAL DISABILITY

The finding indicates that 50% of the participants believe that physical disability is not preventable because it is a result of wrath of God/Allah, and man is unable to control its happening. The mothers/guardians' response could be explained from the point of view of their religious affiliation (Christianity and Islam). In addition, Molvaer (1995) indicated that many local ethnic groups, specially in the Amhara, the well-being of children is often associated with protection of God, angels, saints against any natural or spiritual adversities with the latter specially considered to come from evil spirits. Tirusew, *et. el.* (1995) in a base line survey on disabilities in Ethiopia has also found out that more half of the participants (51.8%) in the survey ascribe the cause of disability to spiritual sources. Similarly, more than half (66.3%) of the participants attribute the causes of their children's physical disability to spiritual sources. And many, 30.2% have associated the disability of their children to health problems, which they have said was caused due to falling of child and being possessed by evil spirit. Out of the eighteen interviewed CWPD, 22.2% attributed the cause of their disability to falling, while another same percentage (22.2%) of CWPD attribute the cause of their disability to *likift* (devil's spirit possession). Falling is an accident ascribed by the mothers/guardians as an antecedent to evil spirit possession. As some of the women in the focus group discussions explained, the occurrence of *likift* or the devil's possession is said to take place in the following manner

> *... the devil likes to be around children who are playing or sleeping alone. If the children stay that way for longer time he gets into their body ... specially he likes the pure soul of the new born babies, that is why we never leave new-born alone. On another occasion, the devil enters into children's or any other person's body when they have accidents of any sorts or when they get scared or when they are hit harshly by some one ...as 'he' [the devil] is an angel of atrocities, he [the devil] always waits for such chances to mix his bad spirit with people and hurt them more in the rest of their life ...*

Why falling is cited as a major cause may have an explanation in terms of possible neglect by mothers, which in turn could be explained in relation to mothers'/guardians' socio-economic status. That is, the fact that the mothers/guardians are low-income earners, spending their days out of home to earn their living and unable to care for their children, could have been a reason for the exposure of children to different kinds of possible accident such as falling. During interview on the initial cause of their children's disability, it was common to listen to mothers/guardians referring to and blaming other members of the family or neighborhood children, saying " *'They' did not watch my child properly while I was away", or " 'they' have caused my child to fall and get possessed by evil spirit"*,...or " *When I left home, my child was playing nicely on a bed, ... but on my return home, I found him/her this way"*

Another possible reason could be problems at birth. That is, the children of the participants could have acquired the physical disability at birth due to improper and insufficient perinatal arrangement. As many as 40% of the participants have said that they have identified their children's disability at birth. Such incidence could be linked to the mothers'/guardians' inability to get safe delivery opportunities. Actually, seven mothers/guardians (50%) out of the fourteen who said physical disability is preventable speculated that their children's disability could have been prevented had they got careful attention by birth attendants.

Still, some of the mothers/guardians have awareness about other possible causes of physical disability, beyond supernatural forces. This mothers/guardians probably developed this awareness through their natural daily experiences of mothering, or through education by the NGOs. The two NGOs involved in the study include in their programme education or awareness creation regarding the causes, intervention and prevention of disability, which they apply through family and community discussions. Some of the cited methods of prevention by the participants are antenatal and postnatal care by birth attendants and mothers, and hospital medication.

Concerning remedy of physical disability, a good number of the mothers/guardians i.e. 80%, said that they believe that their children's physical disability could be improved or cured, but *only* if God/Allah permits it. Since many of the mothers attribute the cause to God's punishment, it is no wonder that they also determine God's forgiveness as cure. Indication to this is that most of the mothers/guardians (70%) have, among others, tried spiritual and traditional means such as *silet* [vow made to various Saints] *tebel* and *Abish* splashing on the back of child's waist to improve child's disability. Molvaer (1995) defines *Abish* as fenugreek porridge often fed to children to make them strong and fat. But apparently *abish* is also found to have another use related to cure of physical disability. During the study, the researcher came to know that *abish* is splashed on the back of child's body to do away with a disability normally known as cerebral palsy; which is commonly referred by the mothers/guardians, their CWPD, as well as their non disabled siblings as "*Yesemayu*".

The treatment adopted by many mothers/guardians also relates to making sacrifices for evil spirits to cast them out of their children's body. In this regard, a mother who found that her son had physical disability said, *"As soon as I understand that my child has twisted hands* *and eyes, I knew that my child had the 'likift'; (the devil's spirit) so I immediately consulted a very good Awakie, who told me that I should act fast before the 'likift' controls my child's mind. So, I have done all my best following the orders of this Awakie...I have slaughtered a hen by the bedside of my son, and kept the blood on the floor for three days ...but my son did not show any improvement, so I took him to Kidane Mihiret [Saint Mary] church and he stayed there for seven days drinking and bathing her [Saint Mary] tebel [holy water]..."*

The elaboration given above explains that the mothers'/guardians' belief on prevention and causes of physical disability influences their methods of interventions. Early identification is said to be the major and important aspect of disability intervention. According to Tirusew (1996) age 0-3 years is the ideal and critical age for early intervention of disabilities. However, though the mothers/guardians have identified their children's disabilities within this period of time, it seems that they did not attempt to follow effective means of early intervention mechanisms. Several researchers (Ringness & gander 1974; Levine, 1965; Kibebew 1986; Molvaer 1995) support this point by indicating that in the Ethiopian communities superstition is used for treatment of the ill.

Aside from religious orientations, traditional beliefs and low level of education, one reason why parents sought spiritual solution more than scientific ones could be attributed to lack of information on the parents' side on the services available on disability in their living area. A good example to this could be the expression of one of the mothers/guardians who has a cerebral palsied boy of seven years old. She said, " *Now that I come to think of it, I am a double sinner who caused the disability on my child, first God gave me a disabled son to punish me for my sin. Second, once I knew that he was born different, I should have helped him to do the sports he is doing now...if I had done that he could have improved a lot ... but then I wouldn't know until the Cheshire boys [the social workers of Cheshire NGO] came to my house. I took my child to 'tebel', which was the only hope I had."*

Boswell (1974) has actually indicated that many children with disabilities grow up without proper treatment at an early period, because of the of information parents miss on the professional and social services that deal with disability and are available in their community. For example, many of the mothers/guardians have indicated (during the interview) that they did not know that the Black Lion Hospital in Addis Ababa provides physiotherapy (in the mother's/guardian's term "sport") to children that have physical disability, until they were informed by the community based rehabilitation workers.

On the whole, the above results show that the belief of the mothers/guardians on the, causes, prevention and remedy of physical disability is generally not related to the scientific explanation. Scientific explanation of the causes of the physical disability include chromosomal abnormalities, radiation, high consumption of alcohol by the mothers, some antibiotics, metabolic disorders, postnatal handicapping conditions, nutritional effects, and child abuse (Tirusew, 1996). Regarding remedy or intervention, a wider service is suggested by David and Orlansky (1988), and this include physical independence, including mastery of daily living skills, self awareness and social maturation, academic growth, and career education, including constructive leisure activities. David and Orlansky (1988) also suggested that the intervention effort must involve interdisciplinary team of professionals and parents.

It is also observed during the study that the two NGOs involved in this study apply physiotherapy and social counseling to help CWPD improve their physical abilities. The group of children with physical disabilities that are involved in the present study are new recruits and no change yet is exhibited by the intervention. However, it is noted that a report of the Cheshire Community Based Rehabilitation Project (CCBRP) regarding cerebral palsied children included in the programme of the year 1999 indicates: "*... an encouraging results were observed on the children with cerebral palsy ... more than half of the cerebral palsied children showed improvement in sitting, grasping objects, and walking with frames ...and almost all children who had clubfoot had surgery and their feet were corrected*" (CCBRP, 2000).

Each of the dimensions of the rearing practices of CWPD invites a number of discussion points.

5.4. REARING PRACTICES INCLUDING COMPARISON OF PRACTICES FOR CHILDREN WITH AND WITHOUT PHYSICAL DISABILITY

5.4.1. Feeding

Feeding has nutritional and social value in the development of children. Andreas & Dale (1992) describe feeding as one of the important elements in the social development of children in Africa. They noted that feeding process is considered as a medium of cultural transformation where children learn how to interact and share with family members and others. In relation to nutritional value Tigist & Dereje (1996) indicated that infants not breastfed have an increased incidence of diarrhoeal, respiratory and skin diseases compared to those breastfed. In this study, the feeding practices of mothers/guardians regarding their CWPD generally show that it has positive elements of nutrition and social values, which are manifested in their practice of breast-feeding and practices at meal times in the family.

Breast-feeding is more than a way of getting milk to the baby; it is also a way of communication and developing attachment between mother and child. Klein (1996), for example, noted that in a study made on an early mother child interaction in Ethiopia, it was observed that physical proximity between the mother and the child were most commonly manifested during breast feeding.

A noticeable result in this study is that 80% of the mothers/guardians have breast-fed their CWPD. However, its impact in making a difference in child's health and growth is determined by its length of application. Kitzinger (1994) indicates that in many cultures children are breastfed often during the day and unrestrictedly up to 3 and 4 years, but working mothers use minimal breastfeeding for a mean of 19.8 weeks (approximately 5 months). In this study, the mothers'/guardians' practice in breastfeeding is in contrast to

Kitzinger's finding but is similar to Tigist's & Derege's finding who found out that out of 1, 202 randomly selected working mothers in Addis Ababa, 90.5% breast fed their children for over 6 months (Tigist & Dereje, 1996). Being working mothers, all mothers/guardians have breastfed their CWPD for 6 or more years, with 54.1% having breast-fed their CWPD for over one year.

The study indicates disparity concerning the breastfeeding practice of the mothers/guardians concerning their children with and without physical disability. All mothers/guardians have said that they have breastfed their children without physical disability while only twenty-four of them did so with the CWPD. In addition, twenty mothers/guardians who have breast-fed the non-disabled children for over one year is greater than those who did the same with the CWPD. The discrepancy could be explained in terms of mothers'/guardians' belief and reaction to the disability of the children, because it was reported by the participants that some mothers have abandoned their children at birth, some considered milk a taboo food, and another reason is related to physiological problem of the child to suck the breast easily.

Eating in a group from one basket/plate is a long-standing social value of the Ethiopians in their feeding tradition. The strength of this social value is described in an old Ethiopian proverb, which is *"a person who eats alone, dies alone"*. Having such a traditional background, eating in a group by sharing a plate would have a positive influence in the personal and emotional development of the children with physical disabilities. How this practice benefits a CWPD is indicated by one of the daughters of the participants that has right hand spasticity. She said, *"I like eating with my non disabled sister, who talks to me and feeds me with 'gursha'* [extra mouthful feeding by a person to his/her companion while eating] *while we eat. And also, when I eat with her, I feel that I am not a Satan..."*

However, the result regarding group eating shows that non-disabled siblings are more uncooperative than their siblings that have physical disability. The uncooperative behaviour of the non-disabled siblings in eating with their brothers and sisters that have physical disability is confirmed by 36.7% of the participants.

Such behaviour of non-disabled siblings could have negative effect on the emotional development of the CWPD by instigating feeling of rejection. Among the daughters of the participants, one that has epilepsy problem is a typical example of such feeling. Asked if she eats with her siblings, she said, *" No, I do not eat with my sisters and brothers when they eat together. They say that they are afraid of the devil spirit that is on me would be transferred to them, in case I get sick while I eat with them ... so my mother gives me my food alone...and I feel lonely and secluded."*

The parents' role towards meeting the needs of their CWPD to socialize while eating is an area that needs adequate attention because it has importance on the development of the self-esteem of the CWPD.

Frequency of eating and quality food provisions are other dimensions of feeding that can have beneficial impact on the physical growth of children. In this regard, the practice of the mothers/guardians is impressive in that, except a few of them (6.7%) of them, the rest have said that they feed their CWPD three and more times in a day. The types of food affordable in the family, according to the mothers/guardians is *injera* [soft pancake made out of special cereal '*teff*'] with *shiro wot[sauce made of bean flour]*, sauce made of cereals, bread, and vegetables. In addition, provided that they can afford to supply the food, 50% of the participants said that they fulfil the food preferences of their CWPD, which include macaroni/spaghetti, meat, egg, vegetables, and sweets and fruits. That could contribute to the nutritional enrichment of child's food intake if the mothers/guardians could supply them, despite their low income and large family size management. Furthermore, it is observed that the mothers/guardians make no discrimination between their CWPD and those without concerning frequency of feeding and fulfillment of food preference of child. The CWPD as well as their non-disabled siblings have also reported have their meals per day as frequently as cited by their mothers/guardians.

Regarding the physiological functionality of their CWPD in eating, not surprisingly, 43% of the participants have indicated that that their CWPD have difficulties in eating. Difficulty in eating is one among many other problem children with physical disabilities face, especially those with cerebral palsy. Children with cerebral palsy lack muscle tone that makes it difficult for them to hold objects chew or make moves (Heward & Orlansky, 1988)

Associated with the above-mentioned eating difficulties, cluttering food on the floor, and lack of appetite are said to be the prevailing eating difficulties of CWPD of thirteen mothers/guardians. Such problems could be improved through constant muscle tone exercises of jaws, tongue and hands (Heward & Orlansky, 1988). The result of this study revealed that the practice of the mothers/guardians in this aspect is different from such treatment. Among the thirteen mothers/guardians, many 46.1% have used spiritual methods such as making the child drink and take bath in *tebel* in order to improve her/his eating difficulty and some of them said that they did not see any change at all.

The way the mothers/guardians tried to tackle the eating problem of the CWPD again related to their belief about the causes of their children's eating problem. For example, a mother who has an eight year-old daughter with cerebral palsy and mental retardation, described her effort to treat her daughter's eating problems by saying: *" The bad spirit that has entangled my child's tongue is preventing her from eating, and sometimes it chokes her throat wanting to take her soul out ...".*

Only a few (6.7%) of the mothers/guardians have made effort to consult medical doctors, to solve the eating problems of their CWPD. A peculiar result worth mentioning here is that some mothers'/guardians' believe that feeding is important in the case of non-disabled children but it *"does not bring any change in the life of CWPD"*. Indeed most of the mothers/guardians believed that *"children with physical disability do not have appetite for food"*

Guidance from traditional healers or "wise men" seems to add to the problem. In this case a mother who said that she did not breast-feed her son, disclosed: " ... *When I knew that my baby is disabled, I consulted a renown Awakie to get a curing medicine. The Awakie ordered me to do certain things, and one of them was, not to give my child milk. He said that milk would aggravate the disability of my child...*"

Generally, it appears that although the CWPD face physiological or biological drawbacks they are not given adequate help to solve their problems and that can aggravate their physical and emotional condition.

But in general, the feeding practice of mothers/guardians is positive and does not indicate noticeable maltreatment. Only a few of the mothers/guardians have deprived their babies from getting breast feeding due to their belief that milk is taboo food for a child with disability.

5.4.2. Health - care

Washing face, hair and body is one of the primary healthcare elements that one should practice daily. In terms of frequency, the practice of mothers/guardians in washing their CWPD is unsatisfactory. For instance, half of the participants said that their CWPD wash their bodies once a week or twice in a month, which was confirmed by the CWPD themselves (i.e ten out of eighteen CWPD (55.6%) who were interviewed said so).

The responses of 26.7% of the participants indicated neglect in CWPD's body washing, while 23.3% of the participants said their CWPD wash rarely.

Four possible reasons could explain the lack of washing among the CWPD. First, the physical limitations of CWPD can make them depend on others to wash. Actually, the responses of 73.3% of the participants indicate that CWPD depend on others for washing;

while eight (26.7%) mothers/guardians said that their non-disabled children need other people's help for washing.

Second, there may be lack of awareness among the mothers/guardians regarding the usefulness of personal hygiene on the health development of children and they may be overloaded in domestic work. Jareg (1990) noted that personal hygiene has crucial place in child development. However, according to him, among the poor and uneducated families it is never a priority. Jareg has further indicated that his community development experiences in Africa show that, mothers' engagements in household chores and in many cases their low awareness in primary health care accounts for the neglect of children's personal hygiene in both urban and rural areas. (Jareg, 1990). This point is reflected in the present study because 60% of the participants said that *mothers* are the ones who follow up the personal hygiene or health care of their CWPD.

Other literature also indicates that, mothers find caring for children with disabilities too challenging and that it requires full energy to fulfil the demands of such children (Heward and Orlansky, 1988). In this regard, 70% of the participants said that they have found it difficult to provide health care for their CWPD, with 57.1% of them saying that they lack the energy to meet the demands of their CWPD.

The third reason as to why mothers/guardians could have possibly neglected washing concerning their CWPD relates to their belief; i.e., 26.6% of the participants said that they believe that *"health care does not bring any change in the life of CWPD";* while none of the participants hold such a belief in reference to their children without physical disability.

Based on empirical data, a fourth reason could be attributed to a general custom of washing of community members in which the participants of this study belongs to and as well as lack of water facilities or supply at household level.

Furthermore, the CWPD are said to have regular and special health problems, including viral and parasitic, and infections and emotional/social problems such as unhappiness, irritability, anger, withdrawal, and fear to mix with people, - the kinds of problems which are regarded to be emotional reactions of children with disabilities (Boswell, 1974).
Once again, most of the mothers/guardians attribute the causes of health problems of their CWPD to spiritual sources such as *buda* and evil spirit. Only some attribute it to bad food, unbalanced diet, and lack of attention and care.

In addition, over half of the mothers/guardians who used *tebel* found the treatment has brought positive change in the special health problem of their CWPD. A mother of a cerebral palsied boy described her son's language difficulties and irritability, and her treatment as follows: *"My boy is always serene, but sometimes he gets so angry that he shouts and wails in strange language, but he calms down when I make him inhale the 'buda medhanit' [medicine to do away with the evil eye spirit] and sprinkle some 'tebel' on his face"*

More over, mothers/guardians have different views when it comes to their beliefs on the intervention to the health problems of their children with and without physical disability. Comparative data on the belief of the mothers/guardians concerning their health care practices revealed that a good percentage of the participants i.e. 63.3%, believe that *" health problems of CWPD has to be treated through traditional / spiritual methods only"* while only 30% of the participants said the statement holds true for their children without physical disability. In particular the proportion of mothers/guardians who treat their CWPD with *tebel* drinking and bathing is greater in the case of the CWPD. The mothers/guardians resorted to spiritual remedies because they relate disability to supernatural sources that their interpretation of any health complaints by CWPD is perceived with a bias.

Regarding maltreatment in health care, there are indications that CWPD are neglected in their personal hygiene. However, as indicated by one mother, the challenge mothers face in caring for their CWPD is serious: " ... *My life is debilitating because I am cursed by God. I have such a child on top of my being destitute ... the caring of this child is almost killing me. If* *only I knew what to do with her ... Her uncleanliness tires me out ... even if I warn her, she soils herself because she does not control her bowel movement, ... to be created to simply put up with such a life is a real curse..."*

In some cases, the CWPD became victims of physical disability after falling while the mothers/guardians were away from home. This suggests that their family members subjected the CWPD to disability by not giving them enough attention. During interview, many mothers/guardians suggested that other members of the family were responsible for the cause of their children's disability. But the matter is a little complicated because the persons who are supposed to be caregivers in the absence of the mother may be other children or neighbors. The overall situation, therefore, could be explained in terms of the mothers'/guardians' socio-economic limitations, which enforced them to expose their CWPD to such deprivations.

5.4.3. Disciplinary Method

Several studies (Hallahan & Kauffman 1988; Heward & Orlansky, 1988; Tirusew, 1996;) indicate that children with disabilities have aggressive and irritable behaviour. Similarly, 76.7% of the participants in this study said that their CWPD have behaviour problems that include crying, irritability, insulting others, aggressiveness, and disobedience.

Regarding the causes of the behaviour problems, 96.6% of the mothers/guardians said that the behavior problems of their CWPD emanate from their disability, makes them feel disliked by their family members. Similarly out of the eighteen CWPD who were interviewed eleven (61.1%) said that they believe their disciplinary problems come from their disability. The CWPD added that the CWPD misbehave because they are spoiled by their parents. These results agree with Boswell's statements that children with disabilities are highly overprotected, and are spoiled by their parents for several reasons such as sympathetic nature of parents, parents' feelings of guilt, parents' fear of hurting the child (Boswell, 1974).

In terms of correction, in this study more than half of the participants (63.3%) use non-corporal punishment such as scolding, advising, and charming to discipline their CWPD. Interestingly, twenty of (66.7%) of the participants also said that they have found *advise* as the most effective disciplinary action that brought positive change in the behavior of their CWPD.

The above finding on parental disciplining practice is found to be notable because it reflects scientifically acceptable disciplinary method by avoiding corporal punishment (Mussen, H., 1990). Corporal punishment harms the child's physical, emotional and cognitive development (Hetherington & Parke, 1986).

Mothers'/guardians' disciplining practices in terms of corporal punishment also diverges from the traditional and dominating experiences of the Ethiopian parenting styles, which is said to be authoritarian (Ringness & Gander, 1974 & Kibebew, 1986; Molvaer, 1995).

The emphasis the mothers/guardians put on corporal punishment could be explained in two ways. First, mothers/guardians could be sympathetic towards their CWPD because the children are disabled. In this connection, over half of the participants have said that they have found it difficult to apply corporal punishment on their CWPD, because of one or more of the following reasons: *"CWPD is already cursed by God/Allah, so does not need additional punishment", "Disability is a punishment by itself, so additional punishment is not necessary," and "CWPD is frail so could not endure punishment."* Tirusew *et.al.* (1995) also in a survey conducted in Ethiopia, found out that one of the parental attitude toward physically disabled children is overprotection. Second, the mothers/guardians could have faced negative reactions from their CWPD when they tried to apply corporal punishment. In the latter case, most of the participants have actually indicated that their attempt in beating have had made their CWPD more stubborn and aggressive.

The above account about non-corporal punishment should not, however, be interpreted to mean that the mothers/guardians avoid corporal punishment in dealing with the misbehavior of the CWPD. In fact, 50% of the participants said that they believe that "*corporal punishment should be applied on children*" by relating this belief to their children without physical disability, while three mothers/guardians (10%) said that the same belief statement holds true for their CWPD. In addition, 40% of the participants said that corporal punishment should increase as the age of non-disabled children increases. A similar number of mothers/guardians (36.7%) expressed the same view regarding their CWPD.

The de-emphasis or avoidance of corporal punishment signals a positive approach. However, if mothers/guardians are over sympathetic and do not consider non-corporal corrective methods sufficiently, that can negatively affect the development of the children. Baumrind (1967, 1973) cited by Mussen (1990) noted that the parents of least mature children are permissive, non-controlling, and warm, and they are lax both in disciplining their children and rewarding them. She suggests that the authoritative child rearing that combines high demandingness with high levels of warmth and responsiveness has the most positive consequences for children.

When it comes to disciplinary methods, the mothers/guardians practice indicates that the children with and without physical disability are mistreated because the results show that mothers/guardians apply physical punishment on them. Moreover, mothers/guardians feel that corporal punishment should increase with the child's age. It is tempting to say that such attitudes and practices arise out of desperation. As one mother put it:

> *... Even now it is difficult to make my child behave well, and eat and dress whatever is available at home. His demands are increasing from time to time. He always wants to look better than his friends at school do. For example, yesterday he came from school and asked me to buy him a pair of leather shoes that fit to his feet. ...This one, I could not tolerate because as you can see I live in distress. The way to make him shut his mouth is to slap him on the face right there and then ...*

This behaviour of mothers/guardians could have emanated from mothers'/guardians' socio-economic background such as distress caused by lack of income, large family size, lack of education, which in turn could arouse edginess, discord and violence among family members.

5.4.4. Informal Sex role Skill Training

Investigations made in the area of disability indicate that it is important to focus on the abilities of disabled people than capitalizing on their disabilities. Brattgard (1974) cited by Boswell (1974) has noted that people with disabilities must be taught to take full responsibility for their actions and choices in life. He further stressed that all general-nursing systems in which the disabled person is segregated must be avoided, and the right way is to train the disabled to take care of himself/herself.

Along the same line the findings of the present study show that most of the mothers expect their female CWPD to learn domestic activities because they believe it could help them lead independent life in the future. With regard to their male CWPD, about one-third of the participants said that they expect them to learn and do activities within their capacities. This result indicates that mothers seem to be less demanding when it comes to skill training concerning their male CWPD. Their answers could have been influenced by the sex role they have with regard to providing informal skill training to their sons. Usually, the common practice is that fathers are the models for boys in terms of transferring informal skill that are regarded important for socialization of boys (Molvaer, 1995).

With regard to the person that provides informal sex role skill training to the CWPD, out of the mothers/guardians who said that they provide informal skill training, the large majority (87.5%) said that *mothers* are the main trainers of their CWPD. One mother/guardian mentioned the *father* as trainer. Also, 46.7% and 66.7% of the participants said that they believe *mothers* are the appropriate informal skill training providers to CWPD and to non-disabled children respectively.

The above results show the minimal role the father has in the informal skills training of CWPD. Boswell (1974) citing Hewett (1970) actually indicates that the father's role in providing routine care needed by children with disabilities is negligible, when compared to that of the mother. Hetherington & Parke (1986) also noted that fathers are merely substitute caretakers in their children's social world, and in spite of current trends, they are still less likely than mothers to be the primary caretaker.

The type of skills the mothers/guardians said they taught their female CWPD include all kinds of domestic activities; while their training to their male CWPD include involving them on errands, repairing household things, up keeping garden. Also, half of the CWPD said they are taught housekeeping and cooking.

Some discrepancies have been reported concerning the mothers'/guardians' practice in training their children i.e., while a large majority of the mothers/guardians (76.6%) said they have trained their non-disabled children, as many as 43.3% of them said that they did not do the same for their CWPD because of their disability. This result is in contrast to the idea that supports the promotion of the abilities of people with disabilities towards their physical and psychological independence. Brattgard (1974) cited in Boswell (1974), noted that institutionalized children who have physical disabilities and who have been trained by their guardians to master daily life activities were able to gain a true knowledge of their capacities, which in turn has created in them a valuable feeling of confidence. Such an opportunity seems to be lost in the case of the CWPD that belong to the 43.3% of the participants. The participants' practice in this aspect seems to be influenced by their excessive sympathy for their CWPD, and possibly due to their underestimation of the CWPD. As one mother said about her cerebral palsied daughter: "*My daughter deserves to spend her time by playing only. She wouldn't have to suffer more than what she does already. To make her do things in the house would be cruel of me. I wouldn't allow that to happen to her as long as I am alive...*"

Concerning the capability of the CWPD, twenty-four mothers/guardians (80%) believe that *"CWPD cannot manage activities of daily life"*. Moreover, despite that the fact that responses belong to small number of participants i.e. five (16.7%), it is worth noting that the participants said they believe that *"CWPD cannot be trained in informal skills"* while none of them said that about their non-disabled children. in addition, thirteen mothers/guardians (43.3%) said that their CWPD could not become self-sufficient.

Overall, the study indicates that parental practices with regard to providing informal sex role skill is biased due to their belief and their regard for CWPD. This is a critical issue because daily living skills are fundamental to the personal and social development of children with physical disabilities (Hewett & Forness, 1977; Heward & Orlansky, 1988). The CWPD will no doubt be disappointed with the bias because, as found in this study, most of them (88.8%) believe that they can be self-sufficient if situations permit them.

The overall results concerning informal skill training show that there is no indication that mothers/guardians overburden the CWPD with work. However, the fact that almost half of the mothers/guardians said that they do not provide informal sex role skill training to their CWPD due to their disability, could be considered as an element of maltreatment because that denies the CWPD the knowledge skills on activities useful for daily living. Such behaviour or practice of mothers/guardians could be the result of the belief and low regard they have towards the ability of CWPD. It could also be attributed to the lack of time or special skill/know how on the mothers'/guardians' side to train their CWPD.

5.4.5. Formal Schooling

Special educationalists highly emphasized the positive role education has on cognitive and social interaction of children with disabilities. In this regard, half of the participants send their CWPD to school, (with 86.7% of them doing the same regarding their non-disabled children). Some of these participants who said that they do not send their CWPD to school did not do that because their CWPD have mobility problems. This problem has been recognized by others. Tirusew (1996) has indicated that children that have physical disability are usually deprived of their education due to their mobility problems and lack of accessibility and facilities both at home and at school Due to this, the researcher suggested that children with physical and health impairments should be served in a wide variety of educational settings, ranging from regular classrooms to homes and hospitals.

The fact that some of the participants do not send their CWPD to school could also be explained by their belief regarding their expectations about educational achievements of their children with and without physical disability. In this respect, 80% of the participants said they believe *"CWPD cannot achieve good grade results in formal education"* while only 30% of them said that they believe this statement applies for their children without physical disability as well. By way of elaboration one of the CWPD, who enrolls in grade six and has polio, described her mother's reaction towards her poor grade by saying: *"When my brother gets poor result in his lesson, my mother gets angry at him. She also beats him and sometimes does not give him food. But when I get poor results, she does not beat me, and I think it is because I am disabled ...She says that the fact that I am going to school is by itself enough."*

Another reason as to why some mothers/guardians did not send their CWPD to school is concern for the protection of their CWPD against social stigma and mockery by peers in school. They also expressed fear of danger their might face on their way to school and back.

Mothers/guardians were in fact very much concerned with the feelings of the CWPD. For example, out of the 96.7% of the participants, who said that they would give education priority to their CWPD than to their non-disabled children, 55% of them said that they would give educational priority to their CWPD in order to protect them against feeling being discriminated by family members, and to compensate them for their disability.

As in the case with other children adequate self-esteem and social interaction have important roles in the overall development of children with physical disabilities. However, the practice of mothers/guardians (i.e., not sending CWPD to school for different reasons) creates a problem for the CWPD. By protecting their CWPD from any social inconvenience they might face by going to school, the parents have allowed their CWPD to miss the opportunity of developing their self-esteem and social competence, as well as educational knowledge. Tirusew, (1996) stressed his point by saying that being restricted from social and school activities can impede the social and emotional development of children with physical disabilities. In addition, Vanistendeal (1998) said that children with disabilities must be helped to do well in spite of the personal and social difficulties they face so that they develop competence that would help them to function well in their lives.

Another point is that the mothers'/guardians' responses on prioritization of educational opportunities for their children reflects lack of objectivity on their outlook regarding the rights of children on education. Their prioritization seems to be influenced by sympathy rather than a true appreciation of the value of education on the overall development of children. [A point of argument here is that an appropriate belief in educational practice should have reflected the provision of equal education opportunity (Article 28, UN CRC, 1992) to all children in a family.]

A comparison of the participants' support for the education of their CWPD and their other children, (while in school), there are differences as well as similarities. For instance, while six out of fifteen mothers/guardians (40%) said that they support their CWPD by buying education materials and school uniforms, and making available study places, fifteen mothers/guardians (57.6%) said that they do the same for their children without physical disability. This result suggests that mothers/guardians give more weight for their non-disabled children's education, which once again could be explained in terms of the regard they have towards the capability of their CWPD. The proportion of participants who said they give moral support to their children to achieve well in school is similar (about 40%) in the case of the CWPD and non-disabled children.

The overall finding on the formal schooling practices of the participants show that mothers/guardians have a gap of knowledge concerning the beneficial value of education with regard to their CWPD. They are more inclined to be guided by their sympathy for their children's disability, which is reflected in the mechanism they chose to cope up with the social and emotional problems of their CWPD. A mother who said that her daughter who has club foot would get hurt while she walks to school could be an example to mothers'/guardians' excessive sympathy. She said: " ... *It is enough that my daughter is 'shiba' [derogatory word used to express physical disability] ...I cannot make her to walk to the school and get hurt by tripping over or knocking her toes against some stones. It is better if she stays at home and live well ...*"

In addition, the mothers'/guardians' outlook towards the capability of their CWPD in school achievement generally seems to be pessimistic. Such low expectation by parents can affect the CWPD negatively. Tirusew (1996) indicates that when expectation of parents are low, they can inhibit social and emotional development of children with physical disabilities. In this respect and from the point of view that half of the participants do not send their CWPD to school, it could be said that there is an element of maltreatment in the practice of mothers/guardians with regard to educating their CWPD. Thus, once again the mothers'/guardians' practice in relation to educating their CWPD show maltreatment, which resulted from mothers'/guardians' low regard or overprotection towards their CWPD.

5.4.6. Parent-child Relationship

The quality of relationship between parents and their children plays a determining role with the emotional and cognitive development of children in general, and on children with disabilities in particular (Rye, 1990). Spending more time with and talking to children enriches child-parent relationship.

The results of the study show that mothers/guardians have positive and close relationship with their CWPD. Among the participants of this study, 70% said that they pass their days talking to and giving care for their CWPD. Regarding the person with whom the CWPD interact more by talking in the family, 83.3% of the participants said that their CWPD talk to their mothers. The father was said to have such a role by only 6.7% of the participants. Moreover, 56.7% of the total participants have said that the main caring person for CWPD is the mother. Hetherington & Parke, (1986) have noted that in a family setting when compared to the mother, the father typically spends less time with the child. The findings of this study also indicate that mothers/guardians spend more time with their CWPD than they do with their non-disabled children.

As Hetherington & Parke (1986) indicate, however, quality of interaction is a more important determinant of social relationships and development than simply amount of contact per se. This aspect was investigated in terms of the difficulty mothers/guardians face in talking to their CWPD, and in terms of the types of talk topic of mothers/guardians and their CWPD.

Regarding the ease of communicating with the CWPD, the results are not clear-cut. Though 40% of the mothers/guardians said that they believe that *"CWPD is intractable and difficult to communicate with"*, when it comes to their practice, 76.7% of them, on the other hand, said that they talk with their CWPD without any difficulty. The mothers/guardians attribute the difficulty of communication to child's aggressiveness, constant complaints and incorrigibility. The children's reported behaviour is in line with the findings of Tirusew *et.al* (1995). In a national base line survey study conducted in Ethiopia, Tirusew *et.al* found out that more than half of the respondents (60%) in the survey have characterized the persons with disabilities as hostile and aggressive.

The topics the mothers/guardians and their CWPD deal with include the child's disability and education, food, and the child's conduct in the family. Such topics may not provide high stimulation for the emotional and cognitive development of CWPD, since they deal on the general life situation of the family. But they indicate a positive ground for promotion of quality of interaction between the CWPD and the mothers/guardians, and a positive home environment and a focussed mediated interaction between mother and child are said to bring about quality result with regard to producing a more intelligent and sensitive child (Klein, 1996).

A more positive and quality interaction is observed in the play activities of mothers/guardians and their CWPD. Among the twenty-eight (93.3%) of the mothers/guardians who play with their CWPD, more than half (53.3%) said they tell the CWPD stories and jokes. The results also show that the type of game mothers/guardians play with their children with and without physical disability is similar.

Vanistendeal (1998) indicates that humor and story telling in a family environment nurture stable emotional relationship with at least one parent or other reference person. This author further noted that through story telling and laughter in the child's normal environment, children with disabilities could gain some stability, warmth and acceptance. Feuerstein (1974) cited by Haywood (1993) also stressed that story telling allows for mediated interaction between parent and children, facilitating transmission of culture to children through a broad set of processes that he called 'intergenerational cultural transfer', which helps children to benefit from their own culture. Story telling is also indicated as one of the effective methods of mediation of transcendence in the early childhood development strategies and programmes such as Mediated Learning Experience that focuses on producing more intelligent and sensitive child, which is also called MISC programmes (Andreas & Dale, 1992).

Children with disabilities who were interviewed for the study have indicated the content of stories their mothers/guardians tell them:

> *My mother tells us how she got married with our father, about the place she grew up, and what her roles were in the family...how she made the 'mesob' [straw baskets used to keep bread] she had carried with her to her husband's place"; " the stories my mother tells me about is how her father fought against the Italians, and about King Haile Silasie ..."; " My*

mother tells me how to become a good cook and housekeeper. She shows me to make 'doro wot' [sauce made of chicken] and 'tella' [local beer] ...

Obviously, the type of stories mediated to the CWPD by their mothers are more related to tradition and history than a mediated learning process focused on developing cognitive aspects of child's development.

Moreover, conflict seems to have no place in the relationship of mothers/guardians and the CWPD, with 60% of the participants saying that their relationship is not marred by conflict. This result may reflect unrealistic view, as any relationship is affected by conflict of various degrees; therefore, the participants' answer would have relevance of acceptance in this study, only if they have referred to a high degree prevalence of conflict.

Concerning mother/guardian – child conflict, 33.3% of the participants said that they have conflict with their CWPD, usually caused by disobedience of child. Among these mothers/guardians, 50% of them said that they use *advice* to solve the conflict, while 20% of these participants said that they use beating. Most of the mothers/guardians who use *advice* said they found *advise* to be a more convenient and effective corrective measure because beating has made the CWPD to react more undesirably.

In general, the results observed in parent-child relationship show that mothers/guardians have a positive relationship with their CWPD. In addition, there is a positive environment that could allow for different kinds of intervention programmes for the CWPD, such as Mediated Learning Experience. Rye (1997) stressed on this point by saying that especially children with cerebral palsy would benefit from such mediation because they have delayed expressive language, which may decrease their potential for interacting and eliciting positive responses from the caregivers. Rye, furthermore, noted that through such quality interaction children with disabilities can develop personal experiences that include their inner security, positive self-respect, trust in oneself, mastery and autonomy.

5.5. REHABILITATION SUPPORTS

The parents and their children with and without physical disability have suggested means of rehabilitation for children with physical disability. Their suggestions included *social and emotional support, formal education and vocational skill training* to the CWPD.

It is observed that there are differences and similarities between the ideas suggested by the three groups on the rehabilitation mechanisms. The mothers/guardians are more concerned about the social and emotional development of the CWPD. Though they recognize the emotional and social aspects of rehabilitation the CWPD considered more formal education and vocational training as fundamental to their rehabilitation. The non-disabled children also support the idea of their CWPD i.e. vocational training and skills on activities of daily living. Interestingly, the rehabilitation mechanisms suggested by the three groups relate to the main intervention requirements suggested by some scholars for children with physical disabilities (Heward & Orlansky, 1988).

CHAPTER SIX

6. SUMMARY, CONCLUSION AND RECOMMENDATION

6.1. SUMMARY

The present study dealt with (parental) rearing of their children with physical disability. It was conducted in Woreda 20 and 25, Addis Ababa, and involved twenty-eight mothers and two grandmothers, (referred to as 'mothers/guardians' or 'participants' or 'parents') as well their children with and without physical disability. The participants are the community partners of two humanitarian organizations, namely, Cheshire Community Based Rehabilitation Project and Voluntary Council for Handicap.

The objectives of the study include the following:

To identify parental rearing practices with regard to their CWPD concerning different aspect of child rearing (e.g. *feeding* and *disciplinary method*), and explore if there are indications of maltreatment related to children with disabilities,

To identify the prevailing understanding of parents or guardians regarding the causes, prevention and remedies/cure of physical disabilities, in relation to the scientific explanations of the causes, prevention, and remedies of physical disabilities.

To identify outstanding similarities and differences between parental ways of child rearing concerning their children *with* and *without* physical disabilities,

To explore parents' belief on rearing practices related to their children *with* and *without* physical disability.

To identify the needs of parents and their children with physical disabilities with regard to supporting their children with physical disabilities

Following a pilot study, which was conducted to try instruments and to establish contacts, data were collected from mothers/guardians, children and other sources, using *triangulation* method (Patton, 1990), which included *interview*, *focus group discussion* and *records.*

Based on the pilot findings and using techniques by Edwards (1957), scales for measuring belief were also employed concerning the rearing practices of children with physical disability.

All data available on children with physical disability from Cheshire Community Based Rehabilitation project participants in *Woreda* 25, and Voluntary Council for Handicap project in *Woreda* 20 were treated for the purpose of the study.

The participants are *twenty-eight* mothers and *two* grandmothers, and each has one child with physical disability. The interview include the *thirty* mothers/guardians, *eighteen* CWPD and their *twenty-three* non-disabled siblings. In addition, *six* and *eight* women group members in neighborhoods in *Woreda* 25 and *Woreda* 20 were involved respectively.

In relation to the background of the mothers/guardians and children involved in the study, the mothers/guardians have a mean age of 37.83 with (66.7%) of them being married, and most (70%) of them having formal and non-formal education. More than half (56.7%) of the mothers/guardians earn their living through petty trade and daily manual labor work, with a mean monthly income of Birr 195.60, and living in *kebele* owned houses having average family size of seven. Most of them (73.3%) are Orthodox Christians and Amhara (70%).

Among the participants' children with physical disability (CWPD) nineteen (63.3%) are females and eleven (36.7%) are males, with a mean age of 9.7 years. Their disabilities include cerebral palsy (56.7%), cerebral palsy with mental retardation (6.7), polio (10%), clubfoot (10%), epilepsy (6.7%), bone deformity on one leg (6.7%), and locked knee (3,3%). Half of the children with physical disability do not go to school.

The findings indicate that generally the parents' beliefs about the, causes, prevention and remedy of physical disability is mainly based on religious and traditional thinking and practices. However, the results also indicate that some of the participants have awareness about "scientific" basis regarding the possible preventive methods and intervention mechanisms such as antenatal and postnatal care concerning physical disability. According to the mothers/guardians, the major causes of disability include superstitious/religious sources and accordingly they use holy water for treatment of disability.

With regard to discrepancy on mothers'/guardians' belief on different rearing practices (e.g. feeding, health care, disciplinary actions) the results indicated a greater proportion of the participants have beliefs that have negative implications on the well being of CWPD than on the non-disabled children. Examples are cited below.

For instance with regard to feeding 63.3% of the participants believe that in the case of their CWPD "*The appetite of a child is limited*" while only 10% of the mothers/guardians agreed on the same belief statement when it is related to their non-disabled children.

In relation to health care 26% of the participants believed that "*Health care does not bring any change in the life of child*" when it applies to their CWPD while *none* said the belief holds true with regard to their non-disabled children.

Regarding feeding practices the results indicated that 80% of the participants have breastfed their children with physical disability, with 54.1% applying it for over one year. However, 100% of the participants have breast fed their children without physical disability, with 79.6% of the participants having breast fed their children without physical disability for a period of over one year.

Another positive practice observed is that except 6.7% of the participants, the rest feed their CWPD three and more times a day, with 50% of the participants fulfilling the food preference of their children. In this regard, the participant's practice is found to be similar for their children without physical disability. Group eating is also encouraged by mothers/guardians, but 53.3% of the participants said that their children without physical disability do not like to eat with their siblings that have physical disability.

The results also revealed that among thirteen mothers/guardians who said that their children have eating problem, 46.1% used only *tebel* as remedial action, with the remaining 53.8%, using *tebel* and providing mashed food to help their CWPD resolve their eating difficulties. The overall results in feeding do not show maltreatment.

With regard to health care practices, washing of CWPD seems to be neglected by half of the participants for different reasons. Actually, 70% of the participants said that they found caring for the health of CWPD to be a difficult task. A few (26%) of the participants also believe that *"health care does not bring any change in the life of CWPD"* while none said this statement holds true for their non-disabled children. The children without physical disability have also similar practice like their siblings with physical disability in both washing pattern and neglect of body washing, but more non-disabled children wash independently than the CWPD.

When it comes to health problems, most of the participants (63.3%) have indicated belief that *"Health problems of CWPD have to be treated through traditional and spiritual means only"* while only some agreed with this statement for their non-disabled children. In terms of practice also out of thirteen mothers/guardians who said that their CWPD have special health problems, eight of them said they used both spiritual means such as drinking and bathing in *tebel* and medical care, to solve the health problems of their children with physical disabilities. But eight of them said they found improvement with the *tebel.* Compared to the CWPD, relatively smaller number of parents use *tebel* to treat their non-disabled children.

In general, the health care practices of participants show that there are indications of maltreatment related to body wash neglect on CWPD, which in turn could be attributed generally to factors such as socio-economic limitations of mothers/guardians as well as the dependence of CWPD in washing on others due to their physical limitations.

The results regarding the disciplinary practices of mothers/guardians as they relate to CWPD show that sympathy and some understanding generally characterize the mothers/guardians for the CWPD because of their disability. In terms of punishment, 63.3% of the participants said that they use non-corporal punishment on their CWPD while 50% of them said that they apply non-corporal punishment on their children without physical disability. Over half of the mothers/guardians found applying corporal punishment on their CWPD to be difficult simply because they sympathize with them. Regarding their belief, 10% of the participants agree that *"corporal punishment should be applied on children with physical disability",* while 50% of the participants said they believe that this belief statement holds true for their children without physical disability. In addition, 40% of the participants said that corporal punishment should increase on their non-disabled children as they grow up; with similar number of mothers/guardians (36.7%) expressing the same belief regarding their CWPD. The participants used mainly *advise* in managing the behaviour of both the CWPD and the non-disabled ones and 66.7% of the participants have found *advising* to be the most effective disciplinary action to correct the behaviour of their CWPD. Beating is rejected because it made the CWPD more stubborn and aggressive.

The practice of mothers/guardians in the informal skill training of both of their children with and without physical disability, in general, reflects the *mother* carries most of the responsibility. The father plays only a little role. The kind of skills provided to females are all types of domestic tasks such as cooking and house keeping, and to the males such as errands and repairing household utilities.

Compared to the CWPD (53.4%), more non-disabled children (76.7%) have got informal sex role skill training. A considerable number of the CWPD (43.3%) have not mainly because the mothers/guardians believe that the *"CWPD cannot manage activities of daily living"* while only few agreed to the belief statement in relation to their non-disabled siblings. Thirteen mothers/guardians (43.3%) also said that their CWPD cannot become self-sufficient, and 69.2% felt that God/Allah predestined CWPD's fate. The participants' overall practice in this regard indicate an element of maltreatment because the CWPD missed out the opportunity of mastering skills that are useful for their daily living. Such behaviour or practice of mothers/guardians could be the result of the belief and low regard they have towards the ability of CWPD. It could also be attributed to the lack of time or special skill/know how on the mothers'/guardians' side to train their CWPD.

Pertaining to formal schooling, the results show that 50% of the participants send their CWPD to school while 86.7% do the same with regard to their children without physical disability. Apart from this disparity, the educational support and reward by parents to their children with and without physical disability is found to be more or less similar.

The participants who do not send their CWPD to school reasoned that the children have mobility problem and that they have to protect the children from possible social adversities. A large majority of the participants (80%) also said that they believe *"CWPD cannot achieve good grade results in formal education"* but only nine mothers/guardians (30%) said this is true for their non-disabled children.

Lack of opportunity to attend school does of course hinder the CWPD from developing their self-esteem and social competence as well as subject-area knowledge, which they could have acquired through their interaction with peers and formal education. Thus, once again the mothers'/guardians' practice in relation to educating their CWPD show maltreatment, which probably resulted from mothers'/guardians' low regard or overprotection towards their CWPD.

In terms of parent-child relationship, the results generally indicate that mothers/guardians have a positive relationship with their CWPD. This practice also revealed the dominant role of the mother than the father in the relationship of CWPD to parents. With regard to the practice, most of the participants said that they pass their daytime talking and giving care for their CWPD. In this respect, mothers are found to spend more time with their CWPD than with their non-disabled children.

Almost all mothers said that they play with their CWPD and their non-disabled siblings by telling stories and jokes. Feuerstein, (1974) cited by Haywood (1993) indicates such kinds of interaction enhance the quality of parent-child relationship as well as the cognitive and cultural development of children.

Regarding intervention, the parents and their children with and without physical disability have suggested means of rehabilitation for children with physical disability. The suggestions included *social and emotional support, formal education and vocational skill training* for CWPD

The overall conclusion is that parental rearing of their CWPD is positive but influenced by their belief, sympathy and low regard towards disability as well as by their socio-economic limitations.

Moreover, the parents show some discrepancies both in their belief towards rearing practices and in actual rearing of their children with and without physical disability. In the case of the latter group of children parents have more positive outlook and provide them with more opportunity such as schooling and training of informal skills. In addition, there are some indications that parents exercise maltreatment on both of their children more likely caused due to their socio-economic limitations.

6.2. CONCLUSION

The results of the study shows that the mothers'/guardians' rearing of their CWPD is *positive* but affected by their *belief*, *sympathy*, and *low regard* towards disability, and their *socio-economic limitations* such as lack of adequate income and education, and large family size.

With regard to their belief, the fact that the majority of the mothers/guardians believes that disability is caused by supernatural sources has *negatively* affected parental rearing specially in finding solutions to feeding and healthcare problems of their CWPD. Parental low regard and sympathy towards their CWPD also affect negatively the schooling and informal skills training provisions to CWPD. With regard to disciplining their CWPD, parents have shown a favourable practice but with tendency of using more corporal punishment on child in future. These incidences, in general, show element of maltreatment.

In the case of discrepancies on beliefs related to rearing practices, parents have greater negative beliefs towards their CWPD than to their non-disabled children.

Aside from their beliefs, in general, parental rearing of their CWPD is found to be positive. Despite their socio-economic constrains, some of the mothers/guardians have provided their CWPD with basic requirements such as food, health care, education, and skill training. Their relationship with their CWPD also shows acceptance of their CWPD with relatively favourable disciplining experience.

The comparison of practices in relation to children with and without physical disability shows that the CWPD have less opportunities in feeding, health care, informal skills training and schooling compared to their non-disabled siblings. Regarding discipline, parents are more lenient in using corporal punishment on their CWPD but they have similar relationship with both groups of their children concerning love and acceptance.

When it comes to intervention, the mothers/guardians and their children with and without physical disability have shown low emphasis or interest in getting basic knowledge about "scientific" characteristics of disability. Rather their concerns are on other but crucial intervention areas such as social, emotional and educational (formal and vocational) supports for the rehabilitation of the CWPD. But interestingly, despite their economic limitations the mothers/guardians and their children with and without physical disability did not emphasise economic input as a means of rehabilitation for their CWPD.

In general, it is observed that a better perspective of the rearing practices by parents of the CWPD could have been achieved if a larger group of the CWPD, their family members such as the non-disabled siblings and the fathers of the CWPD were involved. This was not possible for reasons that include: some of the non-disabled siblings were small children not appropriate for interview; it was difficult to get all of the non-disabled siblings as well as the fathers in each family for interview due to their lack of time and other engagements. Since the purpose of the study was to do an intensive investigation, it was deemed more appropriate to use a reasonably low number of participants.

6.3. RECOMMENDATIONS

In relation to the above conclusions three major strategies are recommended for improving rearing practices of parents with regard to their children with physical disability. They are:

1. Education and awareness raising for the parents and their children about "scientific" explanations on causes, prevention and remedy of physical disability, to change the present understanding of parents that is biased by their beliefs,

2. Social support, formal education, training on vocational skill and as well as skills on activities of daily living for the CWPD to improve their overall development,

3. Income raising programmes at family level as ad-hoc to the above two recommendations.

The above-suggested strategies should put the *CWPD as the central focus* of the intervention, which have to be implemented at *family* and *school* levels.

Children (students) in the family of CWPD (including the CWPD) and schoolteachers can be "*change agents*" in the community who through education and awareness raising dialogues can influence the mothers/guardians of CWPD to change their belief biased practices while rearing their CWPD.

At family level both the CWPD (where child does not severe disability) and their non-disabled siblings could play important role in educating the parents and other family members around disability intervention. The children (siblings) have opportunities of contacts with other social systems outside the family specially the school. The school is a sustainable institutional forum for the education programme due to its proximity to families through their children as well as its predisposition to "scientific" information regarding children's welfare in general and children's disabilities in particular. Moreover, by co-operating with family members, the school can facilitate for inclusion of CWPD in school, which they miss out for different reasons of which one is parents' low regard on the abilities of their CWPD to achieve in school. Cooper, *et.al.* (1995) have stressed the merits of the school in social, personal and academic development of children with special needs by saying that the school is an institution that prise open the barriers of indifference to special needs still encountered in many communities as well as in mainstream schools.

Therefore, with the school support behind, different groups such as *parents' social advisory groups, children's clubs* or *child-to-child* programmes could function to bring about better understanding of disability and its intervention mechanisms at family level. The participation of women neighbourhood groups around disability issues is one commendable work of the NGOs involved in the present study. Such types of activities, in addition to changing beliefs, can address the concern of the mothers/guardians regarding the need for social and emotional support for their children with physical disability.

The school can also have important role in addressing the worries and concern of the children with physical disabilities towards becoming self-reliant citizens through its input of formal education and vocational training including daily life skills to children with physical disabilities. With the latter need (i.e. daily life skills) schoolteachers should have to cooperate with special education teachers in or outside schools, health and other professionals that are available in the community. Once again, the two NGOs involved in the present study provide useful services at family level by training siblings and parents on how to help children with physical disabilities specially cerebral palsied children to acquire skills of daily living activities, through physiotherapy.

The economic limitation, which has a serious effect on parental rearing practices of their CWPD, should have to be dealt with income raising programmes supported by both government and non-government organizations working in the area. Such interventions, however, should be made carefully that they neither disrupt existing coping up mechanisms of the families, nor invite dependency of families and or their children on aid funds. Credit access for example should be made available to mothers/guardians through careful identifications of gaps between their capacities and needs rather than simple handout of money that could possibly make them economically susceptible, if fund is quitted.

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APPENDIX 1

CHILD REARING PRACTICES BY PARENTS OF CHILDREN WITH PHYSICAL DISABLITY

INTERVIEW GUIDE TO BE USED WITH PARENTS

I would like to talk about the way you rear your children. My objective is to come up with possible recommendations that would contribute to the efforts being done today to improve the life of children with disabilities and others.

In this regard, you play an important role. That is why I wanted to ask you some questions.

Please answer the questions that I am going to ask you by sharing your experiences and opinions.

All the information obtained will be kept confidential.

Thank you for your cooperation in this study.

Part I. Background Questions for Parents of Children with physical Disablity (20 minutes)

Directions: Please answer the questions that I am going to ask you. If your are not sure about a question, please feel free to ask for more clarification.

1. Interviewee Code ……………………………..

2. Region ……………. Woreda …………. Zone ……………… District ……………..

3. Male…………… Female ………………..

Note: The researcher without asking the parents shall complete Question No. 1, 2 & 3.

4. Age ……………………

5. Marital status: Single.... .... Married............. Divorced/separated ....

Other ....

6. Major income sources of family ....

....

7. Level of economic status: Do you own - house/s .... car .... business .... other assets

....

8. Family size .... Number of own children .... Number of children belonging to others but living with you ....

9. Religion .... Ethnic origin ....

10. Educational Status:

10.1.	**Literate**	
	Grade 1-4	
	Grade 5-8	
	Grade 9-12	
	Other (Koran, Priest schools etc.)	
10.2.	**Illiterate**	

11. Relation to child with disability ....

12. General Information on children with disability

No.	Name	Type of disability	Age	Sex	Time/age of child on the onset of disability

Part II. Interview Questions on Manner Parents Rear their Children with physical Disability (95 minutes)

Directions: I am going to ask you some questions about the – why and how you have been taking care of your child who has physical disability. Please answer each question as frankly as you can; if a question is not clear please feel free to ask for clarification.

A.	**FEEDING (10 MINUTES)**	
1.	Has your child been breast-fed?	
	Probe: If yes, at what age did you stop breast-feeding? If no, why was she/he not breast-fed?	
2.	What does your child eat?	
3.	What is the preferred type of food by your child? *Probe*: if any, give reasons	
4.	At what age was the preference of food observed?	
5.	How many times do you feed your child in a day? *Probe* - At what age	
6.	**Do you have problems in feeding your child with disability?**	
7.	**If yes, what are the common problems you have in feeding your child?**	
8.	**Does your child have problems in self-care (eating, drinking washing, dressing)?**	
9.	Probe: If your child has one or more than one of the above problems, what do you do?	
10.	**At what age has your child with disability needed the most help in feeding?**	
11.	How does the parent feel about the child's ability to feed herself/himself?	
12.	Does your child prefer to eat alone? *Probe*: Why?	
13.	How often does your child eat together with his/her parents? *Probe*: At what age?	
14.	How often does your child eat with his/her non-disabled siblings?	
	Probe: At what age?	
B.	**HEALTH (14 MINUTES)**	
1.	Does your child get bath? Probe: At what age?	

2.	How often does your child get bath?	
3.	**Who washes him/her?**	
4.	What are the common health problems (illness) you observe in your child?	
5.	In your opinion, what makes children sick?	
6.	Does the child complain about illness more than other children do? Probe: If so, what are the complaints?	
7.	Do you attend to the health condition of the child closely? Probe: If so, how?	
8.	What did you (the parents) do when you realized that the child had a disability? *Probe*: How did you feel?	
9.	What do you think is/are the cause/s of the disability of child?	
10.	What do you do to keep your disabled child healthy?	
11.	What do you do when your disabled child is sick?	
12.	**Children with disability need special care; what types of special health care are being done for your child with disability?**	
13.	**Is it difficult to care for a child with disability?** ***Probe*: If yes, what are the difficulties?**	
C.	**DISCIPLINARY MEASURES (15 MINUTES)**	
1.	What kind of offense or misconduct does your child with disability display at home?	
2.	What types of disciplinary measures do you apply to your misbehaving child?	
3.	Do you think your child's misconduct is due to her/his disability? Probe: I If so, how?	
4.	What disciplinary measures were effective?	
5.	What disciplinary measures were not effective? *Probe*: Why?	
6.	Who administers the disciplinary measure?	
7.	When you compare your child with disability with your non-disabled child, which one of them are difficult to discipline? *Probe*: Why?	
8.	What is the main reason for disciplining your child?	
9.	What is the main misconduct of your child that you think needs to be corrected?	
10.	Do you think a parent should be lenient towards child with disability? *Probe*: if so, why?	
11.	Is it difficult to up bring your child with disability? *Probe*: If yes, why? If no, why?	

D.	**INFORMAL WORK SKILLS (30 MINUTES)**	
1.	What are the things that a female child and a male child is expected to do when she/he is growing up?	
2.	What are the things that your female and male child with disability is expected to do when he/she is growing up?	
3.	What type of informal work skills did you teach to your child with disability when he/she is growing up?	
4.	What skill does the child with disability like and dislike the most? *Probe*: Why?	
5.	What skills are important for your child?	
6.	Who should train the child?	
7.	Is there a difference in the way you teach informal working skills to your child with disability and the non-disabled child? *Probe*: If yes, what are the reasons for using different ways?	
8.	Does your child with disability help his/her family? *Probe*: If yes, in what way? If no, why?	
E.	**FORMAL SCHOOL (5 MINUTES)**	
1.	Have you sent your child with disability to school?	
2.	If you send your child with disability to school, to which type of school does she/hego (church, Koran, home-based, non-formal or formal)?	
3.	If your child with disability is not going to school, what are the reasons?	
4.	If you were given a good support and chance to educate your children, to which of your children would you give priority to go to school? (List them in priority)	
	Probe: What are your reasons for your prioritizing?	
5.	**What is your expectation on your child's educational achievements?**	
6.	**What kind of support do you give to your child in his/her education?**	
7.	**Are there rewards for your child in his/her educational achievements?** *Probe*: if so, what kind?	
F.	**ATTITUDES, VALUES AND BELIEFS (30 MINUTES)**	
1.	Why do you think disabilities occur in children?	

2	Do you think your child's disability could have been prevented? *Probe*: If yes, how? If no, why?	
3.	Do you think the disability of your child can be cured? *Probe*: If yes, what did you do to 'cure' your child's physical disability?	
4.	What types of methods/medicine are used for prevention and cure of physical disability in your community?	
5.	What type of persons can prevent and cure physical disability in your community?	
6.	How are non-disabled and children with physical disability regarded in your community?	
7.	Do you talk about your child's disability problems with other people?	
8.	How did you react when you knew your child is disabled? *Probe*: What was the reason for your reaction?	
9.	Where did you give birth to your child – health clinic or at home?	
10.	According to your tradition, what is the first thing done when a mother gives birth to a child with physical disability?	
11.	Do you think a child with disability can be self-sufficient? *Probe*: If yes, why?	
12.	Do you think a child with disability can support parents? *Probe*: If yes, in what way? If no, why?	
G.	**FAMILY – CHILD INTERACTION (30 NIMINUTES)**	
1.	How do you and your child spend a day? At what age?	
2.	Who often (among the family members) takes care of your child?	
3.	How often do you talk to your child with disability?	
4	Do you have specific time set to talk to your child	
5.	What do you and your child talk about?	
6.	Is it difficult to talk to your child? *Probe*: If yes, why?	
7.	Do you counsel your child? *Probe*; If yes, what are the main areas of your counseling?	
7.	Does your child play with you?	
	If yes? What kinds of play?	
	If no, why?	
8.	Is there any conflict between your and your child? Probe: if so, what are the causes?	
8.1.	What are the impact of the conflict on your child and yourself?	

8.2.	What mechanisms do you use to resolve the conflict?	
9.	Is there any particular request by your child? *Probe*: If yes, what are your responses to the requests?	
6.	Does your child play with his/her siblings?	
7.	At what event? If no, why?	
8.	Does your child participate in social activities?	
	If yes, what type of activities?	
	If no, why?	
9.	Do you hold your child while you feed him/her?	
H.	**PARENTS' NEED OF SUPPORT (5 MINUTES)**	
	What should be done at a family level in order to rear children with disability in a desired way?	