



Addis Ababa University

College of Education and Behavioral Studies

Department of Special Needs Education

**The Prevalence and Socio- Economic Condition of Persons with
Disabilities in Hosanna Town**

By

Tsegahun Ayele

June 2016

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ACRONYMS

AAMR: American Association of Mental Retardation

CBR: Community Based Rehabilitation

CP: Cerebral Palsy

CSA: Central Statistics Authority

CSO: Central Statistics Office

DOC: Daughters of Charity

EPRDF: Ethiopian People Revolutionary Democratic Front

FDRE: Federal Democratic Republic of Ethiopia

ILO: International Labor Office

ICF: International Classification of Functioning

PWD: People with Disabilities

MD: Muscular Dystrophy

MMM: Medical Missionaries of Mary.

MDG: Minimum Development Goal

MOLSA: Ministry of Labor and Social Affairs

NGO: Non-Governmental Organization.

RAD: Rehabilitation Agency for the Disabled

SAD :Swedish Association of the Deaf

SNNP: South Nations Nationalities and Peoples

UNDP: United Nations Development Program

UNGA: United Nations

UNESCO: United Nations Educational, Scientific and Cultural Organization.

UNICEF: United Nations Children's Fund.

USA: United States of America

VCH: Voluntary Counsel for the Handicapped

WB: World Bank

WHO: World Health Organization

Abstract

The data pertaining to incidence, prevalence and situation of persons with disabilities in Ethiopia are fragmentary and incomplete, which need more investigation. The objectives of the study were determining the prevalence of PWDs and investigating their socio-economic conditions. In order to meet these objectives, both quantitative and qualitative methods were used. The quantitative method was used to describe the prevalence of PwDs while the qualitative was employed to reveal the socio- economic condition. A multi-stage cluster sampling was used, classifying the town in to three sub cities, then the three sub cities were divided in to seven kebeles. The kebeles were divided in to twenty villages each. 1200 households were involved to respond to questionnaire to be filled about themselves and PWDs. The interview and focus group discussions were also used to collect data from PWDs and their families. The findings of the study show that the prevalence of PWDs in Hosanna town accounts 1.83% of the total population, which is very low compared to the estimates of WHO 1980 (10%) and WHO and WB 2011 (17.6%). There are various reasons for the difference between this finding and the WHO data. Some of these could be lack of awareness to identify the mild cases of disabilities by respondents, and unwillingness to disclose their children with disabilities. The finding on the socio economic condition revealed that except the situation of deaf children and their families who are in self reliance compared to the other PWDs. Most of the persons with physically, visually and intellectually disabled are poor and beggars. They have no access to community social services, and they are socially discriminated and ignored. Schools and education sectors need to include them in the regular classes. They need Community Based Rehabilitation centers as soon as possible.

Chapter One

1. Introduction

1.1. The Background of the Study

Although definitions of disability vary over time and across countries, essentially it is considered to be a condition, or function judged to be significantly impaired relative to the usual standard of the general population. Disability is often used to refer to individual functioning, including physical impairment, sensory impairment, intellectual impairment or mental health problems. A variety of conceptual models have been proposed to explain disability. Of them, the two important are the medical model of disability, and the social model of disability. The definition of disability has evolved from what is known as an individual focused (medical model) definition to the environment focused (social model) definition. In the case of the former, the focus of the definition is on the physical and mental limitation of the person in contrast to what is deemed as normal physical and mental status. But in the case of the later it looks into a whole range of physical and social environment that can be adjusted in a way that would help the person with functional limitations to fully release his/her potential. The explanation goes up to saying that “...if the environment is designed for full range of human functioning and incorporates appropriate accommodation and support, then people with functional limitation would not be ‘disabled’” (Mont 2007).

In this regard operational definitions have been given by various international organizations in a way that reflects the shift in the understanding of the concept. The conceptual shift has also resulted in guiding the approach of policies and strategies towards ensuring the wellbeing of persons with disabilities. The emphasis, based on the ‘medical model’ was towards providing individual services such as rehabilitation and medical facilities (social welfare program). The shift towards the ‘social model’ has stepped up the approach into creating conducive physical, social and policy environment (right based approach). Two key definitions proposed by the WHO and ILO reflect the shift in the concept of disability as captured in the explanation of the two models. Similarly, disability is any restriction or lack (resulting from impairment) of ability to perform an activity in the manner or within the range considered as normal for human beings (WHO, 1976). It is also a state in which functional limitations and/or impairments are causative factors of existing difficulties in performing one or more activities which, (in accordance with

the subjects age, sex and normative social role) generally accepted as essential basic components of daily living such as self-care, social relationship and economic activity (ILO 2006). Lately, the WHO wing of the International Classification of functioning, Disability and Health (ICF) has come up with robust conceptual framework for defining and measuring disability. The framework has fully incorporated the effect of personal and environmental factors in creating the limitations.

The recent and most significant UN convention on the rights of people with disabilities also defined PWD as “those who have long term physical, mental and intellectual or sensory impairments which in interaction with various barriers may hinder the full and effective participation in society in an equal basis with others (UNGA, 2006). In the view of the two models, the definition captures the individual factor ‘long term physical...’ and the environmental factor ‘various barriers’. Apart from defining the term, the approach also determines the techniques used for measuring disability. As we shall see later Ethiopia is progressive in adopting international standards and conventions though it lags in providing reliable statistics on persons with disabilities. The 1994 census has accounted for PWD based on purely the individual/medical model of disability. The operational definition used for head counting was: a person is disabled if “due to physical conditions or injuries s/he cannot perform activities that other healthy person can perform, including work”. The question which addressed to respondents in the census was “is there a member of this household who is physically or mentally disabled?” this question identifies body functions rather than level of (limitations or hindrance from) participation or activity (WHO, 2007).

The history of disability is as old as human history. The early history of societal involvement with persons with disabilities was primarily based on the recognition of the difference of disabled individuals from that considered normal in appearance or behavior (Tirussew et al, 1995). People who were different from the non-disabled were believed to be possessed by demons or evil spirits. Until the 16th Century, the general picture was similar. Physical and intellectual fitness was essential to a person's life (Barnes, 1996). Reactions to the presence of human beings with disabilities in industrialized nations were varied (Helander, 1993). As the 19th Century came to closer, new voices and new ideas began to be heard. World War II resulted

in a significant increase in the disabled population of most industrialized countries. For many countries, providing those people with a rehabilitation program became a national priority. In the years that followed other groups of disabled people shared the same services (Helander, 1993). The International Year of Disabled Persons in 1981 and the Disabled Persons declared by the United Nations in 1983 put disability into a global context and posed the question of how it may be understood in a multicultural world (Ingested & Whyte, 1995).

Thus people with disabilities in developing countries, like their counterparts in Europe, have encountered many problems. The governments of many countries had never committed themselves to providing public services for these large groups of citizens (Helander, 1993). Access for the disabled persons to the appropriate services in developing countries is generally inadequate. The estimate of those who get such services is generally less than 3 percent in developing countries (Daniel, 1997). The rehabilitation sector was and still is to a large extent managed and financed by charitable organizations (Helander, 1993).

As Hahn (cited in Barton, 1996:8) notes: 'This approach imposes a presumption of biological or psychological inferiority upon disabled persons. It emphasizes individual loss or inability thereby contributing to a dependency model of disability. Labels such as 'invalid', 'crippled', 'spastic', 'handicapped', and 'retarded' all imply both functional lack and lack of worth. Such labels have tended to legitimize negative views of disability'. Richardson et al (1961) book on children's attitudes towards disability is one of the early anthropological studies on the issue of disability. Medical anthropologists have long been interested in physical disability as a social issue (Kellmer Pringle et al, 1966; Rutter et al, 1975. More recent anthropological studies have touched upon disabled people's enabling relationship with their families as well as with members of their communities and explored the effects of disability on their life chances and life styles (Zinkin & McConachie, 1995)

In the context of Ethiopia, the history of peoples with disabilities is not different from other developing countries. Disability is one of the social problems prevalent in Ethiopia (MOLSA, 1996). The rehabilitative services that are available today in our country emphasize on institutional care and they are costly. Therefore they are greatly limit the number of persons with

disabilities who can benefit from them. Worse still, these institutions are very few and concentrated in urban areas and thus excluded the majority of those who need the services (Ibid). The level of esteem and social standing of disabled people is derived from how disability is perceived in society. In contrast to 'healthy people', the disabled face all sorts of discriminations. They are usually recipients of a range of offensive responses by other people. These include horror, fear, anxiety, hostility, distrust, pity, overprotection and patronizing behaviors. The problem lies in defining disability (MOLSA, 1996).

Regarding the 1996 social welfare policy of Ethiopia, the ousted military government had paid little or no attention. Whereas the constitution of Federal Democratic Republic of Ethiopia has laid the foundation for a new policy. This policy falls under article No. 5.6 sub article 5.6.1. Issues constituted under this sub article are: encouraging the disabled to use their abilities to associate with others, to contribute to development; providing them with education and employment opportunities; helping them to receive appropriate medical/ health services; giving appropriate support services in the context of their family and community environment; establishing special centers for care; raising the level of public awareness concerning disability; make effort towards making public places more physically accessible to persons with disability; and providing support and assistances to community action groups, non- governmental organizations and voluntary associations which are involved in providing services to persons with physical and mental disabilities (MOLSA, 1996).

However, disabled children and youth in Ethiopia are among the most socially, economically and politically disadvantaged social groups. In other words, to be disabled means to be discriminated against as well as suffering from social isolation and physical restrictions. Persons with disability do not always have access to rehabilitative services, simply because the availability of such service, due to the low level of attention given to disabled groups by past regimes and the present government. Similarly parents and relatives of disabled were and are still the crucial actors in the provision of care and education for the majority of disabled children and youth (FDRE/MOLSA, 1996:6).

Several global estimates of the prevalence of disability have been made in the past. A UNICEF report (1988) indicated that the percentage of persons with disabilities in developing countries is

estimated to be as high as 20%. WHO in 1976 showed that 10 percent of the world population is disabled (Helander, 1993:21). As Pandey and Advany (1995) indicated, Helander in his latest edition, *Prejudice and Dignity*, 1990, revised his 1974 estimate to 5.21 percent. Helander further indicated that 7 percent of the world children have disabilities predominantly in developing countries (Helander, 1993.) According to the 2011 World report on disability, more than one billion people in the world live with some form of disability, of whom nearly 200 million experience considerable difficulties in functioning. In the years ahead, disability will be an even greater concern because its prevalence is on the rise. This is due to ageing populations and the higher risk of disability in older people as well as the global increase in chronic health conditions such as diabetes, cardiovascular disease, cancer and mental health disorders.

Regarding this, literature shows that in the majority of countries at least 1 out of 10 persons have physical, mental sensory impairment and at least 25% of the entire population is adversely affected by the presence of disabilities (Rehabilitation International Review, 1989). The International Classification of Functioning Disability and Health (ICF 2001) also acknowledges that the prevalence of disability corresponds to the social and economic status. The incidence and prevalence of disabilities in developing countries is higher than that of economically developed countries and the persons with disabilities estimated to be as high as 20% in some of these countries, (UNICEF, 1989). According to the World Health Organization (WHO), the estimate and magnitude of persons with disabilities in developing countries goes over 10% of the total population, which is relatively less than that of the previous estimates.

Tirussew (1998) states that there is an enormous knowledge deficit in relation to disabled persons in Ethiopia. Data pertaining to incidence, prevalence and situation of persons with disabilities in Ethiopia are fragmentary and incomplete. Local surveys were undertaken in 1979-80, 1983, and in 1984 by CSO; but they did not show the whole picture of the country (Tirussew et al, 1995).

The most recent report about the disability status and type of disability in Ethiopia is the national population and housing census of the CSO (1994). According to CSO results, out of the total population of 53,095,877, which the census covered, 988,849 or 1.86 percent were disabled.

Some of the surveys of PWDs undertaken in Ethiopia include- The survey that was done in 1970- 1980, by Ministry of Agriculture, revealed about 1,459,685 PWDs in 2,659,683 population that accounts for 5.48 % (Central statistics Office,1985); In 1983, the survey by Rehabilitation agency of disabled resulted 29,632 PWDs in 14,819,300 under age 15 population, which accounts 3.6% (National Children's Commission, 1983); and In 1984, the National Office of Population and Housing found out 1,244,581 PWDs in 34,500,972 that accounts 3.6 % (Central statistics Office, 1984)

According to the report of the Housing and the Population Census of Ethiopian Government (CSA, 1998), the number of persons with disabilities constitutes 1.9% of the total population. On the other hand, the 1995 focused-baseline survey of persons with disabilities in Ethiopia, the first of its type in the country, revealed that the prevalence of disability is about 2.95% (Tirussew et al., 1995). The findings of this study further revealed the magnitude of specified disabilities in the country as follows ; 41.2% persons with motor disorders (persons who showed inability to walk, to sit, to eat and drink); 30.4% persons with Visual impairment (weak sighted and blind); 14.9% persons with hearing impairment (hard of hearing and deaf); 6.5% persons with cognitive disability (referred as mild, moderate and profoundly retarded); 2.4% persons with speech and language impairments; 2.4% persons with behavioral problems; 2.0% persons with multiple disabilities.

The finding of this survey shows lower magnitude of PWDs in comparison with the other previous estimates made in the country, including the WHO estimations which go over 10% in developing countries. The gap between the WHO estimation and the sample survey by Tirussew et al. can be explained by the scope of the definition of the target population as well as socio-cultural factors. The 1995 focused-baseline survey of persons with disabilities in Ethiopia was limited to children with obvious disabilities such as visual, hearing, motor, speech and language and behavioral problems. It can be also from socio cultural perspective; that some families may not have been willing to disclose that they have a child with disability out of fear of stigmatization or other negative consequences. Moreover the understanding of some families about mild impairments and disabilities is very low to identify them as disabilities.

The present study documented the various types of persons with disabilities and how disability affected their economic conditions their relationship with their immediate family, community

and others. Furthermore, the researcher has engaged on disabilities focused work more than 16 years in Hosanna town in Hadiya zone, so the researcher had observed multi-dimensional challenges of the socio economic problem to people with disabilities confront.

Even though the social and economic challenges are multi-dimensional, there is no sufficient research works which are conducted and showed the specific clear picture of PWD in the town to alleviate social and economic challenges. So that it made the researcher initiate to conduct a research on this issue.

1.2. Statements of the Problem

In Ethiopia, where the income per capita is low and the illiteracy rate is high, and where roads are mostly un surfaced, the impact of various impairments will be quite different from that of developed countries. Limited access to healthcare combined with widespread illiteracy results in communities with greater risk of disability. Complications associated with delivery, iodine deficiency disorders, war and other accidents are factors that contribute to high prevalence rates of disability in Ethiopia (UNDP, 1997). Although the amount of studies into disability in Ethiopia is small, and the studies carried out show that there is a significant prevalence and a lack of knowledge about the conditions. Disability rates in Ethiopia, which vary from a low 1.3% to a high 2.9%, appear to be low if compared with crude disability rates given by international organizations such as WHO (2002)

This study aims to provide information both on the current situation of people with disabilities in Hossana town and investigate on the extent to which prevalence of disability affect the socio economic situation of PWDs. In doing so, the assessment will also look into the influence of the prevalence disability on the social and Economic condition of PwDs in Hossana Town.

Even though the social and economic challenges are multi-dimensional, there is no sufficient research which was conducted on this issue in southern Ethiopia to alleviate social and economic challenges of people with disabilities. This initiated the researcher to conduct a research on this issue. This study is intended to assess the prevalence and impact of disability on the life of the disabled people in Hosanna city in Hadiya zone.

The goal of this study is collecting population data on people with disabilities and investigating the socio economic condition of people with disabilities. Comprehensive and systematic documentation of all aspects of functioning of the population can support the design and monitoring of interventions. The study present data on the prevalence of disability and the information on their socioeconomic circumstances of people with disabilities. It will offer the general picture of people with disabilities in the mentioned specific study area.

1.3. The objective of the Study

1.3.1. General Objectives

The general objectives of the study are to find out the prevalence of PWDs and investigate their socio-economic conditions and provide governments and civil society with a comprehensive description of disability and an analysis of the responses provided based on the best available scientific information; and based on this analysis, recommendations are made to concerned bodies for action at various levels.

1.3.2 Specific Objectives

The specific objectives of this study are to:

1. compile the statistical data of PWDs in Hossana Town;
2. determine the type of disabilities in Hossana Town;
3. investigate the socio-economic and general living conditions of PWDs in Hossana Town;
4. assess the socioeconomic difficulties and vulnerabilities which are currently faced by PWD;

1.4. The Significance of the Study

The study is supposed to have two fold implications. Empirically, findings of the study are hoped to fill the ongoing theoretical need and thereby add values to current knowledge production. Particularly, findings and its implications for social work are believed to serve as input for policy makers so that they can make use of it to enact a new legislation and/or amend the existing laws to provide strong legal support for people with disabilities.

On the other side, the report makes recommendations for action at various levels. It will thus be an invaluable tool for policy-makers, researchers, practitioners, advocates and volunteers involved in disability. Due to the gap of the data and information about children with disabilities many children do not have opportunity of education service. Moreover, there is no community based rehabilitation CBR Programme for PWDs in Hosanna town like many other cities in Ethiopia and other countries too. CBR is one of the best strategies to address PWDs. This research may invite many NGOs to work with PWDs. After finding out the prevalence and the socio economic condition of PWDs in Hosanna Town,

Thus, the findings of the study are expected to:-

- give the data of prevalence of children with disabilities and their socio economic conditions to the schools and education sectors who are ready to include them in education
- give information and data for those who want to work with PWDs in the Hosanna Town.
- Contribute to the understanding of social and economic conditions of PWDs currently.
- Serve as an indicator of further research in this field.

1.5. The Scope of the Study

Disability, a complex multidimensional experience, poses several challenges for measurement. Approaches to measuring disability which vary across countries influence the results. Operational measures of disability vary according to the purpose and application of the data, the conception of disability, the aspects of disability examined – impairments, activity limitations, participation restrictions, related health conditions, environmental factors – the definitions, question design, reporting sources, data collection methods, and expectations of functioning (WHO, 2011).

Due to the mentioned measurement problem, this study focuses on commonly agreed impairment and disabilities such as people with physically disabled, intellectual disabled, visual impairments hearing impairments, communication disorders and epilepsy. It is also limited to Hosanna Town

only. In the second part of the study, the participants are limited to three different types of groups and an individual with disabilities.

1.6. Definitions of Terms

Disability:

Disability is any restriction resulting from impairment or lack of ability to perform an activity in the manner or within the range considered normal for human being It is also the result of environment as well as to some extent hereditary factors.

Prevalence:

Prevalence refers to the proportions /number of occurrences/ cases of events in a certain particular population in at given point in time (Lwanga, et al, 1991)

Socio economic conditions

This phrase refers to the social situation of people within their respective communities, economic level they have and the standard of life they have.

1.7. Organization of the Study

The general structure of the paper consists of the five chapters. The first chapter deals with the background of the study; statement of the problem, research question, objective of the study, significance of the study, delimitation of the study and definition of the terms. The second chapter presents review of related literature that was read and systematically organized from different books and related materials. The third chapter consists of the research methods and procedure employed to collect and analyze the data for the study. Chapter four contained data analysis, interpretation and presentation and finally chapter five deals with summary conclusion and recommendations

Chapter Two

2. Review of Related Literature

In this chapter of the report various issues related to people with disabilities are discussed. Some of these include understanding the concept of disability, types and classifications of disabilities, prevalence of disability and finally the situation of persons with disabilities in Ethiopia.

2.1. Understanding Disability

Disability is part of the human condition. Almost everyone will be temporarily or permanently impaired at some point in life, and those who survive to old age will experience increasing difficulties in functioning. Most extended families have a disabled member, and many non-disabled people take responsibility for supporting and caring for their relatives and friends with disabilities. Disability is a complex, dynamic, multidimensional, and contested. Disability is the umbrella term for impairments, activity limitations and participation restrictions, referring to the negative aspects of the interaction between an individual (with a health condition) and that individual's contextual factors (environmental and personal factors) (WHO, 2011).

2.1.1 .Conceptual Models Disability

A variety of conceptual models have been proposed to explain disability. Of them, the two most important are the medical model of disability, and the social model of disability. In the medical model of disability, disability is the result of a physical condition intrinsic to the individual that may reduce the individual's quality of life and cause clear disadvantages as a result. Hence, curing or managing disability means identifying, understanding, and controlling the disability as well as altering its course. Thus the government, private sector and society should invest in health care and related services to cure disabilities medically, allowing disabled persons to have a "normal" life.

In contrast, the social model of disability proposes that barriers and prejudice as well as exclusion by society (purposely or unintentionally) are the ultimate factors defining who is disabled or non-disabled. The model recognizes that while some people have physical,

intellectual, or psychological differences (which may sometimes be impairments) from the generally accepted standard norm, these do not lead to disability unless society fails to accommodate and include them as part of the “normal” mainstream. Thus, a fundamental aspect of the social model concerns equality and often focuses on changes required in society, regarding in particular: A more positive attitude toward disability and disabled persons; not underestimating the potential quality of life of those with impairments; Increasing social supports that help in dealing with the above barriers; More information for disabled people, for example the training and use of Braille; More emphasis on the physical structures that would facilitate greater access for disabled persons.

The social model focuses on functioning as an interaction between a person and his/her social environment, highlighting the role of society in labeling, causing or maintaining disability within that society through attitudes or accessibility that favors the ‘normal’ majority.

It contends that these negative attitudes stem from the medical model and a subjective value system that can harm the self-esteem and social inclusion of those constantly subjected to it.

The social model of disability often distinguishes between ‘impairment’ and ‘disability’.

Impairment is used to refer to the actual attributes (or loss of attributes) of a person, whether in terms of limbs, organs or mechanisms, including physiological. Disability is used to refer to the panoply of restrictions put in place by society when it does not give sufficient attention to accommodating the needs of individuals with impairments.

The social model also relates to economics. It proposes that people can be further disabled by lack of resources in meeting their needs. It addresses issues such as the underestimation of the potential of people to contribute fully to society and add economic value to society if they are given equal rights and equal access to facilities and opportunities as others.

In addition to the two major models of disability described above, there are some other less commonly-used models, such as: the *moral model* that refers to the attitude that people are morally responsible for their own disability (for example, people have congenital disability as a result of bad actions of parents or grandparents); the *professional model* that provides a traditional response to disability in which an authoritarian, overactive service provider prescribes and acts for a passive client; and the *charity model* that depicts disabled persons as victims of

circumstance, and thus deserving of pity. These, alongside the medical model, are the ones most often used by non-disabled people to define and explain disability. And as we will see in later sections of the report, in Ethiopia we find that these perceptions and attitudes continue to retain a common currency in contemporary society.

Emerging issues and debates surrounding 'disability' include social and political rights, social inclusion and citizenship. In developed countries, the debate has moved beyond a concern about the perceived cost of maintaining dependent people with a disability to the wider struggle to find effective ways of ensuring that people with disabilities can participate in, and importantly contribute to, society in all spheres of life. Many are concerned, however, that the greatest need is in the developing nations, where the vast bulk of the estimated 650 million persons with disabilities reside.

Countries signed up to the Convention will be required to adapt their national laws so that persons with disabilities would have equal rights as others, for example the right to education, employment, and cultural life; the right to own and the social model of disability often distinguish between 'impairment' and 'disability'.

2.2. Persons with Disabilities

Disability is any restriction resulting from impairment or lack of ability to perform an activity in the manner or within the range considered normal for human being (Miron, 1994). The definition of disability is any reduction, resulting from impairment, in the capacity to perform a physical or mental ability (Tirussew, 2001). It is the result of environment as well as to some extent hereditary factors. According to the International Classification of Functional (ICF) Disability and Health, Disability is no longer viewed as merely the result of impairment. The social model of disability has increased awareness that environmental barriers to participation are the major causes of disability. The ICF includes body structure and function, but also focuses on 'activities' and 'participation' from individual and the societal perspectives.

A person may encounter impairment at any time in the entire life span due to prenatal, natal or postnatal diseases and traumas. Impairment can occur to any part of the body resulting variety of

impairment and disabilities. Some of the disabilities include hearing impairment, visual impairment, intellectual disabilities, motor or physical disabilities, language and communication disorders, emotional and behavioral disorders, and chronic health conditions.

2.2.1. Persons with Hearing Impairments

According to Pasonella and Cara (1981) hearing impairment as genetic term indicating a continuum of hearing loss from mild to profound which includes the sub classification of the hard of hearing and the deaf. Hard of hearing is a term used to describe with enough residual hearing to use hearing aid as a primary modality for acquisition of language and communication with others. It ranges from 26dB to 70dB. This condition can adversely affect the person's performance to some extent.

A Deaf is a person whose sense of hearing is non- functional for ordinary use in communication, with or without hearing aid. The hearing loss of a deaf is usually above 70dB. It is so severe that a person is impaired in processing linguistic information which adversely affects the educational performance (Schulle, Carpenter and Ann, 1991). The Swedish Association of the Deaf (SAD) defines the term “deaf” from the deaf community point of view as follows: The term “deaf” is broad. It implies a cultural, social and linguistic identity. The “deaf people” are people who use sign language. SDR does not consider deafness to be a medical term. Deaf people are those who were born deaf, have become deaf in childhood or youth, may have certain hearing residuals but prefer to use sign language. Thus, deaf people are a linguistic minority, and therefore they take part in special cultural community, which in many aspects differs from other cultural groups (SDA, 1994).

2.1.2. Persons with Visual Impairment

The visually impaired are broadly classified into two groups based on the degree of visual impairment. These include the partially (weak) sighted or persons with low vision and the blind. There are legal and educational definitions of the sub- groups briefly (Tirussew, 2001).

Partially Sighted (Weak Sighted) : It is a condition in which one's vision is seriously impaired, defined usually as having between 20/200 and 20/70 central visual acuity in the better eye, with correction. Various aids and educational techniques allow most partially sighted children to be educated as sighted rather than blind children (Vergason,1990; Ysseldyke & Algozine,1995)

Blind (Blindness): It is a descriptive term referring to a lack of sufficient vision for the daily activities of life. Legally, it is defined as having central vision of 20/200 or less in the better eye with correction or having the peripheral vision contractual to an extent in which the widest diameter of the vision field covers an angular distance no greater than 20 degrees (Vergason, 1990; Heward & Orlansky, 1988).

2.1.3. Persons with Intellectual Disability

Recently, the term intellectual disability is replacing the term mental retardation, so the meaning of the later is used for the first. The American Association of Mental Retardation (AAMR) defined mental retardation as: substantial limitation in present functioning. It is characterized by significantly sub average intellectual functioning, existing concurrently with related limitations into or more of the following adaptive skill areas: communication and self-care, home living and social skills, community use and self-direction, health and safety, functional academics, leisure and work. Mental retardation manifests before age 18 (AAMR, 1992).

Currently, educators define intellectual disability in terms of learning characteristics of the children. Accordingly, the classification of mental retardation is usually made on the basis of the available educational provisions. Individuals classified as mentally retarded have a wide range of ability and require diverse educational services. In order to meet these varying needs more efficiently, mental retardation has been classified in educational levels (Zigler , 1986).

Children with Mild Intellectual Disability

They are not noticeably different from ‘normal’ in their physical characteristics and general health. They show delays of only 1 to 3 years in school performances. They are capable of learning of functional academics and personal responsibility. Thus, they are able to function within traditional grade level curriculum with only minor modifications or assistance (Langone , in McLaughlin & Wehman, 1992).

Children with Moderate Intellectual Disability

They have adaptive capacity that is more seriously impaired. They show one half or one third of functioning of the expected for their chronological age. They are able to master self care skills, basic language and cognitive concepts to include functional academics.

Children with Severe Intellectual Disability

They manifest poor motor development during the pre- school years and develop little or no speech. They may learn to talk during their later school years and can learn basic linguistic skills. They may be able to produce simple tasks with close supervision (Sharpton & West in McLaughlin & Weham, 1992).

Children with Profound Intellectual Disability

They manifest only minimal sensor motor functioning during their pre-school years. They may show some motor development during the later school years and may benefit from minimal self-care taking. They require constant supervision in a very structured environment (Tirussew, 2000)

2.1.4. Persons with Motor or Physical Disabilities

Physical disabilities are often grouped into two sub- categories of the physically impaired and the health related problems (Taylor & Stenberg, 1989). Physical disabilities are problems that result from condition affected the central nervous system or loss of limbs or other related functions. Health impaired persons are those suffer from illness or disease that normally affect the operation of various organs of the body. Sometimes these illness or diseases can directly affect the motor movements of the persons (Love & Walthall, 1977; Taylor & Stenberg, 1989). The degree to which the impairment limits the PWDs motor interaction with the environment determines whether the impairment is considered mild, moderate or severe (Love and Walthall, 1977) have provided medically oriented guide lines. Such as: Persons with mild disabilities can ambulate (with or without prostheses or outhouses), use arms and communicate well enough for own needs; Persons with moderate disabilities have difficulties in locomotion, self help, and communication but not totally disabled and so require some special help; Persons with severe disabilities are incapacitated and usually confined to a wheelchair; complete rehabilitation may not be possible.

The classification of motor (physical) disabilities includes orthopedic impairments, health related impairments, accident- based impairments. The orthopedic impairments involve the muscular or skeletal system and sometimes the central nervous system; by limiting movement and mobility, it affects a person's physiological, educational and other achievements. These are the most common disabilities and include club foot, absence of some limbs, poliomyelitis, bone tuberculosis neurological problems, cerebral palsy, amputations and fractures and burns that

causes contractions (Carwood, 1983; Guralnicu M. & Benett, 1987). These limit muscular movements and motilities differ severely and can be sub classified as cerebral palsy, spasticity, athetoid, ataxic, hypotonic, rigidity, poliomyelitis, spina-bifida, epilepsy, muscular dystrophy, leprosy.

The health related impairments refer to all chronic health problems which affect the motor performance of a person. The group is characterized by low vitality, motivation, and low energy level and includes, asthma, diabetes, cystic fibrosis, hemophilia,(Taylor, Stenberg & Richards,1995).The accident- based impairments refer to a severe head and spinal cord injury that creates chronic physical problems that affect the academic behavioral and inter personal performances. These include Traumatic Brain Injury (TBI), Spinal Cord Injury (SCI)

2.1.5. Persons with Communication Disorder

Communication disorder is defined as any condition that inhibits communication such as speech and language problem (Vergason, 1990)

I. Speech Disorders is defined as any imperfection in the production of sounds of languages caused by problems such as inadequate muscle coordination, poor voice quality or organic defects. The most accepted definition emphasizes that the condition to be so identified must interfere with communication, call attention to the speaker, or cause the person anxiety or maladjustment (Tirussew, 2000). They are characterized by abnormal production of sounds and the quality of speech (Taylor & Stenberg, 1989). Speech impairments involve three types of disorders:-

- i) Articulation disorders - omissions, substitutions, distortions, and addition
- ii) Voice disorders (pitch, loudness, voice quality)
- iii) Fluency disorders /disfluencies – stuttering and cluttering

II. Language Disorders are problems with using of proper forms of language (phonology, morphology, syntax) ,using the content of language(semantics), using the functions of languages (pragmatics) (Ysseldyke & Alanize, 1995)

2.1.6. Persons with Behavioral Difficulties

The term behavioral difficulties or disorder means a condition exhibiting one or more of the following characteristics for a long period of time and a marked degree, which affects educational performance (Taylor & Sternberg, 1989, Garwood, 1983)

1. An inability to learn which cannot be explained by intellectual, sensory and health factors.
2. An inability to build or maintain satisfactory interpersonal relationship with peers and teachers.
3. Inappropriate types of behavior or feelings under normal circumstances.
4. A general pervasive mood of unhappiness or depression or
5. A tendency to develop physical symptoms or fear associated with personal or school problems

The term emotional or behavioral disorder means a disability characterized by behavioral or emotional response in schools programs, so different from appropriate age, cultural norms that adversely affect educational performance s, molding academic school, vocational or personal skills (Forness & KIntzer, 1992)

2.2 The Situation of Persons with Disabilities

According to the World Health Organization (WHO, 2007), there are 300 million people with disabilities in the world out of which 210 million (70 percent) live in developing countries.

Apart from demographic reasons, the high prevalence of disability in poor countries shows the existence of causal relationship between poverty and disability. Disability is caused and aggravated by poor living condition, such as poor nutrition, lack of health and sanitation facilities and exposure to various forms of accident. On the other hand, in poor countries, disability makes it difficult for people to get out of poverty. The absence of rehabilitation centers, lack of (equal) access to education, employment and other services makes it particularly a struggle for PwDs to overcome livelihood challenges (ILO, 2006).

Not surprisingly, the most affected groups among the disabled are those that are in developing countries in general and women and children in particular. Statistics by international research organizations show that 80 percent of disabled persons in the developing countries (out of which

more than 70 percent are women) do not have working opportunities. The same statistics shows that nearly 98 percent of children with disabilities are not in school while the same percentages of people with disabilities in developing countries do not have access to rehabilitative and other basic health services (ILO, 2006).

In the case of Ethiopia, it estimated person with disabilities are more than 7.3 million. Even though there is no current data on the situation of PWD, it is believed that the situation is far worse than the average for developing countries. Based on the 1994 survey and information obtained from Ministry of education the percentage of children in special need education program was nearly negligible. Despite some encouraging effort in recent years, there is little noticeable adjustment in the school system that would help to accommodate the need of disabled people. Lack of access to employment is the major challenge for disabled people.

According to the official information from the 1994 census, 85 percent of PwD live in rural areas, where there could be no enabling environmental factors for them to contribute to the labor force. Majority of those few who migrate to urban area make their living as beggars or on the merit of some charity organizations (ILO 2006).

Despite progress in recent year, there is still some doubt on the functionality of the legal and policy environment in setting the stage for giving full recognition to PwD. There is a sense that the issues of disability are sidelined from major international development goals such as the MDG. Given the proportion of disabled people and the situation in which they live, it is difficult to imagine meeting the MDG goals without improving the lives of PwD. The local policy environment in Ethiopia also reflects similar shortcoming when it comes to delivering the final products (details on policies and strategies are in chapter three). The aspect of service delivery is also by far lagging behind from what it ought to be. MoH has in many ways has not taken measures in formulating strategies that are tailored to disabled people. The few services that are currently being rendered are mostly sponsored by NGOs and visibly limited to urban areas and places where there is better accessibility (ILO, 2006).

2.3. Measuring the Prevalence of Disability in Ethiopia

It is difficult to estimate the true number of handicapped people in early society. It was only guess at prevalence when confined by the uncertainty of historic data and the paucity of records (Margret, 1993). The number of PWDs is increasing all over the world. The incidence and prevalence of disabilities in developing countries is higher than in economically advanced countries and the PWDs is estimated to be as high as 20% in some of these countries (UNICEF, 1988). The situation of PWDs in Ethiopia, like other developing countries, is aggravated due to many social and economic problems. It is important and essential to find out the prevalence and trend of disability in a country. One of the importance is for planning different preventive and rehabilitative programs. In Ethiopia, the presence of disabling factors and the absence of preventive services in the country have brought an increase in the incidence of disability (Trussew, 1993). The data of the prevalence of PWDs are fragmentary and incomplete in Ethiopia and include only the obvious impairments such as the blind; the deaf, the profoundly intellectually disabled and those with severe disabilities (Tirussew, 1995).

Measuring the prevalence of disability dramatically varies across countries of the world. The reasons for variation according to Daniel Mont (2007) are absence of universal definition, differences in methodology of data collection, difference in quality of study design. However differences in the social stigma attached to specific types of disabilities could also be one strong reason for under reporting prevalence. The problem of under reporting disability (disability in hiding) is particularly common in developing countries where awareness levels are generally low. Good illustration for this is the contrast in the prevalence rate of disability in countries such as Kenya, Ethiopia, India and Bangladesh (reported as below 3 percent) whereas countries like New Zealand, USA and Canada report above 15 percent (ILO, 2006).

The situation of PWDs in the society can be explained by the understanding of disability in terms of conceptualization of the cause, nature and consequences. In most less developed areas disability as a source of shame disagreement as well as divorce among some families. Disability also can be seen as the perception of the society in the frame- work of their physical limitation or strength, their capacity to learning, their ability to lead their independent life and form a family, their role in socio-cultural and recreational organizations as well as their contributions to the

nation building. In Ethiopia, there is a tendency to think of PWDs as weak, helpless dependent and unable to learn and the subject of charity (Tirussew, 2005). Such understandings and attitudes challenged PWDs not to support themselves and self-reliant in their life situation, rather dependent on other people.

According to Tirussew's study on disability, the social relations are manifested in marginalized interpersonal relationships and participation at family, neighborhood and the community levels. They have limited provision of public services and special programs for PWDs (health, education, transportation, information, recreational activities and legal provisions), restricted involvement in socio- cultural, sports and recreational activities as well as discriminatory practices in employment opportunities. Above all the quality of interpersonal relationships and scope of participation in socio- cultural activities which entail a degree of acceptance, love, care and respect, as well as the range of involvement in mainstream socio-economic activities are very critical for personal development.

Many of PWDs developed depression, frustration, irritability and feeling of helplessness and self-hatred. Deaf children suffer from lack of communication with their peers and teachers in regular ordinary schools. Teachers do not understand deaf children rather ridicule, irritate and made them hopeless. During the class session, deaf students try to gaze at teachers to read the movements of their lips. Teachers believed that the deaf children attend alternatively sometimes ask questions. However deaf students fail to answer, disturbed and discouraged, when the hearing children laugh at them (Tirussew, 2005).

Adults with disabilities face difficulties though they are not developed mentally vulnerable like children with disabilities. The range of their participation in community affairs such as local community organizations, festivals, weddings, funerals and other social occasions are highly limited. PWDs, particularly the severe physical and mental disabilities suffer from stigmatization and discrimination. Other studies confirm that some impairment create a great disadvantages of social stigma for individuals, while other does not (Patricia et al., 1999) On the other hand for poor countries like Ethiopia the only source of data for measuring prevalence is the national census whereas in developed countries they conduct surveys specifically designed for gauging disability prevalence rates. Census based information is usually spatially rich but temporally poor (less frequent and mostly outdated) (WB, 2007).

This is particularly true in poor countries due to the high cost associated to conducting nation wide data collection. In the case of Ethiopia national census is normally conducted once in decade⁹. The recent census was conducted in 2007 but the official report is yet to be released from the office of Central Statistical Authority (CSA 2007). A draft report on the prevalence of disability is obtained from the 2007 census. The draft contained only the new head count of PwD that is divided by types of disability and segregated into different age group.

(WHO 2001) estimates that the average percentage of disabled people in a given country is around 10 percent . Given the argument that disability has causal relationship with poverty, the prevalence is expected to be higher in poor nations. The disability statistics based on the 2007 census puts the number of disable people in Ethiopia at slightly higher than 800. The 2007 draft census report does not have information on regional distribution of PWD.

According to the 1994 census (see table 2-B), Tigray region leads with high prevalence (2.8 percent) followed by Harari (2.23 percent) and Addis Ababa (2.18 percent). Disability focused surveys conducted one year after the census revealed more than 10 percent prevalence in the three most populous regions of the country (Tirusew et al 1995). According to this baseline, the prevalence in Oromia, Amhara and SNNP is estimated at 12.7, 14.0 and 16.8 percentages compared to the corresponding census figure of 2.80, 2.03 and 1.80 for the same regions respectively.

2.3.1. Disadvantages of People with Disability

Regarding social status, 70 to 80 percent of PWD residing in urban areas Ethiopia and 65 to 70 percent of the PWD in rural areas were dependent on support provided by their families (mainly), and social assistance from government and local communities. Only 25 to 35 percent of PWD had any involvement in paid employment (MOLISA, 2005)

An assessment by MOLISA conducted in 2005 across Ethiopian region city reveals that most households with a PWD suffered from low living standards, with 33 percent falling into the category of poor households (the national figure was 22 percent). Indeed, households with multiple PWD's suffered most: 31 percent of households with one disabled person were categorized as poor; the figure for households with 3 PWD rose to 63 percent. Close to one

quarter (24%) of households with a PWD lived in inadequate housing; 65 percent lived in semi-permanent houses. Only 11 percent of households could afford to live in permanent houses.

The educational attainment of PWD was alarmingly low: 41 percent of PWD aged 6 and above were illiterate. Those with an educational attainment of lower secondary level or higher accounted for only 19.5 percent of PWD. Regarding the technical and higher education, 93.4 percent of PWD aged 16 or above received none. In general, the education and vocational levels of urban PWD were higher than that of rural PWD; of male PWD compared to female PWD; and of Viet ethnic compared to those of other ethnicities.

2.3.2. Disability-Related Stigma and Discrimination

In a recent assessment of the disability situation in Ethiopia, the United States Agency for International Development (USAID, 2005) stresses an important issue: the critical need to change the overall negative and dismissive societal attitudes that are hampering the advance of PWD.

The greatest challenge to an inclusive approach to disability, upon which Ethiopian national disability association is based, “is not yet understood by most people in society. As is the case in most countries, most people in Ethiopia, including those in public administration, tend to falsely perceive people with disabilities as inherently incapable of significant participation in the social and economic mainstream”.

Government reports have already documented how stigma and discrimination have hampered the advancement of PWD. For example, in a survey of 720 PWD in regional cities conducted by the Committee for Social Affairs of the National Assembly, nearly 7 percent of PWD reported that in their own families, they were treated worse compared to other family members; 13 percent said they were badly treated by the community.

2.3.3. Traditional Beliefs and Cultural Values towards PWD

The task is difficult because traditional beliefs and cultural values attribute disability to be the result of bad deeds or sins committed by one's ancestors. This stems from the concept of reincarnation, which holds that life is not a linear continuum from birth to death but cyclical.

Only the human body “dies”. The soul never perishes as it reincarnates into another existence and identifies with each life cycle. The life cycle also has its hierarchy of significance, with humans ranking the highest and insects the lowest. People committing evil deeds will not only be punished by being reincarnated as a form of life at a lower level, but their descendants will also suffer disability as a common consequence (Setotaw, 2002). Thus, while there is a general sense of pitiful sympathy towards PWD among the population, they can also be the target of social isolation and ridicule regarding their respective disabilities. *ewre*(blind person), *shiba*(limping person), *qorata*(lunatic person), *lekefetame*(crack-brained person), etc

2.4. Socio-Economic Characteristics of Households Having PWD

2.4.1. Poor Assets

For any household, the house itself is an important asset. Better housing means better living conditions for health, which is related directly to human capability, as discussed above. A house can also be used for economic purposes, for example as a venue for income generating activities. Banks and credit institutions also often consider the value of a house as a pre-condition for offering a loan to a household.

In the study, it is found that housing quality was markedly contrasted between the two groups of households. While nearly half of the households without PWD (48%) in Ethiopia could afford permanent houses built in brick with a solid roof (tile/concrete roof), for households With PWD, the figure was only one third (34%). The contrast is also found in Ethiopia, with 34 percent of “It is very difficult for disabled people to borrow money from a bank or a credit institution to open a business (WHO, 2006).

2.4.2. Poor Accessibility

Regarding access, it is no accident that the residences of households with PWD were often located farther from key infrastructure, economic and social service centers of the community

compared to those households without PWD. For example, *on average* the distance from the house of a household with the PWD to any motorway could be 200 meters farther than that of a house with no disabled person. Similar findings are found for distance to local People's Committee, 400 meters; to local health center, 300 meters; to nearest school, 200 meters; and to major market, 300 meters. Indeed, some houses with PWD were located much farther than these average figures quoted above. While a few hundred meters is not a problem for people with no disability, for PWD, these extra distances can create problems for them in accessing economic opportunities and available services, particularly for those with motor and vision disability (WHO,2006)

2.4.3. Low Income and Expenditure

Income and expenditure are among the most useful indicators of household well-being. Data collected shows that the income per capita of households with PWD was considerably lower than that of households without PWD. The median for annual income per capita for the former households in Addis Ababa is 3.4 million other regional city (slightly more than 200USD (1USD =16,000 Dong by the time of the survey in summer 2007) compared to 4.8 million Addis Ababa (300USD) for the latter households. An annual income of 3.4 million Addis Ababa means a monthly income of 283,000 birr, or about 18USD. The situation was similar across the other studied provinces. Annual income per capita for Addis Ababa and other regional city was 3.1 million for households with PWD versus 4.6 million birr for the other households. For Addis Ababa city is s 3.8 versus 5.7 million birr. Thus, households with PWD also spent less due to their limited income (USAID, 2005).

2.5. Difficulties of People with Disability

It is predictable that PWD often face more difficulties than other people, but little is known about the quantitative measures and patterns of main difficulty of PWD in Ethiopia. This section presents some assessments on difficulties that the surveyed PWD had in various aspects of life, including their daily activities, education, employment, healthcare, marriage and having children, and social participation. These are the key areas where supports for PWD should focus to make a difference in their life. For each type of difficulty, not only levels of difficulty but also methods are important to overcome those difficulties (i.e. their 'coping strategy') are examined. In order

to provide evidence for intervention to support PWD, their opinions of what actions and programs should be made are also analyzed.

Having a disability can create difficulties in one's daily activities. In most survey, the respondents were asked to describe levels of difficulty in performing some basic daily activities, including: eating and/or drinking; hearing and/or speaking; seeing; moving/walking; communication; and personal hygiene. Levels of difficulty in the analysis include: no difficulty (a person can do it by himself/herself without the need of someone's support or the use of instrumental aids); some difficulty (self-performance with some difficulties but without someone's support or the use of aids); substantial difficulty and cannot perform without support or the use of aids (Setotaw, 2007).

2.6. Review of Laws and Proclamation on Disability in Ethiopia

2.6.1 Developmental Social Welfare Policy of the EFDRE by the Ministry of Labor and Social Affairs (MoLSA, November 1996):

The social welfare policy distinguishes the issue of persons with disability at parallel level with other society segments such as youth, women and the elderly whose social welfare is usually a priority of concern. The policy highlights five major problems as follows¹⁴: Since most PWD live in rural areas (85 percent based on the 1994 census) they have limited to no access to social and medical facilities. They are relatively highly exposed to harmful traditions and social stigma; Disability in Ethiopia (as it is elsewhere in poor countries) is caused by poverty, ignorance, war and drought and is aggravated by inadequate nutrition absence/limited medical facilities, harmful traditional practices etc; Children and the elderly are the most vulnerable segments of PWD;

Based on the 1994 census, prevalence of disability disproportionately high in these two groups; PWD in Ethiopia have very limited access to rehab centers because of absence of such centers in the country. Those few centers that exist and operate at the time are Either costly or geographically inaccessible as they are mostly limited to few urban centers; PWD have limited opportunity for education and employment. Their potential to attend normal life activities is constrained by absence of friendly physical environment. Coupled with the stigma and fatalistic view of the society their likely destiny is life-long dependence on other people such as begging.

The policy draft has also stipulated policy actions that have to be implemented in addressing these concern areas. Accordingly it provides a 9 points policy actions directly related to PWD.

The pointes are stated as follows:

Conditions that will enable persons with disabilities to use their abilities as individuals or in association with others to contribute to the development of society as well as to be self-supporting by participating in the political economic and social activities of the country shall be facilitated. Efforts aimed at instilling in person with disabilities a sense of confidence and self-reliance through education, skill training, gainful employment opportunities and other services shall be increased and appropriate legislative measure shall be taken to ensure their welfare.

Mechanisms shall be created by which persons with physical and mental impairment will receive appropriate medical/health services and supportive appliances. Mechanisms by which PWD can receive appropriate support service in the context of their family and community environment shall be created. All effort shall be made to establish special center's where PWDs without any family will be cared for. Appropriate and sustainable educational program shall be launched to significantly raise the level of public awareness concerning the determinants of and consequence of the problems of PWD as well as to change the prevailing harmful traditional attitudes, norms and practices in respect to PWDs. Strategies and programs designed to increase our understanding of the causes and prevalence of physical and mental disability and thereby prevent and mitigate their spread shall be formulated. All effort shall be made to gradually remove all physical impediments and make residential areas, work and other public places more physically accessible to PWDs. Support and assistance shall be provided to community action-groups, NGOs, voluntary association involved in providing service to PWDs. Based on this policy, a national development plan in which many line ministries participate is formulated.

The action points outlined by MOLSA are the following: - Propagate necessary education through mass media gathering on causes of disabilities and the care required conduct proper research and Studies, conduct national vaccination campaign, expand health institutions, teach proper health at the scene of traffic accidents, alleviate socio-economic problems of society, encourage PWD and their associates to participate in preventive campaigns, include disability

education in curriculum, make available trained manpower for occupational safety and health control.

To accomplish the plan, responsibilities have been given to the ministry of Health, Ministry of labor and social affairs, Ministry of Justice, Ministry of Agriculture, Ministry culture and information, Ministry of Transport and communication, Regional governments, NGO, labor unions and the Federal of Ethiopian National Association of Persons with Disabilities. MOLSA being placed at the center shoulders the responsibility to coordinate the implementation by involving the line ministries.

2.6.2 Education and Training Policy (TGE 1994)

The education and training policy (TPE) has acknowledged the need for boosting school enrolment as a whole and enrolment to primary education in particular. The policy mainly advocates for decentralization of the education system, as it should be expected from any federal system, and allow high coverage and equal chance of learning opportunity for nations and nationalities. Among other things, it advocates for learning opportunity in one's own language, a shift towards innovative (job creating) learning and self-administration and management of the education system by regions and localities.

The policy had a sub-objective aimed at achieving educational equity to all groups including persons with disabilities. The objective is stated as “to enable both the handicapped and the gifted learn in accordance with their potential and needs” (TGE _MoEd 1994). Also in reference of the proposed reform of educational structure it states: “Special education and training will be provided for people with special needs” Turning these policies into real action has begun with the emergence of a triple five-year plan, which is part of the PASDEP and the different sectorial versions of PASDEP. The Education Sector Development Program (ESDEP) adopted the policy objectives of TGE and put them into a broader and concrete strategy. In the initial round of the five-year plan, the entire focus was on expanding school facilities and raising enrolment rates. The success reached in these period fairly tally with the millstones of MDG and the PASDEP. However by mid of the second round five-year plan, the need for improved quality of education has surfaced more vividly.

As part of the sector strategy and in response to the growing concern for quality, a document on the general package for education quality assurance in Ethiopia was issued (MoE,2006).

The document underlines the need to look beyond boosting the enrolment rate and put due emphasis on improving quality. In doing so it acknowledged that special need education is far less provided for and the people who ought to benefit from such education have been disadvantaged. Latter on at the beginning of the third five-year plan (2005/2006-2009/2010) MoE launched “strategy for special needs Education program” (MoE 2006).

The core elements of the strategy were on promoting inclusive education system and inclusive schools with an aim to meet the goals of UPEC and EFA15. It outline a range of actions for improving access to education and underlines on the need to give affirmative actions to those deemed as disadvantaged society groups such as females, pastoral and semi-pastoral resident individuals and those with special needs. The strategy founded itself on the ideals the 1994 TEP and the objectives were to: - Implement the TEP and the international principles endorsed by government to honor the rights of citizens to education; Develop and implement guidelines for curriculum modification and support system development in schools for learners with special needs; Facilitates the principles of learners with special needs in technical and vocational education and other higher education institutions; Strengthen special need education programs in teacher education institutions; Improved supply of trained manpower and appropriate material and appropriate materials to schools and other learning institutions;

2.6.3. Health Policy to People with Disabilities

The Ethiopian health sector policy that is currently in use has been developed in 1993. Similar to the other sectors, the health policy was made to be the guiding document for the design of the health sector development strategy /HSDS/ (which is part of the PASDEP) and is meant to span over a period of 15 years from 1997 to 2011. The policy has defined the priority groups for whom the health service facilities have to be improved. Among these are women, children and people in remote (rural areas). The policy has also deliberated that the approach of health service has to mainly follow preventive approach such as the use of Information, Education and Communication (IEC), environmental health, Occupational health and safety. With regard to

curative service priority is given to provision of new health facilities in areas where the service has not reached, rehabilitation of existing health facilities, curative and rehabilitative health facilities such as for mental health problems, control of communicable disease, etc.

The HSDP that is currently in the third and final five-year of implementation is mainly derived from the overall development strategy called the PASDEP. The focuses of the strategy is towards decentralizing the sector in line with federal arrangement and allow regional states to run the health sector by setting their own priority areas. Along the same line, the strategy gives special directions to the emergence and development key components such as health education, manpower development of health professionals, inter-sectorial collaboration, availability of drugs, supplies and equipment's, health specific research and development, health information management system, referral procedures, liberalizing and systematizing health services organizations. The last phase of HSDP has paid particular attention to expanding health service via mass mobilization of health extension workers and active participation of community groups. The necessary institutional and organizational arrangements are created within the federal and regional health offices to cater for smooth implementation of the policy and strategies. overall success of the health sector in meeting self-declared objectives and international milestones such as the MDG and WHO are encouraging. However with regard to specific policy and strategic provision for PWD, the health sector (ministry of health) is relatively ineffectual. The policy has not mentioned the case of PwD in a direct way or as distinct priority groups. The national strategy has not exclusively treated or even mentioned PWD, as group that need particular consideration five years plan (2001-2005).

2.6.4. HIV/AIDS Policy Prevention Disabilities

HIV/AIDS is recognized as social problem whose prevention and control actions have to be envisaged not only in the health sector but also in all sectors of the country. With this in mind a comprehensive HIV/AIDS policy has been developed in 1998 and followed by subsequent strategy for mainstreaming the policy into development strategies of all sectors/ministries.

The process has gone several steps such as the launching of a five years (2001-2005) strategic response by government and the development of implementation manual in 2007. At

organizational level, a national governing body led by the president of the country is created and all participating stakeholders are made to converge at the HIV/AIDS directorate, a body that is created for coordinating HIV prevention efforts and for providing technical and operational support.

HIV/AIDS policy and the subsequent strategies developed and adopted in a wide range of social and economic sectors provide exemplary effort for mainstreaming an agenda in a broader institutional and organizational set up. The policy has been effective in helping various society groups to benefit from projects however the policy, just like the national health policy, has failed to acknowledge the PWD as a distinct group that needs separate strategy and actions. As a result of this omission, PWD (particularly women), remained vulnerable to the pandemic and missed the opportunity to benefit from the policy/strategic attention they deserved.

2.6.5. Sport Policy for PWD

Similar to the other multi-year sector development plans, the ministry of youth and sport has developed policies that in many ways touch the lives of PwD. The sport segment of the ministry has outlined major policy objectives and methods for implementing them in the broader sectorial strategy. In line with its policy in educational institutions, health & fitness institutions, it gives considerable attention to PwDs. The policy document issued by the ministry in 1998 has stated the following two objectives as part of the broader sectoral objective in the multi-year development strategy: To give special attention to disabled students and facilitate their participation in sports suitable for their physical conditions; Ensure the participation of PWD in sports activities at their locality, educational institutions and working places and to also ascertain their equal sharing of the benefits.

As part of this policy reform the ministry has revived the Para-Olympics federation and revamped its organizational capacity by introducing new structure and by forming various functional committees. The new federation is entrusted with a responsibility to mobilize and lead national level talented sports men and women among the PwD. Among other things, the federation formed regional level offices¹⁸, emergency and executive committees and the general assembly.

The national Para-Olympics committee has developed a general vision of enhancing the participation of persons with disabilities in various popular competitive sporting events and put them to becoming active in uplifting the country's grandeur in this particular sporting front. Along with this general vision the committee has drafted a five-point mission statement stated as follows: Establish Para-Olympics federations in all the 9 regional states and ensure the effective outreach of the structures into woreda and Kebele level. Ensure that the persons with disabilities take advantage of sport facilities in places where they live, work and educate. Have to train as many men and women in Para-Olympics sport and help them become capable of winning medals in international competitions. Build sporting facilities that are suitable and accessible for persons with disabilities and ensure that those can be used for hosting competitive Para Olympics events in a sustainable way. (Ministry of Youth and sport, 1998)

2.6.6. Impression on Participation Level of PwD: In Reference to MoE, MoH, MOLSA, MUD and MoYS

The participation of DPOs in policy development and program implementation was assessed in terms of the duties and responsibilities required to carry out both subject matters. Primarily, every policy development involves political leadership (governance), planning, developing the final product and implementation. A blend of expertise on information flow analysis related to legal and other subject matters are vitally important.

On the other hand program implementation refers to an agreed project mission that compels the contracting parties towards legal engagement, joint planning, resource sharing, service delivery and mentoring. Based on this, three criteria were used to appraise the level of DPOs participation in the wider continuum of policy development and program implementation. These are "Inform", "consult"²⁰ and "partnership" these classifications are used to label or identify the place DPOs hold in the process of policy development and program implementation.

Chapter Three

3. Research Design and Methodology

3.1 Design of the Study

According to Chopra *et al.* (2012) research design is the conceptual structure within which research is conducted. They specifically indicated that “a research design is the arrangement of condition for collecting and analysis of data in a manner that aims to combine its relevance to the research purpose with economy in procedure”. A research design is the arrangement for a precise statement of goals and justification. (Zegeye et al, 2009) stated that the goal of descriptive research is to describe some aspect of a phenomenon, i.e., the status of a given phenomenon.

The main objective of this study was to examine the prevalence and socio-economic condition of people with disabilities in Hosanna town. In order to achieve the stated objectives, both quantitative and qualitative approaches were used. The aim of the quantitative approach is to determine the prevalence of people with disabilities in the study area. According to Vaus (2001), the qualitative research approach is fundamental to the research enterprise and has added immeasurably to our knowledge of the shape and nature of our society. He further argued that good description provokes the ‘why’ questions of explanatory research. As said by Zegeye et al. (2009), surveys collect data at a particular point in time with the intention of describing the nature of existing conditions, or identifying standards against which existing conditions can be compared, or determining the relationships that exist between specific events.

A qualitative research also additionally was identified as the most appropriate approach to meet the research aim. Due to this, qualitative research is preferred since researchers aimed at understand how people experience events, how they make sense of their experiences and to explore the socio-economic condition of persons with disabilities (Deborah, 2012). While quantitative data was utilized to estimate statistically specific measurements that can then be said to be representative of the target population of Hossana town as a whole.

3.2. Study area

The participants of the study were drawn from SNNPR, Hadiya zone of Hosanna town. The survey was conducted on participants selected from the whole population of Hosanna Town to

discover the relative incidence, level, type and of distribution of PWDs. Accordingly; the following population became a sample of the study area. Hosanna town is divided in to three sub-cities known as Gofermeda sub city, Sechduna sub city, and Addisketema sub city. The first two sub-cities are divided into three kebeles (sub divisions of the sub-cities) each and the third Addis sub city had two kebeles under it, which means the town is divided in to eight kebeles. According to the kebeles administration offices, they have an average of 1,200 household each. The further divisions of kebeles were villages. There were 20 villages under each kebeles.

3.3. The Sampling Techniques

3.3.1 The Samples for the Prevalence of PWDs

This study employed a multi- stage cluster sampling method to determine the prevalence of PWDs. On the first stage, the eight kebeles were included. Then 150 households from each kebeles. The order of the survey followed the existing house numbers starting from the first house according to the kebeles order. From the survey the average number of the family members is about seven. With this calculation (7X150 households X 8Kebeles) a population of 8,400 in 1200 households is covered by the survey conducted. The sampled population accounts about 10.5% of the total population of the town which is estimated as 84,000(*Central Statistics Agency CSA, 2007*).

3.3.2 The Samples for the Socio Economic Condition of PWDs

In order to study the socio-economic condition of people with disabilities in the town, purposive criterion sampling was used. Various people with various types of disabilities and the parents of two intellectually disabled children are purposefully selected in the following procedure.

Seven persons with disabilities living together as a family

These include five physically impaired and two visually impaired respondents of whom two were women. The group demonstrates a complex mixture of their life and gave variety of information on socio-economic condition of PWDs. During the home to home survey, the researcher purposefully selected this group to find out their social-economic life condition

The parents of two boys with intellectual disability

These couples are another group of case who reflected the social, particularly the education and economic condition of their sons. So they are one target area of the study.

A family with four Deaf Children and for hearing children

In order to balance variety of disability, the researcher purposefully selected this group as one of the case to study their social and economic life condition in comparison to other type of disabilities

3.4. Instruments of Data Collection

In this study a **survey questionnaire** with 24 items were employed. The questionnaire has two sections; the first part deals with the demographic characteristics of participants such as gender, age, education level, parental marital status and socio economic status, and the second section of the questionnaire included the socio-economic conditions of persons with disabilities, when they exist in the households surveyed. The household survey questionnaire was designed for both disabled and non-disabled households but some of its questions were applied to only disabled households vice versa. It includes six sections: household, demographic and socioeconomic characteristics, knowledge about disability, difficulties of disabled persons, supports from community and society for the disabled and their families, information and communication about disability.

The individual questionnaire was applied to collect information from every disabled person. If a disabled person was unable to answer questions, information about this person was obtained from another adult householder or his/her assistant. Each individual questionnaire contains a section on disability status, six sections about the difficulties of disabled individuals, a section on sporting-cultural activities and accessibility to public services, and a section on awareness about the rights of the disabled. In addition to the household survey, **in-depth interviews** were conducted with four various groups in group as well as individually. **Focus group discussions** were also conducted with the three groups to answer questions related to socio economic condition of PwDs. It focused on how and why they live together and the socio economic challenges they face within their community.

3.5 Procedure of Data Gathering

Following the selection of the site of the study, the city administration were asked for permission. At the inception of data collection, the consent of participants will be asked. The data were collected by field surveyors using the questionnaire to each household and partly by the researcher. In order to complete the data collection the following procedure was followed. Selection of data collectors: Four teachers from Hosanna School for the deaf were selected to be data collectors of the data; Training was given how to approach each household and how to identify various types of persons with disabilities; The coverage area was mapped and instructed to the surveyors; The data were collected through home to home survey with a close follow up of the researcher in order to support the surveyors; The researcher collected the data through interviewing the persons with disabilities and their families following the survey. Following this, the purpose of the study was explained for participants and they were given orientation on how to respond to the questionnaire.

3.6 Pilot Test

The main purpose of pilot is to check the reliability and adequacy of the instruments. Before employing the instruments to gather data from respondents, a pilot test was conducted. Then the questionnaire was administered at the three Kifleketemas and the collected data were analyzed using statistical package for social science (SPSS) version 20.

Coefficient reliability and content validity for self-esteem scale in previous study Efrem(1999); cited in Solomon(1999) reported reliability index of cronbach alpha was ($\alpha = 0.82$). In this study a cronbach alpha of ($\alpha = 0.845$) was obtained. Out of the 44 items, 4 items were discarded from the final analysis because of their ambiguity. Hence 40 items were used in the final study.

3.7. Data Analysis

A quantitative method was employed to analyze the data. The data were collected using the instruments developed, subjected to and analyzed with SPSS version 20 The result of the process is presented in detail in the following sections. To summarize the statistical characteristics of persons with disabilities using a descriptive statistics; frequency and percentage were specifically used for each of the demographic items.

The second part of the data was analyzed in depth to give the meaning for the responses of interviews and focus-group discussions. The data gathered from the three groups as case by case was transcribed from the recorded responses. The analysis was made based on the basic questions related their socio economic condition.

3.8 Ethical Consideration

Participation of respondents was strictly on voluntary basis. Informed consent was solicited in written form. Measures were taken to ensure the respect, dignity, freedom and assure confidentiality of each individual participating in the study. Participants were informed that the information they provide on the questionnaire and the interviews would be kept confidential and only be used for the purpose of this study.

Chapter Four

4. Findings

A questionnaire containing 24 items were distributed to collect information about persons with disabilities. The items were categorized in to two major parts. The first part of the questionnaire was designed to collect data about the respondents of and the households profile and the second part was about the persons with disabilities. The structured and semi structured interviews contained ten variety of questions about the life situation of persons with disabilities. There were also four various points of discussions which were raised during the focus group discussions. The results of each part are presented on after the other.

4.1. The Prevalence of Persons with Disabilities.

4.1.1. Demographic Data and Other Characteristics of the Respondents

In this section, the sex, age education, and occupation of the household respondents are presented. From the total of 1200 questionnaires 960 were filled by the responses of the households where in 3.6% persons with various disabilities were identified.

Table 1: Sex of the Respondents

Respondents	Male	%	Female	%	Total	%
Households	497	41.4	703	58.6	1200	100

The number of female respondents exceeds that of the male respondents. This could be due to most of male heads of the households usually gone to work and other business and social affairs, during the data collection times. On the other hand the females or the wives of the heads of the households are accessible at home than their husbands.

Table 2: Age of the Respondents

Respondents	1-26	26-39	40-54	55& above	Total
Households	265	450	383	92	1200
In percent	2.23	37.7	32.1	7.9	100

As we can see from the table of age, the highest age group of respondents refers to the age 26-39, followed by age group 40-54. The number of respondents for age below 26 and above 55 accounts for smaller share. It was only when the adult heads of the households absent that the young and the old involve as participants of respondents.

Table 3: The Education of the Respondents

Respondents	No Education	Primary Education	Secondary Education	Higher Education	Total
Households	174	412	364	250	1200
%	14.5	34.3	30.3	20.8	100

The respondents who attended primary education (34.3%) and secondary education (30.3%) account the larger share. The participants attended higher education (20.8%) are also large following the other two groups. The percentage for those with no education is low (14.5%). In general, the respondents are distributed to all education level with slight variation except for the category of no education

Table 4: The Economic Level of the Households

Respondents	High level	Middle level	Low level	Total
Households	92	574	534	1200
%	7.7	47.9	44.5	100

The economic level is categorized into three depending on the net income estimation per a month. Accordingly the high level group is that who has the monthly net income of above ETB 5,000; the middle level economy group are those with those a monthly net income of ETB between 1,000.00 & 5,000.00, and those with low economic level have a net income below ETB 1,000.00. According to this categorization of economic level, most of the households of the respondents are in the middle level (47.9%) and low level (44.5%) economy. Very few (7.7%) of the respondents are categorized under high level of the economy. This labeling of the level of economy depends on what the participants' response.

Table 5: The Occupation of the Respondents

Occupation of the respondents	Households	%
Trade and sales activities	349	29.1
Government and NGO employees	320	26.7
Private work- self employment	203	16.9
Retirement pay	110	9.2
Daily base work- wedge pay	66	5.5
Renting houses	56	4.7
Depend on other's support	52	4.3
Agricultural activities	24	2.0
With no work	20	1.6
Total	1200	100

The occupation of the respondents refers to the means of living or the source of their income. It is revealed on the table ,that trade and the sales activities accounts the highest (29.1%) source of income, followed by government and non- government employees ,which accounts (26.7%). Very few households are unemployed (1.6%).

4.1.2. Prevalence of People with Disabilities

From the second part of questionnaire which deals with persons with disabilities, the following findings were identified

Table 6: The Type and prevalence of People with Disabilities

Types of Disability	Prevalence	%
Motor or Physical Disabilities	59	37.3
Visual Impairment	41	25.9
Hearing Impairment	32	20.3
Intellectual Disabilities	10	6.3
Communication disorder	8	5.1
Epilepsy	4	2.5
Total	154	100

From the survey conducted in Hosanna town, six various types of disabilities with sum total prevalence of 158, were identified. This number accounts about 1.83% of the population covered in the sample survey, which is about 8,400 in 1200 households.

From the distribution of various types of disabilities, the motor or physical disabilities accounts the highest share (37.3%) followed by visual impairment that accounts (25.9%) and hearing impairment, accounts (20.3%). The above mentioned impairments are usually easier to identify by the respondents as well as by the community. The rests, intellectual disabilities (6.3%), communication disorder (5.1%), epilepsy (2.5%) and dwarf (2.5%) are found fewer incidences. All of the later ones are difficult to identify, particularly, the mild level cases may not be included at all. Some others like emotional and behavioral difficulties couldn't be found at all, for the identification is very difficult.

Table 7: Age and Gender Distribution of Persons with Disabilities

Age category	Male	%	Female	%	Total	%
1 – 14	12	7.6	10	6.3	22	13.9
15 – 25	13	8.2	14	8.9	27	17.1
26 – 39	14	8.9	9	5.7	23	14.6
40 - 54	16	10.1	15	9.5	31	19.6
55 and above	27	17.1	28	17.7	55	34.8
Total	82	51.9	76	48.1	158	100

The age profile of persons with disabilities ranges from birth to old age (above age 55 and disabilities are distributed to all age groups. The old age (above age 55) constitutes the largest share (34.8%) of person with disabilities. It is logical that from human development that is the process of aging or old age, there is a decline in sensory and, motor body of human beings. The next highest disabilities belong to age group category between age 40 &54, which accounts 19.6%. The other age group categories have the same amount of disabilities, except for age group between 15& 25 which accounts 17.1%.

The comparison of disability between males and females shows that the percentage of disabilities with men exceeds that of the females.

Table 8: The Living Conditions of Persons with Disabilities

The living conditions of Persons with Disabilities	Frequencies	%
Dependent on families and on others	43	27.2
Give services for the families (kitchen services)	28	17.7
Beggars on the street	19	12
Government employees including teachers	10	6.3
Employed on daily base	9	6.0
Small scale trading and sales activities	8	5.1
Renting houses	8	5.1
Students	6	3.8
Depend on retirement income	5	3.2
Prostitutes	5	3.2
Agricultural activities	4	2.5
Private business like wood-workshop	4	2.5
Unidentified	9	6.0
Total	158	100

Table 8 shows us a variety of employment of people with disabilities. It is better to say that it is life struggle to survive. As it is presented the largest percent (27.2%) of persons with disabilities are dependent on families. Another picture that we can see from the data is that large numbers of persons with disabilities (17.7%) are servants of their own families, their relatives or the households of other people. The share of the beggars (12%) is not also small. Few numbers of persons with disabilities are leading their daily life by managing to produce their living cost which includes being employees of various organizations (6.3%),small scale traders (5.1%), house renting (5.1%) and private business owners (2.5%). Very few women with disabilities are identified as prostitutes, which makes the life very difficult.

4.2. The Socio- Economic Conditions of PWDs

In order to investigate the socio economic condition of people with disabilities, the researcher qualitatively studied using structured and semi-structured interviews, and focused- group discussions. The participants involved under this topic were purposely selected individuals and groups of persons with disabilities. They are grouped into three cases. The first case consists seven various type persons living together as a family, the second case is about four Deaf children in a family, the third case is about two children with intellectual disability in a family and the forth case is about a physically handicapped woman living with a given family.

Case 1. A Group Various Persons with Disabilities Living Together

Table 9: The profile of participant in case 1: Seven persons living together in certain room

Type of Disability	Specific	Sex	Age	Education	Marital status	Occupation
Physically Impaired	A leg	M	35	Primary Grade 4	Unmarried	Begging
Physically Impaired	A leg	M	45	Primary Grade 8	Unmarried	Daily work
Physically Impaired	A hand	M	54	No education	Unmarried	Begging
Physically Impaired	A hand	M	42	No education	Divorced	Begging
Physically Impaired	Two legs	F	36	No education	Married	Care for kids
Visually Impaired	Completely	M	40	No education	Married	Begging
Visually Impaired	Completely	F	38	No education	Divorced	Begging

From the observation directly made at their home, it was learnt that the life of a number of persons with various disabilities is one of the finding of this study. Usually it is not common to get many persons with disabilities living together. This group contains five physically impaired of which two of the impairment refers to one of the legs each, two of the men have amputation on their hands and a women is with totally paralyzed both legs. The remaining two are totally blind man and women. From their profile we can see that men's number exceeds that of women by two times .They are all adults between ages 35 to 54.Regarding their education only two of had the chance of attending school and had a primary education during their school age; the other five had no education experience at all.

Concerning the marital status of the group members, three of the men are unmarried, a physically disabled man and a blind woman are divorced. These two were married when they were in country side with their respective wife and husband. The blind woman has a 10 years old daughter with her who guides here in the town while begging. The remaining blind man and physically disabled woman are couples, husband and wife. They have six years old son and a two months old baby girl. Their small boy is guiding his blind father.

The other variable considered was their occupation which means their life style or a way by which they get income for their living cost. In respect to their occupation, it is only a man that is involved in daily work and earning some income. Four of the men and one of the women are engaged in begging and get their daily income for them and their families. The remaining physically handicapped woman is responsible for feeding her two kids and her husband.

They all share a house with two rooms. The house belongs to a seventy years old non- disabled woman. According to the woman, the owner of the house and the group of these persons with disabilities, during the group discussion, they pay rent for the house, on the base of their agreement that depends on their daily income from begging. Otherwise they just live with her as a family; however, she has no other income, she has compassion for these persons with disabilities. Though they share the house for economic reasons each individual and the couple with their kids are independent. They run their own way of living. Most of the time the beggars have their meals wherever they get either provided by other people or purchasing from small scale restaurants and tea shops, except the blind man who has a family to take care.

The social life of this group varies depending on different occasions and situations. As they all seep together except the couples, who use the other small room, they also share reports of everyday activities in the evenings. Sometimes, they have different interests and have conflict, particularly when two of the members become drunkard. Otherwise, almost all of them do not have any social interaction with the other community members. They are really alienated, segregated from any kind of social participation, like idir, mahiber, equb etc. Their children are also victim of the problem since they are not yet sent to school because they are always busy guiding their parents.

Case 2. A Family with Four Deaf Children

Table 10: The Profile of a Family with Four Deaf Children

Family Status	Age	Hearing Status	Education	Occupation
Father	58	Hearing	Primary (grade 8)	Technician
Mother	52	Hearing	Primary (grade 4)	Trader
First Son	28	Deaf	Diploma + 2yrs	Employee of ELPA
Second Son	25	Deaf	Diploma	Job-seeker
Third Son	22	Hearing	Secondary(grade 10)	Shop keeper
Fourth Son	22	Hearing	Secondary(grade 10)	Bajaj drivers
First daughter	17	Deaf	Primary (grade 8)	Student
Second daughter	13	Deaf	Primary (grade 5)	Student

Education of the Deaf children of the family

The profile of this family shows us that the hearing and the deaf members of the family are equal. From the group discussion and interview to some members of the family, it was explained almost all of them are educated at different level of education. According to their explanation the four deaf children have been lucky to be enrolled in Hosanna Mekane Yesus School for the Deaf and receive fair education, develop their sign language and share social and special deaf cultural values. The first two deaf sons, after completing grade 10 and introduction to vocational training in wood work, metal-work, they both joined at as of their ages and graduated awarded Diploma in electricity. The older boy continued his higher education in Adama University in Bachelor of Science in electrical engineering. The second boy is looking for job after his completion of vocational training in the college. The next two hearing boys are identical twins and, they both completed the secondary education in regular school. The two younger girls are currently attending in grade eight and grade five in Hosanna Mekane Yesus School for the deaf.

Occupation of the Deaf Children

In regard to their occupation, the family in general seems to have the middle level of economy. Like any other community of Hosanna Town the father and mother of the family are doing well

to secure their means of living more of by private business of repairing electronic equipment and trading butter respectively. Their older deaf son is the employee of Ethiopian Light and Power production Corporation. Thus, he is able to lead his own independent life. The second deaf boy, while looking for job suffers from communication gap with managers and personnel of various organizations. The two hearing identical twins engaged in private business of Bajaj driving and shop keeping. This seems the advantage for hearing comparing with deaf to work within the community using their oral speech.

Communication Media and Social Interaction within the Family

The Parents uses both Guragegna and Amharic languages. As there are four members of the family are four out of eight (50%), the sign language is the dominating language in the presence of the deaf children. There is no gap of communication within the family. The hearing boys serve them in interpreting for the deaf brothers and sisters when they need any time anywhere. Due to the interest of using media of communication, the deaf are more close to each other than the hearing members of the family. Outside the family the deaf are still looking the deaf group in the town to be together and their everyday experiences to each other.

Case 3.The Case of Two Brothers with Intellectual Disability in a Family

Table 11: The profile of the two boys with intellectual disability

	Age	Cause	Severity	Education
Older boy	10	Luck of care during delivery	Moderate	None
Younger boy	8	Mother take medicine during pregnancy	Moderately sever	None

Causes and Characteristics

From the observation and structured and semi structured interview with the father of the two children with intellectual disability, the profile of the children shows as that they are brothers with age difference of two years, age of ten and eight. According to the father’s explanation the causes of the disabilities of the two children are different. The cause of the intellectual disability was due to the luck of care, the umbilical cord of the baby was not tie and blood was run out,

during delivery time. The father referred to the cause for intellectual disability of the second boy as the mother of the child took un prescribed medicine during her pregnancy time. The two boys children have nearly the same character, that they display character except the younger child is more severe than his older brother.

Adaptive Skills and Social Interaction

According to their father report during interview, the two children are able to feed themselves, though they are somehow are not tidy as they are expected on their age. They know how to use a toilet, play various games by themselves at home. They have good love and understanding with in the family, with parents and mother. They have one years old sister with whom they play with in the home. It is only when the father take them to recreation, they go out of their home compound. As a result they don't have any social interaction with neither their neighborhood nor the school peers.

Education the two children

The children do not attend to school, because no school is appropriate for children like them, intellectually disabled in the town On the other hand, in spite of the fact that the father is a teacher in one of the elementary schools in the town, he is ashamed of his kids to take them to the regular school; rather he is trying to educate them at home by himself. The parents are very much worried about their future life.

Case 4: A Woman with Physical Disability

This woman is 36 years old who is living with the family of her younger sister. She is physically disabled, who uses her both hands and both legs to move actively, even long distances about a kilometer, but couldn't stand up and walk. She is also very active in her perceptions and use of language. She is not married and has no occupation that she may get her own income; rather she serves the family members of her sister by cooking, cleaning and all kitchen services.

Education

According to her explanation, she completed the primary education when she was 20 years old walking about half a kilometer away from home .She appreciates two of her teachers who

encouraged and support her while she was attending school being different from her classmates. But since then she couldn't continue her education due to the the secondary school location is far and lack of support to go to school.

Occupation and Social Interaction

Her duty now is serving her younger sister by cooking meals, cleaning and organizing the house, washing clothes and looking after the house until the children come from school and the couples come from the work place. She emotionally, expressed her wish to continue her education as,

“... I know that I have a potential to study further, to have a job, and lead my own life, instead of being servant without any payment. But I don't know what to do, where to go, to whom to talk.”

In general the situation she is living victimized her from using the community's resources, like education and health services. Socially, the interaction with the family she is living with is very minimal; there are no common issues to discuss with any of the family members including her sister, except in relation to her duty. No way of interaction with others outside the family members.

Chapter Five

5. Discussion Conclusion and Recommendations

5.1. Discussions

5.1.1. The Influence of the Respondents on the Findings of Prevalence of PWDs

To determine the prevalence of disabilities in a given area, the characteristics of the respondents have its own effect. From the findings of this study 58.6% PWD were female and 41.1% were male. In most cases, mothers (females) have better closeness to their children; thus, the findings is more reliable or the sex factor does not affect the finding. The highest category of age of the respondents refers to ages (26- 39), followed by (40- 54) which means most of the respondents are adults and the information seems more dependable.

The education factor may have some effect on the findings because the majority of the respondents have the primary education (34.3%) and secondary education (30. 3%), which may lack some awareness on disabilities, particularly the mild cases. This means there child be some variations from the actual prevalence of persons with disabilities. From the level of economy, the respondents with the high level are very low (6%) while the middle level (48.9%) and the low level (45.1%) accounts the majority, which implies that disability is more related to low economic status.

5.1.2. Factors Affecting the Prevalence of PWDs

The incidence and prevalence of the finding accounts 1.83%. It is very low comparing to the WHO estimation, which is 10%. In general, the figure obtained in the study is low in the town. This sort of discrepancy could be explained in way that some of the disabilities such as intellectual disability, behavioral disorders, and language and speech disorders are not easily detectable by parents or participants in the study (Tirussew, at el., 1995). In this study, there is no any case of emotion and behavioral disorder. Since this survey is done home to home in the town, not in the schools, where the emotional and behavioral disorder can be identified, the participants may not consider as disability within the families at home.

Moreover, the parents, for many socio-cultural reasons, may not be willing to disclose the fact that they have a child with certain disabilities; such as leprosy, sever intellectual disability, cerebral palsy, etc. Another reason for the low number of disability could be that many persons

with disabilities may reside in the churches, mosques and on the streets which are not included in this study (Tirussew, 1995). In relation to the type of distribution the first two, physically disabilities (37.3%) and visual impairments (25.9%) relatively easier to identify and reveal them in comparison with other disabilities.

5.1.2. The General Life Condition of PWDs

Most of persons with disabilities are living within the families with low incomes. Except few, most of disabled people have poor employment conditions. One of the most interesting finding of living condition is that of the case of a group of persons with various disabilities living together in a single house. The situation is difficult to handle the use of toilet cooking situation etc. The welcoming of the old woman for all different persons with disabilities is very unusual and which should be appreciated for it is a different attitude from the other community. The cases of four deaf children and the two children with intellectually disabled can be mentioned as a good situation interims of their living conditions since they are living in a good situation comparing to the others. The worst case is that of a woman with physically impaired, who lives with the family of her sister. She is ignored ,victimized, loose her self-esteem and identity

5.1.3. The Social Interaction of PWDs.

The social condition of PWDs seems weak both in the family and in the community. The group of seven various disabilities have very loose social relationship. However, they spend the night, they have no much socialization each individual and the couple with their kids organizes their life privately except for some special occasions. One of the reasons for this could be the physically disabled and the visually impaired have different developmental characteristics. The deaf children have good social interaction with the family members since they have no barrier of communication. The common factor for all the cases is that there is social gap between the community and various types of disabilities. The main problem is attitude of the society that neglects, discriminates and ignored the PWDs. The problem with the deaf people is a communication barrier.

5.1.4. Education of PWDs

The education of PWDs is very poor in general; however there are some examples of educated persons with disabilities. In the condition of the seven various disabilities it is only two of them

who have primary education (28.6%) and the others are with no educational experience (71.4%). This situation clearly implies that it is not easy for physically and visually disabled persons in the town or the surrounding rural areas. The societal relations are manifested in marginalized interpersonal. They have limited provisions of public services and special programs for PWDs (health, education and others (Tirussew, 1995). The deaf children are all educated having better chance to be in special Hosanna School for the Deaf. In comparison to other impairment the deaf have better opportunity of education due to the presence of special school for the deaf, special unit for the deaf in regular government and since school and the two colleges of teachers education and vocational and technical training are welcoming deaf students. The children with intellectual disabilities are victims of the lack of opportunity to education. The attitudes of both the family and the community and the schools is not ready to provide educational support to these children. There is lack of inclusive setting to include and provide education for all

5.1.5. The Occupation and Economic Status of PWDs

In general, the majority of PWDs are dependent on others, beggars, service givers in the kitchen of others without payment, with no any job, which result to have very low economic level. It is still, possible to say that the deaf have relatively self-supporting occupation like wood work producer, teacher, technician which brings them to the middle level of the economy. Occupationally, very few of them involve in small scale business, renting houses, are able to lead their life.

5.2 Conclusion

The main objectives of this study are to find out the prevalence of PWDs and to investigate the socio economic condition in Hosanna town. Accordingly the researcher used both quantitative methods for surveying PWDs and qualitatively studied the socio-economic condition of PWDs. Questionnaires were filled of 1200 households by field surveyors. Observations, both structured and semi-structured interviews, and focused group discussions were employed to collect the data.

The findings answered the questions with the related justifications. The study revealed that the prevalence of PWDs accounts 2.79% of the total population of Hosanna Town. Various reasons are discussed for this low amounts of prevalence comparing with the estimate of WHO ,which is

10% . The highest share of disability goes to physical impaired followed by visual impairment. Disabilities like behavioral disorders learning difficulties did not appear at all.

The socio-economic condition of PWDs in the town in terms of social life, education, occupation and economic level is generally poor, except to that of the deaf people. The deaf are in a better socio economic condition when compared to the other PWDs.

5.3. Recommendations

The awareness raising and attitude change should be done by all concerned bodies. The community needs to work to bring change in attitudes towards PWDs. In order to change the life of PWDs, community based rehabilitation CBR are the best strategy to provide community resources. So I recommend CBR organizations to consider Hosanna and the surrounding areas regarding CBR. It is clear that our country ratified the UN and international conventions and proclamations, all the concerned bodies should work hard to implement the guidelines about PWDs.

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Appendix I

A questionnaire to be answered by the member of the household, preferably by one of the spouses

1. Background Information

Address: Sub-city _____ Kebele _____

Mender (Village) _____ House Number _____

Sex _____ Age _____ Marital Status _____

Position in the family _____ Economic Level _____

Education Level _____ Occupation _____

Religion _____ Ethnic group _____

Family size _____

- If there is A person with Disability (yes / no)

The type of disability _____

Sex _____ Age _____ Marital status _____

Education _____ Occupation _____

Cause of the disability _____

On set of the Disability _____

The severity of impairment _____

Appendix II

Semi structured interview guides to investigate the socio economic condition in

Explain the situation of

General Life_____

Social interaction

Education_____

Occupation_____

The level of the economy_____