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ATTITUDE TOWARDS FEMALES WITH DISABILITIES:
THE CASE OF WOLAYITTA ETHNIC GROUP

BY

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This thesis has been submitted for exam with my approval as University advisor.

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ABSTRACT

The purpose of this study was to investigate the attitude of society towards females with disabilities in Wolayitta ethnic group. A structured questionnaire focusing on attitude measuring was administered to a purposefully selected 216 males and 184 females from randomly selected six kebeles in two woredas of Wolayitta zone. Key informant interview, Focus group discussions and Case studies were implemented to confirm with findings of quantitative study. Tables, percentages, mean scores, and chi-square were employed on the analysis of data. The findings indicated that the community in Wolayitta ethnic group has enough information and knowledge towards disability and they are aware of types and causes of disabilities. Even if the community has information and knowledge towards disabilities, the society has misconceptions, negative perceptions and attitudes towards females with disabilities.

The results indicated statistically significant agreement differences (at 0.0000 level) between urban and rural dwellers regarding females with disabilities are useless and unproductive. It could be that urban dwellers have accessibility of mass-media and other technological development influences and interventions of some organizations in urban areas to have information and knowledge towards females with disabilities are productive and valuable. But there were no

significance differences between male and female respondents regarding females with disabilities are useless and productive. The result also indicates that there were statistically significant disagreement differences among religion subgroups (at 0.0000 level) in favour of Protestants regarding females with disabilities are productive and useful. This could be that religion had brought attitudinal changes towards humanity.

In most cases females with disabilities are isolated, neglected and segregated in Wolayitta ethnic group. It was concluded that the attitude towards females with disabilities was negative due to other variables that influence the community differently. Agitation and public education, intervention of governmental and non-governmental organizations through community-based activities are recommended and suggested to create awareness and to bring attitudinal changes towards females with disabilities in Wolayitta ethnic group.

CHAPTER ONE

1. INTRODUCTION

1.1 Background

It is envisaged that the combination of poverty, ignorance, war, famine and drought with absence of adequate preventive and rehabilitation services could produce high prevalence of disability in Ethiopia. The country is one of the developing countries where information and knowledge about persons with disabilities of the total population is minimal. There is a lack of accurate information about the magnitude and types of disabilities as well as their causes and consequences (FDRERA & CSA, 1996).

According to the report given by the International Rehabilitation Review (UNICEF, 1988) global population of disability amounts above 500 million. Out of the 500 million, over 80% are in developing countries and most of them do not have access to rehabilitation and/or habitation services of any kind due to various factors, the major being lack of resource. In some countries, over 50% of impairments were caused by malnutrition. No country has all its transport systems accessible. In some countries, disabled people are unable to vote or stand for political office because of inaccessibility or being barred from doing so (EFPD, 2000: p. 25).

Until the recent years, the number of persons with disability and their type was not well known in Ethiopia. The World Health Organisation (WHO, 1980) estimated about 10%

of the total population of developing countries are persons with disabilities. According to (CSA, 1998) the number of persons with disabilities constitutes 1.9% of the total population that is there were 988,853 disabled persons in Ethiopia. Out of these 189,774 (19.19%) were persons with hearing and speaking problems, 319,194 (32.28%) were person with visual impairment, 317,801 (32.14%) were persons with motor disorders, 64,081 (6.48%) were persons with mental problems, 34,371 (3.48%) were persons with leprosy and 63,632 (6.34%) were persons with other multiple disabilities in Ethiopia. Out of the 988,853 persons with disabilities 166,239 (16.81%) were living in urban areas, while the rest 822,614 (83.19%) live in rural areas. However, there is no statistical data that indicates the number of male and female persons with disabilities.

There were 174,941 persons with disabilities found in the Southern Nations, Nationalities and People's Region (CSA, 1994). There is no statistical data that indicates the number of persons with disabilities at zonal level in SNNPR. Wolayitta is one of zonal administration in SNNPR, which is bounded in the North by Hadiya and Kambata-Timbaro zone, on the East by Sidama zone, on the South by Gamo-Goffa zone and on the West by Dawuro zone.

This study was focused on the attitude of community in Wolayitta ethnic group towards females with disabilities, such as those who have motor disorders, visual impairment,

hearing impairment, language/communication disorders, leprosy, behavioural problems and multiple disabilities.

1. 2 Statement of the Problem

Disability is a social and individual problem. People belonging to different ethnic groups in Ethiopia have different attitudes towards persons with disabilities in general and females with disability in particular. People's attitude towards females with disability has not been researched in Wolayitta in particular. Therefore, it is intended to have tangible or reliable study that can give the reflection of community attitude towards females with disabilities in Wolayitta ethnic group.

1.3 Research Questions

The following interrelated leading questions are investigated in the study.

- ◆ What is the level of information, knowledge and awareness towards disability among Wolayitta ethnic group?
- ◆ What are some of the factors that contribute to disability or the main causes of disabilities in general?
- ◆ What are people's attitudes towards persons with disabilities in general and females with disabilities in particular in Wolayitta ethnic group?

- ◆ What socio-economic and psychosocial impact does people's attitude towards females with disabilities have among Wolayitta ethnic group?
- ◆ What are some of the possible intervention strategies to be recommended to address the problems of persons with disabilities in general and females with disabilities in particular?

1. 4. Objectives of the Study

1.4.1 General Objective

The main objective of the study is to investigate the attitude of people towards females with disabilities in Wolayitta ethnic group.

1.4.2 Specific Objectives

The specific objectives of the study are:

- ◆ To gather relevant information on how people perceive females with disabilities in Wolayitta ethnic group;
- ◆ To measure the level of awareness of people towards persons with disabilities among the members of Wolayitta ethnic group;
- ◆ To assess the socio-economic and psychosocial impact of attitudes towards females with disabilities in Wolayitta ethnic group;

- ◆ To point out some of the possible intervention strategies to change people's attitude towards disability.

1. 5. Justification and Significance of the Study

This study is the first of its kind that was conducted on the attitude towards females with disabilities among the Wolayitta ethnic group. Therefore, the researcher hopes that the findings of the study:

- ◆ Can be used as a baseline or preliminary information source for organisations or persons who are interested to work in the area of disability and gender issues specially for community based programs;
- ◆ Give relevant information about the situation of females with disabilities in Wolayitta ethnic group;
- ◆ Serve as a basis for more rigorous and controlled studies on the area of disability;
- ◆ Indicate the strategies for intervention and sustainable programs to empower females with disabilities to be productive citizens.

1. 6. Delimitation of the Study

Because of financial and time constraints the scope of the study is delimited to Wolayita ethnic group who live in two woredas in Wolayita Zone, out of seven woredas. And it is delimited to the attitude survey towards females with disabilities in this ethnic group.

1.7. Definition of Key Terms.

The major concepts used in this study are operationally defined as follows:

- ◆ **Attitude:** Feelings' of communities of Wolayitta ethnic group towards persons with disabilities in general and females with disabilities in particular.

- ◆ **Awareness:** Knowledge of community in Wolayitta ethnic group as a result of information they have in identifying types of disabilities and persons with disabilities in general and females with disabilities in particular.

- ◆ **Community:** Those people who are living in the same environment with persons who have different types of disabilities where the study has been conducted.

- ◆ **Disability:** According to WHO (1980), classification system the "consequence of impairment with functional performance and activity by the individual" (p. 14).

- ◆ **Females with Disabilities:** Those women who have physical (motor) disorder, visual impairment, hearing impairment, mental retardation, leprosy, psychosocial disorders and multiple disabilities.

- ◆ **Person with Disability:** a person who is unable to see, hear or speak or suffering from injuries, to his limbs or from mental retardation, due to natural or man-made causes; however, that the term does not include persons who are alcoholics, drug addicts and those with psychological problems due to socially deviant behaviours (Proclamation No.102/1994. *Proclamation to Rights of Disabled Persons to Employment* in Ethiopia).

- ◆ **Wolayitta Ethnic Group:** People of Wolayitta nationality who reside in Southern, Nations, Nationalities, and People's Region (SNNPR), in Wolayitta Zone, in seven woredas: namely Boloso-Sore, Damot-Gale, Damot-Woyide, Kindo-Koyisha, Offa, Humbo, and Soddo-Zuria.

CHAPTER TWO

2. REVIEW OF RELATED LITERATURE

2.1 Attitude of Society towards Persons with Disabilities (*General Overview*)

Attitudes are tendencies to respond to people, ideas, and events in evaluative ways. They are composed of beliefs, feelings, and behaviour tendencies. Attitudes and reaction to handicap are wide-ranging and complex. They are based on variables considered related to and important to attitudinal formation (for example, family background, culture and personality). Age, sex, and other demographic variables appear to be significant determinants in the manner in which attitudes towards the disabled are expressed rather than in their formation (Berns, 1985; Myers, 1983; Siller, 1976).

The disability process... starts with impairment, which leads to disability that (in turn) leads to handicap. The definitions are: ***Impairment***: any loss or abnormality of psychological, physiological, or anatomical, or other genetic or environmental agents; ***Disability***: any restriction or lack of ability to perform an activity in the manner or within the range considered normal for human being; and ***Handicap***: a disadvantage for a given individual that limits or prevents the fulfilment of a role that is normal (depending on age, sex, and social and cultural factors) for that individual (WHO, 1980).

Disability is a social problem as well as an individual problem. Primarily it is a social problem, because what stops the individual disabled person from contributing is the attitude of non-disabled persons towards him or her. These attitudes towards persons

with disability do not have self-worth, they lack confidence, they believe that they are good for nothing. The discrepancies, which exist in the livelihood of persons with disabilities and non-disabled persons, are by and large attributable to the general public attitude, which is predominately characterised by enduring stereotyped attitude (Coleridge, 1993: 16).

Savolainen (1997b) pointed out that in the traditional belief people consider disability is a result of divine punishment and can be transmitted to the next generations of a family. Because of these people fear, shame and avoid persons with disabilities and the disabled left alone or hidden.

Because of perceptions of able-bodied people, disability as a tragedy, a loss or a deficiency people can assume that persons with disability are unproductive. The negative response of most able-bodied people to persons with disability is based on many reasons but mainly on ignorance and avoidance. Local beliefs and customs cause people to look down upon persons with disabilities. For example, in some areas, people believe that children are born disabled or deformed because their parents did something bad or displeased the gods (Coleridge, 1993).

Disability is seen as a driven course “justifies” low esteems for disabled people and their families.... Morale trespasses or “sins” and evil thoughts may remain hidden, but

the appearance of disability in a family will make the “sin” visible to all. In a close knit society this may lead (one) to rid oneself or (one’s) family of such obvious proof of evil doing (Helander, 1984; cited in Encyclopaedia of Special Education).

In all societies, persons with disabilities (handicapped) have the same social needs as other people. They need to be loved and respected. They need to play and explore the world with other people. They need opportunities to develop and use their bodies and minds to their fullest ability. They need to feel welcome and appreciated by their family and community. However, in many cultures, attitudes of the society towards the handicapped are not given the full chance and wrong without appreciating the right. In developing countries community assume that persons with disabilities are the rejected part of society. They are denied educational opportunity. Disabled children have less opportunity to attend schools than normal children do. The presence of one child with visible and stigmatising disabilities in a family has negative consequences for the marriage of not only the child, but also that of the brother and sister. Disabled people want equal opportunities and full participation in order to enjoy the same rights like all citizens. They are being discriminated, oppressed and exploited because of what they are (WHO, 1980; SAFOD, July 1993).

2.2 The Attitude of Society towards Females with Disabilities in Particular

In developing countries, a woman's status is considered to be subjugated and dependent. When she becomes disabled she loses her status all together as there are often no facilities provided to rehabilitate her in her role. Thus she becomes totally isolated, immobile and confined to the house. It is much more difficult for her than it is for a male with disability to participate in public activities or meetings, unless special efforts are made to help her do so. For her, there is no disability allowance, no environmental adjustment, practically no access to education or training and therefore to employment, and no opportunity to become involved in self-help movements. As far as marriage problem is concerned, the situation of disabled women in developing countries is much more difficult, as marriages are mostly arranged. Stereotyped concepts, prejudices and negative attitude about disability are so deep-rooted that they greatly influence these arrangements. Attitudes and ignorance are particularly virulent where blind women are concerned, no one would readily consider marrying off a blind girl or asking for her hand in marriage. Objects of false pity and mindless charity, blind women are often relegated to the lowest status in the community - they are isolated from society and confined to a corner of house and live in obscurity, silent misery and total social and economic dependency (Boylan, 1998).

The marital opportunities of females with disability are limited. For example, the blind women are downward to in marriage than blind men. This happens due to people's

perception of persons with disability and gender relations, particularly as they are manifested in the roles of a housewife. It is a known fact that mortality among disabled children is much higher than unimpaired children.... Disabled adults have generally lower incomes than able-bodied adults and, consequently, they are more likely to suffer from poverty. Visibly disabled, adult women such as blind are often abandoned by their husbands and deprived of their children (Ingstand and Whyte, 1995).

Sighted men in Uganda perceive blind women as possible sexual partners but not normally as suitable housewives. People's perception of blind (as helpless, useless, vulnerable, and sick) and the culturally determined domestic roles of women are significant factors that determine the nature of such relationships. Because of the functional characteristics attributed to sight, so-called normal people associate loss of sight with lack of physical functions. This has been referred to as spread. Because of it, men envisage only obstacles and lack of coping in everyday life situations of blind woman. In the public sphere of the Uganda household, in which members of the extended family, neighbours, and friends actively take part, participants cannot envisage housewives' roles for blind women. Nevertheless, sighted men and blind women do engage in sexual relationships, which are considered less legitimate and therefore of a lower social status (Sentumbwe, N., in Ingstand and Whyte, 1995: pp. 170-171).

As it is cited in Instand and Whyte (1995), Nayinda in his study towards “Sighted Lovers and Blind Husbands: Experiences of Blind Women in Uganda” pointed out that parents have prejudice towards their blind female children:

“To begin with, not many parents saw the purpose of educating a blind child. They consider it as a waste of money since God had cursed them by giving them a blind child. The blind child had to be kept at home until he or she died a natural death. Also, because of the usual sexist traditional beliefs that men are more important than women, parents are not very keen to help their blind daughters because they are more helpless than the blind boys”.

Concerning to the sexual relationships, he points out that a blind girl will normally not be socially acceptable as a potential housewife:

“Sighted men fear the reactions of others, mostly their relatives, (too much) to get too involved with blind women. For instance, it is difficult for a sighted man to introduce a woman who cannot see to his relatives and friends. He would feel ashamed, as, in our culture, marriage is not a thing between only two persons. Even if a sighted man makes you pregnant, he would not like it to be known that so-and-so has a child with a handicapped woman”

Boylan (1998) pointed out that women with disability suffer not only from the usual discrimination against females but also from further discrimination against their disability. Nevertheless, this double prejudice is the root cause of the inferior status of women with disabilities, making them the world’s most disadvantaged group. It is the cause of hostility and negative attitudes that are often debilitating for disabled woman than the disability itself. Having a disability prejudice, particularly for women in developing countries where the majority of the millions of disabled women can be

found diminishes sharply their often-inferior role, even in their own households. The stigma of disability, with its myths and fears, increases their social isolation.

2.3 Types of Disabilities

There are different types of disabilities that happened to human beings for different reasons. Disability by type include: Motor disorders, Visual impairment, hearing impairment, Mental Retardation, Speech and Language disorders, Behavioral problems, and Multiple disabilities.

With regard to the background information towards persons with disabilities in the case of Ethiopia, the community keeps most of these persons in their home secretly because of social stigmatisation. There is due to a lack of information on the real causes of disabilities. The traditional society at large believes that the causes of disabilities are punishment inflicted by God in relation to their families' sin or disobedience to God. People perceive that persons with disabilities especially those who are females depend on able-bodied persons; they are burden to the community in general and to the parents in particular (EFPD, 2001).

2.3.1 Behavioural Disorders

Types of disabilities that involve substantial personal distress, as indicated by self-deprecating remarks, unrealistic anxieties sadness and depression, or an inability to make friends are examples of behavioural disorders. Other behaviour disorders including aggression bizarre statements or actions, and disruptive rule violations impede the productive performance of others. Behaviour disorders can happen as a result of environmental conflict that refers to aggressive-disruptive, hyperactive, and social maladjustment problems, personal disturbance includes anxiety-depression and social withdrawal problems (Cullinan, Epstein, & Lloyd, 1983: in Haring, et al., 1994).

2.3.2. Mental Retardation

It is another kind of disability that happens to human being for different reasons.

According to the AAMR (1992) manual, mental retardation is defined as follows:

“Mental retardation refers to substantial limitations in present functioning. It is characterised by significantly sub average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests before age 18.” (American Association on Mental Retardation, 1992, p.5).

2.3.3. Communication Disorders

These include speech disorder and language disorders. A speech disorder is an impairment of voice (the absence or abnormal production of vocal quality, pitch, loudness, resonance, and/or duration), articulation of speech sounds and/or fluency (the abnormal flow of verbal expression, characterized by impaired rate and rhythm which may be accompanied by struggle behaviour). Language disorder is the impairment or deviant development of comprehension and/or use of spoken, written, and/or other symbol system.

The disorder may involve (1) the form of language (phonologic, morphologic, and syntactic systems), (2) the content of language (semantic system), and/or (3) the function of language in communication (pragmatic System) in any combination (Haring, et al., 1994, p.352).

2.3.4. Visual Impairment

This can be defined legally and educationally. The **legal** definition involves assessment of visual acuity and field of vision. A legally blind person has visual acuity of 20/200 or less in the better eye even with correction (e.g., eyeglasses) or has a field of vision so narrow that its widest diameter subtends an angular distance no greater than 20 degrees. The fraction 20/200 means that the person sees at 20 feet what a person with normal vision sees at 200 feet. Legally blind individuals qualify for certain legal benefits, such as tax advantages and money for special materials. The **educational** definitions of visual impairment refer to those visually impaired individuals who can read and print, even if they need magnifying devices or large-print books, as having **low vision**.

Society has misconceptions about persons with visual impairment that is they assume that blind people are helpless and dependent. The fact is that with a good attitude and favourable learning experiences a blind person can be as independent and possess as strong a personality as a sighted person (Hallahan & Kauffman, 1991).

2.3.5 Hearing Impairment

This includes persons who have deafness and hard of hearing. **Deafness** has been defined as a sensory deficiency that prevents a person from receiving the stimulus of sound in all or most of its forms and as a condition in which perceivable sounds (including speech) have no meaning for ordinary life purposes. **Hard of Hearing** is when a person has a significant hearing loss that makes some special adaptation necessarily (Katz, Mathis, & Merrill, 1978; Wolfe & Rawlings, 1986: in Heward & Orlansky, PP.252-253).

There are two types of hearing impairment: Conductive and Sensorineural hearing loss. **Conductive Hearing Loss** is the one that reduces the intensity of sound reaching the inner ear, where the auditory nerve begins. To reach the inner ear, sound waves in the air must pass through the external canal of the outer ear to the eardrum, where the vibrations are picked up by series of bone as structure in the middle ear and passed on to the inner ear. The sequence of vibration may be blocked anywhere along the line.

Wax or malformation may block the external canal, the eardrum may be broken or unable to vibrate; the movement of the bones in the middle ear may be obstructed. Any condition hindering the sequence of vibration or preventing them from reaching the auditory nerve may cause a condition loss (Bamford and Suonders, 1994; Gallagher, 1983). **Sensorineural impairment** involves damage to the fine structures in the inner ear or auditory nerve transmitting the impulse to the brain. Sensor neural hearing loss may be complete or partial and may affect some frequencies (especially the high ones) more than others (Bamford and Sounders, 1994).

There is also central auditory disorders which result from damage to the central nervous system, results in problems with auditory comprehension and discrimination (Schulze, Carpenter and Ann, 1991). Conductive hearing loss can be effectively reduced through prompt medical care and by implication of sound when severity of the condition warrants, whereas, sensorineural hearing loss, there is relatively restricted ranges of options for treatments, i.e., they are not medically or surgically treatable and require rehabilitative efforts.

Mixed Hearing Loss when both conductive and sensor neural losses are present, the loss is classified as mixed loss. There may be significant gap between air and bone condition thresholds, but the air condition component of the loss may be resolved.

Many persons with mixed losses can benefit from amplification, although some have problems similar to those of persons with sensorineural losses (Tirussew, 2000).

2.3.6. Leprosy

Disability may be the result of biological factors affecting the individual before birth or the result of natural or manmade causes of damage. Among these factors leprosy is one of the leading cause of disability in the world. Leprosy is a chronic disease that damages the nerve cell around the different parts of the body affecting the motor behaviour both in fine and gross motors. The mutilating effect of the disease generates great fear and horror from people. The disability caused by leprosy affects the individual's social life more than his physical capacity, because of stigma. People in different society have a particular wrong concept of leprosy. The prejudice that is directed to the sufferers of this disease as result of false beliefs and inadequate knowledge about the disease have led to persecution and segregation of these victims. The history of man's inhumanity toward his fellow man with leprosy has been the sad story of misery suffering, ostracism, and rejection (Latapi F. et al., 1980)

The belief that leprosy is transmitted by heredity is deep rooted. Except for few people who had the chance to understand the nature of the diseases from various sources, whatever the educational level of the individual, the belief is that leprosy is transmitted

by heredity. Because of such deep-rooted concepts about leprosy, persons living with leprosy are stigmatised and isolated from all interactions in society. The leprosy-disabled individual, however, faces still another problem. The society believes that: the disease is contagious; the disease is transmitted by heredity. Although the family members of persons disabled by any other cause feel ashamed of and tend to hide the disabled member of the family, these persons are not stigmatised in the society. For example, there are marriage unions between two lovers that have broken because of the late discovery that one of the parents had leprosy. Such serious stigma or segregation affecting not only the disabled but also the family members, are common among the leprosy-disabled individual (ENAP, 2000).

Leprosy is a communicable disease that could be transmitted from an infectious person to a healthy one. However, the mode of transmission is not clear. The authorities in the field, specified three possible ways in which the germ could enter into the body of the healthy person. These possible routes are the skin, the gastro intestinal tract, and respiratory tract (Crochrane, 1964). However, all leprosy sufferers could not transmit the germ because only a certain proportion of patients could communicate the disease in this way. The proportion of victims that can be considered as potentially infectious will not exceed 60% of leprosy patients (Jopling, 1978). Further more, the closed cases bacteriologically negative cases cannot pass the disease to the healthy individual. There is also a consensus among leprologists that children are more susceptible to leprosy

than adults. Accompanying this, Jopling (1978) cited that the child is born healthy, however, he easily contracts the disease from his mother. The societal stigmatisation and the psychological and social stress that follows have grave consequences to the victims as well as the family in social relations such as marriage, schooling work and entertainment.

2.3.7 Motor Disorders

These are disabilities caused by the damage to brain. When the brain is damaged, sensory abilities, cognitive functions, and emotional responsiveness as well as motor performance are usually affected. A very high proportion of children with cerebral palsy are found to have hearing impairments, visual impairments, perceptual disorders, speech defects, behaviour disorders, mental retardation, or some combination of several of these handicapping conditions besides motor disability. They may also exhibit such characteristics as drooling or facial contortions (Heward & Orlansky, 1995).

2.4 The Main Causes for Disability

According to WHO (1980), the term “Disabled Person” means any person unable to ensure by himself or herself; wholly or partly, the necessities of normal individual and/or social life, as a result of a deficiency, either congenital or not, in his/her physical

or mental capabilities. Considering this definition one can imagine that disability has been associated with humanity ever since man started to work for his living. Stories and age-old written scriptures also confirm this. The worldwide concept of the causes of disability, which include polio, leprosy, trachoma, measles, and others, is differently understood in many societies from the scientific explanation. Many societies look at the disabilities as being caused by heredity or from curses and sin.

2.4. 1 Economic Factors

The prevalence of sensory, mental and physical impairment is higher in countries of early stages of economic development than in the industrial part of the world. In most parts of the world, many causes of disability related to poverty. For example: When mothers do not get enough food to eat- during pregnancy, often their babies are born early or underweight. These babies are much more likely to have cerebral palsy, which is one of the most common severe disabilities. Also, some birth defects are related to poor nutrition during the first months of pregnancy (Werner, 1987). It is widely accepted that attitudes towards disability have a major impact, positive or negative, on the lives of people with impairment (Marsh, 1992; Berine et al., 1994; cited in Cherinet, 1999).

2.4.2 Developmental Factors

According to Developmental Disabilities Assistance and Bill Rights Act of 1984

(Public Law 98-527) Developmental Disability is:

A severe chronic disability of a person which (a) is attributable to a mental or physical impairment or combination of mental or physical impairment; (b) is manifested before the person attains age twenty-two; (c) is likely to continue indefinitely; (d) results in substantial limitations in three or more of the following areas of major life activity: (i) self care, (ii) receptive and expressive language, (iii) learning, (iv) mobility, (v) self-direction, (vi) capacity for independent living, (vii) economic self-sufficiency; and (e) reflects the person's need for a combination and sequence of special, inter-disciplinary, or generic care, treatment, or other services which are of lifelong or extend duration and are individually planned and co-ordinate (Haring et al., 1994 p.221).

Developmental classification of the causes of disability describes that it is related to factors that can exist during prenatal, perinatal and postnatal periods. Disability can happen during prenatal period due to inefficient agent: viral (rubella/German measles or AIDS in mother), bacterial (venereal disease in mother), protozoa (toxoplasmosis in mother), anoxia (reduced oxygen to the brain), nutritional, maternal disease (hypertension/pressure in mother and diabetes/sugar in mother), drugs and chemicals. Disability happens in perinatal period because of birth trauma (breech and other abnormal deliveries and forceps delivery) and in postnatal period it can happen as a result of complications of infectious diseases, meningitis, poisoning, head injuries, malnutrition and environmental retardation (Thorburn et al., 1990)

Coleridge (1993) indicated that disability is the developmental issue because it dehumanised on the practical level, disabled people are left out of developmental planning and their voice is not heard in decision-making circles. The traditional model of disability regards disabled people as unfortunate, different, “blemished”. He also pointed out that in most cultures and religions, disability is seen as a punishment or the result of ancestral anger or retribution is divine forces. Such beliefs are not confined to religious regarded in the best as ‘primitive’. Christianity is no exception: where it mentioned in Bible, impairment is linked with being unclean, an outcast, and/or possessed by demons.

Coleridge (1993) cited also the Nazi Euthanasia program saw disabled people as useless, eaters; and as a drain on resources. So under Hitler, in an effort to exterminate disabled people altogether as “imperfections, which contaminate the genetic stream”. In the medieval Germany Martin Luther strongly endorsed the killing of disabled bodies as “incarnations of the devil”, and many centuries before him the Spartans insisted up on it by law for the same reasons as Hitler.

2.4.3 Environmental Factors

Several environmental toxins may have effects on the developing foetus. In particular, generally normal foetus is dependent on his or her mother for both nutrition and elimination of waste of products of metabolism. If the mother is deficient in a crucial nutrient or has been exposed to toxin, the foetus' early intrauterine development may be dramatically altered. AAMD (1973) the term psychosocial disadvantage or cultural-familial retardation that is used today to refer to mental retardation caused by environmental influences (cited in Heward and Orlansky, 1988: p.103).

2.4.4 Infections

In uteri fatal infections: The Transplacental of various, a parasite, or a spirochete (syphilis), especially during the first trimester, may compromise the foetus, causing congenital hearing defecates, mental retardation, and associated speech and language delays. The earlier an infection occurs in the pregnancy, the more profound are the physical abnormalities in the new birth (Butler, 1994).

Heward and Orlansky (1988) pointed out that the causes of mental retardation are referred to as clinical or pathological (brain damage) retardation. These causes have been categorized by the AAMD as:(1) Infection and intoxications (e.g. rubella, syphilis, encephalitis, and meningitis exposure to drugs or poisons, blood group incompatibility); (2) Trauma and physical agent (e.g. accidents before, during, and after

birth; anoxia); (3) Metabolism and nutrition (e.g., phenylketonuria, or PKU); (4) Gross brain disease (such as tumour); (5) Unknown prenatal influence (e.g., hydrocephalus, microcephalus); (6) Chromosomal abnormality (e.g., Cri-du-chat syndrome, Down syndrome, Turner syndrome; (7) Gestational disorders (e.g., prematurely, low birth weight).

2.4.5 Other Different Factors

These include maternal rubella known as German measles that cause deafness, visual impairment, heart disorders and a variety of other serious disabilities when it affects a woman during pregnancy. Hereditary causes, prematurely and complications of pregnancy, meningitis (a bacterial or viral infection), orthopaedic and neurological impairment that involves the nervous system, affecting a person's ability to move, use, feel, or control certain parts of the body, chronic illness and other health-related conditions, accidents and other artificial and natural factors can cause disabilities. The family conditions are other factors that contribute for misconceptions about disabled children. For example, disabled infants and children are frequently characterized by extremes of behaviour, which in turn influence the interactions they have with parents and siblings (Tirussew, 2000).

2.5 Situation of Persons with Disabilities in Ethiopia

Persons with disabilities have for many years been despaired, isolated and discriminated moreover their situation is becoming worse and worse. Discrimination, above all, is a distinguishing mark all disabled persons have been suffering the world over in general and in Ethiopia as developing country in particular.

2.5.1 Prevalence of Disability in Ethiopia

Unfortunately there is no, enough reliable statistical data on the prevalence of disability and the situation of persons with disabilities (PWDs) in Ethiopia. However, there are at least three factors that compel us to accept WHO's estimate. The first is the prevalence of the two major sources of disability-poverty and ignorance. The second is the presence of infectious disease that causes disability. The last factor is the recurring draught, famine and war (EFPD, 2001).

According to (Tirussew et al., 1995) disability by type and its prevalence in Ethiopia was: Motor Disorder (41.2%), Visual Impairment (30.4%), Hearing Impairment (14.9%), Mental Retardation (6.5%), Speech and language Disorder (2.4%), Multiple Disorders (2.0%), and Behavioural Disorder (2.0%).

Savolainen (1997a) pointed out that it is common knowledge that there are a remarkable number of persons with disabilities in Ethiopia. However, the exact number of persons with disabilities is not known, although some estimates exist. It is very difficult to get the exact and reliable information because of two major reasons. Firstly, definition of disability is not exact, but vary among different studies. In fact it is not easy at all to define disability exactly because disability is and must be understood as relative issue. A person with impairment is regarded as disabled only when he/she cannot fulfil the requirement set by the environment. And willingness and capability of different environments or communities to facilitate for the needs of impaired persons vary. Thus, not only the physical or psychological characteristics of an individual but also the natures of his or her environment define how disabled one is. Secondly, getting accurate information on number of persons with disabilities is difficult in a country as large as Ethiopia. No ongoing records with full coverage of persons exist. Even the census has been carried out with ten-year interval, although both 1984 and 1994 census included data collection on disabilities based on sample of the whole population. But getting accurate data on disabilities in large surveys like the census and some other surveys carried out recently (e.g. RAD & CSA, 1996) is difficult, because data is collected from households by surveyors that do not have or very little training on disabilities. It is impossible to obtain such data by using such personal in surveys that are on the other hand covering and well representative of the whole country. Therefore the most any large surveys with relatively uneducated surveyors can reach is a crude

picture of the number of what could be called “obvious” disabilities (blindness, deafness, physical disabilities or clear motor disorders, some disabling chronic illnesses and moderate or severe mental retardation).

Keeping this reservation in mind it can, however, be estimated that the prevalence of these “obvious” disabilities in today’s Ethiopia is somewhere around 3% of the whole population. Some major studies carried out have ended up with figures very close to each other. The 1984 Population and Housing Census estimated the prevalence to be 3.61%, the focused-baseline survey of persons with disabilities in Ethiopia, which was the first of its kind in the country, revealed that the prevalence of disability is about 2.95% (Tirussew et al., 1995) and the aggregate estimate of Socio Economic Survey on Disabled Population, in the 1994 Census, of the 10 regions of the country indicated that there were 953,534 persons with disabilities (Seme and Melaku, 1997).

In general we can say, that we have some estimates of the number of persons with obvious disabilities in Ethiopia and their problems, but the scope of actual problems what all persons with disabilities face their everyday living is not fully understood. Abu-Habib (1997) mentioned that women with disability indeed doubly marginalized by their communities and organisations at the national and international levels. It is further cited that it is necessary and relevant to research and work on issues of gender and disability, because women with disability are indeed worse off than their able-

bodied sisters are. This is a gender-based phenomenon considered as “double disability” created by socio-cultural, attitudinal barriers and other confounded factors deep-rooted in the social system. In other words, women with disabilities may not have equal right and privilege to enjoy the meagre resources available likes that of the male disabled. Moreover, their role in different spheres of life such as in the socio-cultural, political affairs, sports and in the decision making process is relatively low or non-existent

Fellow (1993) pointed out that it is also assumed to be true that women with disabilities are stricken by male domination, prejudiced educational and hiring treatments in education and in hiring as well as role discrimination. Generally the circumstance of persons with disabilities in Ethiopia, especially women are extremely daunting and worse. To a greater extent, they are the most misunderstood, marginalized and excluded from the mainstream and constitute the poorest of the poor in the society. They earn their livelihood either through looking for alms or charity or being life-long dependent on their parents and relatives (cited in Tirussew’s study on Gender perspective of Disability in Ethiopia, 1999).

Having a disability is still considered shameful, and persons with disability are stigmatised and excluded from community life in many places in Ethiopia (Teklehaimanot et al., 1991; Tirussew et al., 1995).

2.5.2. Types of Disabilities and number of Persons in Ethiopia

There are many persons in Ethiopia who have different types of disabilities. According to CSA, 1998 Report of Population by Disability Status indicates the number of persons with disabilities as follows:

Table 1: *Number of Persons with Disabilities in Ethiopia in different Regions.*

Region	All Persons in the Region	Persons with Disabilities
Oromia	18,465,449	333,653
Amhara	13,828,909	281,291
Benishangul-Gumuez	460,325	7,341
Tigray	3,134,470	90,742
Dire Dawa	248,549	4,226
Gambella	162,271	2,581
SNNPR	10,368,576	174,941
Addis Ababa	2,100,031	45,936
Afar	1,051,642	13,546
Harai	130,691	2,909
Somali	3,144,968	31,686
Total	53,095,881	988,852

In general some estimates of the of persons with obvious disabilities in Ethiopia and their problems, but the scope of actual problems what all persons with disabilities face in their every day living is not yet perhaps fully understood.

2.6 National Laws and Policies towards Disability in Ethiopia.

Ethiopia has started developing its national policies and laws focusing on disabilities quite late. For instance, there was no health policy till the late 1950s. Similarly, the Developmental Social Welfare Policy was issued in 1990s (*cited in MOLSA, FDRE, 1996*).

The first official material that addresses the issue of social welfare in Ethiopia is the 1958/9 decrees that officially established by the “ Ministry of Social Welfare and Social Affairs”. With the establishment of the Minister for the Developmental Social Welfare Policy is the first policy material in the country that justifiably addressed the need in developing policy direction in the relation with social welfare. The policy in 1996 has clearly indicated that disability is “ one of the social problems prevalent” in the country.

Regarding the National Laws, the New Constitution, developed in 1995, in its Article 41 Sub-Article 5 has included a provision that directly addresses the issue of the disabled. In article 41 No.5, it is indicated, “ the state shall, within available means, allocate resources to provide rehabilitation and assistance to the physically and mentally disabled...”. With regards to the Rights of the Disabled to Employment

Opportunities, “*The Rights of Disabled Persons to Employment Proclamation No. 101/1994*” emphasises the fact that there are “ Many people suffering from disability” and that these people “have got less job opportunity” and it has become imperative to “stop such discriminations and protect the rights of disabled persons to compete for and get employment on the basis of their qualification...”

With regard to the Education and training Policy, it is indicated that the policy ensuring the need in cultivating the potentials of people with disabilities, has indicated that one of the general objectives is to “*cultivate the cognitive, creative, productive and appreciative potential of citizens by appropriately relating education to environmental and societal needs*”. The policy under its specific objectives focuses on the need of the disabled; thus, in No. 2.2.3 it is stated “*To enable both the handicapped and the gifted learn in accordance with potential and needs*”.

In this line of developmental, the policy, owing to the special developmental needs of PsD, has noted the “*curriculum developed and textbooks prepared (shall be) based on sound pedagogical and psychological principles and are up to international standard, giving due attention to concrete local conditions...*”(MOE, 1994).

The problem of persons with disabilities is the disabling attitudes of people and environment. Secondly, it is the inability to function in the ‘accepted way’ due to their

impairments. When the individual disabled person has loss of function, dependency on others is inevitable. The dependency created by limited function will eventually put the person with disability in a status where he/she cannot earn a living. He/she will be considered only as a consumer i.e. (he /she receives as distance to move, to be created when sick, to be fed, etc. by others members of the family; all of which condition depletion of resources without a replenishing of the family's resource). The assistance given over a long period of time, be it in time or finance, will negatively affect the psychosocial ties between the one being cared for the case givers "Parents complained about their own fatigue from lifting feeling, dressing, bathing and toiling their child. The great amount of time required in such care usually overburdens mothers". (Speck and O.Lerrigo, 1964:34; cited Tigabu, G.1997).

Despite the attitudes and practices, the societies could not avoid the presence of persons with disabilities, because accidents, wars, communicable diseases, malnutrition and ageing cause a majority of disables throughout a normal life span. Charity and "poor house" approaches were designed to remove the persons with disabilities from sight of the community and give care in an isolated manner. Although, great majorities of PWDs have lived in their family and in their community, gradually care for PWDs was institutionalised, many of PWDs were brought together into the same compound to live under charity. They were segregated and confined to a limited space in order to be cared for by religious organisations, public services, and later on, by governments.

Gradually, the segregated institutions for the PWDs provided improved, professional rehabilitation services thinking that the beneficiaries abilities and skills will develop as skills developed, the disabled would be able to lead an independent life (Tigabu G, 1997).

Southern Nations, Nationalities and People’s Region is one of the Regional States of Ethiopia where about forty-five different ethnic groups who reside in 12 zone and 7 special woredas administrations with the total population 10,368,576. Out of these total populations in the region, 174,941 were persons with disabilities (CSA, 1994). Wolayitta is one of the zonal administrations in the Southern Nations and Nationalities and People’s Region where there is no statistical data that indicates the number and sex of persons with disabilities and their types. According to Zone Planning and Economic Development, 1994 E.C report there are seven woredas, 294 kebeles (273 rural and 21 urban) with the total population of 1,406,628. Even if Wolayita is the densely populated area in the country there is no real data that indicates the number of persons with disabilities and their type. However, within the ethnic group there are persons with different disabilities and people have different attitudes towards persons with disabilities in general and females with disabilities in particular.

Table 2: *Number of Population, Sex and Residence in each Woreda of Wolayitta zone*

Name of Woreda	Sex	R e s i d e n c e
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y	Male	Female	Total	Rural	Urban	Total
Boloso-Sore	147,442	153,700	301,142	40	4	44
Damot-Gale	129,026	132,868	261,894	51	3	54
Damot-Woyide	88,733	90,704	179,437	51	1	52
Humbo	57,929	57,999	115,928	35	1	36
Kindo-Koyisha	83,849	84,844	168,693	37	1	38
Offa	66,298	67,272	133,570	25	1	26
Soddo-Zuria	122,384	123,580	245,964	34	10	44
Total	695,661	710,967	1,406,628	273	21	294

** Source: Zonal Planning and Economic Development Department, 1994 E.C Statistical Report.*

CHAPTER THREE

3. METHODOLOGY

3.1 Study Design

The study employed both quantitative and qualitative instruments to examine the attitude of community towards females with disabilities in SNNPR in Wolayitta Zone. Primary data collection activities were undertaken to provide information on types disabilities and attitude towards disabilities in general and females with disabilities in particular. These included individual interviews and focus group discussions. A broad cross-section of Wolayitta ethnic group members and Wolayitta language speaking population were reached and participated in data collection activities. The survey included both rural and urban areas. A rural community situated within 20 kilometres of the selected Woreda town was chosen randomly and included in the study. Both primary and secondary sources were used.

3.2 Study Populations and Selection of the Participants

The study has included population of the two woredas of Wolayitta zone, namely Damot Gale and Soddo Zuria. Three kebeles from each woreda a total of six were randomly selected and used for the study. From the randomly selected six kebeles three were from urban and the other three were from rural areas. A total of 400 subjects, 200 from each woreda were chosen systematically and included in the study.

Respondents aged from 20-60 years were identified and used for interviews in each of the six sites. Both male and female respondents were targeted for each data collection activity, as shown in Table 3. A broad-spectrum population by age, residence (rural vs urban), marital status, religion, educational levels, occupation and ability to provide useful information about themselves and their attitudes towards disabilities in general and females with disabilities in particular were included. The population is homogeneous in ethnicity and the number of house holds in each selected site identified from the kebele / PA offices and the subjects were distributed proportionally to the number of HHs in each site and one individual was selected randomly from one household.

3.3 Selection of Study Sites

A protocol visit was made to Wolayitta zone administration and two of the woredas of Wolayitta zone were randomly selected. People are homogeneous in their ethnicity and there is no socio-culture variation within the community. After the selection of the woredas, official letters were maintained to both woredas. In each woreda administration there are lists of urban kebeles and rural PAs. From these kebeles/PAs the study sites were randomly selected. In both urban and rural areas, there are lists of kebeles/PAs. In urban areas from all kebeles the sites were randomly selected. In the case of rural areas, from PAs that are found within 20 kilometres radius were selected

randomly and official letters were given to each of the selected kebeles/PAs administration to secure permission to conduct the research study. Then a contact was made with the officials of the selected six (6) study sites, three urban and rural areas in both Woredas.

In all randomly selected urban and rural kebeles/PAs there are 5-9 sub-kebeles, which is called "sucha" in Wollayitta language, are clustered. From clustered sub-kebeles (shucha) one was selected randomly in each kebele/PA and a household list was made for that sub-kebele (shucha) before conducting the study. It is assumed that 6% of the targeted population are living in each sub-kebeles (shucha). After listing the households in each randomly selected sub-kebele (shucha), the systematic sampling technique was used to collect the data.

Table 3: *Study Woredas, Kebeles/ PAs and Number of Population in the Study Sites*

<i>Name of Woreda</i>	<i>Name of selected kebeles/PAs</i>	<i>Residence</i>	<i>Number of Population in Kebele/PA</i>			<i>No of HHs</i>	<i>Targeted Pop.</i>
			<i>Male</i>	<i>Female</i>	<i>Total</i>		

<i>Damot-Gale</i>	<i>Bodditti 02</i>	<i>urban</i>	<i>3366</i>	<i>3660</i>	<i>7026</i>	<i>1250</i>	<i>75</i>
	<i>Warbira-Suqqe</i>	<i>rural</i>	<i>3441</i>	<i>3499</i>	<i>6940</i>	<i>1250</i>	<i>75</i>
	<i>Adde-Shantto</i>	<i>rural</i>	<i>2495</i>	<i>2527</i>	<i>5022</i>	<i>834</i>	<i>50</i>
<i>Soddo-Zuria</i>	<i>Higher 1-Kebele 02</i>	<i>urban</i>	<i>4875</i>	<i>5475</i>	<i>10350</i>	<i>1334</i>	<i>80</i>
	<i>Higher 2-Kebele 03</i>	<i>urban</i>	<i>3373</i>	<i>2703</i>	<i>6076</i>	<i>1200</i>	<i>72</i>
	<i>Dalbo-Atiwaro</i>	<i>rural</i>	<i>2051</i>	<i>2081</i>	<i>4132</i>	<i>800</i>	<i>48</i>
<i>Total</i>		<i>urban+rural</i>	<i>19601</i>	<i>19945</i>	<i>39546</i>	<i>6668</i>	<i>400</i>

Source: Urban kebeles and Rural PAs Offices report 1994 E.C.

3.4 Study Instruments

The main data collection instruments are four types, which are categorized into two groups: the quantitative and qualitative instruments.

3.4.1 Quantitative Instruments

A. Structured Questionnaire: - This was focusing mainly on attitude measuring scale. It has three sections: section one focuses on the demographic characteristics of the respondents, section two measures the respondents' knowledge and information towards disabilities, and section three obtains ideas by using a three point attitude scale, with a continuum "*Disagree*", "*uncertain*" "*Agree*", and to measure the attitude of

respondents towards females with disabilities. This measuring scale consists of 20 items and the participants were asked to indicate the extent of their agreement with each statement using a three-point attitude scale. The given scale values were, 1=disagree, 2= uncertain, 3= agree to the stated items.

3.4.2 Qualitative Instruments

To confirm the quantitative result obtained through structured questionnaire, qualitative instruments (In-depth Key Informant Interview, Focus Group Discussion and Case Study) were used.

A. Key Informant Interview:- Before starting the data collection exercise a researcher worked with local officials (kebele leaders) to identify people who were knowledgeable about the local area in terms of cultural practices or beliefs. Semi-structured interviews, which consist open-close ended items, were conducted with influential people in each kebele. These were selected from among: Kebele officials (Local administration members), Traditional leaders (Respected elders within the community), Civic organization representatives (Women and Youth Association members), NGOs workers, Religious leaders, Male/female persons with disabilities, and Teachers.

The researcher identified three key informants within each study site. The key informant interviews were distributed across the kebele. Thus, per study site, three key informant interviews were completed. Effort was made to interview one person from each of the groups mentioned above.

B. Focus Group Discussion:- Two Focus group discussions were conducted in two woredas. One was with able-bodied males in woreda one because mostly males have negative attitude towards FWDs. SO to dig out and know the of males' attitude particularly. The other was with females with disabilities particularly those who have leprosy and engage in begging activities near around churches and market places in woreda two. Before conducting the discussion the following points were explained:

- ◆ About the purpose of the study,
- ◆ The study confidentiality, and about
- ◆ The voluntary nature of their participation during the focus group discussion.

The Focus group participants consisted 8-9 persons who are members of Wolayitta ethnicity and speak the wolayitta language where the study was conducted. In the Focus groups the researcher acted as a moderator and assisted by a note taker who speak the Wolayitta language fluently. A tape recorder was used to record all discussions. Almost two hours were used for each session to discuss on issues pertaining to the attitude towards females with disabilities. Focus group interviews were audio taped. After the

Focus group discussion was finished, the researcher and the note taker reviewed the tape-recorded notes and made reasonable summary of the focus group discussion that is very useful for data analysis.

C. Case Studies: - Two case studies were conducted with females with disabilities. One case study was conducted with a female who has a motor disability in Woreda two and the second case was conducted with a girl who has multiple disabilities (Motor disorder, communication disorder and mild mental retardation) in Woreda one.

3.5 Validation of the Instrument

Before applying the instrument to the main study a pilot study was conducted in Addis Ababa in Woreda 14, Kebeles 21 and 22 (Old Kera) where Wolayitta ethnic group members are living and in Addis Ababa University Sidist kilo campus with Wolayitta ethnic group students to improve the reliability and content of the instrument.

The total number of participants used in the tryout study was 30 (M=17, F=13), that is 3 Visually impaired males, 4 females with disabilities (2 with motor disorders and 2 visually impaired), 14 able-bodied males and 9 able-bodied females were included in the pilot study. After administering the instrument, some participants were asked for feedback and hence unclear items were modified accordingly to minimise item

ambiguity. To examine attitude of society towards females with disabilities in this try out study a Likert-type Five-Point Scale ranging from *strongly disagree* to *strongly agree* was used. During this pilot study it was observed and identified that those respondents who were illiterate and with lower education were confused to differentiate between *strongly disagree* and *disagree*, and also between *strongly agree* and *agree*. Therefore, for the main study the instrument for attitude measuring scale minimized from five-point scale to the three point scale ranging from *disagree* to *agree* (disagree, uncertain and agree). The scale was composed of 20 items/statements 10 with positive and 10 with negative concepts.

On the basis of the given responses, the internal consistency of items was tested by using a split half method (by applying Pearson product Moment correlation coefficient formula and then the Spearman Brown formula) was used to check the reliability of the full length of the measuring attitude scale.

The obtained result from the tryout study showing the internal consistency of the odd and even items among subjects was found 0.81. The reliability of the attitude scale was found 0.87. The validity of the instrument was confirmed through content validity as evaluated by professionals, psychometricians, and special education experts on disability issues. Thus, the instrument was found valuable to collect the data for the

main study and hence it was administered as scheduled. The obtained data in the main study was tabulated and organised for further analysis.

3.6. Recruitment and Training of Field Staff

The field staffs were composed of the researcher (coordinator), one note taker/supervisor, 6 interviewers (4 males and 2 females). The interviewers were recruited from those who completed 12th grade and elementary school teachers who have graduated from 12+TTI. They were also those who speak and write the local language and who participated in different data collecting activities and have experiences in supervision of large-scale socio-economic surveys. One day training was given to the interviewers and supervisor/note taker. The training was given in the classroom on interview techniques and on how to complete the questionnaire and establish rapport with the interviewees. During the training mock interview was carried out to exercise the fieldwork.

CHAPTER FOUR

4. ANALYSES AND DISCUSSION OF THE FINDINGS

The results of the study are presented in two sections. Section one is findings of quantitative study and section two is findings of qualitative study.

4.1 Findings of Quantitative Study

The results of quantitative survey have been mostly presented by using tables, percentages, means scores, and chi-square that refer to all variables collected in the questionnaire. An attempt was made in this study to know the level of information, knowledge and awareness of community towards persons with disabilities in general and females with disabilities in particular. And an attempt also has been made to examine the attitudes of community in Wolayitta ethnic group towards females with disabilities.

Questions consisting of 14 items were used to gather the information and to measure the level of knowledge and awareness towards disabilities. Questions consisting of 20 items of a three-point attitude scale were used to investigate the attitude of community towards disability. These were administered to a total of 400 subjects in two woredas of the study area.

4.1.1 Background Profile of the Respondents

The demographic characteristics of the respondents are presented as follows.

Table 4: Sex and Age of Respondents

<i>Sex</i>	<i>N</i>	<i>%</i>	<i>Ten year age group</i>			
<i>Male</i>	<i>216</i>	<i>54</i>		<i>20-29</i>	<i>83</i>	<i>20.8</i>
<i>Female</i>	<i>184</i>	<i>46</i>		<i>30-39</i>	<i>161</i>	<i>40.3</i>
<i>Total</i>	<i>400</i>	<i>100</i>		<i>49-49</i>	<i>117</i>	<i>29.3</i>
				<i>50-59</i>	<i>31</i>	<i>7.8</i>
				<i>60</i>	<i>8</i>	<i>2.0</i>
				<i>Total</i>	<i>400</i>	<i>100.0</i>

The obtained result shows that, 216 (54%) were male respondents and 184 (46%) were female respondents and with respect to the age of respondents it ranges from 20-60 years, with a mean of 37.05 years. In general, the age of 61% of the respondents was between 20-39 years and 39% of the respondents' age was between 40-60 years.

In terms of ethnicity and language all of 400 (100%) subjects were members of Wolayitta ethnic group and Wolayitta language speakers as their mother tongue. Out of 400 participants 262 (67%) speak Amharic as their second language, and 98 (24.5%) speak different languages as their third language.

Table 5: Religion and Marital Status of the Respondents.

Religion	N	%		Marital Status	N	%
Orthodox	124	31.0		Married	316	79.0
Muslim	9	2.3		Single (Unmarried)	54	13.5
Protestant	232	58.0		Divorced	8	2.0
Catholic	28	28.0		Widowed	22	5.5
Others	7	7.0		Total	400	100.0
Total	400	1.8				

In table 5 it is shown that concerning the religion of the respondents: 232 (58%) were Protestants; 124 (31%) were Orthodox; 28 (7%) were Catholic; 9 (2.3%) were Muslim and 7 (1.8%) were other different religion followers. Here the conclusion indicates that Protestant religion is the dominating religion in the study woredas. Concerning the marital status of the respondents: 316 (79%) were married, 54 (13.5%) were single (unmarried), 22 (5.5%) were widowed and 8 (2%) were divorced.

Table 6: Educational Level and Occupation of Respondents

Educational Level	N	%		Occupation	N	%
Illiterate	90	22.5		No Working	26	6.5
Read and Write	53	13.3		Farmer	67	16.8
Primary (1-8)	91	22.8		House Wife	130	32.5
Secondary (9-12)	112	28.0		Merchant	42	10.5
Higher Education	47	11.8		Student	20	5.0
Technical School	7	1.8		Civil Servant	111	27.8
Total	400	100.0		Others	4	1.0
				Total	400	100.0

Regarding the educational background of the respondents: out of 400 respondents 90 (22.5%) were illiterate, 53 (13.3%) were who can read and write, 91 (22.8%) were at

elementary school educational level (grades 1-8), 112 (28%) were secondary education level (grades 9-12), and 54 (12.6%) were technical and higher education grade level educated persons. Concerning the occupation of the respondents: out of 400 subjects 197 (49.3%) were farmers and housewives, , 42 (10.5%) were merchants, 26 (11.5%) were unemployed, 20 (5%) were students and 115 (28.8%) were civil servants and others.

4.1.2 Information, Knowledge and Awareness towards Disability

As mentioned in the earlier sections of this study, there were misconceptions or lack of information about disability, which widely prevail in all levels of society in most parts of the world. In this study it was intended to know the information, knowledge and level of awareness towards females with disabilities among the Wolayitta ethnic group. Thus the community’s level of information, knowledge and awareness was tested by providing some questions about types of disabilities. From the total subjects used in this study, 389 (97.3%) of the respondents pointed out that they know somebody male or female who has disability within the community. As tested in this study out of 400 subjects for each item the respondents reported the following types disabilities.

Table 7: Types of Disabilities reported by Respondents

Types of Disabilities	N	%
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Visual Impairment	359	89.8
Hearing Impairment	321	80.3
Motor disorder	301	75.3
Leprosy	296	74.0
Language/Communication disorder (Dumb)	291	72.8
Hearing Impairment and Language Disorder	267	66.8
Mentally Retarded	223	55.8
Behavioural Problems	206	51.5

As shown on table 7, the respondents specifically reported that they know persons with different types disabilities within the community. 359 (89.8%) reported that they know persons who has visual impairment; 321 (80.3%) pointed out that they knew persons with hearing impairment; 301 (75.3%) mentioned that they knew persons with motor disorders; 296 (74%) reported that they knew persons with leprosy; 291 (72.8%) reported that they knew person who have language or communication disorders; 267 (66.8%) mentioned that they knew persons with hearing impairment and language disorders; 223 (55.8%) pointed out that they knew persons with mental retardation; and 206 (51.5%) reported that they knew persons who have behavioural problems. The conclusion shows the society in Wolayitta ethnic group has information, knowledge and awareness towards types of disabilities.

Even if there is no statistical data that gives the number of persons with disabilities in Wolayitta zone, in this study it was intended to estimate the number of persons with disabilities in Wolayitta zone. Considering the information given by the respondents the

researcher has tried to estimate the number of persons with disabilities in Wolayitta zone. The estimation was based on the majority of the respondents 216 (54%) were reported that the number of persons with disabilities in each kebele would be about 100 and above. Therefore, based on the estimation given by the respondents it was estimated that the number of persons with disabilities would be about 29,400 (294 urban and rural kebeles multiplied by 100 persons per kebele).

Still in measuring the level of information, knowledge, and awareness towards females with disabilities in Wolayitta ethnic group an item that says “*Whose disability is the worst, males with disabilities or females with disabilities?*”. The conclusion shows that 226 (56.5%) of the respondents mentioned female’s disability is the worst compared to male’s disability.

Regarding traditional beliefs towards disability, Savolainen (1997b) pointed out that, people consider disability is a result of divine punishment and can be transmitted to the next generation of a family. Because of these people fear, shame and avoid persons with disabilities and left alone or hide them away from the eyes of able-bodied persons. In this study it was tested the society attitude towards disability that it can be communicable or transmitted by heredity and physical contact and in identifying which type (s) of disability (ies) can be communicable /transmitted by heredity and physical contact.

Table 8: Responses to disabilities can be communicable \transmitted by heredity &Physical contact

Types of disability that can be communicable and transmitted by heredity .	N	%
Leprosy	314	78.5
Mental Retardation	90	22.5
Language Disorder	52	13.0
Visual Impairment	37	9.3
Hearing Impairment	33	8.3
All kinds of disabilities	6	1.5

The obtained result on table 8 shows that; 322 (80.5%) of the respondents reported that disability could be communicable and transmitted by heredity and physical contact. Regarding types of disability that can be communicable or transmitted: 314 (78.5%) of the respondents reported leprosy; 90 (22.5%) respondents reported mental retardation; 52 (13%) reported language disorder; 37 (9.3%) reported visual impairment; 33 (8.3%) reported hearing impairment; and 6 (1.5%) reported all kinds of disabilities can be communicable and transmitted by heredity and physical contact.

The conclusion shows that there is a gap towards information and knowledge to community in Wolayitta ethnic group towards disability and types of disabilities that can be transmitted and communicable from person to person. 80.5% the respondents reported that disability can be transmitted and communicable from person to person. 78.5% of the respondents reported that leprosy at large is a communicable disability

from person to person. In the previous studies it was reported by (Crochrane, 1964) that Leprosy is a communicable disease that could be transmitted from and infectious person to healthy one. Here the conclusion implies that community has lack of information, knowledge and awareness in identifying types of disabilities that can be communicable and transmitted. So it needs the intervention of others who are knowledgeable towards the issue to make the community aware towards disability.

In relation to the level of awareness and knowledge towards females with disabilities, an attempt was made that subjects indicate some factors that contribute to disability in general. In previous studies it was mentioned that disability could happen as result of biological factors, economical factors, developmental factors, environmental factors, infections, and other different factors (WHO, 1980; Werner, 1987; Thorburn, 1990; Heward and Orlansky, 1988).

In this study an attempt was made to measure the community’s knowledge in relation to the causes of disabilities. For an item that says, “How disability can happen to somebody?”. The following table shows the number and percentage of respondents towards causes of disability.

Table 9: Causes of Disability as mentioned by Respondents

Causes of Disability as Reported by Respondents	N	%
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Accidents	377	94.3
Small pox and Polio	327	81.8
Carelessness to prevention of disabilities	266	66.5
By Nature For unknown Reasons	263	65.8
Inherited from Parents	259	64.8
Wage of curse and calamity	230	57.5
By joking on and ignoring other person with disabilities	209	52.3
Mother and father make sin or disobeying the will of God	198	49.5
Drug and alcohol abuse and smoking	163	40.8

As it is indicated on the table above: 377 (94.3%) of the respondents reported that disability can happen due to accidents; 327 (81.8%) reported that disability happens because of smallpox and polio; 266 (66.5%) mentioned that it can happen due to persons' carelessness towards preventing disabilities; 263 (65.8%) reported that disability can happen because of nature for unknown reasons; 259 (64.8%) stated that it can be inherited from parents; 230 (57.5%) reported it can happen because of wage of curse and calamity; 209 (52.3%) mentioned that it can happen by joking on and ignoring other persons with disabilities; 198 (49.5%) mentioned that disability happens due to the sin of mother and father or displeasing the wills of God; 163 (40.8%) reported it can happen due to drug and alcohol abuse and smoking. The finding indicates that people have mentioned different reasons that how disability can happen to somebody. Therefore, the conclusion is that community has information, knowledge and awareness towards disability and its causes.

Still to know the level of information, knowledge and awareness towards females with disabilities' to the community in Wolayitta ethnic group, the statements were presented about possibilities of preventing the occurrences of disabilities and willingness to take care of females with disabilities. The items were: *“Is it possible to prevent disability; Are you willing to take care of a female with disability who is your friend, relative or family member?”* The obtained results indicate that: 268 (67%) of the respondents mentioned that it is possible to prevent the occurrences of disabilities and 344 (86%) reported that they are willing to take care of a female with disability if she is a friend or a family member. So the result shows that some community are aware of preventing disability and they are willing to take responsibilities of females with disabilities.

4.1. 3 Attitudes of Community towards Females with Disabilities

In different ethnic groups community perceive persons with disabilities in general and females with disabilities in particular in different ways. In this study an attempt was made to measure the perceptions of community towards females with disabilities in Wolayitta ethnic group. Out of 400 subjects used in this study the following results were found as indicated to each item by the respondents.

Table 10: *How Females with Disabilities are perceived by the society.*

How females with Disabilities are perceived	N	%
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Seen as sick persons	243	60.8
Perceived as unproductive and useless persons	232	58.0
Dependents and burden to parents and community	259	64.8
Seen equally like other human beings those who can be trainable, educable and productive	81	20.3

As the respondents mentioned, in Wolayitta ethnic group females with disabilities are seen as sick persons, useless and unproductive persons, dependents on other able-bodied persons and burden to the community and as well as to the parents. Very few respondents reported that FWDs are equal with other human beings and perceive them as those who can work and produce, and who can be trainable and educable.

As shown on the table above 243 (60.8%) of the respondents reported that persons with disabilities are seen as sick persons; 232 (58.0%) reported that females with disabilities are useless and unproductive persons; 259 (64.8%) reported that with females disabilities are dependants and burden to the community and as well as to the parents. 81 (20.3%) reported that with females disabilities are equal with other human beings and perceive them as those who can work and produce, and who can be trainable and educable.

To measure the community's perceptions towards females with disabilities the statement was presented as follows: *“Do people in Wolayitta ethnic group hide females with disabilities at home not to be seen by others?”* was presented. The obtained results

indicates that, 256 (64%) of the participants mentioned that it is true that people in the Wolayitta ethnic group hide females with disabilities not to be seen by others. This is done because society believes it is shameful having such persons to a family. Besides this 345 (86.3%) respondents reported that in previous times' people killed or buried alive when a female with disability was born to the family. Not only disabled female child, but also they killed or buried alive when an able-bodied female was born at first or at last to parents. This was because a female child was not valued within the society. This feeling still exists in some area in the rural society.

On the other hand to measure the attitude of community, subjects were asked to express their feeling regarding taking responsibilities of females with disabilities. The obtained result shows that: 355 (88.8%) respondents reported that parents are more responsible for their female children than males with disabilities; 327 (81.8%) reported government; 287 (71.8%) reported community as a whole; 275 (68.8%) reported the relatives; 236 (59.0%) reported Non-Governmental Organisations (NGOs); 229 (57.3%) reported Civic Organisations; 221 (55.3%) reported Humanitarian Organisations; 179 (44.8%) some individuals; 177 (44.3%) reported persons with disabilities themselves should be responsible. In contrary, very few 24 (6%) of the respondents said that females with disabilities are useless, therefore, they should be disappeared. The result indicates that community is aware in taking responsibilities of females with disabilities, but very few people due to poor knowledge and lack of

awareness towards disability and lack of capacity to take care of females with disabilities reported their negative attitude towards females with disabilities.

As far as marriage is concerned, making marriage with females with disabilities is for able-bodied males is shameful and is seen inferior in Wolayitta culture. In this study the obtained result indicates that, 312 (78%) of the respondents mentioned that if an able-bodied male loves a female with disability he would marry her. But some others see this approach as shameful to an able-bodied male. The result also indicates that mostly those females with disabilities make marriage with males with disabilities in Wolayitta.

4.1.4 Responses of the Respondents on Attitude Scale Items

On the basis of the respondents’ reaction to each of specific item in the attitude scale, percentages and mean scores were computed in order to describe the position of the respondents along the continuum in their attitude towards females with disabilities within the Wolayitta ethnic group. In the following table the summarised findings of the respondents on the attitude scale items are shown in terms of frequency, percentage, mean score.

Table 11: *Summarized Results of Attitude Scale in terms of Frequency, Percentage, and Mean Score*

No	Statements	1	2	3	Mean
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		Disagree		Uncertain				
		N	%	N	%	N	%	
1	Persons with disabilities particularly females cannot be trainable, and cannot perform what able-bodied persons do.	239	59.8	17	4.3	144	36.0	1.76
2	Females with disability are useless and unproductive	281	70.0	37	9.3	82	20.5	1.50
3	It is much more difficult for females with disabilities than males with disabilities to participate in public activities or meetings in Wolayitta culture.	97	24.3	29	7.3	274	68.5	2.44
4	Females with disabilities are dependent on others; they are burden to the community and beggars when compared to males with disabilities.	62	15.5	20	5.0	318	79.5	2.64
5	A female with disability gives a birth to a child with disability	338	84.5	39	9.8	23	5.8	1.21
6	In Wolayitta culture it is shameful to an able-bodied male to marry a female with disability because his relatives/parents and friends neglect or isolate him.	64	16.0	32	8.0	303	75.8	2.60
7	Because of their disabilities' females with disabilities are aggressive/harsh when we compare them to able-bodied females.	68	17.0	27	6.8	305	76.3	2.59
8	A blind woman can give a birth to a sighted child.	72	18.0	14	3.5	314	78.5	2.61
9	Females with disabilities in Wolayitta ethnic group are highly discriminated and segregated socially.	194	48.4	26	6.5	180	44.9	1.97
10	Females with disabilities should not be employed in any organisation because they cannot perform as well as able-bodied females can do.	238	59.5	40	10.0	122	30.5	1.71

No	Statements	1	2	3	Mean
11	A female female who has leprosy in the				

	culture of Wolayitta has great problem to marry an able-bodied male	47	11.8	34	8.5	319	79.8	2.68
12	Females with disabilities cannot be educated.	299	74.8	24	6.0	76	19.0	1.47
13	It is preferable having a male child with disability rather than having a female child with disability because female is weak by nature and she is burden mostly to her parents.	126	31.5	22	5.5	252	63.0	2.32
14	Females with disabilities should not be at the same school if the opportunities are provided to children with disabilities to be educated because the attitude of other able-bodied children in the school is negative towards them and they can develop psychological failure.	159	39.8	56	14.0	184	46.0	2.06
15	In Wolayitta culture females with disabilities marry mostly males with disabilities.	79	19.8	35	8.8	286	71.5	2.52
16	A deaf woman can give a birth to a deaf child because deafness is a hereditary problem that comes from mother to child.	335	93.8	35	8.8	29	7.3	1.23
17	Mentally retarded female can give a birth to a mentally retarded child because mental retardation is a disability that can be transmitted from mother to child.	279	69.8	59	14.8	62	15.5	1.46
18	Females with disabilities can perform all activities that able-bodied females can do and they can carry all their home responsibilities.	159	39.8	40	10.0	200	50.0	2.10
19	A woman who has motor disability can give a birth to a child who has motor disability because it is a disability comes from part of mother.	332	83.0	40	10.0	28	7.0	1.24
20	A mother who has behavioural problem can give a birth to a child who has behavioural problem because behavioural problem is a genetic problem that comes particularly from mother's gene.	287	71.8	40	10.0	73	18.3	1.47

The respondents were asked to show their agreement on that *females with disabilities cannot be trainable and cannot perform what able-bodied persons do*. The obtained result indicates that 59.8 per cent (M=1.76) of the respondents indicated their

disagreement to the statement. Concerning the item *females with disability are useless and unproductive*, 70.3 per cent (M=1.50) of the respondents reported their disagreement to the statement.

Regarding the attitudes towards the statement: *“It is much more difficult for females with disabilities than males with disabilities to participate in public activities or meetings in Wolayitta culture”*. The obtained result indicates that 68.5 per cent (M=2.44) of the respondents pointed out their agreement to the statement that this is true within the society. Another reaction was the perceived effects of community towards females with disabilities that *they are dependent on others; they are burden to the community and beggar when compared to males with disabilities*. The obtained result shows that 79.5 per cent (M=2.64) of the respondents agreed with the statement.

Regarding the statement that *a female with disability gives a birth to a child with disability*, the obtained result shows that 84.5 percent (M= 1.21) of the respondents reported that they disagree with the statement. Concerning the attitude of community towards the marriage of females with disabilities, for the item: *“It is shameful to an able-bodied male to marry a female with disability because his relatives/parents and friends discriminate/dissocialised him”*. 75.8 percent (M=2.60) of the respondents agree with the statement. Regarding the reaction of the respondents about psychosocial conditions of females with disabilities: *because of their disabilities females with*

disabilities are “agressive”and “harsh” when compared to able-bodied females. The obtained result indicates that 76.3 per cent (M=2.59) of the respondents mentioned their agreement to the statement.

Therefore, mostly the findings show that even if the community in Wolayitta group has information, knowledge and awareness towards disability and types of disabilities, there is misconceptions and negative attitudes towards females with disabilities.

For the statement that “*a blind woman can give a birth to a sighted child*”, 78.5 per cent (M=2.61) of the respondents mentioned their agreement to the statement. As to the psychosocial conditions of females with disabilities in Wolayitta ethnic group, *females with disabilities are highly discriminated and segregated socially.* The obtained result indicates that 54.9 per cent (M=1.97) of the respondents agreed that females with disabilities are discriminated and segregated socially within Wolayitta ethnic group.

It was attempted to measure the people’s attitude towards females with leprosy. The obtained result indicates that 79.8 per cent (M= 1.71) of the respondents reported that people in Wolayitta ethnic group do not make marriage with a female who has leprosy. This is because the community fears that leprosy can be communicable from mother to child.

On the other hand, the participants indicated that in Wolayitta culture females with disabilities mostly make marriage with males who have the same types of disabilities. With regard to this statement 71.5 percent (M= 2.52) of the respondents reported that persons with disabilities (females with disabilities and males with disabilities) make marriage each other. Concerning the attitude of society towards the performances of females with disabilities the respondents were asked to indicate their reaction to the statement: "*Females with disabilities can perform all activities what able-bodied females can do*". The obtained result shows that 50 per cent (M=2.10) of the respondents reported their agreement to the statement.

In the proceeding paragraphs, the general profile of the group on the basis of Chi-Square and the relation of some demographic variables to change of attitude are presented.

4.1.5 The Relation of some Demographic Variables to Attitude towards Females with Disabilities on the basis of Chi-Square

Chi-square was employed to determine the prediction of respondents' attitude towards females with disabilities. The relation of independent variables such as *educational level, religion, sex* and *residence* were crosschecked with dependent variables to know their significance. The dependent variables used for cross-tabbing were: *Females with disabilities are useless and unproductive; Females with disabilities are dependent on other able-bodied persons and they are burden to the community as well as to parents; it is shameful to an able-bodied male to marry a female with disabilities* and *Females with disabilities are aggressive and harsh when compared with able-bodied females.*

After cross-tabbing the dependent variables with independent variables the obtained results through three points scale were dichomatised to the two points scale by applying Babbie (1995) methodology, that is by distributing the scores of *uncertain* to scores of *disagree* and *agree* statements.

Table 12: *Differences between Urban and Rural Dwellers with respect to Disagreement about Females with Disabilities are Useless and Unproductive.*

	Urban	Rural	df	X ²	P
Observed	192	116	1	18.7532	0.0000
Expected	154	154			

The result on table 12 indicates that the frequency of urban dwellers were significantly different from rural dwellers regarding *females with disabilities are useless and unproductive.* That is, urban dwellers reported that females with disabilities are

productive and valuable. This could be that urban dwellers have accessibility and opportunities to get information and knowledge from mass media and organizations working towards disabilities and they were aware towards disability. So they reported that females with disabilities could be productive and useful.

Table 13: *Differences between Males and Females with respect to Disagreement about Females with Disabilities are Useless and Unproductive*

	Males	Females	df	X ²	P
Observed	168	142	1	2.1806	0.1398
Expected	154	154			

The result on table 13 shows that the frequency of males and females were not significant at ($X^2_{(1)} = 2.1806$, $p > 0.1398$). This means that there were no differences between the attitudes of male and female respondents regarding females with disabilities are useless and unproductive.

Table 14: *Differences among Religion sub groups with respect to disagreement about uselessness and unproductively of females with disabilities.*

	Orthodox	Muslim	Protestant	Catholic	Others	df	X ²	p
Observed	92	6	184	20	7	4	383.6375	0.0000
Expected	61.8	61.8	61.8	61.8	61.8			

As shown in table 14 (fourteen) there were statistically significant disagreement differences among religion subgroups at ($X^2_{(4)}=383.6375$, $p < 0.0000$), in favour of Protestants regarding females with disabilities useless and unproductive. In this study

was indicated that protestant religion is dominating in the study areas. Therefore, Protestants believed in that females with disabilities could be valuable and productive. So Protestant religion had brought attitudinal changes towards humanity that females with disabilities can be productive and useful within the community.

Table 15: *Differences in agreement among respondents' educational levels concerning females with disabilities are dependents on other able-bodied persons and they are burdening their families and to the community as a whole.*

	Illiterate	Read & Write	Pri. Educ.	Sec. Educ.	Higher Educ.	Tec. Sch.	df	X²	p
Observed	83	51	78	85	32	6	5	92.3254	0.0000
Expected	55.8	55.8	55.8	55.8	55.8	55.8			

As table 15 (fifteen) shows there were significant agreement differences among educational levels of respondents about females with disabilities are dependents on other able-bodied persons and they are burden to their families and to the community as a whole at ($X^2_{(5)} = 92.3254, p < 0.0000$). This implies that the agreement of respondents with elementary and secondary educational level on this issue was high compared to those respondents with lower and higher educational levels. Therefore, the finding indicates it needs further investigation with regard to the education in relation to disability issues, especially females with disabilities.

Table 16: *Disagreement difference between **males** and **females** with regard to the attitudes of respondents towards the statement, it is shameful to an able-bodied male to marry a female with disability.*

	Males	Females	df	X²	p
Observed	64	24	1	6.9143	0.0086
Expected	35	35			

The result on table 16 (sixteen) shows that there is statistically significant disagreement differences between males and females about the opinion that it is shameful to an able-bodied male to marry a female with disability at ($X^2_{(1)}=6.9143, p< 0.0086$). This depicts that males did not feel shameful about the concept of marriage with females with disabilities.

Table 17: *Place of **Residence** differences with respect to disagreement about feeling of shameful to marry females with disabilities for able-bodied males*

	Urban	Rural	df	X²	p
Observed	46	23	1	7.6667	0.0056
Expected	34.5	34.5			

As we can see from table 17, the frequency of urban dwellers is significantly different from rural dwellers about feeling of shameful for males to marry females with disabilities at ($X^2_{(1)}= 7.6667, p< 0.0056$). This shows that urban dwellers had positive attitude towards marrying females with disabilities. This could be still urban dwellers have different opportunities in creating awareness towards disabilities.

Table 18: *Educational Level differences about females with disabilities are aggressive and harsh when compared to able-bodied females.*

	Illiterate	Read & Write	Pri. Educ.	Sec. Educ.	Higher Educ.	Tec. Sch.	df	X²	P
Observed	76	49	83	83	32	4	5	94.9266	0.0000
Expected	54.5	54.5	54.5	54.5	54.5	54.5			

As it is seen from table 18 (eighteen), there were significant differences among respondents agreement with respect to their educational levels about an item that females with disabilities are aggressive and harsh when compared to able-bodied females at ($X^2_{(5)} = 94.9266, p < 0.0000$). This implies that those respondents who have primary and secondary educational level were agreed on this issue when compared to others with different educational levels. Still the finding points it needs further investigation towards educational level and females with disabilities.

4.2 Findings of Qualitative Studies

In this section the qualitative findings of the study, that is results obtained from In-depth Key-Informants Interview, Focus Group Discussions, and Case Studies for the attitude towards females with disabilities in Wolayitta ethnic group are presented.

4.2.1 Results of the Key Informant Interview

In the in-depth key informant interview 18 informants (three from each site), were interviewed in six study sites. These key informants were composed of: three kebele officials, one traditional healer, two religious leaders, three persons with disabilities, four opinion community leaders, two teachers, one NGO worker and two civic organisation representatives. All of the key informants were from Wolayitta ethnic group members.

4.2.1.1. Demographic Characteristics of the Key Informants

Concerning the age of key informants, they were in the age bracket of 32-65 years old. Regarding their sex, eleven of them were males and seven were females. With regard to their residence, nine of the informants were living in urban areas and the rest nine were living in rural areas. Regarding their marital status twelve of them were married, four of them were divorced, one widowed and one single (unmarried). Concerning the religion of the informants, ten were Protestant; five of them were Orthodox; and three were Catholic religion followers. Concerning the educational background of the informants: three were illiterate, four were with basic education levels, three were elementary education level (grades 1-8), three were secondary educational level and five were above grade twelve levels.

Table 19: *Composition and Distribution of Key informants and their demographic characteristics.*

Age Category	Male	Female	Total	%
31-40	3	2	5	27.7
41-50	3	4	7	38.9
51-60	2	1	3	16.7
>-60	3	0	3	16.7
Total	11	7	18	100.0
Residence				
Urban	4	5	9	50.0
Rural	7	2	9	50.0
Total	11	7	18	100.0
Marital Status				
Married	9	3	12	66.6
Single	1	-	1	5.6
Divorced	-	1	1	5.6
Widowed	1	3	4	22.2
Total	11	7	18	100.0
Level of Education				
No Education	2	1	3	16.7
Basic Education	2	2	4	22.2
1-8 Grades	1	2	3	16.7
9-12 Grades	1	2	3	16.7
>12 Grades	5	-	5	27.7
Total	11	7	18	100.0
Religion				
Orthodox	3	2	5	27.7
Protestant	6	4	10	55.7
Catholic	2	1	3	16.6
Total	11	7	18	100.0

4.2.1.2. Information, Knowledge and Attitude towards Disability

In this section the findings obtained from the key informants towards the information, knowledge, perceptions and attitudes of people in Wolayitta ethnic group towards persons with disabilities in general and females with disabilities in particular are discussed.

All the key informants mentioned that they know what disability is and there are different types of disabilities in their community. They pointed out types of disabilities such as, Visual impairment, Hearing impairment, Communication or Language disorders, Motor disorders, Leprosy, Mental Retardation, Behavioural disorders, and multiple disorders.

In this study the informants also pointed out that the community in Wolayitta ethnic group perceives females with disabilities as useless, weak potentially, unproductive, dependants on others, burden to parents and relatives. For these purposes females with disabilities are isolated, segregated and dissocialized and not permitted to participate in different social activities. Still now in the rural community of Wolayitta ethnic group, females with disabilities are hidden not to be seen by other able-bodied community members. Although the informants pointed out that even nowadays not only females with disabilities also those able-bodied females are seen inferior, irresponsible persons for any position within the community, and females are home bounded and they have

obligation to take responsibilities at home to perform such activities like child rearing, cooking, water fetching, taking care of cattle, working at home and performing other different activities as they are ordered by their husbands.

In previous studies Colerdige (1993) mentioned that local beliefs and customs cause people to look down upon persons with disabilities. For example, in some areas, people believe that children are born disabled or deformed because their parents did something bad or displeased the gods. In this study regarding the statement “*In some culture people kill or buried alive a female, if she is born with disability*”, all the informants reported that this was true and practical in ancient times in Wolaiyyta culture. In ancient times females with disabilities were killed or buried alive because community assumed that they can contaminate the generation and others believe that having a female with disability is shameful to her parents, having such child is a curse of god or elders and results of sins of parents.

“Not only females with disabilities were killed, buried alive or hide in Wolayitta culture in the previous times, also if a family has an able-bodied female child at first or at the last birth, the community kills or buried alive her. This was because the community believed in that a female cannot hold any responsibility within the community. Having a female at first or at last birth means a family is cursed by God, they said. They believed in that a female is an incomplete person within the society”, she cannot defend the community from the enemy, she is inferior at any societal position and she is cursed by god....” as most of the informants mentioned.

The informants mentioned that nowadays this activity is not practiced because of religious and modern educational influences society has brought attitudinal changes against such bad activities.

In addition, to measure the level information, knowledge and awareness towards disability the informants were asked to indicate the causes of disabilities. Concerning the causes of disability the informants pointed out that disability can happen due the following reasons. Because of man-made accidents and naturally for unknown reasons, because of sickness, drug and alcohol abuse (for example they mentioned that some people became blind because they used traditional and modern tape-worm medicine), because of curse of elders and for parents did bad things to others, moreover, by ignoring or hating others with disabilities.

Regarding the responses to fear of females with disabilities, eleven out of eighteen key informants reported that they are afraid of females with disabilities. They mentioned the reasons, that females with disabilities particularly those who have leprosy can transmit or communicate their disability to others. Those females with disabilities have no chance to marry able-bodied males. The informants mentioned the reasons that females by nature are weak and along with this, marrying females with disabilities is another burden or additional problem to the husband. Also socially it is shameful to the husband if he marries a female with disability. Others mentioned that a female with

disability could contaminate the generation by her disability; in some cases a female with leprosy can give a birth to child with disability who cannot perform or work something.

Along with this, the community in Wolayitta mostly never send females with disabilities to schools. According to the informants report community has poor awareness and even they do not believe in education of female. Moreover, there is poor accessibility of schools for disabled children. The informants were asked to express their ideas about that they are volunteer to marry a female with disability for themselves, or for their child or for relative. Seventeen of the informants mentioned that they are not volunteer to marry a female with disability because they said that she is burden, she cannot perform anything at home, she can transmit her disability to the generation (particularly the one with leprosy) and also shameful within the community and in family wise.

4.2.2 Results of Focus Group Discussion

There were two major categories of Focus Group Discussions conducted in this study. The first FGD was conducted with able-bodied males in Damot-Gale Woreda at Warbira Suqqe Peasant Association (PA). The second FGD was conducted with

females who have leprosy in Soddo Zuria woreda at Soddo town Higher 2 Kebele 03. In each group discussion there were 8-9 discussants were participated.

4.2.2.1. Findings of Focus Group Discussion with Able-bodied Males

A group discussion conducted in Damot Gale woreda at Warbira Suqqe PA with able-bodied males who have 9 (nine) members. All of the discussants were married. The discussants were aged from 28-58 years old. The educational level of the discussants was: two of them were illiterate, three of them were at elementary education level (grade 1-8), and three of them were secondary education (grades 9-12) level. All of them were Protestant religion followers and all of them were farmers.

With regard to information and knowledge about females with disabilities in Wolayitta community, all discussants reported that they know females with different types of disabilities such as those who have motor disorders, communication disorders, visual impairment (blindness), leprosy, mental retardation, hearing impairment (deafness), language disorders (dumb) and behavioural disorders.

Concerning the perception of community towards FWDs the discussants mentioned that mostly females with disabilities are isolated and neglected socially. Particularly those females with leprosy are not permitted to participate in any social activities with able-

bodied persons. They are not confidential to eat, to drink and to sit together with able-bodied persons at the same places. Marrying females with leprosy strictly prohibited in the culture of Wolayitta because community believes in that leprosy can be communicable or transmit up to the seventh generation.

The discussants mentioned that community perceives, those persons with disabilities in general and females with disabilities in particular as sick persons, as useless persons, as unproductive persons and burden to the society, dependents on able-bodied persons and they are shameful to parents. They also reported that the community perceives females with disabilities particularly those who have hearing impairment (deaf females) as hard workers, aggressive and harsh. Mostly society is afraid of them and in rare cases some community members make aware their children to stay away from hearing impaired females. In most cases the rural society develops phobia to their children towards those females with hearing impairment rather than males with hearing impairment.

Females with disabilities are also perceived by the community members as those who cannot be educable, trainable and cannot participate actively with able-bodied persons/ females. They are isolated not only by the community also neglected and ignored by their parents and siblings at home as discussants mentioned.

Regarding to how disability can happen to somebody, the discussants mentioned that disability can happen to somebody by physical and sexual contact such as leprosy; because of smallpox and polio; by laughing, hating or ignoring and joking on those who have disabilities; because of a wage of curse and calamity; by drug and alcohol abuse; because of accidents and sickness and it can happen naturally for unknown reasons.

Concerning the socio-economic and psychosocial status of females with disabilities within the community the discussants expressed that females with disabilities make marriage with males who have disabilities. Mostly they never make marriage with able-bodied males. In some rare cases those able-bodied males who are very poor economically and those who are old-aged make marriage with visually impaired females and hearing impaired females. In some cases' community elders advise those able-bodied males who have childbearing problem, to make marriage with visually impaired and hearing-impaired females. They say that the womb of a female is not deaf or blind and she can give a birth to an able-bodied child. The discussants mentioned that community uses females with disabilities mostly for labour work. This is because society assumes that females with hearing impairment are hard workers, talented and effective in their physical work performances.

In the case of educating and training of females with disabilities the discussants mentioned that except females with visual impairment the rest couldn't be trainable or educable. They said that we saw only blind males and females who are learning and teaching in formal schools and churches. Even if those who have motor disabilities work in some areas based on the knowledge they have before they became disabled. In addition they mentioned that females with visual impairment can perform some household activities without having any training or education. They reported that visually impaired females perform some household activities such as cooking food, cleaning home, fetching water, preparing coffee and other household activities by using their visual map towards their social environment.

In some cultures society hide or kill when a female child is born with disabilities. With regard to the culture of Wolayitta the discussants expressed that in previous times hiding and killing or burying alive females with disabilities was common in Wolayitta culture. Not only disabled female child, the community burying alive if an able-bodied female child who born at first or at last to her parent. This was because the community believed in that a female cannot be a leader or responsible person at home level for parents and within the community at all societal level. Two of the participants who were 55 and 58 years old mentioned that they personally knew some females who burying alive because they born at first to their parents. Now days there are no such inhuman activities applied within Wolayitta ethnic group. The changes came as a result

of religion expansion and community became aware of modern education. The elder discussants pointed out that such worst community activities were stopped since Queen Zewuditu became the Emperor of Ethiopia. Community became conscious and aware after Queen Zewuditu because she was a female Emperor who handled and administered the people of Ethiopia. Thus, society became aware towards females ability to hold public responsibilities as discussants reported.

Finally the discussants were asked to give their responses and suggestions towards females with disabilities. Concerning responsibilities of females with disabilities: Parents at home, community at societal level and Government in general should take the responsibilities of all persons with disabilities and females in particular by agitating and educating community to create awareness towards FWDs that they are productive and useful like other able-bodied persons.

4.2.2.2. Findings of Focus Group Discussion with Females with Leprosy

This Focus Group Discussion was conducted with females who have leprosy because they are strictly isolated and segregated from the community. They are not permitted to attend in any social activities either with other able-bodied persons or persons with other kinds of disabilities. Therefore, it is highly intended to know more about females with leprosy in particular.

The discussion was conducted in Soddo-Zuria Woreda in Soddo town at Higher 2 Kebele 03 with females who have leprosy disability. The discussants were eight in number and they were under the age bracket 22-45 years old. All of them were illiterate and Orthodox religion followers. They are engaging in begging near around churches and market places. Regarding their marital status five of them were married, one single (unmarried), one widowed, and one divorced.

Concerning information and knowledge towards disability the discussants expressed that they know persons or females with different types of disabilities, such as those with leprosy, blindness, motor disorders, dumb/language disorders, and hearing impaired or deafness. Community attitudes towards females with disabilities, particularly those with leprosy the discussants have reported that they are neglected, ignored and isolated from other able-bodied persons. They are living alone themselves in separate areas far away from other able-bodied community members. They mentioned that they are completely discriminated and not allowed to be at all public gathering places. Even they are not permitted to attend in churches in common places with other able-bodied people.

In responses to the problem of being a female and females with disabilities the discussants expressed that they are double marginalized, isolated and neglected from

different societal activities. Because of this stigmatisation of society the discussants stated that they have great sorrow feelings, inferiority complexes and other psychosocial problems within the society. The discussants reported that they can work or perform according to their ability, but there is no opportunity to participate in any activity within the community because of public stigmatisation. They mentioned that they are unable to make marriage with able-bodied persons, to participate in all social occasion and they are highly discriminated because community assume that they can transmit leprosy to other healthy people. They also mentioned that they are discriminated for double purposes: Firstly for that they are females and secondly for that they are females with leprosy. They mentioned that society is not even volunteer to bury persons with leprosy died. In previous times community burn homes of persons with leprosy disabilities when they died.

Concerning the statement "*how disabilities can happen to somebody?*"; the discussants reported that disability happens to somebody by: Physical contact; heredity; curse of a God; bad did of parents; accidents; nature; evil eyes; polio and smallpox; by disobeying the rules and regulation of God; disabilities like leprosy can happen by eating, drinking, living at the same places and using the same utensils together; and for unknown factors that can cause disability in prenatal period. The discussants expressed that females with disabilities can be trainable, educable and productive according to their ability if they are provide with opportunity. A good example is there are blind people who are

learning, teaching and working in their environment. Because of community's ostracism of persons with leprosy either males or females with leprosy are hopeless to get such chances. So they become beggars under trees, they said.

Regarding to transmission of disability from person to person, and concerning the statement "*Do you believe that a female with disability can give a birth to a child with disability?*". Most of the participants in the discussion reported not all but some like leprosy could be transmitted from person to person. And a female with leprosy can give directly a birth to a child with leprosy. One of the discussion member mentioned "*I have three children who were normal at their birth, but after 5-12 years old all of them became leprosy victims. So leprosy is communicable and transmitting disability from parents to children*". Some of the discussants expressed that they heard it is possible to avoid and prevent leprosy with effective medical treatment to have healthy children from a mother who has leprosy. However, none of them benefited from such prevention or medical treatment as they mentioned.

In addition, the discussants indicated that in previous times in Wolayitta culture society kill or hide not only females with disability also they kill or hide a healthy female. This happened, because the community believed that a female couldn't represent at any place or stand for any position within the community or for her parents at any public leading position. They said because females are cursed by God and weak by nature when

compared to males. Therefore, it was not only having a female child with disability, but also having a female child at first or last birth was shameful, as discussants indicated.

About the responsibilities of females with disabilities, all discussants mentioned that the government should take their responsibilities. This is because the community in general have negative attitude towards disabled persons, particularly those with leprosy.

4.2.3 Results of Case Studies

In this section the results obtained from two cases are presented. Case one is the result of a semi-structured interview conducted with a female who has a motor disability and case two is the result of a semi-structured interview conducted with a mother of a female child who has multiple disabilities. The mother was used because the child cannot express and talk what the researcher wants to know more about the client.

4.2.3.1 Case-One: A Female with Motor Disability

A. Demographic Characteristics of a Client

The name of the case is MT who is 35 years old. Her birth place is in Southern Nations, Nationalities and People's Region, in Wolayitta Zone, in Soddo Zuria woreda at Soddo town in Higher 2, kebele 03. She is Protestant religion follower (Full Gospel). She is unmarried lady who graduated with Diploma in Amharic language from Cotebe

Teachers' College in 1978 EC. Currently she is living with her parents in Soddo town in Higher 2 kebele 03 in house number 154. Both her parents are alive and engage in trading and economically they are from a middle class in their environment. She has three sisters and six brothers and now she is working at Soddo primary school as a school secretary.

B. Psychosocial Situations of the Client

The client was adventitiously disabled in which the disability happened to her when she was 26 years old in Miazia 29, 1980 EC. As she mentioned when she slept at night on the bed, something burnt all parts of her body below her neck and from that moment for unknown reasons the problem happened to her and she became unable to move from place to place. Now she is moving from place to place with the help of other persons by using a wheelchair. About the psychosocial conditions of the client, she expressed that she has inferiority feeling due to her inability to get marriage; the community perception as she is a sick person; and the school community attitude as she is unproductive. Most of the school community members understand that she simply comes only to get salary, they never believe on her performances because their mind is injected negatively that females with disabilities never perform something she said. She is a Diploma holder in language and she is capable to teach her students effectively, but due to students and teachers attitude as she cannot teach because of her disability as

assumed she is working as school secretary out of her profession make her always angry as she mentioned.

She also pointed out that she has sorrow feeling because of inability to move effectively in discomfort able physical environment because of physical barriers. The client expressed that she blocked by school administration or other officials the chance to upgrade her educational status because of their negative out look, as she is female and also a female with disability who is valueless even if she upgrade her education. She also mentioned due to lack of information and low level of awareness of and their negative attitudes towards disabilities community perceive and assume persons with disabilities particularly females with disabilities are unproductive and useless.

Finally, She reported that her parents and sibling have positive attitude towards her. Because she is earning monthly income/salary and she helps all of them and not dependent on them. For this purpose they have positive attitude towards her and they are co-operative with her she is very happy. In addition, she expressed people from the same religion have positive attitude towards her. Her church brothers and sisters have true love to her and help morally and spiritually, therefore, she strongly happy due to their support as she reported. Regarding to disability can be communicable/transmit from one person to person, the client mentioned that disability is not communicable or not transmitted, but it happens to somebody for many different reasons. Besides this the

client mentioned that females with disabilities are not aggressive and harsh when compare to other able-bodied females. It is the idea originated from the negative attitude of community.

4.2.3.2 Case-Two: A Female with Multiple Disabilities

A. Demographic Characteristics of a Client

Name of the client is SS. She is 17 years old individual who has motor disability, mild mental retardation and language disorder. Her birthplace and current address are in the Southern Nation, Nationalities and People's Region in Wollaytta zone, in Damot Gale woreda at a place called Adde-Shantto Peasant Association. The client is illiterate and unmarried girl who is completely dependent on her parents and who is home bounded for 16 years. Both of her parents (father and mother) are alive and her mother is house spouse and her father is a guard in MOA with very low payment on monthly basis. She has four brothers and two sisters. SS can hear but not talk because of her language disorder and mildly mental retardation that cannot perform anything. Because her inability to express regards of herself the researcher used SS's mother to collect all information regarding SS.

B. The Psychosocial Situation of the Client

According to the client's mother report the problem towards the lady's motor disorder happened in her postnatal period as a result of injure occurred when the client was five

months after her birth. Because of her disability, the mother reported that she has very great feeling of sorrows; she stayed for more than sixteen years at home on the bed. So she is the only person who takes/carries all responsibilities of the daughter. By this time (at this age) not only the mother but the client herself feels that she is ignored, neglected, and isolated by others and by her siblings. Because of these perceptions of others she is very angry, aggressive, emotional and develops harsh behaviour. So she is mostly sick psychologically, and she has negative feelings towards her siblings including her father and the community as a whole in the social environment.

The mother was asked to give some information about some of psychological problems that the client faces. According to the mother's report the client seriously feels when her siblings are ignoring and isolating her they are not working according to her need or request. She becomes very angry, she expresses her feelings by crying (tear dropping). She cries because she feels that they know that she is unable to stand up, to walk or to do something as she like. So she always develops inferiority complex and negative attitude towards her siblings including her father. The mother mentioned that some people including my friends and relatives say "*it is preferable if the daughter die from such type of living conditions*". They perceive her negatively, they ignore, dislike her even to see her facially. It is not only that the client, but the mother herself developed inferiority complex and worsens to society's negative attitude to the client. People assume that females with disabilities are aggressive and have harsh behaviour.

Regarding this idea the mother of the client mentioned that it is objectively true, because the community perceives females with disabilities as sick persons, useless and unproductive, aggressive and harsh, those who are cursed by God or they are results of mother's and father's sin. These misconceptions of society and isolation, ignorance, and neglecting of females with disabilities make them to be aggressive and to develop harsh behaviour towards able-bodied persons. In addition, the mother mentioned that because of the negative attitudes of siblings at home, the client developed behaviors like angry, sorrows, aggressiveness and other emotional behaviours towards them. When she grows older she strongly developed bad behaviours particularly since she has been 13 years old. Besides her motor disability three years ago she faced another falling accident and now she is completely physically disabled, became bedsores and bedwetting. All these factors and community attitude towards her make her to be sick psychologically.

CHAPTER FIVE

5. SUMMARY, CONCLUSION AND RECOMMENDATION

5.1 Summary

In quantitative study 400 subjects (216 males and 184 females) who were in the age bracket of 20-60 years with the mean of 37.05 years were used in two woredas of Wolayitta zone. All of the subjects used for this study were members of Wolayitta ethnic group. Protestant was found as the dominating religion in the study areas in which there were 238 (58%) followers. 316 (79%) of the subjects were married and 257 (63.4%) were from elementary and above educational levels.

In the qualitative study 18 key informants (11 males and 7 females) 9 from rural and 9 from urban areas who were in the age category of 31-65 were used. Two FGDs were conducted: one with able-bodied males composed of 9 members who were in the age bracket of 28-58 years old and who live in the rural areas and the other with females with leprosy composed of 8 members and who were in the age category of 22-45 and all of who were Illiterates from urban areas were used. The findings of both quantitative and qualitative studies indicate that the society in Wolayitta ethnic group has enough information, knowledge and awareness towards persons with disabilities in general and females with disabilities in particular. In quantitative finding it was

mentioned that 97.3% of the respondents pointed out that they know somebody male or female who has disability within the community. In the qualitative findings, all the key informants, focus group discussants and case study clients mentioned that they know different types of disabilities what disability is and there are persons with different types of disabilities in their community. Such persons include those with visual impairment, hearing impairment, communication or language disorders, motor disorders, leprosy, mental retardation, behavioural disorders, and multiple disorders.

56% of the respondents reported that female's disability is the worst; 80.5% reported that disability particularly leprosy (78.5%) can be communicable and transmitted by heredity and physical contact. Most of the respondents mentioned that society in Woliyyta ethnic group perceives females with disabilities are sick persons, useless and unproductive, dependants on other able-bodied persons and burden to the parents and to the community. Respondents mentioned that disability could happen due to accidents, diseases such as smallpox and polio, naturally for unknown reasons, wage of curse and calamity, inherited from parents, sin of mother and father, by joking and ignoring other persons with disabilities and drug and alcohol abuse and smoking.

64% of the respondents reported that people in Wolayitta hide females with disabilities not to be seen by others because community believes in that having such persons to a family is shameful. 86.3% reported that in previous times' people in Wolaiyyta ethnic

group kill or buried alive when a female with disability born and when they a female at first and at last birth. 75.8% of the subjects mentioned that it is shameful to an able-bodied male to marry a female with disabilities because his relatives, parents and friends discriminate or segregate the person; 71.5% of the respondents mentioned that females with disabilities make marriage with males who have the same types of disabilities; 76.3% of the subjects reported that because of their disabilities' females with disabilities are aggressive and harsh when compared to able-bodied females. In general Females with disabilities are segregated, isolated and neglected from public activities.

5. 2 Conclusion

The objective of the present study was to investigate the attitude of people towards females with disabilities in Wolayitta ethnic group. From seven woredas of Wolaiytta zone, two woredas were selected at random. From these sample woredas, 400 subjects (216 males and 184 females) were systematically selected from six (three urban kebeles and three rural Peasant Associations) and used for quantitative study. Also for qualitative study eighteen key informants, two focus group discussions (one with able-bodied males and the other with females who have leprosy) and two case studies were used.

Four instruments: Structured Questionnaire; Key Informant Interview; Focus Group Discussion and Case Study were used to collect data. The scale consisting of 20 items was incorporated to the questionnaire and used for data collection. Initially, the instruments were administered on a pilot sample. Considering this, item analysis was carried out and the instruments were improved. Percentages, tables, mean score and chi-square were employed to analyse the data. Based on the findings, the following conclusions are derived:

1. Generally, regarding the information, knowledge and awareness of community towards disability in general and females with disability in particular, 97.3% of the subjects reported that they know what disability is, types of disabilities and females with disabilities. Specifically, 89.8% reported that they know visual impairment; 80.3% reported that they know hearing impairment; 75.3% reported that they know motor disorders; 74% reported that they know leprosy; 72.8% reported that they know language or communication disorders; 55.8% reported that they know mental retardation and 51.5% reported that they know behavioural disorders. Key informants, focus group discussants and case study participants mentioned the same types of disabilities, as they know.
2. Concerning the community perceptions towards females with disabilities in Wolayitta ethnic group, Findings of both quantitative qualitative studies show that

the society has misconceptions towards females with disabilities. Mostly society perceives females with disabilities as potentially weak, unproductive and useless. So FWDs are segregated; isolated and neglected from public activities. Still now community hide FWDs at home not to be seen by others. Because the community believes that having a female with disability is shameful to parents. 64% of the subjects reported that this is true within the society nowadays. Besides to this 86.3% of the subjects reported that in previous times in Wolayitta ethnic group people kill or buried alive when a female child born with disability and an able-bodied female child born at first or at last to parents.

3. Still now society devalue females and believes in that a female cannot hold any responsibility, cannot represent and stand for any place to the community or parents at any public leading position.
4. Concerning marriage of females with disabilities' people in Wolayitta has negative attitude. 75.8% of the subjects mentioned that it is shameful to an able-bodied male to marry a female with disabilities because his relatives, parents and friends discriminate or segregate the person. In relation, it was found that 71.5% of the respondents mentioned that females with disabilities make marriage with males who have the same types of disabilities. There were statistically significant differences between urban and rural dwellers in which urban dwellers have had positive attitude

towards marrying females with disabilities. 76.3% of the subjects reported that because of their disabilities females with disabilities are aggressive and harsh when compared to able-bodied females. There were statistically significant differences among respondent's agreement concerning their educational levels about females with disabilities are aggressive and harsh when compared to able-bodied females. Those who are with primary and secondary education level are more agreed with the statement.

5. On the other hand results obtained from the qualitative studies show that, all the key informants used for this study reported that the community in Wolayitta ethnic group perceives females with disabilities as useless, dependants on others, burden to parents and relatives, who cannot be productive by their own and shameful for their family. For these purposes females with disabilities are isolated, segregated and dissocialised from different social activities. Moreover, the results obtained from the focus group discussion with able-bodied males indicated that the perception of community towards FWDs is that mostly females with disabilities are isolated and neglected socially. From the above findings, one may arrive at the following specific conclusions.

- ❖ There is no reliable data and information about the situation and prospects of persons with disabilities in general and females with disabilities in particular in Wolayita zone.

- ❖ Both quantitative and qualitative findings indicate that community in Wolayitta ethnic group has enough information, knowledge and awareness towards disabilities in general females with disabilities in particular.

- ❖ Even if there is information, knowledge and awareness towards disability in general and females with disabilities in particular, the community in Wolayitta ethnic group has misconceptions negative attitude towards females with disabilities.

- ❖ Mostly society in Wolayitta perceives females with disabilities as potentially weak, unproductive and useless. So FWDs are segregated; isolated and neglected from public activities and having a female with disability is shameful to parents.

- ❖ Females are not valued and there is a belief in some members of the community that a female cannot hold any responsibility at societal level and they that females are weak and incapable to handle responsibilities even they are able-bodied.

- ❖ There is statistically a significance difference between urban and rural dwellers. The urban dwellers reported that females with disabilities are productive and valuable. Also there is a statistically significant differences among religion sub-groups in which Protestants believed that persons with disabilities could be valuable and productive.

- ❖ Concerning marriage of females with disabilities' people in Wolayitta has negative attitude. Females with disabilities make marriage with males who have the same types of disabilities.

5.3 Recommendations

Discrimination, above all, is a distinguishing mark all persons with disabilities have been suffering all over Ethiopia in general as a developing country and in Wolayitta in Particular. The problems of disability are so complex that they cannot easily be tackled by one organization. It thus needs the active involvement of governmental, non-governmental organizations and the society as a whole. To rehabilitate persons with disabilities in general females with disabilities in particular it needs the actual full participation, education adjusted to the specific needs, access to culture, occupational mainstreaming etc. will have vital role together with work of awareness.

In this study, attitude towards females with disabilities in Wolayitta ethnic group is dealt with. The results indicate that there are some misconceptions and negative attitudes towards females with disabilities. Thus, the following short term and long term recommendations are set to avoid misconceptions and negative attitude towards females with disabilities in Wolaiytta ethnic group.

I. Short Term Recommendations:

1. Agitate and make the public that all persons with disabilities are productive, Valuable and they can be trainable, educable like other able-bodied persons. Teach the community for the human rights that females with disabilities could be productive if they are provided with different opportunities, promote their well-being, assist them to develop high self-esteem and struggle for the attainment of equal opportunities and full participation in any social, economic, political, etc., activities. These can be achievable through sensitisation:

- ❖ By working volunterly for human rights on community based program;
- ❖ By avoiding discrimination and accepting FWDs in all social, economical and Political activities;
- ❖ By conducting workshops and seminars community members and showing models that FWDs are productive;

2. Provide awareness education on the causes disabilities and increase the participation of parents, government bodies and the community at large through Information, Education and Counselling on prevention of the problem and assistance that could be provided to females with disabilities. Create awareness to the society and keep up the psychosocial make up of females with disabilities by building abilities, rights, skills and moral security. These could be implemented through Information, Education and Education (IEC) mechanism. Therefore,

- ❖ Produce and distribute flip-charts, leaflets, brochures etc. to the community;
- ❖ Show videos, films to the community that PsD can perform and produce;
- ❖ Use schools, churches, market places and all public gathering places to provide IEC to the community regarding disability;
- ❖ Use mass media to make aware the society regarding policies and laws towards PsD and Females.
- ❖ Give opportunities for females with disabilities to participate in providing IEC.

3. Implement and make practical Laws and Policies endorsed by Government regarding PsD and Women:

- ❖ Facilitate and motivate the involvement of policy makers, appropriate government organizations, and community as a whole.

II. Long Term Recommendations

4. Organize the associations of females with disabilities and encourage and support them to realize their objectives that might bring attitudinal changes to other able-bodied persons towards females with disabilities as well as other PWDs. That is,

- ❖ By making FWDs aware of Laws and Policies endorsed by government regarding rights of disabled persons and Women Policies;
- ❖ By creating conducive atmosphere for females with disabilities to work Females organization/associations;
- ❖ By creating opportunities to females with disabilities to participate in formal education, vocational training, in any social, economical, political, etc. involvement that can empower their quality of life.
- ❖ By teaching the community to develop skills to disability prevention, care, and rehabilitation on community approaches by using local social structures such as *Ikub, Idir, Mahiber* etc

5. Maintain the research studies, working co-operation with those engaged in prevention of disability and make implementation about alleviating the issue of disability through the country in general and in Wolayitta in particular in co-operation with concerned bodies,
6. Create work opportunities, open projects and vocational training centres to ensure that females with disabilities are productive. Implement the socio-economic rehabilitation projects that provide the opportunities to females with disabilities;
7. Formulate Local NGOs that work against disabilities; Work for implementation Laws and Policies endorsed by government concerning females with disabilities and human rights.

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APPENDICES

APPENDIX-A QUESTIONNAIRE.

*ADDIS ABABA UNIVERSITY SCHOOL OF GRADUATE STUDIES
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY MASTER'S THESIS*

TYPE OF INSTRUMENT: QUESTIONNAIRE (CODE: 1)

This is a questionnaire designed to members of Wolayitta ethnic group who are in the age bracket 20-60 years old. The main objective of the questionnaire is to investigate attitude towards females with disabilities in the ethnic group. Therefore, you are kindly requested to give your opinion independently. Your response will be kept confidentially and in secrete. Do not write your name at any section of the questionnaire. The researcher is responsible for any concern of the findings in the study. Thank you in advance for your cooperation!

SECTINON ONE:- Demographic Characteristics of the Respondent.

101. Name of study woreda_____ Code /__/___/
102. Urban 01 /__/___/ Rural 02 /__/___/
103. Name of Kebele/Farmer Association_____Code/___/___/
104. House Hold Serial Number /__/___/
105. Sex of the Respondent (circle) 1. Male 2. Female
106. Age /___/___/yrs old.
107. Nationality: 1. Wolayitta 4. Guraghe 7. Oromo
2. Kambata 5. Amhara 8. Dorze
3. Hadiya 6. Sidama 9. Other (specify)_____

Please give your responses for the following statements by circling the numbers in front of each statement/option.

108. In general, what language do you speak?

1. Wolayitta 2. Amharic 3. Other (specify)_____

109. Religion:

1. Orthodox 2. Muslim 3. Protestant 4. Catholic 5. Other (specify)_____

110. Marital Status:

1. Married 2. Unmarried 3. Divorced 4. Widowed 5. Separated 6. Other (specify)_

111. Educational Level:

- | | |
|-----------------------------------|------------------------|
| 1. Illiterate | 4. Secondary Education |
| 2. Literacy (reading and writing) | 5. Higher Education |
| 3. Primary Education | 6. Vocational Training |

112. Occupation:

1. Not working 2. Farmer 3. House Wife 4. Merchant 5. Student
6. Government/ Private organization employee 7. Other (specify)_____

SECTION TWO:- Knowledge and Information about Disability.

201. Do you know a male or a female who is with disability? 1. Yes 2. No → Q 203

202. If yes, what is the type of disability that a male or a female whom you know has ?
(if any other?)

- | | | |
|----------------------------|--------|-------|
| A. Visual Impairment | 1. Yes | 2. No |
| B. Hearing Impairment | 1. Yes | 2. No |
| C. Motor Disorder | 1. Yes | 2. No |
| D. Leprosy | 1. Yes | 2. No |
| E. Mentally Retarded | 1. Yes | 2. No |
| F. Language Disorder(Dumb) | 1. Yes | 2. No |

- G. Behavioral Problems 1. Yes 2. No
- H. Hearing Impairment and Dumb 1. Yes 2. No
- I. Other (specify)_____ 1. Yes 2. No

203. How do you assume the number of persons with disabilities in this kebele/PA?

1. Up to 100 2. 100-200 3. 200-300 4. More than 300

204. How do you see a person with disability?

- A. A sick person 1. Yes 2. No
- B. Useless 1. Yes 2. No
- C. Dependent 1. Yes 2. No
- D. Burden to the family 1. Yes 2. No
- E. Unproductive 1. Yes 2. No
- F. Equally like other human being 1. Yes 2. No
- G. Who can produce according to their ability 1. Yes 2. No
- H. Who can be trained and work 1. Yes 2. No
- I. With Sympathy 1. Yes 2. No
- J. Other (specify)_____ 1. Yes 2. No

205. How do you see a female with disability compared to a male with disability?

- A. A female with disability is worst 1. Yes 2. No
- B. A male with disability is worst 1. Yes 2. No
- C. The same as/equally 1. Yes 2. No
- D. Depends on the level of disability 1. Yes 2. No

206. Can disability transmit by physical contact and hereditarily from one person to another? 1. Yes 2.No→ Q. 208

207. Which kind of disability can transmit from one person to another by physical contact and hereditarily?

- A. Leprosy 1. Yes 2. No
- B. Blindness 1. Yes 2. No
- C. Deafness 1. Yes 2. No

- | | | |
|-----------------------|--------|-------|
| D. Mental retardation | 1. Yes | 2. No |
| E. Language disorder | 1. Yes | 2. No |
| F. All kinds | 1. Yes | 2. No |

208. In your opinion how disability can happen to somebody? Because

- | | | |
|---|--------|-------|
| A. Parents did something bad to others | 1. Yes | 2. No |
| B. Inherited from parents | 1. Yes | 2. No |
| C. Evil eyes/possessed by demons | 1. Yes | 2. No |
| D. Accident | 1. Yes | 2. No |
| E. Curse of others | 1. Yes | 2. No |
| F. Bad deeds by others | 1. Yes | 2. No |
| G. A wage of curse and a calamity
from godly or supernatural power | 1. Yes | 2. No |
| H. By joking other disabled Persons | 1. Yes | 2. No |
| I. Carelessness | 1. Yes | 2. No |
| J. Drug addiction | 1. Yes | 2. No |
| K. Smoking | 1. Yes | 2. No |
| L. Small Pox/Polio | 1. Yes | 2. No |
| M. For Unknown reasons | 1. Yes | 2. No |
| N. Nature | 1. Yes | 2. No |
| O. Others (Specify)_____ | 1. Yes | 2. No |

209. Is it possible to prevent disability? 1. Yes 2. No 3. DK

210. Are you willing to take care of a female with disability who is your friend, relative or family 1. Yes 2. No 3. DK (I do not know)

211. Females with disabilities are hidden at home in the culture of Wolaiytta

1. Yes 2. No 3. DK

212. In previous times in some cultures people kill a female, if she born with disability. Because they assume that she is useless. This is/was true in the culture of Wolayitta.

1. Yes, in previous 2. Yes still present
3. It was in previous time, but not nowadays 4. DK

213. Who should be responsible to take care of females with disabilities?

- | | | |
|---|--------|-------|
| A. Parents/Family members | 1. Yes | 2. No |
| B. Government Organization | 1. Yes | 2. No |
| C. NGOs | 1. Yes | 2. No |
| D. Civic Organizations | 1. Yes | 2. No |
| E. Humanitarian Organization | 1. Yes | 2. No |
| F. Community as a Whole | 1. Yes | 2. No |
| G. They are useless; therefore they should be avoided | 1. Yes | 2. No |
| H. Relatives | 1. Yes | 2. No |
| I. Some individuals | 1. Yes | 2. No |
| J. The disabled persons themselves | 1. Yes | 2. No |
| K. Other (specify)_____ | 1. Yes | 2. No |

214. In Wolayitta culture if able-bodied male loves a female with disability he can marry her. 1. Yes 2. No 3. DK

SECTION THREE:- ATTITUDE TOWARDS DISABILITIES

Please give your responses to the following statements by marking (X) under 1 for "Disagree"; under 2 for "Uncertain" and under 3 for "Agree".

NO	STATEMENT	1	2	3
3.1	Persons with disabilities particularly females cannot be trainable, and cannot perform what able-bodied persons do.			
3.2	Females with disability are useless and unproductive			
3.3	It is much more difficult for females with disabilities than males with disabilities to participate in public activities or meetings in Wolayitta culture.			
3.4	Females with disabilities are dependent on others; they are burden to the community and beggars when compared to males with disabilities.			
3.5	A female with disability gives a birth to a child with disability			
3.6	In Wolayitta culture it is shameful to an able-bodied male to marry a female with disability because his relatives/parents and friends neglect or isolate him.			
3.7	Because of their disabilities females with disabilities are aggressive and harsh when we compare them to able-bodied females.			
3.8	A blind woman can give a birth to a sighted child.			
3.9	Persons with disabilities particularly females with disabilities in Wolayitta ethnic group are highly discriminated and segregated socially.			
3.10	Females with disabilities should not be employed in any organization because they cannot perform what able-bodied females can do.			
3.11	A female with leprosy can transmit/communicate to her child therefore; a female who has leprosy in the culture of Wolayitta has great problem to marry an able-bodied male or the able-bodied males never marry a woman with leprosy.			
3.12	Females with disabilities cannot be educated because females' education is useless.			
3.13	It is preferable having a male child with disability rather than having a female child with disability because female is weak by nature and she is burden mostly to her parents.			
3.14	Females with disabilities should not be at the same school if the opportunities are provided to children with disabilities to be educated because the attitude of other able-bodied children in the school is negative towards them and they can develop psychological failure.			
3.15	In Wolayitta culture females with disabilities marry mostly males with disabilities.			
3.16	A deaf woman can give a birth to a deaf child because deafness is a hereditary problem that comes from mother to child.			
3.17	Mentally retarded female can give a birth to a mentally retarded child because mental retardation is a disability that can be transmitted from mother to child.			
3.18	Females with disabilities can perform all activities what able-bodied females can do and they can carry all their home responsibilities.			
3.19	A woman who has motor disability can give a birth to a child who has motor disability because it is a disability comes from part of mother.			
3.20	A mother who has behavioural problem can give a birth to a child who has behavioral problem because behavioural problem is a genetic problem that comes particularly from mother's gene.			

Appendix B. Key Informant Interview

ADDIS ABABA UNIVERSITY SCHOOL OF GRADUATE STUDIES DEPARTMENT OF EDUCATIONAL PSYCHOLOGY MASTER'S THESIS

TYPE OF INSTRUMENT: KEY INFORMANT INTERVIEW (CODE: 2)

Objective:- This is a key informant interview prepared to the key persons in Wolayitta ethnic group to get available information about attitude towards females with disabilities in the Wolayitta Community. (The Key Informants may include Traditional Healers, Opinion Community Elders, Community Leaders, Religious Leaders, Persons working in organisations towards disabilities, Civic Organisations Leaders, Humanitarian Organisations Workers/Leaders, Persons with disabilities, Parents/Family members of females with disabilities, Workers of MOE, MOH, Justice, etc). Therefore, you are one of the key informants who can provide information towards females with disabilities. Your response will be used only for the research purpose only and kept confidential and secret. Your name will not be written in any page of the interviewing paper and the researcher is responsible for all findings of the study.

Part I: Personal Information

1. Date of Interview: _____
2. Sex: 1. Male 2. Female (Circle)
3. Age_____ 4. Marital status_____ 5. Educational level_____
6. Ethnicity_____ 7. Religion_____ 8. Occupation_____
9. Present Address:
 - 9.1 Region_____ 9.2 Zone_____ 9.3 Woreda_____
 - 9.4 Kebele_____ 9.5 Urban/Rural_____

Part II. Information, Knowledge and Attitude Towards Disabilities.

201. Do you know what disability is? 1 Yes 2. No 3 DK (I do not know)

202. If your answer is “Yes”, Please, tell/list the types of disabilities you know in your community.

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

203. Are there females with disabilities in your community? (Circle)

- 1. Yes 2. No 3. DK

204. If yes, what type of disabilities do they have?

- 1. _____ 5. _____
- 2. _____ 6. _____
- 3. _____ 7. _____
- 4. _____ 8. _____

205. How do the community see females with disabilities in Wolayitta ethnic group?

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____
- 7. _____ 8. _____

206. From among males and females with disabilities, whose disability is seen as the worst?(Circle)

- 1. Males with disabilities 2. Females with disabilities 3.Both of them seen equally

207. Why? Because

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

208. In your opinion, how disability can happen to somebody (male/female)?

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

209. Do you believe that disability can be communicable?

- 1. Yes 2. No 3. DK

210. If yes, which kind of disability/disabilities can be communicable?

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

211. How can disabilities communicable?

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

212. Are you scared from females with disabilities? Circle) 1. Yes 2. No 3. DK

213. If “Yes”, please state the reason/s why you are scared of females with disabilities?

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

214. If “No”, please state the reason/s why you are not scared of females with disabilities?

- 1. _____ 4. _____
- 2. _____ 5. _____
- 3. _____ 6. _____

215. In Wolayitta ethnic group do females with disabilities have problems in being married with non-disabled males? 1. Yes 2. No 3. DK

If your answer is “Yes”, why and how?

216. In some cultures' society hide or kill persons particularly females who be born with disability. Is this practised in Wolayitta ethnic group? (Circle)1.Yes 2. No 3. DK

217. If your answer is “Yes”, why?

218. Do females with disabilities in Wolayitta ethnic group participate in public activities or meetings? 1. Yes 2 No 3. DK

219. If your answer is “No”, Why?

220. Do the community in Wolayitta ethnic group send females with disabilities to schools to be educated? 1. Yes 2. No 3. DK

221. If your answer is “No”, why?

222. In your opinion, who is responsible within the community to take care of females with disability?

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |
| 7. _____ | 8. _____ |

223. Are you willing to marry for yourself or for your boy/relative to a female with disability? 1. Yes 2. No 3. DK

If your answer is "No", why?

224. Do you believe that a female with disability can give a birth for a child with disability? 1. Yes 2. No 3. DK

If your answer is "Yes", how?

225. Please give your opinion towards females with disabilities.

THNK YOU IN ADVANCE FOR YOUR CO-OPERATION

APPENDIX- C: CASE STUDY GUIDE

**ADDIS ABABA UNIVERSITY SCHOOL OF GRADUATE STUDIES
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY MASTER'S THESIS**

TYPE OF INSTRUMENT: CASE STUDY (CODE: 3)

Objective:- This is a case study guide to maintain an interview to collect information about a female with disability. The interviewee should be a female who has any kind of disability and we prepare the interview only for volunteer respondents. The findings of the research will be kept secretly and will be used only for the research purpose.

Part One. Personal Particulars

1. Use code only for identification. (Code) _____
2. Age: _____
3. Type/Kind of Impairment/Disability _____
8. Birth Place: 4.1 Region _____ 4.2 Zone _____ 4.3 Woreda _____
4.4 Kebele/ Farmer Association _____ 4.5 Village _____
5. Current Address: 5.1 Region _____ 5.2 Zone _____ 5.3 Woreda _____
5.4 Kebele/ Farmer Association _____ 5.5. Urban/Rural _____
- 6 Educational Status _____ 7. Marital Status _____
8. Work Situation _____ 9. With whom are living _____
10. Family Background:
 - 10.1 Mother alive _____ Not alive _____
 - 10.2 Father alive _____ Not alive _____

10.3 Family's Occupation: Mother's _____ Father's _____

10.4 Economic Situation: Poor _____ Middle _____ Rich _____

10.5 Number of Siblings: Sisters _____ Brothers _____ Total _____

Part Two: Psychosocial Situation

1. When and how did this problem of disability happened to you?
2. What do you feel for that you are being a female with disability?
3. What are the psychosocial major difficulties you face for being a woman with disability?
4. How do your parents, siblings, relatives, friends and community in general perceive you for that you are a female with disability?
5. Can you tell me the problems you faced because of your disability towards education, marriage, economy, work situation, social situation, social ceremonies & interaction, in community affairs and others?.
6. In the community where you live, do they equally treat you in any social occasion?
7. What is yours livelihood income?
8. Some people say that persons with disabilities, particularly females with disabilities are useless and unproductive, are not trainable and educable. How do you see this saying?
9. People say that a female who has leprosy can transmit to her seventh generation. Do believe in this saying? Why?
10. Community members say that females with disabilities are aggressive and harsh because of their disabilities. Do you agree with this saying? How?

***THANK YOU IN ADVANCE FOR
YOUR COOPERATION!***

APPENDIX- D: FOCUS GROUP DISCUSSION GUIDE

**ADDIS ABABA UNIVERSITY SCHOOL OF GRADUATE STUDIES
DEPARTMENT OF EDUCATIONAL PSYCHOLOGY MASTER'S THESIS**

TYPE OF INSTRUMENT: FOCUS GROUP DISCUSSION (CODE 4)

Objective:- This is a Focus Group Discussion guide to maintain an interview with a group members to collect information about a female with disability. The information will be used only for the research purpose only and the finding will be kept in secret. Therefore, please give the information you have about females with disabilities and discuss and present your opinion attitude towards females with disabilities freely.

PART ONE: INTRODUCTION

1. Type of Discussants _____
2. Date of discussion _____
3. Place of discussion: Urban _____ Rural _____
 - 3.1 Woreda _____
 - 3.2 Kebele/Farmer Association _____

PART TWO: CHARACTERISTICS OF DISCUSSANTS

No	Name	Sex	Age	Educational Level	Religion	Occupation	Marital Status
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

PART THREE: KNOWLEDGE, INFORMATION AND ATTITUDE TOWARDS FEMALES WITH DISABILITIES.

1. Do you know females with disabilities in your community)? If yes, what are the types of disabilities do the females have?
2. How does the community see/perceive them? Are they segregated/isolated or live together with able-bodied people? Are they participating in any public activities/meetings equally with others?

3. Can disabilities transmit from females to others? In your opinion how disability happens to somebody?
4. Do females with disabilities marry able-bodied males? If your answer is “No”, why?
5. Do you believe that females with disabilities can be educable or trainable and productive? And can they perform all activities like able-bodied females?
6. Do you believe that females with disabilities give birth to children with disabilities Why/How?

7. In some cultures, community kills or hides females with disabilities who be born with disability. How much this is true or practised in Wolayitta ethnic group?
8. In your opinion, who should be responsible to take care of females with disabilities?
9. In general, what is the attitude of community in Wolayitta ethnic group towards females with disabilities? What should be done to help them?

Thank you in advance for your Co-operation!

DECLARATION

I hereby declare that this thesis is my original work done under the guidance of Dr. Yusuf Oumer Abdi. All relevant sources used for the thesis are duly acknowledged.

ALEMU ABERA BABISSO