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COMMUNITY PERCEPTION OF THE PHYSICALLY HANDICAPPED AND ITS EFFECTS ON THEIR VOCATIONAL CHOICE: A CASE STUDY OF SAJOCAH BAFUT

(SAINT JOSEPH CHILDREN AND ADULT HOME)

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SUMMARY

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DEDICATION

To my beloved sibling Caroline, Judith, Emmanuel Ernest, Prudence and Olivia

CERTIFICATION

This is to certify that this thesis entitled ''community perception of the physically handicapped and its effects on their vocational choice'' was carried out by **Constance Asoh Neba** (**20V3017**) in the faculty of science of Education, department of specialized Education, specialty of physical handicap university of YAOUNDE1 under the supervision of

Sign……………………………….
Date……………………………….

Dr Mbei Adolf Tanyi.

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LIST OF ABBREVIATIONS

GBD; Global Burden Of Diseases.

UNCRD; United Nations Conventions on Rights of persons with Disabilities.

AD; After the Death of Christ.

ACAS; Advisory, Conciliation and Arbitration service.

WHO; World HealthOrganization.

PLWD; People Living With Disabilities.

MINAS; Ministry of Social Affairs.

CNPS; National Social Security Fund.

FNE; National fund of Employees.

SAJOCAH; Saint Joseph's Children and Adult Home;

NGOs; Non-GovernmentalOrganizations.

SJCHS; Saint Joseph Comprehensive High School.

HO; Null Hypothesis.

HA; Alternative Hypothesis.

PTSD; Post Traumatic Stress Disorder.

MDE; Major Depressive Episode.

APA; American Psychological Association.

ADHD; Attention Deficit Hyperactivity Disorder.

NLDC; Nonverbal Learning Disorder.

CP; Cerebral Palsy.

MS; Multiple Sclerosis.

MD; Muscular Dystroph.

CSPDM; Canadian Society of Professionals in Disability Management.

MICS; Cameroon Multiple Indicator Cluster Survey.

CNIS; Cameroon Multiple Indicator Cluster Survey.

UNICEF:United Nations Children Emergency Fund

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RÉSUMÉ

Notre travail sur la perception des handicapés physiques par la communauté soulève un problème de recherche sur le chômage et le sous-emploi des personnes vivant avec un handicap (PLWD) en raison de la perception négative de leur communauté. La principale question de recherche est la suivante : "Comment la perception de la communauté affecte-t-elle les choix professionnels des personnes handicapées ? Pour répondre à cette question, nous avons émis l'hypothèse générale suivante : "Il n'y a pas de relation significative entre la perception de la communauté et les choix professionnels des personnes handicapées physiques".

Des auteurs tels que (Bryan, 2010) soulignent qu'il est regrettable que les sentiments négatifs et la discrimination à l'égard des personnes handicapées proviennent toujours des superstitions des premiers hommes et soient vieux de plusieurs siècles. Ces perceptions sont enracinées dans les contextes économiques, culturels et sociaux. Ce que nous avons vérifié à travers les quatre hypothèses de recherche suivantes:

RH1 : il n'y a pas de relation significative entre la discrimination et les choix professionnels des handicapés physiques.

RH2 : il n'y a pas de relation significative entre la condescendance et les choix professionnels des handicapés physiques.

RH3 : Il n'y a pas de relation significative entre l'évitement social et les choix professionnels des handicapés physiques.

RH4 : Il n'y a pas de relation significative entre l'internalisation et les choix professionnels des handicapés physiques.

Nous avons mené une enquête exploratoire en utilisant un questionnaire de type likert pour obtenir des données pertinentes. Les données ont été analysées à l'aide de statistiques descriptives et inférentielles (moyenne, pourcentage, fréquence et écart-type). L'hypothèse a été testée à l'aide de la régression linéaire du logiciel SPSS (Statistics Package for Social Sciences) version 25.

À l'issue de l'analyse des résultats, nous avons constaté que la perception de la communauté est un prédicteur significatif des choix professionnels des personnes handicapées physiques avec une moyenne globale de 1,928.

En conclusion, la perception de la communauté a une influence positive sur les choix professionnels des handicapés physiques. Par conséquent, l'étude recommande que le gouvernement du Cameroun et les autres acteurs de l'éducation spécialisée prennent des mesures appropriées pour orienter la communauté sur les droits des personnes handicapées physiques. Enfin, des suggestions pour des études ultérieures ont été faites.

ABSTRACT

Our work on community perception of the physically handicapped raises a research problem on the unemployment and under employment of people living with disabilities (PLWD) due to negative perception from their community. The main research question here being “how does community perception affect the vocational choices of the physically handicapped? To answer this question, we took a general hypothesis that “There is no significant relationship between community perception and the vocational choices of the physically handicapped.

Authors such as (Bryan, 2010) ague that it is unfortunate that negative feelings and discrimination towards persons with disabilities still originate from superstition of early man and are centuries old. These perceptions have been rooted in the economic, cultural and social contexts. What we have verified through the following four research hypothesis: RH1: there is no significant relationship between discrimination and the vocational choices of the physically handicapped.

RH2: There is no significant relationship between condescension and the vocational choices of the physically handicapped.

RH3: There is no significant relationship between social avoidance and the vocational choices of the physically handicapped.

RH4: There is no significant relationship between internalization and the vocational choices of the physically handicapped.

We engaged an exploratory survey research which used a likert type questionnaire in sourcing relevant data. The data was analyzed using both descriptive and inferential statistics (mean, percentage, frequency and standard deviation). The hypothesis tested using linear regression statistics package for social sciences (SPSS) version 25.

At the end of the analysis of results, we found out that community perception is a significant predictor of the vocational choices of the physically handicapped with an overall mean of 1.928.

Concluding that community perception has a positive influence on the vocational choices of the physically handicapped. Therefore the study recommends that the government of Cameroon and other special need education stake holders take appropriate actions to orientate the community on rights of PLWD. Lastly, suggestions for further studies were made.

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CHAPTER ONE

1.0 GENERAL INTRODUCTION

Disability is part of the human condition. Almost everyone will be temporally or permanently impaired at some point in life, and those who survive to old age will experience increasing difficulty in functioning. Furthermore, most extended families have a disabled member and many non-disabled people take responsibility. This issue will become more acute as the demographics of society change and more people live to an old age. Worth noting here is the fact that disability prevalence would likely increase in the future. This is due to increasing natural disasters, armed conflicts, diseases and an ever aging population. According to the World Health Organization (WHO) 2001 disability has three dimensions. Impairment in a person's body structure or function, or mental functioning; examples of impairments include loss of limb, loss of vision or memory loss. Activity limitation, such as difficulties seeing, hearing talking. (WHO) updated copy 2022 defines disability as a condition or function judged to be significantly impaired relative to the usual standard of an individual or group.

Hence, Disability is not just a health problem or attribute of individuals, but it reflects difficulties individuals may experience in interaction with society and physical movements. Evidently the term "disability" has many different meanings; the global burden of disease (GBD) however, uses the term disability to refer to loss of health, where health is conceptualized in terms of functioning capacity in a set of health domains such as mobility, cognition, hearing, and vision. For disabled persons and their families situation becomes doubly difficult due to general health problem and unique social stigma attached to various types of disability. Disabled people experience various barriers due to restriction of participation and their lives are affected with poor health outcomes, low education, lack of social and economic participation, higher rates of poverty and increased dependency.

Disability studies are an academic discipline that examines and theorizes about the social, political, cultural, and economic factors that define disability. The disability rights movement, scholars, activists and practitioners construct debates around two distinctly different models of understanding of disability - the social and medical models of disability (Disabled-World.com). However, there are many other models that are used in disability

studies. Disability scholars use models to identify the different factors that are implicated in disabilities.

The society creates social barriers like stereotyping, stigmatization, discrimination, isolation which are some of the challenges people living with disabilities face every day. The issue of social exclusion that stem from the belief that having a disability makes you 'less than" the so called normal or "Supra-Human" being close to deities, as infra-animality (Stiker, 2001, p.23), makes it more cumbersome. This implies that the society perceive disabled persons to lack necessary knowledge, skills, attitudes, support that the so-called to actively participate in society. Perception of disability is an important construct affecting not only the well-being of individuals with disabilities, but also the moral compass of the community. Negative perception toward disability disembowels individuals with disabilities and lead to their social exclusion and isolation.

They way the community perceives people with disability, greatly influences their activities in general and life as a whole beginning from education to social interactions and livelihood or empowerment. People with disabilities are considered as outcasts and there is no need for them to be educated, trained or own good jobs for themselves. Disables are seen as people who need to be catered for people who only have to be helped or aided to survive in life. By Contrast, a healthy society encourages positive perception towards individuals with disabilities and promotes social inclusion. Citing the United Nations Convention on Rights of Persons with Disabilities (UNCRD) signed 30th March and 3rd May 2008 reasonable accommodations are designed for an individual and what he or she requires in a specific learning, work or other situation. According to UNCRPD, reasonable accommodation mean necessary and appropriate modification and adjustments not imposing a disproportionate or undue burden, where needed in a particular case, to ensure to persons with disabilities the enjoyment or exercise on an equal basis with others off all rights and fundamental freedoms". In this view, the problem of disabled persons not having the right to choose what kind of education or vocational training he/she likes becomes evident in the Cameroonian context. In the so called inclusive classrooms there are no trained educators, no adaptive materials and curriculum; no adaptive techniques and technology to be able to help the disabled persons achieve academically like others. Later in life, these persons face disproportionate socio-economic marginalization resulting in poor health, lower quality education, inadequate vocational training, limited employment prospects and generally broad ranging restrictions on their community participation. Due to these social barriers placed on them by the society, the disabled persons resort to any activity that can keep live moving or provide bread rather than

being rehabilitated and gaining autonomy per say. In Cameroon, there exist laws for protection of persons with disabilities. These laws include inter alia the most heralded 1986 constitution and the 2010 law relating to the protection and welfare of persons living with disabilities.

Perception of disability is an important construct affecting not only the well-being of individuals with disabilities, but also the moral compass of the community. Negative perception toward disability disembowels individuals with disabilities and lead to their social exclusion and isolation. By contrast, a healthy society encourages positive perception toward individuals with disabilities and promotes social inclusion. Disability is part of human condition. Almost everyone will be temporally or permanently impaired at some point in life and those who survive to old age will experience increasing difficulty in functioning. Most extended families in Cameroon have a disabled member, every epoch has faced the moral, educational and political issue of how best to include and support people with disabilities. This issue will become more acute as the demographics of society change and more people live to and old age. This chapter of the study provides a background to the study and is organized into different sections which include the historical background, conceptual background, theoretical background contextual background, statement of the research problem, scope of the study, significance of the study and operational definition of terms

1.1 Background to the study

The background of this study provides a foundation that enhances proper understanding of the study

1.2 Historical Background

This subsection of the background attempts to organize how the perception and treatment of people living with disabilities has occurred through time and space in the world, Africa and Cameroon. Looking back, the approach to people with disabilities has been less than desirable; there is a long history of abuse, discrimination and lack of compassion and understanding**.** As Roeher (1969) observes, an examination of attitudes towards people with disabilities across culture suggests that societal perceptions and treatment of persons with disabilities are neither homogeneous nor static. Variations in the treatment of persons with disabilities are manifesting in Africa as in other parts of the world (Amoako 1977).For the early tribes and nomads, survival were paramount. It is not exactly known for sure how a person with a disability was cared for; there has been some research that indicates they were cared for. Limited literature in disability history, however, continues to pose a great challenge to trace the development and formation of perceptions towards persons with disabilities.

Nonetheless, there is evidence of a consistent Western cultural bias against people with accredited impairments in the antecedents of what we now refer to as western society long before the emergence of industrial capitalism. Examples can be found in Greek culture, Judean/Christian religions and European drama and art since well before the Renaissance (Barnes, 1990; 1991; 1992; Thomas, 1982).

The Greek achievements in philosophy, the arts, and in architecture have had a profound effect on the culture of the entire western world (Devonport, 1995; Risbero, 1975). This influence includes how they perceived and treated people living with disabilities. The Greek Empire was obsessed with human perfection. They believed beauty and intelligence were intertwined. This belief laid the ground work for future beliefs related to people living with disabilities. The Greek obsession with bodily perfection, which can be traced back to 700-675 BC. (Dutton, 1996), found expression in prescribed infanticide for children with perceived imperfections (disability).Infanticide in the form of exposure to the elements for sickly or weak infants was widespread and in some states mandatory (Tooley, 1983).The now familiar association between impairment, exclusion and impotency is clear. Moreover, the Western link between impairment as a punishment for sin also has its roots in Greek culture
Following their conquest of Greece, the Romans absorbed and passed on the Greek legacy to the rest of the known world as their empire expanded. The Romans too were enthusiastic advocates of infanticide for `sickly' or `weak' children drowning them in the river Tiber. Like the Greeks, they treated harshly anyone whose impairments were not visible at birth. People of short stature and deaf people were considered objects of curiosity or ridicule. In the infamous Roman games `dwarfs' and `blind men' fought women and animals for the amusement of the Roman people. Even the disabled Emperor Claudius, who escaped death at birth only because he was from the highest echelon of Roman society, was subject to abuse from both the Roman nobility and Roman Guards prior to his ascendancy to the imperial throne. Even his mother, Antonia, treated him with contempt and referred to him as `a monster of a man, not finished by nature and only half done' (Garland, 1995, p. 41). According to the Disability History Exhibit web site: "Greek response to disability was Abandonment, Exposure, Mutilation." (Alaskan D.H. & S.S. 2011)
Influenced by Greek society since, at least, the time of Alexander the Great (Douglas, 1966) the Jewish culture of the ancient world perceived impairments as un-Godly and the consequence of wrongdoing. Biblical text is replete with references to impairment as the consequences wrongdoing. The Old Testament, for instance, states that if humans are

immoral then they will be blinded by God (Deuteronomy, 27-27). These traditions are continued in the New Testament too. In the book of Matthew, for example, Jesus cures a man with palsy after proclaiming that his sins a forgiven (9-2).

Unlike other major religions of the period the Jewish faith prohibited infanticide. This became a key feature of subsequent derivatives, Christianity and Islam, as did the custom of `caring' for the `sick' and the `less fortunate' either through alms giving or the provision of `direct care' (Davis, 1989). However, the opposition to infanticide and the institutionalization of charity is probably related to the fact that Jewish society was not a particularly wealthy society. It was predominantly a pastoral economy dependent upon the rearing of herds of cattle, goats and sheep, as well as on commercial trade. In addition, unlike their neighbors, the Jewish people were a relatively peaceful race, prone to oppression themselves rather than the oppression of others. In such a society people with impairments would almost certainly have been able to make some kind of contribution to the economy and the well-being of the community (Albrecht, 1992). Furthermore, in its infancy Christianity was a religion of the underprivileged; notably, `slaves and women', charity, therefore, was fundamental to its appeal and, indeed, it's very survival. Nonetheless, being presented as objects of charity effectively robbed disabled people of the claim to individuality and full human status. Consequently, they became the perfect vehicle for the overt sentimentality and benevolence of others - usually the priesthood, the great and the good.

Following the fall of Rome in the fifth century AD Western Europe was engulfed by turmoil, conflict and pillage. Throughout `the Dark Ages' the British Isles were made up of a myriad of ever-changing kingdoms and allegiances in which the only unifying force was the Christian Church. Given the violent character of this period it is likely that social responses to people with impairments were equally harsh (Barton L.& Mike, O., 1997).But by the thirteenth century, and in contrast to much of the rest of Europe, a degree of stability had been established in the British Isles. An indication of English society's attitude to dependence, and by implication impairment, is evident in the property transfer agreements of the period (Macfarlane, 1979).Until the seventeenth century, people rejected by their families and without resources relied exclusively on the haphazard and often ineffectual tradition of Christian charity for subsistence. People with `severe' impairments were usually admitted to one of the very small medieval hospitals in which were gathered `the poor, the sick and the bedridden'. The ethos of these establishments was ecclesiastical rather than medical (Scull, 1984).

There was also a steady growth in the numbers of people dependent on charity in the 18th century. This was the result of a growing population following depletion due to plagues, successive poor harvests, and an influx of immigrants from Ireland and Wales (Stone, 1984). Hence, the fear of `bands of sturdy beggars' prompted local magistrates to demand an appropriate response from the central authority; the Crown (Trevelyan, 1948). To secure allegiance the Tudor monarchs made economic provision for those hitherto dependent upon the Church. The Poor Law of 1601, therefore, is the first official recognition of the need for state intervention in the lives of people with perceived impairments. But a general suspicion of people dependent on charity had already been established by the statute of 1388 which mandated local officials to discriminate between the `deserving' and the `undeserving' poor (Stone, 1984).

Moreover, although `English individualism' was well entrenched by the thirteenth century the Church remained a formidable force in English and European culture. Besides offering forgiveness and a democratic afterlife in a frequently hostile world where for many life could be `nasty, brutish and short' (Hobbes, 1983) the Christian Church asserted and retained its authority by propagating and perpetuating fear - fear of the Devil and of his influence. The biblical link between impairment, impurity and sin was central to this process Indeed, St Augustine, the man credited with bringing Christianity to mainland Britain at the end of the sixth century AD, claimed that impairment was `a punishment for the fall of Adam and other sins' (Ryan and Thomas, 1987, p. 87).

Disabled people provided living proof of Satan's existence and of his power over humans. Thus, visibly impaired children were seen as `changelings' - the Devil's substitutes for human children. The Malleus Maleficarum of 1487 declared that such children were the product of the mother's involvement with sorcery and witchcraft. The religious leader and scholar accredited with the formation of the Protestant Reformation, Martin Luther (1485 - 1546) proclaimed he saw the Devil in a disabled child; he recommended killing them (Haffter, 1968).

As in the ancient world, people with impairments were also primary targets for amusement and ridicule during the middle Ages. Analysis of the joke books of Tudor and Stuart England show the extent of this practice. Besides references to the other mainstays of `popular' humour such as foreigners, women, and the clergy, every impairment `from idiocy to insanity to diabetes and bad breath was a welcome source of amusement (Thomas, 1977, pp. 80-81).

Children and adults with physical abnormalities were often put on display at village fairs (Nicholli 1990) visits to Bedlam were a common source of amusement, and the practice of keeping `idiots' as objects of entertainment was prevalent among the wealthy (Ryan and Thomas, 1987).

Taken together these developments provided a new found legitimacy for already well-established myths and practices from earlier `less enlightened' times. Thus, the nineteenth century is synonymous with the emergence of `disability' in its present, form. This includes the systematic individualization and medicalisation of the body and the mind (Armstrong, 1983; Foucault 1975), the exclusion of people with apparent impairments from the mainstream of community life into all manner of institutional settings (Scull, 1984) and, with the emergence of `Social Darwinism', the `Eugenics Movement', and, later, `social hygiene' `scientific' reification of the age old myth that, in one way or another, people with any form of physical and or intellectual imperfections pose a serious threat to western society. The `logical' outcome of this was the proliferation of Eugenic ideals throughout the western world during the first half of the twentieth century (Jones, 1987; Kevles 1985), and the systematic murder of thousands of disabled people in the Nazi death camps of the 1930s and 40s (Burleigh, 1995; Gallagher, 1990). It is important to remember too that Marxist Communism also has its roots firmly planted in the material and ideological developments which characterized eighteenth- and nineteenth-century Europe, and that many of its principal protagonists, both in Britain and overseas, embraced eugenic ideals as an essential corollary of the `Utopian' hope for a better society.

The concept of disability has been examined from various cultural perspectives across the continent of Africa and found that the perception of disability is not uniform (Eskay M., Onu V. C., Igbo J. N., Obiyo N. 2012). As we grow in our knowledge of the dynamics surrounding the concepts of culture and disability, we begin to realize that individual perceptions and languages play a vital role in our understanding of who we are as a people and as a culture. According to Wright (1960), language is not merely an instrument for voicing ideas, but also plays a role in shaping ideas by guiding the experience of those who use it. Scheer and Groce (1988) pointed out that when different cultures used positive language to describe individuals with disabilities, these individuals with disability ended up integrating well into the society.

A study conducted among the Tonga People revealed that both positive and negative attitudes and behaviour towards children with disabilities. The complexities of these attitudes were influenced by their historical background, life experiences, social, cultural and

economic factors (Muderedzi. J., Arne H. E., Stine H. B. & Babill S. 2017).In most traditional African cultures, including Cameroon and Zimbabwe, there is a strong belief that people's lives are controlled by ancestral spirits and that disability is of spiritual origin (Pepra O., Mckenzie, Mprah W., &Nsaidzedze S.B., 2016; Marongwe& Mate, 2007; Mpofu & Harley, 2002; Shoko, 2007). Disability stigma (discrimination) as well as curtesy stigma (discrimination acquired as a result of being related to a person with a stigma) has been noted to be present in Zimbabwe (Khupe, 2010; Lang & Charowa, 2007).

On the other hand, studies from other African communities such as the Xhosa in South Africa (Mckenzie & Swartz, 2011), BaTswana in Botswana (Ingstad, 1997), and Maasai in Kenya (Talle, 1995) have found that children born with anomalies were seen as "a gift from God" and remained valued members of the community. In Zimbabwe, Dengu (1977) found that it was through the introduction of Christianity that disabled children started to be seen as gifts from God, although in some cases feelings of shame persisted, leading to cases of hiding.

Perceptions and beliefs about disability as a punishment, the result of ancestral anger or retribution by divine forces, have been found in many cultures (Braathen & Ingstad, 2006; Coleridge, 1993; Devlieger, 2005; Talle, 1995). There are several beliefs for the negative attitudes revolving around children with disabilities in Nigeria. These beliefs cut across the Nigerian society and hence have asimilar impact on the citizens' attitudes on learners with disabilities. According to Onwuegbu (1977), Abang(1985) and Ozoji (1990) and later supported by Marten (1990) and Eskay (2009), the causes of such negative perceptions on learners with disabilities were related to: (1) a curse from God (due to gross disobedience to God's commandments); (2) ancestral violation of societal norms (e.g., due to stealing); (3) offenses against gods of the land (e.g., fighting within the society); (4) breaking laws and family sins (e.g., stealing and denying); (5) misfortune (e.g., due to marriage incest); (6) witches and wizards (e.g., society saw them as witches and wizards); (7) adultery (a major abomination); (8) a warning from the gods of the land (due to pollution of water and the land); (9) arguing and fighting with the elders (a societal taboo); (10) misdeed in a previous life (such as stealing); (11) illegal or unapproved marriage by the societal elders (arguing and fighting against the elderly advice in marriage); (12) possession by evil spirits (due to gross societal disobedience); and many others.

A study from Ghana, (Wright, 1960) found that children with disabilities were seen as protected by supernatural forces, were the reincarnation of a deity and were always treated with kindness, gentleness and patience. Studies among the Shona and Kalanga of Zimbabwe,

(Khupe, 2010; Lang &Charowa, 2007) have highlighted negative attitudes such as disabled people constitute a burden to society and that disability is associated with evil. A study by Jackson and Mupedziswa (1988) among the Karanga in Zimbabwe found that beliefs and attitudes expressed by informants toward persons with disability often seemed to be in contradiction with how they acted towards them.

It is important to note that while in Western societies impairment is primarily seen as an individual affair and functionally limiting at the bodily or cognitive level, in many non-Western societies what is perceived to be the cause and/or consequences of impairment may be dysfunctional social relations or the transgressing of social order (Shuttleworth & Kasnitz, 2005). In non Western societies one's disability and culture are central to determine the position or the status that the individual is given in a specific society. Often, one's disability conforming to social expectations frequently is rewarded for that behavior; the culture tends to accept those who are willing to conform to given values, standards of behavior and ethical concerns. Cultural understanding is also shaped by the meanings attached to various behaviors by the social and economic organization of a given society, or by other internal and external cultural dynamics, or imposed standards upon all citizens of that given culture. Murphy (1990) indicated that disability had been defined by society and was given meaning by a culture; therefore, there were various cultural perspectives of what disability was and how disability in people was perceived and treated in various cultures.

From the cultural perspective, large- and small- scale societies perceive disability differently. In small-scale societies, close interactions between individual members are the norm; each individual may have extended and multi-strand relationships with other members of that society (Scheer & Groce, 1988). Individuals may interact in the course of economic production, during leisure time, or while participating in the arts or ceremonies. The social identity in these small-scale societies is based on family clan and other characteristics but not on the individual's physical characteristics.

Despite the emergence of the social model and the rights approach to disability, culture and religion still influence the understanding of disability substantially in many societies (Reinders, 2011; Trescher, 2017). Attitudes and perceptions are socially as well as culturally constructed and dynamic in nature and may vary with the social situation in which they are acted upon (Edgerton, 1970; Ingstad, 1997). Ingstad and Sommerschild (1983) found that previous life experiences are another important source of influence on people's attitudes and behaviour toward disabled persons. They found that previous positive experiences in handling other types of crises became a source from which parents could draw when they got

a disabled child. They identified two types of reactions to the experience of having a disabled child; those who said that they got a terrible shock which it took them sometime to overcome, and those who saw it as just one of those things that happen in life. Differences in attitudes towards a disability depended on whether or not it is perceived as a troubling disability in that it causes problems for others and takes the mother away from carrying out chores necessary for the survival and daily life of the family. Each family would have their own constructed notions of disability that might influence the treatment of and relationship with the disabled child (Ingstad, 1995).The diversity of disability experiences across the world needs to be acknowledged in order to understand attitudes towards disability especially in the developing world like Cameroon where there is scarce information due to lack of research

1.3 Conceptual Background

This subsection of the study provides a conceptual groundwork for proper comprehension of the main concepts of the study which are perception, physical disability and vocational choice.

1.3.1. Perception of Disability

People are constantly evaluating and making judgments about other people and events. We react to people and situations on the basis of our perception i.e how we evaluate and judge them. Perception of disability is an important construct affecting not only the well-being of individuals with disabilities, but also the moral compass of the society. Negative attitudes toward disability disempowered individuals with disabilities and lead to their social exclusion and isolation. By contrast, a healthy society encourages positive attitudes toward individuals with disabilities and promotes social inclusion (Babik& Gardner, 2021).

Despite the obvious benefits of inclusive education and social inclusion, children with disabilities are not always accepted by their typically developing peers. Across cultures, children with disabilities encounter negative attitudes, bullying, social exclusion, and isolation (Ochs et al., 2001; Hanvey, 2002; Nowicki and Sandieson, 2002; Cummins and Lau, 2003; Kelly, 2005; Laws and Kelly, 2005; Odom et al., 2006; Guralnick et al., 2007; Shah, 2007; Vreeman and Carroll, 2007; Nugent, 2008; Gannon and McGilloway, 2009; Koster et al., 2010; de Boer et al., 2012a; Lindsay and McPherson, 2012; Snowdon, 2012; Kayama and Haight, 2014). Socially excluded children may have unsatisfying peer relationships, low self-esteem, and lack of achievement motivation, which affect their social and academic aspects of life, mental health, and general well-being (Juvonen and Graham, 2001; Brown and Bigler,

2005; Murray and Greenberg, 2006; Pijl and Frostad, 2010; Lindsay and McPherson, 2012; Mâsse et al., 2012).

Attitudes toward individuals with disabilities vary with the type of disability. For example, children with emotional or behavioral disabilities and those with multiple disabilities are perceived more negatively by their typically developing peers than children with a specific physical disability (McCoy and Banks, 2012). Moreover, children with intellectual disability are perceived more negatively than children with a physical disability (Nowicki, 2006; de Laat et al., 2013), with level of social inclusion being positively related to the mental age of the child with disability (Carvalho et al., 2014). In the school context, with its high expectations to learn and negative future consequences of failing to do so, intellectual disability may have greater salience to typically developing children than physical disability.

Children with positive attitudes toward peers having disabilities may be more willing to interact with them compared to children with negative attitudes (Diamond, 1993; Okagaki et al., 1998; Roberts, 1999; Roberts and Smith, 1999; Favazza et al., 2000; Gaad, 2004). As a result, more exposure to individuals with disabilities may lead to better understanding of disability and higher levels of acceptance (Hong et al., 2014). Thus, attitudes drive behavior, which, in turn, affects the individual's knowledge, beliefs, and attitudes. Interventions improving children's knowledge about disabilities and providing exposure to those with disabilities is the most successful technique of changing children's attitudes toward peers with disabilities (Diamond and Carpenter, 2000; Nikolaraizi et al., 2005; Nowicki, 2006; Rillotta and Nettelbeck, 2007; Siperstein et al., 2007; Feddes et al., 2009; Kalyva and Agaliotis, 2009; Gasser et al., 2014; Armstrong et al., 2016).

Developmental psychologists suggest that early childhood is the best time to intervene against the formation of negative attitudes toward disability, before these attitudes and behavior patterns become fully established and difficult-to-change (Killen et al., 2011; Lee et al., 2017).Family plays a significant role in shaping children's beliefs and attitudes toward others: parenting styles and children's attachment styles may determine the child's future attitudes toward individuals with disabilities. Importantly, there is an intricate interplay between parental factors and children's personality factors. Being the primary agents integrating children into society, parents may significantly influence their children's attitudes toward out-groups in general and individuals with disabilities in particular (Hellmich and Loeper, 2019).Importantly, parents may communicate their beliefs and attitudes to children explicitly through discussions or explicit teaching, or implicitly by modeling their

values in daily interactions with other people or by providing their children opportunities to interact with out-group peers (Dunn, 1993; Castelli et al., 2007; Hellmich and Loeper, 2019). People with disabilities have been stigmatized throughout history as a function of negative perceptions. In many cultures, disability has been associated with curses, diseases, dependence, and helplessness. Disability stigma can play out in a number of ways including; not get married to a normal person, not being enrolled in particular jobs like the military, farming, and sports etc. overall negative perceptions may lead to the following:

1.3.1.1. Social avoidances

People with disability may be left out of social activities or they may find their friends become more distant after they develop a disability. People may be hesitant to make eye contacts or start a conversation with someone who has a visible disability. When children with disabilities are constantly avoided, they too learn to isolate themselves. Social avoidance is a distinct subtype of social withdrawal that involves a desire to avoid social interaction due to anxiety and a preference to spend time alone (Asendorpf, 1990). These two components, social anxiety and preference for solitude, jointly increase the likelihood of social maladjustment among children with disabilities. For example, feelings of social anxiety inhibit positive social interactions and reduce social opportunities, further contributing to problems in interpersonal relations (La Greca, 2001; Russell et al., 2011). Moreover, because socially avoidant children seek out more solitude, they might miss out on important opportunities to practice and develop new cognitive and social skills (Coplan et al., 2009; Jones et al., 2015). Indeed, past research has shown that compared to their more sociable counterparts, socially avoidant children experience more peer difficulties and internalizing problems. For example, Coplan et al. (2006) found that compared with other children, avoidant children reported the highest levels of negative affect and depressive symptoms and the lowest levels of positive affect and overall well-being. Similarly, Nelson (2013) reported that social avoidance was related to peer difficulties among young adults. Bowker and Raja (2011) also found that social avoidance was associated with peer-exclusion.

1.3.1.2. Discrimination

People with disabilities may be denied jobs, housing or other opportunities due to false assumptions or stereotype about disabilities. It is unlawful to discriminate against an individual by reason of disability. Discrimination issues typically relate to flawed or inconsistent organizational policies, procedures or practices that have failed to

accommodate people's physical or mental impairments as required by law. Understanding and recognizing different types of disability discrimination can help the society to take a proactive approach to prevent discrimination and avoid people with disabilities suffering less favorable treatment because of their condition.

There are four main types of discrimination recognized by the Advisory, Conciliation and Arbitration Service (ACAS) which include, Direct discrimination, indirect discrimination, Harassment and Victimization (Morris, 2019). Article 5 of the Convention of the rights of people living with disabilities emphasize on the equality and non-discrimination of people living with disabilities. It states that everyone is equal before and under the law. Everyone is entitled to the equal protection and benefit of the law without discrimination.

1.3.1.3. Condescension (Over protection)

People living with disabilities may be coddled or overprotected due to perceptions of their helplessness. Lowered expectations and over-protection of the individual with a disability can cause lowered self-esteem which can result in a life time of underachievement and failure to reach their full potential (Sanders k. J., 2006). Over-protection and lowered expectations of persons with disabilities may result in several unwanted and unintended consequences which can have lifelong impact. The prejudicial attitudes of those around a child with a disability often include overt acts of sympathy and pity. This discomfort may cause the person with a disability to be segregated and may exaggerate the sense of inequality. Adolescents with disabilities may not be prepared to make decisions for themselves because of their subjection to low expectations and because they are micromanaged by parents and educators. This negative feedback keeps the individual in an inferior and dependent position, often giving up on him/her self (Nakamura C.Y., 1959).Parents unknowingly cause their child to become powerless by failing to allow the child the opportunities to advocate for themself. Parents who over-protect their children can deprive them of their independence as they transition into adulthood and inadvertently promote dependence on others. Physical disabilities significantly impact development of the child's personality in that they may lack a sense of belonging. Parents who over-protect the child with a disability will continue to over- protect as the child enters adolescence and young adulthood. Another consequence of over-protection may be hostility of the child toward the parents (Sanders, K.J., 2006).

> *"For all parents…who have a child (with a disability), the diagnosis represents a loss which must be grieved. The loss for which the parent grieves is of the dream that all parents have of how their child and how their life would turn out. Their dream does not include a child with disabilities… The grief engendered by the death of a family member is acute and terminal…The grief experienced by the parent of a child with special needs is chronic. There is usually minimal emotional support carrying a fetus for 9 months and delivering a healthy child. When the child has a disability, the mother feels she has failed in some way…Grief very often translates into…behavior that is not helpful for the child. Guilt-ridden parents tend to over-protect their child ('I let something bad happen to you once. I am not going to let that happen again… I am going to make it up to you." (Laterman D. (2004)*

Negative effects of over-protection and lowered expectations have far- reaching consequences. All that lack of belief can have an effect on one's self. Individuals with disabilities are not expected to do more, so they do not. In some reviews, the responses by over-protected college students included: "I was restricted at home; was prohibited to go on trips; rarely allowed to leave home; I could never go where I wanted; they balked against my independence." (Nakamura C.Y., 1959).A consequence of lowered expectations can lead the individual to believe that the disability is the root cause of all his/her futility and uselessness. The over-protected child with a disability is often not challenged to strive for excellence; they are allowed to settle for less (Yura T., 1983).

Children with disabilities may have developmental delays or physical limitations which could have an impact on the individual and how they are perceived by others. These differences may cause the child to develop perceptions about him/her which may be based on actual functional limitations. "Parents must be aware of the child's perceptions concerning her/himself so that child's perception of the disability does not negatively affect the child's ability to reach their full potential." (Yura T., 1983) One of the tasks of effective parenting is to teach their child appropriate behavior. Society and culture have different expectations about persons with disabilities, which may influence the parent's role as a parent of child with disabilities (Woolfsen L., 2oo4). This task can become even more essential and complicated. In the past, all too often, individuals with disabilities were hidden in institutions and in backrooms of homes. In today's world, youngsters with disabilities are in public and private schools (not segregated in classrooms for individuals with special needs); as adults, they are involved in all forms of employment, entertainment and just about all settings for everyday activities. This requires that they be given the opportunity to develop their full potentials to become functional members of their respective communities and contribute to the development of their communities

1.3.1.4. Internalization

People with disabilities may themselves adopt negative believes about their disabilities and feel ashamed or embarrassed about it. In sociology and other social sciences, internalization means an individual's acceptance of a set of norms and values (established by others) through socialization. John Finley Scott (1994) described internalization as a metaphor in which something (i.e. an idea, concept, and action) moves from outside the mind or personality to a place inside of it. The structure and the happenings of society shape one's inner self and it can also be reversed. To internalize is defined by the Oxford American Dictionary as to "make (attitudes or behavior) part of one's nature by learning or unconscious assimilation: people learn gender stereotypes and internalize them." Through internalization individuals accept a set of norms and values that are established by other individuals, groups, or society as a whole. Lev Vygotsky, a pioneer of psychological studies, introduced the idea of internalization in his extensive studies of child development research. Vygotsky provides an alternative definition for internalization, the internal reconstruction of an external operation. He explains three stages of internalization (Vygotsky, 1978):

1. An operation that initially represents an external activity is reconstructed and begins to occur internally.
2. An interpersonal process is transformed into an intrapersonal one.
3. The transformation of an interpersonal process into an intrapersonal one is the result of a long series of developmental events.

In this study we consider internalization as the non-conscious mental processes by which the stereotypes (beliefs, feelings etc) or negative attitudes of the “so called normal “individuals are assimilated into the self and adopted by people living with a disability.

1.3.2 Disability

Two competing conceptual models of disability have been used to define the origins of the abnormal physiological and psychological functioning (LoBianco and Sheppard-Jones, 2008). The medical model considers disability a feature of the person, directly caused by diseases, disorders, traumas, or other health conditions, which would require medical treatment or intervention with the primary goal to “correct” the problem within the individual (Johnston, 1996; Marks, 2000; Mitra, 2006; Forhan, 2009; Nind et al., 2010; Brandon and Pritchard, 2011; Palmer and Harley, 2012; Bingham et al., 2013). By contrast, the social model does not consider the disability an attribute of the individual, but rather a socially

created problem (Hutchison, 1995; Mitra, 2006; Purdue, 2009; Barney, 2012). In this case, the problem that needs to be corrected lies not within the individual, but within the unaccommodating social environment (Brandon and Pritchard, 2011; Roush and Sharby, 2011; Barney, 2012; Palmer and Harley, 2012; Bingham et al., 2013).

According to the social model, disability could be imposed by society on individuals with impairments through isolation and exclusion from everyday activities (Brandon and Pritchard, 2011; Bingham et al., 2013). Such isolation and exclusion may stem from society's unfavorable perceptions of people with disabilities and unwillingness to remove environmental barriers impeding full participation (LoBianco and Sheppard-Jones, 2008; Forhan, 2009; Palmer and Harley, 2012). However, neither medical nor social model acknowledge the complex nature of disability. Therefore, a comprehensive integration of the two approaches produced the biopsychosocial model, which considers disability in the context of an interaction between biological, psychological, and societal factors, each limiting the individual's functioning to some extent (Engel, 1980; Borrell-Carrió et al., 2004; Thomas, 2004; Shakespeare, 2006; Le Boutillier and Croucher, 2010). However, considering the nature of this study it is the social model of disability that is relevant.

1.3.2. Physical Disability

A physical disability is a substantial and long-term condition affecting a part of a person's body that impairs and limits their physical functioning, mobility, stamina or dexterity (Carehome.co.uk). The loss of physical capacity results in the person is having a reduced ability, or inability, to perform body movements such as walking, moving their hands and arms, sitting and standing as well as controlling their muscles. A physical disability does not necessarily stop you from performing specific tasks but makes them more challenging. This includes daily tasks taking longer to complete, such as getting dressed or difficulty gripping and carrying things.

It is important to note that defining physical disability is not about the physical condition itself but how it impacts daily life, such as the ability to carry out work activities. A person may be born with a physical disability or acquire it in life due to an accident, injury, illness or as a side effect of a medical condition. Examples of physical disability include cerebral palsy, multiple sclerosis, epilepsy, Carpal tunnel syndrome, amputations and spinal cord injuries. Just as types of physical abilities and how they impact a person's daily life are all different,

causes of physical disabilities also vary. Physical disabilities can be caused by hereditary, congenital or acquired reasons.

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1.3.3. Vocational Choice

Choice come in to place when one is faced with the option of selection from more than one possibility. Vocational choice therefore refers to selecting a vocation from more than one possibility. Making a good vocational choice will depend on both internal and external factors. The internal factors constitute the aptitude, self-esteem and self-efficacy, level of maturity and experiences of the individual making the choice. The external factors the home

background, availability of vocational schools and equipment, availability of vocational counselors, finance etc. Even for the "so called normal" individual making a good vocational choice is an arduous task. Indeed, making wise vocational choices is one of the important considerations for all young people. Having a disability simply adds extra considerations to such decisions. Guidance from career counselors can be helpful. Most can guide students to information on many aspects of a vocation/career choice, from the nature of the work involved to required skills and education to forecasts of job availability and salary expectations.

Assessing aptitude and interest can help people living with disabilities to narrow their list of careers to suit their situation. Most children living with disabilities have a limited awareness of the range of careers available that build on their interests and aptitudes. Finding an appropriate career mentor can be especially useful for a child with a disability. If the mentor has the same disability as the student, they can help a student assess the impact of a disability on the typical tasks of a given career, as well as help the student find assistive tools and strategies to overcome barriers. Organizations such as the American Foundation for the Blind have programs to match professionals with disabilities with students interested in pursuing a particular career (wolffe, 2010).Vocational identity formation is an important task in career development and ego-identity achievement(Raskin, 1994; Savakis, 1985; Sharf, 2002).Possessing a secure vocational identity, or a "clear and stable picture of one's goals, interests, personality, and talents"(Holland, Daiger, & Power, 1980, p. 1), contributes to appropriate vocational decision–making and confidence in one's ability to make career-related decisions. Failure to form a stable vocational identity often results in career indecision (Holland et al., 1980).

Individuals with disabilities typically have a more complex vocation/career development process than their peers and are more susceptible to vocational identity and career decision–making problems (Enright, 1996; Luzzo, Hitchings, Restish, & Shoemaker, 1999; Ochs & Roessler, 2001).Career decision-making difficulties are related to impaired decision-making skills, unclear goals, lack of vocational information, perceived barriers, and value conflicts (Germeijs & DeBoeck, 2003; Holland et al., 1980; Ladany, Melincoff, Constantine, & Love, 1997; Osipow, 1999)and are a significant obstacle to employment for many people with disabilities (Enright, 1996; Enright, Conyers,& Szymanski, 1996; Hagner & Salomone, 1989). Because of the staggering unemployment and underemployment rates reported for individuals with disabilities (Hanley-Maxwell, Szymanski, & Owens-Johnson, 1998), there is heightened need to understand career-related issues for these individuals. Research suggests

there are a number of individual and environmental factors that influence the career development process for people with disabilities. Individual factors include, but are not limited to, gender (DeLoach, 1989), cultural background (Enright et al., 1996; Szymanski & Hershenson, 1998), socioeconomic status (Blustein, Juntunen, & Worthington, 2000), self-esteem (Munson, 1992), self-efficacy (Szymanski & Hershenson, 1998), and disability status. Environmental factors such as family involvement (Hitchings, Luzzo, Ristow, Horvath, Retish, &Tanners, 2001), work experiences (Blustein et al., 2000; Ohler, Levinson, & Barker, 1996), and decision-making opportunities (Hagner & Salomone, 1989) have been found to affect the vocational decision–making abilities of individuals with disabilities. Vocational behavior may also vary because of characteristics of a person's disability(Aune & Kroeger, 1997; Enright, 1996; Hitchings et al.,2001; Szymanski &Herschensohn, 1998).One disability characteristic that has received limited attention is whether the disability is physical or cognitive. Research on the career development of people with disabilities indicates that individuals with cognitive disorders and those with physical impairments encounter different barriers during the career development process. Hitchings, Luzzo, Retish, Horvath, and Ristow (1998) found that individuals with developmental or cognitive disabilities displayed greater difficulty in understanding how their disability affects their employment when compared with persons with physical impairments. Enright et al. (1996) postulated that individuals with cognitive disabilities often have limited experience in making career decisions because of high dependency needs and overprotective caregivers.

As a result, individuals with cognitive disorders are likely to have impaired vocational decision–making skills (Enright et al., 1996) that may lead to unrealistic expectations about vocational training and employment opportunities (Falvo, 1999; Hagner & Salomone, 1989; Szymanski & Hershenson, 1998). Davis, Anderson, Linkowski, Berger, and Feinstein (1985) reported that the greatest vocational barrier for individuals with physical impairments is often social discomfort or shame resulting from physical appearance. Elliott, Uswatte, Lewis, and Palma tier (2000) identified a relationship between high goal instability and greater social discomfort and self-consciousness in individuals with physical disabilities. Essentially, embarrassment regarding physical impairment can impede a person's capacity to set vocational goals and pursue career ventures. Although both disability types (cognitive and physical) may lead to impaired vocational development, they may do so through different sets of vocational cognitions. While the current study does not completely disagree with the views of Davis, Anderson, Landowska, Berger, and Feinstein(1985) above , it rather postulates that the greatest vocational barrier in Cameroon is the non-availability of assistive technology and

poorly adapted and the attitudes of the community towards the people living with disabilities in general.

Studies assessing the relationship between disability status and dysfunctional vocational/career thoughts have produced mixed results. Dipeolu, Reardon, Sampson, and Burkhead (2002) examined career thoughts in a sample of college students both with and without learning disabilities. Contrary to expectations, the researchers found that the students with disabilities indicated fewer dysfunctional career thoughts overall, less commitment anxiety, and less confusion regarding vocational decisions than peers without disabilities. Streusel, Lustig, Keim, Ketz, and Malesky (2002) assessed career thoughts in a group of individuals with disabilities from the community and in a group of college students without disabilities; the scientists found no significant differences between groups. The researchers however noted several limitations to the study, including a 15-yearmean age difference between the two groups. Holland et al. (1980) found that vocational identity increases with age and level of education. Therefore, age and education level could affect the relationship between career thoughts and vocational identity. Notwithstanding the above studies portray that contrary to societal stereotypes, people living with disabilities have the potential to make appropriate vocational choices commensurate to their respective disabilities. Therefore what determine their vocational success is the community perceptions/attitudes towards them, assistance and not their respective disabilities? Previous studies have not examined the effect of specific disability types on career thoughts and vocational identity, nor have they examined the relationship between career thoughts and vocational identity by disability type (Lease, Streusel, 2005). It is therefore, on account of the above short coming that the current study sets out to examine community perception and vocational choices of the physically handicap. This study is further inspired by the notion that the type of disability suggests the appropriate vocations for the individual in question. This understanding will prevent unrealistic optimism and permit concerned individuals to choose vocations appropriate to their condition.

1.4 Theoretical Background

Two groups of theories are relevant for this study (theories of perception and Vocational choice). These two groups of theories general endeavor to sharpen our understanding on how one arrive at a vocational choice and the processes involved in the formation of a belief system (perception).

1.4.1. Theories of Perception

Humans generally perceive and form impressions about what ever exist in their environment. The cultural background of every individual influence how he/she perceives, interpret and react to environmental stimuli. For the purpose of this study, theories of perception will then help us to understand how community members come about with their impressions about the physically disabled, interpret and react to their condition

Most relevant theories and explanations of perception as a process of acquiring and processing of information may be divided into two basic groups, according to the direction of information flow. The first is a group of theories which suppose using only bottom–up processes when acquiring and processing sensory data. By bottom–up processes, we mean processes that start at the lowest sensory levels — that means(from the cortex's point of view) at the most distant levels of cognitive apparatus — and then they gradually lead to more complicated and complex processes which take place in higher (cortical) structures which are responsible for more global and abstract ways of thinking.

On the contrary, the top–down theories suppose that in the process of discrimination, but mainly when processing sensory stimulus, we start by "feeling" sensory data on receptors, but their processing presumes a downward influence of higher cognitive contents which organize and later determine them. Such influence we can call the top–down effect. The core of this approach is the fact that in order to process sensory stimulus, one needs to have prior experience or knowledge, or other influences which help to organize and form cognitive contents (Demuth, 2013). The knowledge can either be handed down to us or created by us. Whether the knowledge is created or inherited, culture is implicated in the process. It seems that our environment determines the way in which we perceive as well as its content. On the other hand, individual differences of our sensory and cognitive apparatus, specifics of personal history and uniqueness of our location in space and time open up a question of subjectivity or objectivity of perception and the problem of individual dissimilarities or universality of perceptions.

1.5 Contextual Background

This subsection of the background focuses on reactions towards disability and disabled people in historical and contemporary terms in Cameroon. Cameroon is a multicultural nation and hence the perceptions towards people living with disabilities are multifaceted. There is a long history of killing, abandonment, labeling and many other forms of maltreatment of

people living with disabilities in Cameroon. However, the situation is gradually changing for the better. Conflict is known to generate injuries and trauma that can result in disabilities. For the injured, the situation is often exacerbated by delays in obtaining emergency health care and longer-term rehabilitation. Violence and conflict are estimated to account for 1.4% of people living with a disability (WHO & World Bank 2011). Within the context of Cameroon the ongoing arms conflict between the English speaking regions and the Government of Cameroon has greatly increased the prevalence rate of people living with physical disabilities. The war between the government of Cameroon and Bokoharam, coupled with multiple road accidents due to extreme bad roads have been a contributing factor to a steady rise in the number of people living with physical disabilities. Prior to the boko haram insurgency and the Anglophone crisis, there have been multiple intertribal conflicts that have rendered many people physically handicapped,

Disability rights are not new rights per se, rather, they bring poignancy to human rights that already exist but have been historically denied or marginalized. The challenges and impediments faced by PLWD's in Cameroon are significant and should therefore not be treated with levity. Consequently, the Cameroonian legislator has hitherto enacted a plethora of laws and set up commendable institutional mechanisms for the protection of this category of persons. However, a critical examination of these laws and their actual fulfillment reveals a yearning gap between legal theory and practical reality. There exist a plethora of laws for the protection of the rights of PLWD's in Cameroon. These laws encompass International Ratified Conventions, Regional Norms and Domestic Statutes. An analysis of these laws will help provide a better grasp of the legal framework both at the international, regional and national levels. The principal international texts that have been established to protect the rights of PLWD's include the 1948 Universal Declaration of Human Rights and the 2006 Convention on the Rights of Persons with Disabilities. These Conventions are applicable in Cameroon by virtue of Article 45 of the Cameroonian Constitution (the highest law of the Land). The constitution provide in its preamble that "the state shall provide all its citizens with conditions necessary for their development;- the state shall ensure the protection of minorities and shall preserve the rights of indigenous populations in accordance with the law". The Preamble of the Cameroonian Constitution, therefore, obliges the state to ensure the protection of minorities. Worth mentioning is the fact that PLWD's generally fall under the category of minorities, and hence their protection.

Moreover, the 2010 Law Relating to the Protection and Welfare of Persons with Disabilities is the main law that protects the welfare of PLWD's in Cameroon. In this respect, it aims at

the prevention of disabilities; social, economic and psychological rehabilitation and integration of PLWD's; and promotion of national solidarity in favour of PLWD's (Section 1 of the 2010 Law). The Cameroonian Ministry of Social Affairs is the primary ministry charged with the responsibility of protecting the rights of PLWD's. The Ministry is made up of several Departments. Its department of Social Protection of PLWD's is one of its core Department charged with the duty to elaborate, implement and follow up the socio-economic reinsertion policy of PLWD's, the implementation of Government's policy of special education, health assistance, equipment and professional training of PLWD's. It further helps PLWD's by providing subventions to private institutions delivering care to these persons, promotion of development programs and capacity to mobilize and manage resources of target populations, enter technical relationships with national and international organisms of promotion of PLWD's and collection of statistical data on target populations, in conjunction with the technical structures concerned (Ministry of Social Affairs – Minas). The ministry has hitherto implemented various schemes for the betterment of PLWD's. In 2006, the Ministry of Social Affairs took the following steps for the betterment of the rights of PLWD's.

On 22 March 2006, the Minister of Social Affairs and the Director of CNPS signed an agreement aimed at improving assistance to disabled persons and victims of industrial accidents. The agreement was also implemented within CNPS, which provided its disabled staff members with special vehicles to facilitate their transport to work. On 4 September 2006, a partnership agreement was signed between the Minister of Social Affairs and the National Director of FNE on facilitating the integration of vulnerable persons into training programs and gainful employment to help PLWD's to economic and social independence. A meeting between the Ministers of Higher Education and Social Affairs on 13 March 2006 led to the signature of a joint circular letter aimed at ameliorating the conditions of disabled and vulnerable students by providing them with accommodations, integrating them into University "work-study programs" and finding vacation internships for them. On 10 April 2006, a meeting was held between the Ministers of Social Affairs and Public Works to ensure the effective application of the 1983 Act on disabled persons' access to public buildings and of the related implementation Decree No. 90/1516 of 26 November 1990;

Looking at the adequacy of the initiatives and/or action plans formulated by the government of Cameroon to protect the rights of PLWD's, it might be tempting to establish that these fundamental initiatives have been successful in accomplishing significant Human Right improvements in the arena of the fight for the protection of the rights of PLWD's. Such an establishment would be fundamentally flawed. PLWD's in Cameroon face the difficulty of

moving from one place to another. Many roads are not paved and muddy. The terrains are hilly and most regions are mountainous. This means that those with mobility impairments face the challenge of moving their bodies on these landscapes.
Moreover, PLWD's face stigmatization. Most parents who have children with disabilities don't send them to school. This is because they think that it's wastage of money as they may not easily gain employment in the future (Rachel, 2014).

PLWD's are amongst the most marginalized and at-risk populations in any crisis-affected country. With the upsurge of the Anglophone brouhaha, Anglophone regions have been embroiled in a cycle of deadly violence. The crisis has exacerbated an already difficult situation for PLWD's. Between February and May 2019, Human Rights Watch interviewed 48 PLWD's living in the Anglophone regions to investigate how the crisis in the North-West and South-West regions has affected them. It was realized that PLWD's have been among those killed, violently assaulted, or kidnapped by government forces and armed separatists. One of such victims, a 43-year-old man with hearing disabilities was killed on May 5th, 2019 by soldiers from the Rapid Intervention Battalion when he failed to answer their questions. The crisis in the Anglophone regions has exacerbated an already difficult situation for PLWD's (Human Rights Watch Reports, 2019).Several reasons could be advanced for the aforementioned challenges. They include inter alia, the lack of awareness of the existence of disability rights, weak enforcement of existing laws and policies, and the lack of a political will for their implementation. It is therefore imperative that policy formulation, legitimization, implementation, and evaluation be given credence in matters related to disability in Cameroon.

STATEMENT OF THE PROBLEM

It is evident that most people living with disabilities in Cameroon still witness negative perceptions from their respective communities that may affect their Vocational choices. Hence high rates of unemployment and under employment amongst people living with disabilities. Individuals with disabilities typically have a more complex career development process than their peers and are more susceptible to vocational identity and career decision making problems (Enright, 1996; Luzzo, Hitchings, Restish, 1999; Ochs & Roessler, 2001). Career decision making difficulties are related to impaired decision making skills, unclear goals, lack of vocational information, perceived barriers and value conflicts (Germeijs & Deboech, 2003; Holland et al, 1980; Ladany, Melincoft, Constantine & love 1997; Osipow, 1999) and are significant obstacles to employment for many people with disabilities.

Research further suggests there are a number of individual and environmental factors that influence the career development process for people with disabilities. Individual factors include cultural background (Enright et al., 1996; Szymanski & Hershenson, 1998), socioeconomic status (Blustein, Juntunen, & Worthington, 2000), self-esteem (Munson, 1992), and disability status. Environmental factors such as family involvement (Hitchings, Luzzo, Ristow, Horvath, Retish, & Tanners, 2001), have been found to affect the vocational decision–making abilities of individuals with disabilities. Vocational behavior may also vary because of characteristics of a person's disability (Aune & Kroeger, 1997; Enright, 1996; Hitchings et al., 2001; Szymanski & Hershenson, 1998). Therefore, dysfunctional community beliefs about people living with disabilities may lead to significant others choosing vocations that do not appeal to the interests of the disable children. On the other hand disable children may find it difficult to make good vocational choices because of over protection. Based on the above, this study sets out to investigate the influence of community perceptions on the vocational choices of the physically handicapped in the Bafut Community.

1.6 Objectives of the Study

1.7.1a Main Objective of the Study

- The main objective of this study is to investigate community perception of the physically handicapped and its effects on their vocational choice.

1.7.1b Specific objectives

This study specifically is to:

- Examining the effects of Discrimination on the vocational choices of the physically handicaps.
- Assessing the effects of Condescension on the vocational choices of the physically handicapped.
- Investigating the effects of social avoidance on the vocational choices of the physically handicapped.
- Finding out the effects of internalization on the vocational choices of the physically handicapped.

1.8 Research Questions

1.8.1Main Research Question

- ❖ The central question of this study is “how does Community Perception affect the vocational choices of the physically handicapped?”

1.8.2 Specific Research Questions

- ❖ How does Discrimination affect the vocational choices of the physically handicapped?
- ❖ How does condescension affect the vocational choices of the physically handicapped?
- ❖ How does social avoidance affect the vocational choices of the physically handicapped?
- ❖ How does internalization affect the vocational choices of the physically handicapped?

1.9 Research Hypotheses

1.9.1 Main Hypothesis

- ❖ Ha: There is a significant relationship between community perception and the vocational choices of the physically handicapped

1.9.2 Specific hypotheses

- ❖ Ha: There is a significant relationship between Discrimination and the vocational choices of the physically handicapped.
- ❖ Ha: There is a significant relationship between condescension and the vocational choices of the physically handicapped.
- ❖ Ha: There is a significant relationship between social avoidance and the vocational choices of the physically handicapped.
- ❖ Ha: There is a significant relationship between internalization the vocational choices of the physically handicapped.

Table 1: Operationalization and summary of general hypothesis and specific hypotheses

General Hypothesis	**Independent Variable**	**Indicator**	**Modality**
There is a significant relationship between community Perceptions and the vocational choices of the physically handicapped	Community perception	-Discrimination - Condescension -Social Avoidance -Internalization	Strongly Agree Agree Disagree Strongly Disagree
	Dependent Variable Vocational Choice	-commercial - industrial -General - apprenticeship	1 2 3 4
Hypothesis 1 There is a significant relationship between Discrimination and the vocational choices of the physically handicapped	**Independent Variable** Discrimination	-education -parental care -peer group interaction -access to human basic services	Strongly Agree Agree Disagree Strongly Disagree
	Dependent Vocational Choice	commercial - industrial -General - apprenticeship	1 2 3 4
Hypothesis 2 There is a significant relationship between condescension and the vocational choices of the physically	**Independent Variable** Condescension	-decision making -protection - effort making - participation in	Strongly Agree Agree Disagree Strongly Disagree

handicapped		house chores	
	Dependent Variable Vocational Choice	commercial - industrial -General - apprenticeship	1 2 3 4
Hypothesis 3 There is a significant relationship between social avoidance and the vocational choices of the physically handicapped	**Independent Variable** Social Avoidance	Despise Friendship Play mate selection Sharing items	Strongly Agree Agree Disagree Strongly Disagree
	Dependent Variable Vocational Choice	commercial - industrial -General - apprenticeship	1 2 3 4
Hypothesis 4 There is a significant relationship between internalization the and the vocational choices of the physically handicapped	**Independent Variable** Internalization	Self-fulfillment prophesy Self-worth dependency	Strongly Agree Agree Disagree Strongly Disagree
	Dependent Variable Vocational Choice	commercial - industrial -General - apprenticeship	1 2 3 4

Table 2: Synoptic table of hypothesis, variables, indicators and modalities

Subject	General Hypothesis	Research Hypotheses	Variable	Indicator	Modality	Items	Research Tools	Statistical Tools
Community perception of the physically handicap and Vocational choice	There is a significant relationship between community perception between and vocational choice	**Hypothesis 1** There is a significant relationship between Discrimination and the vocational choices of the physically handicapped	Discrimination	Discrimination	SA A D SD	20	Questionnaire	
		Hypothesis 2 There is a significant relationship between condescension and the vocational choices of the physically handicapped	Condescension	Condescension	SA A D SD	12		
		Hypothesis 3 There is a significant relationship between social avoidance and the vocational choices of the physically handicapped	Social Avoidance	Social Avoidance	SA A D SD	17		

		Hypothesis 4 There is a significant relationship between internalization the and the vocational choices of the physically handicapped	Internalization	Internalization		12		

1.9.2.1 Justification of the study

The number of people affected by physical disabilities is on a steady rise and Cameroon is a signatory to a number of conventions on the rights of people living with disabilities. This creates a need to conduct research in order to:

- ❖ Ascertain the under the extent to which Cameroon is implementing the demands of the conventions
- ❖ Understand the challenges faced in course of implementation of the conventions
- ❖ Understand the challenges which physically handicapped person encounter with respect to their vocational choices
- ❖ Propose solutions to the problems encountered
- ❖ Inform policy etc
- ❖ National rehabilitation centers (center for persons with disabilities Etugebe Yaounde Bulu blind center Buea, handicapped rehabilitation center Mefou Afamba Yaounde etc.), To include vocational training and vocational choice counseling in their programmes

1.9.2.2: significance of the study

This study will be significant to vocational education stake holders, the physically handicapped, NGOs interested in the wellbeing of the physically handicapped and policy makers.

1.9. 2. Scope of the Study

Geographically, the study will be limited to the Bafut sub-Division in the North West Region of Cameroon. Conceptually, this study is limited to community perception and vocational choices of the physically handicapped. Furthermore, the indicators of community perceptions are limited to discrimination, Condescension, Social Avoidance and internalization. The theoretical perspective of the study is limited to theories of perception. The instruments for data collection will be limited to questionnaires and interview and the data analysis will involve both descriptive and inferential statistics.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

This chapter reviews literature related to the phenomenon under study. The importance of reviewing related literature in a scholarly exercise like this cannot be overemphasized. This helped the researcher to acquaint and draw insights from scholarly works closely related to this study. The literature was reviewed and organized under the following main headings: conceptual review, theoretical review, and empirical review.

2.1 Conceptual Review

2.1.1 Disability

According to the Webster Miriam's dictionary disability is a physical, mental, cognitive, or developmental condition that impairs, interferes with, or limits a person's ability to engage in certain tasks or actions or participate in typical daily activities and interactions**.** Disability is further defined as any impairment of the body or mind that limits a person's ability to partake in typical activities and social interactions in their environment (Scheer & Groce, 1988). The United Nation's Conventions on the rights of Persons with Disabilities (UNRPD) (2011) recognizes disability as an evolving concept and states that "persons with Disabilities include those who have long term physical, mental, intellectual and sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on equal basis with others". The American Disability Act (ADA) defines disability, with respect to an individual, as 'a physical or mental impairment that substantially limits one or more of the major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment (ADA Act of 1990).According to the social model of disability which appeared in the 1960s, disability is considered as a social product, as a result of society's inadequacy to the specificities of its members. The model identifies the presence of physical and social barriers which makes it difficult for people with disabilities to exercise their rights and freedoms in all aspects of life. In this same light WHO (2011) says disability is thus not just health problems. It is a complex phenomenon, reflecting the interactions between features of person's body and features of society in which he/she lives. From the above definitions of disability, it obvious that disability is a deviation from

normal functioning but the difficulties which the individuals face are exacerbated by community perception and social interactions.

Disability is not just a health problem or attribute of individuals, but it reflects difficulties individuals may experience in interaction with society and physical movements. For disabled persons and their families, the situation becomes doubly difficult due to general health problem and unique social stigma attached to various types of disability. Disabled people experience various barriers due to restriction of participation and their lives are affected with poor health outcomes, low education, lack of social and economic participation, higher rates of poverty and increased dependency.

In general, Disability studies are an academic discipline that examines and theorizes about the social, political, cultural, and economic factors that define disability. The disability rights movement, scholars, activists and practitioners construct debates around two distinctly different models of understanding of disability - the social and medical models of disability (Disabled-World.com). However, there are many other models that are used in disability studies. Disability scholars use the models to identify the different factors that are implicated in the proper comprehension of disabilities.

Hence, Disability is not just a health problem or attribute of individuals, but it reflects difficulties individuals may experience in interaction with society and physical movements. Evidently the term "disability" has many different meanings; the global burden of disease (GBD) however, uses the term disability to refer to loss of health, where health is conceptualized in terms of functioning capacity in a set of health domains such as mobility, cognition, hearing, and vision. Disability studies are an academic discipline that examines and theorizes about the social, political, cultural, and economic factors that define disability. Disability scholars use models to identify the different factors that are implicated in disabilities. Disability scholars also classify disability in to different Categories. These categories may include: social, mental, psychological, intellectual, physical disability etc.

2.1.2 Social Disability:

A social disability can refer to any disorder that leads to the inability to make progress socially and emotionally meaning the impact of the disorder degrades a person's quality of life. Some social disabilities are recognized federally under the IDEA- they can include autism, other health impairment, intellectual disability, emotional disturbance, among others. When the impact is so great, an individual might qualify for services through a school district

if they are school age, or if they are an adult, they may qualify for federal or state disability insurance to support any services they need to treat their disability and lead a productive life (https://www.quora.com/What-does-a-social-disability-mean). Examples include Post Traumatic Stress Disorder (PTSD), Major Depressive Episode (MDE). Depression etc.

2.1.3 Mental Disability:

According to the WHO mental disorder is characterized by a clinically significant disturbance in an individual's cognition, emotional regulation, or behavior. It is usually associated with distress or impairment in important areas of functioning. There are many different types of mental disorders. Mental disorders may also be referred to as mental health conditions. The latter is a broader term covering mental disorders, psychosocial disabilities and (other) mental states associated with significant distress, impairment in functioning, or risk of self-harm. Some examples include Anxiety Disorders, Depression, Personality Disorders, Eating Disorders, and psychotic Disorders etc

2.1.4 Psychological disability:

According to the APA (2013), a psychological disorder is a condition that is said to consist of the following:

- ❖ There are significant disturbances in thoughts, feelings, and behaviors. A person must experience inner states (e.g., thoughts and/or feelings) and exhibit behaviors that are clearly disturbed—that is, unusual, but in a negative, self-defeating way. Often, such disturbances are troubling to those around the individual who experiences them.
- ❖ The disturbances reflect some kind of biological, psychological, or developmental dysfunction. Disturbed patterns of inner experiences and behaviors should reflect some flaw (dysfunction) in the internal biological, psychological, and developmental mechanisms that lead to normal, healthy psychological functioning.
- ❖ The disturbances lead to significant distress or disability in one's life. A person's inner experiences and behaviors are considered to reflect a psychological disorder if they cause the person considerable distress, or greatly impair his ability to function as a normal individual (often referred to as functional impairment, or occupational and social impairment).
- ❖ The disturbances do not reflect expected or culturally approved responses to certain events. Disturbances in thoughts, feelings, and behaviors must be socially

unacceptable responses to certain events that often happen in life. Some believe that there is no essential criterion or set of criteria that can definitively distinguish all cases of disorder from no disorder (Lilienfeld & Marino, 1999). Examples of psychological disabilities include manic depression, bi-polar disorder, schizophrenia, personality disorders, post-traumatic stress disorders, anxiety disorders, delusional disorders, and eating disorders. Psychological disabilities can create barriers to education in different ways.

2.1.5Physical disability

A physical disability is identified as a disability associated with a physical impairment. Physical activity limitations may also be used to identify physical disability, but should be defined as limitations in performing simple activities that are clearly associated with physical (rather than intellectual, etc.) abilities (Wen &Nicola, 1999). Therefore a physical disability is a substantial and long-term condition affecting a part of a person's body that impairs and limits their physical functioning, mobility, stamina or dexterity. The loss of physical capacity results in the person was having a reduced ability, or inability, to perform body movements such as walking, moving their hands and arms, sitting and standing as well as controlling their muscles. A physical disability does not necessarily stop you from performing specific tasks but makes them more challenging. This includes daily tasks taking longer to complete, such as getting dressed or difficulty gripping and carrying things. It is important to note that defining physical disability is not about the physical condition itself but how it impacts daily life, such as the ability to carry out work activities. A person may be born with a physical disability or acquire it in life due to an accident, injury, illness or as a side effect of a medical condition.

Physical disability may also constitute any physiological disorder or condition, cosmetic disfigurement, or anatomic loss affecting one or more of the following body systems: neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, hemic and lymphatic, skin, and endocrine systems' (Americans with Disabilities Act of 1990).Examples of physical disability include cerebral palsy, multiple sclerosis, epilepsy, amputations, spinal cord injuries, deaf, dumb, blindness, learning disabilities (dysgraphia, dyslexia, dyspraxia, dyscalculia, dysorthography and attention deficit hyperactive syndrome (carehome.com). Just as types of physical abilities and how they impact a person's daily life are all different, causes of physical disabilities also vary.

2.1.6Types of Physical Disabilities

Learning Disability: According to the Individual with Disability Education Act (IDEA, 2004) The term learning disability' means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. Learning disabilities vary from individual to individual and may present in a variety of ways. Learning disabilities may manifest as difficulty: (1) processing information by visual and auditory, means, which may impact upon reading, spelling, writing, and understanding or using language, (2) prioritizing, organizing, doing mathematics, and following instructions, (3) storing or retrieving information from short or long term memory, (4) using spoken language, and (5) clumsiness or difficulty with handwriting. Examples of learning disabilities include:

Dysgraphia-At its broadest definition, dysgraphia is a disorder of writing ability at any stage, including problems with letter formation/legibility, letter spacing, spelling, fine motor coordination, rate of writing, grammar, and composition. Acquired dysgraphia occurs when existing brain pathways are disrupted by an event (e.g., brain injury, neurologic disease, or degenerative conditions), resulting in the loss of previously acquired skills.(Chung J., Patel D. R, and Nizami, I., 2020).

Dyscalculia: The word "Dyscalculia" is a contemporary derivative of the Latin "dys", which means a form of special difficulties not inabilities and the Greek "calculus". Freely interpreted this word means “counting-stone”. Out of this combination, “dyscalculia” was created, to refer to difficulties with counting (Adler 2008). A common result of dyscalculia is a high level of mathematics anxiety. Dyscalculic children may soon come to hate mathematics, and try and avoid it. There is not very much awareness of dyscalculia in most countries and many teachers may not have had any training in how to teach learning disabled children. Dyscalculia (also called mathematics disability or numlexia) is a specific learning disability involving innate difficulty in learning or comprehending arithmetic. Mathematics disabilities can also occur as the result of some types of brain injury, in which case the proper term is acalculia, to distinguish it from dyscalculia which is of innate, genetic or developmental origin. Dyscalculia is a specific learning disability (or difficulty) in mathematics. It was originally defined by the Czechoslovakian researcher Kosc (1974), as a difficulty in mathematics as a result of impairment to particular parts of the brain involved in mathematical cognition, but without a general difficulty in cognitive function.

Dyspraxia-Dyspraxia also known as developmental coordination disorder (DCD), is a symptom collection which overlaps with other neuro-developmental conditions, such as attention deficit hyperactivity disorder (ADHD), dyslexia, and social and communication impairment. The DSM-1V classification1 for DCD describes difficulties across a range of living and learning skills, with the child's motor performance abilities differing from one situation to another and across a period of time. The key elements are difficulties with activities requiring fine and gross motor function, such as handwriting, dressing and team games, and poor organizational skills (Kirby A., 2004)

Nonverbal Learning Disorder (NLD): A Nonverbal Learning Disorder is demonstrated by below-average motor coordination, visual-spatial organization, and social skills. By definition, NLD is a relative strength in left-brain skills, which are largely verbal, and weakness in right-brain nonverbal skills. As such, to understand NLD, it is important to understand the right hemisphere of the brain (Hauser J., 2019).The right side of the brain is responsible for the collection and integration of multiple sources of information, particularly sensory information, lending to an organized "big picture" understanding of events or information. The right brain is thus not only important for basic visual processing and reasoning, but it is also responsible for the organization and coordination of information and skills across a wide range of domains, including learning, motor coordination, self-regulation (e.g. sensory regulation and attention), social thinking, and task management. It is important to understand that NLD is a *relative* deficit, meaning that it is a personal weakness. Some individuals with NLD may have nonverbal skills that are all technically "average or better," but they are still discrepant from that person's strong verbal skills, causing variability within the profile.

Dyslexia: Dyslexia is a neurobiological, developmental, language-based learning disability that affects individuals' ability to learn to read (accuracy and fluency) and the development of spelling skills. Individuals with dyslexia have difficulty connecting spoken language and the printed word because they have deficits in the phonological component of language. Difficulty decoding words accurately and fluently can affect reading comprehension and vocabulary development (Kim, Y. S., Wagner, R. K., & Lopez. D., 2012; Snowling, M. J., 2019).Spelling difficulties may affect the production of written composition. Dyslexia can lead to poor academic performance, low self-esteem, and lack of motivation. It is not a sign of low intelligence, laziness, or poor vision, and occurs across the range of intellectual abilities (Berninger, V. W., Lee, YL., Abbott, R. D., &Breznitz, Z., 2013; Denton, C. A.,

Fletcher, J. M., Anthony, J. L., & Francis, D. J.,2006). Furthermore, according to the Individuals with Disabilities Education Act (IDEA), the working definition of dyslexia labels it as a "specific learning disability." It is "a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations, including conditions such as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia (IDEA, 2004).

Attention Deficit Hyperactivity Disorder: ADHD is a condition that is characterized by the following: Presence of symptoms of inattention, hyperactivity and impulsiveness; Onset before the age of 7 years and usually from birth; At least moderate impairment of functioning in more than one setting (school, home and health care, i.e. your consulting room) and At least moderate impairment of function in several domains (school achievement, friendships, leisure activity or home life) (Ougrin D, Chatteton S. &Banarsee R., 2010).The long-term negative impact of the effects of ADHD is serious and enduring. A third of young people diagnosed face unhappy, problematic futures including poor relationships, significant educational underachievement and later unemployment, high levels of involvement with drug and alcohol misuse, antisocial behaviour and criminality.

Mobility Disability: Mobility is defined as the ability of an individual to purposively move about her environment. Mobility limitations are impairments in movement and affect between one third and one half of adults age 65 or older (Webber, Porter, &Menec, 2010). Mobility limitations affect an individual's health and well-being in multiple ways, including increasing the risk of disability (Webber et al., 2010). In older adults, development of disability, the inability to perform one's usual activities due to a physical or mental health problem, is typically a dynamic process that arises from multiple insults occurring over time (Verbrugge & Jette, 1994). The Disablement Process posits that functional limitations restrictions in basic physical and mental actions such as mobility precede disability (Verbrugge & Jette, 1994). However, not all functional limitations will result in disability and it is therefore important to distinguish the role each plays in the health of individuals. By assessing limitations and disability in conjunction, we can begin to understand how particular risk factors and health outcomes are associated with mobility limitations in the presence and absence of disability. A person with a Mobility Disability may or may not use a wheelchair, scooter, electric personal assisted mobility device, crutches, walker, cane, brace, orthopedic device, or similar equipment or device to assist her or his navigation along sidewalks, or may be semi-

ambulatory. Examples include but are not limited to amputation, paralysis, cerebral palsy, stroke, multiple sclerosis, muscular dystrophy, arthritis, and spinal cord injury.

Amputation: this is the action of surgically cutting off a limb. This can be as a result of accident or disease. Amputation is traumatic both as a surgery itself and also due to its consequences. Perceived as an aggression to bodily integrity, besides physical suffering, it can initiate or aggravate a series of disharmonies that disrupt the patient's well-being. Desmond and MacLachlan (2002) consider that amputations cause considerable changes in everyday life of the patient, and especially in psychosocial relationships. Physical disability can lead to despair, depression, nervousness, anxiety, loss of self-esteem, stigma, isolation, and the recognition of weakness (Khan et al., 2018). The decision to amputate a limb is difficult for medical staff, the patient, and his/her family (Boccolini, 1995)

Cerebral Palsy: Cerebral palsy (CP) occurs in young children and is a group of non-progressive disorders that damage the brain, causing impairment of motor function. Including associated disabilities such as intellectual and behavioral, a person with cerebral palsy usually has problems with movement and co-ordination. Cerebral palsy is not a defined, separate disease classification, but an umbrella term encompassing etiologically diverse symptoms, which change with age. The term "cerebral paralysis" was used for the first time more than 170 years ago, by the English orthopedic surgeon William little, who correlated a difficult labour and neonatal hypoxia with limb spasticity and consequential musculoskeletal deformities (Little W.J., 2012). Over the years, the definition of cerebral palsy has been repeatedly changed (Keith MRC., Mackenzie I., Polani P., 1959; Mutch L., Alberman E., Hagberg B., Kolama K. &PeratMV., 1992). According to the current definition, developed by an international team of experts, cerebral palsy is a group of permanent, but not unchanging, disorders of movement and/or posture and of motor function, which are due to a non-progressive interference, lesion, or abnormality of the developing/immature brain (BaxM., Goldstein M., Rosebaum P. et al, 2005; Cans C., Dott H., Platt M.J., Colver A.,Prasauskene A., krageloh& Mann I., 2007). The diagnosis of cerebral palsy is mainly based on motor function and posture disorders that occur in early childhood and persist until the end of life; they are non-progressive, but change with age. Motor function disorders, which are the core symptoms of cerebral palsy, are frequently accompanied by other dysfunctions, such as: sensation, perceptual, cognitive, communication and behavioural disorders, epilepsy, and secondary musculoskeletal disorders (Rosenbaum P., Paneth N., Leviton A., et al, 2007).

Sensory Disability: Sensory Impairment is the impairment in the senses viz., sight, hearing, smell, touch, taste and spatial awareness (Salai S.C., 2021).

2.1.7 Types of Sensory disabilities

A: Single Sensory Impairment: Single Sensory Impairment indicates the impairment in a single or one sense.

Hearing Impairment: A person is said to have hearing impairment if he/she cannot hear at all, or can hear only loud sounds, shouted words, or only if the speaker was sitting in front, or would usually ask to repeat the words spoken to him/her. The Persons with Disabilities Act (1995) have adopted the definition that a person shall be deemed to be deaf if he/she has loss of 60 decibels more in the better ear in the conventional range of frequencies.

Visual Impairment: According to Persons with Disabilities Act (1995) blindness refers to a condition where a person suffers from any of the following conditions, namely: Total absence of sight or Visual acuity not exceeding 6/60 or 20/200 (snellen) in the better eye with correcting lenses or Limitations of the field of vision subtending an angle of 20 degree or worse.

B: **Dual Sensory Impairment**: Dual sensory impairment is the combination of impairment in the senses i.e, hearing and sight impairment. Those with a less severe degree of both sight and hearing impairment may also be referred to as having a dual sensory impairment or loss. The words dual sensory impaired and deaf-blind are generally accepted as inter-changeable words. When a person has difficulties seeing and hearing then the person can be termed deaf-blind. The sensory impairments indicate the impairment in the senses (Salai SC., 2021).

Stroke: According to the definition proposed by the World Health Organization in 1970, "stroke is rapidly developing clinical signs of focal (or global) disturbance of cerebral function, with symptoms lasting 24 hours or longer, or leading to death, with no apparent cause other than of vascular origin". (Warlow C.P., 1998)Quite recently, a new definition of stroke that incorporates clinical and tissue criteria has been proposed by the American Stroke Association for the 21st century. This definition is much broader and includes any objective evidence of permanent brain, spinal cord, or retinal cell death attributed to a vascular etiology based on pathological or imaging evidence with or without the presence of clinical symptoms (Sacco R.L., Kasner S.E., Broderick., J.P., et al, 2013)). Stroke has a huge public health

burden, which is set to rise over future decades because of demographic transitions of populations, particularly in developing countries (Adogu P.O.U., Ubajaka C.F., Emelumadu O.F., Alutu C.O.C., 2015). Generally, strokes can be classified into two major categories, namely, ischemic stroke and hemorrhagic stroke. Ischaemic stroke is caused by interruption of the blood supply to a part of the brain resulting in sudden loss of function, while hemorrhagic stroke is attributed to rupture of a blood vessel or an abnormal vascular structure (Bamford J., Sandercock P., Dennis M., Burn J. & Warlow C. 1991). Generally, ischaemic strokes account for about 80% of stroke cases while haemorrhagic stroke accounts for 20% but the actual proportions of stroke types depend on the population (Bamford J., Sandercock P., Dennis M., Burn J. & Warlow C. 1991).

Multiple sclerosis (MS): Multiple Sclerosis is briefly called MS. It's an inflammatory disease in which the myelin sheaths of the nerve cells are damaged in the brain and spinal cord. The body mistakenly attacks the protective material around the neurons (axons) of the brain and the spinal cord. This means that the immune system which typically works against infections, confuses and attack to internal tissues with foreign objects such as bacteria. In the MS, the immune system attacks to myelin sheets over nerve fibers. This condition can damage the myelin and eliminate it from the nerve field partly or completely and makes wounds that are called lesion, plaque or sclerosis. Damage to myelin results in disruption of the messages transfer in the direction of the nervous system. The message may be slow or inaccurate and it also may be transmitted from one strand to another or rejected altogether. this damage can interfere with the parts of the nervous system ability that are responsible for communication, resulting in high levels of physical symptoms (Mostafa M., 2020).

Muscular Dystrophy (MD): MD is a progressive neurological disease group including several types of hereditary, primary and incurable muscular diseases involving muscular weakness, which usually progresses relatively slowly (Brooke 1986, Edwards 1989, Harper 1988, Walton & Gardner-Medwin 1988). The development of a progressive disease may cause great stress in the afflicted individual (Boutaugh & Brady 1996). A progressive disease like MD involves successive transitions to new situations due to repeated losses of functional capacity (Ahlström 1994, Ahlström & Gunnarsson 1996, Walton & Gardner-Medwin 1988). The capacity to perform activities of daily living is essential for a person to maintain his or her roles in the family, at work and in society as a whole (Kielhofner 1992). Since there is no cure or treatment for MD, it is important to give recurrent support and care both to the

persons´ with MD and to their families, assisting them to manage their daily life and to find meaningful occupations (Wilcock 1993).

2.2 Causes of Physical Disabilities

Scientists are not sure of the exact causes of disabilities. However, recent studies link the cause to hereditary, congenital and acquired.

2.2.1 Hereditary:

A person with a hereditary disability has had the condition since birth or developed the condition because of inherited genetic problems (Berg V., 2020). Some disabilities are known to be inherited, such as spinal muscular atrophy and muscular dystrophy (diseases of the muscles and nerves). Women who already have one or more children with an inherited disability are more likely to give birth to another child with the same problem. Other disabilities can result when close blood relatives (such as brothers and sisters, first cousins, or parents and children) have children together. Children born to mothers 40 years of age or older are more likely to have Down syndrome. However, most disabilities are not inherited.

2.2.3 Congenital:

Congenital disability means that the disorder developed before or during the birth of a child. Congenital disorders (birth defects) are an abnormality of body structure, function or chemistry present at birth that results in physical or mental disabilities. While all the causes of congenital disorders are not known, some disorders can be prevented. Actions you take can help prevent congenital disorders and make a better life for your baby. These disorders are caused by factors such as alcohol or chemicals that come from outside the developing child's body. The parents can control exposure to some of these factors, such as alcohol and tobacco smoke (Centre for Disease Control and protection, 2021). Many disabilities in babies are caused by harmful conditions of women's lives. If women can get enough nutritious food to eat, can protect themselves from work with toxic chemicals, and can get good health care, including care at the time of childbirth, then many disabilities could be prevented.

2.2.4 Acquired

A person can acquire a physical disability due to a number of reasons. These can be severe accidents, brain injuries, infections, diseases and as a side effect of disorders and other medical conditions, such as a stroke and dementia. Good health care can prevent many

disabilities. Difficult labor and birth can cause a baby to be born with a disability such as cerebral palsy. Trained birth attendants who can identify risks and handle emergencies can prevent babies from being born with many disabilities. Immunization can also prevent many disabilities. But many times vaccines are not available, or people who are poor or live far from cities cannot afford them, or there are not enough for everyone. If a woman gets German measles (rubella) during the first 3 months of pregnancy, her child may be born deaf. Some illnesses a pregnant woman may get can cause physical or learning problems when her baby is born. Illnesses that can cause birth defects include German measles (rubella), which is a common cause of deafness in newborn babies. There is a vaccine that gives protection against rubella, but a woman who gets an immunization of the rubella vaccine should not get pregnant for one month afterward

2.3 Effects of Disabilities

The impact of disability may take many forms. The first effects are often physical pain, limitation of mobility, disorientation, confusion, uncertainty and a disruption of roles and patterns of social interaction. The first effects are often physical pain, limitation of mobility, disorientation, confusion, uncertainty and a disruption of roles and patterns of social interaction. Disabled people are minority groups, starved of services and mostly ignored by society, live in isolation, segregation, poverty, charity and even pity. Due to discrimination they do not go to public places and not free to get those rights which a non-disabled person gets. They are deprived of education and employment.

2.3.1 Effects on the disabled person

The course of the child's physical, psychological, and social development will forever be altered by the disability. Since development proceeds sequentially, and since relative success at mastering the tasks of one stage is a prerequisite for facing the challenges of the next stage, one could anticipate that the earlier the onset, the greater the adverse impact on development (Eisenberg, Sutkin, and Jansen 1984). There are many ways in which the accomplishment of development tasks is complicated for persons with disabilities. This, in turn, has an effect on their families as well as on which family roles can be assumed by the person with disability (Perrin and Gerrity 1984).

Parents, fearing injury or more damage to their young child, may restrict their child's efforts to explore and learn, or they may overindulge the child out of sympathy or guilt. If other

people react negatively to the child's disability, parents may try to compensate by being overly protective or overly solicitous. These parent behaviors further compromise the child's development of autonomy and self-control.

As children with disabilities move into school environments where they interact with teachers and peers, they may experience difficulties mastering tasks and developing social skills and competencies. Although schools are mandated to provide special education programs for children in the least restrictive environment and to maximize integration, there is still considerable variability in how effectively schools do this. Barriers include inadequate financing for special education; inadequately trained school personnel; and, very often, attitudinal barriers of other children and staff that compromise full inclusion for students with disabilities.

Developmental tasks of adolescence, developing an identity and developing greater autonomy are particularly difficult when the adolescent has a disability. Part of this process for most adolescents generally involves some risk-taking behaviors, such as smoking and drinking. Adolescents with disabilities take risks too, sometimes defying treatment and procedures related to their condition, such as skipping medications or changing a prescribed diet. Issues related to sexuality may be particularly difficult because the person with disability has fears about his or her desirability to a partner, sexual performance, and worries about ever getting married or having children (Coupey and Cohen 1984). There is some evidence that girls may be at greater risk for pregnancy because of their desire to disavow their disability and prove their normalcy (Holmes 1986). Teens with mental impairment may be subjected to sexual exploitation by others.

When disability has its onset in young adulthood, the person's personal, family, and vocational plans for the future may be altered significantly. If the young adult has a partner where there is a long-term commitment, this relationship may be in jeopardy, particularly if the ability to enact adult roles as a sexual partner, parent, financial provider, or leisure partner are affected (Ireys and Burr 1984). When a couple has just begun to plan a future based on the assumption that both partners would be fully functional, they may find the adjustment to the disability too great to handle. The development of a relationship with a significant other after the disability is already present is more likely to lead to positive adjustment. Young adulthood is that critical transition from one's family of origin to creating a new family unit with a partner and possibly children. When disability occurs at this stage, the

young adult's parents may become the primary caregivers, encouraging or bringing the young person home again. The risk is that the developmental course for the young adult and his or her parents may never get back on track. This is influenced in part by the extent to which there are independent living options for persons with disabilities to make use of in the community.

When the onset of disability occurs to adults in their middle years, it is often associated with major disruption to career and family roles. Those roles are affected for the person with the disability as well as for other family members who have come to depend on him or her to fulfill those roles. Some kind of family reorganization of roles, rules, and routines is usually required. If the person has been employed, he or she may have to give up work and career entirely or perhaps make dramatic changes in amount and type of work. The family may face a major loss of income as well as a loss in health and other employee benefits. If the person is a parent, childrearing responsibilities may be altered significantly.

The adult may have to switch from being the nurturer to being the nurtured. This may leave a major void in the family for someone to fill the nurturing role. If the person is a spouse, the dynamics of this relationship will change as one person is unable to perform as independently as before. The partner with the disability may be treated like another child. The sexual relationship may change, plans for having more children may be abandoned, lifestyle and leisure may be altered. Some spouses feel that their marital contract has been violated, and they are unwilling to make the necessary adjustments

Children of a middle-aged adult with a disability also experience role shifts. Their own dependency and nurturing needs may be neglected. They may be expected to take on some adult roles, such as caring for younger children, doing household chores, or maybe even providing some income. How well the family's efforts at reorganization work depend ultimately on the family's ability to accommodate age-appropriate developmental needs. In families where there is more flexibility among the adults in assuming the different family roles, adjustment is easier.

The onset of disability in old age is more expectable as bodily functions deteriorate. This decline in physical function is often associated with more depression. An older person may live for many years needing assistance in daily living, and the choices of where to get that assistance are not always easily made. Spouses may be unable to meet the extra caretaking

needs indefinitely as their own health and stamina decline (Blackburn 1988). Adult children are often in a position of deciding where their elderly parent or parents should live when they can no longer care for themselves. Having their parents move in with them or having them moves to a nursing home or seniors' residence are the most common options. However, each of these choices carries with it emotional, financial and social costs to the elderly person as well as to his/her adult children.

2.3.2 Effects of Disabilities on Families

Disability places a set of extra demands or challenges on the family system; most of these demands last for a long time (Murphy 1982). Many of these challenges cut across disability type, age of the person with the disability, and type of family in which the person lives. There is the financial burden associated with getting health, education, and social services; buying or renting equipment and devices; making accommodations to the home; transportation; and medications and special food. For many of these financial items, the person or family may be eligible for payment or reimbursement from an insurance company and/or a publicly funded program. However, knowing what services and programs one is eligible for and then working with a bureaucracy to certify that eligibility (often repeatedly) is another major challenge faced by families. Coordination of services among different providers (such as a physician, physical therapist, occupational therapist, dietician, social worker, teacher, and counselor) who often are not aware of what the other is doing and may provide discrepant information is another challenge faced by families (Sloper and Turner 1992). While care coordination or case management is often the stated goal of service programs, there are many flaws in implementation. Families experience the burden of this lack of coordination.

The day-to-day strain of providing care and assistance leads to exhaustion and fatigue, taxing the physical and emotional energy of family members. There are a whole set of issues that create emotional strain, including worry, guilt, anxiety, anger, and uncertainty about the cause of the disability, about the future, about the needs of other family members, about whether one is providing enough assistance, and so on. Grieving over the loss of function of the person with the disability is experienced at the time of onset, and often repeatedly at other stages in the person's life.

The disability can consume a disproportionate share of a family's resources of time, energy, and money, so that other individual and family needs go unmet. Families often talk about

living "one day at a time." The family's lifestyle and leisure activities are altered. A family's dreams and plans for the future may be given up. Social roles are disrupted because often there is not enough time, money, or energy to devote to them (Singhi et al. 1990).

Friends, neighbors, and people in the community may react negatively to the disability by avoidance, disparaging remarks or looks, or overt efforts to exclude people with disabilities and their families. Families often report that the person with the disability is not a major burden for them. The burden comes from dealing with people in the community whose attitudes and behaviors are judgmental, stigmatizing, and rejecting of the disabled individual and his or her family (Knoll 1992; Turnbull et al. 1993). Family members report that these negative attitudes and behaviors often are characteristic of their friends, relatives, and service providers as well as strangers (Patterson and Leonard 1994).

People with disabilities (PLWD) face physical and attitudinal barriers to participation in employment opportunities, education and development processes in general. The Social model of disability views this exclusion as 'disabling' and as caused by the way in which society is organized, making PLWD more vulnerable to poverty and exclusion from the labour market. Exclusion from employment is also linked to exclusion from education and training opportunities, often due to the same barriers (accessibility and negative attitudes of parents, teachers and children).

Even where PLWD are employed, exclusion may be evident. In surveys of work arrangements in Australia, Canada, the UK and the USA, it was found that PLWD may be under-employed relative to their level of training, have lower income levels, have less promotion prospects, are at greater risk to become unemployed and are more often in non-standard work arrangements (Elwan 1999; Emmett, 2006).Exclusion of PLWD is also evident in the fact that disability is closely related to poverty, both a cause and a consequence. Poverty increases the risk of disability, for example through lack of healthcare, poor nutrition, greater exposure to injuries or lack of knowledge about prevention. Disability also adds to the risk of poverty, for example due to the costs associated with the disability, discrimination in the labour market or exclusion from education. This means that PLWD are more likely to experience discrimination that leads to financial difficulties and social and economic deprivation. PLWD can be caught in a vicious cycle of poverty and disability, each being both a cause and a consequence of the other (Elwan, 1999; ILO, 2000; DFID, 2000; Yeo, 2001; Yeo and Moore, 2003; Mitra, 2005; Yeo, 2005; Emmett, 2006; Nagata, 2007).

2.3.4 Effects of Disability on the society

Although in principle workers, their families and employers ought to carry out some financial burden of disability, the society as a whole must bear the rest. This additional burden is reflected in the costs of auto insurance, social security payments, social services, and health care. Here are examples of the costs associated with disability incurred by Canadian society (Canadian Society of Professionals in Disability Management (CSPDM) 2022)

- ❖ Each person with a disability who exhausts sick leave/disability benefits and must go on social assistance moves from being a benefit contributor to a benefit recipient. Canadian society also loses the contributions these individuals make as a result of their education, hard work and creativity.
- ❖ A single person, who becomes disabled and goes on a disability pension at age 35, will require a capitalized pension of $220,940 in order to pay an annual pension of $9,252 until age 65 or $980,410 if the eligible pension amount is $48,000.
- ❖ Between 1996 and 1997, $3 billion was paid in Canada/Quebec Pension Plan Disability Benefits.
- ❖ $400 million was paid in Employment Insurance Sickness Benefits during that same period.
- ❖ Auto insurers paid $1.8 billion to persons with disabilities.
- ❖ The Insurance Corporation of BC spends approximately $300 million per year on wage replacement for those injured in automobile accidents.

Even though the above cites the particular case of Canada, it equally indicate that every society is affected to some extent by the presence of people with disabilities and can go through the same or similar challenges.

Persons with disabilities in Cameroon continue to face diverse barriers that prevent them from enjoying their full civil, political, economic, social, cultural and developmental rights. This is largely due to lack of awareness, ignorance and prejudice in our society. It is also because some legislation fails to protect the rights of persons with disabilities and inclusive education in Cameroon.

2.4 Inclusive education in the Context of Cameroon

Though the terms "inclusion" and "inclusive education" are often used, the concept of inclusion remains difficult to define. Research suggests there is no commonly understood meaning of *inclusion* (Epstein & Elias, 1996). *Inclusive education* is a strategy to ensure

education for all students in the same classroom. A comprehensive definition of inclusive education could be achieved by considering Mitchell's (2010) „*Magic Formula'* of inclusive education. The formula is: Inclusive Education = Vision + Placement + Support + Resources + Leadership + 5As (Acceptance, Access, Adapted Curriculum, Adapted Assessment, and Adapted Teaching). Conferring to the formula, for achievement of an inclusive education system there should be a *vision* at all levels of education in a country; *Placement* that should be age appropriate and in community/neighborhood schools; *Support* which must be available for students, families and professionals; *Resources* (e.g., trained teachers, assistive technologies, infrastructure); appropriate educational *leadership* that facilitates inclusion; and, the "5As" (Mitchell, 2010). Thus, inclusive education is a strategy to address educational needs of all children in a systematic way in a regular school classroom.

Ensuring education for all is a stated priority of the Cameroon education system. This reflects a contemporary philosophical commitment to social justice in the country's education provision and is in keeping with a number of international declarations and initiatives such as the UNESCO Declaration on Education for All (UNESCO, 1990), the Dakar Framework (UNESCO, 2000) and the Salamanca Declaration on Inclusive Education (UNESCO, 1994). These declarations both advocate for, and impose legal as well as ethical obligations on nations to include all children with disabilities in educational settings. As a result, an inclusive approach to education has featured as the means of achieving education for all children in Cameroon (Ahsan & Burnip, 2007). To further understand the challenges faced by countries such as Cameroon in implementing the comparatively new concept of inclusion there is a need to examine factors involved in inclusive education. Specifically, this study examined the community perception and its implication on the vocational choices of children living with disabilities.

According to Decree No. 2018/6233 IPM of 16th July 2018 fixing the procedures for the application of law n° 2010/002 of 13 April 2010 on the protection and promotion of persons with disabilities in Cameroon Article 4 the State promotes inclusive education and vocational training for people with disabilities through:

- Introduction to appropriate communication methods allowing them to access normal schooling and vocational training programs
- The development of standards in school, university and vocational training programs for teachers to learn sign language and braille

- ❖ The development of traditional public institutions to facilitate access for pupils and students with disabilities in classrooms
- ❖ The provision of specialized teachers and trainers in public schools and universities that receive pupils and students with disabilities;
- ❖ The assignment of qualified personnel in private special education institutions;
- ❖ Initial and continuing training of specialized staff in the supervision of disable people,
- ❖ The provision of pupils and students with disabilities with educational materials appropriate to the nature of the disability;
- ❖ The use of interpreters for sign language in schools or universities;
- ❖ The introduction for the hearing impaired of the spell check test in place of the dictation test;
- ❖ The installation of pupils or students with disabilities in rooms located on the ground floor or near the board, depending on the nature of their handicaps, exempts them from age.

2.5 Notion of Perception

Interest in perception dates back to the time of the ancient Greek philosophers who were interested in knowing how people know the world and gain understanding of the world. As psychology emerged as a science separate from philosophy, researchers became interested in understanding how different aspects of perception worked. In addition to understanding the basic physiological processes that occur, psychologists were also interested in understanding how the mind interprets and organizes these perceptions. The Gestalt psychologists proposed a holistic approach, suggesting that the sum equals more than the sum of its parts. Cognitive psychologists have also worked to understand how motivations and expectations can play a role in the process of perception.

2.5.1Community Perception of Disability

Disability does not have nor had the same perception in all civilizations. Its treatment and considerations have been very complex and diverse within its regions and have generated multiple discriminatory behaviors. Today, we live in a new social paradigm developed with human rights in mind that people with disabilities enjoy. This new model, more human, has been adopted in most countries of the world. These rights are consistent with equality in

opportunities thanks to the support in new policies and new action programs in favor of education, health, and work rights to help them enjoy their full potential.

Perception of disability is an important construct affecting not only the well-being of individuals with disabilities, but also the moral compass of the society. Negative attitudes toward disability dis-empower individuals with disabilities and lead to their social exclusion and isolation. By contrast, a healthy society encourages positive attitudes toward individuals with disabilities and promotes social inclusion. Perceptions of people with disability greatly affect their inclusion in their communities and their capacity to achieve basic goals. Examples of negative attitudes towards people with disability include derogatory stereotypes, beliefs that people with disability have a lesser position in society or that they have a diminished capacity to contribute due to their impairment. Holding such attitudes leads people to maintain social distance from people with disability and exclude them from their social networks (DeniseT. ,Fisher K.R., Purcal C., Deeming C. and Sawrikar P. 2001). Community attitudes vary according to the type of disability. Attitude research shows many people are uncomfortable with mental illness, but less so with physical disability (ACT DAC 2007; Wallace 2004). Research has also shown evidence that people have different perceptions towards persons with disabilities. Marshall, Kendall,

Banks and Gover (2009) argue that, being different from other people has led to perception of negative feelings and discrimination towards persons with disabilities. It is unfortunate that to-date, factors influencing the perception of persons with disabilities as being different still originate from the superstition of early man and are centuries old. This perception has been rooted in the economic, cultural and social contexts which has persisted and transferred-on from generation to generation (Bryan, 2010). Kitchen (2007) views negative social attitudes and pity as invisible barriers that prevent persons with disabilities from being included in society. There still exists community's persistent assumption that persons with disabilities' expectations and performance should be lower. That is the reason why community is sometimes surprised when they find that persons with disabilities can perform.

Block (2002) provides different perceptions by society regarding persons with disabilities, some of which exist to date as follows: sub-human organism according to beliefs of the nineteenth and twentieth century; menace to society implying a danger that can harm others; object of pity in need of charity; sick i.e., their disability is regarded as illness. It is upon this perception of sickness that the medical model evolved because it emphasizes cure, treatment

and diagnosis. It should be noted that, while disability can be a result of sickness, most persons with disabilities are not sick. Other perceptions include the following: a burden to society by draining resources without contributions; object of ridicule, a form of joke for amusing others; the least of God's people who should be poor and oppressed; eternal child by being infantilized i.e., treating an adult like a child; a bizarre and grotesque i.e., viewed as freak or frightening sight. Similarly, Smith (2007) suggests that, Christian charities perceive persons with disabilities as defenseless people whom the Christian community has to take social responsibility of helping. This charity perception coupled with a feeling of pity confirms the religious beliefs as correct and ethical, resulting into negative perception towards persons with disabilities as cared for or helped because they believe that, they cannot do anything for themselves. Marshall, et al (2009) argues that many Muslim communities consider persons with disabilities as a case of shame, pity and a result of evil spirits or curses. The perception of people with disabilities can play out in a number of ways including:

Social Avoidance: People with disabilities may be left out of social activities, or they may find that friends become more distant after they develop a disability. People may be hesitant to make eye contact or start a conversation with someone who has a visible disability. The social participation of the disabled people is unsatisfactory and low, one of the reasons often overlooked but of great importance may lie in the disparate patterns of social interaction between the disabled people and the abled people (Shen L., Welan X., ShanfonH., Zhongchen & Lin Z. 2018). Social avoidance might be bidirectional i.e the disable avoiding the table and the able avoiding the disabled. Because of their own and social reasons, the disabled people are at a disadvantage in their social status and resource distribution. Therefore, they are in an unequal position in their interactions with abled people, which results in their low level of social participation.

The social interactions of the disabled people are not optimistic with simple social network, simple social interactive object and low social interaction willingness as the main manifestations of their difficulties in social interactions. Reasons for the disabled people's difficulties in social interactions may lie in the following aspects: (1) one is that the abled people tend to show negative attitudes (e.g., social stigma) and behaviors to the disabled people in daily lives (Zhang et al., 2015). For example, it is reported that the disabled people claimed discriminations from their peers (Moore et al., 2011) and families (O'Reilly et al., 2016); (2) the other possible reason is the unequal status in social interactions between the disabled and abled people. The disabled are on the fringes of society, both in terms of

accessing to social resources and the distribution of living environment as well as working opportunities, socio-economic status and quality of life, compared with abled people (Riddell and Weedon, 2014). Such an unequal status may be the core reason why the disabled people do not want to participate in social interactions and establish good relationships with other people, especially the abled people. However, the studies aiming directly at the social interaction patterns between the disabled and abled people in unequal status are still rare.

Cooperation and competition are basic forms of social interactions. People need to have social interactions and exchanges of resources with others for survival and development in society (Wang et al., 2016). Cooperative behavior is an important factor in maintaining good social interactions as well as the redistribution of interests of social subjects. Therefore, cooperative behavior is of particular importance for the disabled people who are at a disadvantage of resource distribution and social status. For example, a possible reason why the disabled people show low cooperation is that they may take into account their own economic conditions or status when interacting with the abled people in the hope of making up for these deficiencies in the distribution of resources so as to distribute more resources to themselves and less resources to the abled people. Even worse, the disabled people's low cooperation and unfriendliness may in turn affect the abled people's attitudes and behaviors toward them, such as indifference or avoidance (unwillingness to interact with the disabled people). While acknowledging that social avoidance can be initiated either by the person living with a disability or the person without a disability, this study has been limited to the social avoidance initiated by the person living without a disability. Younger people and people with more education tend to have more positive attitudes towards people living with a disability. It seems clear that negative attitudes, along with misconceptions and lack of awareness, present barriers to social inclusion in various life domains such as education, employment and community participation (Denise T., Karen R. F., Christiane P., Deeming C. & Sawrikar (2011).

Discrimination: Disability discrimination is when you are treated less well or put at a disadvantage for a reason that relates to your disability in one of the situations covered by the Equality Act. The treatment could be a one-off action, the application of a rule or policy or the existence of physical or communication barriers which make accessing something difficult or impossible. The discrimination does not have to be intentional to be unlawful.

The Equality Act 2010 says that you must not be discriminated against because:

- ❖ You have a disability
- ❖ Someone thinks you have a disability (this is known as discrimination by perception)
- ❖ You are connected to someone with a disability (this is known as discrimination by association).

It is not unlawful discrimination to treat a disabled person more favorably than a non-disabled person. There are six main types of disability discrimination: direct discrimination, indirect discrimination, failure to make reasonable adjustments, discrimination arising from disability, Harassment and victimization.

Condescension: This attitude or behavior of people who believe they are more intelligent or better than other people. Disabled children's opportunity to act as agents may be compromised because adults have the power to choose who are entitled to express agency. Disabled children spend much time in institutions and with professionals of different fields. People with disabilities face a dilemma in dealing with patronizing help: Although accepting unsolicited assistance can incur psychological costs, confronting the helper has been shown to incur interpersonal penalties.
People with disabilities face a dilemma in dealing with patronizing help: Although accepting unsolicited assistance can incur psychological costs, confronting the helper has been shown to incur interpersonal penalties.

The most common example of condescension is the habit some people can't seem to break, of speaking to disabled people of any age like they are immature children. It's using an uncharacteristically soft, slow, high-pitched, cooing voice when speaking to disabled youth and adults. But it's not just about tone of voice. It's also the assumption that disabled people are less self-aware, less able to know and manage their own needs, less able to understand things.

Condescension is also closely related to sentimentality, which seems to dominate many people's understanding of disabled people. It's the tendency to view virtually all aspects of disability in terms of deeply emotional narratives of sadness and suffering vs. perseverance and triumph. It's thinking of disabled people as elevated innocents, people who carry a special moral goodness somehow connected with their disability. It's confusing gushing,

doting praise with empowerment, or wonder and amusement with respect and love (Pulrang A. 2022).

One important source of both condescension and sentimentality is the misused and misleading idea that certain kinds of disabled adults are *child-like*. People talk to and think about disabled people this way because on some level they actually *do* view disabled people as less fully human. Or, they see disabled people as inherently disadvantaged, occupying a permanent “underdog” role in society — despised in some ways, idolized in others. Condescension and sentimentality towards disabled people may persist because in troubled, cynical times, people crave moral purity and simplicity, and happy stories of personal achievement free of politics or ideology. As long as disabled people remain uncomplicated, cheerful, and plucky as individuals, they are easy to root for, and perfect vessels for non-disabled people’s vague and impersonal goodwill.

For adult people living with a disability it’s insulting as an adult to be talked to like a child. And even seemingly *positive* regard can quickly come to feel fake, overdone, and misplaced. It stops feeling like personal praise or kindness rightfully earned. Instead, it feels like empty emoting that has more to do with a non-disabled person’s own personality and emotional investments than the disabled person’s actual character or achievements. All of this makes it harder for some disabled people to gauge how they are *actually* perceived. It makes them doubt their true value and place in society.

Internalization: The abled people have an inherent prejudice against the disabled people that results in the formation of public stigma (Forber-Pratt et al., 2017). While on the other hand, the disabled people internalize the public stigma. They recognize and accept the cultural stereotype of the group they live in and apply it to themselves, and thus self-stigma forms (Ditchman et al., 2013).Simply put, self-stigma is a mark of shame that you put on yourself. It may also be a mark of dishonor with a particular experience. Stigma is created by societal changes that may make you feel like an outcast. It creates a feeling that you do not belong because you have something that's not accepted by society. Over time, after living with this type of stigma; you might come to believe that these things are true. To understand stigma in your life, it can be helpful to consider stigma examples. Some forms of self-stigma can be life threatening. One of the most common examples is feeling like you're a burden that your family would be better off without you. This can lead to suicidal ideation. It's a key reason people with self-stigma withdraw and isolate. There are wide ranging consequences of self-

stigma. It can be a barrier to recovery, increase depression, reduce self-esteem, reduce empowerment and increase among other consequences.

Children with disabilities in Cameroon

Information about the prevalence of children living with impairments and disabilities, and their daily lives, is now emerging. We are aware of some studies which provide information about the prevalence of disabilities in children: a prevalence of impairments and disability study in the North West Region (Cockburn, Wango, Benuh and Cleaver, 2011; Cockburn, Cleaver and Benuh, 2014; ICED, 2014), and national census information which included the Cameroon Multiple Indicator Cluster Survey (MICS), (Loaiza & Cappa, 2005; CNIS, 2010; CNIS 2012). Cameroon was one of the West African countries that was included in UNICEF's MICS studies rounds 2 (2000-2001) and 3 (2005-2008). The module on child disability provided some insight into the state of children with disabilities in the country. The data from MICS-2 indicate that 23% of children between the ages of 2 and 9 in Cameroon are living with at least one type of impairment (Loaiza & Cappa 2005). Common impairments are difficulties with spoken communication (7%) and mental impairment (6%). In 2009, a study in the North West region used the ICF framework to identify the prevalence of impairments and disabilities in the general population (Cockburn, Cleaver and Benuh, 2014). This study found that 11.9% of the people identified as living with a disability were children (0 – 14 years). Common impairments were seeing impairments, hearing impairments and mobility impairments. Based on these reports, it is estimated that there are significant number of children with disabilities living in Cameroon. There are limitations of these two studies: for example household surveys often do not include children who are living in institutions or orphanages and those hidden away from the community.

2.6 Disability and Vocational education

The problem of arriving at a suitable vocational choice for members of the general population is a very challenging task and disabilities can make this exercise even more challenging, There is substantial evidence that disabled people are less employed than non-disabled people (DeLeire, 2000; Jones et *al.*,2003; Hum et *al.,* 1996), but there are different potential reasons why this may be the case. The interaction between disability and labour participation can be rationalized along the lines of disability affecting both the supply of labour and the demand for labour (Madden, 2004; Mitraet Sambamoorthi, 2008). It is true that the nature of one

disability can prevent people living with a disability from exercising certain vocations but the negative views which the community holds about people living with disabilities can blow their conditions out of proportion, the self-concept of PLWDs and the community perceptions can therefore combine to affect the vocational choices of PLWDs.

Globally, 15 percent of the population has some form of disability (World Health Organization). The data from MICS-2 indicate that 23% of children between the ages of 2 and 9 in Cameroon are living with at least one type of impairment (Loaiza & Cappa 2005). If their right to decent work is promoted and protected through inclusive vocational education, they can contribute in a significant way to the GDP. Cameroon is one of the countries which ratified the UN Convention on the Rights of Persons with Disabilities. It is pledge bound to ensure the rights of persons with disabilities in the country. To support this commitment, the government has made the inclusion of persons with disabilities in skills training and employment a key priority. However, the level of implementation of inclusion cannot be ascertained for the moment **.**Like nondisabled persons, persons with disabilities are unique, with individual likes and dislikes, abilities, interests and skills. Disability adds another level of diversity that one must consider in decision making that involves people living with disabilities. Making a vocational choice for the so called normal is a difficult exercise and even be more difficult one for those living with a disability. However, we will explore a few procedures of arriving at a vocational choice.

2.6.1 Vocational Choice

This is the act of choosing between two or more vocations. Whatever vocation anyone is training for is a choice he/she makes or is suggested/ forced on him. Perhaps to address the issue of community perception and vocational choice of the physically handicap, it makes sense to start with how people in general arrive at their vocational choices. Motivation to learn can be sustained in the phase of difficulties if learners make informed personal vocational choices. It is therefore likely that at the point of making the vocational choice, the people can face the following problems as suggested by Williamson (1939):

- **No choice**: They have difficulty to discriminate sufficiently among existing occupations to make a choice and hence have no choice of their own. This means others will suggest an occupation to them. The risk here is that the person concerned may in the long run discover that the vocation is the best for him/her.

- **Uncertain Choice**: The individual may have some vocational information but is uncertain about the information.
- **Unwise choice**: There may be a mismatch between the individuals abilities/interests/resources etc and the occupation which he/she selects. This issue can pose even more serious problems for a person living with a disability. People living with a disability need to select a vocation that is commensurate with their disability
- **Discrepancy between Interests and Aptitudes**: The person may select an occupation which he/she do not have the required mental stamina or sufficient mental abilities.

Also, vocational development is not concerned solely with the choice of an occupation but also with the process by which such choices can be purposefully, integrated within a patterning of other decisions thereby maximizing success. The cost of training, setting up a workshop after graduation and the relevance of the skills acquired are very important points to take into consideration too.

Bordin (1946, p.174), commenting upon Williamson's problem categories, suggested that "the assignment of the individual's difficulties to one of this set of difficulties does not provide a basis for prediction of the relative success of different treatments". This observation led him to develop five other problem categories more psychologically oriented than Williamson's.

- Dependence
- Lack of information
- Self-conflict
- Choice anxiety
- No problem

Byrne (1958, p 187) expressed displeasure at generalizing to high school students from the college samples used by Williamson and Bordin. He suggested that the problems could more adequately be described thus:

- Immaturity
- Lack of problem solving skills
- Lack of insight
- Lack of information
- Lack of assurance
- Domination by authority

Robinson (1963, P.332) suggested another modification of this diagnostic constructs into the following categories:

- ❖ Personal maladjustment
- ❖ Conflict with significant other
- ❖ Discussing plans (instead of Bordin's no problem category)
- ❖ Lack of information about environment
- ❖ Immaturity
- ❖ Skill deficiency

In each of these four problem criteria by Williamson, Bordin, Byrne, and Robinson-symptoms or causes or some interactions of the two are confounded. The important point, however is that they all imply a deficit of some type in the behavioral repertoire of the individuals which impedes them from making an informed vocational choice. If the "so called normal people" have problems arriving a good vocational choice the people living with a disability will find it even harder. Their problem of arriving a good choice can be seriously affected by the perceptions their communities have towards them. It is evident in literature that the community through prejudice and stigmatization view handicapped people as underdogs not able to interact and do anything useful for themselves. These community views are likely to adversely affect their vocational choices. But the reverse is true if the community view disability in a way that their support will aid and make the disabled person supportive and autonomous especially economically.

2.7 Theoretical Review

2.7.1 The Social Model of Disability

In the social model, disability is not an attribute of an individual, but rather a complex collection of conditions, many of which are created by the social environment. Hence, the management of the problem requires social action and is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of persons with disabilities in all areas of social life. From this perspective, equal access for someone with an impairment/disability is a human rights issue of major concern. Society has the obligation to remove barriers by making the physical environment useable, information accessible, laws and policies just and implemented, and attitudes about disability based on acceptance of diversity.

When barriers are removed, people with disability can be independent and equal in society. There are multiple barriers that can make it extremely difficult or even impossible for people with disability to function. Here are the most common barriers.

1. **Attitudinal barriers:** are created by people who see only disability when associating with people with disabilities in some way. These attitudinal barriers can be witnessed through bullying, discrimination, and fear. These barriers include low expectations of people with disabilities, and these barriers contribute to all other barriers.
2. **Environmental barriers:** inaccessible environments, natural or built, create disability by creating barriers to inclusion. Examples of architectural or physical barriers include:
   - ❖ Sidewalks and doorways that is too narrow for a wheelchair, scooter, or walker.
   - ❖ Desks that is too high for a person who is using a wheelchair, or other mobility device.
   - ❖ Poor lighting that makes it difficult to see for a person with low vision or a person who lip-reads.
   - ❖ Doorknobs that is difficult to grasp for a person with arthritis.
3. **Institutional barriers:** include many laws, policies, practices, or strategies that discriminate against people with disabilities. Examples of organizational or systemic barriers include:
   - ❖ Denying reasonable adjustments to qualified individuals with disabilities, so they can perform the essential functions of the job for which they have applied or have been hired to perform.
   - ❖ Public transport being inaccessible to people with disability, which acts as a barrier in their day-to-day lives and reduces the ability of people with disabilities to participate fully in community life
4. **Communication barriers:** Communication barriers are experienced by people who have disabilities that affect hearing, speaking, reading, writing, and/or understanding, and who use different ways to communicate than people who do not have a disability. Examples of communication barriers include:
   - ❖ Written health messages may be inaccessible to people who are blind or vision impaired from receiving the message because of:
   - ❖ Small print or no large-print versions of material, and
   - ❖ No Braille or electronic versions for people who use screen readers.
   - ❖ Auditory health messages may be inaccessible to people who are deaf or have hearing loss from receiving the message because:

- ❖ Videos do not include captioning.
- ❖ Complicated health messages may be inaccessible to people with a cognitive disability from receiving the message because:
- ❖ The use of technical language, long sentences, and words with many syllables which are not provided in Plain Language or Easy English.

2.7.2 Relevance of the model

The social model is relevant to this study because it shifts the focus from the people living with disabilities to the interaction of members of the community (social context). It is this shift that is the basses of inclusive education and accessibility. Also this shift enables actors in the field of special needs education to address issues of access to basic human needs, social protection /rights of P.W.D.S.

2.8 Social identity theory:

Social identity theory is an interactions social psychological theory of the role of self-conception and associated cognitive processes and social beliefs in group processes and intergroup relations. Originally introduced in the 1970s primarily as an account of intergroup relations, it was significantly developed at the start of the 1980s as a general account of group processes and the nature of the social group.

Social identity theory was proposed in social psychology by Tajfel and his colleagues (Tajfel, 1978; Tajfel & Turner, 1979). Social identity refers to the ways that people's self-concepts are based on their membership in social groups. Examples include sports teams, religions, nationalities, occupations, sexual orientation, ethnic groups, and gender. (Identification as non-disabled or disabled can also constitute a social identity.) Social identity theory addresses the ways that social identities affect people's attitudes and behaviors regarding their in group and the out group. Social identities are most influential when individuals consider membership in a particular group to be central to their self-concept and they feel strong emotional ties to the group. Affiliation with a group confers self-esteem, which helps to sustain the social identity. Some key processes associated with important social identities include *within-group assimilation* (pressures to conform to the in group’s norms) and forms of *intergroup bias* (positively evaluating one's in group relative to out-group [i.e., in group favoritism] and possibly negatively evaluating the out group). In developmental psychology, social identity theory has been used to explain conformity and socialization in peer groups

(e.g., Archer, 1992; Harris, 1995; Leaper, 2000) and group-based prejudice (e.g., Bigler & Liben, 2007; Nesdale, 2004).

Therefore Social identity theory offers a motivational explanation for in-group bias. First, judgments about self as a group member are held to be associated with the outcome of social comparisons between the in-group and relevant out-groups. Second, it is assumed that people desire a satisfactory self-image, and positive self-esteem. Positive self-evaluation as a group member can be achieved by ensuring that the in-group is positively distinctive from the out-group. Usually group members will engage in social competition with out-groups to try to make the in-group positively distinctive. The theory has been used extensively in considering in-group favoritism and out-group discrimination.

Social identity theory has been significantly extended through a range of sub-theories that focus on social influence and group norms, leadership within and between groups, self-enhancement and uncertainty reduction motivations, deindividuation and collective behavior, social mobilization and protest, and marginalization and deviance within groups. This highly influential theory of group processes and intergroup relations have redefined how we think about numerous group-mediated phenomena. As mentioned earlier, within this theoretical framework, we consider the so called normal people and people living with disabilities as two separate groups. Through this theoretical lens we can better understand the dynamic group processes that make the so called normal perceive the people living with a disability as an out group and treat them differently and vice versa. A proper comprehension of the group and intergroup dynamics through this theoretical perspective can provide a rational premise for attitude change and hence effective inclusion**.** Research indicates that group stereotyping and prejudice are more likely when social identities are salient; conversely, downplaying the salience of intergroup differences can mitigate prejudice (Bigler & Liben, 2006; Hewstone et al., 2002). For example, assigning children from different social groups (e.g., based on gender, disable/disable, or race/ethnicity) to work cooperatively on a task can reduce prejudice.

2.8.1 Relevance of the theory

This theory holds that people establish their self-identity as member of a group. Therefore members of a given group constitute the "in group" and those who do not belong to this group constitute the out group “out group”. In group members evaluate themselves positively and evaluate the out group negatively. This present study consider the so called "normal

"people as belonging to a group and the people living with disabilities as another group. Thus this theory is relevant to this study because it account for origin of stereotypes, negative attitudes and discrimination against people living with disabilities.

2.9 Empirical Review

In their experimental study titled “Reducing Avoidance of Social Interaction with a Physically Disabled person by Mentioning the Disability following A request for Aid” Judson M., FayeZ., Belgrave, Katty M., &Boyer (1984) examined the effectiveness of strategies for reducing avoidance of social interaction with a physically disabled person. Female college students privately expressed their preference for social interaction before and after learning the other was a female in a wheelchair or nondisabled. The results provide evidence for the effectiveness of mentioning the disability following a request for aid related to the disability (the Request-mention Strategy). Change in preference for social interaction was more positive when the disabled person employed the Request-mention strategy than when she said nothing. Requesting aid without mentioning the disability was not found to be effective. A request for aid unrelated to the disability was clearly ineffective. The disabled person who said nothing was avoided, in comparison to when the same person was nondisabled. Favorability of impressions of the other, as measured by ratings of her characteristics, was not influenced by the experimental conditions. The findings of this study falls in line with one of the notions commonly held by the religious community that disabled persons are and object of pity.

Shen L., Welan X., ShanfonH., Zhongchen & Lin Z. (2018) conducted another experimental study in China. The study respectively recruited 41 and 80 disabled people in two experiments and adopted give-some games and public good dilemma to explore social interaction patterns between the disabled and abled people. The results were as follows: (1) the disabled people preferred to interact with the disabled people and the abled people preferred to interact with the abled people. (2) The disabled people had higher cooperation, satisfaction and sense of justice when interacting with the disabled people than interacting with the abled people. (3) Advantage in the number of the disabled people could reverse their disadvantage in the identity. These results are of important practical value, which provides related theoretical support for the disabled people’s federation and communities when carrying out activities for the disabled people. On the other hand, this segregation is unhealthy since the table and disable must cohabit in the same community

In another study titled “the effects of Vocational Rehabilitation for people with physical disabilities’ conducted by Dean D., &Pepper J (2017), the results imply that Vocational Rehabilitation services have large positive long-run labor market effects that substantially exceed the cost of providing services. This result indicate that even though the use of assistive devices and adaptive learning environments may make the training of people with a disability a little expensive, these expenses can be recovered in the long run. This study also demonstrate that there is ability in disability (the people living with a disability are capable to learn and live a productive life).

The Australian Department of Families, Housing, Community Services and Indigenous Affairs (FAHCSIA) commissioned the Social Policy Research Centre (SPRC) to conduct a scoping project investigating current research on community attitudes towards people with disability. It was an initial step towards building an evidence base on Australian community attitudes to people with disability, on the impact of these attitudes on outcomes for people with disability and on effective policies for improving community attitudes towards them.

The following are conclusions on common characteristics of policies and initiatives that appear to be successful in changing attitudes and overcoming prejudice towards people with disability resulting from the above study:

- resourcing the overall strategy adequately
- supporting the participation of people with disability in the design and implementation of the overall strategy
- addressing all three levels of intervention—personal, organizational and structural
- recognizing the diversity of disability types and circumstances of people with disability
- Implementing the strategy over a prolonged period of time to reinforce positive attitudes and replace negative attitudes.

CHAPTER THREE

RESEARCH METHODOLOGY

3.0 Introduction

This chapter presents the plan (blue print) which specified the procedural outline of how data relating to the study was systematically collected and analyzed. This chapter is organized under the following headings: Research design, study Area, population of the study, area of study, sample and sampling technique, design and construction of the data collection instrument, validity and reliability of instrument, instrument administration procedure, and method of data analysis. It equally took into consideration some ethical issues to ensure the respect of the rights of the research participants and research norms.

3.1 Research Design

A high breed or mixed method of both qualitative and quantitative methods where used. Qualitative method used for data collection through questionnaires, interviews and observation. According to Jost S, 2016 qualitative research is exploratory or interrogative research and tries to get "under the surface." The aim is to garter insight in to how people live, what they do, how they used things or what they need in their every day or professional lives.

Quantitative research on the other hand tries to fine answers to concrete questions by generating numbers and facts. "The goal is to establish a representation of what consumers do or what consumer think ".Barnham, 2015.

3.2 Study Area

This study was conducted in the Bafut Sub-Division. The Bafut sub Division is made up of 53 villages of the Bafut first class Fondom and the Mundum's I and II Autonomous second class Fondoms in Mezam Division of the North West Region of Cameroon. Bafut is situated between longitude 10° 01 and 10° 00 East, and between latitude 6° 05 and 6° 10 North (Bafut council, 2013). Bafut is situated about 20 kilometers North West of Bamenda town and covers an estimated area of about 4500 square kilometers (Bafut Council, 2013). The inhabitants of Bafut rely mostly on agriculture for their livelihood. They rear animals like goats, fowls and cows in the upper part of Bafut. Traditionally the entire tribe is controlled by a paramount chief (Fon Abumbi II). Each village in the chiefdom is controlled by a third

class chief while the Quarters are controlled by Quarter heads. The Bafut people have a rich cultural heritage like traditional dances and a peculiar way of dressing and a palace which was built by the Germans. The palaces have museums that attract a number of tourists. There equally exist ends of year festival popularly called “mandele” which bring together the sons and daughters and tourists together at the end of each year. They have touristic sites like caves, waterfalls and gifted in handy crafts.

3.3 Population of the Study

The population of this study comprised of all the physically handicapped attending secondary schools (Government Secondary Schools, Mission Secondary Schools and Lay Private Secondary Schools) in the Bafut Sub-Division. Due to the Anglophone crisis only four schools are operational in the Bafut sub Division. Out of these schools only Saint Joseph Comprehensive High School (SJCHS) and Saint Joseph Children and Adult Home (SAJOCAH) were accessible to the researcher.

3.4 Sample and Sampling Technique

A sample is a smaller group of elements drawn through a definite procedure from a specified population (Nworgu, 1991). The sample size of this population was made up of 18 males and 22 females of people living with disabilities, 8 male parents, and 7 female parents. 7social workers (2males ad 5 females) making a total of 62.

Table 2: Sample Distribution

SN	**School/Community**	**Sample size**		
		F	**M**	**T**
1	SJCHS	5	4	9
2	SAJOCAH	8	7	15
3	Disable children from the community	9	7	16
4	Parents	7	8	15
5	Social workers	5	2	07
TOTAL		**34**	**28**	**62**

(M= male, F=female, T=total)

A sampling technique is a plan specifying how elements will be drawn from the accessible population (Nworgu, 1991). Consistent from the definition of survey designs and Kerlinger's observation, it is obvious that the idea of sampling is fundamental in survey designs. This is because only part of the population is studied and findings from this fraction of the population are expected to be generalized to the entire population. Therefore, good and sound practice demands that survey designs consider not only what proportion of the population (sample size) is to be included in the study, but also how to obtain a resultant sample that is sufficiently representative of the population. The latter refers to an appropriate sampling technique or procedure. In order to obtain a representative sample in this study the researcher adopted two sampling techniques at different levels of the research. These sampling techniques include the following:

- Snowball sampling is non-probability sampling methods where currently enrolled research participants help recruit future subjects for a study. This technique is called "snowball" because the sample group grows like a rolling snowball. Non-probability sampling means that researchers, or other participants, choose the sample as opposed to randomly selecting it, so not all members of the population have an equal chance of being selected for the study (Simkus, 2022).
- **Incidental sampling**: this is a technique in which an initial number of individuals to meet are not set and where the sample size will depend on how available the targeted participants will be as well as on the chance of meeting them during the period covered by the study. This method was used to select the sample (physically Handicap) that was used in this study.

The original intention was to use the simple random technique to select the sample. This is because the use of the simple random technique has the merit of selecting a sample with higher variability than the incidental sampling technique and snow ball technique that was used as a last resort. This was because of difficulties encountered in the field that made the simple random technique not practically feasible. For instance, the ongoing armed conflict in the area prevented the researcher from using the random sampling technique.

3.5 Description of the Data Collection Instrument

The data collection instrument used for this study was a questionnaire. The variables that were measured in this study were: Community Perception (independent Variable) and Vocational Choice (dependent variable). The Questionnaire items for the independent variable were constructed using descriptors of community perception (discrimination, social avoidance, condescension and internalization). On the other hand, the dependent variable questionnaire was constructed using the different vocational options for the participants to indicate their choice of vocation. This instrument uses the Likert scales ranging from strongly disagree to strongly agree. The entire questionnaire was made up of 65 items that were rated by the disabled, parents and social workers. Out of the 65 items 23 items were measuring discrimination, 7 measuring condescension, 8 were measuring internalization and 10 were measuring social avoidance.

3.6 Validity and Reliability of Instruments

Validity refers to the degree to which an instrument measures what it is supposed to measure. Therefore, an important criterion by which an instrument's psychometric adequacy can be evaluated is its validity. To ensure the content validity the items, were constructed using descriptors of the variables that were identified in existing literature. Further scrutiny was done by the researcher's colleagues and then finally the instrument was constructed and presented to the supervisors for Validation. After this the necessary corrections recommended by the supervisor on the entire instrument were done. In line with this the researcher contend that the, comprehensiveness, logicality and adequacy of the instrument was checked.
Reliability on the other hand refers to a scientific observation's repeatability or reliability (Howard, 1985). If an observation or rating is not repeatable, its usefulness as evidence in scientific endeavors is limited.

3.7 Administration of Instrument

The instrument for data collection was personally administered, supervised and collected by the researcher. Personal administration of the instrument offered the opportunity for the researcher to gain more insight from the verbal and non-verbal communications that took place between participants and the researcher. More so, this strategy had the advantage of reducing instrument mortality/ attrition and falsification that is common when dishonest research assistants are used for instrument delivery and collection.

3.8 Method of Data Analysis

Descriptive statistics will be used to analyze data from questionnaires on students, parents and social workers. Data from this questionnaire shall be analyzed using SPSS (software version 25). Frequency, percentage, main score where use the Likert scale questionnaire for analysis'. The hypotheses were tested using simple linear regression for correlation.

Table 3: Synoptic table of hypothesis, variables, indicators and modalities

Subject	General Hypothesis	Research Hypotheses	Variable	Indicator	Modality	Items	Research Tools	Stat. Tools
Community perception of the physically handicap and Vocational choice	There is a significant relationship between community perception between and vocational choice	**Hypothesis 1** There is a significant relationship between Discrimination and the vocational choices of the physically handicapped	Discrimination	Education Parental care	SA A D SD	20	Questionnaire	Statistical Package for Social Sciences (SPSS)
		Hypothesis 2 There is a significant relationship between condescension and the vocational choices of the physically handicapped	Condescension	Decision making protection	SA A D SD	12		
		Hypothesis 3 There is a significant relationship between social avoidance and the vocational choices of the physically handicapped	Social Avoidance	Despise Playmate selection	SA A D SD	17		

		Hypothesis 4 There is a significant relationship between internalization the and the vocational choices of the physically handicapped	Internalization	Self-Worth dependency		12		

3.9 Ethical Considerations

In any study, the researcher has the obligation to uphold ethical norms in other to protect the research participants and exhibit professional maturity. The intent of this research was to contribute to the community perception impact on the vocational choice of people living with disabilities. It would be ironical an unethical or counterproductive to cause any emotional or psychological harm to the very people the study seeks to contribute to their positive development. On the basis of this consideration, we carried out the investigation with a high degree of respect for the dignity and psychological/emotional welfare of all who participated in the study. This was in line with APA's (2000) explicit code of research ethics. The study achieved the protection of the research participants (teachers) by doing the following:

- ❖ For all the schools involved, the researcher first of all obtained permission from the school principal after giving him a letter of introduction from the University of Yaoundé. Afterwards, the principals then introduced the researcher to the research participants. The same approach was used with the participants from the community. The construction of the questionnaire items were gender friendly (he/she was used consistently instead of him when referring to the personal pronoun).

- ❖ At the first meeting with the participants, the researcher took time off to explain to them the objective of the study and offered them the possibility to ask questions where they had doubts. The researcher endeavored to give satisfactory answers to all the questions which they raised. It was therefore after disclosure of the purpose of the study and clarification of doubts that the researcher went ahead to sort for the participants' informed consent. No participant was compelled to participate in the study.
- ❖ The researcher did all to maintain a cordial relationship with all the participants without infringing into their privacy.
- ❖ Also, the researcher assured respondents that their responses were going to remain strictly confidential and anonymous.
- ❖ In the data analysis section the researcher avoided using the names.

Lastly, to respect authors' rights, the researcher endeavored to acknowledge all the sources that provided useful information for this study.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION OF RESULTS

4.0 INTRODUCTON

This chapter presents the research findings and analysis. The study investigates community perception of the physically handicapped and its effects on their vocational choice with a case study in SAJOCAH Bafut. The data were collected through questionnaires Findings were presented to respond to the four specific objectives of this study. The study sought to provide answers to four specific objectives; (i) To examine the effects of Discrimination on the vocational choice of the physically handicapped ; (ii) To assess the effects of condescension on the vocational choices of the physically handicapped ; (iii) To investigate the effects of social avoidance on the vocational choices of the physically handicapped; (iv) to find out the effects of internalization on the vocational choices of the physically handicapped in SAJOCAH Bafut. .

4.1 Demographic characteristics

Demographic characteristics of participants in this study include the gender, age and level of education.

4.1.1 Gender of respondent

The gander for this study include both male and female, physically handicapped, parents and social workers in and around SAJOCAH Bafut.

Table 4. Gender of respondent

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid Male	18	43.9	45.0	45.0
Female	22	53.7	55.0	100.0
Total	**40**	**97.6**	**100.0**	

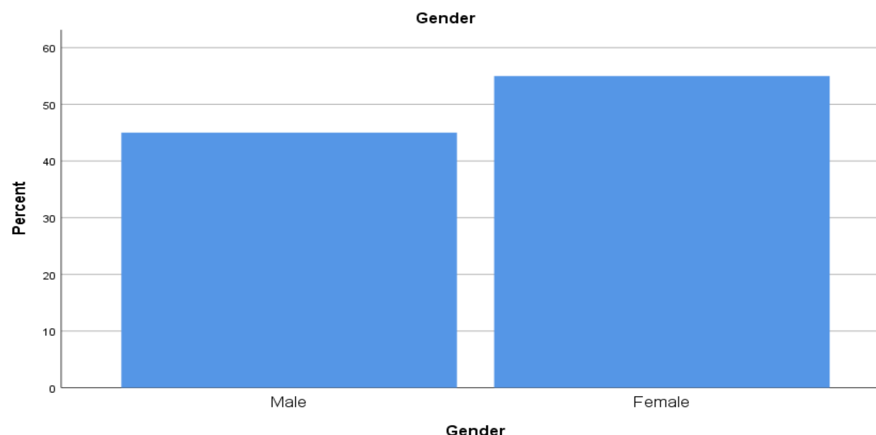

Figure 1: Gender of respondent

Source: field data 2022

The pie chart on gender distribution shows that females constituted a bigger number of respondents (53.7%) as compared to (43.9%) for male respondents. This shows that majority of the respondents where females.

4.1.2 Age of respondents

The age range of the respondents ranged from 10 - 60 with an age range distribution of **10 - 20, 20-30, 30-40, 40-50, 50-60.**

Table 5. Age range of respondents

Age	Frequency	Percent	Valid Percent	Cumulative Percent
10-20 years	16	39.0	40.0	40.0
20-30 years	19	46.3	47.5	87.5
30-40 years	2	4.9	5.0	92.5
40-50 years	2	4.9	5.0	97.5
50-60 years	1	2.4	2.5	100.0
Total	**40**	**97.6**	**100.0**	

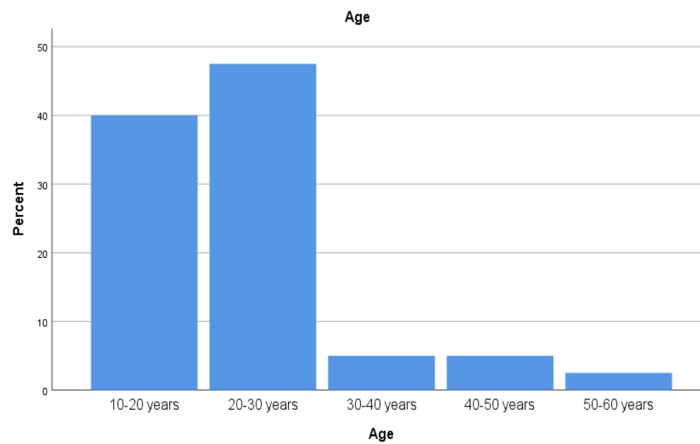

Figure 2: Age range of respondents

Source field data 2022

The highest proportion of respondents of(46.3%) with age range of (20-30 years)as shown on figure4.2; (39.0%) respondents had age range of (10-20 years); 4.9% had two sets of respondents (30-40 years) and (40-50 years) with the same percentage. Finally, 2.4% respondents had an age range of (50-60 years). This shows that a majority of the respondents had an age range of (20-30 years). This is a good age range to be able to choice evocation and do training for a specific job.

4.1.3 Educational level of respondents

From the information collected, respondents were divided in to four categories based on their educational levels. This is Primary, Secondary, Higher education and low educational qualification.

Table 6 Educational level of respondents

Age	Frequency	Percent	Valid Percent	Cumulative Percent
Primary	7	17.1	17.5	17.5
Secondary	28	68.3	70.0	87.5
Higher Education	1	2.4	2.5	90.0
No eduactional qualification	4	9.8	10.0	100.0
Total	**40**	**97.6**	**100.0**	
Primary	**7**	**17.1**	**17.5**	**17.5**

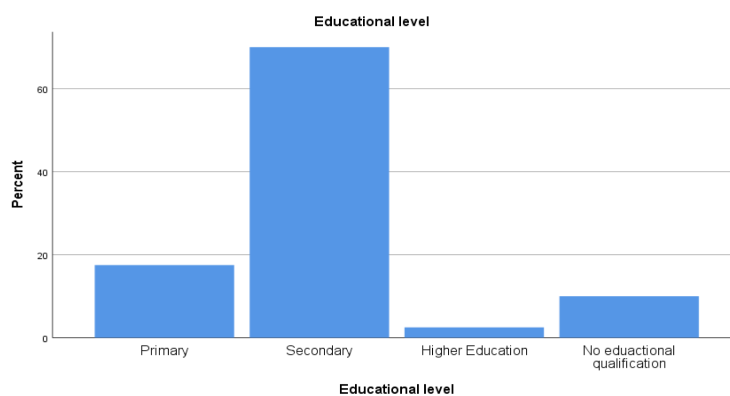

Figure 3: Educational level of respondents

Source field data 2022

Majority of the respondents were of the level of secondary with 68.3% ; followed by primary with 17.1%; no educational qualification with 9.8% and finally higher education with 2.4%. From the information collected, it is evident that majority of the respondents were of the secondary level, who are not well trained in any vocation. At the level of secondary schools they do not yet have specific training in any vocation of their choice.

4.2 Presentation of findings

This section presents the findings according to the study variables and objectives. This study had four specific objectives to answer; (i) to examine the effect of discrimination on the vocational choice of the physically handicapped; (ii) to assess the effect of condescension on the vocational choice of the physically handicapped ;(iii) to investigate the effect of social avoidance on the vocational choice of the physically handicapped ;(iv) to find out the effect of internalization on the vocational choice of the physically handicapped. For each case, the frequencies, percentages, weighted mean and standard deviation were used to present and analyze data for appropriately reporting findings following objectives.

Analysis of dependent variable (vocational Choice)

Table 7: Presentation of participants vocational choices

S/N	Vocational Choice	Frequency and percentage		
		Males	Females	Total
1	Commercial	2(5%)	5 (12.5%)	7 (17.5%)
2	Industrial	4 (10%)	2 (5%)	6 (15%)
3	General Education	3(7.5%)	4 (10%)	7 (17.5%)
4	Apprenticeship	9(22.5%)	11 (27.5%)	20(50%)
Total		18 (45%)	22 (55%)	40 (100%)

As evident from the table above 2 (5%) of males and 5(12.5%) of females selected commercial education; 4 (10%) of males and 2(5%) of females selected technical education; 3(7.5%) males and 4(10%) of females selected General Education; and 9 (22.5%) of males and 11(27.5%) of females selected apprenticeship. In all, a total of 7 (17.5%) participants selected commercial education; 6(15%) selected industrial education and 20 (50%) selected apprenticeships.

4.2.1 Objective one

Effects of discrimination on the vocational choice of the physically handicapped

The effects of discrimination of the vocation choice of physically handicapped in SAJOCAH Bafut was a ten item statement. The responses were presented in a likert scale of 1-4 (strongly agree, agree, disagree strongly disagree) the respondents were asked to rate their level of agreement or disagreement. The results were as shown in table 4.5.

Table 8 the effects of discrimination of the vocation choice of physically handicapped in SAJOCA H Bafut.

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Standard Deviation
	Frequency and Percentage; N=108					
	F(%)	F(%)	F(%)	F(%)		
My parents often meet the need of the other siblings before mine	25(62.5)	10(25.0)	3(7.5)	2(5.0)	1.55	.846
I am often served before any other person in public	1(2.5)	1 (2.5)	20(.50)	18(45)	3.38	.667
Quite often I am interested in activities but prevented by others from engaging in them	22(55)	17(42.5)	0	1(2.5)	1.50	.641
Due to my disability I can’t go to any school of my choice	25(62.5)	14(35)	0	1(2.5)	1.43	..636
I have been denied the opportunity to use public transport facilities because of my disability	20(50)	15(37.5)	1(2.5)	4(10)	1.73	.933

Most public buildings are accessible to me	3(7.5)	1(2.5)	14(35)	22(55)	3.38	.868
My parents show signs of regret of having me as a son/daughter	13(32.5)	17(42.5)	8(20)	2(5)	1.98	.862
My parents often complain of my medical expenses.	12(30)	21(52.5)	4(10)	2(5)	2.08	1.366
I have been ridiculed because of my condition in several occasions	14(35)	25(625)	0	1(2.5)	1.70	.608
Most people around me pity me rather than show me love	10(25)	25(62.5)	5(12.5)	0	1.88	.607
Overall total					**2.06**	**0.822**

Source field data 2022

As indicated on table 4.5, most of the respondents fell in the category of those who strongly agreed on the effect of discrimination on the vocational choice of the physically handicapped in SAJOCAH Bafut. In parents meeting the needs of sidelines before them (62.5%: mean =1.55) strongly agreed with the statement; often served before others in public(2.5%: mean =3.38)strongly agreed with the statement; interested in activities but often prevented by others (55%: mean =1.50)strongly agreed with the statement ;can't go to any school of my choice (62.5%: mean =1.43) strongly agreed to the statement; denied to use public transport facilities because of disability (50%: mean =1.73)strongly agreed with the statement ; most public buildings are assessable (7.5%: mean =3.38)strongly agreed with the statement ; parents shows signs of regret of having me as a child (42.5%: mean =1.98)agreed with the statement ; parents often complained of my medical expenses (52.5%: mean =2.08)agreed ; ridiculed because of condition (62.5%: mean =1.70)agreed ; most people around me pity me rather than show love (62.5%: mean =1.88)agreed.

On the other hand, some respondents strongly disagreed and disagreed on the effect of discrimination on vocational choice of the physically handicapped. Often served before others in public (50%: mean =1.55) disagreed; parents meet their needs first (7.5%: mean =1.55) disagreed ; interested in activities but prevented by others (2.5%: mean =3.38); access to public buildings (55%: mean =3.38) strongly disagreed ; can't go to any school of my choice (2.5%: mean =1.43) strongly disagreed ;parents complain of medical bills(10%: mean =1.98)disagreed ; parents regret (20%: mean =1.98)disagreed; ridiculed in public (2.5%: mean =1.70)strongly disagreed ; people pity me rather than show love (12%: mean =1.88) disagreed.

As a result, the overall average mean of responses was 2.06 (SD =0.822) on the effect of discrimination on the vocational choice of the physically handicapped in SAJOCAH Bafut . The overall average mean fell in the range of high mean. This indicated that many of the respondents strongly agreed on the effect of discrimination on the vocational choice of the physically handicapped in SAJOCAH Bafut.

4.2.2 Objective 2

Effects condescension on the vocational choice of the physically handicapped

The effect of condescension on the vocational choice of physically handicapped in SAJOCAH Bafut was a seven item statement. The responses were presented in likert scale of 1-4 (strongly agreed, agreed, disagreed, and strongly disagreed). The respondent were asked to rate their level of agreement or disagreement. The results were as shown in table 4.6.

Table 9 effect of condescension on the vocational choice of physically handicapped

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Standard Deviation
	Frequency and Percentage; N=108					
	F(%)	F(%)	F(%)	F(%)		
My parents do not allow me to do any house chores	12(30)	7(17.5)	20(50)	1(2.5)	2.25	.927
Virtually everything is done for me	10(25)	9 (22.5)	19(47.5)	2(5)	2.33	.917
My parents always take decisions on my behalf	24(60)	15(37.5)	1(2.5)	0	1.43	.549
My parents often tell me not to strain	12(30)	19(47.5)	9(22)	0	1.93	.730
Quit often I am given undue favor	14(35)	22(55)	3(7.5)	1(2.5)	1.78	.698
I am satisfied with my situation	3(7.5)	18(45)	14(35)	5(12.5)	2.53	.816
I see no need studying.	5(12.5)	20(50)	8(20)	7(17.5)	2.43	.931
Overall total					**2.097**	**0.795**

Source: field data 2022

As indicated in table 4.6 most of the respondents fell in the categories of those who agree on the effect of condescension on the vocational choice of the physically handicapped in SAJOCAH Bafut . On parents do not allow them do house chores (30% ; mean =2.25) strongly agreed; virtually everything is done for me (25% ; mean =2.33) strongly agreed; parents take decision me (60% ; mean =1.48) strongly agreed ; parents tell me not to strain (47.5% ; mean =1.93)agreed ; undue favour (55% ; mean =1.78)agreed ; satisfies with my situation (45% ; mean =2.53)agreed ; I see no need studying (50% ; mean =2.43)agreed.

On the other hand, some responded equally strongly disagreed and disagreed on the effect of condescension on vocational choice on the physically handicapped in SAJICA Bafut. Parents don't allow me to do house chores (50% ; mean =2.25) disagreed ; everything is done for me (47.5% ; mean =2.33) disagreed ; on parents take decision for me (2.5% ; mean =1.43) disagreed; parents tall me not to strain (22% ; mean =1.93)disagreed on unduefavour (7.5% ; mean =1.78) strongly disagreed ; I am satisfied with my situation (35% ; mean =2.58)disagreed ; I see no need studying (20% ; mean =2.43) disagreed.

As result, the overall average mean of responses was 2.097 (SD =0.795) on the effect of condescension on the vocational choice of the physically handicapped in SAJOCAH Bafut . The overall average mean fell in the range of high mean in the range. This indicated that many of the respondents agreed on the effects of condescension on the vocational choice of the physically handicapped in SAJOCH Bafut .

4.2.3 Objective 3

Effects of social avoidances on the vocational choice of physically handicapped in SAJOCAH Bafut

The effect of social avoidance on the vocational choice of the physically handicapped in SAJOCAH Bafut was a ten item statement. The responses were presented in a likert scale of 1-4(strongly agreed, agreed, disagreed, and strongly disagreed). The respondents were asked to rate their level of agreement or disagreement. The results were as shown on table 4.7.

Table 4.7 effects of social avoidance on the vocational choice of the physically handicapped in SAJOCAHBafut .

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Standard Deviation
	Frequency and Percentage; N=108					
	F(%)	F(%)	F(%)	F(%)		
Most of the children around me do not select me as their play mate	22(55)	14(35)	4(10)	0	1.25	.677
Quite often the people around me hardly initiate any form of conversation with me	16(40)	21(52.5)	2(5.0)	1(2.5)	1.70	.687
When I try to join people in an activity, they move away from me	11(27.5)	27(67.5)	1(2.5)	1(2.5)	1.80	.608
I notice that most people feel uneasy when I am around them	10(25)	26(65)	3(7.5)	1(2.5)	1.88	.648
Most people around me do not share their items with me	9(22.5)	28(65)	3(7.5)	1(2.5)	2.08	1.289
Most people around me refuse whatever I offer to them	17(42.5)	18(45)	4(10)	1(2.5)	1.73	.751
People outrighly tell me to come close to them	10(25)	24(60)	5(12.5)	1(2.5)	1.93	.694
I have witness some form of rejection in public institutions	17(42.5)	19(47.5)	3(7.5)	1(2.5)	1.70	.723
I am always a failure in group work	8(20)	17(42.5)	14(35)	1(2.5)	2.20	.791
I am always laughed at when playing together.	18(45)	17(42.5)	5(12.5)	0	1.68	.694
Overall total					**1.795**	**0.756**

Source field data 2022

As indicated on table 4.7, most of the responded fell in the category of those who agreed on the effect of social avoidance on the vocational choice on the physically handicapped. Other children do not select me for a play mate (55% ; mean =1.25) strongly agreed: conversation with others

(52.5% ; mean =1.70) agreed : rejection from activities (67.5% ; mean =1.80) agreed; people feel uneasy around me (65% ; mean =1.88) agreed ; people refuse my offers (42.5% ; mean =1.78)strongly agreed, people tell me not to come close to them (60% ; mean =1.93)agreed ; rejection in public institutions (47.5% ; mean =1.70)agreed ;failure in group work (42.5% ; mean =2.20)agreed ; laugh at when playing together (42.5% ; mean =1.68)agreed .

On the other hand , some respondents equally strongly disagreed on the effect of social avoidance on the vocational choice of the physically handicapped in SAJOCAH Bafut ; children do not select me for play mate (10% ; mean =1.25) disagreed; initiate conversation with me (5% ; mean =1.7) disagreed ; move away from me in activities (2.5% ; mean =1.80) strongly disagreed ; people feel uneasy when I am around them(7.5% ; mean =1.88) disagreed ; people do not share items with me (7.5% ; mean =2.08) disagreed; people refuse my offers (10% ; mean =1.73) disagreed ; people asked me not to come close to them (12.5% ; mean =1.93)disagreed; rejection in public (7.8% ; mean =1.70) disagreed ; failure in grope work (35% ; mean =2.20) disagreed ;laugh at me when playing (12.5% ; mean =1.68) disagreed

As a result, the overall average mean of responses 1.795(SD =0.756) on the effects of social avoidance on the vocational choices of the physically handicapped in SAJOCAH Bafut . The overall average mean fell in the range of high mean. This indicated that many of the respondents agreed on the effects of social avoidance on the physically handicapped in SAJOCAH Bafut .

4.2.4: Objective Four

Effects of internalization on the vocational choices of the physically handicapped in SAJOCAH Bafut .

The effect of internalization on the vocational choice of the physically handicapped in SAJOCAH Bafut was an eight item statement. The responses were presented in a likert scale of 1-4 (strongly agreed,agreed, disagreed, strongly disagreed) . The despondence were asked to rate their level of agreement or disagreement. The results were as shown on table 4.8 (20%; mean =2.43) .

Table 10 Effect of internalization on the vocational choice of physical handicapped in SAJOCAH Bafut

Statement	Strongly Agree	Agree	Disagree	Strongly Disagree	Mean	Standard Deviation
	Frequency and Percentage; N=108					
	F(%)	F(%)	F(%)	F(%)		
Deep with me I know that my disability has limited me in so many ways such as employment, sporting activities, free movement	33(82.5)	4(10)	2(5)	1(2.5)	1.28	.679
I belief I cannot become very rich	15(37.5)	16(40)	6(15)	3(7.5)	1.93	.917
It is impossible for me to do the things that I like because of my disability	26(65)	12(30)	2(5)	0	1.40	.591
I cannot live a complete life without the help of others	14(35)	25(62.5)	1(2.5)	0	1.68	.526
I feel that I have no value	10(25)	26(65)	3(7.5)	1(2.5)	1.88	.648
I consider myself a burden to people	13(32.5)	25(62.5)	2(5)	0	1.73	.554
I feel that my situation cannot be changed	10(25)	19(47)	10(25)	1(2.5)	2.05	.783
I regret my situation everyday	17(42.5)	19(47.5)	4(10)	0	1.68	.656
Overall total					**1.76**	**0.677**

Source: field data 2022

As indicated on table 4.7, most of the respondents fell in the category of those who strongly agreed on the effect of internalization on the vocational choice of the physically handicapped in SAJOCAH Bafut . On disability limitation (82% ; mean =1.28) agreed ; cannot become rich(40% ; mean =1.98); impossible for me to do things I like (62% ; mean =1.68); agreed I can't do without the help of others (65% ; mean =1.88);strongly agreed I fell I have no value (62.5% ; mean =1.68) ; I consider my serve a burden (62.5% ; mean =1.68) ;I fell my situation cannot be changed (47% ; mean =2.07);I regret my situation every day(47.5% ; mean =1.68);agreed.

On the other hand, some respondents equally disagreed and strongly disagreed on the effect on internalization on the vocational choice of the physically handicapped in SAJOCAH Bafut.

Limited because of disability (15% ; mean =1.28) ; I cannot be came rich(5% ; mean =1.98) ; disagreed ; impossible for me to do things alike(2.5% ; mean =1.68); disagreed I fell I have no value (7.5% ; mean =1.78); disagreed ; I fell my situation cannot be changed (2.5% ; mean =1.28) disagreed ; I regret my situation (2.5% ; mean =1.78) .

As a result, the overall average mean of respondents was1.78 (SD =0.667) on the effect of internalization on the vocational choice of the physically handicapped in SAJOCAH Bafut .The overall average mean fell in the range of high mean. This indicates that many of the despondence strongly agreed on the effect of internalization on the vocational choice of the physically handicapped in SAJOCAH Bafut.

4.3 hypotheses testing

4.3.1 HaI: there is a significant relationship between discrimination and vocational choice of the physical handicapped.

Table 11: Summary of Hypothesis 1

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.281[a]	.079	.055	1.235

a. **Predictors: (Constant), Discrimination**
b. **Dependent variable : vocational choice**

This table provides the R and R^2 values. The Rvalue represents the simple correlation which is .281[a] which indicates a high degree of correlation. The R value indicates how much the total variation in the dependent variable (vocational choice) can be explained by the independent variable (discrimination) .In this case, 79% which is very large.

The next table is ANOVA table which report how well the regression equation fits the data (predicts the dependent variable.)This shown below.

Table 12: ANOVA Table for Hypothesis 1

Model		Sum of Squares	ANOVA[a]Df	Mean Square	F	.
	Regression	4.988	1	4.988	3.269	.000[b]
	Residual	57.987	38	1.526		
	Total	62.975	39			

a. Dependent Variable: Vocational Choice
b. Predictors: (Constant), Discrimination

This table indicates that the regression model predicts the dependent variable significantly well. Here the P<.000[b] which is less than 0.05 and indicates the overall regression model statistically, significantly predicts the outcome value.

The next table is a coefficient table. The coefficient table provides us with the necessary information to predict vocational choice effectiveness.

Table 13: coefficient

		Coefficients	Coefficients		
Model	Unstandardized B	Std. Error	Beta	t	sia
1(Constant)	480	.985		.488	.001
Discrimination	848	.469	281	1.808	.000

a. **Dependent Variable: Vocational Choice**

A simple linear regression was conducted to qualify the relationship between community perceptions on vocational choice

The independent variable community perception has strong positive predictive powers (Bata =.281) on the dependent variable vocational choice and this is statistically significant at .000.

4.3.2 Hypothesis 2: There is a significant relationship between condescension and vocational choice of the physically handicapped.

Table 14. summary of hypothesis 2

Model summary

Model	**R**	**R Square**	**Adjusted R Square**	**Std. Error of the Estimate**
1	.249[a]	.062	.037	1.247

a. **Predictors: (Constant), Condescension**
b. **Dependent variable: Vocational choice**

This provides the R and R^2 value. The R value represents the simple correlation which is .249[a] which indicates a high value of correction. The R^2 value indicates how much the total variation in the dependent variable (condescension choice) of the physically handicapped can be explained by the independent variable (condescension) in this case 62% which is very high.

The next table is the ANOVA table which reports how well the regression equation fits the data. That is (predicts the dependent variable).

This is shown below.

Table 15 ; ANOVA table for Hypothesis 2

		Sum of Squares	**ANOVA[a]**Df	Mean Square	F	.
Model	Regression	3.889	1	3.889	2.501	.122[b]
	Residual	59.086	38	1.555		
	Total	62.975	39			

a. **Dependent Variable: Vocational Choice**
b. **Predictors: (Constant), Condescension**

The table indicates that the regression model predicts the dependent variable significantly well. Here the P (sig)<.001[b] which is less than 0.05 and indicates the overall regression model statistically, significantly predicts the outcome value .

The next table is the coefficient table. The coefficient table provides us with the necessary information to predict condescension on the vocational choice of the physically handicapped .

Table 16 Coefficient of prediction of Hypothesis 2

Model	Unstandardized B	Coefficients Std. Error	Coefficients Beta	t	sig
1(Constant)	1.066	.759		1.404	.168
Condescendions	.554	.350	.249	1.582	.122

a. **Dependent Variable: Vocational Choice**

A simple leaner regression was conducted to quality the relationship between condensation and vocational choice of the physically.

4.3.3Hypothesis 3: There is a significant relationship, between social avoidance and vocational choice of the physically handicapped.

Table 17: summary Table of Hypothesis 3

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.372[a]	.138	.116	1.195

a. **Predictors: (Constant), SocilalAvoidance**

The table provides the R and R^2 values. The R value represents the simple correlation which is .372[a] which indicates a high value of correlation. The R^2 value indicates a high value of 1.38% which indicates a high value of correlation. The R^2 value indicates how much the total variation in the dependent variable (vocational choice)of the physically handicapped can be explained by the independent variable (social avoidance). In this case .135% which is very large .

The next table is the ANOVA table which reports how well the regression equation fits the data. That is (predicts the dependent variable). This is shown below.

Table 18: ANOVA table for Hypothesis 3

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	.
1	Regression	8.707	1	8.707	6.097	.018[b]
	Residual	54.268	38	1.428		
	Total	62.975	39			

a. Dependent Variable: Vocational Choice

b. Predictors: (Constant), SocilalAvoidance

The table indicates that the regression model predicts the dependent variable significantly well. Here, the P(siq)<..018[b] which is less than 0.65 and indicates the overall regression model statistically, significantly predicts the outcome value .

The next table is the coefficient table. This table provides us with the necessary information to predict social Avoidance on vocational choice of the physically handicapped.

Table 19: coefficient of prediction of hypothesis 3

		Coefficients	Coefficients		
Model	Unstandardized B	Std. Error	Beta	t	sia
1(Constant)	.379	.771		.492	.626
Social Avoidance	1.013	.410	.372	2.469	.018

a. **Dependent Variable: Vocational Choice of the physically handicapped**
b. **A simple leaner regression was conducted to quality the relationship between social Avoidance and vocational choice of the physically handicapped.**

4.3.4 Hypothesis 4: There is a significant relationship between internalization and vocational choice of the physically handicapped.

Table 20: Summary of Hypothesis 4

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.161[a]	.026	.000	1.271

a. **Predictors: (Constant), Internalization**

b. **Dependent variable : vocational choice of the physically handicapped**

This table provides the R and the R^2 values .The R value reprehends the simple correlation which is .026 which indicates a high value of correlation. The R^2 value indicates how much the total variation in the dependent variable vocational choice of the physically handicapped can be explained by the independent variable.(internalization) in this case 0.00% which is very large .

The next table is the ANOVA table which reports how well the regression equation fits the data . That is, (predicts the dependent variable) which is illustrated below.

Table 21: ANOVA table of Hypothesis 4

ANOVA[a]

Model		Sum of Squares	Df	Mean Squar	F	.
1	Regression	1.629	1	1.629	1.009	.321[b]
	Residual	61.346	38	1.614		
	Total	**62.975**	**39**			

a. **Dependent Variable: Vocational Choice**

b. Predictors: (Constant), Internalization

This table indicates that the regression model predicts the dependent variable significantly well. The P (sig) <.001[b] which is less than 0.05 and indicates the overall regression model statistically, significantly predicts the outcome value.

The next table is the coefficient table. This table provides us with the necessary information to predict internalization on vocational choice of the physically handicapped.

Table 22: Coefficient of prediction of Hypothesis 4

Model	Standard deviation B	Coefficients Std. Error	Coefficients Beta	t	sig
1(Constant)	1.422	.824		1.726	.092
Internalization	.472	.470	.161	1.005	.321

a. Dependent Variable: Vocational Choice

A simple leaner regression was conducted to internalization and vocational choice of the physically handicapped.

Table 23: summary table of findings

SN	OBJECTIVES	MEAN	DECISION	THEORY
01	Examining the effects of Discrimination on vocatio choices of the physically handicapped	2.06	**Strongly agree**	Social identity theory
02	Assessing the effects of Condescension on vocational choices of the physically handicapped	2.097	**Agree**	Social model of disability
03	Investigating the effects of social avoidance on vocational choices of the physically handicapped	1.795	**Strongly agree**	Social identity theory and social model
04	Finding out the effects of internalization on vocational choices of the physically handicapped	1.76	**Strongly Agree**	Social model

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0. Introduction

This chapter focuses on the summary of findings of the study which formed the foundation for discussion. The discussions provided a firm basis on which conclusions and recommendations were advanced to address the community perception of the physically handicap and its effects on the vocational choices in SAJOCAH Bafut, it also suggested areas for further research.

5.1: Summary of findings

The following are the summary findings presented under the objectives of the study as follows:

5.1.1: Discrimination and its effects on vocational choice of the physically handicap

The findings show that most of the respondents strongly agree that they are being discriminated upon in different settings with a mean of 2.06.

5.1.2: Condescension and its effects on vocational choice of the physically handicap

From the responses of the respondents, this study indicated there is a relationship between condescension and vocational choices of the physically handicap. Sixty percent of the respondents agreed that there is a relationship between condescension and vocational choice with a mean of 2.097.

5.1.3: Social avoidance and its effects on vocational choice of the physically handicap

The study findings reveal that there is a relationship between social avoidance and vocational choice of the physically handicap with a mean of 1.795. The alternative hypothesis was retained indicating that there is a significant relationship between social avoidance and vocational choice.

5.1.4: Internalization and its effects on vocational choice of the physically handicap.

The study findings reveal that there is a significant relationship between internalization as revealed by the verification of hypothesis with a mean of 1.76.

5.2Discussions of findings

The findings of this study were discussed using the objectives of the study as the main themes as follows:

5.2.I: community perception and its effects on the vocational choice of the physically handicap in SAJOCAH Bafut.

From the findings of this study, community perceptions affect the vocational choices of the physically handicap. The effects of discrimination, condescension, social avoidance and internalization interact in a series of complex ways to influence the vocational choices of the physically handicap and hence their chances of employment. In the study conducted by Dean D., &Pepper J (2017), the results indicate that Vocational Rehabilitation services have large positive long-run labor market effects that substantially exceed the cost of providing vocational services like vocational guidance and counseling

Therefore community perceptions of the physically handicap greatly affects their inclusion in the community and hence their chances to live and independent, fulfilled lives and contribute to the development of their respective communities. Examples of negative attitudes towards people living with disabilities include derogatory stereotypes, beliefs that people with disability have lesser position in society or that they have a diminished capacity to contribute in the development of their community. Across cultures, children with disabilities encounter negative attitudes, bullying, social exclusion, and isolation (Ochs et al., 2001; Hanvey, 2002; Nowicki and Sanderson, 2002; Cummins and Lau, 2003; Kelly, 2005; Laws and Kelly, 2005; Odom et al., 2006; Guralnick et al., 2007; Shah, 2007; Vreeman and Carroll, 2007; Nugent, 2008; Gannon and McGilloway, 2009; Koster et al., 2010; de Boer et al., 2012a; Lindsay and McPherson, 2012; Snowdon, 2012; Kayama and Haight, 2014). The presence of negative attitudes as revealed by this study necessitates a change of attitudes if the endeavours of inclusion of the people living with disabilities in Cameroon must be realized. Children with positive attitudes toward peers having disabilities may be more willing to interact with them compared to children with negative attitudes (Diamond, 1993; Okagaki et al., 1998; Roberts, 1999; Roberts and Smith, 1999; Favazza et al.,

2000; Gaad, 2004). As a result, more exposure to individuals with disabilities may lead to better understanding of disability and higher levels of acceptance (Hong et al., 2014). Thus, attitudes drive behavior, which, in turn, affects the individual's knowledge, beliefs, and attitudes. Interventions improving children's knowledge about disabilities and providing exposure to those with disabilities is the most successful technique of changing children's attitudes toward peers with disabilities (Diamond and Carpenter, 2000; Nikolaraizi et al., 2005; Nowicki, 2006; Rillotta and Nettelbeck, 2007; Siperstein et al., 2007; Feddes et al., 2009; Kalyva and Agaliotis, 2009; Gasser et al., 2014; Armstrong et al., 2016).

Developmental psychologists suggest that early childhood is the best time to intervene against the formation of negative attitudes toward disability, before these attitudes and behavior patterns become fully established and difficult-to-change (Killen et al., 2011; Lee et al., 2017). Family plays a significant role in shaping children's beliefs and attitudes toward others: parenting styles and children's attachment styles may determine the child's future attitudes toward individuals with disabilities. Importantly, there is an intricate interplay between parental factors and children's personality factors. Being the primary agents integrating children into society, parents may significantly influence their children's attitudes toward out-groups in general and individuals with disabilities in particular (Hellmich and Loeper, 2019). Importantly, parents may communicate their beliefs and attitudes to children explicitly through discussions or explicit teaching, or implicitly by modeling their values in daily interactions with other people or by providing their children opportunities to interact with out-group peers (Dunn, 1993; Castelli et al., 2007; Hellmich and Loeper, 2019).

People with disabilities have been stigmatized throughout history as a function of negative perceptions. In many cultures, disability has been associated with curses, diseases, dependence, and helplessness. Disability stigma can play out in a number of ways including; not get married to a normal person, not being enrolled in particular jobs like the military, farming, and sports etc.

5.2.2: Discrimination and its effects on the vocational choice of the physically handicap.

The findings of the study reveal that is a relationship between discrimination and vocational choice of the physically handicap in SAJOCAH Bafut. The null hypothesis was rejected and the alternative retained indicating that there is a significant relationship between discrimination and vocational choices. Other research findings exist to support the fact that

apart from discriminatory behaviors affecting the vocational choices of people living with disabilities, they suffer other forms of disability. Personal interactions and casual observations of the researcher led the researcher to understand some barriers which make access to vocations of their choices difficult. The parents and other members of the community choose vocations for the disables that do not match their interests. Individuals with disabilities require more complex career development processes that require the services of a qualified vocational guidance counselor with a good knowledge of people living with disabilities. There are some scholars that attest to the fact that the career development process for the people living with disabilities is quite complex (Enright, 1996; Luzzo, Hitchings, Retish, Shoemaker1999; Ochs & Roesler, 2001). The researcher is of the opinion that parents and community members may not have this expertise. Discrimination takes different forms including direct discrimination, indirect discrimination, and failure to make reasonable adjustments, discrimination arising from disability, harassment and victimization

5.2.3: Condescension and its effect on the vocational choice of the physically handicap

The findings of this study indicated that condescension has an effect on the vocational choice of the physically disable. The alternative hypothesis was retained indicating that there is a significant relationship between condescension and vocational choices. Some parents try to compensate for the disability of their disabled child and end up over protecting the child. Over protection of the child has a negative impact on the cognitive and affective development of the child. Such children grow up to lack the ability to make good decisions. They may also find it difficult to live an independent life. In this study, it is evident that most of the parents take decisions including that of vocational choices for their children. Item 3 on the questionnaire which states that "my parents take decisions on my behalf" had a 60percent response rate of strongly agree for the item. Pulrang (2022) intimate that "people living with disabilities are disadvantaged because they are considered childlike underdogs…..Based on this parents and significant others make decisions on behalf of the disabled people because the always consider them to be immature to make decisions for themselves.

5.2.4: Social Avoidance and its effects on vocational choice of the physically

The findings of this study portray that there is a significant relationship between social avoidance and vocational choice of the physically handicap. The response rate of item 8 on the questionnaire which states that "I have witnessed some form of public rejection in public institutions' was 47 percent". This rejection is implicated in vocational choice. To make good

vocational choices the people living with disabilities require information from significant others. If they are rather rejected by these significant others, they may lack the necessary information to make good choices. Indeed, the disabled are on the fringes of society, both in terms of access to social resources and the distribution of living environment as well as working opportunities, socio-economic status and quality of life, compared with abled people (Ridell and Weeden, 2014). If there is social inclusion, accessibility, rehabilitation, the gap between disabled and the so called normal will be closed.

5.2.5: Internalization and its effects on the vocational choices of the physically disable

The findings of this study revealed that there is a significant relationship between internalization and vocational choice. Internalization is the non-conscious mental processes by which the stereotypes (beliefs, feelings etc) or negative attitudes of the "so called normal "individuals are assimilated into the self and adopted by people living with a disability. The structure and the happenings of society shape one's inner self. Experience has shown that some people living with disabilities have a low self-esteem that affects their day to day lives. Therefore, they feel ashamed of themselves and lack self-confidence. The low self-esteem affects the decisions they make including their vocational choices

5.3Conclusion

This study concludes that community perceptions of the people living with disabilities affect their vocational choices negatively. This is evident in the fact that most parents and significant others in this study made vocational choices on the behalf of people living with disabilities. In many cultures, disability has been associated with curses, diseases, dependence, and helplessness. Disability stigma can play out in a number of ways like through discrimination, condescension, social avoidance and internalization. The way the community perceives people with disability, greatly influences their activities in general and life as a whole beginning from education to social interactions and livelihood or empowerment. In many societies there exist a host of negative attitudes towards the people living with disabilities. These negative attitudes create social barriers that interfere with the normal functioning of the individuals leaving with disabilities. it is therefore not the disability that constitute the problem but the social barriers. This makes it necessary for any community to look for ways to combat these negative attitudes.

It is based on this change of attitude that any meaningful inclusion of people living with disabilities can be achieved. Disability is part of human condition. Almost everyone will be temporally or permanently impaired at some point in life and those who survive to old age will experience increasing difficulty in functioning. For this reason the fight for the rights of people living with disabilities should be the concern of all members of a community. This holistic approach can be justified that even those who are so called normal may become disabled tomorrow. People with positive attitudes toward peers having disabilities may be more willing to interact with them compared to people with negative attitudes. As a result, more exposure to individuals with disabilities may lead to better understanding of disability and higher levels of acceptance. Thus, attitudes drive behavior, which, in turn, affects the individual's knowledge, and beliefs. Interventions improving community's knowledge about disabilities and providing exposure to those with disabilities is the most successful technique of changing community attitudes toward peers with disabilities.

Developmental psychologists suggest that early childhood is the best time to intervene against the formation of negative attitudes toward disability, before these attitudes and behavior patterns become fully established and difficult-to-change. Family plays a significant role in shaping children's beliefs and attitudes toward others: parenting styles and children's attachment styles may determine the child's future attitudes toward individuals with disabilities. Importantly, there is an intricate interplay between parental factors and children's personality factors. Being the primary agents integrating children into society, parents may significantly influence their children's attitudes toward out-groups in general and individuals with disabilities in particular. Importantly, parents may communicate their beliefs and attitudes to children explicitly through discussions or explicit teaching, or implicitly by modeling their values in daily interactions with other people or by providing their children opportunities to interact with out-group peers. Therefore effective strategies to fight against negative community attitudes towards people living with disabilities will be more successful if we target the family.

5.4: Recommendations

Based on the findings the following recommendations were made:

- This study recommends that the ministry of social affairs should organize regular vocational guidance and counseling sessions for people living with disabilities.

- The vocational centres run by the Ministry of social affairs should include assessment units. The personnel of this unit should be able to assess the nature of disabilities and suggest suitable vocations in relation to disability type.
- Non-Governmental Organizations in the field of special needs education should complement the efforts of the government to organize vocational guidance and counseling sessions for people living with disabilities.
- Successful people living with disabilities should use different social media and communication channels to provide relevant Career information to the general public and people living with disabilities in particular
- Sensitization campaigns should be organized by all educational stake holders of good will using different social media and communication channels.

5.5 Suggestion for further studies

- This current study can be replicated using a larger sample size
- A comparative study of this nature can be carried out using two ethnic groups with different cultures to assess the impact of culture on the perception of people living with disabilities

5.6: Limitations of the study

This study was carried in the North West Region of Cameroon in the mist of the ongoing armed conflict. As a result of this conflict, the researcher was unable to have access to some of the potential participants of the study. There were equally financial constraints and problems of epileptic power supply

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