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SOCIAL VULNERABILITY AND ITS EFFECTS ON THE SELF ESTEEM OFTHE PHYSICALLY HANDICAPPED

- THE CASE STUDY OF 34 AMPUTEES IN THE BAMENDA I AND II, NORTH WEST OF CAMEROON

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CERTIFICATION

This is to certify that this thesis titled “Social vulnerability and its effects on the self-esteem of the physically handicapped (amputees)” was conducted by Nchangnwi Olivia (20V3020) in the Faculty of Science of Education University of Yaounde I, under the supervision of

Sign …….. Date…….

Supervisor’s name

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DEDICATION

This work is dedicated to my kids,

Numfor Akongnwi shu

Shu Afanwi Shu

Sirri Sonia Shu

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ABSTRACT

This study titled “Social Vulnerability and its Effects on the Self-esteem of the Physically Handicapped: Case Study of 34 Amputees in Bamenda I and II, North West of Cameroon was guided by one main research question/objective/hypothesis and 4 specific research questions/objectives/hypotheses. The social model of disability, the social identity theory and the cognitive theory of depression were used to guide the interpretation and discussion of the findings. It was observed that the amputees in the Bamenda I and II were exposed to a lot of disadvantages that made them socially vulnerable thus, making their self-esteem to be low. The descriptive statistics used for analysis were mean, percentage, frequency and standard deviation. We tested hypothesis using linear regression on (SPSS) version 25. The findings were analyzed and presented using both descriptive and inferential statistics. The analysis revealed that there is a significant relationship between social vulnerability and the self-esteem of the physically handicapped (amputees). Specifically the results also revealed that there is a significant relationship between attitudes, access to basic human services, access to social protection and social capital and the self-esteem of the physically handicapped (amputees) ascertained by the overall mean of 2.1375, acknowledging the fact that it is the social barriers that limit the people living with disabilities (amputation) and not their condition. The study recommended that efforts should be made by the community and all educational stake holders to minimize the challenges of the people living with physical handicaps (amputations). Lastly, suggestions were advanced for further studies.

KEY WORDS: Disability, Physical Disability, Social Vulnerability, Self-esteem and Amputees.

RESUME

Cette étude intitulée “La vulnérabilité sociale et ses effets sur l’estime de soi des handicapés physiques : étude de cas de 34 amputes à la Municipalité I et II de Bamenda, Nord –Ouest du Cameroun a été guidée par une question/objectif/ hypothèse de recherche principale et 4 questions de recherche spécifiques/objectifs/hypothèses. Le modèle sociale de handicap, la théorie de l’identité et la théorie cognitive de la dépression ont été utilisés pour guider l’interprétation et la discussion des résultats. Il a été observé que les amputes de la municipalité I et II de Bamenda étaient exposes a des nombreux désavantages qui les rendaient socialement vulnérables, ce qui rendait leur estime de soi faible. Les statistiques descriptives utilisées pour l’analyse étaient la moyenne, le pourcentage, la fréquence et l’écart type. Nous avons teste hypothèse à l’aide de la régression linaire sur la version 25 de (SPSS). Les résultats ont été analyses et présentes à l’aide de statistiques descriptives et différentielles. L’analyse révélé qu’il existe une relation significative entre la vulnérabilité sociale et l’estime de soi des handicapés physiques (amputés). Plus précisément, les résultats ont également révélés qu’il existait une relation entre les attitudes, l’Access aux services humains de base, l’accès à la protection sociale et au capital social et l’estime de soi des handicapés physiques (amputes) déterminée par la moyenne globale de 2.1375. L’étude conclut donc qu’il existe une relation significative entre la vulnérabilité et l’estime de soi des handicapés physiques (amputés), reconnaissant le faire que ce sont des barrières sociales qui limitent les personnes vivant avec un handicap (amputation) et non leur condition. L’étude recommandait que les efforts soient faits par la communauté et tous les acteurs de l’éducation pour minimiser des défis des personnes vivant avec un handicap physique (amputés). Enfin, des suggestions ont été avancées pour d’autres études.

MOTS CLES : Handicap, Handicap physique, vulnérabilité sociale, Estime de soi et Amputés.

ABBREVIATIONS

ACPF:	African Child Policy Forum
ADA:	American Disabilities Act
ADHD:	Attention Deficit/Hyperactivity Disorders
ADD:	Attention Deficit disorder
AD:	After the Death of Christ
APA:	American psychological Association
COVID19:	Corona Virus Disease
CRDP:	Convention on the Rights of Persons with Disabilities
DSM-IV:	Diagnostic and Statistical Manual
DD:	Development Disability
E.A:	Equality Act
EEA:	Employment Equality Act
ESA:	Equality Status Acts
HIV:	Immune Deficiency Virus
ID:	Intellectual Disability
IFC:	International classification of Functioning
ILO:	International Labour Organization
MICS:	Multiple Indicator Cluster Survey
NOG:	North Officer Group
NWTDC:	North West Territories Disability Council
NGOs:	Non-Governmental organizations
RNIB:	Royal National Institute of the Blind
SGA:	Substantial Gain Activity
SE:	Self-Esteem
SDG:	Sustainable Development Goals
TMT:	Terror Management Theory
UNICEF:	United Nations, International Children's Education Fund
UKDPC:	United Kingdom Disabled People's Council.
UNFPA:	United Nations Population Fund
UNCRDP:	United Nations Convention on Rights of People with Disability

WHO: World Health Organization

WASH: Water Sanitation and Hygiene

WB: World Bank

CHAPTER ONE

GENERAL INTRODUCTION

This general introductory chapter gives a bird's eye view of the entire research project as it originates and ends. As such, it will feature the historical background, conceptual background, theoretical back ground, contextual background, statement of the problem, objectives of the study, research questions, research hypothesis, justification of the study, significance of the study, scope of the study and operational definitions of terms.

According to the world Health Organization (WHO) "disability is part of being human. Almost everyone will temporarily or permanently experience disability at some point in their life." A crucial point here is how others perceive disability. People with disabilities could experience a feeling of being totalized, as their disability may make them feel that other people devalue them as human beings and see them as being inferior and abnormal. In addition, this feeling may make it difficult to integrate the experience of disability into their lives by affecting how they perceive themselves, their capabilities and self-worth (Lutz and Bowers, 2005).

People with disabilities might tend to internalize negative attitudes about disability, behave in a manner consistent with societal expectations and develop negative constructions of the self, and they may often experience social isolation due to the stigma attached to their disability (Blinde and McClung, 1997; Blinde and Taub, 1999). Thus, stigma handling strategies are an important tool for people with disabilities to cope with situations in everyday life (Krantz, Bolin, and Persson, 2008). Due to societal and disability-related obstacles, individuals with physical disabilities may experience difficulties in mastering tasks and participating in daily life activities since barriers within society seem to prevent them from participating in social communities. The Danish National Centre for Social Research displayed a clear tendency that as with most types of disabilities, physical disabilities have a reducing effect on all types of participation in society, which concerns social life in relation to family and friends, as well as participation in societal areas such as education, employment and leisure time activities (Bengtsson, 2008).

These vulnerabilities may affect the way they value themselves i.e. their self-esteem. Self-esteem (SE) has become a household word. Teachers, parents, therapists, and others have focused efforts on boosting self-esteem, on the assumption that high self-esteem will cause many positive outcomes and benefits (Baumeister et al. 2003). SE is considered integral to the self-concept, and can be defined in terms of positive feelings about the self (Uchida, March & Hashimoto 2015). It is integral to an individual's sense of their own value (Fox & Corbin 1989; Sonstroem 1997), a principal component of mental health (Jambor & Elliott 2005), a strong indicator of a healthy lifestyle (Hintermair 2007; Bendíková 2010; Bendíková 2014), and an important indicator of well-being (Shek & McEwen 2012; Nemček 2016a). Although minority groups, like people with disabilities, often suffer stigmatization (Jambor & Elliott 2005; Johnson & Yarhouse 2013) and poor SE (Salehi et al. 2014), it is widely believed that membership of such a group has a protective effect on SE because of the tendency to identify with the minority group (Crocker & Major 1989; Jambor & Elliott 2005). As mentioned earlier, Blinde and McClung (1997) and Blinde and Taub (1999) on the contrary contend that People with disabilities might tend to internalize negative attitudes about disability, behave in a manner consistent with societal expectations and develop negative constructions of the self, and they may often experience social isolation due to the stigma attached to their disability. The above seem to suggest that as individuals, people living with disabilities may be predispose to low self-esteem but membership in an association of people living with disabilities may result in higher self esteem

Promotion of health and quality of life for disabled people is one of the World Health Organization's objectives. One way of boosting SE is participation in sport (Labudová, Nemček & Kraček 2015; Bendíková & Labudová 2012). There are numerous benefits of sport participation in terms of both physical and psychological well-being (e.g., self-esteem). SE is an important psychological variable (Bardel, Fontayne, Colombel & Schiphof 2010) and facet of personality (Adie, Duda, & Ntoumanis 2008) in competitive sport. Adie, Duda, & Ntoumanis (2008) demonstrated that individuals with higher SE tend to perceive competitive sport as challenging, whereas individuals with lower SE regard it as threatening. Although it is well known that participation in sport (at the recreational and elite level), can promote well-being not only among healthy athletes but also those with non-communicable diseases (Onagbiye, Moss & Cameron 2016; Moss et al. 2016; Bendíková & Nemček 2016) and disabilities (Kurková 2010;

Uchida Marsh & Hashimoto 2015; Nemček 2016b; Nemček 2016c). From the above it is evident that perception of disability may have an effect on the self-esteem of those living with disabilities. This study thus set out to investigate how social vulnerability affects the self-esteem of the physically handicapped –case study of 34 amputees in the Bamenda I and II, North West Region of Cameroon.

1.1 Historical Background

Historically the perception and attitudes towards people living with disabilities have evolved from negative to positive over time. At a certain point (era of extermination) the Greek and Romans once considered disability as a "punishment of the gods" – A bad or evil sign (Tremblay & Montenegro, 2007) and as such Plato and Aristotle called for infanticide. During this era, disabled persons were chained, left on hill sides to die, thrown off cliffs, locked away or drowned. Ciceron calls for the purity of the race, a society free of "defectives" and emphasize a Need for military Superiority. Therefore, someone with a disability resulting from war (soldiers) is taken in charge by the city.

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. One could also argue that throughout history there have been many forms of discrimination of those with disabilities and that included such perceived disabilities as being a minority race, female poor. For the early tribes and nomads, survival was 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. Then again early life was a matter of survival, if an individual was unable to join in hunting and gathering; they were of no use and as the tribe moved on, the disabled were left behind if they couldn't keep up (SAIL on Blog, 2018).

The Greek Empire was obsessed with human perfection and as such, they believed beauty and intelligence were intertwined. This may have laid the ground work for future beliefs. It is widely acknowledged that the foundations of western `civilization' were laid by the ancient Greeks. Their 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). The Greek obsession with bodily perfection, (Dutton, 1996), found expression in prescribed infanticide for children with perceived imperfections (impairments). Infanticide in the form of exposure to the elements for sickly or weak infants was widespread and in some states mandatory (Tooley, 1983). In the Western World the 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 (Len B. and Mike O., 1997). 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).

However, both the Greeks and Romans developed `scientifically' based treatments for people with acquired impairments. Aristotle, for example, attempted to study deafness and Galen and Hypocrites tried to cure epilepsy which they saw as a physiological rather than a metaphysical problem. The Romans developed elaborate hydrotherapy and fitness therapies for acquired conditions. But in each of these societies such treatments were only generally available to the rich and powerful (Albrecht, 1992; Garland, 1995).

Several of the above traits are reflected in Judean/Christian religions -often seen as the principal source of contemporary western moral values. 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. Much of Leviticus is devoted to a

catalogue of human imperfections which preclude the possessor from approaching or participating in any form of religious ritual:

None of your descendants throughout their generations who has a blemish may approach to offer the bread of his God. For no-one who has a blemish shall draw near, a man blind or lame, or one who has a mutilated face or a limb too long, or a man who has an injured hand, or a hunch back or a dwarf, or a man with a defect in his sight or an itching disease or scabs or crushed testicles' (Leviticus, 21. 16-20).

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 are forgiven (9-2). But 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, its 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. 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. When surrendering property rights to their children, elderly parents were often forced to ask for very specific rights in return (Macfarlane, 1979, p.141). 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).

However, during the sixteenth century the wealth and power of the English Church was greatly reduced because of a series of unsuccessful political confrontations with the Crown. There was also a steady growth in the numbers of people dependent on charity. 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).

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' humor 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).

The proliferation of Eugenic ideals throughout the western world during the first half of the 18th century, the systematic individualization and medicalization 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 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.

However, the nineteenth-century was also significant for an upsurge of Christian charity and `humanitarian' values among the Victorian middle and upper classes. As a consequence several charities controlled and run by non-disabled people `for' disabled people were founded during this period. One example is the British and Foreign Association for Promoting the Education of the Blind, now known as the Royal National Institute for the Blind (RNIB) which was set up in 1863 (RNIB, 1990).

It is clear from the above that to appreciate fully the extent and complexity of the oppression of disabled people within contemporary Western society, an insight into the material and social forces which shaped western culture is essential. It is essential because for most, both disabled and non-disabled, people the biggest barrier to disabled people's inclusion into mainstream economic and social activity is the attitudinal barrier. In the above section we have argued that this is little more than a reflection of western cultural values, and that this value system has its roots in the complex interplay between the economy and the culture of the ancient world of Greece and Rome, rather than the material and ideological changes which engulfed Europe and the western world in the eighteenth and nineteenth centuries.

This is not to suggest that negative attitudes are peculiar only to western culture, or that people with apparent impairments have always been rejected within the context of everyday life in societies which appear to adhere to it. Africans in general and Cameroon in particular have exhibited diverse attitudes towards disability. As mentioned earlier, cultural responses to people with perceived impairments are by no means universal; whilst there are several examples of cultures which accommodate the needs of so called disabled people, there are others which do not. Moreover, although infanticide for children with visible impairments has consistently characterized in western cultural development, it is evident that such people have existed throughout recorded history Africa and Cameroon. There are several reasons for this. Notably,

human beings are not simply `cultural dupes'. It is likely, therefore, that many parents rejected such practices and supported their disabled offspring.

Traditional beliefs about the causes of disability remain prevalent across Africa. One set of explanations is linked to traditional animism. Killing and abuse of children with disabilities are covert phenomena, occurring in some developing regions, such as in some African countries. Similar to the practice of ritual killing of spirit children in Ghana, the phenomenon of the snake child in Cote d'Ivoire (known as Ivory Coast), is the ritual abandonment or killing of children with intellectual disability (ID) (Bayat, 2014). This carries beliefs that disabilities are punishments for bad deeds, or the result of witchcraft. The concept of disability has been examined from various cultural perspectives across the continent of Africa and found that in every culture, disability was perceived differently and such perception shaped the kind of services rendered. 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. Characteristics and interpretation of those characteristics are dramatically influenced by the culture in which the individual with disability resides. In Africa in general and Nigerian society in particular, children with disabilities have been incorrectly understood, and this misunderstanding has led to their negative perception and treatment. In Nigeria, there exist false beliefs about the causes of disability, which have included: a curse from God; ancestral violations of societal norms; offenses against the gods of the land; breaking laws and family sins; misfortune; witches and wizards; and adultery, among others (Eskay M., Onu V.C., Igbo J.N., Obiyo N., Ugwuanyi L.,2012).

According to the Toolkit in Disability for Africa, in African societies, there are examples of positive and empowering beliefs about disability. However, as is the case in many settings in Africa, disability is sometimes also associated with negative perceptions resulting in stigma,

discrimination, exclusion and violence, as well as other forms of abuse of persons with disabilities. Based upon its field studies in Cameroon, Ethiopia, Senegal, Uganda and Zambia, the African Child Policy Forum (ACPF) reports that common beliefs about the causes of childhood disability include: sin or promiscuity of the mother, an ancestral curse; or demonic possession (ACPF, 2011). In some cases persons with disabilities are subjected to physical violence and assault as a result of stigma and harmful beliefs. Also there are many examples of people who claim to be able to provide treatments and remedies to "cure" certain types of disability. Some of these treatments are rooted in local custom while others are provided in conventional biomedical settings, with harmful consequences for the health, life and dignity of persons with disabilities.

In Somalia human rights reports indicate that some serious mental health conditions are subject to local village practices –the so-called 'hyena cure' – according to which a person with a mental health condition is thrown into a pit with one or more hyenas that have been starved of food on the basis that the hyenas will scare away the *djinns*, or evil spirits, that inhabit the person (World Health Organization & Mental Health and Poverty Project, Mental Health and Development, 2010 p. 9). In some communities in Tanzania, Malawi and Burundi there is a belief that the body parts of persons with albinism bring good luck, wealth and medical cures, as well as success in elections. As a result, persons with albinism, often children, in these countries have been abducted and wounded or killed. In many countries there is a common folk belief that, if someone with HIV has sex with a virgin, the virus will be transferred from the infected person to the virgin. The practice, known as "virgin rape", has reportedly even involved rape of infants and children. Persons with disabilities, both men and women – often incorrectly assumed to be sexually inactive (hence virgins) – are also now at risk. Accounts from many areas report that persons with disabilities have been raped repeatedly (WHO/UNFPA, 2009).

In the past in Cameroon, persons with disabilities were completely rejected by some cultures, in others; they were outcasts, while in some they were treated as economic liabilities and grudgingly kept alive by their families.

1.2 Conceptual background

This section of the study provides a conceptual background of disability, physical disability, social vulnerability and self-esteem which constitute the overarching concepts of the study

1.2.1 Disability

The Center for Disease control considers disability as "any condition of the body or mind that makes it more difficult for the person with the condition to do certain activities (activity limitation) and interact with the world around them (participation restrictions)." In addition the Social Security Administration defines disability as "inability to engage in any Substantial Gainful Activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." Also the Americans with Disabilities Act (ADA) consider "an individual with a disability" as a person who has a physical or mental impairment that substantially limits one or more major life activities, a person who has a history or record of such impairment, or a person who is perceived by others as having such impairment. The American Disability Act (ADA) does not specifically name all of the impairments that are covered."

As evident in the definitions above, the term "Disability" has different connotations, depending on context. While the social context focuses on issues like prejudice, the medical context utilizes a diagnostic- therapeutic paradigm. The US Department of justice takes a legal approach to define disability under the Americans with Disabilities Act, as does the Social Security Administration. The rehabilitation approach to disability integrates many concepts by using the World Health Organization International Classification of Functioning, Disability and Health (ICF) model. In order to understand the diverse perspectives on disability, conceptual models have been formulated.

These conceptual models can be used not only to define disability, but also to understand the impact of the disability and context-specific factors on function. The models have applications for quantitative and qualitative assessment of disability and functioning, to inform needs and resources, monitor costs, direct social policy, and maximize awareness and acceptance globally.

While there are many models of disability, two categories stand at the ends of a spectrum – the "individual" or "medical" model and the "social model"

Individual or medical model

Following this model from the biomedical approach, disability is considered an intrinsic reality to the individual. It is defined as a 'bodily, physical or mental impairment' belonging to him and having the consequences of limiting him/her to the level of his social participation. This model follows a cause- and- effect logic: a disease or trauma causes an organic and functional impairment; this results in incapacity for the person; this disability translates into social disadvantage or disability. Disability is clearly the result of the individual's impairment.

Social model

Following this model that appeared in the 1960s, disability is considered a social product, as a result of the society's inadequacy to the specifities of its members. The origin of disability is therefore external to the individual. This conception is clearly opposed to that underlying the medical model. The type of intervention proposed will thus change: rather than a curative action aimed at the normalization of the individual, the social model will abandon the ideal of healing and promote the development of the remaining capacities of the person in order to make him autonomous in his daily life (logic of empowerment). This model also advocates the removal of physical and social barriers. It is a question of adapting the environment and the services, making them accessible and usable for people with physical or psychological disabilities. Legislation against discrimination and for equality is inspired by this model (see for example, Art 8 para 2 of the Swiss Constitution and the Act on Equality for Persons with Disabilities Marcia Rioux (1997) cited by Ravaud (2001,pp. 62-63) proposes a typology of the different approaches to disability.

However, there is no single correct definition of disability. The nature and severity of disabilities vary greatly (Mont 2007). DFID (2015) acknowledge that there cannot be a one-size fits all definition of disability. UNCRPD (2006) define persons with a disability as including those who have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with

others. DFID (2015) states that impairment is disabling when individuals are prevented from participating fully in society because of social, political, economic, environmental or cultural factors. Disability can be defined as the relationship between a person's impairment and their environment (Impairment + barrier = disability or Impairment + accessible environment inclusion) (Al Ju'beh 2015).

The contested definition of disability is one factor that complicates attempts to obtain an exact disability prevalence figure. Other factors include the quality and methods of data collection, rigor of sources and varying disclosure rates (Mont 2007; Al Ju'beh 2015). Poor service provision and stigma may result in lower disclosure. National statistics can be misleading, incomparable and inaccurate. These limitations may result in a higher prevalence of disability in developed countries being reported compared to developing countries (Al Ju'beh 2015).
Developing countries have predominantly collected disability data through censuses or use measures focused exclusively on a narrow choice of impairments. These countries tend to report low disability rates. Countries that collect their data through surveys and measure activity limitations and participation restrictions in addition to impairments tend to report higher prevalence. Data gathered from institutionalized populations tends to result in higher prevalence rates (WHO and World Bank 2011). Despite these potential influences, the evidence suggests that low and middle income countries do in reality have higher disability prevalence, in comparison to high income countries (Mitra and Sambamoorthi 2014).

Based on 2010 global population estimates, the WHO and World Bank (2011) estimate that more than a billion people live with some form of disability. This equates to 15% of the world's population, which is 5% higher than a previous WHO estimate from the 1970s. The two sources of statistical information that underpin the 2011 estimate of global disability prevalence are the World Health Survey and the Global Burden of Disease. Estimates reflect current knowledge and available data as both sources are known to have limitations with regards to measuring disability.

In the past, national survey and census data could not be compared directly with either of these sources as there was no consistent approach across countries to disability definitions and survey questions (WHO and World Bank 2011). The World Health Survey estimates that around 785

million (15.6%) persons 15 years and older live with a disability. The Global Burden of Disease estimates a figure of around 975 million (19.4%) persons. Of these, 110 million people (2.2%) have significant difficulty functioning, while 190 million (3.8%) have “severe disability” – the equivalent of disability inferred for conditions such as quadriplegia, severe depression, or blindness. Only the Global Burden of Disease measures childhood disabilities (0–14 years), which is estimated to be 95 million (5.1%) children, of whom 13 million (0.7%) have severe disability (WHO and World Bank, 2011).

A retrospective analysis of data from the World Health Survey (2002-2004) for 54 countries estimated global prevalence of disability to be 14%. For this study disability was measured as having at least one severe or extreme difficulty with bodily functions (seeing, concentrating) and activities (moving around, self-care) based on an individual's self-reports (Mitra and Sambamoorthi, 2014). The main trust of this study is how ever limited to physical disabilities to which we now turn our attention to.

1.2.2 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 (Care home.co.uk). The loss of physical capacity results in the person 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, sensory (blind, deaf, dumb), learning disabilities, 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.

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 all years lived with 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 Boko haram, 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, The everyday life of people with physical disabilities may often differ in various ways from that of able-bodied people, and several researchers have focused on the Experience of disability in relation to everyday life.

On an individual level, impairments may limit the extent to which people with physical disabilities may be involved in some activities, and may imply that they spend more time on the activities of daily living than the average population (Gaskin, Andersen, and Morris, 2009; Lutz and Bowers, 2005). Individuals with physical disabilities often find their social interactions and social network limited (Isaksson, Ska¨r, and Lexell, 2005), with isolation possibly affecting the range of their life experience and influencing their effectiveness in social situations (Blinde and Taub, 1999).On an individual level, physical disability can be defined as a physical condition that affects a person’s mobility, physical capability, stamina or dexterity.

1.2.3 Vulnerability

Broadly defined, vulnerability is the potential to suffer loss or harm. This can include structural vulnerability of buildings and lifelines, biophysical vulnerability (physical exposure) of people and places to natural events, and social vulnerability describing differential susceptibility based on social, economic and political factors (O'Keefe et al. 1976; Cutter, 2001). The scientific use of

vulnerability is deeply rooted in geography and natural hazard science; moreover the term is increasingly being used as a central concept in various other traditions such as ecology, public health, poverty and development, secure livelihoods and famine, sustainability science, land change, and climate impacts and adaptation. The term is used in various ways by the scientists from different knowledge areas, and even within the same research area. For example, natural scientists and engineers use the term in a descriptive way while social scientists use it in a specific explanatory model (O'Brien, et al., 2004; Gow, 2005).

The concept of 'vulnerability' has been contentious and contested even in disability studies. It has been associated with the medical model of disability, which portrays disability as an individual problem or a personal tragedy (Burghardt, 2013). Roulstone et al. (2011: 352) have argued that the concept 'play[s] down individuals' rights to independent living and full judicial rights'. Taking a different but no less critical approach, (Shakespeare and Watson, 2001: 27) have advocated for universalizing vulnerability: 'we are all impaired. Impairment is not the core component of disability …, it is the inherent nature of humanity.' A related line of critique has targeted the normativity of non-vulnerability: 'It is… the normative, invulnerable body of disablist modernity that is the problem.' (Hughes, 2007: 681) In a similar vein, (Davis, 2002) has proposed a 'dismodernist ethics' where 'impairment is the rule, and normalcy is the fantasy. Instead of abandoning or universalizing the idea of individual vulnerability, this study focuses on the social determinants of vulnerability. Scholars in other disciplines have conceptualized 'social vulnerability' as a condition of pre-existing social structures where certain social factors exacerbate the effects of impairment (Bergstrand et al., 2015)

Evidently, vulnerability has no universal definition. Experts from various disciplines use the concept and define vulnerability, which leads diverse measuring methods to serve their own purpose and interests. Approaches to define vulnerability vary among the disciplines because of the various components of risk, household response and welfare outcomes (Shitangsu, 2013).

Notwithstanding, few definitions of vulnerability have been widely agreed upon, in large part because the study of hazards vulnerability has proceeded under at least three distinct conceptual framings. These include risk-hazard, political ecology, and social-ecological systems frameworks (Eakin and Luers, 2006), although other typologies have been suggested (Liverman, 1990;

Cutter, 1996; Turner et al. 2003; Adger, 2006). Each is situated within a larger human-ecological modeling framework in which hazards and disasters stem from complex interactions between environment and society. However, the frameworks differ in their conceptualization of the dominant components, processes, and relationships that define human-environmental interactions. Conceptual framing is important because it drives the types of questions that are posed, the analytical methods used to answer them, and the solutions that are implemented. Over time, conceptual frameworks of vulnerability evolved from an initial focus on physical and managerial aspects to more explicit inclusion of social drivers and differential impacts. The conceptual framework found suitable for this study is focus on the social characteristics of the society.

1.2.4 Social Vulnerability

As applied in social science research, the term vulnerability generally describes a state of people and populations rather than physical structures, economies, or regions of the earth (Wisner et al. 2004). Vulnerability can vary significantly across both social and geographic space (Liverman, 1990; Bohle et al. 1994b; Cutter, 1996). Social space refers to who is vulnerable, and is defined by the political, economic, and institutional capabilities of people at a specific time and place (Bohle et al. 1994b; Wisner et al. 2004). By contrast, geographic space describes the location and scale at which people and places are vulnerable (Cutter, 1996). A focus on the social determinants of vulnerability helps explain why people with similar levels of exposure may experience very different levels of adverse impact. The social vulnerability perspective has its roots in the domains of political economy and political ecology. Political economy researchers generally focus on how political, economic, social, historical, and institutional factors produce differential exposure and susceptibility, with particular attention paid to cross-scalar interactions (Burton, Rufat & Tate, 2018).

Social vulnerability refers to the inability of people, organizations, and societies to withstand adverse impacts from multiple stressors to which they are exposed. These impacts are due in part to characteristics inherent in social interactions, institutions, and systems of cultural values (Wikipedia).

1.2.5 Social Characteristics (indicators) of social interactions

Some characteristics (indicators) of social interactions include: income, access to basic services and social protection, attitude and culture to risk/disasters, social capital etc. However, for the purpose of this study access to basic services, access to social protection, attitude and social capital will be further examined.

a) Attitudes

The attitudes of specific societies are critical in assessing both the intensity of disability (i.e. how disabling a given type or level of impairment becomes for the individual disabled person) and in assessing areas where collective action is likely to fail the disabled community, and hence public action be desirable. In addition to the attitudes of the general society, the attitudes of persons with disabilities and their families are important, in some ways even more important. At the same time, the different sets of attitudes clearly interact, so that negative views about disabled people in the broader community are likely to be internalized in many cases by people with disabilities and their household members. By implication, the self- esteem of the disabled person is affected by the attitude he has towards him/herself and the attitudes of the immediate family members and the larger community.

b) Access to Basic human Services

For the physical and economic development of any human being, it is imperative for him/her to have access to some basic human services like health care, education, transport facilities, communication, involvement in decision making, employment, and access to public space, access to credit facilities from financial institutions etc.

c) Access to Social Protection

Social protection is concerned with protecting and helping those who are poor and vulnerable, such as children, women, older people and people living with disabilities, the displaced, the unemployed, and the sick. There are ongoing debates about which interventions constitute social protection, and which category they fit under, as social protection overlaps with a number of livelihoods, human capital and food security interventions (Harvey et al., 2007).

Social protection is commonly understood as “all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and

enhance the social status and rights of the marginalized; with the overall objective of reducing the economic and social vulnerability of poor, vulnerable and marginalized groups" (Devereux & Sabates-Wheeler, 2004: i).

This definition is in line with usage in international development, and may be different from social policy definitions in high-income countries. Social protection is usually provided by the state; it is theoretically conceived as part of the 'state-citizen' contract, in which states and citizens have rights and responsibilities to each other (Harvey et al., 2007).
The objectives of social protection vary widely, from reducing poverty and vulnerability, building human capital, empowering women and girls, improving livelihoods, and responding to economic and other shocks. As a result, the form and function of social protection programs can be quite disparate, according to the particular objective (Hanlon et al., 2010: 28).

'Safety nets' are a form of social protection which helps people meet immediate basic needs in times of crisis. Typical short-term goals are to mitigate the immediate impact of shocks and to smooth consumption. The World Bank has a slightly different definition, which defines 'safety nets' as social assistance programs (Gentilini et al., 2014).

Other forms of social protection aim at longer-term development and enabling people to move permanently out of poverty (Babajanian et al., 2014). Long-term goals include improving opportunities for inclusive growth, human capital development, equity and social stability. Some social protection programs intend to be transformative, supporting equity, empowerment and human rights.

There are several different conceptual approaches to analyzing social protection objectives and impacts. Each conceptualizes potential impacts in different ways: transformation; human capital; vulnerability; and human rights. Devereux and Sabates-Wheeler (2004) provide the most commonly used conceptual framework, which describes four social protection functions:
Protective: providing relief from deprivation (e.g. income benefits, state pensions)
Preventative: averting deprivation (e.g. savings clubs, social insurance)
Promotive: enhancing incomes and capabilities (e.g. inputs)

Transformative: social equity and inclusion, empowerment and rights (e.g. labor laws)

The first three functions (the three Ps in the PPP+T framework) were originally conceptualized by the International Labor Organization (ILO.)) The addition of the transformative element positions social protection not just to alleviate poverty but to transform lives, through pursuing policies that rebalance the unequal power relations which cause vulnerabilities. In practice, social protection interventions usually cover multiple functions and objectives.

d) Social Capital

Social Capital is a concept that aims at emphasizing the importance of social contacts between groups and within groups. It primarily means that social networks have a value associated and that they are not always detrimental in nature as previously thought of. The concept of social capital also stresses that social networks lead to increased productivity in individuals, teams and organizations. This increased productivity can be both financial and otherwise. This means that social contacts can lead to increase in confidence, fulfillment by fostering positive relationships. The essence being that just like any other capital form (human, physical, financial) social capital is also important and beneficial to the sustenance of society.

The term social capital has been used in varied forms in various disciplines. World Bank, for example, uses it to define societal and economic development. Corporate pundits similarly use it to mean an approach of organization development. Judson Hanifan championed the use of social capital. He used it in his discussions of rural school community centers. He promoted the importance of social intercourse among people for building goodwill and sympathy among fellow members and to promote cooperation.

There can be a multitude of reasons that can act as barriers to social capital creation or development. These factors vary across geographies and cultures. For example in developing or third world countries social networks remain nucleated around family and identity. There is little or no social capital creation across families and castes. This is on account of the mistrust between two families or strata that is detrimental to the very idea of social capital. Due to society’s negative attitudes towards people living with disabilities there is reason to believe that people living with disabilities can find it even more difficulty to form healthy social networks.

Hence not being able to form healthy social networks the development of the self-esteem of people living with disabilities may be hampered.

1.3 Self-esteem

We all have an innate sense of who we are: our self. Not only do we possess a highly elaborated cognitive self-concept, but we also hold a highly accessible affective sense of how skilled, lovable, and worthy we are as a person. This global evaluation of one's worth is known as self-esteem. Self-esteem is typically viewed as a continuous dimension ranging from high to low: People with high self-esteem feel very positive about themselves, whereas those with low self-esteem feel ambivalent or uncertain about themselves. Truly negative self-evaluations or Self-hatred are unusual and typically found only in clinical populations (Brown et al., 2001; Leary and MacDonald, 2003). This global evaluation is the most common definition of self-esteem, and is considered relatively stable (i.e., an individual can be said to have a dispositional level of self-esteem). It is also sometimes referred to as self-worth, self-regard, or self-evaluation – all of which have the same essential meaning. The construct of self-esteem has a long and checkered history within the discipline of psychology. William James (1890), one of the first psychologists, first proposed that people develop high self-regard when they consistently meet their personally important goals or standards in life. He also recognized that such 'meeting' is subjective, and not objectively accurate. Contemporary views of self-esteem similarly concern one's perceived, rather than objectively assessed, worth. Throughout the twentieth century, self-esteem was heralded as a psychologically important construct. .

People possess a fundamental desire for self-esteem: we want to feel good about ourselves. This is implied by all theoretical perspectives on self-esteem – from James and Maslow to sociometer theory and Terror Management Theory. Indeed, abundant evidence demonstrates that people are willing to go out of their way to seek out high self-esteem, value past experiences that increased their self-esteem, and often prefer self-esteem boosts to other pleasant options such as eating one's favorite food or having sex (Bushman et al., 2011; Zeigler-Hill, 2013). Thus, feeling good about oneself is highly motivating.

Self-esteem has been conceptualized as an outcome, motive, and buffer. Self-esteem continues to be one of the most commonly researched concepts in social psychology (Baumeister, 1993; Mruk, 1995; Wells & Marwell, 1976; Wylie1979). Generally conceptualized as a part of the self-concept, to some self-esteem is one of the most important parts of the self-concept. Indeed, for a period of time, so much attention was given to self-esteem that it seemed to be synonymous with Self-concept in literature on the self (Rosenberg, 1976, 1979). This focus on self-esteem has largely been due to the association of high self-esteem with a number of positive outcomes for the individual and for society as a whole (Baumeister, 1993; Smelser, 1989). Moreover, the belief is widespread that raising an individual's self-esteem (especially that of a child or adolescent) would be beneficial for both the individual and society as a whole. Self-esteem refers most generally to an individual's overall positive evaluation of the self (Gecas, 1982; Rosenberg 1990; Rosenberg et al. 1995). It is composed of two distinct dimensions, competence and worth (Gecas, 1982; Gecas & Schwalbe, 1983). The competence dimension (efficacy-based self-esteem) refers to the degree to which people see themselves as capable and efficacious. The worth dimension (worth-based self-esteem) refers to the degree to which individuals feel they are persons of value.

In the context of disability and chronic illness, diminished self-esteem has been associated with increased pain and fatigue (Cornwell & Schmitt, 1990; Krol et al., 1994) and greater functional imitation (Burckhardt, 1985; Taal, Rasker, & Wiegman, 1997). Losing the ability to perform activities of daily living can threaten one's sense of self.

Intimate relationships and other sources of social connection and support can offer an important validation of one's worth among persons with disabilities (Crisp, 1996). Conversely, social isolation is widely associated with health problems and mortality (Berkman & Syme, 1979). Relationships often furnish positive social support which itself serves an important function in the lives of persons with physical disabilities (Patrick, Morgan, & Charlton, 1986), yet social isolation is one of the most common secondary conditions associated with any primary disability (Coyle et al., 2000; Ravesloot, Seekins, & Walsh, 1997). Physical restrictions, such as chronic pain and fatigue, may discourage people from being socially integrated. With environmental barriers and a lack of positive messages and opportunities, a disabled may become disconnected

and isolated from sources of support systems and intimacy, employment opportunities, and health promotion.

One of the main pillars of the perception of someone's appearance is self-esteem. Self-esteem is a positive or negative orientation toward oneself: an overall evaluation of ones worth or value. Self-esteem encompasses beliefs and emotions such as triumph, despair, pride and shame. Being the main factors of beauty, body image and self-esteem are obviously affected by limb amputation. Studies have been performed among amputees focusing on either body image or self-esteem. This study is performed on amputees focusing on self-esteem.

Research on self-esteem has generally proceeded on the presumption of one of three conceptualizations, almost independently of the others. First, self-esteem has been investigated as an outcome. Scholars taking this approach have focused on processes that produce and inhibit self-esteem (e.g. Cooper Smith, 1967; Harter, 1993; Petrson and Rollins 1987; Rosenberg, 1997) Second, self-esteem has been investigated as self-motive, noting the tendency for people to behave in the ways that maintain or increase positive evaluation of the self (Kapan 1975; Tesser 1988) Finally, self-esteem has been investigated as a buffer for the self, providing protection from experiences that are harmful (Longmore and Damaris, 1997; Pearlin and Schooler 1978; Spencer, Josephs and Steele 1993; Thoits, 1994).

Maslow (1943) included self-esteem as a fundamental need in his influential hierarchy, arguing that it is not possible to achieve fulfillment without first meeting the need for self-worth and self-respect. Similarly, leading humanistic theorist Carl Rogers (1959) focused on self-worth (i.e., self-esteem) as reflecting the congruence between one's current self and ideal self. According to Rogers, self-worth reflects the extent to which parents (and others) provide us with unconditional positive regard (i.e., love and respect). If others convey unrealistic ideals, or lead us to believe we are not meeting those ideals, self-worth suffers. Like Maslow, Rogers Saw high self-worth as important for helping a person to face challenges, cope effectively with problems, and form healthy relationships. However, self-esteem really became popularized in the 1960s.Rosenberg's (1965) large-scale survey of adolescents raised the concept's profile among researchers by developing the first questionnaire measure of self-esteem and linking it empirically to anxiety and depression. At the same time, Coopersmith (1967) and Branden (1969) made well publicized

links between self-esteem and confidence, academic achievement, and mental health. Self-esteem became viewed as a panacea – the key to success in life. The following decades saw the development and dominance of the so-called 'self-esteem movement' in Western society, which focused on the idea that raising people's (especially children's) self-esteem will make them happy, successful, and law-abiding. This principle was used abundantly to design educational curricula, rehabilitation programs, and self-help books that would increase the self-esteem of students, people convicted of crimes, and those suffering from addictions or other psychological difficulties (Nolan, 1998).

According to the Identity Theory of self-esteem, self-esteem is an outcome of, and necessary ingredient in, the self-verification process. Self-esteem buffers the negative emotions that occur when self-verification is problematic (Cast and Burke, 2002), for instance when faced with a stressor or depression (Hall et al,1996) Identity consistency is associated with subjective well-being to some extent (Suh, 2002). Consistent with the Dual-risk model of individual development, people with a disability tend to have a high degree of sensitivity, which means that they are vulnerable to suffer from external influences. In the case of comparing themselves with others, they are less likely to accept and identify themselves, which leads to negative emotions, low life satisfaction, and sensitivity to others' perspectives. In our study, we provide evidence that social protection, basic human services, social capital and attitudes may elicit positive emotions, higher subjective wellbeing and lower perceived discrimination and low self-esteem. This may be because people with more social support feel a more positive atmosphere and tend to form the concept of self-respect, self-worth, self-efficacy and self-care promoting the level of subjective wellbeing. Due to the role of self-esteem, it is necessary to provide ample social support and pay more attention to networks to improve the level of self-esteem of people with physical disability.

Finally, self-esteem is an important individual factor because it determines personality and influences human healh.Self-esteem and health behaviors have been positively linked in the general population (Hurst,Boswell, Boogaard, & Watson, 1997). Self-esteem and perceived health status have been associated among people with physical disabilities (Cornwell & Schmitt,

1990). Nosek (1998) underscores that, in the context of disability, health status and health promoting practices are critical factors in the person's ability to live independently.

1.4 Contextual Background

This section of the study addresses how research on the main concepts of the study (social vulnerability and Self-esteem) has been approached by other researchers. A vast number of Social vulnerability studies have been conducted as a response to the management of Natural disasters, Understanding the complexity of vulnerability to disasters, including those triggered by floods, droughts and epidemics is at the heart of disaster risk reduction. Despite its importance in disaster risk reduction, there remains a paucity of approaches that contribute to our understanding of social vulnerability that is hidden in dynamic contextual conditions.

Research on self-esteem has generally proceeded on the presumption of one of three conceptualizations, and each conceptualization has been treated almost independently of the others. First, self-esteem has been investigated as an outcome. Scholars taking that approach have focused on processes that produce or inhibit self-esteem (e.g., Coopersmith, 1967; Harter 1993; Peterson & Rollins 1987; Rosenberg 1979). Second, self-esteem has been investigated as a self-motive, noting the tendency for people to behave in ways that maintain or increase positive evaluations of the self (Kaplan 1975; Tesser, 1988). Finally, self-esteem has been investigated as a buffer for the self, providing protection from experiences that are harmful (Longmore & DeMaris, 1997; Pearlin & Schoole,r 1978; Spencer, Josephs & Steele 1993; Thoits, 1994).

1.5 Theoretical Background

1.5.1 The Self Esteem Theories

No one considered self-esteem as a unique trait to be studied and defined until the psychologist William James who introduced his theory of self-esteem in 1890. Since that time, other psychologists and psychology theorists have built on that original theory to further define self-esteem, describe how it forms, and ask questions about the purpose or function of self-esteem

(Theories of Self-Esteem: Early & Modern, 2019). Beginning with the work of William James, let's follow the early development of self-esteem theory.

William James used a simple formula to define self-esteem, stating that self-esteem equals success divided by our pretentions. Pretensions, in this case, refer to our goals, values, and what we believe about our potential. So, if our actual achievements are low and our believed potential and goals are high, we see ourselves as failures. Conversely, you can probably remember an experience like this, if your success exceeds your expectations, you feel great about yourself, and your self-esteem rises.

In this study we grouped the theoretical contributions of Cooley and Mead, even though they worked in different decades - Cooley in 1902 and Mead in 1934 - because both constructed related theories which contributed to the formation of symbolic interactionism. Symbolic interactionism claims that people base their thoughts and behaviors towards things and people on the basis of the meaning or value they believe those subjects possess. These thoughts and behaviors are further modified through interaction with others and their influence. These two theorists both proposed that self-esteem comes from social interaction rather than a single, inner notion of our worth. We develop our sense of self-worth through the way others treat us and the rules our society sets to define achievement. However this study contend that self-esteem does not solely depend on social interactions but that individuals play a vital role in developing and sustaining their self-esteem

A leader in the study of self-esteem in the early second-half of the 20th century, Stanley Cooper smith, introduced the idea that self-esteem begins early in life. Self-esteem builds positively from early childhood if the individual is raised with love and security. Throughout childhood and into our adult lives, our self-esteem builds or falls from that early-childhood baseline through positive and negative experiences.

Morris Rosenberg, a contemporary of Cooper smith, also studied the development of self-esteem, focusing on adolescence rather than early childhood. His theories proposed that self-esteem developed more during the uncertainty of adolescence. During this stage of development,

Rosenberg claims that self-esteem is built on an evaluation of the self in comparison with others. This means adolescents compare themselves to peers they see around them to evaluate their value while thinking about how others might see them.

More contemporary theories focus on the role self-esteem plays in our lives and psychological well-being. This follows the question of why we have self-esteem rather than continuing to theorize about what self-esteem is or how it develops Self-esteem has been conceptualized as an outcome, motive, and buffer, but there is no overall theory of self-esteem. However in this study, we suggest that social identity theory can provide an overarching theoretical framework for the integration of the various conceptualizations of self-esteem. Henri Tajfel's greatest contribution to psychology was social identity theory. Social identity is a person's sense of who they are based on their group membership(s).

Tajfel (1979) proposed that the groups (e.g. social class, family, football team etc.) which people belonged to were an important source of pride and self-esteem. Groups give us a sense of social identity: a sense of belonging to the social world.

One of the main pillars of the perception of someone's appearance is self-esteem. Self-esteem is a positive or negative orientation toward oneself: an overall evaluation of ones worth or value. Self-esteem encompasses beliefs and emotions such as triumph, despair, pride and shame. Being the main factors of beauty, body image and self-esteem are obviously affected by limb amputation. Studies have been performed among amputees focusing on either body image or self-esteem. This study is performed on amputees focusing on self-esteem.

Generally, conceptualized as part of the self-concept, to some, self-esteem is one of the most important parts of the self-concept. Indeed, for a period of time, so much attention was given to self-esteem that it seems to be synonymous to self-concept in literature of self. Rosenberg (1976, 1979). This focus on self-esteem has largely been due to the association of high self-esteem, Research on self-esteem has generally proceeded on the presumption of one of three conceptualizations, almost independently of the others. First, self-esteem has been investigated as an outcome. Scholars taking this approach have focused on processes that produce and inhibit self-esteem (e.g. Cooper Smith, 1967; Harter, 1993; Petrson and Rollins, 1987; Rosenberg, 1997)

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According to the Identity Theory of self-esteem, self-esteem is an outcome of, and necessary ingredient in the self-verification process. Self-esteem buffers the negative emotions that occur when self-verification is problematic (Cast and Burke, 2002), for instance when faced with a stressor or depression (Hall et al,1996) Identity consistency is associated with subjective well-being to some extent (Suh, 2002). Consistent with the Dual-risk model of individual development, people with a disability tend to have a high degree of sensitivity, which means that they are vulnerable to suffer from external influences. In the case of comparing themselves with others, they are less likely to accept and identify themselves, which leads to negative emotions, low life satisfaction, and sensitivity to others' perspectives. In our study, we provide evidence that social protection, basic human services, social capital and attitudes may elicit positive emotions, higher subjective wellbeing and lower perceived discrimination and low self-esteem. This may be because people with more social support feel a more positive atmosphere and tend to form the concept of self-respect, self-worth, self-efficacy and self-care promoting the level of subjective wellbeing. Due to the role of self-esteem, it is necessary to provide ample social support and pay more attention to networks to improve the level of self-esteem of people with disability.

1.5.2 Vulnerability theories

The understanding of vulnerability is guided by theories derived from different schools of thought. "Western systems of law and justice have inherited a political liberalism that imagines a 'liberal legal subject' as the ideal citizen – this subject is an autonomous, independent and fully-functioning adult, who inhabits a world defined by individual, not societal responsibility, where state intervention or regulation is perceived as a violation of his liberty. Social arrangements and institutions with significant effects on everyone's lives, such as the family, are deemed "private"

and their operation and functioning relegated to ideologies of meritocracy and the free market. Vulnerability theory challenges the dominance of this static and individualized legal subject, and argues for the recognition of actual human lives as socially and materially dynamic.

1.6 Statement of the problem

The number of people in Cameroon suffering from physical disabilities especially amputations is on a steady rise as a function of the current Anglophone armed conflict, intertribal wars, Boko haram insurgency, road accidents and other natural courses like illness. Amputation of a limb is an irreversible physical phenomenon that can present a plethora of physical and psychosocial challenges to the person involved. The most immediate challenge facing the person who has had an amputation is acquiring an artificial limb and becoming proficient in its use. Consequently, the majority of research is concerned with the ensuing physical adjustment (mobility), the prosthesis and factors that impede or facilitate this adjustment process (Pohjolainen and Alaranta, 1991; Hagberg et al, 1992; Pernot et al, 1997; Sherman, 1997; Kent and Fyfe, 1999). In contrast to the physical aspects, the issues of what psychosocial experiences are involved in adjusting to amputation remains comparatively under-researched. While this research is important for eliciting the potential sequel to amputation, and consequently has implications for clinical and treatment purposes, there is the danger of presenting a one-sided picture of amputation.

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. Indeed amputation patients can experience a distorted body image, decreased self-esteem, social isolation, and increased dependency on others (Grossman, 1990). Emotions created by breaking up the integrity of the body due to amputations cause a distorted body image, leading to inadequate and negative feelings about the body and decreased self-esteem (Asano M., Rushton P., Miller W.C., Deathe B.A., 2008; Boutoile D., Feraille A., Maulaz D., Krempf, 2008; Gossman E.F., 1990). During the post-amputation period, perceived social

support, adaptation to the prosthesis, amputation type, presence of phantom and stump pain, self-esteem, and body image issues are among the factors reported to affect quality of life and psychosocial functionality significantly (Cybarczyk B., Nyenhuis D., Nicholas JJ., Cash S.M., & Kaiser J. 1995; Holzer LA, Sevelda F, Fraberger G, Bluder O, Kickinger W, & Holzer G., 2014). The body image of an amputee can therefore affect the interaction (social and intrapersonal) relationships among peers negatively and hence low self-esteem. Varma, Rubenfeld, Tarbot and Setoguchi (1939) affirm that social support is a determinant of self-esteem. The way you appear in front of someone will affect the way the person will value you (Ndje M. N ., & Foje N.N, 2019). In spite of the fact that the number of amputees in Cameroon is on a steady increase, the social interactions are far from being adapted for the normal functioning of amputees. This study therefore identifies social interactions as a mitigating factor influencing the self-esteem of amputees and hence sets out to investigate the effects of social vulnerability on the self-esteem of amputees in Bamenda I and II, North West of Cameroon.

1.7 Objectives of the Study

1.7.1 Main Objective

- The main objective of this study is to identify the effects of Social Vulnerability on the Self -esteem of the physically handicapped (amputees).

1.7.2 Specific objectives

The aim of this study is to:

- To determine the effects of attitudes on the self-esteem of the physically handicapped (amputees).
- Examine the effects of access to basic human services on the self- esteem of the physically handicaps (amputees).
- Assess the effects of access to social protection on the Self-esteem of the physically handicapped (amputees).
- Find out the effects of social capital on the self-esteem of the physically handicapped (amputees).

1.8 Research Questions

1.8.1Main Research Question

- How does social vulnerability influence the self-esteem of the physically handicapped (amputees)?

1.8.2 Specific Research Questions

- How do attitudes affect the self-esteem of the physically handicapped (amputees)?
- How does access to human basic services affect the self-esteem of the physically handicapped (amputees)?
- How does access to social protection affect the self-esteem of the physically handicapped (amputees)?
- How does social capital affect the self-esteem of the physically handicapped (amputees)?

1.9 Research Hypotheses

1.9.1 Main Hypothesis

- Ha: There is a significant relationship between social Vulnerability and the self-esteem of the physically handicapped (amputees).

1.9.2 Specific hypotheses

. Ha: There is a significant relationship between attitudes and the self-esteem of the physically handicapped (amputees).

- Ha: There is a significant relationship between access to human basic services and the self-esteem of the physically handicapped (amputees).

- Ha: There is a significant relationship between social protection and the self-esteem of the physically handicapped (amputees).

- Ha: There is a significant relationship between social capital and the self-esteem of the physically handicapped (amputees).

Table 1: Operationalization and Summary of General Hypothesis and Specific Hypotheses

General Hypothesis	**Independent Variable**	**Indicator**	**Modality**
Social vulnerability of the Physically handicapped and its effects on their self esteem	IV: Social Vulnerability	-attitudes -basic Human services -social protection -social capital	Strongly Agree Agree Disagree Strongly Disagree
	Dependent Variable Self Esteem	-self Efficacy -self Efficacy -Identity	Strongly Agree Agree Disagree Strongly Disagree
Hypothesis 1 There is a significant Relationship between Attitudes and self esteem	**Independent Variable** Attitude	feelings -behavior -knowledge	Strongly Agree Agree Disagree Strongly Disagree
	Dependent variable Self Esteem	-self Efficacy -self Efficacy -Identity	Strongly Agree Agree Disagree Strongly Disagree
Hypothesis 2 There is a significant relationship between access to human basic services and the self-esteem of the physically handicapped	**Independent Variable** Basic Human Services	-Education -health Care - Transport	Strongly Agree Agree Disagree Strongly Disagree
	Dependent Variable Self Esteem	-self Efficacy -self Efficacy -Identity	Strongly Agree Agree

			Disagree Strongly Disagree
Hypothesis 3 There is a significant relationship between social protection and the self-esteem of the physically handicapped	**Independent Variable** Social Protection	assistance -employment -insurance -retirement benefit	Strongly Agree Agree Disagree Strongly Disagree
	Dependent Variable Self Esteem	-self Efficacy -self Efficacy -Identity	Strongly Agree Agree Disagree Strongly Disagree
Hypothesis 4 There is a significant relationship between social capital and the self-esteem of the physically handicapped	**Independent Variable** Social capital	-Family -friends -colleagues	Strongly Agree Agree Disagree Strongly Disagree
	Dependent Variable Self Esteem	-self Efficacy -self Efficacy -Identity	Strongly Agree Agree Disagree Strongly Disagree

1.9.1 Justification of the study

As justification for this study, the researcher asserts that there is dire need to conduct a study on social vulnerability of the physically handicapped (amputees). It is evident that people living with a disability have received inhumane treatment from their fellow “so called normal” human beings over the years. Even though the situation is getting better many of them still suffer many forms of social injustice and so their self-esteem may be affected in diverse ways. Cameroon is also a signatory to many conventions on human rights including the rights of persons living with disabilities for example the Convention on the Rights of People living with Disabilities and its

Optional Protocol of 2006. It is thus imperative to conduct this study in order to find out how the Cameroonian community and the government promote social justice and equity for the wellbeing of the physically disabled (amputees), boosting their self-esteem in the 21st century, in which many other countries are making tremendous effort to promote the economic and psychological development for the once marginalized people living with disabilities. This study is also justified because the number of the physically injured is on a steady rise in Cameroon. Violence and wars are always associated to physical disabilities. Currently, the Boko haram insurgency and the armed Anglophone conflict in the Anglophone regions have kept the physically disabled casualties on a steady rise. There have also been numerous intertribal wars in Cameroon that left many with amputations. The numerous road accidents observed especially at the month of December in Cameroon is another contributing factor for the steady rise in the number of the physically handicapped (amputees) in Cameroon who need rehabilitation, reintegration in to the mainstream society. .

1.9.2 Significance of the Study

The findings of this study will be significant or beneficial to the government for policy formulation and implementation, advocacy for the physically disabled, NGOs working for the interest of the physically disabled; the physically disabled themselves and the general public because it is envisaged that the findings will inspire attitude change towards the people living with physical disabilities, give access to basic human services, social protection and social capital.

1.9.3 Scope of the study

Geographically the study will be limited to Bamenda I and II in the North West Region of Cameroon. Conceptually the independent variable (social vulnerability) was limited to access to human basic services, access to social protection, attitudes of the community towards people living with physical disability and social capital and the dependent variable limited to Self-esteem. The control of this study was limited to the attitudes of the physically handicapped towards themselves and others. Disability was limited to physical disability (amputees). The theoretical perspectives were limited to the social model, social identity theory, cognitive theory of depression, the vulnerability theory and the self-esteem theory.

1.9.4 Operational Definition of Terms

Disability: This refers to any factors that hinder an individual from going on with his/her daily activities like any other so called "normal" person.

Physical Disability: This is a physical condition that affects a person's mobility, physical capability, stamina or dexterity,

Self Esteem: The value that an individual assigns to him/herself

Access to Human Basic Services: The ease with which an individual gain access to health care, education, transportation, communication, employment, involvement in decision making, access to public space.

Access to social protection: The possibility with which the physically handicapped have access to all public and private initiatives that provide income or consumption transfers against livelihood risks to reduce the economic and social vulnerability.

Attitudes of physically handicaps: The feelings which the physically handicapped hold towards themselves

Community attitudes: The feelings which the family and community members hold towards the physically handicapped.

Social vulnerabilities: The potential risks that the physically handicapped can suffer from as a function of social interactions.

Social capital: The circle of social networks that the physically handicapped have established that he or she can turn to for assistance (financial or psychosocial)

CHAPTER TWO

REVIEW OF RELATED LITERATURE

This chapter deals with the review of literature related to the present study. The chapter reviews literature related to the main phenomena (disability, social vulnerability, and self-esteem) under study and related concepts that might directly or indirectly have a bearing on the study. This section was organized under the following headings: conceptual, theoretical and empirical review.

2.1 Conceptual review

2.1.1 Disability

Disability is an important public health issue. 1 billion people (15% of the world's population) in 2004 lived with some form of disability; of them, about 185 million or 3% of the world's population experienced very significant difficulties in functioning (WHO/WB, 2011) is part of the human condition The United Kingdom Disabled People's Council (UKDPC, 2011) and other user-controlled organizations use disability to mean 'The disadvantage or restriction of activity caused by a contemporary organization which takes little or no account of who have impairments and thus excludes them from the mainstream social activities. 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. Different definitions of disability are used in different contexts – for example to set eligibility for particular services, or to outlaw discrimination on grounds of disability. There is no definitive list of conditions that constitute a disability. Any such list could leave out people with significant but rare conditions. There can also be a wide range of difference between how individuals with a particular condition are affected, ranging from mild to severe difficulties. A person's environment, which includes the supports they have and the physical or social barriers they face, influence the scale of the challenges they face in everyday life.

The (**Equality Acts,** Employment Equality Acts and the Equal Status Acts), which outlaw discrimination on grounds of disability, use a wider definition, and cover past as well as current disability. Disability means:

(a) The total or partial absence of a person's bodily or mental functions, including the absence of a part of a person's body;
(b) The presence in the body of organisms causing, or likely to cause, chronic disease or illness;

(c) The malfunction, malformation or disfigurement of a part of a person's body;
(d) A condition or malfunction which results in a person learning differently from a person without the condition or malfunction; or

(e) A condition, disease or illness which affects a person's thought processes, perception of reality, emotions or judgment or which results in disturbed behavior."

Census 2011, and other official surveys, used the following definition of disability: A person with one or more of the following long-lasting conditions or difficulties: Blindness or a severe vision impairment, Deafness or a severe hearing impairment, an intellectual disability, a difficulty with learning, remembering or concentrating, a difficulty with basic physical activities, a psychological or emotional condition, a difficulty with pain, breathing, or any other chronic illness or condition (https://nda.ie/disability-overview/definitions).

According to the World Health Organization, disability has three dimensions: Impairment in a person's body structure or function, or mental functioning; examples of impairments include loss of a limb, loss of vision or memory loss, activity limitation, such as difficulty seeing, hearing, walking, or problem solving. One billion people, or 15% of the world's population, experience some form of disability, and disability prevalence is higher for developing countries. Persons with disabilities are more likely to experience adverse socioeconomic outcomes such as less education, poorer health outcomes, lower levels of employment, higher poverty rates and low self-esteem.. Poverty may increase the risk of disability through malnutrition, inadequate access to education and health care, unsafe working conditions, a polluted environment, and lack of access to safe water and sanitation. Disability may also increase the risk of poverty, through lack of employment and education opportunities, lower wages, and increased cost of living for people living with a disability (World Bank, 2022).

As COVID-19 continues to have wide-reaching impacts across the globe, it is important to note how persons with disabilities are impacted by the pandemic, including health, education, and transport considerations. In the area of health, many persons with disabilities have additional underlying health needs that make them particularly vulnerable to severe symptoms of COVID-19 if they contract it. Persons with disabilities may also be at increased risk of contracting COVID-19 because information about the disease, including the symptoms and prevention, are not commonly provided in accessible formats such as print materials in Braille, sign language interpretation, captions, audio provision, and graphics.

With widespread school closures, children with disabilities have lacked access to basic services such as meal programs; assistive technologies; access to resource personnel; recreation programs; extracurricular activities; and water, sanitation, and hygiene (WASH) programs. COVID-19 has led to a sudden shift in the role of the parent/caregiver to act simultaneously as their teachers, in addition to exacerbating the digital device between learners related to access to equipment, electricity, and the internet.

Global awareness of disability-inclusive development is increasing. The United Nations Convention on the Rights of Persons with Disabilities (CRPD) promotes the full integration of persons with disabilities in societies. The CRPD specifically references the importance of international development in addressing the rights of persons with disabilities.

The 2030 Agenda for Sustainable Development clearly states that disability cannot be a reason or criteria for lack of access to development programming and the realization of human rights. The Sustainable Development Goals (SDGs) framework includes seven targets which explicitly refer to persons with disabilities, and six further targets on persons in vulnerable situations, which include persons with disabilities (World Bank, 2022).

Over the last few years interest in the social and political dimensions of disablement has intensified considerably both at the general level and in universities and academic institutions. The inclusion of disabled people -people with perceived impairments whether physical, sensory or intellectual -into the mainstream of economic and social life is now a major issue for policy makers and politicians in both rich and poor countries alike; indeed, many now have some form of legislative framework with which to combat discrimination on the grounds of impairment

(Doyle, 1995; NOG, 1996; Stone, 1996). This has had a significant impact within colleges of further and higher education. As a consequence, there is a growing literature on the various barriers to inclusion and the experience of disablement; recent examples include Barnes (1991), Hales (1996), Morris (1996), French (1994), and Zarb (1995). The biggest obstacle to disabled people's meaningful inclusion into mainstream community life is negative public attitudes. These range from overt prejudice and hostility, condescension and pity to ignorance and indifference, and in these diverse ways they influence how we think about both ourselves and other people.

In disability studies we often use the term impairment, disability and handicap interchangeably. Similarly, there are common associations with these words, such as the terms visual impairment, learning disability, and physical handicap. We can only develop a better grasp of the roles of treatment, intervention, and environmental modifications in helping and assisting individuals with special needs the moment we distinguish these different terms from one another. The often cited definitions of these terms are provided by the World Health Organization (1980) in the International Classification of Impairments, Disabilities, and Handicaps. Impairment is defined as “any loss or abnormality of psychological, physiological or anatomical structure or function.” Disability, on the other hand, means “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being.” Lastly, handicap is defined as “a disadvantage for a given individual that limits or prevents the fulfillment of a role that is normal.”

When we unpack these definitions based on their traditional use, impairment means that there is a problem with an organ or structure of the body. It is focused on the actual malformation or malfunction in the body. When we say disability, it means that a person has a functional limitation due to his or her impairment. When we say handicap, it means that the person experiences a disadvantage in filling a normal role in life compared to his or her peers due to the functional limitation caused by the impairment. We can use the terms above with examples to make the differences clearer,

- **Physical impairment** pertains to a loss of an anatomical structure; for the benefit of this exercise, let’s say the person lost a leg due to an accident. He can wear prosthetics as a replacement of the lost leg.

- **Physical disability** now refers to the inability to walk. To be able to navigate the surroundings, the person can use a wheelchair.
- **Physical handicap** now means that this person faces disadvantages that prevent him or her to perform a normal role in life, such as not being able to climb stairs anymore. Or run a marathon. Or be a basketball player. Here is where the environment plays a part. By providing wheelchair access, lift, ramps for the person with physical disability, he or she will have no problem going up to the next floors of a building. By providing multi-sport events for athletes with physical disabilities, such as Paralympics, the person will still be able to participate in sports.

It is very important for the community to know that we have a vital role in helping individuals with special needs. By adapting and modifying the environment to be able to assist and accommodate them, their disability does not have to be a handicap. Let us remember, a handicap is a disadvantage, and oftentimes, it is the environment that causes the disadvantage. When we do our part to meet their needs, they are able to fulfill a role similar to their peers.

2.1.2 Types of Disabilities

There are many types of disabilities but they are generally divided into the following categories: physical, social and mental, disabilities. It is worth noting that some people may suffer from multiple disabilities. This study is however limited to one form of physical disability..

2.1.2.1 Mental handicap

According to the Oxford Learners Dictionary, mental handicap refers to having difficulty learning or understanding things because of a brain condition .According to WHO, mental handicap 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 function for example anxiety disability, depression, personality disability, and eating, psychological disability. Mental handicap is the disturbance to a degree of the development of cognitive functions such that perception, attention, memory and sense of thinking as well as their deterioration following a pathologic process.

2.1.2.2 Social handicap

Social handicap is the systematic barrier, derogatory attitudes and social exclusion (intentional or inadvertent) which make it difficult or impossible for individuals with impairments to attain their valued functioning .According to the social model of disability, social handicap is often referred to as "barriers approach" where disability is viewed not in terms of the individuals impairment but in terms of the environmental, structural and attitudinal barriers that impinge upon the lives of disabled people and which have the potential to impede inclusion in society. Asocial disability can refer to any disorder that leads to inability to make progress socially and emotionally meaning the impact of the disability degrades a person's quality of life .Some social disabilities are recognized under the IDEA- they can include autism, other health impairments, intellectual disability, emotional disturbance among others.

Types of social handicap

These include: pervasive development disorder, major depressive episodes, cognitive defects, depression, social interaction, oxytocin and trauma.

Examples of people who suffer from social handicap include street children, prostitutes, refugees, prisoners, internally displaced persons, and minority group such as the pigmies.

2.1.2.3 Physical handicap

According to Oxford Learner's Dictionary, a physical disability means you cannot use a part of your body completely or easily, or that you cannot learn easily or because of having an illness, injury or medical condition that makes it difficult for you to do the things that other people do.

According to the NWTDC, physical disability is defined as any limitation that someone experiences that causes difficulty in doing the usual activities of daily living. Disability is also a dynamic lived experience of restricted or limited participation in live that results from interaction of individual's body impairment and their physical and social environment.

On an individual level, physical disability refers to the deficiencies, the troubles of functioning, limitations of participation which originate from biological, biomophorlogical and biosocial problems. A physical disability is the kind which affects the person's mobility and dexterity. A

person with this disability may need to use equipment to move around and carry on their daily activities. Some physical disabilities are temporal while some are permanent, some are from birth while some acquired later in life. Physical disability can be acquired or be present from birth or happen as a result of taking a particular medicine. For instance, people who have broken a bone, may not be always able to recover the way one would expect them to.

Types of physical handicap

Amputation: This is the action of surgically cutting off a limb. This can be as a result of accident or disease. Amputations can be divided into lower and upper limb amputations. Lower limb amputations vary from the partial removal of a toe to the loss of the entire leg and part of the pelvis. The following list provides a summary of the typical forms of lower limb amputation:

- Partial foot amputation – this commonly involves the removal of one or more toes. This amputation will affect walking and balance.
- Ankle disarticulation – an amputation of the foot at the ankle, leaving a person still able to move around without the need for prosthesis
- Below knee amputations (transtibial) – an amputation of the leg below the knee that retains the use of the knee joint.

- Through the knee amputations – the removal of the lower leg and knee joint. The remaining stump is still able to bear weight as the whole femur is retained
- Above knee amputation (transfemoral) - an amputation of the leg above the knee joint
- Hip disarticulation – the removal of the entire limb up to and including the femur. A variation leaves the upper femur and hip joint for better shape/profile when sitting
- Hemipelvectomy (transpelvic) – the removal of the entire limb and the partial removal of the pelvis.

Upper limb amputations vary from the partial removal of a finger to the loss of the entire arm and part of the shoulder. The following list provides a summary of the typical forms of upper limb amputation*:*

- Partial hand amputation - amputations can include fingertips and parts of the fingers. The thumb is the most common single digit loss. The loss of a thumb inhibits the ability to

grasp, manipulate or pick up objects grasping ability. When other fingers are amputated, the hand can still grasp but with less precision.

- Metacarpal Amputation – this involves the removal of the entire hand with the wrist still intact
- Wrist disarticulation – this form of amputation involves the removal of the hand and the wrist joint
- Below elbow amputation (transradial) – the partial removal of the forearm below the elbow joint
- Elbow disarticulation – the amputation of the forearm at the elbow.
- Above elbow amputation (trans-humeral) - the removal of the arm above the elbow
- Shoulder disarticulation and forequarter amputation is the removal of the entire arm including the shoulder blade and collar bone.

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). Knowing the psychological consequences of limb amputation is useful for practitioners in the medical field because it helps them develop effective counseling and rehabilitation programs. Various studies investigated the psychological consequences of limb amputations (Khan et al., 2018).

Although the self of one individual is stab across adulthood (Markus and Kunda, 1986), it may be subjected to important changes and variations as a result of traumatic life experiences (Saakvitne et al., 1998). Because limb amputation is perceived as traumatic (Desmond and MacLachlan, 2002), we consider that it should lead to shifts and modifications on the individual self-structure. Because it affects the integrity of the body, the talents, and skills, which are components of the self-structure, are affected. As a consequence, the "representational world" of the individual is subjected to important modifications. Therefore, the affected individual perceived himself as different and usually inferior compared to the period before amputation, and

this perception may activate negative cognitions associated with catastrophizing regarding his future functionality and adaptation. These negative cognitions usually lead to exaggerated negative affectivity such as anger, anxiety, hostility, or depressive tendencies (Beck et al., 2005). Further, negative affectivity tends to lead to maladaptive behaviors (Beck, 2011). While the current study acknowledges that the source of low self-esteem can be the amputee's cognitions, we, further intimate that social interactions can mitigate or aggravate the situation.

After amputation, patients can experience a distorted body image, decreased self-esteem, social isolation, and increased dependency on others (Grossman E.F, 1990). During the post amputation period, perceived social support, adaptation to the prosthesis, amputation type, presence of phantom and stump pain, self-esteem, and body image issues are among the factors reported to affect quality of life and psychosocial functionality significantly (Rebarczyk B., Nyenhuis D., Nicholas JJ, Cash SM & Kaiser J., 1995; Holzer L.A., Sevelda F., Faberger G., Blude O., Kickinger W., & Holzer G., 2004). The current study is interested self-esteem issues that are associated with the social vulnerabilities of amputees. Different coping strategies have been shown to have different outcomes on adaptation after amputation. Problem focused strategies are associated with positive psychosocial adaptation (Dun D.S, 1996), while emotion-focused and passive strategies are associated with negative psychosocial outcomes (Livneh H., Antonak RF., & Gerhardt J., 1999).

Cerebral Palsy: This refers to group of non-progressive conditions characterized by abnormal motor condition posture resulting from brain insult or injuries occurring in the peri-natal, neo-natal or infant period of development.

Sensory disability: It involves the senses. Sensory disabilities include blindness or significant vision loss, deafness or significant hearing loss, the inability to speak, and the lack of balance from disorders such as vertigo or Meniere's disease according to the (NWTDC,2017)

Learning disabilities: According to the Cambridge English Dictionary, learning disabilities are any of various disorders (as dyslexia or dysgraphia) that interferes with an individual's ability to learn resulting in impaired functioning in verbal language, reasoning or academic skills (as reading, writing and mathematics)and are thought to be caused by difficulties in processing and integrating information.

According to the North West Territories Disability Council (NWTDC, 2017) learning disabilities affect the way that people with average or above average intelligence, process and express information. Learning disabilities are permanent, ranging from mild to severe and encompasses a group of disorders. Learning disabilities are situations that hinder children from achieving academically comparative to their peer Learning disabilities are due to genetic and or neurobiological factors that alter brain functioning in a manner which affects one or more cognitive processes related to learning. These processing problems can interfere with learning basic skills such as reading, writing, mathematics, coordination, reasoning.. They can also interfere with higher level skills such as organization time planning, abstract reasoning, long or short term memory and attention.

On an individual level, learning disabilities are disorders that affect the learning abilities and skills of preschool age and school age children decreasing their academic performance, as compared to that of their peers. These learning dishabilles include dyslexia, dyspraxia, dysgraphia, dyscalculia, dysothorgraphy, Attention Deficit and Hyperactivity Disorder, auditory disorder.

Dyslexia

According to Katie Davis, dyslexia is a reading disorder characterized by a primary phonological processing deficit. People with dyslexia struggle to decode individual words and have poor spelling abilities. He adds that those with dyslexia may also have difficulties with reading fluently; reading comprehension and pronunciation, though symptoms vary from person to person.

Dyslexia is not a new condition and was first described almost 150 years ago. In 1878, a German neurologist noticed that some of his patients had difficulty reading and would consistently put words in wrong other. He described this as “word blindness”. In 1887, a German ophthalmologist named Rudolph Berlin replaced the term “word blindness” with dyslexia according to the Rudolph Berlin Center.

On an individual level, dyslexia is a learning disability which affects children of pre-school and school age by impairing their reading ability. Those children are poor in conversation, shy away from group work, face difficulty in spelling and reading

The types of dyslexia include phonological, surface, rapid naming deficit and double deficit dyslexia.

Dyspraxia

Dyspraxia Foundation (1999) cited by the Scottish executive Education Department (2001) offers a comprehensive definition of dyspraxia as "an impairment or immaturity in the organization of movement which leads to associated problems with language, perception and thought" (p4)

Macintyre (2001) stresses that dyspraxia is an enduring condition and children with dyspraxia have consistently low level of motor performance. Dyspraxia is a neurological disorder that impacts an individual's ability to plan and process motor tasks.

According to the National Center for Learning Disabilities, individuals with dyspraxia have difficulty in planning and completing fine and gross motor tasks. These can range from motor movements such as waving goodbye to more complex ones such as sequencing steps, to brush one's teeth. Dyspraxia is a common disorder that affects fine/and/ or gross motor coordination in children and adults. It impacts; Articulation and speech, memory, perception and thought, mental processing. It affects coordination skills such as tasks requiring balance or playing sports or fine motor skills such as writing or using small objects. Children with dyspraxia may display difficulties with self-care, riding a bike and play.

Dyscalculia

Individual with dyscalculia have difficulties with all areas of mathematics problems not explain by a lack of proper education, intellectual disabilities, or other conditions.

Dyscalculia is a mathematic learning disability that impairs an individual ability to learn numbers related concepts, perform accurate mathematics calculations, reasons and problem solve and perform other mathematic skills. It is sometimes called "number dyslexia" or "mathematics dyslexia".

It is present in about 11% of children with attention deficit hyperactivity disorder (ADHD or ADD) Students with dyscalculia find mathematics puzzling frustrating and difficult to learn, says (Glynis Hannell,2005) a family psychologist and author. There are two types:

Developmental Dyscalculia (DD) This is a learning disability affecting the ability to acquire school level arithmetic skill, affecting 3-6% of individuals.

Acquired dyscalculia sometimes called '**acalculia'** is the loss of skill in mathematical skills and brain injury and other cognitive impairments.

Dysothorgraphy

Dysothorgraphy is a writing disability that develops in children as a difficulty to write words correctly and to follow grammatical rules. They have difficulties in sounds and writing. This disorder tends to affect children who have other language disorders or delays such as dyslexia. It affects some people more than others, but the most common symptoms tend to be spelling, mistakes, article confusion and misuse. Not using apostrophes or using them incorrectly, confusing letters, writing them words together or mistaking spoken and written words.

Attention Deficit/Hyperactivity Disorder

According to (Bibi Leila Hoseini, Maryam Ajilian, Gholamreza khademi,2014),Attention Deficit/Hyperactivity Disorder is a chronic condition that affects millions of children and often persist into adulthood. ADHD includes a combination of problems such as difficulty sustaining attention, hyperactivity and impulsive behavior.

The current DSM-IV (American Psychiatric Association APA, 1994) diagnostic guidelines list three subtypes of ADHD :(a) primarily inattentive, (b) primarily hyperactive and impulsive, or (c) both combined.

Individuals with ADHD of the interactive subtype tend to be disorganized, easily pulled off course, forgetful and inattentive (DSM-IV, APA, 1994). They tend to be disorganized mentally and physically. They tend to make careless mistakes and are not good at paying close attention to detail.

Individuals with ADHD of the hyperactive or impulsive subtype are inclined to be very disorganized and sloppy because they are often impatient to carefully attend to detail or to put things away. They can have trouble waiting their turn, may blurt out an answer before hearing the whole question, and may interrupt others. They may intrude on others conversation or game without considering beforehand that it might be inappropriate.

Vulnerability

By Oxford Learners Dictionary, vulnerability refers to the fact of someone being weak and easily hurt physically or emotionally. By Cambridge English Dictionary, it refers to someone being able to be easily physically or mentally hurt, influenced or attacked.

Broadly defined, vulnerability is the potential to suffer loss or harm. This can include structural vulnerability of buildings and lifelines, biophysical vulnerability (physical exposure) of people and places to natural events, and social vulnerability describing differential susceptibility based on social, economic and political factors (O'Keefe et al., 1976; Cutter, 2001). As applied in social science research, the term vulnerability generally describes a state of people and populations rather than physical structures, economies, or regions of the earth (Wisner et al., 2004). Vulnerability can vary significantly across both social and geographic space (Liverman, 1990; Bohle et al., 1994b; Cutter, 1996). Social space refers to who is vulnerable, and is defined by the political, economic, and institutional capabilities of people at a specific time and place (Bohle et al., 1994b; Wisner et al., 2004). The concept of vulnerability in this study adopts the social science approach and therefore applies to the state of people living with disabilities. Thus the literature on social vulnerability in this study describes the differential susceptibility of people living with a disability based on the social, economic and political factors but with particular attention to social factors. Vulnerability means the quality or state of being exposed to the possibility of being attacked or hurt or injured or harmed either physically or emotionally. It involves a combination of factors that determine the degree to which somebody’s life is put at risk. Dimensions of social Vulnerability may include poverty, class, race, ethnicity, age, disability, health, marital status, language and gender.

2.2.2. Social Vulnerability

The concept of individual ‘vulnerability’ as a social feature is defined as ‘universal, inevitable, enduring aspect of the human condition (Fineman, 2008). From this point of view, vulnerability should be perceived as a feature forming part of the human nature (as a part of human identity), as a result of which feature individuals are constantly exposed to potential (intended or unintended) harm connected with the risk of the changing circumstances (due to the constantly evolving character of societies), or with the adopted assumption that such individuals have to be subordinated to other individuals. From this perspective, also the vulnerability of a certain group should be seen as a dynamic concept, ascribed to – but also permeating into – the notion of minority groups (PeroniL., & TimmerA., 2013). When we attempt to capture the essence of the definition of a ‘vulnerable group’ in the language of human rights, we should consider that such a group is made up of individuals who particularly frequently experience unequal treatment or need to introduce special instruments for their protection in society. Nevertheless, it has to be emphasized that even though social vulnerability concerns, first and foremost, an individual as such, the notion should not be reserved for the outcome of an assessment of individual’s situation only. It seems possible that a different thesis can be adopted, namely that individuals with a common feature or established identity can be classified, within a single group, as vulnerable individuals. By the same token, vulnerability is an inherent part of a given social situation and consequently can be ascribed to a whole group of people distinguished by it (Peroni, L. & Timmer A, 2013). Thus people living with a disability constitute a minority group and as such vulnerable and struggle for inclusion.

The biggest obstacle to disabled people's meaningful inclusion into mainstream community life is negative public attitudes. These range from overt prejudice and hostility, condescension and pity to ignorance and indifference, and in these diverse ways they influence how we think about both ourselves and other people. In the broadest sense there are two explanations for this phenomenon. The first, and the older of the two, suggests that cultural perceptions of impairment are shaped by deep rooted psychological fears of the abnormal and the unknown. The second explains disabled people's oppression in terms of material considerations such as the economy

and the way that it is organized or what is sometimes termed `the mode of production (Barton &Hike, 1997).

Thus the marginalization or vulnerability of disabled people is caused by prejudices, which are deeply rooted in each society and which are based on common stereotypes (Solanke, 2017). Stereotypes, in turn, convey a negative message, because they comprise unjustified simplifications or generalizations, while the image they create is incomplete, because they ascribe certain (usually negative) features regardless of whether all the elements of the image form a coherent whole (Buchowska, 2011). A stereotypical approach has far-reaching negative consequences for those who want to exercise their rights despite the prejudices in their environments. The issue is important inasmuch as it may lead to a structural problem if the stereotype is used by state authorities. Beyond any doubt, if state authorities – including the administration of justice (Rowne, 2016) – follow stereotypes, this may lead to substantive and factual errors. This arises as practices that work to the disadvantage of certain people [disabled persons]. These practices can be overt or covert actions or omissions to act and create structural or institutional discrimination (Solanke, 2017) .Discrimination or vulnerability is a deeper manifestation of status loss on the continuum of stereotyping.

The Medical or individual model of disability has negatively affected the way persons with disabilities are treated in their communities, at job sites (for those who are fortunate to be employed), and in educational milieu. This model sees people with disabilities as patients or sick people and also sees disability as an individual problem that needs to be cured by the individual himself.

Historically, people with disabilities have been stereotyped in many different ways. Some of the stereotypes used to label people with disabilities persist in the mind of the public today. Incomplete information, mistaken perceptions, isolation and segregation have perpetrated many of these stereotypes.

The way people think about disability affects the care and education of PWDs. Myths and misconceptions about disability are common. Promoting negative images of disability is a form of discrimination because it creates barriers to full citizenship for people who have a disability.

There are many stereotypes or images associated to PWDs and these stereotypes labeled on PWDs have had very negative influences on the way they are educated. Some stereotypes of disabled people portray them as being: pitiable and pathetic, sinister or evil, tragic but brave, laughable, aggressive, burdens/outcasts, non-sexual and incapable of fully participating in everyday life.

The following are some common attitudes and stereotypes that emerge repeatedly in our societies and communities (Renne M., 2015):

People with disability deserve pity: Disability is seen by many people as a personal tragedy and so disabled people deserved to be pitied. PWDs are often viewed as tragic figures that society should pity. According to them, the burden of disability is unending; life with a disabled person is a life of constant sorrow and agony and that the able-bodied stand under a continual obligation to help them. People with disabilities and their families are the most perfect objects of charity and their role is to inspire benevolence in others, to awaken feelings of kindness and generosity. Unfortunately, contrary to what many might think, disability does not mean a poor quality of life, it is often the negative attitudes of society and the lack of accessibility within the community that are the real tragedy.

People with disability cannot lead a productive and a fulfilling life: According to this stereotype, it is assumed that disabled people cannot have a good "quality of life". It promotes the assumption that people with disabilities will not be able to have a family, get a good job or take on responsibilities. The focus still remains continually on the person's impairment rather than on the person's abilities. People with disabilities are capable of participating fully in community life just like their non-disabled peers. The challenge is to focus on their abilities not on their limitations.

People with disabilities are sick and in constant pain: Many people see PWDs as being under constant agony and pain. They see disability as a sickness that needs to be fixed, an abnormality to be corrected or cured. But it should be noted that people with disabilities are like people without disabilities, they get sick on occasion or sometimes may be in pain.

People with disability are wheelchair bound: Many people still assume that the wheelchair is a source of life for PWDs without which they cannot live a fulfilling life. Unfortunately, PWDs typically do not view themselves as "confined to their wheelchair". In the same way, a person without a disability is not described as confined to their car, so also a disabled person is not supposed to be confined to their wheelchair. A wheelchair, like an automobile, is a form of mobility that contributes to a person's independence.

People with disabilities are brave, courageous, heroic and inspirational for living with their disability. PWDs are often portrayed as super humans and courageous as they triumph over adversity. This stereotype puts a lot of pressure on disabled people to be cheerful, accepting and ready to "make the most of their condition". The impairment gives disabled persons a chance to exhibit virtues they did not know they had and teach the rest of us patience and courage. George Covington, a writer who is blind once said that; "we're seen as inspirational, and inspiration sells like hot cakes. My disability isn't a burden: having to be so damned inspirational is". This stereotype does not allow for people to have complex emotions and sees disabled people as being different rather than ordinary.

People with disabilities are helpless and dependent. This stereotype tends to mean that PWDs are to be pitied as they spend their whole life depending and needing other people's help. Traditionally this stereotype was used by charities in order to raise funds.

People with disabilities are to be feared: Traditionally, PWDs have always been associated to witch craft. Many people feel that disability is a sign of ill omen to be feared. This sometimes explains why a lot of hatred, suspicion and violence are associated to disability. They are seen as a menace to others, to themselves and to their community. This is especially true of people with mental disabilities. PWDs are consumed by an incessant and inevitable rage and anger at their loss and at those who are not disabled. Those with mental disabilities lack the moral sense that would restrain them from hurting others.

They key component of this process of stereotyping is the use of dichotomous categories: male/female white/black; healthy/disabled. Because of the fact that individuals do not live in isolation, but in a society filled with a network of various kinds of relationships, links, and

dependencies, no individual is separate from systems of difference which serve to position people in various, often inequitable ways (Pelgrave, 2001). It is imaginable that some will be more regularly at the former and others most frequently at the latter end of the spectrum. By virtue of their position in a social hierarchy, members of marginalized groups (PWD) are unlikely to be viewed as contributors to important collective social goals. On the other hand less privileged groups (PWD) feel an obvious pressure to conform to norms which they do not fully accept. This is the process resulting in the formation of the so-called vulnerable groups, whose rights are – as a rule – limited and stratified by the social majority controlling the decision-making processes in the society.

However, over the last few years interest in the social and political dimensions of disablement has intensified considerably both at the general level and in universities and academic institutions. The inclusion of disabled people -people with perceived impairments whether physical, sensory or intellectual -into the mainstream of economic and social life is now a major issue for policy makers and politicians in both rich and poor countries alike; indeed, many now have some form of legislative framework with which to combat discrimination on the grounds of impairment (Doyle, 1995; NOG, 1996; Stone, 1996).

It should be noted that the above stereotypes and attitudes have been carved out by the society that continues to exclude persons with disabilities from meaningful participation in the development processes of their respective communities. Therefore it is within the social characteristics of social interactions that the vulnerabilities are imbedded. There are many social dimensions that impact vulnerabilities. However, this study has limited its scope to attitudes, basic human services, social protection and social capital. The selection of these characteristics is based on the premise that access to social capital, basic human services, social protection and the attitudes of the community towards the people living with a disability affect the degree of vulnerabilities and self-esteem of the PWDs.

a) Social capital: Intimates that relationships and other sources of social connection and support can offer an important validation of one's worth among persons with disabilities (Crisp, 1996). Conversely, social isolation is widely associated with health problems and mortality (Berkman & Syme, 1979). Relationships often furnish positive social support which itself serves an important

function in the lives of persons with physical disabilities (Patrick, Morgan, & Charlton, 1986), yet social isolation is one of the most common secondary conditions associated with any primary disability (Coyle et al., 2000; Ravesloot, Seekins, & Walsh, 1997).

However, Social capital has multiple definitions, interpretations, and uses. Early attempts to define social capital focused on the degree to which social capital serves as a resource – be it for public good or private benefit. Robert D. Putnam (1993) suggested that social capital would facilitate co-operation and mutually supportive relations in communities and nations and would therefore be a valuable means of combating many of the social disorders inherent in modern societies. In contrast, others focus on the private benefits derived from the web of social relationships in which individual actors find themselves. This is reflected in Nan Lin's concept of social capital as "Investment in social relations with expected returns in the marketplace". Daniel P. Aldrich describes three mechanisms of social capital:

i- **Bonding capital*:*** the relationships a person has with friends and family, making it also the strongest form of social capital.

ii- **Bridging capital**: the relationship between friends of friends, making its strength secondary to bonding capital.

iii- **Linking capital**: the relationship between a person and a government official or other elected leader.

The current study conceptualizes social capital as social networks (bonding, bridging or linking capital) that assist people living with disabilities to overcome their vulnerabilities.

b) Social protection: Social protection has long been a domestic concern of wealthy nations, which have developed sophisticated institutional arrangements in order to protect against their citizens risk and provide assistance to the destitute. Social protection has however been largely neglected, or addressed only with inappropriate tools, in the majority of poor countries, where emphasis has been placed instead upon the primacy of economic growth. Several factors can be seen to explain the increased attention to social protection within development debates in recent years (Norton, Conway& Foster, 2001).

The current growth in interest in development agencies in the issue of social protection derives, to a large extent, from the global reaction to various forms of economic or financial crisis over

the 1990s. Rights to elements of social protection are contained in the Universal Declaration of Human Rights. In order to make these rights meaningful at the national level, governments and the international community need to meet the following challenges. Notions of social protection need to be converted into entitlements and standards which embody a sufficient level of consensus about the state's role, and the levels of risk and deprivation that are unacceptable within a given society, to ensure policy which is deliverable, effective and sustainable. Social protection plays a key role in realizing the rights of persons with disabilities of all ages: providing them with an adequate standard of living, a basic level of income security; thus reducing levels of poverty and vulnerability.

Social protection is a human right, grounded in the right to social security, and enshrined in the Universal Declaration of Human Rights (1948). This means that States have an obligation, under international human rights law, to guarantee a minimum level of social protection and that all individuals hold the right to social protection. In many countries this right to social protection is enshrined in the Constitution. The level of social protection an individual can claim depends on the national context. At a minimum, social protection should be enjoyed without discrimination and provide a basic level of benefits to enable individuals and families to acquire at least essential health care, basic shelter and housing, water and sanitation, food and basic education

A rights-based approach makes social protection a human right, not a matter of charity, needs, kindness or compassion. A rights-based approach to social protection means that central human rights principles of equality and non-discrimination, participation, transparency and accountability should be applied in the design, implementation, monitoring and evaluation of social protection systems. Social protection also contributes to the realization of several other human rights, such as the right to an adequate standard of living, the right to education and to the highest attainable standard of health.

c) Basic human services: Article 9 of the Convention on the Rights of Persons with Disabilities emphasizes the Accessibility to basic human services and intimates that:

1. To enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others, to the physical environment, to transportation, to

information and communications, including information and communications technologies and systems, and to other facilities and services open or provided to the public, both in urban and in rural areas. These measures, which shall include the identification and elimination of obstacles and barriers to accessibility, shall apply to, inter alia:

- ❖ Buildings, roads, transportation and other indoor and outdoor facilities, including schools, housing, medical facilities and workplaces;
- ❖ Information, communications and other services, including electronic services and emergency services.

2. States Parties shall also take appropriate measures to:
   - ❖ Develop, promulgate and monitor the implementation of minimum standards and guidelines for the accessibility of facilities and services open or provided to the public;
   - ❖ Ensure that private entities that offer facilities and services which are open or provided to the public take into account all aspects of accessibility for persons with disabilities;
   - ❖ Provide training for stakeholders on accessibility issues facing persons with disabilities;
   - ❖ Provide in buildings and other facilities open to the public signage in Braille and in easy to read and understand forms;
   - ❖ Provide forms of live assistance and intermediaries, including guides, readers and professional sign language interpreters, to facilitate accessibility to buildings and other facilities open to the public;
   - ❖ Promote other appropriate forms of assistance and support to persons with disabilities to ensure their access to information;
   - ❖ Promote access for persons with disabilities to new information and communications technologies and systems, including the Internet;
   - ❖ Promote the design, development, production and distribution of accessible information and communications technologies and systems at an early stage, so that these technologies and systems become accessible at minimum cost.

If these the previews of this article are fully implemented then the vulnerabilities of PWDs will be brought to the barest minimum.

d) Attitudes: Psychologists define attitudes as a learned tendency to evaluate things in a certain way. This can include evaluations of people, issues, objects, or events. Such evaluations are often positive or negative, but they can also be uncertain at times. There are three components of attitudes (cognitive, affective and Behavioral). The components of attitudes are sometimes referred to as CAB or the ABC's of attitude.

- **Cognitive Component:** Your thoughts and beliefs about the subject
- **Affective Component:** How the object, person, issue, or event makes you feel
- **Behavioral Component:** How attitude influences your behavior

Attitudes can also be explicit and implicit. Explicit attitudes are those that we are consciously aware of and that clearly influence our behaviors and beliefs. Implicit attitudes are unconscious but still have an effect on our beliefs and behaviors. Nothing is more essential to the well-being of people with disabilities than acceptance and support given by the public (Malla A, Shaw T., 1987). As by Helen Keller, a famous disabled writer with disabilities, “the chief handicap of the blind is not blindness, but the attitude of seeing people towards them”. Attitudes toward the disability involve multidimensional evaluation of people, which can be either positive or negative, or comprised or both (Dunn DS., 2015) . A number of studies have addressed the impacts of different attitudes, for example, positive social attitudes could facilitate inclusion and facilitate acceptance by family, friends, and employers (Findler L, Vilchinsky N, Werner S., 2007), while negative attitudes may lead to low expectations, discrimination, and marginalization (Kleintjes S, Lund C, Swartz L., 2013). To be more specific, evidence showed that negative attitudes of the healthcare professionals have been indicated as a barrier for the participation of individuals with disabilities in several demands such as physical activity, fitness, and education settings (Rimmer J.H, Riley B, Wang E, Rauworth A, Jurkowski J., 2004).

Given this global situation and the importance of attitude, the public must be urged to rethink and promote their attitudes towards people with disabilities, in order to build a more inclusive society. Evidence shows that social inclusion, community participation and the empowerment of

people with disabilities are central concepts guiding current policies and services provided around the world (Morin D, Rivard M, Crocker AG, Boursier CP, Caron J., 2013). Public attitudes towards disabled people not only affect their integration into the community and access to public services (Verdonschot MML, de Witte LP, Reichrath E, Buntinx WHE, Curfs LM.G., 2009; Scior K., 2011), but also influence their daily lives and social participation (,Kleintjes S., Lund C, Swartz L., 2013; Verdonschot MML, de Witte LP, Reichrath E, Buntinx WHE, Curfs LM.G., 2009) , such as employment (Burge P, Ouellette-KuntzHln L.R., 2007). As recognized by several studies (,Zheng Q, Tian Q, Hao C, Gu J, Tao J, Liang Z, et al., 2016; Murchison C. A., 1935), attitudes can be formed by people's past and present experience, indicating that a variety of factors could mediate and impact public attitudes toward disabled people. The concept of attitude is multidimensional (Antonak R.F, Livneh H., 2000; McCaughey T.J, Strohmer D.C., 2005), but public attitudes towards people with various disabilities have not been addressed in current available studies. It is therefore necessary to identify the influential factors and determine if the association between those factors and the public attitudes exits. This could provide insights into appropriate measures to not only promote the positive attitudes (Murchison C. A., 1935) but also modify the negative attitudes (Malla A, & Shaw T., 1987).

2.3 Self- Esteem

The image of the body is a psychic construction that a person makes of his own body based on both psychological and social factors, in particular the history of the subject and the aesthetic values conveyed in the social; it is about how the subject perceives himself and how he thinks he is perceived by others, what we call 'self-image'. Self-image has an inescapable influence on self-esteem, defined by (Rodriguez Tome,1997,P.25) as 'the evaluative component of self-representations and beliefs about oneself'. A positive self-esteem would be accompanied by a psychological well-being. However, it should be noted that self-esteem is a multidimensional reality that takes into account the beliefs associated with it, the resulting evaluations and the context in which such evaluation takes on the meaning. It is built from childhood, is reconstructed in the face of the physical, psychological and social changes that mark interactions of amputees in the mainstream society

According to the Oxford Learners Dictionary, self-esteem refers to confidence and satisfaction in oneself. Self-esteem is an emotions-based assessment about one's self-worth or value (Erol and Orth, 2011). Self-esteem is an emotions-based assessment about one's self-worth or value (Erol and Orth, 2011). Having healthy self-esteem can influence your motivation, your mental well-being, and your overall quality of life. However, having self-esteem that is either too high or too low can be problematic. Better understanding what your unique level of self-esteem is can help you strike a balance that is just right for you (Kendra & Susman, 2021). In psychology, the term self-esteem is used to describe a person's overall subjective sense of personal worth or value. In other words, self-esteem may be defined as how much you appreciate and like yourself regardless of the circumstances. There are 4 components that define the esteem you might feel for yourself: self-confidence, identity, feeling of belonging, and feeling of competence.

2.3.1 Self Confidence

Self-confidence is defined as "individuals' performance expectancies and their self-evaluations of ability and completed performances" (Lenney, 1981) and confidence in one's ability (Benabou and Tirole, 2002; Stajkovic, 2006). Moreover, Eccles and Harold's (1991) identified self-confidence as self-concept of abilities. Self-confidence includes two key constructs which are (a) perceived competence and (b) a lack of anxiety (Clement, 1980). Specifically, individuals feel self-confident when they recognize that they have the needed ability to complete the task in question successfully. Self-confidence can change depending on the situation. It's normal to feel quite confident in some circumstances and less confident in others. A healthy amount of self-esteem is necessary to have the self-confidence to meet life's challenges and participate in things you find enjoyable and rewarding. Many people experience low self-esteem or low self-confidence. Some are only affected in particular situations, but for others it can be restricting or debilitating. If you have low self-esteem or low self-confidence, you may find that individual negative or disappointing experiences affect how you feel about yourself.

Self-confidence has been further distinguished into 'general' and 'specific' (Cox, 1964; Bell, 1967; Lampert and Rosenberg, 1975; Locander and Hermann, 1979). Specific self-confidence (SSC) refers to "the subject's confidence with respect to the decision at hand" and general self-confidence (GSC) is defined "as the extent to which an individual believes himself/heself to be

capable, significant, successful, and worthy" (Locander and Hermann, 1979: 270). Lampert and Rosenberg (1975) defined SSC as a person's self-stated degree of confidence in judging a specific context at a given point of time, whereas GSC indicates whether a person exhibits the personality trait of self-confidence irrespective of any specific context.

2.3.2. Identity

Many studies have examined the concept of "identity". Erikson (2006), who introduced it into the scientific circulation, defined identity as "internal continuity in the time and space of personality belonging to a certain community" (p. 6).The concept of identity is related to the synonymous concepts of "self-awareness" and "self-concept" that preceded it (Cote, 2018). The first of psychologist who began to develop the "self-concept" was James (2018). He considered the global personality "self" to be a dual entity in which "self-conscious" and "I as an object" connect. The knowable in self and the knowing subject are different aspects of personality (James, 2018). According to the theory of Cooley (2000), the idea of a person about himself is formed strictly under the influence of surrounding people opinions, and according to Mead (1934), it is due to real relations with them, their joint activities. Individual self, Mead (1934) emphasizes, is a kind of social structure generated by experience of human interaction with other people. Within this theoretical framework, this study postulate that the self-esteem of people living with disabilities is affected by the attitudes of the community in which they are members. Further we hold that the negative attitudes of the community towards the people living with disabilities render them vulnerable. Then these social vulnerabilities have the potential to lower the self-esteem of individuals living with disabilities (in this case amputee).Through the mastering of culture as a complex set of symbols with values common to members of society, a person also gets an idea of himself/herself as a person, i.e. "self-concept." It is a reflection of his social roles and assessments of him/her as an individual by other people. In general every individual is born within a giving culture and he/she grows within this culture which specifies the way people with disabilities are treated.

Self-identity which directly affects the regulation of personality behavior, consists of three components: (a) real self-attitudes – an idea of one's physical data, actual abilities, status (what a person really is); b) social self-attitudes – perceptions of the individual about what other people

see in him; c) perfect self-attitudes – ideas about what he would like to become. Comparing the image of the real self with the image of the ideal self plays a cardinal role self-esteem formation. In this current study, we suppose that there is an interiorization of the reactions of surrounding so called “normal” individuals. It is obvious that the discrepancy between the real and ideal “self”, recognized by the by people living with disabilities causes serious intrapersonal conflicts and thus having a bearing on their self-esteem.

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2.3.3. Feeling of belonging

Sense of belonging has been described in the literature as the extent to which an individual feels included, respected, accepted, and supported by others in different social contexts (Baumeister & Leary 1995; Hagerty et al., 1992). According to Maslow (1962), individuals have a natural, life-long desire to feel that they belong. A sense of belonging is a crucial element in self-esteem. Try as we might, we cannot function without others as we are social beings. From the moment we are born and bonded with our parents, we begin the social cycle of inclusion: in family, relatives, schools, friends, relationships, associations and work. There is no escaping others because they validate our existence and reinforce our culture and identity. Others act as mirrors which reflect our existence. When this reflection is confusing, or does not match with our own self-perception, it leads to isolation or an identity crisis. Other people’s attention, recognition, praise, affection

and love are lifelines to our endeavors, reinforcing who we are and giving us the purpose to continue with our lives. When others we care about reject us, we are likely to reject ourselves too, internalize the hate and spew it back on the family and community in the form of deviant, selfish behavior.

There is an increasing amount of research on the experiences of belonging in inclusive classrooms for students with special education needs (e.g., Goodwin & Watkinson, 2000; Hagborg, 1998; Schnorr, 1997; Williams & Downing, 1998). These studies suggest that, with appropriate support, inclusive education can increase the sense of belonging. On the other hand, scholars have argued that restrictive and segregated special education placements can weaken the experiences of belonging (Ellis, Hart, & Small-McGinley, 1998, Kunc, 1992; Williams & Downing, 1998). Notwithstanding the present study, intimate that the concept of inclusion has been overemphasized in educational settings and under emphasized at the local community level. The forces that work against inclusive education originate from the family/community and not the school. At this back drop this study advance the argument that the endeavors of inclusion should take a holistic approach beginning from the family, the community and then the school. For a meaningful inclusion of people living with disabilities, the perpetrators of the cultures that enhance exclusion should be targeted (cultural or community inclusion).

2.3.4. Feeling of competence

Mulder (2011) defines competence as "**capability to perform effectively**". The author equates the concept of capability with that of ability: "The meaning of the concept is mostly defined as being able to perform effectively" (p. 12). Elliot and Dweck (2005) concluded that competency self-perceptions were all-pervasive and powerful, "a basic psychological need that has a pervasive impact on daily life, cognition and behavior, across age and culture … an ideal cornerstone on which to rest the achievement motivation literature but also a foundational building block for any theory of personality, development and well-being" (p. 8). Perceived competencies a key construct in most theoretical models of achievement motivation, and has been widely studied since the beginning of psychological research. The popularity of research into competence self-perceptions and associated positive self-belief constructs stems from their universal importance and multidisciplinary appeal. The importance of these constructs is

highlighted by the frequency with which their enhancement is identified as a major focus of concern in diverse settings, including education, child development, mental and physical health, social services, industry, and sport/exercise. For many developmental researchers and early childhood programs (e.g., Fantuzzo et al., 1996), self-concept and competence perceptions more generally have been a “cornerstone of both social and emotional development” (Kagen, Moore, & Bredekamp, 1995, p. 18; also see Davis-Kean & Sandler, 2001; Marsh, Ellis, & Craven, 2002). Similarly, the importance of a person’s sense of competence has been widely accepted as a critical psychological construct that leads to success in educational settings (Chen, Yeh, Hwang & Lin, 2013; Marsh & Craven, 2006; Marsh & Yeung, 1997a, b), social and emotional situations (Donahue, et al., 1993; Harter, 2012; Marsh, Parada, Craven, & Finger, 2004), and daily life more generally (Elliot & Dweck, 2005).

Some scholars see "competence" as a combination of practical and theoretical knowledge, cognitive skills, behavior and values used to improve performance; or as the state or quality of being adequately or well qualified, having the ability to perform a specific role. Whether, people living with disabilities exhibit a sense of competence or not may be hinged on the perceptions of the community in which they live.

Generally people with understated self-esteem usually hypertrophy (exaggerate) the significance of failures. Low self-esteem implies self-rejection, self-denial, negative attitude towards their personality, which is due to underestimation of their successes and merits. With low self-esteem, uncertainty, often objectively unfounded, is a stable quality of personality and leads to the formation of such features as inertia, passivity, hesitation which ultimately create an inferiority complex in a person. This can cause a self-perpetuating cycle of negative thinking where negative expectations for the future discourage you from trying. This leads to disappointing outcomes. For example, if a person living with a disability lacking self-confidence receive a low mark for an assignment, he/she may think, "What else could I expect? I'm stupid. This proves it, and I might as well leave." If he/she have healthy self-esteem and receive a low mark, he/she may think, "I wonder where I went wrong? I'll find out so that I can do better next time." Although he/she may feel disappointed by the low mark, he/she don't feel diminished as a person.

Low self-confidence can result in shyness, communication difficulties social anxiety and lack of assertiveness. Anxiety is the antonym of self-confidence. Thus to reiterate, lack of anxiety enhances the self-confidence of an individual (Clement, 1980; and Hanton et al., 2004). Low self-esteem may cause you to develop a strong critical internal voice (an 'inner critic') that tends to express itself loudly when you're feeling distressed, overwhelmed or judged by others. In this current study we are supposing that social interactions have the potential to foster or diminish the development of “inner critic” in people living with disabilities. That is to say that healthy social relationship diminishes inner criticism and vice versa. This inner critic can cause significant personal distress by contributing to feelings of sadness, anxiety or anger. Believing your inner critic can cause you to think negative things about yourself, believe your negative thoughts are always true, ignore your strengths and abilities, focus on your mistakes and failings while ignoring the positive, expect the worst, avoid challenges or situations where you feel you could be judged by others and think that you don't deserve to have pleasure or fun.

Other terms that are often used interchangeably with self-esteem include self-worth, self-regard, and self-respect. Self-esteem tends to be lowest in childhood and increases during adolescence, as well as adulthood, eventually reaching a fairly stable and enduring level. This makes self-esteem similar to the stability of personality traits over time. Self-esteem is believed to have a basis in genetics and experiences during key phases of personal and physical development (Bandura, 1993; Erol and Orth, 2011).

Self-esteem impacts our decision-making process, our relationships, our emotional health, adour overall well-being. It also influences motivation, as people with a healthy, positive view of themselves understand their potential and may feel inspired to take on new challenges. People with healthy self-esteem:

- Have a firm understanding of their skills
- Are able to maintain healthy relationships with others because they have a healthy relationship with themselves
- Have realistic and appropriate expectations of themselves and their abilities
- Understand their needs and are able to express them

People with low self-esteem tend to feel less sure of their abilities and may doubt their decision-making process. They may not feel motivated to try novel things because they don't believe they're capable of reaching their goals. Those with low self-esteem may have issues with relationships and expressing their needs. They may also experience low levels of confidence and feel unlovable and unworthy.

The literature addressing self-esteem of people with disabilities strongly suggests that it is not disability per se, but rather the contextual, social, physical, and emotional dimensions of the impact of disability that may influence self-esteem and other aspects of the self (Barnwell & Kavanagh, 1997; Brooks & Matson, 1982; Craig, Hancock, & Chang, 1994; Walsh & Walsh, 1989). People develop their identities, in part, based on their interpretations of how others evaluate them, similar to the phenomenon that Cooley (1902) called the ‘‘looking glass self’’. In other words, we look into the eyes of the other to get to know ourselves and evaluate our self-worth. This aspect of the self that is based on external feedback and approval or affection from significant others have been linked to self-esteem (Adler, 1979; Bednar & Peterson, 1995; Mead, 1934).

2.4 Theoritical Review

In this part of the study, it will be a question for us to go through the theoretical currents which better explain the phenomenon studied. We devote this part of our work to theories that develop our objective of study which is centered on the effects of social vulnerability on self-esteem of the physically handicapped (amputees). The phenomenon mainly studied is social vulnerability and self-esteem. We define social vulnerability in ‘Clarification of concept’ section in chapter one. Here, we are going to understand it further through a number of theoretical approaches.

There are several theories that make clear the understanding of the concept of disability. We shall in this study be using the social model theory, the social identity theory and the cognitive theory of depression to better understand the phenomenon.

2.4.1 Social model

According to the social model of disability, whose proponent was Mike Oliver (1983), disability is not an attribute of an individual, but rather a complex collection of conditions most of which

are created by the social environment where there are varying characteristics, behaviors and attitudes. Following this model that appeared in the 1960s, disability is considered as a social product, as a result of society's inadequacy to the specifities of its members. The origin of the disability is therefore external to the individual. This conception is clearly opposed to that underlying the medical or the individual model. The type of interventions proposed will thus change; rather than a curative action aimed at the normalization of the individual, the social approach will abandon the ideal of healing and promote the development of the remaining capacities of the person in order to make him autonomous in his daily life (logic of empowerment). This model also advocates the removal of social and physical barriers. It is a question of adapting the environment and services, making them accessible and usable for people with physical or psychological disabilities. Legislation against discrimination and equality is inspired by this model see for example Art. 8 para. 2 of the Swiss constitution 3 and Act on equality for persons with disabilities 4 Marcia Rioux (1997) cited by Ravaud (2001, pp.62-63) proposes a typology of the different approaches to disability. As we have already seen, the two classic approaches differ depending on whether we focus the problem of disability on the individual or on society. Rioux then identifies two variants of each model, each with specific consequences in terms of treatment, prevention or social responsibility. We propose here a synthetic painting, adapted from Ravaud (2021, p.63), itself made after (Rioux, 1997).

Hence, the management of problem requires social action and is the collective responsibility of society at large to make modifications necessary for the full participation of persons with disabilities in all areas of social life. From this perspective, equal access for someone with disability is a human rights issue for 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, equal, autonomous and productive in society. There are multitude barriers that can make it extremely difficult or even impossible for people with disability to function. Below are the most common barriers.

i) Attitudinal barriers

These 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 to people with disabilities, and these barriers contribute to all other barriers.

ii) Environmental barriers:

They are Inaccessible environments, natural or built, and create disability by creating barriers to inclusion. Example of architectural or physical barriers include: Sidewalks and doorways that are too narrow for a wheelchair, scooter, or walker.

- Desks those are 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.
- Door knots those are difficult to grasp for a person with arthritis.

iii) Institutional barriers:

These include many laws, policies, practices, or strategies that discriminate against people with disabilities. Examples of organizational or systemic barriers include refusal of reasonably 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 file

This theory thus is linked to this study "Social vulnerability and its effects on self-esteem of the physically handicapped (amputees)" as it clearly highlights the difficulties that the amputees which is the case study in present study go through which hinders them from independence, autonomy, productivity and inclusion in mainstream societal activities.

2.4.2 Social identity theory

This is an interactionist social psychological theory of the role of self-conception and associated cognitive processes and social beliefs in group processes and intergroup relations. Social identity theory was proposed in social psychology by Tajfel and his colleagues (Tajfel, 1978, Tajfel & Tumer, 1979). Social identity refers to the ways that people's self-concepts are based on their membership in social groups such as, sports teams, religions, nationalities, occupations, sexual

orientation, ethnic groups, and gender. (Identification as nondisabled or disabled can also constitute a social identity).

Social identity theory addresses the way's that social identities affect people's attitudes and behaviors regarding their in group and the out group. Social 1dentities 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 groups norms) and forms of intergroup bias (positively evaluating ones 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 (eg, Archer,1992, Harris,1995, Leper, 2000) and group-based prejudice (e.g., Bigler & Liben, 2007, Nesdale,2004). Therefore Social identity theory offers a motivational explanation for in-group bias. It is evident that amputees belonging to an in group will identify themselves with the group members which will act as a catalyst to their self-esteem. 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 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.

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. Thus, 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 (eg., based on gender, disable/disable, or race/ethnicity) to work cooperatively on a task can reduce prejudice.

2.4.3 Cognitive theory of depression

We will insist here on the initial work of A.T. Beck, his theory of depression, in particular on the notion of cognitive psychology and on the development of depression according to A.T Beck 4.2.1.1.early work by A.T Beck. Until the early 1960s, A.T Beck worked with depressed subjects using the classical psychoanalytic method. By using the technique of free association in which the patient must say whatever comes to mind, without censoring their ideas, which allows access to depressed memories or fantasies, and triggers calming or disappearance symptoms by abreaction when an adequate emotional discharge accompanies them (Braconnier, 1998). A. T. Beck observes in some patients the presence of thoughts involving much more distortion of reality as compared to other types of productions, which are immediately followed by unpleasant emotions which appear to consciousness quite briefly (A.T. Beck, 1961).

This category of thought corresponds to a system of internal communication, at real dialogue with oneself which differs from the ideas usually produced. Patients do not report these thoughts, it is because they cannot ‘identify’ them as such, simply because of their very rapid nature and automatic as (and not due to defense mechanisms or resistance). It is because of their rapid and automatic characteristics that A-T-Beck called them automatic thoughts (A.T Beck, 1976).

The analysis of the automatic thoughts of the depressed highlights negatively oriented cognitive functions which are manifested by a drop in self-esteem, negative self-depreciation, negative predictions, a negative interpretation of events with cognitive theory of A.T. Beck. The concept of cognitive psychopathology in an extended definition constantly adapts to his environment, through various internal activities of perception, processing of information, knowledge building

processes, emotional processes. Cognitive psychology is primarily the study of “normal” predictions, a negative interpretation of events with cognitive theory of A.T. Beck. The concept of cognitive psychopathology in an extended definition constantly adapts to his environment, through various internal activities of perception, processing of information, knowledge building processes, emotional processes. Cognitive psychology is primarily the study of “normal” behaviors and activities. The notion of cognitive schema makes it possible to account for all of this functioning. When there is disturbance at a level of the cognitive system, inappropriate thoughts, emotions or behaviors will appear which will tend to have a less functional character. When these disturbances become continuous, the tip the “normal” individual toward a ‘pathological’ the tips the ‘functioning pathology will thus take hold thought the exaggeration and rigidity of increasingly unsuitable processes and through their increasing frequent use. An example of a dysfunctional schema is ‘I have to achieve great things or my life will be a failure. ‘ The dysfunctioning schema of the depressed is dominated by a strong charge of negativity that engenders negative cognition about himself, the world and the future 125 a set described by Beck as the ‘cognitive negative situations, similar to those of the past that these structures with content are reactivated. The losses can be very diverse (death, love. Employment, etc.), some being dramatic. The patient perceives that he has lost something that he considers essential to his happiness or tranquility. This reactivation will then exert a negative influence on the processing of information resulting in cognitive biases, the individual directing his resources towards the elements of the environment which are consistent with his schema. Thus, the depressed subject demonstrates a greater attention to depressive stimuli, resolves an ambiguous situation by a negative interpretation, and demonstrates an easier recall for depress genic information. This cognitive theory of depression by A.T. Beck makes a clearer explanation and understanding about the depression that the amputees in this study go through. Amputation in itself is very traumatic both as a surgery and also due to its consequences and when the amputees encounter societal barriers such as attitudinal, inadequate services, no employment, no insurance, loss of relationships, stereotypes, stigmatization, their traumatic pain is reactivated and they interpret themselves as failure, burden, dependent, beggars which brings down their self-esteem. The activation of this depressive schema causes a chain of negative automatic thoughts. The amputee evaluates his experiences negatively. He over interprets experiences of deprivation, defeat, failure. He sees himself as deficient, failed, inadequate, unworthy, and attributes these unpleasant

events to a personal deficiency. He anticipates that the current difficulties will continue infinitely. He foresees a difficult life filled with frustrations and deprivation. Since he attributes his difficulties to his imperfection due the loss of a member (amputation), he blames himself and becomes increasingly critical of himself. His life experiences activate cognitive patterns around themes of loss. The emotional, motivational, behavioral and vegetative mechanisms of depression stem from these negative self-evaluation. The amputee's sadness is an inevitable consequence of his feelings of pessimism, deprivation, and self-criticism thus, setting a wide stage for low self-esteem.

2.5 Empirical Review

There exist overwhelming research evidence that reveal that people living with disabilities all over the world still suffer from diverse forms of discrimination and injustice in their different communities. This is in spite of the existence of conventions on the rights of people living with disabilities. These injustices render PWDs vulnerable in different ways that affect their endeavors to maintain a high self-esteem, participate in self-development, community development and live a fulfilled life. Monedero, Cuesta & Angelo (2014) investigated the relationship between social image of disability, vulnerability of the dignity of women with disability and social contexts in Spain and concluded that: financial difficulties make people with disabilities more invisible. Disability in women adds a multidimensional factor that is poverty. Development policies are still required to achieve rights, the denial of human rights at the level of health, employment and education determines their situation of generalized poverty and social exclusion. Worth noting here is that the denial of rights of people living with a disability renders them vulnerable.

In another conducted by Opoku, Mckenzie, Mprah and Nsaidzedze (2016), they assessed the experiences of persons living with disabilities in the Buea Municipality of Cameroon after the endorsement of the Convention on the Rights of People Living with Disabilities (CRPD). In addressing the research questions, this study provided insights and understanding into the extent to which the CRPD has been implemented in the Buea Municipality of Cameroon from the perspectives of persons with disabilities. It is worth noting here that Cameroon adopted the CRPD on the 13th of December 2006 and so this assessment was done 10 years after the

adoption. From the findings of this study it was evident that the implementation of the CRPD was still lagging behind. The findings of the study indicated that the community still demonstrates negative attitudes towards people living with disabilities and that the people living with disabilities still have difficulties of access to basic services (Education, health care and Employment).

In another cross sectional survey study conducted in Australia by Temple, Kelaher & Williams (2018), it was found that: Despite protections in legislation and international accords, significant proportions of Australians with a disability experience discrimination or engage in avoidance behaviors in various settings with potentially important human capital contexts, such as the workforce, education and healthcare. Furthermore in late 2008, the Australian Government released a discussion paper inviting consultations intended to inform the development of a National Disability Strategy by asking the community to respond to a series of questions about their experiences of disability. More than 750 submissions were received in response, more than half from individuals and the remainder from a range of organizations (Deane, 2009). The findings of the consultations included in the National Disability Strategy Consultation Report, Shut Out (Deane, 2009, p. 4), show that more than half of the submissions received (56 per cent) identified exclusion and negative social attitudes as critical issues. It is possible that these submissions could provide a rich source of information about the experiences people with disability have with public attitudes. It is these attitudes that create social vulnerabilities as a function of social interactions.

Gallagher P. & Maclachlan M., (2001) in a research aimed to explore whether and how people think about their amputated limb, and whether if they considered anything good had emerged from their amputation. He took 104 people to carry out the Trinity Amputation and Prosthesis Experience Scales (TAPES) and two open ended questions. Most participants were young and had traumatic amputations. 56% of the people thought about their amputated limb. People with bilateral or a trans-femoral amputation were more likely to think about their amputated limb than people with a trans-tibia amputation. 48% considered that something good has happened as a result of the amputation. Furthermore, finding positive meaning was significantly associated with more favorable physical capabilities and health rating, lower levels of Athletic Activity Restriction and higher levels of adjustments to limitation. The above assertion shows that some

amputees where still able to maintain a positive self-esteem despite their body image. Self-esteem reflects an individual's overall subjective emotional evaluation of his or her own worth. It is the decision made by an individual as an attitude towards the self. Self-esteem encompasses beliefs about oneself, (for example, "I am competent", "I am worthy"), as well as emotional states, such as triumph, despair, pride, and shame. Amputees will turn to evaluate themselves at times negatively because of their modified body image.

According to Postma A., Kingma A. & Ruiter J. (1992), physical complains were reported more often by patients with amputated limbs and the amputees showed low self-esteem and isolation in social life, due to their disability and also they felt diminution on the quality of life and disability as measured on the visual analog scale. Bessel, Dures A., Semple E., & Jackson (2012), body image encompasses the way in which a person feels that his or her body image will affect interaction, playing a significant role in social and interpersonal relationship. The body image of an amputee can therefore affect the interaction, social and interpersonal relationship among peers negatively and hence low self-esteem. However, despite the fact some will have low self-esteem others will still maintain a positive self-esteem despite their body image with the help of some social resilience factors. In Cameroon the number of disability due to amputation seems to be on steady increase due to Accidents, the current arm conflict in the North West and South West Regions of Cameroon and the Boko Haram in the Northern region. yet persons with disabilities in Cameroon live and survive in communities not well adapted to accommodate them. Therefore, the extent of their survival most likely depends on their self-esteem which otherwise varies among the amputees.

Summary of literature Review

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. There is no one single universally accepted definition of Disability. Rather different definitions of disability are used in different contexts. Disabilities can generally be classified into physical, intellectual and mental disabilities, Physical disabilities are made up of muscoskeletal and Neuromuscular disabilities .The causes are either Hereditary (congenital) or acquired (accidents) . 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. The social identity theory makes an attempt to explain how the negative attitudes towards PWDs are formed and maintained. This theory supposes that people who belong to the same group usually attribute more positive traits to members of the group and vice versa.

Two competing conceptual models of disability have been used to define the origins of the abnormal physiological and psychological functioning .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 . By contrast, the **social model** does not consider the disability an attribute of the individual, but rather a socially created problem. In this case, the problem that needs to be corrected lies not within the individual, but within the unaccommodating social environment According to the social model, disability is imposed by society on individuals with impairments through isolation and exclusion from everyday activities. Such isolation and exclusion may stem from society's unfavorable perceptions of people with disabilities and unwillingness to remove environmental barriers impeding However, neither medical nor social model acknowledge the complex nature of disability. Therefore, a comprehensive integration of the two approaches produced the **bio psychosocial model**, which considers disability in the context of an interaction between different factors. The inclusion of disabled people -people with perceived impairments whether physical, sensory or intellectual -into the mainstream of economic and social life is now a major issue for policy makers and politicians in both rich and poor countries alike. Indeed, many now have some form of legislative framework with which to combat discrimination on the grounds of impairment. Notwithstanding, research indicates that despite the legislative framework put in place many countries have failed to properly implement it and so negative attitudes towards PWDs continue to persist. Having done with literature, the stage is set for the preceding chapter which deals with methodology.

CHAPTER THREE

RESEACH METHODOLOGY

INTRODUCTION

This chapter describes research methods used, focusing on information related to the research questions. The chapter is organized under the following headings: Research design, 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. The chapter ends consideration of ethical issues to ensure the respect of the rights of the research participants.

3.1 Research Design

This study adopted the case study design. Gerring (2004) notes that the efforts of many authors to clarify the concept of a case study have often lead to a definitional jumble because every time someone tries to clarify the confusion using definitions, it only makes it more confusing (Gerring,2004, p. 342). Flyvbjerg (2011) therefore believes that if a definition of a case study is needed, it is better that it is more general and does not contain a plethora of meticulous descriptions (ibid., p. 302). This study however deems the definition of Sagadin suitable. Sagadin (1991) states that a "case study is used when we analyze and describe, for example each person individually (his or her activity, special needs, life situation, life history, etc.), a group of people (a school department, a group of students with special needs, teaching staff, etc.), individual institutions or a problem (or several problems), process, phenomenon or event in a particular institution, etc. in detail.

3.2 Area of Study

This study was conducted in Bamenda, also known as Abakwa or Mankon Town. Bamenda is a city in the Northwestern Region of Cameroon and capital of the Northwest Region. The current (2020) metro area population of Bamenda is 533,000, a 3.7% increase from 2019. The metro area population of Bamenda in 2019 was 514,000, a 3.84% increase from 2018. So the population is on a steady rise. The Economic activities in Bamenda town are dominated by small

and medium-sized enterprises, trading and by agricultural produce from the neighboring divisions. There are a variety of banks and microfinance institutions in town. One major product of the region is coffee (www.urbanfoodplus.org). There are no big industries in the city. The cosmopolitan nature of the town makes it a residence for people from diverse cultural backgrounds. The Bamenda city is sub-divided into three council areas namely, Bamenda I, Bamenda II and Bamenda III as can be seen in the map at the appendix.

3.3 Population of the Study

The target population for this study comprised of the physically handicapped (amputees) living in Bamenda. This population is located in the Bamenda I and II which is located in the Bamenda with access population being 45 amputees.

Table 2: population Distribution

S/N	Population	Male	Female	Total
01	Upper limb amputees	12	9	21
02	Lower limb amputees	15	9	24
Total		27	18	45

Source: Field work, Bamenda I and II North West, (2022).

3.4 Sampling Technique and Sample Size

A sampling technique is a plan specifying how elements will be drawn from the accessible population (Nworgu, 1991). Consistent with the definition of survey designs and Kerlinger's observation, it is obvious that the idea of sampling is fundamental in survey designs. Three sampling techniques (purposive and snow ball) were used in this study. The total sample of the study was made up of 34 participants.

Table 3: sample Distribution: The sample size was determined using the Krejcie and Morgan table which implied that sample was 34 respondents. The sample was distributed as follows:

S/N	Sample	Male	Female	Total
01	Upper limb amputees	9	6	15
02	Lower limb amputees	12	7	19
Total		21	13	34

3.5 Instrument for Data Collection

The instrument used for this study was a structured Questionnaire. . The variables that were measured in this study were: social vulnerability (independent variable) and Self Esteem (Dependent variable). The Questionnaire items for the independent variable were constructed using descriptors of social vulnerability (attitudes, access to basic human services, social protection and social capital). On the other hand, the dependent variable questionnaire was constructed using the different descriptors of Self Esteem. This instrument was a Likert scale questionnaire which graded the level agreement or disagreement of respondents using strongly agree, agree, disagree and strongly disagree.

3.5.1 Validity and Reliability of Instrument

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 of the research instrument, the selection of the indicators or descriptive adjectives of the questionnaire were preceded by an elaborate review of related literature on the research variables. An initial set of the questionnaire items was constructed and presented to some classmates for scrutiny. Some of their views were factored in and a second questionnaire was constructed by the researcher. This second questionnaire was then presented to the supervisors for scrutiny. Reliability is a scientific observation's repeatability or replicability (Howard, 1985). If an observation or rating is not repeatable, its usefulness as evidence in scientific endeavors is limited. The reliability of the instrument was

tested using the Crobach Alpha coefficient. Reliability was 0.820 Crobach Alpha which makes the questionnaire reliable for the study.

3.5.2 Administration of Instruments

The instrument for data collection was personally administered, supervised and collected by the researcher after introduction and creating a conducive atmosphere by giving the objective of the study. Personal administration of the instrument offered the opportunity for the researcher to asked some probing questions, observe and gain more insight from the verbal and nonverbal communications that took place between respondents 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. This approach also has a role to play in the reliability of the data collected and the research findings.

3.6 Method of Data Analysis

Key

Strongly agree	SA
Agree	A
Disagree	D
Strongly Disagree	SD

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

Subject	General Hypothesis	Research Hypotheses	Variable	Indicator	Modality	Items	Research Tools	StatTools
Social vulnerability of the Physically handicapped and its effects on their self esteem	There is a significant Relationship between social Vulnerability of the Physically handicapped and self esteem	**Hypothesis 1** There is a significant Relationship between Attitudes and self esteem	IV: Attitudes	-feelings -behavior - knowledge	SA A D SD	3	Questionnaire	statistical Package for Social Sciences (SPSS)
			DV: Self Esteem	-self Efficacy -self Efficacy -Identity	SA A D SD	6		
		Hypothesis 2 There is a significant relationship between access to human basic services and the self-esteem of the physically handicapped	IV: basic human Services	- Education -health Care - Transport	SA A D SD	5		
			DV: Self esteem	self Efficacy -self Efficacy -Identity	SA A D SD	6		

		Hypothesis 3 There is a significant relationship between social protection and the self-esteem of the physically handicapped	IV: Social Protection	-assistance -employment -insurance -retirement benefit	SA A D SD	3 6		
			DV: Self Esteem	self Efficacy -self Efficacy -Identity	SA A D SD			
		Hypothesis 4 There is a significant relationship between social capital and the self-esteem of the physically handicapped	IV: Social Capital	-Family -friends -colleagues	SA A D SD	3		
			DV : Self Esteem	-self Efficacy -self Efficacy -Identity	SA A D SD	6		

Descriptive statistics will be used to analyze data from questionnaires from amputees and parents. Data from these questionnaires shall be analyzed using SPSS (Software version 25).

Frequency, percentage, means score were used on the likert scale questionnaires for analysis. The hypotheses were tested using simple linear regression for correlation.

3.7 Ethical Considerations

All participants participated voluntarily and gave their consent for inclusion prior to the beginning of the study. The purpose of the study was explained in advance. Contact information was collected only for the purpose of acquisition of participants' additional information in cases where the need arose. This information has been linked at no time to the other data of the study.

CHAPTER FOUR

DATA ANALYSIS AND PRESENTATION OF RESULTS

INTRODUCTION

This chapter presents the research findings and the analysis The study investigates the effects of social vulnerability on the self-esteem of the physically handicapped (amputees) in the Bemenda I and II in the North West Region of Cameroon .The data were collected through questionnaires. Findings were presented to respond to four specific objectives of the study The study sought to provide answers to four specific objectives: (i) To examine the effects of attitudes on the self-esteem of the physically handicapped (amputees);. (ii) To assess the effects the effects of access to basic human services on the self-esteem of the physically handicapped (amputees); (iii) To determine the effects of access to social protection on the self-esteem of the physically handicapped (amputees); (iv) To explore the effects of social capital on the self-esteem of the physically handicapped (amputees).

4.1 Demographic characteristics of participants

Demographic characteristics of this study incudes the gender, age and level of education.

4.2.1 Gender of respondent

The gender for this study included male and female amputees of the Bamenda I and II in the North West of Cameroon.

Table 4: Gender respondent

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	13	35.3	35.3	35.3
	Male	21	64.7	64.7	100.0
	Total	34	100.0	100.0	

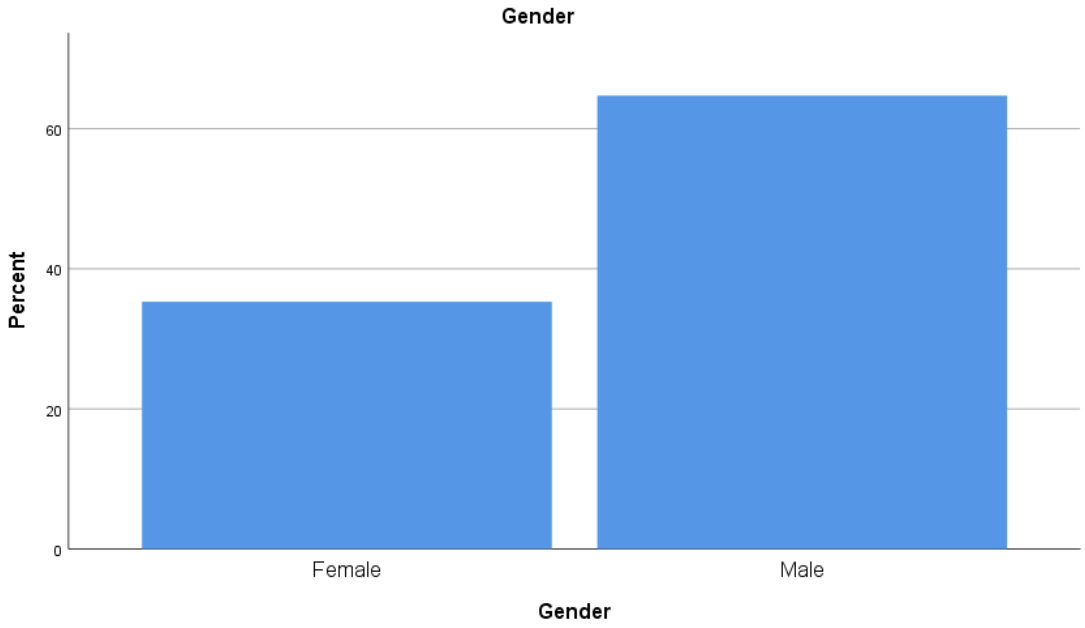

Figure 4.1: Gender of respondents
Source: Field data (2022)

The bar chart on gender distribution shows male constituted a bigger number of respondents (64.7) as compared to (35.3) for female respondents. This shows that majority of the respondents of the questionnaire were male respondents.

4.2.2 Age

The age of the respondents was distributed in five ranges. First range (10-20 years); Second range (20-30 years); Third range (30-40 years); Fourth range (40-50 years); Fifth range (50-60 years).

Table 5: Age

Age

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	10-20 years	1	2.9	2.9	2.9
	20-30 years	14	41.2	41.2	44.1
	30-40 years	6	17.6	17.6	61.8
	40-50 years	11	32.4	32.4	94.1
	50-60 years	2	5.9	5.9	100.0
	Total	34	100.0	100.0	

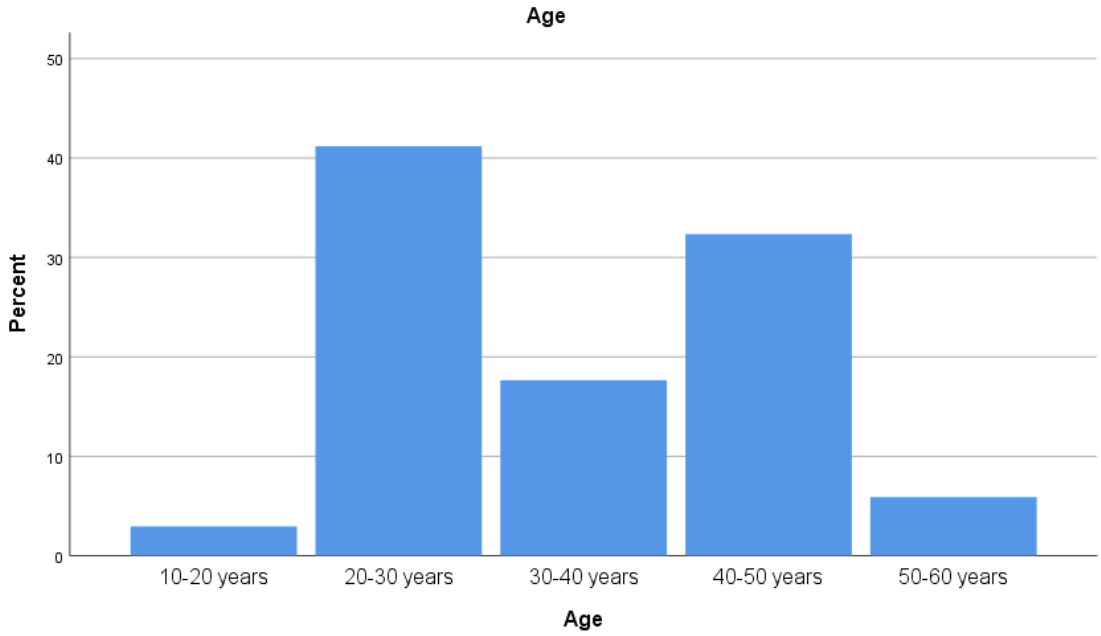

Figure 4.2 **Age**

Source: Field data (2022)

The highest proportion of respondents of 41.2 % with age range (20-30 years); Seconded by respondents of 32.4 % with age range (40-50 years); Thirdly respondents of 17.6%; with age range (30-40 years) ; Fourthly, respondents of 5.9 % with age range (50-60years); And finally respondents of 2.9 % with an age range of (10-20years).This shows that respondents with age range (20-30 years) carried the highest proportion.

4.2.3 Educational level of respondents

From the information collected, respondents were divided into three categories based ion their educational qualification. That is, primary. Secondary and higher educational level.

Table 6: Education level of respondents

Educational Level

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Primary school	11	32.4	32.4	32.4
	Secondary school	14	41.2	41.2	73.5
	Higher Education	9	26.5	26.5	100.0
	Total	34	100.0	100.0	

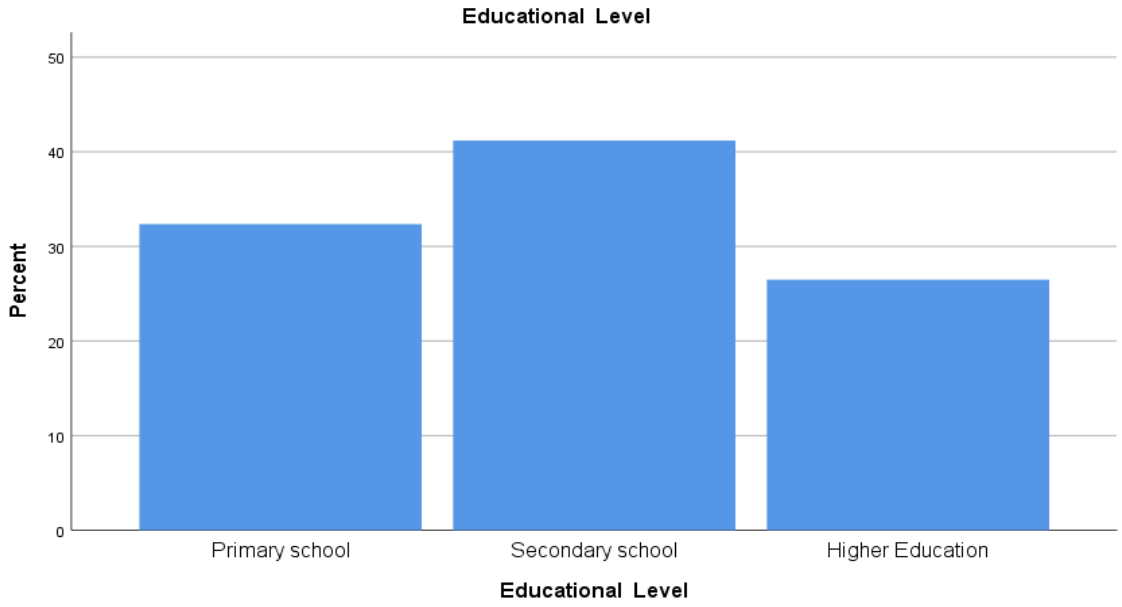

Figure 4.3: Educational level

Source: Field data (2022)

Majority of the respondents were secondary 41.2%, followed by primary with 32.4% and finally 26.5% for higher education. From the information collected, it is evident that respondents of the secondary were the majority.

4.3. Presentation of findings

4.3.1. Objective one

The effects of attitude on self-esteem of the physically handicapped (amputees). The responses were presented in a Likert scale 1-4 (strongly agree, agree, disagree, and strongly disagree). The respondents were asked to rate their level of agreement or disagreement. The results were shown on table below.

Table 7: Presentation of effects of attitudes on the self-esteem of the physically handicapped (amputees)

	Statement	Strongly Agree	Agree	Disagree	Strongly	Mean	Standard
		Frequency and Percentage; N=108					
		F(%)	F(%)	F(%)	F(%)		
1	People do not have respect for me	18(58.9)	6(17.6)	2(5.9)	8(23.5)	2.00	1.255
2	I have a positive attitude towards myself	15(44.1)	9 (26.5)	6(17.6)	4(11.8)	1.97	1.058
3	I have been excluded from certain activities such as sports, dancing because of their disability	3(8.8)	20(58.8)	6(17.6)	5(14.7)	2.38	.853
Overall total						**2.11**	**1.05**

Source: Field data (2022)

As indicated in table 7, most of the respondents fell in the category of those who strongly agreed and agreed on the effects of attitudes on the self-esteem of the physically handicapped (amputees) in the Bamenda I and II of North West with statement people do not have respect for me, data (58.9%, mean = 2.00) strongly agreed with the statement – I have a positive attitude

towards myself (44.1%; mean =1.97) strongly agreed; I have been excluded from certain activities such as sports, dancing because of my disability (58.8%, mean= 2.38) agreed.

On the other hand, some of the respondents strongly disagreed and disagreed. For no respect (5.9%); positive attitude (17.6%); exclusion (8.8%). As a result, the overall average mean of responses was 2.11 (SD=1.05) on the effects of attitude on the self-esteem of the physically handicapped (amputees) in the Bamenda I and II of the North West. The overall average mean fell in the range of high mean. This indicates that many of the respondents strongly agreed on that attitude affect the self-esteem of the physically handicapped (amputees).

4.3.2. Objective two

The effects of access to basic human services on the self-esteem of the physically handicapped (amputees) in the Bamenda I and II of the North West was a five item statement. The responses were presented in a Likert scale 1-4 (strongly agree, agree, disagree, strongly disagree). The respondents were asked to rate their level of agreement or disagreement. The results were shown on table below.

Table 8: Presentation of effects of access to basic human services on the self-esteem of the physically handicapped (amputees) in the Bamenda regional hospital of the North West.

Statement		Strongly	Agree	Disagree	Strongly	Mean	Standard Deviation
		Frequency and Percentage; N=108					
		F(%)	F(%)	F(%)	F(%)		
4	I am asked to pay extra charge for their my wheel chair when traveling by public transport	18(52.9)	7(20.6)	6(17.6)	3(8.8)	1.82	1.029
5	I have been refused certain opportunities like transportation, admission into school because my wheel chair and disability will pose	20(58.8)	12 (35.3)	1(2.9)	1(2.9)	1.50	.707

	inconveniences						
6	I easily gain access to public space such as hospital, church, law courts, and shops.	1(2.9)	1(2.9)	10(29.4)	22(64.7)	3.56	.705
7	I am always given preference in public service	1(2.9)	4(11.8)	5(14.7)	24(70.6)	3.53	.825
8	My Parents prefer to meet the needs of normal siblings before those of mine such as educational, health needs	15(44.1)	8(23.5)	6(17.6)	5(14.7)	2.03	1.114
	Overall total					**2.48**	**.876**

Source: field data (2022)

As indicated in table 4.6, most of the respondents fell in the category those of who strongly agree and agree on the effects of access to basic human services on the self-esteem of the physically handicapped (amputees) in the regional hospital of the north West. With statements ; I am asked to pay extra charges for my wheel chair, when travelling, data (52.9%, mean 1.82) strongly agreed, I have been refused certain opportunities like transportation, admission into school because my wheel chair poses inconvenience (58.8%, mean 1.50), strongly agreed. I easily gain access to public space such as hospital, church, law courts and shops (64.7%, mean 3.56) disagreed, I am always given preference in public service (70.6%), mean 5.53) disagreed; my parents prefer to meet the needs of "normal" siblings before mine such as educational, health needs (44.1%, mean 2.03). from the responses of the respondents, there is evidence that access to basic human services affect the self-esteem of the physically handicapped (amputees) in the Bamenda I and II of North West. As a result, the overall average mean of responses was 2.48, (SD=876) on the effects of access to basic human services on the self-esteem of the physically handicapped (amputees) in the Bamenda I and II of North West.

4.3.3 Objectives 3

The effects of access to social protection on the self-esteem of the physically handicapped (amputees) in the Bamenda I and II of North West was a three item statement. The responses

were presented in a Likert scale 1-4 (strongly agree, agree, disagree and rate their level of agreement or disagreement. The results were shown on table below.

Table 9: Presentation of effects of access to social protection on the self-esteem of the physically handicapped (amputees).

	Statement	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**	**Mean**	**Standard Deviation**
		Frequency and Percentage; N=108					
		F(%)	**F(%)**	**F(%)**	**F(%)**		
9	I have been refused formal employment , social opportunity, electoral posts because of disability protection	13(38.2)	13(38.2)	4(11.8)	4(11.8)	1.97	1.000
10	I have been refused loan from financial institution due to my disability	10(29.4)	14(41.2)	7(20.6)	3(8.8)	2.09	.933
11	All amputees have benefited from a social protection program organized by the ministry of social affairs	14(41.2)	15(44.1)	00	5(14.7)	1.88	.1.008
	Overall total					**1.98**	**0.966**

Source: field data (2022)

As indicated in table 4.7, most of the respondents fell on the scale of strongly agree and agree on the effects of access social protection on the self-esteem of the physically handicapped (amputees) in the Bamenda I and II of North West. I have been refused formal employment, social opportunity, electoral post, because of my disability data (38.2% strongly agreed; 38.2% agreed, mean 1.97); I have been refused loan from financial institution due to my disability (41.2%, mean 2.09% agreed; agreed; all amputees have benefited from social protection program organized by the Ministry of Social affairs (41.2%, mean 1.88) strongly agreed. From the

respondents responses, it shows the access social to protection affects the self-esteem of the physically handicapped (amputees) in the Bamenda I and II of North West. As a result, the overall average men of responses was 1.9, (SD= 966) on the effects of access to social protection on the self-esteem of the physically handicapped (amputees) in the Bamenda I and II of the North West

On the other hand, a few respondents expressed disagreement. Refusal of employment, social opportunities electoral post (11.8%); refusal granting loan (8.8%); benefits from social protection program (14.7%); the result therefore gives clear evidence that access to social protection affects the self-esteem of the physically handicapped (amputees)as confirmed by the overall average mean 1.98 (SD=0.966).

4.3.4 Objective 4

The effects of social capital on the self6estee; of the physically handicapped (amputees) in the Bamenda I and II of North West was a three item statement. The responses were presented in a Likert scale 1-4 (strongly agree, agree, disagree, strongly disagree). The respondents were asked to rate their level of agreement or disagreement. The results were presented on table below.

Table10: Presentation of the effects of social capital on the selfestee of the physically handicapped (amputees).

	Statement	Strongly	Agree	Disagree	Strongly Disag	Mean	Standard Deviation
		Frequency and Percentage; N=108					
		F(%)	F(%)	F(%)	F(%)		
12	People around me make fun about my condition	13(38.2)	13(38.2)	4(11.8)	4(11.8)	1.97	1.000
13	My immediate family members no longer show interest in me like they did before the disability	10(29.4)	14(41.2)	7(20.6)	3(8.8)	2.09	.933
14	I face different forms of discrimination form members of my community such as avoidance, exclusion from decision making	14(41.2)	15(44.1)	00	5(14.7)	1.88	.1.008
	Overall total					**1.98**	**0.966**

Source: field data (2022)

As indicated on table above most the respondents fell in the category of those who strongly agree and agree. For the statement: people around me make fun of my condition, (38.2%, 38.2%) strongly agreed and agreed respectively with mean 1.97; my immediate family members no longer show interest in me like they did before my amputation (41.2%, mean 2.09) agreed; face different forms of discrimination from member of my community such as avoidance, exclusion from decision making (44.1%), mean 1.88) agreed that social capital affects the self-esteem of the physically handicapped (amputees) in the Bamenda I and II of North West. The overall mean being 1.98 (SD= 0.966) shows physically handicapped. (amputees).

4.3.5 Dependent variation self-esteem of Physically handicapped (amputees)

Self-esteem of physically handicapped (amputees) being affected by social vulnerability was a six item statement. The responses were presented in a Likert scale 1-4 (strongly agree, Agree,

Disagree, and strongly Disagree). The respondents were asked to rate their level of agreement or disagreement. The results were presented on the table below.

Table 11: Presentation of amputee's ratings on their self esteem

Statement		Strongly	Agree	Disagree	Strongly Disag	Mean	Standard Deviation
		Frequency and Percentage; N=108					
		F(%)	F(%)	F(%)	F(%)		
15	I am very satisfied with my situation	3(8.8)	3(8.8)	5(14.7)	23(67.6)	3.41	.988
16	I think I am not useful to society	6(17.8)	6(17.6)	5(14.7)	17(50)	2.97	1.193
17	Even though an amputee still, I feel that I have some good qualities	22(64.7)	11(32.4)		1(2.9)	1.41	.657
18	I am able to carry on activities as 'normal' people.	10(29.4)	5(14.7)	8(23.5)	11(32.4)	2.59	1.234
19	I feel that I have failed in my life	9(26.5)	3(8.8)	7(20.6)	15(44.1)	2.82	1.267
20	There is little or nothing amputees can do to improve their condition.	4(11.8)	6(17.6)	11(32.4)	13(38.2)	2.97	1.029
	Overall total					**2.695**	**1.06**

Source: field data (2022)

As indicated on table above most of the respondents fell in the category of those who strongly Disagreed and some on the scale of strongly agreed that the self-esteem of the physically handicapped (amputees) is affected by social vulnerability. I am very satisfied with my situation statement (67.6% mean= 3.41) strongly disagreed; I think I am not useful to society(50%, mean =2,97) strongly disagreed' Even though an amputee, I still feel that I have some good qualities (64.7%, mean =1.41) strongly agreed; I am able to carry on activities as "normal" people(32,4%, mean = 2.59)strongly agreed ; I feel that I have failed in my life (44,1%, mean = 2.82) strongly Disagreed. There is little or nothing amputees can do to improve their condition (38.2%, mean= 2.97) strongly disagreed that self-esteem of the physically handicapped (amputees) in the Bamenda I and II of North West is influenced by social vulnerability. From the results, it shows that though the self-esteem of the physically handicapped amputees in the Bamenda I and II is

affected by social vulnerability, they still have hope, as some feel that they still have good qualities, feel useful in society, and feel they have not failed in life.

The overall average mean stands at 2.695,(SD 1.06); indicating the influence of social vulnerability on the self-esteem of the physically handicapped (amputees).

3.6 Verification of hypotheses:

Decision rule

If P (Sig) value is greater than 0.05 then the null is retained and the alternative rejected; and if the P (Sig) value is less than 0.05, the alternative is retained and the null is rejected.

Main hypothesis: Ha: There is a significant relationship between social Vulnerability and the self-esteem of the physically handicapped (amputees)

Hypothesis 1: There is a significant relationship between attitudes and self-esteem of the physically handicapped (amputees).

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.927[a]	.859	.859	.280

a. Predictors: (Constant), Attitudes

b. Dependent Variable: Self- esteem

This table provides the R and R^2 values. The R value represents the simple correlation which is 92.7% which indicates a high value of correlation. The R^2 value indicates how much the total variation in the dependent variable (self-esteem) of the physically handicapped (amputees) can be explained by the independent variable (attitudes) in this case, 85.9% which is indeed large.

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

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	95.927	1	95.927	1227.405	.000[b]
	Residual	15.709	32	.078		
	Total	111.635	33			

a. Dependent Variable: Self esteem

b. Predictors: (Constant), Attitudes

This stable indicates that the regression model predicts the dependent variable significantly well. Here, the P value which is less than 0.05 indicates that overall regression model statically and significantly predicts the outcome value.

The next table is the coefficient table. The coefficient table provides us with the necessary information to predict attitude on self-esteem of the physically handicapped (amputees)

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	.784	.043		18.131	.000
	Atitude	.755	.022	.927	35.034	.000

a. Dependent Variable: Self- esteem

A simple linear regression was conducted to qualify the relationship between attitude and self-esteem of the physically handicapped (amputees). From the findings, there is evidence that the independent variable –attitudes was a positive predictor as is clearly indicates that attitudes affect the self-esteem of the physically handicapped (amputees) in the Bamenda I and II, North West of Cameroon. Therefore, there is a significant relationship between attitudes and the self-esteem of the physically handicapped (amputees).

Hypothesis 2: Ha: There is a significant relationship between access to basic human services and the self-esteem of the physically handicapped (amputees).

Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.873[a]	.762	.794	.874.779

a. Predictors: (Constant), Basic human services

This table provides the R and R^2 values. The R value represents the simple correlation which is 87.3% which indicates a high value of correlation. The R^2 value indicates how much the total variation in the dependent variable (self-esteem) of the physically handicapped (amputees) can be explained by the independent variable (access to basic human services). In this case 76.2 which is very large.

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

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	44182633.37	1	441882633..37	57.737	.000[b]
	Residual	13774291.07	32	.765238.393		
	Total	57956924.44	33			

a. Dependent Variable: Self esteem

b. Predictors: (Constant), Basic human services

The table indicates that the regression modal predicts the dependent variable significantly well. Here, the P (siq) which is less than 0.05 indicates the overall regression model statistically and significantly predicts the outcome value.

The next table is the coefficient table. The coefficient table provides us with the necessary information to predict basic human services on the self-esteem of the physically handicapped (amputees)

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	8286.786	1852.256		4.474	.000
	Basic human services	.564	.074	.873	7.598	.000

a. Dependent Variable: Self esteem

A simple linear regression was conducted to quantify the relationship between access to basic human services and self-esteem of the physically handicapped (amputees).From the results, it can be concluded that access to basic human services was a positive predictor as it affects the self-esteem of the physically handicapped (amputees). Therefore, there is significant a relationship between access to basic human services and the self-esteem of the physically handicapped (amputees) in the Bamenda I and II, North West of Cameroon.

Hypothesis 3: Ha: There is a significant relationship between social protection and the self-esteem of the physically handicapped (amputees).

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.827[a]	.684	.666	9.411

a. Predictors: (Constant), Social protection

This table provides the R and R^2 values. The R value represents the simple correlation which is 82.7% which indicates a high value of correlation. The R^2 value indicates how much the total variation in the dependent variable self-esteem of the physically handicapped (amputees) can be explained by the independent variable social protection, in this case 64.8% which is very large.

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

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	3450.712	1	3450.712	138.959	.000[b]
	Residual	1594.308	32	88.573		
	Total	5045.020	33			

a. Dependent Variable: Self esteem

b. Predictors: (Constant), Social protection

The table indicates that the regression modal predicts the dependent variable significantly well. Here, the P (siq)< 0.05 indicates the overall regression model statistically and significantly predicts the outcome value.

The next table is the coefficient table. This table provides us with the necessary information to predict social protection on self-esteem of the physically handicapped (amputees)

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	12.762	8.276		1.542	.140
	Social protection	2.391	.383	.827	6.242	.000

a. Dependent Variable: Self esteem

Simple linear regression was conduction to identify the relationship between access to social protection and the self-esteem of the physically handicapped (amputees). From the findings, it is evident that the independent variable- access to social protection was a positive predictor as it affects the self-esteem of the physically handicapped (amputees) in the Bamenda I and II, North

West of Cameroon. Therefore it can be concluded that there is a significant relationship between access to social protection and self-esteem of the physically handicapped (amputees).

Hypothesis 4: Ha: There is a significant relationship between social capital and the self-esteem of the physically handicapped (amputees)

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.922[a]	.851	.850	.288

a. Predictors: (Constant), Social capital

This table provides the R and the R^2 values. The R value represents the simple correlation which is 92.2% which indicates a high value of correlation. The R^2 value indicates how much the total variation in the dependent variable - self-esteem of the physically handicapped (amputees) can be in this case 85.1% 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 in the table below.

ANOVA[a]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	94.973	1	94.973	1145.691	.000[b]
	Residual	16.662	32	.083		
	Total	111.635	33			

a. Dependent Variable: Self esteem

b. Predictors: (Constant), Social capital

This table indicates that the regression model predicts the dependent variable significantly well. The P (siq) < 0.05 indicates the overall regression model statistically and significantly predicts the outcome value.

The next table is the coefficient table. This table provides us with the necessary information to predict social capital on the self-esteem of the physically handicapped (amputees).

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	.720	.046		15.527	.000
	Social capital	.658	.019	.922	33.848	.000

a. Dependent Variable: Self esteem

A simple linear regression was conducted to quantify the relationship between social capital and the self-esteem of the physically handicapped (amputees). From findings, the variable- social capital was a positive predictor for it is evident that it affects the self-esteem of the physically handicapped (amputees) in the Bamenda I and II, North West of Cameroon. Therefore we can conclude that social capital has a significant relationship with the self-esteem of the physically handicapped (amputees).

Summary of Findings

Main objective: To examine the effects of social vulnerability on the self-esteem of the physically handicapped (amputees) in the Bamenda I and II, North West of Cameroon.

SN	OBJECTIVES	MEAN	DECISION	THEORY
1	To determine the effects of attitudes on the self-esteem of the physically handicapped (amputees).	2.11	Strongly agree	Social model of disability
2	To examine the effects of access to basic human services on the self-esteem of the physically handicapped (amputees)	2.48	Strongly agree	Social model of disability
3	To assess the effects of access to social protection on the self-esteem of the physically handicapped (amputees)	1.98	Agree	Social model of disability
4	To find out the effects of social capital on the self-esteem of the physically handicapped (amputees)	1.98	Agree	Social identity theory, cognitive theory of depression.

CHAPTER FIVE

SUMMARY OF FINDINGS, DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter focuses on the summary of the study which formed the foundation for discussions. This part of the study has the major highlights of summary of findings, discussion, conclusion and recommendations. The discussion provided a firm basis upon which conclusion and recommendations were advanced to address the effects of social vulnerability on the self-esteem of the physically handicapped (amputees). It also includes suggested areas for further research.

5.2 Summary of findings

The following are the key findings under the four objectives of the study.

5.2.1: Attitudes and its effects on the self-esteem of the physically handicapped (amputees).

We were investigating if there is a relationship between attitudes and self-esteem of the physically handicapped (amputees). From findings, the alternative hypothesis was retained confirming the relationship between attitudes and self-esteem of the physically handicapped (amputees) as there was a high overall average mean of 2.11 and standard deviation 1.05. This is in line with social model of disability which highlights that disability is as a result of social and physical barriers including attitudinal.

5.2.2 Access to basic human services and its effects on the self-esteem of the physically handicapped (amputees).

The findings show that the majority of respondents held the opinion that access to basic human services has a significant relationship with the self-esteem of the physically handicapped (amputees). This is affirmed by the high overall average of mean 2.48 with standard deviation 0.875. It is further affirmed by the social model of disability that advocates for the removal of social and physical barriers and adapting the environments and the services making them accessible and usable for people with disabilities.

5.2.3 Access to social protection and its effects on the self-esteem of the physically handicapped (amputees).

Form findings, the study shows that a large proportion of respondents affirmed that access to social protection affects the self-esteem of the physically handicapped with an overall average mean of 1.98 and standard deviation of 0.966. This is in line with the social model of the disability theory which considers disability as a social product as a result of the society's inadequacy to the specificities of its members.

5.2.4 Social capital and its effects on the self-esteem of the physically handicapped (amputees)

The study shows that social capital affects the self-esteem of the physically handicapped (amputees) as indicated by the overall average mean of 1.9 and standard deviation of 0.966. Thus, article 8, para 2 of the Swiss Constitution and the Act on equality for people with disabilities Marcia Rioux (1997) is against discrimination. Art 4 of the Cameroon law of 2010 emphasizes on inclusion.

5.3 Discussion of findings

This section discusses the key findings with respect to social vulnerability and self-esteem of the physically handicapped (amputees). Social vulnerability is as a result of social interactions. We will discuss the findings of this study in themes. The main objective of the study was to examine the effects of social vulnerability on the self-esteem of the physically handicapped (amputees), in the Bamenda l and II, North West of Cameroon. Findings show that there is a significant relationship between social vulnerability and self-esteem. As a function of interaction with the other members of the community and society at large, these persons living with disabilities meet with obstacles and disadvantages, which make them exposed and their self-esteem affected adversely, thus making them vulnerable. Adversely, thus making them vulnerable as applied in social science research, the term vulnerability describes a state of people and populations rather than physical structure, economics and or regions of the earth (Wisher et al, 2004). This supports that people are vulnerable as they interact with the "normal" and this affects their self-esteem negatively.

5.3.1 Attitude and its effects on self-esteem of physically handicapped (amputees)

Specifically examining the effects of attitudes on the self-esteem of the physically handicapped (amputees), the alternative hypothesis was retained which shows that there is a relationship between attitudes and self-esteem. Findings on attitudes with respect to its effects on Self-esteem indicate that, the attitudes of people affect the self-esteem of the physically handicapped (amputees). The "normal" exhibit many forms of discrimination to the physically handicapped (amputees) through cognitive, affective and behavioral patterns, lowering their self-esteem. The Department for International Development (DFI, 2015) states that impairment is disabling when individuals, are prevented from participating fully in society because of social, political, economic, environmental or cultural factors, affirming the fact that attitudes affect the self-esteem of the physically handicapped (amputees).

Empirically in a cross sectional survey study conducted in Australia by Temple; Kelaher and Williams (2018), it was found that; despite protections in legislation and international accords, significant proportions of Australians with a disability experience discrimination or engage in avoidance behaviors in various settings with potentially important human capital contexts, such as education and health care. Assessing the effects of basic human services on self-esteem of the physically handicapped (amputees), there is an adverse impact. There is a clear indication that amputees have difficulties in benefiting in educational, health, and transportation services as compared to "normals". These difficulties lower their self-esteem as one of the research participants expressed his feelings of depression loudly " I regret being brought to this world". In line with this assertion, (Solanke, 2017) postulates that there are structural or institutional discrimination, because of stereotypes. This affects body image, body schema, self-respect, thus leading to low self-esteem.

The findings of the consultations included in the National Disability Strategy consultation report which serve to position people in various inequitable ways. Empirically, Dures A , Semple E, and Jackson (2012) assert that body image encompasses the way in which a person feels that his or her body image will affect interaction, playing a significant role in social and interpersonal relationship. This makes clear that social capital affects self-esteem as the body image of the physically handicapped (amputees) at post-amputation is tempered with. According to Postma A.

Kingma A & Ruiter J. (1992) physical complains were reported more often by patients with amputated limbs and the amputees showed low self-esteem and isolation in social life due to their disability.

5.3.2 Basic human services and its effects on the self-esteem of the physically handicapped (amputees)

Assessing the effects of basic human services on self-esteem of the physically handicapped (amputees), there is an adverse impact. There is a clear indication that amputees have difficulties in benefiting in educational, health, and transportation services as compared to “normals”. These difficulties lower their self-esteem as one of the research participants expressed his feelings of depression loudly “ I regret being brought to this world”. In line with this assertion, (Solanke, 2017) postulates that there are structural or institutional discrimination, because of stereotypes. This affects body image, body schema, self-respect, thus leading to low self-esteem

5.3.3 Access to social protection and its effects on self-esteem of the physically handicapped (amputees).

In determining the effects of access to social protection on the self-esteem of the physically handicapped (amputees) findings show that there is an adverse impact of social protection thus, lowers their self-esteem. There is evidence that there are no sufficient interventions such as insurance, workshops, accompaniments and human capital, food security interventions put in place to sustain independent and autonomous living for the amputees. This renders them poor, frustrated, depressed, in constant trauma, more sick, less productive as also postulated by (Harvey et al., 2007).

Empirically, in Cameroon, a number of disabilities due to amputation seem to be on a steady increase due to accidents, current arm conflict in the North West and South West Regions and Boko Haram in the Northern region. Many people are internally displaced and lack security and accommodation, which affect the physically disabled more thus affecting their self-esteem adversely. In this wise, we can say that social protection affects the self-esteem of the physically handicapped (amputees).

5.2.4 Social capital and its effects on self-esteem of the physically handicapped (amputees)

In exploring the effects of social capital on the self-esteem of the physically handicapped, findings affirm that social capital affects self-esteem. Social capital In the study shows the social network that the physically handicapped still possess after amputation such as family members, friends, community members. We realized from findings that these relationships are not maintained to optimum as before amputation. As a result, low self-esteem sets in; Pelgrave (2001) ascertains that because of the fact that individuals do not live in isolation, but in a society filled with a network of various relationships, links and dependencies, no individual is separate from system of difference shut out (Deane , 2009,p.4), shows more than half of the submissions received (56%) identified exclusion and negative social attitudes as critical issues. It is therefore evident that our own findings are in line with the finding of the above authors to affirm that relationships affect the self-esteem of the physically handicapped (amputees).

5.4 Conclusion of the study

The study concluded that in general, social vulnerability affects the self-esteem of the physically handicapped (amputees) in the Bamenda I and II with an overall average mean of 2.1375; thus, evidence that social vulnerability has a significant relationship with the self-esteem of the physically handicapped (amputees). Specifically, attitudes affect self-esteem with an overall average mean of 2.11; showing that attitudes have a significant relationship with self-esteem. Access to basic human services affects self-esteem with an overall average mean of 2.48 and evident that access to basic human services has a significant relationship with self-esteem. Access to social protection affects self-esteem with an overall average mean of 1.98 and showing that access to social protection has a significant relationship with self-esteem. Social capital affects self-esteem with an overall average mean of 1.98, evidently indicating that it has a significant relationship with the self-esteem of the physically handicapped (amputees) in the Bamenda I and II, North West of Cameroon. In this wise, they see themselves as deficient, failed, inadequate, unworthy and attribute these unpleasant events to a personal deficiency. They anticipate that the current difficulties will continue indefinitely. They foresee a difficult life filled with frustrations and deprivations. Since they attribute their difficulties to imperfection due to loss of a member (amputation), they blame themselves and become increasingly critical of

themselves. Their life experiences activate cognitive patterns around themes of loss. On the other hand, positive attitudes, accessibility, protection and productive relationships will boost their self-esteem thus, making life worth living.

5.5 Recommendations

The following policy recommendations were made from the finding of this study.

a) The Government should educate the public on the rights of persons living with disabilities such as good services in hospitals, offices
b) In addition, more public space should be made accessible to persons living with disabilities such as building camps in hospitals, churches, schools.
c) Furthermore, the ministry of social affairs should empower them by facilitating obtaining loan providing jobs of them.
d) Again, the government should encourage them to belong to social groups like sport club which will help extend their social network where their self-esteem can be boosted. Thus government should assist them with sports equipment.

5.6 Suggested areas for further research

In order to continue to give this study adequate scholarly attention, we would suggest that:

- The study should be replicated and larger population should be used.
- Comparative studies should be carried out using different types of disabilities. That is, finding out the effects of social vulnerability on the self-esteem of the blind, deaf, those with cerebral palsy, learning disabilities to see how each group is affected and to find out which group is affected most.
- A further study should be carried out to investigate the coping strategies of persons living with disabilities who exhibit a high level of self-Esteem.
- A broader study should be carried out in Cameroon to have a concrete result of the effects of social vulnerability on the self-esteem of amputees

5.7 Limitations of the study

The study had some limitations which were as follows:

- There was very little review on Cameroonian authors in this work. That was why many reviews were consulted from Africa and Europe.
- There were financial and time constraints.
- There was limitation in the domain of security as a result of the on going crisis in the area where we went for field data.

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UNIVERSITY OF YAOUNDE I

FACULTY OF SCIENCE OF EDUCATION DEPARTMENT OF SPECIALIZED EDUCATION SPECIALTY: PHYSICAL. HANDICAP

DEAR SIR/MADAM,

I am a graduate student from the University of Yaoundé 1 on research as a requirement tor the award of a Master's Degree in specialized education. The topics on my research is "social vulnerability of the physically handicapped and effects on their self Esteem". I want to solicit for your help to kindly take off take your busy schedule to provide some information by completing the items on the questionnaire below. The items are intended to find out information about social Vulnerability and self-Esteem. You are free to ask questions wherever the need arises.

Lastly we may also, carry out a face to face interview afterwards (at your convenience) or

reach you on phone, if the need arises. I sincerely assure you that I will be HIGHLY PROFESSIONAL in my conduct and your HONESST responses shall be treated with UTMOST CONFIDENTIALITY and your identity shall remain ANOMYMOUS.THIS QUESTIONNAIRE IS INTENDED FOR ACADEMIC PURPOSE ONLY.

Thank you, for your understanding and co-operation

Part 1: Demographic information

Instruction: Tick (✓) in the box and fill the spaces with your appropriate

responses.

1. Contact number…… 2. Age.....
3. Sex: Male ☐ Female ☐
4. Level of education: Primary ☐ Secondary ☐ Higher Educatio ☐

Indicate by ticking the appropriate option how strongly you agree or disagree with each statement.

Key

Strongly agree	1
Agree	2
Disagree	3
Strongly disagree	4

S/N	Item	Response options			
Questionnaire items on attitude		1	2	3	4
1	People do not have respect for me.				
2	I have a positive attitude towards myself.				
3	I have been excluded from certain activities such as sports, dance because of my disability.				
Questionnaire items on access to basic human services					
4	I am asked to pay extra charge for my wheel chair when travelling by public transport.				
5	I have been refused certain opportunities like transportation, admission into school because my wheel chair and disability will pose inconveniences.				
6	I easily gain access to public space such as hospital church, law courts, and shops.				
7	I am always given preference in public service.				
8	My parents prefer to meet the needs of normal siblings before mine such as educational, health needs.				
Questionnaire items on social protection					
9	I have been refused formal employment, social opportunity, electoral posts because of my disability.				
10	I have been refused loan from financial institution due to my disability				
11	All amputees have benefited from a social protection programs				

	organized by the ministry of social affairs.				
12	People around me make fun about my condition.				
Questionnaire items on social capital					
13	My immediate family members no longer show interest in me like they did before the disability.				
14	I face different forms of discrimination from members of my community such as avoidance, exclusion from decision making.				
Questionnaire items on self esteem					
15	I am very satisfied with my situation.				
16	I think I am not useful to society.				
17	Even though an amputee, I still feel that I have some good qualities.				
18	I am able to carry on activities as ‘normal’ people.				
19	I feel that I have failed in my life.				
20	There is little or nothing amputees can do to improve their condition.				

APPENDICES