Natalie, Smith. THE FACE OF DISABILITY IN NIGERIA: A DISABILITY SURVEY IN KOGI AND NIGER STATES, Vol 22, No 1 (2011), p. 35-47
DOI 10.5463/DCID.v22i1.11

Appendix

SURVEY QUESTIONNAIRE

Disability Study - Client's Survey Form

COVER SHEET

- **SCREENING QUESTION:**

My name is …….. and I am part of a team conducting research about people with disabilities. We would like to find out whether anyone in your household has a disability.

What we mean by disability includes someone with problems of:

- ***Seeing – blind in one or both eyes, unable to see someone near or far away***
- ***Hearing – deaf in one or both ears, difficulty hearing what other people say***
- ***Communicating – speaking, being understood, holding a conversation***
- ***Movement Activities – moving from lying to sit to stand, moving arms / legs***
- ***Moving Around – the house, neighbourhood, up/down stairs, public transp.***
- ***Daily Life Activities – bathing, toileting, feeding, dressing, cleaning, washing cloth, caring for children or animals etc***
- ***Intellectual Disability – thinking problems, slow in walking & talking***
- ***Learning Difficulty – slow in class, unable to learn reading & writing, attending and concentrating.***
- ***Psychiatric / Emotional disorder – abnormal behaviours, hearing voices, depression, phobias, obsessions, anger problems.***

- **GAINING CONSENT:**

When you identify a person with disability ask them the following question:

We want to ask if you are willing to spend some time with me to answer some questions about your disability (OR – your child / relatives disability).

If the answer is 'YES' continue with the questionnaire.

- **INTRODUCTION TO RESPONDENT:**

Thank you for agreeing to answer our questions. Your answers are confidential and will not be disclosed to anyone apart from the research team.

Please try and help me with all the information you can, so that we understand your situation better. If you don't understand any question, please ask me to explain it more clearly to you.

Name of person with disability: _____

Home Address: _____

_____

	State	LGA	Town / Village	Interviewee

				Number
In words				
Code (Initials)				

Disability Study - Client's Survey Form

	State	LGA	Town / Village	Interviewee Number
In words				
Code (Initials)				

Interviewer's Name	
Date Filled	
Time Interview Started	

ALL ANSWERS ARE IN RELATION TO THE PERSON WITH THE DISABILITY

Please CIRCLE THE NUMBER corresponding to the response given:

1. **Respondent:** ***Who is answering this questionnaire?***

Person with a disability	1
Care-Giver of person with disability	2
Head of household of person with disability	3
Other (specify):	4

2. **Religion**:

Islam	1
Christian	2
Traditional	3

3. **Sex:**

Male	1
Female	2

4. **Age in Years:**

0-5	1	**36-40**	8
6-10	2	**40-45**	9
11-15	3	**46-50**	10
16-20	4	**50-60**	11
21-25	5	**60-70**	12
26-30	6	**70-80**	13
31-35	7	**80+**	14

5. **Tribe:**

Gwari	1
Nupe	2
Hausa	3
Yoruba	4
Igala	5
Ebira	6
Ibo	7
Other (specify):	8

6. Marital Status:

Single	1
Married	2
Divorced	3
Widowed	4

7. If you (OR ….. PWD) are married, how many wives / husbands do you have? ☐

8. How many children do you (OR ….. PWD) have? ☐

9. Do you (OR ….. PWD) have difficulty in any of the following areas?

	Yes	**No**
Visual Impairment /Seeing – blind in one or both eyes, unable to see someone near or far away	1	2
Hearing Impairment - deaf in one or both ears, difficulty hearing what other people say	1	2
Communication - speaking, being understood or holding a conversation	1	2
Movement activity - moving from lying to sit to stand, moving arms / legs	1	2
Moving around - the house, neighbourhood, up/down stairs, public transp.outside environment)	1	2
Daily life activities - bathing, toileting, feeding, dressing, cleaning, washing cloth, caring for children or animals etc	1	2
Intellectual disability / developmental delay - thinking problems, slow in walking & talking	1	2
Learning difficulties - slow in class, unable to learn reading & writing, poor attention& concentration compared to others.	1	2
Mental illness / emotional disorder – psychological & psychiatric problems, abnormal behaviours, hearing voices, depression, phobias/abnormal fears, obsessions, anger problems	1	2
Other (specify):	1	2

10. How old were you (OR ….. PWD) when these difficulties started?

0-1	1	**25-30**	10
1-2	2	**30-35**	11
2-3	3	**35-40**	12
3-4	4	**40-45**	13
4-5	5	**45-50**	14
5-10	6	**50-55**	15
10-15	7	**55-60**	16

15-20	8	**60-70**	17
20-25	9	**70-80**	18

11. What do you think caused your (OR ….. PWD's) health condition?

Before or during Birth	1
Disease / Sickness	2
Injection	3
Sin / Disobedience	4
Curse by God	5
Juju / Witchcraft	6
Eating certain foods	7
Domestic Accident	8
Motor Accident	9
Political violence	10
Old age	11
Don't know	12
Other (specify):	13

12. What does <u>your family</u> think caused your (OR ….. PWD's) health condition?

Before or during Birth	1
Disease / Sickness	2
Injection	3
Sin / Disobedience	4
Curse by God	5
Juju / Witchcraft	6
Eating certain foods	7
Domestic Accident	8
Motor Accident	9
Political violence	10
Old age	11
Don't know	12
Other (specify):	13

13. If '2' was selected in either table above, do you know the name of the disease or sickness?

Polio	1
Spinal cord damage	2
Stroke	3
Leprosy	4
Meningitis	5
Cerebral Palsy	6
Club feet (deformed feet at birth)	7
Hereditary disorder (spinal bifida, downs syndrome)	8
Diabetes	9
Measles	10
High blood pressure (hypertension)	11

Epilepsy	12
Mental Illness	13
Arthritis	14
Don't know	15
Other (specify):	16

14. ***What immunizations have you (OR ….. PWD) received?***
(Ask to see immunization card if available)

	Yes	Part	No	Don't know
BCG	1		3	4
Polio (complete 3 doses)	1	2	3	4
DPT (complete 3 doses)	1	2	3	4
Measles	1		3	4
Meningitis / CSM	1		3	4
Yellow Fever	1		3	4
Hepatitis B	1		3	4
Other (specify):	1		3	4

15. ***What assistive devices do you (OR ….. PWD) have?***
(Select what is used by the person with disabilities, ask to see them and circle the condition of device)

Assistive Device	**Type**	**Condition of Device**		
		Good	**Bad**	**Not used**
Hearing Aid	1	1	2	3
Eye Glasses	2	1	2	3
Crutches	3	1	2	3
Wheelchair	4	1	2	3
Tricycle	5	1	2	3
Walking Frame	6	1	2	3
Walking Stick	7	1	2	3
White Cane (for blind)	8	1	2	3
Artificial Limb	9	1	2	3
Calipers	10	1	2	3
Splints	11	1	2	3
Special footwear (moulded shoe, elephant boot, raised shoes)	12	1	2	3
Neck collars	13	1	2	3
Back brace / Corset	14	1	2	3
None	15	1	2	3
Other (specify):	16	1	2	3

16. Others with disability:

	Yes	**No**	**If 'Yes', how many have disability**
If you (OR ….. PWD) are married, does your husband / wives also have disability?	1	2	
If you (OR ….. PWD) have children, do any of them also have disability?	1	2	
If you (OR ….. PWD) are not yet married and do not have children, does any other family member have a disability?	1	2	

17. ***Which of the following schools have you (OR ….. PWD) ever been to?***

Nursery school	1
Primary school	2
Secondary school	3
Tertiary education	4
Vocational training	5
School for Handicapped	6
Islamic	7
None	8
Other (specify):	9

18. Effect of Disability on Education:

	Yes	No	Don't Know
Have you (OR ..... PWD) ever been refused entry into school because of your / the disability?	1	2	3
Have you (OR ..... PWD's) level of education helped you to find any work?	1	2	3

19. Occupational status: (You can circle more than one if appropriate)

Student	1
Farming	2
Housewife	3
Petty Trading	4
Labourer	5
Mechanic	6
Carpenter	7
Fishing	8
Tailoring	9
Blacksmith	10
Business	11
Civil Service	12
Begging	13
None	14
Other (specify):	15

20. Working status:

Never worked	1
Self-employed	2
Worked before, but unemployed now	3
Still Employed	4
Other (specify):	5

21. If selected '3' above, why did you stop working?

Retired	1
Retrenched (due to rationalization / cut backs)	2
Fired / Sacked	3
Injury/accident at work	4
Illness	5
Because of disability	6
Other (specify):	7
Don't know	9

22. How much money (on average) do you (OR ..... PWD) earn in a month?

Nothing (cross-check very well)	1
N 100 – 500	2
N 500 – 1,000	3

N 1,000 – 2,000	4
N 2,000 – 3,000	5
N 3,000 – 4,000	6
N 4,000 – 5,000	7
N 5,000 – 6,000	8
N 6,000 – 7,000	9
N 7,000 – 8,000	10
N 8,000 – 9,000	11
N 9,000 – 10,000	12
N 10,000 – 15,000	13
N 15,000 – 20,000	14
N 20,000 or above	15

23. What are the TWO MAIN THINGS that this monthly income is spent on?
[Do not read out; circle at least TWO answers]

Item	**Choice** *Circle at least TWO*
a. Household necessities i.e. food, groceries etc.	1
b. Clothing	2
c. Rent/accommodation	3
d. Recreation/entertainment	4
e. Transport	5
f. Education	6
g. Water and electricity	7
h. Rehabilitation and health care services	8
i. Assistive devices	9
j. Personal assistant/carer (care for self)	10
k. Other (specify):	11
l. Don't know	12

24. Which of these health services, if any, are you (OR ….. PWD)*aware* of?
What services, if any, have you (OR ..… PWD) ever *needed?*
What services, if any, have you (OR ..… PWD) ever *received?*
Did they *improve* your (OR ….. PWD's) health condition?

	Aware of service 1=Yes 2=No	Needed service 1=Yes 2=No	Received service 1=Yes 2=No	Improvement in condition 1=Yes 2 = No
	(1)	(2)	(3)	(4)
a. Medical rehabilitation (e.g. physiotherapy, occupational therapy, speech and hearing therapy, surgery, casting, splints etc)				
b. Assistive devices service (e.g. from an orthopaedic workshop – crutches, calipers, walking stick, wheelchair, hearing/visual aids, Braille etc.)				
c. Special Educational services (e.g. remedial therapist, special school, early childhood stimulation, regular schooling, etc.)				
d. Vocational training (e.g. employment skills training – tailoring, carpentry, apprenticeship etc)				

	Aware of service 1=Yes 2=No	Needed service 1=Yes 2=No	Received service 1=Yes 2=No	Improvement in condition 1=Yes 2 = No
	(1)	(2)	(3)	(4)
e. Economic Empowerment (e.g. provision of micro-crdeit, small loans, grinding mills/engine etc)				
g. Basic Amenities (e.g. provision of housing, electricity, water, schools etc).				
f. Counselling for person with disability (e.g. psychologist, psychiatrist, social worker, school counsellor etc)				
g. Counselling for parent/family				
h. Welfare services (e.g. social worker, disability grant, etc)				
i. Health services (e.g. at a primary health care clinic, hospital, home health care services etc.)				
j. Traditional healer/faith healer				
k. Other (specify):				

25. If you (OR ….. PWD) did not receive any of these services, what are the reasons for NOT using or receiving these services?

SERVICE	Reason for NOT RECEIVING Service
a. Medical rehabilitation	
b. Assistive devices service	
c. Special Educational services	
d. Vocational training	
e. Economic Empowerment	
g. Basic Amenities	
f. Counselling for person with disability	
g. Counselling for parent/family	
h. Welfare services	

i. Health services	
j. Traditional healer/faith healer	
k. Other (specify):	

26. People have said many things about the effects that people with disabilities have on their families. I am going to read to you a number of these things. Please tell me if these happen to you (OR ….. PWD).

Statement	Always	Sometimes	Never	Don't know
My disability affects the whole household?	1	2	3	4
My disability places financial pressures on my household?	1	2	3	4
My family argues because of my disability?	1	2	3	4
My family was given enough information to understand my disability?	1	2	3	4
My family doesn't understand why I need so much help?	1	2	3	4
My family feel fine about helping me?	1	2	3	4

27. I am going to ask you about the difficulties you (OR ….. PWD) have in doing various activities:

Types of Activities **ASK THIS QUESTION:** ***Do you have difficulty doing this activity because of your disability?***	**Activity limitation** ***(Capacity)*** 0 no difficulty 1 mild difficulty 2 moderate difficulty 3 severe difficulty 4 unable to carry out the activity 5 don't know	**Participation restriction** ***(Performance in your "current environment" is where you spend most of your time: where you live, work, go to school or play)*** 0 no problem 1 mild problem 2 moderate problem 3 severe problem 4 unable to perform 5 don't know	**Severity of Disability** ***(Assistance required from assistive device or other people)*** 0 no assistance 1 help from assistive device 2 help from another person 3 help from assistive device and from another person 4 don't know
	(1)	**(2)**	**(3)**
1a. SENSORY EXPERIENCES			
a. watching / looking / seeing			
b. listening / hearing			
1b. BASIC LEARNING & APPLYING KNOWLEDGE			
a. learning & acquiring skills (manipulating tools, learning names, learning to read & write)			
b. reading / writing / counting / calculating			
c. thinking / problem solving			
d. contributing to household decisions			
2. COMMUNICATION			
a. understanding others (spoken, written or sign language)			

Types of Activities **ASK THIS QUESTION:** ***Do you have difficulty doing this activity because of your disability?***	**Activity limitation** ***(Capacity)*** 0 no difficulty 1 mild difficulty 2 moderate difficulty 3 severe difficulty 4 unable to carry out the activity 5 don't know	**Participation restriction** ***(Performance in your "current environment" is where you spend most of your time: where you live, work, go to school or play)*** 0 no problem 1 mild problem 2 moderate problem 3 severe problem 4 unable to perform 5 don't know	**Severity of Disability** ***(Assistance required from assistive device or other people)*** 0 no assistance 1 help from assistive device 2 help from another person 3 help from assistive device and from another person 4 don't know
b. communicating with others (speaking /sign language)			
c. communicating using devices (handset / phone / typewriter / computer / Braille machine)			
3. MOBILITY			
a. staying in one body position			
b. changing a body position (moving from lying to sit to stand)			
d. lifting / carrying / moving / handling objects			
e. fine hand use (picking up/grasping/manipulating/release)			
f. hand & arm use (pulling/pushing/reaching/throw/catch)			
g. walking			
h. moving around (crawling/climbing/running/jumping)			
j. using transportation to move around as a passenger			
k. driving a vehicle (car/boat/bicycle/riding an animal)			
4. SELF CARE			
a. washing yourself			
b. care of body parts, teeth, nails and hair			
c. toileting			
d. dressing and undressing			
e. eating and drinking			
f. looking after your own health			
5. DOMESTIC LIFE			
a. buying things in the market			
b. preparing & cooking meals			
c. doing housework (washing cloths / cleaning)			
d. taking care of personal objects (mending / repairing)			
e. taking care of others			
6. INTERPERSONAL BEHAVIOURS			
a. interacting socially with others			
b. making friends and maintaining friendships			
c. interacting with persons in authority			
d. interacting with strangers			
e. creating and maintaining family relationships			
f. creating and maintaining intimate relationships			
7. MAJOR LIFE AREAS			
a. going to school and studying (education)			
b. getting and keeping a job (work & employment)			
c. handling income and payments (economic life)			
8. COMMUNITY, SOCIAL AND CIVIC LIFE			

Types of Activities **ASK THIS QUESTION:** ***Do you have difficulty doing this activity because of your disability?***	**Activity limitation** ***(Capacity)*** 0 no difficulty 1 mild difficulty 2 moderate difficulty 3 severe difficulty 4 unable to carry out the activity 5 don't know	**Participation restriction** ***(Performance in your "current environment" is where you spend most of your time: where you live, work, go to school or play)*** 0 no problem 1 mild problem 2 moderate problem 3 severe problem 4 unable to perform 5 don't know	**Severity of Disability** ***(Assistance required from assistive device or other people)*** 0 no assistance 1 help from assistive device 2 help from another person 3 help from assistive device and from another person 4 don't know
a. clubs/organisations (community life)			
b. recreation/leisure (sport/play/craft/hobbies/art/culture)			
c. religious/spiritual activities			
d. political life and citizenship			
e. family gatherings (naming ceremonies / weddings)			
9. OTHER (specify)			
a. Going to farm & farming (if relevant)			
b.			
c.			
d.			
e.			

28. What makes it EASIER for you to participate in your community?
(Think of things like products or devices, assistive technology, personal support, services, systems, organizations, policies, even attitudes – and tell me specifically what these might be). ***(Write down what respondent says in their own words.)***

_____

_____

_____

29. What makes it HARDER for you to participate in your community?
(Think of things like products or devices, assistive technology, personal support, services, systems, organisations, policies, even attitudes – and tell me specifically what these might be). *(Write down what respondent says in their own words.)*

_____

_____

_____

Time interview ended: _____

Questionnaire monitoring	Signature	Date
Questionnaire filled by:		
Questionnaire cross-checked by:		
Checked by supervisor:		