COLLEGE OF EDUCATION AND BEHAVIORAL STUDIES

THE DEPARTMENT OF SPECIAL NEED EDUCATION

THE PRACTICE OF REHABILITATION PROGRAM IN CHESHIRE (MENAGESHA REHABILITATION CENTRE) FOR PEOPLE WITH PHYSICAL DISABILITIES

BY:

MAKDA KIFLE

JULY, 2020

ADDIS ABABA UNIVERSITY

Addis Ababa University

College of Education and Behavioral Studies

Department of Special Needs Education

The Practice of Rehabilitation Program in Cheshire (Menagesha Rehabilitation Centre) for People with Physical Disabilities

By:
Makda Kifle

A Thesis Submitted to the Department of Special Needs Education in Partial Fulfillment of the Requirement for MA Degree in Special Needs Education

Addis Ababa University

Collage of Education and Behavioral Studies

Department of Special Needs Education

As thesis research advisors, I hereby certify that I have read and evaluated this thesis is prepared under my guide, by Makda Kifle entitled ‘‘The Practice of Rehabilitation Program in Cheshire (Menagesha Rehabilitation Centre) for people with physical disabilities’’ I recommended it be submitted as fulfilling the thesis requirement.

Tilahun Achaw (PhD) _____ _____

Major Advisor Signature Date

As members of the Board of Examiners of the MA Thesis Open Defense Examination, we certify that we have read, evaluated the thesis prepared by Makda Kifle and examined the candidate. We recommended that the Thesis be accepted as fulfilling the thesis requirement for the degree of Master of Art in Special Needs Education.

_____ _____ _____

Chairperson Signature Date

_____ _____ _____

Internal Examiner Signature Date

_____ _____ _____

External Examiner Signature Date

ACKNOWLEDGEMENTS

First of all, I would like to thank Almighty God for his unconditional love and help throughout my life.

I would like to extend my sincere gratitude to my advisor, Tilahun Achaw (PhD) for his kindness, outstanding guidance and constructive criticism. Thank you Dr, I can't forget your support and friendly approach.

I am thankful to all my families. Especially, My Father Kifle Assefa, while alive, he has always been supportive and believes in me, My Mother Frehiwot Yohannes, for her continuous and unwavering love and support over the challenging times, and My Brother, Abiy Kifle, for his love, guidance and advice.

I would like to thank Ato Kedir Kassim the manager of Menagesha rehabilitation center and all the staffs for their warm welcome and cooperation also for providing me with necessary data. I am highly indebted towards Ato Tura Demu (senior physiotherapist) and Ato Mesfin Endale for their kindness and support.

My special thanks go to Habtamu Getnet and Wonidmu Alemayehu, who helped me in bringing this study into reality. God bless you all and all yours abundantly!

TABLE OF CONTENTS

STATEMENT OF THE AUTHOR

I the undersigned declare that this Thesis is my original work and has not been presented for any degree in any University and all the source of materials used for the Thesis have been dually acknowledged. It has been submitted in partial fulfillment of the requirements for MA. Degree in Special Needs Education at the ADDIS ABABA UNIVERSITY and is deposited at the University Library to be made available to borrowers under the rules of the Library.

Brief quotations from this thesis are allowable without special permission provided that accurate acknowledgement of source is made. Requests for permission for extended quotation from or reproduction of this manuscript in whole or in part may be granted by the permission of the author.

Name of the author: Makda Kifle Signature _____

Place: Addis Ababa University, Ethiopia

Date of Submission: July 2020

LIST OF ACRONYMS

AAU: Addis Ababa University

CRPD- United Nations Convention on the Rights of Persons with Disabilities

CSE- Cheshire Services Ethiopia

FGD – Focus Group Discussion

ILO – International Labor Organization

JICA- Japan International Cooperation Agency

MOH- Ministry of Health

MOLSA- Ministry of Labor and Social Affairs

MRC- Menagesha Rehabilitation Centre

NGO – Non Government Organization

PWDs- Person with Disabilities

WHO- World Health Organization

WRD- World report on disability

ABSTRACT

The objective of the study was to assess the practice of rehabilitation program in Cheshire (Menagesha Rehabilitation Center) for people with physical disabilities. To realize the purpose of the study, the researcher used qualitative research design with special employment of case study. A total of 32 participants were selected from rehabilitated members and staff members of the center by using purposive (non-probability) sampling method. After conducting interview, focus group discussion, observation and document review results were emerged from the empirical data. Based on the analysis, the steps to obtain the rehabilitation program include registration and appointment then assessment or examination by multidisciplinary team follows. Components of the program are basically divided in to Physiotherapy and social work service. Opportunities were identified to be; receiving surgical and medical treatments including basic educational and computer skills for free, Job satisfaction and adding up knowledge about rehabilitation, cleanliness of the center, new buildings and extension plan to broaden the service. Concerning challenges; insufficient human and material resources and unmet need of individual counseling, lack of human and material resources, little attention given to follow up, low family involvement, lack of commitment, high work load, no special need professional involvement, and lack of attention given regarding prevention of disability and collaboratively working with other responsible bodies were identified. Based on the findings recommendations are forwarded.

CHAPTER ONE

INTRODUCTION

1.1. Background

According to World Health Organization (WHO, 2011) rehabilitation has long lacked a unifying conceptual framework. Historically, the term has described a range of responses to disability, from interventions to improve body function to further comprehensive measures intended to promote inclusion. For some people with disabilities, rehabilitation is crucial to being able to take part in education, the labor market, and civic life. Rehabilitation is always voluntary, and some individuals may require support with decision-making about rehabilitation choices. In all cases rehabilitation should help to empower people with disabilities.

The definition of 'disability' is also varied and deals with the concept of external barriers. The World Health Organization's (2013) definition of disability involves the interplay between 'impairments, activity limitations, and participation restrictions' whereby disability is the interaction between the impairment that a person has and the limitations imposed by their physical or social environment (WHO, 2013).

The World Health Organization (2017) defines disability as a wide term that includes impairments, which are problems in body function or structure; activity restrictions, which are difficulties individual experiences in performing a task or action; and participation limitations, which are difficulties individual experiences in life situations. Despite this definition, disability is not just a health problem. It is a complex, diverse phenomenon that reflects the interaction between features of a person´s body and also features of the society in which a person lives in.

The World report on disability (WRD, 2011) described rehabilitation in the context of persons with disabilities as measurements that assist them in order to accomplish and maintain the finest function as possible, to attain self-dependence and to be able to interact with their environment.

Based on the World Report on Disability jointly issued by the World Bank and World Health Organization, there are an estimated 15 million children, adults and elderly persons with disabilities in Ethiopia, representing 17.6 per cent of the population. A vast majority of people with disabilities live in rural areas where accesses to basic services are inadequate. In Ethiopia, 95 per cent of all persons with disabilities are estimated to live in poverty. Many relay on family support and begging for their livelihoods. A study in Oromia region, for instance, showed that 55 percent of the surveyed persons with disabilities depend on family, neighbors and friends for their living, while the rest generate income through self-employment, begging and providing house maid services (WRD, 2011).

Rehabilitation interventions promote a comprehensive process to facilitate attainment of the optimal physical, psychological, cognitive, behavioral, social, vocational, a vocational and educational status within the capacity allowed by the anatomic or physiologic impairment, personal desires and life plans, and environmental (dis)advantages for a person with a disability. Consumers/patients, families, and professionals work jointly as a team to identify realistic goals and develop strategies to achieve the highest possible functional outcome, in some cases in the face of a permanent disability, impairment, or pathologic process (ACPF, 2011).

Rehabilitation is therefore fundamental for persons with disability to attain functional independence and assist them to have an improved quality of life. In order to enhance the effectiveness of rehabilitation, it is essential to seek clients' perspectives of the rehabilitation services and to incorporate these perspectives into the planning and delivery of rehabilitation services. Hence, this study aims to explore the components and steps of the rehabilitation program in Menagesha rehabilitation centre, to investigate the opportunities that assists the rehabilitation program to be provided effectively, to assess the challenges that hinder the rehabilitation program from better rehabilitation service provision and to indicate possible measures that should be taken to minimize the challenges that the Centre faces.

1.2 Statement of the Problem

According to the World Health Organization (WHO, 2011), People that live with disability incorporates 70% in developing countries. Apart from demographic reasons, the high prevalence of disability in poor countries shows the existence of causal relationship between poverty and disability. Disability is caused and aggravated by poor living condition, such as poor nutrition, lack of health and sanitation facilities and exposure to various forms of accident. On the other hand, in poor countries like Ethiopia, disability makes it difficult for people to get out of poverty. The absence of rehabilitation centers, lack of equal access to education, employment and other services makes it particularly an uphill battle for people with disabilities to overcome livelihood challenges.

The state of persons with disabilities in Ethiopia is tragic and severe mainly due to the presence of diversified pre and post-natal disabling factors like infectious diseases, difficulties contingent to delivery, under-nutrition, malnutrition, harmful cultural practices, lack of proper child care and management, civil war and periodic drought and famine, the absence of early primary and secondary preventive actions. Major current draw backs concerning disability are: Lack of public understanding, Lack of information regarding the number and status of disabilities, Shortage of basic needs, such as vocational training placement, health facilities and inaccessibility to assistive devices (Tirussaw, 1998).

Knowledge about disability is not widespread in Ethiopia: few children with disability receive an education; many disabled adults are unemployed; and historical beliefs about the cause and nature of disability are common. Furthermore, disability is frequently seen as a charity issue: there is minimal understanding of the social model of disability, which views impairment as an ordinary part of life, and disability as the consequence of society's lack of accommodation to and discrimination against PWDs. (ACPF, 2011)

Wegayehu (2004) found that, few rehabilitation services that exist in Ethiopia are located in Addis Ababa, Mekele, Awassa, Arbaminch, Dire-Dawa, and Jima. Tigabu (2008) also disclosed that, in Ethiopia, rehabilitation services provision institutions could address only to 1 % of the total rehabilitation needs of PWDs. Adequate rehabilitation service is sadly lacking in most

developing countries. When available, rehabilitation is usually found in the urban centers, inaccessible to many because of financial costs and/or geographical distance.

The general review of literature on rehabilitation practice found that, only 1% of the total rehabilitation needs of persons with disabilities in Ethiopia are addressed, which is a very serious concern and demands attention in all stages of the government level. In addition to that, no research has done in Menagesha rehabilitation center in investigating the practice of the rehabilitation service as indicated by the manager of the Center. Therefore, this study has been conducted to fill this gap and to provide the evidence on the practice, service, challenges and opportunities of Menagesha Rehabilitation centre.

1.3. Research Questions

This research aimed to address the under listed research questions,

- ✓ What are the steps and components of the rehabilitation program in Menagesha rehabilitation center in its rehabilitation service provision?
- ✓ What are the main opportunities that assist the rehabilitation program for better rehabilitation service provision?
- ✓ What are the main challenges that hinder the rehabilitation program from better rehabilitation service provision?

1.4. Objective of the Study

1.4.1 General objective

The general objective of the study is to investigate the practice of rehabilitation program in Menagesha rehabilitation centre.

1.4.2 Specific objectives

1. To explore the steps and components of the rehabilitation program in Menagesha rehabilitation centre.

2. To investigate the opportunities that assists the rehabilitation program to be provided effectively.

3. To assess the challenges that hinder the rehabilitation center in giving better rehabilitation service provision.

1.5 Significance of the Study

Living with disability can interfere with a person's ability to participate actively in economic and social life (Phillips &Noumbissi, 2004). This is exacerbated in contexts where rehabilitation services are unavailable or inadequate. Rehabilitation is therefore of fundamental importance for the persons with disability to achieve functional independence and have an improved quality of life. In addition, much remains to be learned about this center, what problems it faces, what opportunities it has for future and others. It is hoped that the findings of the study will,

- ✓ Give insight about the practice of the rehabilitation program in Menagesha rehabilitation center.

- ✓ provide information to special need professionals that enable them to work with people with physical disabilities in the rehabilitation center

- ✓ Assist authorities in Cheshire Service of Menagesha rehabilitation center to intervene in identified challenges and to maximize strengths.

- ✓ Provide information for future research in the same area.

1.6. Definition of Terms

The following are definition of terms frequently used in the study.

Rehabilitation

The WRD (2011) described rehabilitation in the context of persons with disabilities (PWDs) as measurements that assist PWDs in order to achieve and maintain the best function as possible, to attain self-dependence and to be able to interact with their environment.

Practice

In the present study, practice refers to performances habitually done at Menagesha rehabilitation center for rehabilitation service provision. The questioner, interview questions and observational checklist will be prepared by the researcher based on the general research question and the specific objectives. To explore practice; Observation, questioner and interview will be used as instruments.

Opportunity

The present study, opportunities refer to different circumstances, situations or conditions which are favorable and can be utilized by Menagesha Rehabilitation Center for attainment of its mission in the rehabilitation program. The questioner, interview questions and observational checklist will be prepared by the researcher based on the general research question and the specific objectives. To investigate Opportunity; Observation, questioner and interview will be used as instruments.

Challenge

In this investigation, it refers to different situation that hinders the center from achieving its mission of providing quality rehabilitation service for children with physical disability. The questioner, interview questions and observational checklist will be prepared by the researcher based on the general research question and the specific objectives. To Assess Challenge; Observation, questioner and interview will be used as instruments.

1.7. Scope of the study

Once case determined; is important to consider what case will not be also. One of the common pitfalls associated with case study is that there is a tendency for researchers to attempt to answer a question that is too broad or a topic that has too many objectives for one study" (Baxter & Jack, 2008. Therefore, this study is interested in examining the practice of rehabilitation program of MRC, to investigate the opportunities that assist the rehabilitation program to be provided effectively, to assess the challenges that hinder the rehabilitation program from better rehabilitation service provision and to indicate possible measures that should be taken to minimize the challenges that the Centre faces.

1.8 Organization of the study

This study will be organized in five chapters. The first chapter will deal with the background of the study, statement of the problem, scope of the study, significance of the study, limitation of the study and organization of the study. The second chapter expected to review different related literature. In the third chapter, the researcher will deal with the methodology and procedures employed to collect and analyses the data. In the fourth chapter, there will be discussion and analysis of the data which will be collected from respondents and gained from watching films. Finally, in the fifth chapter summary of the findings, conclusions and recommendations will be addressed.

CHAPTER TWO

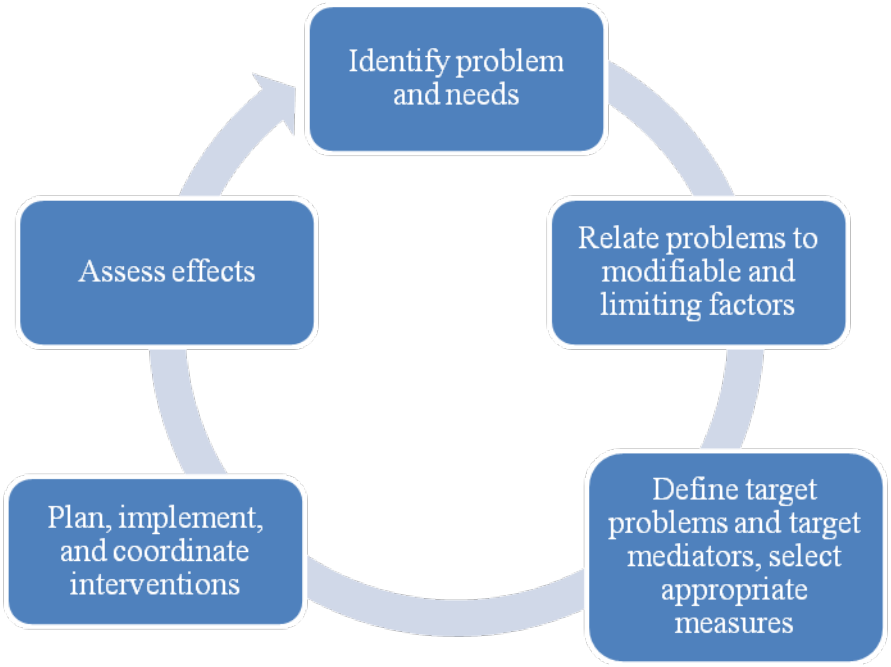
REVIEW OF RELATED LITERETURE

2.1 Definition of Rehabilitation

The WRD (2011) described rehabilitation as "a set of measures that aid individuals who experience, or are likely to experience disability to attain and sustain optimal functioning in interaction with their environments". Rehabilitation is a vital component of universal health coverage along with, prevention, promotion, treatment and palliation.

Rehabilitation involves identification of a person's problems and needs, relating the problems to significant factors of the person and the environment, defining rehabilitation goals, planning and implementing the measures, and assessing the effects. Educating people with disabilities is important for developing knowledge and skills for self-help, management and decision-making. PWDs and their families experience better health and functioning when they are partners in rehabilitation program (Llewellyn, 2010). Rehabilitation is therefore a set of interventions required when a person is experiencing or is likely to experience restrictions in everyday performance due to ageing or a health status, including chronic diseases or any disorders, injuries or traumas.

There is a rising need for rehabilitation worldwide related with changing health and demographic trends of increasing prevalence of non communicable diseases and population ageing. The rehabilitation of PWDs involves the provision of medical, psychological, educational, social and vocational services. In Ethiopia, there are both governmental and nongovernmental services, which attempt to accommodate for the special needs of PWDs. However, among the millions of people facing various degrees of disabilities only few are beneficiaries of the rehabilitation services Tirusew (1993) as cited in Kahsay (2010).



Source: A modified version of the Rehabilitation Cycle from (Steiner, 2002).

2.2 Settings and Components of Rehabilitation Service Intervention

The convenience of rehabilitation services in different settings varies within and across nations and regions. Medical rehabilitation and therapy are typically offered in acute care hospitals for situations with acute onset. Follow-up medical rehabilitation, therapy, and assistive devices could be provided in a wide range of settings, including specialized rehabilitation wards or hospitals; rehabilitation centers; institutions such as residential mental and nursing homes, hospitals, prisons, residential educational institutions, and military residential settings; or single or multi professional practices which can be office or clinic. Longer-term rehabilitation may be offered within community settings and accommodations such as primary health care centers, schools, workplaces, or home-care therapy services (Haig, 2007).

Rehabilitation interventions usually involve multiple disciplines. There are different kinds of professionals who take part in and participate to the rehabilitation process within a team approach. The list is long, and it includes (although is not limited to) such professionals as the following:-Physicians, Occupational Therapists, Physical Therapists, Speech and Language Pathologists**,** Audiologists, Rehabilitation Nurses**,** Social Workers, Case Managers,

Rehabilitation Psychologists**,** Neuropsychologists, Therapeutic Recreation Specialists, Rehabilitation Counselors**,** Orthotics and Prosthetics (Margaret & Nancy, 2013)**.**

2.3 Components in Rehabilitation Service Provision

According to the study of (Banja, 1997), Assessment, objectivity and interventions are the basic components of rehabilitation service provision,

2.3.1 Assessment

Central to the rehabilitation program is the primacy of the assessment. Disability theorists explained that assessments are central to the exercise of professional power, defining problems and framing solutions in ways that suit the professionals' agenda. Therapists treat what they measure. Thus the ideological foundations of the forms of assessments used within rehabilitation establish the basics for subsequent interventions and for result measurements. If therapists stick to an individual medical model of practice and gives attention for assessing specific skills, these will be the targets for intervention, irrespective of their importance or significance to individual clients' lives or environmental circumstances (Gillman 2004).

The nature of the questions in the assessment will verify whether the therapist will distinguish the client's goals and priorities or whether the assessment will be directed along lines stated by the therapist (Reynolds, 2004).

The elements that are included in an assessment and the way in which they are scored typically reflect societal norms (Johnston & Milks 2002). The majority of assessments reveal the assumption that certain ways of performing actions are better than others, independence is 'better 'than interdependence , and that each entry on the assessment is of equal significance to the client. Assessments usually measure whether a client can carry out a specified activity, irrespective of whether they wish to do so, or could do so in their own environment or within a span of time they regard as to be reasonable. Assessments are intended to verify needs, and meanings of needs. Coincidently, to fall directly within refer of whichever profession is undertaking the assessment.

2.3.2 Objectivity

Science is the product of the explanations and perceptions of humans; thus claims to objectivity are not sustainable (Latour 1987).Many scholars acknowledge that all analysis is a form of interpretation, for example, assessments of a patient's quality of life verified a wide variability in scores between different physicians and health professionals Ferrarotti (1981) noted that because people who are being observed or assessed will persistently change their own behavior according to the behavior of the observer, it renders any presumption of objective knowledge.

Dockery (2000 p 98) notes that the "outsider "is no more able to suggest value-free or neutral knowledge than the "insider"; rather, they speak from different positions. unfortunately, 'the dominant experience of PWDs when they place themselves in the hands of professionals is one of "knowledge denial" rather than knowledge enhancement as their ways of knowing and accounting for their experience are devalued as insufficiently "dispassionate" and "objective"' (Dorn1998 p 198).It has been noted that therapists treat what they measure. The nature of the assessment thus dictates the nature of subsequent interventions.

2.3.3 Intervention

The term 'intervention' is favored instead of 'treatment', not solely because 'treatment' implies client passivity but also to reflect a mode of practice that will focus on environmental changes and to modifying individuals' abilities (Hammell, 2004).

The consequences of impairment depend not only upon specific dysfunctions but upon the context in which the impairment is experienced (Oliver, 1988). As Reynolds (2004, p 111) explained: 'medically similar illnesses may have widely different meanings and suggestions for individuals, depending upon their social context, personal priorities and resources'. The experience of living with a stroke for example, will be determined by a range of environmental variables such as income, social support, physical access to the home and community, and social policies and services, personal variables, for example, one's age, role expectations (such as worker, wife, mother), interests and beliefs (like fate or divine will) and the meanings or values that the person attributes to all these factors (Hamm ell 2004a). These personal dimensions will determine the priorities for intervention and cannot be addressed by a generic, as mentioned

above, the prescriptive approach to stroke 'management' for instance. The objective of rehabilitation is not to 'manage the stroke' but better assist someone to manage their life, given the occurrence of a stroke.

2.4 Opportunities and Challenges in Rehabilitation Service Provision

Rehabilitation can reduce the impact of a wide range of health conditions that includes diseases (acute or chronic), disorders, injuries or trauma. It is a highly integrated form of health care that complements other health interventions, such as medical and surgical interventions, helping to realize the best outcome possible. Rehabilitation can also help to minimize or slow down the disabling effects of chronic health conditions, such as cardiovascular disease, cancer and hypertensions by equipping people with self-management strategies and the assistive products they require, or by addressing pain or other complications Rahman, 2009). Rehabilitation that begins early produces better functional results that works for almost all health conditions associated with disability. There are opportunities and challenges while providing rehabilitation service. The lists are written as below,

2.4.1 Opportunities of Rehabilitation Service Provision

Rehabilitation is an investment, with cost benefits for both the individuals and society. It is an important part of universal health coverage and is a key strategy for achieving Sustainable Development. Rehabilitation "Ensures healthy lives and promote well-being for all at all ages". It provides along a continuum of care ranging from hospital care to rehabilitation in the community. It can improve health outcomes, reduce costs by shortening hospital stays, reduce disability, and improve quality of life. Rehabilitation needs are not supposed to be expensive (Stucki, 2005).

The following are the opportunities in rehabilitation service provision;

- ✓ Maintaining quality of life and preventing conditions that endanger it. Furthermore, Rehabilitation enables individuals to participate in education and gainful employment, remain independent at home, and minimize the need for financial or caregiver support.

- ✓ Helps to minimize or slow down the disabling effects of chronic health conditions, such as cardiovascular disease, cancer and hypertensions by equipping people with self-management strategies and the assistive products they need, or by taking care of pain including other complications and also Prevents secondary disabilities and complications that impede rehabilitation, such as contractures, spasticity, atrophy of muscles, pressure sores, epileptic seizures (Soroker, 1989)
- ✓ Helps to early recognition, control and follow-up of medical conditions that contribute to poor functional recovery such as cognitive heart failure, , infections, metabolic disorders and malnourishment (Kalra, 1995)
- ✓ Assists in early detection and treatment of depression which, if continual, unfavorably affects recovery (Mossey, 1990)
- ✓ Plays a great role in enhancement of motivation, cooperativeness and expansion of social support (Eldar, 1995)
- ✓ Helps to avoid costly hospitalization, reduce hospital length of stay, and prevent re-admissions and also within discharge plan it arranges for continuing of care to meet the individual need (Boyce,1996)

2.4.2 Challenges in Rehabilitation Service Provision

Unmet rehabilitation service can delay discharge, restrict participation, limit activities, increase dependency on others for assistance, and decrease quality of life. These negative outcomes can have broad social and financial implications for individuals, families, and communities in general. Despite acknowledged limitations such as the quality of data and cultural variations in perception of disabilities, the need for rehabilitation services can be anticipated in several ways. These include data on the prevalence of disability; disability-specific surveys; and population and administrative data. Prevalence data on health conditions related with disability can provide information to assess rehabilitation needs. Disability rates can be correlated with the increase in non-communicable conditions and global ageing also (Fulda, 2009).

The following are the challenges in rehabilitation service as indicated from the study of Celia & Mary (2007).

- ✓ Adequate medical rehabilitation is woefully lacking in most developing countries, even when available, medical rehabilitation is usually found in the urban centers, inaccessible to many because of financial costs and/or geographical distance.
- ✓ Physicians and other related professionals with rehabilitation training are uncommon.
- ✓ Physical therapists and other professionals have widely variable levels of training and autonomy.
- ✓ Occupational therapists are uncommon, Speech therapists, rehabilitative nurses, and psychosocial personnel are rare and also prosthetic and orthotic personnel availability and level of training varies.

Rehabilitation results are the advantages and changes in the functioning of an individual over time that are attributable to a single measure or set of measures. Habitually rehabilitation outcome measures have focused on the individual's restriction level. More recently, outcomes measurement has been extended to comprise individual activity and participation outcome. Measurements of activity and participation outcomes assess the individual's performance across a range of areas – including communication, self-care, mobility, work, education and employment, including quality of life. Activity and participation outcomes may also be measured for programs. For instance, the number of people who remain in or return to their home or community, independent living rates, return-to-work rates, and hours spent in leisure and recreational pursuits. Rehabilitation outcomes may also be measured through changes in resource use -for example, minimizing the hours required each week for support and assistance services (Turner-Stokes, 2005).

CHAPTER THREE

RESEARCH METHODS

3.1 Research Design

Qualitative research design is used to explore the practice, opportunities and challenges of Menagesha Rehabilitation Centre. The rationale behind the selection of qualitative research design is the nature of the research problem. According to Creswell (2008), qualitative research design is a means for exploring and understanding the meaning individuals and groups ascribe to the social or human problem. When detail description is needed to define and analyze human experience, qualitative research would be the right choice for the study (Marvast, 2004).

For this specific research, the researcher took up case study strategy of inquiry. A qualitative case study is an approach to research that facilitates exploration of the phenomenon within its context using variety of data sources (Baxter & Jack, 2008).

The rationales behind the researcher used the case study approach is that; case study helps to uncover the realities of contemporary complex social phenomena while retaining the holistic and meaningful characterizes of real life events. That is case studies are appropriate if and when the research is concerned with uncovering contextual factors in phenomena and when boundaries are not clearly between the phenomena and the context (Yin, 2003).

The concern of this research fits in this description in that it is difficult to look for the case of challenges and prospects of the center without considering the context of the center in which these prospects and challenges were created. Without considering the contexts such as the organization of the staff, building of the center, the political situation, the nature and back ground of family and individuals of beneficiaries in the center; it is difficult to understand the phenomena of challenges and prospects of the center. This reality makes qualitative case study strategy of enquiry best approach for this research.

The selection of specific type of case study is guided by the overall purpose of the study. Based on the purpose of the study, the type of case study that used is explanatory case study, this is because, exploratory case studies used to explore situations in which the intervention being evaluated has no clear, single set of out-comes (Yin, 2003). Since the study is done in a unique context of the Menagesha rehabilitation center, and data were collected from different units in the center (family members, rehabilitated members and staffs); the case become single case with embedded units

3.2 The Study Area

Cheshire Services is an independent non-profit making organization which provides orthopedic and social rehabilitation services for children and young people with disabilities in Ethiopia. It is located in Oromia region about 25 Km away from Addis Ababa. The charity was founded in 1962 by British war hero Lord Geoffrey Leonard Cheshire, by invitation from Emperor Haile Selassie's grandchildren, with the intention of rehabilitating children with disabilities. It was first established for Mentally Retarded children. And the place was suggested by Emperor Haile Selassie just by thinking that it was comfortable to disabled children. Over the years Cheshire Services has become affiliated with many international charities and continues to expand its operations treating a wider range of disabilities across the whole of Ethiopia.

The Menagesha Rehabilitation Centre continues to be the flagship of Cheshire Services Ethiopia. It is the largest rehabilitation centre and is continually adapting to changing needs. Professionals provide quality orthopedic and social rehabilitation to up to 63 residential children and an increasing number of outpatients.

3.3 Study Population

In time of the study, there were out patients and in patients who receive the rehabilitation service. Out patients who receive the rehabilitation service were total 135, male (80) and Female (55). But the target populations for the study are the inpatients who receive the rehabilitation service were fifty five (55) in number, Male (35) Female (20), and the workers in the center were thirty nine (39) Male (20) Female (19).

3.4. Sampling Technique and Study Participants

To achieve the objectives of the research participants were selected in collaboration with MRC from staff and rehabilitated members. The selection of rehabilitated members of the centers was specially recommended by both the medical and social department concerning the ability to express well and one month of duration minimum in the center. Hence, eleven (11) rehabilitated members (five female and six males) were selected for interview. Also, eight staff members (8) from each department were selected through purposive sampling techniques by considering their work experience in the center (three female and five male). Which are two Counselor, one senior physiotherapist, two physiotherapy aid, one orthopedic technologist, one hand craft professional and the manager were included. In addition, two consecutive FGD were conducted with rehabilitated clients of the center. The first FGD was done with six (6) rehabilitated clients of the center and the second FGD was with eight (7) rehabilitated members. In general, all participants involved in the study were thirty two (32) in number.

3.5 Data Collection Instruments

To conduct the research, data were collected from both primary and secondary sources trough in-depth interview, observation, FGD and document review. This is because qualitative case study is an approach to research that facilitates exploration of the phenomenon within its context using verity of sources (Baxter & Jack, 2008). In order to gather the primary information, interview, Focus Group Desiccation (FGD) and direct observations were used within the centre. Whereas to collect secondary information document review was used.

3.5.1. Interview

The researcher conducted face to face interviews with the selected beneficiaries of the rehabilitation service the interview guide was prepared by the researcher based on the general research question and the specific objectives. The interviews involve unstructured and generally open ended questions. The responses from the interviews were recorded in a tape recorder. The interview lasted from fifty minute to one hour. The recorded responses will be transcribed to written notes in Amharic and then will be translated into English for analysis.

3.5.2. Focus Group Discussion

According to Hancock, Ockleford, and Windridge, (2009) the recommended size of a focus group is 6 – 10 people, having fewer than this could limit the potential interaction, and having more than this could make it difficult for everyone to join in the discussion. Accordingly, two consecutive FGDs were conducted with rehabilitated members of the centre in order to make possible comparison of data from both discussions; six (6) and seven (7) members were included in each focus group discussion. Like that of interview questions, open ended questions were prepared as a discussion guideline.

3.5.3 Observation

Observation was done after getting consent from the organization. Observation of the services which has been delivered by the rehab centre to beneficiaries (food, shelter, play grounds, recreational centers and outreach services) was guided by the observation checklist. During the period of direct observation notes were taken on the points in the observation. While in the process of observation, care givers of the patients were not informed about the observation in order to avoid deliberate actions and to be free from biases. According to Krueger and Newman (2006), if those being observed know the true purpose, they would modify their behavior which will make it impossible to learn from the situation.

3.5.4. Document review

Reviews of secondary sources were useful before conducting the field of study. As a result attempt was made to review some materials related to the rehab center functions such as broachers, publications, books, reports, journals, manuals and guidelines. This helped to have some background on the issue understudy and to strength the primary sources.

3.6 Data Collection Procedure

Before engaging in data collection activity, I made sure that necessary pre-conditions were met. Agreement from the center was gained before interview and focus group discussion, and observation were started. Letter of request from Addis Ababa University was sent to MRC and given to delegated manager of the center and after discussion with concerning body the center

permitted me to collect the necessary data that I want. The center also provided me with one safe room to interview and discuss with participants.

The first data collection task was observation. First of all I carried out an extensive observation about the situation of the center, beneficiaries, caregivers and the staff members to have an overall picture of the status of the rehabilitation program based on the observation checklist. The observation was not one time task due to this I took notes based on what I have observed each day throughout the whole process of data collection and analysis.

Secondly, just after the initial observation, I started to collect data through document review, interview and FGDs. I got through review of different reports and broachers of the center provided me with an overview of the center, its intentions and the contextual factors in play. After completion of in-depth interview and FGD with participants the final stage was closure, after the end of data collection and analysis, meeting was made after end of data collection with the delegated manager of the centre.

3.7. Methods of Data Analysis

The data generated in this study will be analyzed using qualitative analysis techniques. According to Marriem (1998) qualitative data analysis is a complex process that involves moving back and forth between concrete bits of data and abstract concepts, between inductive and deductive reasoning and between description and interpretation.

Since the objective of the study is to explore the prospects and challenges of MRC, thematic analysis which according to Cough and Medill (2007) as cited in Temesgen (2010), focuses on the coding of qualitative data, producing cluster of texts with similar meaning often searching for the central theme and capturing the essence of the phenomenon under investigation was used. The collected data transcribed verbatim from in-depth interview, FGD and key informant interview. After the transcription, coding and thematic development procedure was followed which was the most commonly used method of analytic procedure in qualitative research (Croswell, 2007). Therefore in order to develop code labels, I read each transcribed data

repeatedly and listing the record session to construct meaning and synthesis and condensed them to themes. This enabled me to search for meanings that can serve as a ground for broader conceptualization. In line with this memo writing was made since it enabled to document thoughts and ideas of the researcher (Yin, 2003). As texts are fractured into meaning units, transcripts will be replaced by the resulting code as a focus of analysis. This was done in relation with and referring to the research question and literature review since it helped for reframing and re contextualizing (Creswell 2007).

Analysis of data that was collected through document also followed the same procedure. The researcher defined codes and began to develop his own themes to put the data into categories to help her analyze and sort and the data. So in order to analyze critically and interpret the findings, case analysis was applied in line with the findings from the direct observation, documents and interviews.

3.8. Ethical Consideration

The analysis as well as disclosure of material facts conducted in an ethical and strictly supervised procedure. Strong ethical considerations will be attended in the study; clients will be requested for their permission on the interview and the use of information confirmed as to only the study purpose. Formal letter will be received from the AAU, department of special needs education will be submitted to the rehabilitation centre to grant ethical clearance.

CHAPTR FOUR

FINDINGS AND DISSCUSSION

4.1 Introduction

In this chapter, data obtained from the beneficiaries receiving the rehabilitation service and workers in each department and the manager through in-depth interviews, focus group discussions, documents analysis and observations presented and analyzed. This study intends to explore the components and steps of the rehabilitation program, to investigate the opportunities that assist the rehabilitation program to be provided effectively. And to assess the challenges that hinder the rehabilitation program from better rehabilitation service provision. The data generated from the participants using the tools indicated above have been organized into meaningful and manageable units and patterns.

4.2. Demographic Characteristics of the Participants

The socio-demographic characteristics of the participants of the research; from rehabilitation service beneficiaries (In depth interview and FGDs) are number of males fourteen (14) and female are ten (10). Since the sampling strategy employed by the researcher is purposive, no effort was done to make equal representation of both sexes except the care taken to achieve the purpose of the study.

Concerning the educational status of the respondents, majority of the participants twelve (12) of them are on primary education level, while two (2) of them reported to be illiterate. Those who attended secondary education are eight (8) and above secondary educational level are two (2).

As of the length of stay on the center, six (6) of the participants stay six month and above. Fourteen (14) of the participants has a duration of three to six month and four (4) of the participant stay below three to one month.

Beside the participants of in patients, eight (8) workers were included. Two (2) Counselors, one (1) senior physiotherapist, two (2) physiotherapy aids, one (1) orthopedic technologist, one (1) hand craft professional and the manager.

Sex	Age	Qualification	Work experience in the centre	Current position
Male	37	Masters in rehabilitation	12 years	Manager
Male	28	B.SC in Physiotherapy	4 years	Senior Physiotherapist
Female	40	Grade 6	4 years	Hand craft professional
Male	35	B.A in Economics	9 years	Data encoder and documentation officer
Female	22	B.A in Sociology	3 months	Social worker
Male	30	B.A in sociology	6 months	Senior social worker
Female	20	12 complete	2 months	Physiotherapy aid
Male	38	Diploma in orthopedic technology	6 years	Orthopedic technologist

Table1. Socio-Demographic Characteristics of Participant

4.3. Range of services provided by Menagesha Rehabilitation center (MRC)

In this section data obtained through document analysis (Cheshire service Ethiopia, 2018) is presented. The practice of the rehabilitation program, the components and steps of the rehabilitation service is discussed below.

Since its establishment in 1962, MRC has been providing different services for admitted member of the center, out patients, for family members and community as well. The rehabilitation services are generally delivered under the umbrella of two broad programs. The first broad program is the in-patient rehabilitation program and the second one is outpatient rehabilitation program. There is also referral and outpatient rehabilitation service given by the center. Many of the people that visit the center are victims of club foot and amputee. The center supplies a comprehensive range of treatments including walking aids, artificial limbs, physiotherapy, counseling and social rehabilitation as well as education facilities and recreational activities.

- **In Patient Rehabilitation program**

Under the in-patient rehabilitation program services like shelter, food, clothing, dormitory, recreational, medication and counseling services are provided to admit individuals of the center with physical disability. In addition to this, the institution also implement different environmentally contextualized services like demonstrative farming and Animal-assisted therapy (AAT), particularly, Donkey-assisted therapy (DAT). According to the interview with the manager, Donkey assisted therapy (DAT) is aimed to use the benefits of positive animal-child interactions and relationships. The purpose of Donkey-assisted therapy is to improve a child's social, emotional, physical and cognitive functioning. The Donkey-assistive therapy relies on the physical and emotional qualities offered by the nature of donkeys. Donkeys can develop strong social and emotional bonds with children; and they are readily trainable, manageable, accessible and affordable. The assumption in the Donkey assisted therapy is that the children with physical disabilities ride donkeys and get a therapy through riding. Riding will give the children therapy and enhance their mobility. Furthermore, the Donkey-assisted therapy is fun and child-friendly.

Children are also taken to the farm and encouraged to work on farming. According to the social workers, the demonstrative farming is aimed to improve the children's mobility through participating in locally known economic activities. The children are familiar with these activities and do not need training. The social workers argued that demonstrative farming helps the children improve their mobility and learn the skills of local economic activities at the same time.

- **Outpatient Rehabilitation program**

MRC Services Outpatients department offers orthopedic treatment to young people and adults as well as a counseling service to help patients overcome social and physical barriers they may face due to their disal,.bility. Customized prosthetic limbs, walking aids and wheelchairs are prescribed to patients on an individual basis. This makes a lasting difference on an individual's life.

- **Outreach Rehabilitation Program**

Due to the size and nature of the Ethiopian landscape it may not be possible for people with disabilities to reach one of the regional centers. The outreach program travels directly to the heart of more than 20 rural and distant communities to provide orthopedic treatment and diagnosis benefiting approximately 4000 children. The program has two main aims:

- ❖ Assessment - New cases can be assessed and rehabilitation materials can be issued on the spot. This is also how many children gain access to the residential facilities at Menagesha.

- ❖ Ongoing Rehabilitation - When children have undergone residential rehabilitation it is vital that they do not regress into their former state of immobility. The Outreach Team visits these children in their own regions every six months to monitor their level of care and to ensure that they are receiving an appropriate level of education.

- **Community based rehabilitation Program**

The Community Based Rehabilitation Program brings persons with disability together, parents and rehabilitation workers to improve the lives of children with developmental, physical and sensory disorders. Skills for essential daily activities such as proper positioning, feeding, bathing and dressing are provided. Other services include mobility and orientations for the

visually impaired, sign language for hearing impaired and simple exercise therapy are provided.

- **Regional center Rehabilitation Program**

Cheshire Services has many regional outreach centers that deal with the needs of people with disability near to their home. Currently centers are located in Hawassa, Dire Dawa and Harar which are constantly expanding to meet the needs of the people in their respective areas.
If it is not possible to treat a disability at a regional centre the patient is often admitted to the rehabilitation center in Menagesha.

4.4 Steps of the Rehabilitation Program

For all clients coming to Cheshire Menagesha Rehabilitation Center the following steps are followed (Cheshire service Ethiopia, 2018).

1. Referral , registration and Appointment (Self or other organization, or health posts including hospitals)
2. Assessment or Examination by Multidisciplinary team (Physiotherapist, Ortho-prosthesis, Social workers, and the client)
3. Based on assessment finding prescription will be made by the same team above(on) what services should be provided,
4. Then, for Prosthesis, Orthotic, orthopedic Shoe and wheelchairs follows next step:
    - Measurement
    - Production
    - Product preparation
    - Fitting
    - User training and handing over of product
    - Discharge
    - Follow ups

During this services procedure if clients come across any problems like physical and or psychological problem they will get:

- Counseling services for psychological challenges

- Physiotherapy services for pain management and fitness and ADL (activity daily life.

4.5 Components of the Rehabilitation Program

For Inpatients who are getting residential care services: Basically the rehabilitation service is classified in to two: - physiotherapy and social work (Cheshire service Ethiopia, 2018).

- **Physiotherapy**

Physiotherapy:

1. Assessment and treatment plan which includes:
    - General body strengthening exercise
    - Conservative Manipulation (Plaster correction
    - Different physiotherapy treatment as per physiotherapist recommendation
        - ✓ Massage and Mobilization
        - ✓ Electrotherapy
        - ✓ Hot pack
        - ✓ Hydrotherapy
        - ✓ Fitness training
    - Surgical intervention
    - Provision assistive devices
    - Gait training
    - Handing over devices
    - Discharge and follow ups plan

There were three physiotherapists, one assistant physiotherapist and four physiotherapist aids at the time of research.

- **Social work**

Baseline assessment which includes:

- Psychological status and behavior of children
- Educational status or Literacy

- Self esteem, decision making and empathy status
- ADL (Activity Daily Life) Management capacity

Intervention plan

- Counseling
- Informal Education Session
- Handcraft skills training session
- Demonstrative Farm training session
- Animal Assisted therapy (Donkey Facilitated Learning)Session)
- Computer skills training session

Discharge and follow up plan,

4.6. Opportunities of the Rehabilitation Program

Opportunities were picked up from interview, focus group discussion and observation of data collection process through analyzing and giving meaning to the entire information gathered. Finally the following themes are identified as the opportunities that can be utilized to maximize effectiveness and efficiency in service delivery of the center.

4.6.1 Giving Surgical and Medical Treatments for Free

Respondents through the interview and focus group discussion express their high satisfaction regarding the free surgical and medical treatment they receive. Stucki (2005) stated that Rehabilitation needs are not supposed to be expensive. Rehabilitation provides along a continuum of care ranging from hospital care to rehabilitation in the community. It can improve health outcomes, reduce costs by shortening hospital stays, reduce disability, and improve quality of life. Inpatients receive medical and surgical treatments for free including shelter, food, basic educational and recreational services. Medical treatments are given in the center by the physiotherapists, orthopedic technologies, and social worker. On the other hand, the surgical treatment is usually done in collaboration with Balcha governmental hospital and Cure international pediatric hospital.

Here is what one of the beneficiaries (eighteen years old who stayed in the center for five months) informed in the interview,

> *I used to think that I will not get treatments because my families are poor and we live in country side. I used to be lonely because nobody wants to be a friend with me due to my club foot. Everyone calls me ''shefafa''. I used to cry and couldn't concentrate on my education. But now, I am very happy I received the surgical and medical treatments for free and can't wait until I go back to my country show my leg to families, friends and all villagers. All the children I met here share my feelings. We all are very happy with the services we got without any payment.*

4.6.2 Giving Basic Education and Computer Skill Classes for Free

Respondents state their high fulfillment regarding the basic education they receive and the fundamental computer education they gain. The treatments usually last to six months. The children left their home and school to receive the treatments. So the basic education and computer skills they get able them to learn new skills and knowledge, learn from each other and make their mind stay active. Nine from eleven beneficiaries interviewed mentioned this as opportunity and one of the respondents (who stayed in the center for six months) noted that:

> *Since I came from country side the probability of having computer skills is very low. Here, I am learning the basic skills of computer and I am also getting knowledge from the books provided to us.*

In addition to that, one of the respondents in focus group discussion said that "I couldn't go to school since the school founds far from my home and was hard for me to walk the distance due to my disability. But here, I learned how to read and write English and I learned how to open and paint using computer."

4.6.3 Job Satisfaction of the Workers

Workers claimed that they are happy regarding the free surgical and medical treatment the inpatients are receiving. From eight workers interviewed seven of them stated that witnessing the changes of the care receivers after the treatments, looking at the excitement of the inpatients and

families makes them feel accomplished and give them job satisfaction. The orthopedic technologist with six years of experience in the center explained,

> *I am always very happy witnessing the change in the patients. For instance, One of our inpatient who came from Gonder used to have a sever club foot. I thought it will not be corrected but we decided to give it a try. He received the surgical treatment and long time taken medical admission in one of the hospitals we collaboratively work with. The result turned out to be amazing. Now, he doesn't look as if he used to have club foot. There are different astonishing stories like this. Looking the patients smiles and the happiness of their families give us the workers a sense of job satisfaction.*

4.6.4 Enabling the Workers to Add up Knowledge and Skills of Rehabilitation

As it's clearly noted in the literatures, the availability of rehabilitation centers in Ethiopia is irrespective to the need. The professionals, working in this few centers have the chance to add up their knowledge and skills. As the study shows by Wegayehu (2004), few rehabilitation services that exist in Ethiopia are located in Addis Ababa, Mekele, Awassa, Arbaminch, Dire-Dawa, and Jima. Tigabu (2008) also disclosed that, in Ethiopia, Adequate rehabilitation service is woefully lacking in most developing countries. When available, rehabilitation is usually found in the urban centers, inaccessible to many because of financial costs and/or geographical distance. Rehabilitation service coverage is very minimal irrespective of the need in the country. From eight workers six of them claimed that their knowledge and skill regarding rehabilitation is growing and moreover a respondent (senior physiotherapist who worked in the center four years) said that "The services provided the trainings we took, the organizations we collaboratively work with and all the exposures regarding the area of rehabilitation enables me to add my knowledge and skill. In addition to that, all the experiences give me confidence and I am willing to share my knowledge and skill*."*

4.6.5 Cleanliness of the Center

The center is very beautiful to sight. Wide, green and clean. The researcher was able to visit the places where services are given, the offices, kitchen, the dorms, shower rooms, toilets and the compound during observation.

The manager added:

> *''It is Cheshire's culture that everyone cleans his/her space in the office and also the inpatients are supposed to clean over their dorm with the help of the cleaners to develop a sense of responsibility and neatness.''*

4.6.6 Good Interaction

I was able to notice the good interaction among staffs to patients, staffs to staffs and patients to patients. Patel (2002) found that, Positive communication is the key to a successful rehabilitation program. Communication between health professionals, team members, and rehabilitated person should be smooth. One of the inpatient in the focus group discussion described:

> *Since we stay for months together, we develop a sense of family thoughts towards each other and also with the workers in each department. We see each other as brother and sisters. Even if any problem happened between us we will inform to our monitor. Monitors are selected from us and by us. We have four monitors in general. We have two male and two female monitors. These monitors lead and assist us in collaboration with the social workers.*

A staff in the interview also said that staffs think the children beyond patients. Through passing most of our times together, we have a special feeling for the inpatients and the same goes with the staffs to staff relationship. As we all are here with one purpose of helping the patients, we strive towards achieving that. And, we believe good interaction has its huge impact in the process.

4.6.7 New Buildings and Extension Plan

Menagesha rehabilitation center is able to be residential home for children with noma (a gangrenous disease leading to tissue destruction on the face, especially on the mouth and checks) by jointly working with an organization called ''facing Africa''.There is also a construction of orthopedic surgical Hospital with a plan to perform the surgical and medical treatments in the center to substitute the services given at Balcha and Cure Hospital.MRC is working collaboratively with St Paulo's Hospital of burn and trauma center. The manger said that "There is a plan of extension of the rehabilitation services. MRC is working with "Facing Africa" and St. Paul Millennium medical college. There is a plan to work with responsible others with the same vision.''

4.7. Challenges of the Rehabilitation Program

Like that of the opportunities, Challenges were picked up from the entire data collection process through analyzing and giving meaning to the entire information gathered. Finally the following themes are identified as the challenges that can be utilized to maximize effectiveness and efficiency in service delivery of the center.

4.7.1 Insufficient Human and Material Resources

In MRC, the lists of professionals are inadequate irrespective of the need. The same also goes in shortage of materials resource. As it's clearly shown in the study Margaret & Nancy (2013) there are a variety of professionals who participate in and contribute to the rehabilitation process within a team approach. Yet, Eight from eleven interviewed beneficiaries complains about the insufficient resources which is highly seen in computer room and hand craft mainly. One beneficiary (who stayed in the center for two months) responded,

> *''There are only two computers which works and every one of us want to use it. It took long time to reach to my turn to use the computer. Besides that, when I have a question to ask the teachers most of the time I found them busy with others I wish if there were teachers to teach us well and enough computers to use. ''*

The same goes in hand craft lesson, as stated by one of the respondent in focus group discussion,

> *''I love doing hand crafts they are attractive to my sight. I used to do it at home with my mother after she showed me how to make it. Since I don't go out much due to my disability, I do hand crafts at home. Here, I learned new techniques and am eager to learn more but due to the scarcity of the resources, I couldn't do as of my wish.''*

As that of the inpatients, the workers also responded that there is lack of human and material resources. In each department this problem is visible. At the time of the research work, there are only two social workers for the 52 children. These two professionals have responsibility to counsel and give education. Both the social workers responded that they couldn't attain the expected result due to the load of the work and lack of human resources in their department. The same problem also goes in physiotherapy and orthopedic workshop, in both departments the

insufficient human and material resources holds them back from reaching their goal. Parallel to that, there is high workers turn over. The reason to that according to the respondents is low salary and benefit irrespective of the work load they have. This is mainly seen in physiotherapy department. The head Physiotherapist explained,

> *''There is a high staff turnover in our department. Student Physiotherapists took only one course regarding rehabilitation. Since the skills are new to the physiotherapists, it took me more than two months to teach the new physiotherapists. The timely turn over holds me back from doing my job and focus on teaching new comers.''*

Lack of material resources is also a problem seen is all departments. All the workers agreed that they could have done and reached lots of people if materials were available. This is mainly a problem in orthopedic work shop. Prosthetic limbs, walking aids and customized shoes are made on site not only for the inpatients for the out patients also. So there is a high demand of products in the department, so do human resources.

4.7.2 High Work Load and Lack of Commitment

As a result of human resource insufficiency, there is high work load on the workers. This leads to unmet rehabilitation service needs. As its stated in Fulda (2009).unmet rehabilitation needs can delay discharge, limit activities, restrict participation, cause deterioration in health, increase dependency on others for assistance, and decrease quality of life. These negative outcomes can have broad social and financial implications for individuals, families, and communities. The manager claimed the problem and explained that there is a budget scarcity to add number of professionals. Most of the donors are international supporters which they can't rely on their continuity to support the center. There could be a chance of them to say "we don't have money to give this year" and also the government's policy regarding 80 % for the program and 20 % for admin has challenged them to hire professionals and to answer the question of material scarcity.

As indicated above, both the inpatients and workers stated that there is both material and human resource scarcity. In addition to that, lack of commitment and high staff turnover is seen. This is especially noticed in physiotherapy department.

A senior physiotherapist who worked in the center for four years responded in interview,

> *As a physiotherapist myself, I believe that my hands are gold. This days, physiotherapist give services in consumers home and get four hundred birr in hour minimum due to that we couldn't get a professionals who are committed to stay in the center since the salary is low comparing to working in home care services. This is a huge challenge we are facing now days even though we are adding salary and benefits we couldn't meet to the physiotherapist's expectations. This creates in satisfaction and lack of commitment. This is not a problem only in physiotherapy department but also the question of all departments. We all have a question of salary and benefit increase.*

4.7.3 Unmet Need of Individual Counseling

The center being residential, the children found far from families and loved ones, the social workers has responsibility to closely follow these children and intervene as of their need.A successful rehabilitation program depends not only on physiological factors but also on the emotional and psychosocial attitudes of the beneficiary (Feltz, 2002). These factors have a significant influence on compliance, performance, and the expectations of both the beneficiary and the health professional. Four from eleven respondents in the interview mentioned this problem that they receive group counseling but rarely get individual counseling. Respondent (who stayed in the center for two and half month) in interview explained,

> *''I miss my parents, siblings, friends and homeland. I stay in the center for the past five months far from my loved ones. This is the first time in my life I stay away from my families for this long. Though, I met friends who are like family here. I usually cry alone. Want to go home and see my families so badly. I wish if I receive individual counseling so that I will get advice to manage my feelings but nobody seems to notice it. Because, there are a lot of us and the social workers seems busy with other duties. ''*

4.7.4 Little Attention given to the Follow up Program

There is a visible gap in the follow up process in MRC.As it's clearly noted in the literature review, Turner-Stokes (2005) stated that, follow up is basics in the rehabilitation process. Rehabilitation outcomes are the benefits and changes in the functioning of an individual over

time that are attributable to a single measure or set of measures. Traditionally, rehabilitation outcome measures have focused on the individual's impairment level. More recently, outcomes measurement has been extended to include individual activity and participation outcome. Measurements of activity and participation outcomes assess the individual's performance across a range of areas – including communication, mobility, self-care, education, work and employment, and quality of life. Activity and participation outcomes may also be measured for programs. Four from eight interviewed workers mentioned this as a challenge. As the social worker explained that they do have follow up and outreach visit twice a year in the program. But, claimed that they are meeting the needs as expected. This is mainly due to the human resource shortage. There are many service seekers; irrelevant to the number of the staffs. In order to solve the problem regarding follow up, they are trying to work with other organizations which are found in the surrounding of the inpatients after discharge. This organization helps them in carrying out the follow up process. For instance, responsible professionals write discharge summery and notes when patients are discharged then health center around the home town of the patients will follow and carry out this orders and they will track them in that manner.

4.7.5 Low Family Involvement in the Rehabilitation Process

From eleven inpatients interviewed ten of them came to receive the treatment from remote areas which makes it hard for the families to have a regular visit and participate in the rehabilitation process. Consumers/patients, families, and professionals work together as a team to identify realistic goals and develop strategies to achieve the highest possible functional outcome, in some cases in the face of a permanent disability, impairment, or pathologic process. (ACPF, 2011).yet, the manager explained that, families play important role in rehabilitation programs. Furthermore elaborates that they are trying to involve the families as much as possible and began inviting care givers recently so that they play their role in the process. Parallel to that, care givers took training about disability causes, type, prevention and management, which lasts from ten to fifteen day. After the completion of the training they will be assigned to train minimum of ten people which are found in their village and be called Ambassadors of MRC. This is done only once so far and there is a plan to continue doing this kind of activities regularly.

4.7.6 Unavailability of Special Need Education Professional

As the center is trying to do its best though the challenges stated above, the role of special need professionals seems to be forgotten. Rehabilitation team compromises special need professional. Yet, there is no special need professional in the center and the manager replied that they believe in the role of a special need professional for a successful rehabilitation program. Especially, special need professionals are highly needed in the education department but in the time of research counselors were the ones playing the e role of special need professionals. Yet there is a short term plan to hire qualified professional.

4.7.7 Lack of Attention given Regarding Prevention and Early Intervention of Disability

Even though the center is mainly working on rehabilitation, it's very important to consider working on the prevention of disability as well. As stated in the study of Roberts (2008) the effectiveness of early intervention is particularly marked for children with, or at risk of, disability, and has been proven to increase educational and developmental gains. The manager answered that they are trying to do their part on prevention aspect though it's not enough. This is mainly done in the outreach program which is holding twice a year. In the outreach program, education about prevention of disabilities and also early diagnosis of disabilities are given. In addition to that they started to train mothers (care givers) of the inpatients by inviting them to stay in the center for a training which lasts for ten days while covering their necessary accommodation. Then, these mothers (care givers) are obligated to train other minimum twenty people on their surroundings.

4.7.8 Little Attention given for the Promotion of the Center

As Menagesha is a center that has been serving for the past more than 50 years, it doesn't get enough acknowledgment from government, nongovernmental and other responsible bodies. Five of the eight interviewed workers explained that little is done in promoting the centers vision and missions. The manager mentioned that there are a lot of people who doesn't know anything about MRC when the center is a pioneer when it comes to rehabilitation service provision. To react to this problem, there is a plan to have a promotion team that works mainly in promoting the center. In addition to that, in the year 2019 EC they started organizing road run that promotes

MRC. There were more than 300 people participated in the run and there is a plan to make the road run annually.

4.7.9 Lack of Attention in Collaborative working with Responsible Bodies

As clearly described in the study of Wegayehu (2004) few rehabilitation services exists in Ethiopia and also Tigabu (2008) disclosed that, in Ethiopia, rehabilitation services provision institutions could address only to 1 % of the total rehabilitation needs of persons with disabilities. Adequate rehabilitation service is woefully lacking in most developing countries. When available, rehabilitation is usually found in the urban centers, inaccessible to many because of financial costs and/or geographical distance. In order to solve the problem responsible bodies should jointly work together. The manager explained that they are trying to work with governmental and nongovernmental organizations but there is a lot way to go. On the time of study, MRC were working with organization called “facing Africa” by being a residential center for inpatients with noma (a form of gangrene affecting the face, usually caused by a bacterial infection) and St Paul millennium medical college with a plan to own orthopedic surgical hospital in the compound of MRC. Furthermore, there is a plan to make MRC a study center of rehabilitation programs.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

5.1. Conclusion

MRC, since its establishments as a formal rehabilitation center in the country, it has been performing inpatient, outpatient and outreach services for people with physical disability. In the inpatient activities the services provided are generally divided in to two namely Physiotherapy and social work. In physiotherapy, services such as general body strengthening exercises, conservative manipulation and different physiotherapy treatment as per physiotherapist's recommendation are given. And under social work, services like counseling, informal educational session, hand craft skill training, demonstrative farm training and computer skill training session are given. These services are given with full accommodation shelter, food and recreation. On the other hand outpatient services compromises, orthopedic treatment and counseling. In the outreach, services like assessment of new cases and ongoing rehabilitation for the children who received the services before will be monitored for their progress.

This qualitative investigation aimed at exploring the practice of MRC'S rehabilitation program in general and specifically to identify the opportunities and challenges of the center. It is done by document analysis; observation, focus group discussion and interviewing with eleven (11) beneficiaries who were selected purposefully with the help of staff members and eight (8) staffs from different department including the manager were also part of the study. In addition, two consecutive FGD were conducted with rehabilitated clients of the center. The first FGD was done with six (6) rehabilitated clients of the center and the second FGD was with eight (7) rehabilitated members. In general, all participants involved in the study were thirty two (32) in number.

The study has three focus areas. These are, exploring components and steps of the rehabilitation program, investigating the opportunities that assist the rehabilitation program to be delivered effectively and to assess the challenges that hinder the rehabilitation program from better rehabilitation service provision.

The first focus area of the center was steps and components of the rehabilitation program. The steps include registration and appointment, assessment or examination by multidisciplinary team (physiotherapist, ortho-prosthesis and social workers). Then based on the findings decision will be made by the team and services need to be provided for the client will be differentiated. Components of the service are basically divided in to two. Physiotherapy and social work as described above.

The second focus area was investigating the opportunities that assist the rehabilitation program to be delivered effectively. Thus, Opportunities were identified as providing surgical and medical treatments for free, Giving basic educational and computer skills, Job satisfaction and adding up knowledge of rehabilitation for the workers, cleanliness of the center, good interaction with patient to professionals, patients with patients and professionals with professionals. New buildings and extension plan to broaden the service.

The third focus area was to assess the challenges that hinder the rehabilitation program from better rehabilitation service provision. Therefore, Challenges were identified as insufficient human and material resources, high work load and lack of commitment of the workers, no special need professional involvement in the rehabilitation process, unmet need of individual counseling, little attention given to follow up, low family involvement and little attention given for the promotion of the center, lack of attention given regarding prevention of disability and in collaboratively working with other responsible bodies.

5.2. Recommendation

Based on the findings of the research and documents reviewed on the issues, implication of the findings for special need professional intervention, policy implications and implications for MRC were identified.

- ✓ **Recommendation for special need professionals:** There are many areas in which special need professionals can intervene based on the findings of the research. Special need professional can intervene in searching, identifying and connecting clients with the rehabilitation centers and should highly participate in the rehabilitation process. The professionals should play their role in a way to participate families of the beneficiaries and also should point a way to collaboratively work with responsible bodies in the area.

Special need professionals should participate in promoting public campaign to fight stigma and discrimination against people with disability and their families. This is because the participation of the community in designing and implementation of health care services is both cost effective and best means in fighting stigma and discrimination. Stigma can't stop by intervening on only clients and their families. Therefore, special need professionals can play the role of community outreach worker in the center in order to minimize the stigma and discrimination on patients.

- ✓ **Recommendation for special needs education department: -** Little has been done in understanding the current situation of rehabilitation centers in Ethiopia. Therefore, special needs professionals have to involve in research and inquiry that help to understand the current situation of rehabilitation practice in the country. Strategies of diversifying and utilizing the opportunities of such center and minimizing the challenges have to be integrated to the teaching process of special need courses.

- ✓ **Recommendation for MRC: -** As being pioneer in the country, MRC should work collaboratively with responsible bodies. That way, more people with disability could be addressed and expected rehabilitation practice can be delivered. The centre can also be training centre for rehabilitation so that it will answer the demand of professionals in the area.

- ✓ **Recommendation for policy makers: -**policymakers should play a great role by collaboratively working with special needs education and rehabilitation service professionals in paving a way regarding policies for optimal rehabilitation service practice.

REFERENCE

ACPF (2011).Children with disabilities in Ethiopia: The hidden reality Addis Ababa: The African Child Policy Forum.

Banja JD 1997 Values and outcomes: the ethical implications of multiple meanings. Topics In Stroke Rehabilitation 4(2):59–70

Bigelow J et al.A picture of amputees and the prosthetic situation in Haiti.*Disability and Rehabilitation*, 2004,26:246-252.doi:10.1080/09638280310001644915 PMID: 15164958

Carpenter C 200 The contribution of qualitative research to evidence-based practice. In: Hammell KW, Carpenter C (eds) Qualitative research in evidence-based rehabilitation. Churchill Livingstone, Edinburgh, p 1–13

Convention on the Rights of Persons with Disabilities. Geneva, United Nations: 2006 (http://www2.ohchr.org/english/law/ disabilities-convention.

Davidson I, Waters K 2000 Physiotherapists working with stroke patients: a national survey. Physiotherapy 86(2):69–80

Department of Health Western Cape 2003 Healthcare 2010: Health Western Cape's plan

For ensuring equal access to quality health care. Department of Health, Western Cape: Cape Town.

Durkin M. The epidemiology of developmental disabilities in low-income countries.*Mental Retardation and Developmental Disabilities Research Reviews*, 2002, 8:206-211. doi:10.1002/mrdd.10039 PMID: 12216065

Feltz DL, Ewing ME. Psychological characteristics of the elite young athlete.Med Sci Sports Exerc. 2002; 19:98–105.

Fulda KG et al. Unmet mental health care needs for children with special health care needs stratified by socioeconomic status. *Child and Adolescent Mental Health*, 2009, 14:190-199. doi:10.1111/j.1475-3588.2008.00521.x

Gomm R, Davies C 2000 Using evidence in health and social care. Open University and Sage, London, Preface

Haig AJ. Developing world rehabilitation strategy II: flex the muscles, train the brain, and adapt to the impairment. *Disability and Rehabilitation*, 2007, 29:977-979. Doi: 10.1080/09638280701480369 PMID: 17577733

Johnston M, Nissim E, Wood K, et al 2002 Objective and subjective handicap following spinal cord injury: interrelationships and predictors. Journal of Spinal Cord Medicine 25:11–22

KahsayTareke (2010). The state of community based rehabilitation approaches of children with disabilities, Unpublished MA thesis Addis Ababa University.

Kephart G, Asada Y. Need-based resource allocation: different need indicators, different results? *BMC Health Services Research*, 2009, 9:122- doi: 10.1186/1472-6963-9-122 PMID: 19622159

Kahonde, CK., Mienzana, N., & Rhoda, A. (2010).SA Journal of Physiotherapy 2010 Vol 66 No3

Patel DR. Pediatrics neurodevelopment and sports participation: when arechildren ready to play sports. Pediatr Clin North Am 2002;49:505–531.

Phillips H, Noumbissi A 2004 Disability in South Africa. African Population Studies/ Etude de la Population Africaine 19(2): 115-138.

MOLSA (1999), National program of Action for Rehabilitation of person withDisabilities Addis Ababa, Ethiopia

Steiner WA et al. Use of the ICF model as a clinical problem-solving tool in physical therapy and rehabilitation medicine. *Physical Therapy*, 2002, 82:1098-1107. PMID: 12405874

Stucki G et al. Rationale and principles of early rehabilitation care after an acute injury or illness. Disability and Rehabilitation, 2005, 27:353-359. Doi: 10.1080/09638280400014105 PMID: 16040536

Tirussaw, T. (1998), Persons with Disabilities of High Achievement Profile in Ethiopia, RaddBarner.

WegayehuTebeje (2004). A study of the principles and practices of community based Vocational rehabilitation and its implication for Ethiopia, Ontario institute of Education. University of Toronto

World Health Organization. (2011). Disaster Risk Management for Health: People with Disabilities and Older People. WHO.Available: http://www.who.int/hac/events/drm_fact_sheet_disabilities.pdf

World Health Organization.(2011). World report on disability**.** 20 Avenue Appia, 1211 Geneva 27: WHO press.

World Health Organization (2013) *Disabilities*, [Online], Available: http://www.who.int/topics/disabilities/en/

World Bank and World Health Organization: World Report on Disability, Washington, D. C., 2011.

Barbotte E, Guellimin F, Chan N, Lorhandicap Group. Prevalence of impairments, disabilities, handicaps and quality of life in the general population: A review of recent literature. Bull World Health Organ 2001;79:1047-55.

World Health Organization.International Classification of Functioning, Disability and Health 2001.Available from http://www.who.int/classifications/icf/en/. [Lastaccessed on 2011 Oct 30].

World Health Organization. WHO Multi-country survey study on health and responsiveness 2000-01. Available from http://www.who.int/healthinfo/survey/whspaper37.pdf. [Last accessed on 2011 Oct 30].

Yin, K.R.(2003).Case study Research: Design and Methods. Sage publication. California

ANNEXES
Annex -1

Informed consent form

Dear respondent: - My name is MakdaKifle. I am a graduate student of the Department of Special Needs Education at Addis Ababa University. I am currently working on my Thesis project entitled "Practice of rehabilitation program in Cheshire (Menagesha Rehabilitation Centre) for people with physical disabilities". The aim of this research is to explore the practice, challenges and prospects of MenageshaRehabilitation Centre and to indicate implication for different stockholders based on the findings of the study.

The participants of the study will be staff members who work in the centre, rehabilitated clients and family members of the clients. The respondents should be willing to participate in the study.

I will use tape recorder to avoid wastage of information and to correctly handle the conversation we did and finally after completion of research the notes and records will be destroyed.

Respondents have the right not to respond for some of the questions that are not clear for them or quitting participation at all if they are not comfortable with. However, in other cases the respondent's honest and right answers to questions are very essential to achieve the objective of the research.

By signing this form, you agree to participate in this research, under the provided conditions.

Name of the respondent (pseudonym): _____

Date: _____

Signature: _____

If you have any doubt or questions in the process of inquiry you can use the following address to contact me though:

Mobile Number: - +251 913 15 29 09
Email: - makdakifle1@yahoo.com

Thank you for your time!

Annex-2

In-depth interview guide for rehabilitated members of MRC

The principal purpose of this in-depth interview is to obtain data for the study intended to investigate the practice, challenges and prospects of the rehabilitation program in Menagesha Rehabilitation Center and to indicate implication for different stockholders based on the findings of the study.

You are selected for this study because you could provide adequately enough information on these issues. Therefore your unreserved co-operation in providing the most genuine information will be appreciated.

The interview will be tape recorded in order not to miss any relevant information and to transcribe it easily. However, the information will be kept confidential. Thank you for the willingness to conduct the interview.

1. Socio-demographic feature of the discussants

Sex: _____

Age: _____

Educational level: _____

2**. Would you tell me the reason why you entered to this center?**

Proving question

☐when did you join the center?

☐ how long did you stayed in this center?

☐ did you checked in any other institutions before you joined here?

3. What are the services provided to you in the center?

Proving question

- What services are given to improve your social life with in the center and out of the center with the larger community?
- What are the procedures used during the service provided to you?
- What are the components of the services provided to you?

4. Tell me about your relationship with your family members?

Proving question

- With whom were you living with?
- How often your family members visit you?
- Does your family members co-operate with the center in order to facilitate your rehabilitation?
- Do you think that the support that you got from your family members is enough?
- If your answer is yes or no, Please mention the reason why you said the support is enough?

5. What do you think about the improvements/ strength of the center?

Proving question

- What are the positive changes you observed in treatment, counseling and recreation?
- What are the opportunities you observed as sources for the strength and improvement of the center?
- What do you think should be done to sustain the strengths and improvement observed in the center?

6. What are the challenges you observed in this center?

Proving question

☐What do you think are the remedies for such challenges?

7. is there anything else that you can add?

Annex -3

Interview questions for staff members

The principal purpose of this in-depth interview is to obtain data for the study intended to investigate the practice, challenges and prospects of the rehabilitation program in Menagesha Rehabilitation Center and to indicate implication for different stockholders based on the findings of the study.

You are selected for this study because you could provide adequately enough information on these issues. Therefore your unreserved co-operation in providing the most genuine information will be appreciated.

The interview will be tape recorded in order not to miss any relevant information and to transcribe it easily. However, the information will be kept confidential. Thank you for the willingness to conduct the interview.

1. Socio demographic characteristics of the participants

Age: _____

Sex: _____

Educational level: _____

Current Position in the center: _____

Profession: _____

Experience in the center: _____

Experience in the current position: _____

***2.* Roles strengths and needs of the center**

2.1 What are the services your department provides in MRC in meeting the social and economic need of individuals with physical disability and their family?

2.2 How do you perform the roles and provide services?

2.3 What are the strategies and procedures employed?

2.4 What are the components of rehabilitation services provided in your department?

2.5 Did you receive trainings regularly?

2.6What do you think are opportunities for the rehabilitation program from the perspective of your department?

2.7. What is the strength of the rehabilitation services provided in your department?

2.8. What is the improvement you observed in the rehabilitation service provided in your department?

2.9 What are the strategies you used to sustain the strength and improvement you have observed in the rehabilitation services provided by your department?

2.10What do you think are the challenges of your department?

2.11How do these challenges can be addressed?

2.12 Is there anything that you can add?

Annex-4

Observation Guide

1. The situation of clients	Excellent	Very Good	Good	Poor	Very Poor
A. The compound and building					
B. Dormitory					
C. Recreational centers					
D. Services received					
E. Improvement observed					

2**. The situation of staff members**

A. Staff construction and sanitation

B. Multi-disciplinary team relationship

C. Client professional relationship

3. The steps and components of service provision in physiotherapy service?

A. Steps employed in the service

B. Components of the service

C. Opportunities of the services

D. Challenges observed in the service

E. Measures taken to resolve the challenges

4. The steps and components in counseling service provision?

A. Steps employed in the service

B. Components of the service

C. Opportunities of the services

D. Challenges observed in the service

E. Measures taken to resolve the challenges

5. The steps and components in hand craft and play room service provision?

A. Steps employed in the service

B. Components of the service

C. Opportunities of the services

D. Challenges observed in the service

E. Measures taken to resolve the challenges