

**INVESTIGATING THE IMPLEMENTATION
OF COMMUNITY-BASED REHABILITATION
PROGRAM FOR CHILDREN WITH PHYSICAL
DISABILITIES IN ADAMA TOWN**

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Daba Feyissa Shiferaw

Acronyms

ASE – Arizona Special Education

BOE- Bureau of Education

CBR- Community Based Rehabilitation

CBRP- Community Based Rehabilitation Program

CBSE- Community Based Special Education

CP- Cerebral Palsy

CRC- Convention on the Rights of the Child

CSA- Central Statistics Office

DLSA- Department of Labor and Social Affairs

DOH- Department of Health

DOE- Department of Education

FGD- Focus Group Discussion

GO- Governmental Organization

IBR- Institution Based Rehabilitation

IDC- International Disability Consortium

IGA- Income Generating Activities

ILO- International Labor Organization

MD- Motor Disorder (Disability)

MOLSA- Ministry of Labor and Social Affairs

MOH- Ministry of Health

NGOs - Non-Governmental Organizations

PWDs- Persons with disabilities

PACT- Private Agency Corporate Together

RAD-Rehabilitation Agency

RCC- Rehabilitation Center for children

Redd Barna- Norwegian Save the children

RBE- Redd Barna Ethiopia

RHU- Rehabilitation unit

RW- Rehabilitation Workers

SNE- Special Needs education

UCPRE- United Cerebral Palsy Rehabilitation and Educational Foundation

UN- United Nations

UNDP- United Nations Development program

UNESCO- United Nations Education, Scientific and Cultural Organization

UNESCR- United Nations Economic and social Council

UNICEF- United Nations Children Fund

VCH- Voluntary Council for the Handicapped

WACT- Women and Children Tracing NGO

WCFP- World Confederation for Physical therapy

WHO- World Health Organization

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Abstract

This Study is designed to investigate the implementation of Community-Based Rehabilitation program for four groups of children with physical disabilities namely Cerebral Palsy (CP), Polio, amputee and clubfoot children in Adama town. The study was conducted by using qualitative as well as quantitative methods. Consultation of documents and questionnaire were also used to complement the focus group discussion. By using both data collection methods, 104 subjects were completed the questionnaire while 16 children and 14 adults were respectively participated in five focus group discussion sessions. Regarding Children with physical disabilities, they are 58 in number and their mean age is 15.5 with SD 1.49. This implies that their age difference is not significant. In other words, majorities of the sampled children's age lies in the age group of Adolescence. The Prevalence of Polio, CP, Clubfoot and amputee is higher among male children than females. Out of the total sampled group male children constitutes 64%. The prevalence of physical disability is high among male than female because male children are exposed to accidents, falls and different unknown disabling factors. Similarly, there appears to be a relationship between educational level and income of parents and prevalence of physical disabilities. In this regard, majorities of children with Physical disabilities those who were involved in CBR programs are from families of low income and low educational level. This study also finds that community based rehabilitation program has been able to brought about substantial changes in the lives of its program participants in terms of awareness raising, facilitating their material, perceptual and emotional pathways to

empowerment both at children and paternal levels. Parents who were previously not involved in any income generating activities have now began showing improvement in their livelihood as well as in rendering basic rehabilitation services for their children with physical disabilities. Parents' awareness about the causes of physical disability is significantly changed from the previous religious beliefs to understanding about the real possible causes of Physical disability as a result of CBR intervention. This study also found out that except in few community organizations, involvement of the community in planning, decision-making, and evaluation of the CBR program was minimal. However, Participation of children in community based rehabilitation services such as in disability club formation, participating in disabled children's association and child-to-child interaction activities was high and had enhanced their self-confidence and reduced feelings of isolation and dependency.

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CHAPTER ONE: INTRODUCTION

1.1 Back Ground of the Study

At present, children with disabilities around the world live in especially difficult circumstances. Different governmental and Non- governmental organizations have been trying to ameliorate the situation of these children. However, most of the attempts made in developing countries like Ethiopia are uncoordinated and not adequately involve the community in rehabilitation activities. Researchers agree that there is a clear mismatch between rehabilitation services rendered on one side and magnitude of children with disabilities on the other (SHIA, 1995).

Children with disabilities like other non-disabled children should have to deserve special attention, protection, and assistance from their families, communities and from national as well as international organizations. According to Article 23 of the United Nations Convention on the Rights of the child:

“... Mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child’s active participation in the community” (UN-CRC, 1989:23).

Though the UN-Convention on the rights of the child encourages active participation of disabled children in the community, there are no sound benchmarks as to what kind of educational and psychological assistance should be given to children with disabilities in developing countries like Ethiopia. However, according to the Declaration on the rights of persons with disabilities (1989), children and adults with disabilities have the right to medical, psychological, and functional treatments including prosthetic and orthopedic appliances, medical and social rehabilitation, education, and vocational training and other rehabilitation services. This declaration also includes aid, counseling and placement services that enable them to develop their capabilities and skills to the maximum and will develop the process of their social integration and reintegration. To this effect, community based rehabilitation program has serve persons with disabilities without distinction or discrimination on the basis of race, color, religion, sex, political or other opinions. CBR is about 20 years old and is operating in more and more countries and it is now being reviewed

worldwide (Health Link, 1998). Unfortunately, some people as limited see CBR only to making crutches and calipers for poor, passive and uneducated persons with disabilities. A full, well-rounded CBR program can be so much more.

Accordingly, the number of persons with disabilities who need community based rehabilitation services in developing countries alone would expected to be 130- 150 million by the year 2000 out of which 40% of them are children below the age of 18 years of age (Helander, 1989). World Health Organization (WHO, 1996) also estimates that only less than two percent of adult and children with disabilities in developing countries receive rehabilitation of any kind. The survey conducted on 33 developing countries identified 14 million persons with physical disabilities out of which one in six needed some forms of appliances (O'Toole, 1991). This survey also shows that only one percent of children with physical disabilities had received few forms of rehabilitation aid at all. Thus, in developing countries including Ethiopia, little has been done to either prevent or to alleviate the problem. This problem is combined with the inevitable limitations accompanying poverty and under development. Although the precise number of adults and children with disabilities in developing countries are debatable, 98% of such adults and children are totally neglected from getting rehabilitation services as indicated by WHO 1996 reports.

The 1994 population and Housing census of Ethiopia also shows that there are about 333, 585 persons with disabilities in the country. Among this population, it has been estimated that more than 37% of them are persons with physical disabilities. In addition to this, a base line survey conducted by Tirusew and et al (1995), in Ethiopia reveals the distribution of disability as follows:

- “ Persons with physical disability 30.9%.
- Persons with visual impairments 30.4%.
- Persons with chronic and crippling health conditions 10.3%.
- Persons with speech and language problems 2.4%
- Persons with multiple disability 2.4%
- Persons with behavioral problems 2.2%.
- Persons with hearing impairments 21%”.

In this survey study, physical disability stands as a major group of disability in Ethiopia. This prevalence may be attributed to civil wars, natural calamities, disease, malnutrition as well as other congenital factors. The survey study as well as the census of the population in the

country estimated the prevalence of disability very low in a country where frequent famine, drought and war are rampant. This prevalence is also said to be very low when compared to the WHO estimation that is 10%. It is also low because of three reasons. In the first place, parents for a number of socio cultural reasons are not willing to disclose the fact that they have a child with certain disabilities. The second reason is that children with disabilities are kept behind the door due to the negative attitude of the community towards persons with disabilities. The third reason is that there is a serious gap between the demand for rehabilitation and the magnitude of persons with disabilities in the country so that participation of children with disabilities in schools and different socioeconomic activities of the country is very low.

In recent years, the adoption of a rehabilitation program in developing countries like Ethiopia has most often take place in one of the following ways: A non-governmental organization (NGO) from developed country on one part and local sister organizations and government institutions on the other side. Rehabilitation projects established with purely the external donors' fund are not usually sustainable (Ingstad and Whyte, 1995). In the past two decades, however, NGOs and governmental organizations have tried to reach a larger population, usually through community based rehabilitation program.

Therefore, investigating about the on going community Based rehabilitation program in Adama town is important to design effective and successful intervention strategies for children with physical disabilities. In this regard, the purpose of this paper is to look at how Community based rehabilitation program had actively involve members of the community, families, organizations, rehabilitation workers and others in meeting the needs of children with physical disability and in helping them to find a meaningful place in the community.

1.2 Brief Description of the Study area

Adama is the capital town of East Showa zone found in the eastern part of Oromia regional state. According to the Population and Housing census of 1994 the total population of the town was estimated to be 127,842 out of which children under the ages of 15 years were more than 55,000. It was projected that the total population in the town would be more than 185,000 by the year 2000. The town is about 90 Km away from the capital city of the country (Addis Ababa) and it is located in a low land climatic area having annual rainfall of 750mm and an altitude of 1630 meters respectively (East Showa Zone Planning Office Report, 1996). Currently, the town is caught by different social and economic problems, lack of water,

housing, health services and lacks of employment opportunities are some of the major problems mainly manifested in the area. Street children, prostitutes, children with disabilities, beggars, persons with mental disorder and unemployed youth are also highly concentrated in the town. The area is a commercial Zone and a route for a railway to Djibouti so that adults and older children were migrated from other parts of the country to seek a job in the town. The town is inhabited by 44.4% of Amahara, 26% Oromo, 14.8% Gurage and 14.6% other ethnic groups respectively (CSA, 1994).

In 1992, the Rehabilitation Agency initiated a pilot project in Adama district. The Community Based Rehabilitation (CBR) service was initiated to persons with disabilities (PWDs). The main target population was persons with physical disabilities, visually impaired, hearing impaired and mentally retarded children. Physically disabled children including cerebral palsy, clubfoot, polio and amputee were the major ones. In addition to Rehabilitation Agency's initiatives, Redd Barana-Ethiopia (Norwegian save the children) had started implementing community based rehabilitation program for children with disabilities in 1994 in the town (RB-E, 1994). Before 1992, little or no information was available neither on the causes of disabilities nor on the number of children with physical disabilities that determine the services required in achieving maximum potential in Adama town. The Rehabilitation Agency (1992) also estimated that the total population of persons with disabilities in Adama town was about 1349. According to this figure, the distribution of disability was as follows: Visual impairment 36%, physical disability 32%, hearing impairment 11.3%, mental retardation 9% and other type of disability constitutes 11 percent (RAD, 1992).

On the other hand, a survey conducted by Redd-Barna Ethiopia in 1993 shows that the exact registered number of children with disabilities alone was 592. In addition, the annual report of RAD (1995) CBR project shows that out of the total persons with disabilities included in the CBR services, 52 of them were children with physical disabilities. Similarly, 43 children with motor disabilities were included in the CBR project of Redd Barna Adama project (Redd Barna, 1996). Accordingly, the number of children with physical disabilities that have received CBR services in the town reached more than 95 in the past six years. Awareness creation, home visits, income-generating activities, counseling, rendering appliances, referral, education, health and vocational training were some of the major activities so far jointly undertaken by both organizations.

Therefore, this research project has been carried out based on the above figures and activities undertaken by community based rehabilitation programs of the two organizations in the area in the past six years.

1.3 Statement of the Problem

The number of children with physical disabilities / physical disability/ who face difficulties in obtaining psychological, social, health and educational services has been estimated to be very high in Adama town (Redd-Barna, 1994). Over work, poverty, severe social stress and tensions make parental involvement in CBR a difficult proportion in the area. In addition to this, Community –based Rehabilitation service in Adama town is so limited to date to meet the demands of the growing number of children with physical disabilities. The efforts so far made by RAD and Redd Barna for instance are very limited when compared with the magnitude of the problem and needs of children with physical disability. Thus, the situation of children with physical disabilities in Adama may be explained in that there is a serious gap between the demand for rehabilitation services and the service being rendered so far. In this study, I look at how children with physical disabilities and their parents are involved in the CBR program, whether it helps to empower them and raise their self-esteem, or whether parents and community attitudes towards disability have become more positive. Based on the issues raised above, the investigator carried out the present study to give answer for the following questions:

1. What beliefs do children with physical disabilities and their parents have about the causes of physical disability before and after the intervention of CBR Program?
2. Do CBR programs actively involve parents, community members and children with physical disabilities in its overall activities?
3. Is there any relationship between CBR activities and educational services in rehabilitating children with physical disabilities?
4. Had been there any possible changes observed on parents, community and children with physical disabilities as a result of CBR program intervention?

1.4 Objectives of the Study

1.4.1 General objective

The general objective of this study is to investigate how Community-Based Rehabilitation program involves members of the community, parents, and rehabilitation workers in meeting the needs of children with physical disabilities.

1.4.2 Specific Objectives

The specific objectives of this study are:

1. To investigate how community based rehabilitation approach plays a significant role in integrating children with physical disabilities in to the social and educational activities.
2. To understand the involvement of family members, children with physical disabilities and the community in rehabilitation process
3. To investigate changes observed on family members, children with physical disabilities and the community as a result of community based rehabilitation services.

1.5 Significance of the Study

The limited Community-Based Rehabilitation services for most disabled children with physical disability in Adama town and the task that are left ahead is never a relaxing situation. Thus, calling for the study about the implementation of CBR is very imperative. There fore, this research project will contribute to:

1. Identify major causes of physical disability in relation to CBR interventions that would serve as a basis for further research development in the areas of CBR program.
2. Make concerned authorities and policy makers aware of the existing gap between the need for rehabilitation of children with physical disability and the nature of the services being given to meet these needs.
3. Suggest and recommend possible ways and procedures in which short and long-term strategies for community-based rehabilitation program can be designed.

1.6 Delimitation

This research work is delimited to urban Keble's of Nazareth town. Children with physical disability in the rural areas of Adama woreda are not included in this study.

In general, the study is delimited to:

- CBR services carried out by Redd Barna and Rehabilitation Agency in Adama town only.

- Among many types of physical disabilities, the study is also only delimited to polio, cerebral palsy, clubfoot, and amputee.

1.7. Limitation

Since the study is conducted only on one town, fair generalizations are not free of limitations. Furthermore, the absence of adequate and comprehensive domestic research work in the area under study also counts against the attempts of a more substantial research work.

1.8. Definition of Terms

Cerebral Palsy (CP) is a disorder of muscle control that causes difficulty with moving and positioning of the body and small parts of the brain that controls movement has been damaged before or after birth. (UCPEF, 1997).

“**Child**” in this paper is used as defined by the United Nations convention on the Rights of the child, Article 1 as every human being below the age of 18 years. Thus, in this paper, a person with physical disability below the age of 18 years is said to be a child.

Community: is a group of people living in the same area and sharing the same or basic values and organizations. Community in this context consists of people living together in some form of social organization and cohesion. Its members share in varying degrees of economic, social and cultural characteristics, as well as interests and aspirations in Adama town.

Community-Based Rehabilitation is a strategy with in the community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities. CBR is implemented through the combined efforts of disabled people themselves, their families, and communities, and the appropriate health education, vocational and social services (ILO/UNESCO/WHO, 1994).

Disability: is any restriction or lack resulting from an impairment of ability to perform an activity in the manner or with in the range considered normal for a human being (WHO, 1989).

Impairment: is any loss or abnormality of psychological, physiological or anatomical structure or function (WHO, 1989).

Intervention is the introduction of an activity or program designed to bring about changes for children with physical disabilities and their parents.

Orthopedic Impairment is a motor disability caused by an anomaly, disease or impairment by other condition (e.g. cerebral palsy, spina bifida, muscular dystrophy, polio, club foot or traumatic injury) where the child requires specialized services in order to benefit from social and an educational program (Sharon & et al, 1996).

Participation implies “the right and responsibility of disabled people to make choice and therefore, explicitly or implicitly, to have power over decisions which affects their lives”(UNESCR, 1979).

Physical Disability (Physical disability) is the condition that interferes with child's ability to use his or her body for movement and educational performance. For the purpose of this paper, Children With Physical Disability /Physical disability/ are: defined as those whose physical limitations interfere with school attendance, social integration, learning and mobility to such an extent that special services, training, equipment, materials or facilities are required.

Rehabilitation: is the combined and coordinated use of medical, social, educational and vocational measures for training or retraining children with physical disabilities to the highest possible level of functional abilities (Helander, 1989).

Social Integration: in this paper is the means to remove physical, psycho-social and economic barriers imposed on children with physical disabilities by participating them with in their community.

CHAPTER TWO: REVIEW OF LITERATURE

2.1. General Overview of Rehabilitation

The goal of rehabilitation is to help children or persons with disabilities to enjoy the best quality of life possible by enhancing the disabled person's natural abilities in the natural environments (RCC, 1998). According to Rehabilitation Center for Children (WHO, 1996), enhancing natural abilities in natural environments refers to the type of service to assist disabled children in their own communities by sharing information by transferring knowledge and skills to care givers. This indicates that the type of rehabilitation that provides service in the disabled child's natural environment is very effective because the child is most likely to demonstrate his or her abilities in a familiar setting.

In this case, measures used to assist people with disabilities to improve their abilities in activities such as self-care, communication, moving around, developing vocational skills are generally considered to be rehabilitation measures (WHO, 1996). Similarly, rehabilitation is stated as " the restoration of the handicapped to the maximum physical and mental utilization of which they are capable"(MOH RH unit, 1990:27). This implies that rehabilitation is generally considered to be the component of tertiary prevention that focuses on the reduction and elimination of a disability.

According to Helen Jackson (1993), the third level or territory intervention aims at creating equal opportunities and the full integration of the people with disabilities. Helander (1993) also, elaborates this idea in that rehabilitation includes not only the training of disabled people but also interventions in the general system of society, adaptation of environment and protection of human rights. As cited by Tirusew (1998) and stated by Herr (1993), the aim of rehabilitation is at understanding people with disabilities, their rights and special needs to empower them. In this regard, provisions of all rehabilitative services being carried out are justified by the human rights perspective rather than charity approach. The United Nations Declaration on the Rights of peoples (UN, 1975) emphasis that " Persons with disabilities have the right to services as human and legal rights (cited in WHO, 1997:32). In addition to this, the Convention on the Rights of the Child (UN, 1989) recognize Children's right to education and the right to rehabilitative services ensuring that children with disabilities have effective access to receive health, care services, education, training, preparation for

employment, recreational opportunities and rehabilitation services in a manner conducive for the children's achievement of the fullest possible for individual development and social integration. The convention on the right of the child was ratified by Ethiopia government and it infers that people with disabilities in general have the need and rights to all aspects of rehabilitation /Social, educational, medical and psychological) in order to maximize their potential and minimize disability (Cited in Tirusew & etal, 1998).

According to Helander, E. (1995) disability imposes a considerable social, economic and emotional cost on disabled people, their families, and wider community. Thus, without effective rehabilitation measures carried out, disabled people particularly children with disability may lead unhappy, dependent lives, and become burdens to them and to society. Many researches found out that the biggest challenges falls on persons with disabilities in developing countries where disabled people often live with low dignity, respect, and unmet needs. The great majority of persons with disability at present lead their life's with low dignity, in absolute poverty, victimized by beliefs that they are possessed by evil spirits or that there very presence in society is proof of divine punishment (Helander, 1993).

As long as poverty and malnutrition, war and conflict, ignorance and superstition characterize huge areas of the globe, the numbers and beliefs of persons with disabilities continue to rise (ILO/ UNESCO/WHO, 1994). According to WHO RHB UNIT, (1996) there in a need for a new pattern of services characterized by fewer experts, less advanced forms of training, simplified methods of intervention and above all the participation of those concerned in decision about provision. This issue is also supported by Cowely (1987), in that a great deal of time is still spent on examining the inadequacies of the existing service models in the area of rehabilitation which cannot be closed by developing or even expanding services only.

To carry out rehabilitation programs, approaches such as institution based rehabilitation, out reach program and community based rehabilitation are very essential and has been undertaken for a long period of time except CBR (WHO, 1996). On the other hand, some of the major types of rehabilitation indicated by different professionals including medical, psycho educational and CBR approach are imperative and useful. These types of rehabilitation services have close relationship to each other in combating against the problems of disability. To overcome the challenges of disability in the process of rehabilitation approaches that involve persons with disabilities at a grass root level are

required. World Health Organization has been joined by its sister Organizations namely the ILO and UNESCO in adopting community based rehabilitation as a most viable strategy to meet the global challenges of disability and this partnership has now been formalized in a joint paper on CBR (ILO/UNESCO/WHO, 1994). Before dealing with elaborating about CBR, let I pinpoint some issues concerning CBR Program vs IBR model.

2.2. Community Based Rehabilitation Approaches vs. Institution Based Rehabilitation

Institution in this case refers to " those establishments, which provide direct health, education or social services with in a defined catchment area" (UNESCO, 1994). Institutions have a limited advocacy and awareness raising role in relation to high lighting the needs and rights of disabled people in their operational areas (cited by Tigabu, 1998 WHO, 1996). Institutions bring groups of disabled children, young people or adults to a place where resources, buildings and expertise are located and provision is centralized (Helader, 1995).

In the past three decades, community based rehabilitation approach was viewed as an alternative to the institutional model of rehabilitation. However, Currently community based rehabilitation is an approach which provides a link between the community worker and the professionals; and link between the disciplines of health and education (Fulcher, 1989). Therefore, the current approach views the two approaches regarded as complementary not totally exclusive. Miles (1985) advocates centers /institutions/ as with mid level trained workers run by the community and using local materials which could become training bases for parents as well as professionals. However, in the early days, institutions offer accumulated experience, opportunities for in service training, scope for innovations and much needed family relief (1989).

Werner (1989) indicates that in many countries more collaborative works of both CBR and the merits of traditional approaches are adopted. As Mconkey (1986) observes, CBR is not one approach, but it focuses on a number of forms of service in the areas of health, education and social welfare issues. In this regard, the improved relationship between or among infrastructures or partners could help the dpersons with disabilities in rehabilitation process. But in the traditional institution based approach, the partners' relationship could not be effective like CBR. The issue of participation and involvement of the community and persons with disability is not taken into consideration in institution based of approach (Ibid).

According to UNESCO's (1994) report, special schools and centers for the handicapped are particularly important in CBR and should be seen as resources by the communities they serve. This has been a tendency to see such institutions as being irrelevant to CBR programs. Currently many researchers agree on the vital role of schools and rehabilitation centers as a resource for CBR activities. CBR and IBR could have many major differences though they complement each other. The CBR philosophy advocates discouraging the policy of bringing groups of disabled to centers, but encouraging the institutions to move to the beneficiaries and the ideal would be to have movement both ways, with institution running out reach services in local communities where it was feasible to do so, and clients are traveling in to the institutions for the special services that could not still provided locally (UNESCO, 1994). As this assumption indicates, the involvement of institutions in community rehabilitation services is very vital together with CBR services.

According to UNESCO report institutions undertake the following activities when they incorporates the issues of CBR.

- “ Educate society on its role in preventing those of its members with disabilities being” handicapped”).
- Develop a greater awareness in society of the presence and special needs of disabled people.
- Educate society on its role in the provision of services for its disabled members.
- Invite and encourage the involvement of disabled people in the provision of these services”(UNESCO, 1994:24).

In conclusion, in CBR program people with disabilities go through the process of rehabilitation in their home and communities. Community members and persons with disability involve in the process of rehabilitation because the rehabilitation and social integration of disabled people is a concern of the community. On the other hand, the traditional ways of rehabilitating disabled people through institutional service deals with the involvement of parents partially and not involves beneficiaries and the community at all.

2.3. Community Based Rehabilitation Approach: A Response to the Challenge of Disability

2.3.1. The Essence of Community Based Rehabilitation

To meet the global challenge of disability, in 1989 WHO has been joined by its sister organizations, namely, the ILO and UNESCO in adopting community Based Rehabilitation (CBR) as the most viable strategy (ILO/UNESCO/WHO, 1994). A significant priority with in this global approach was to focus on persons with disabilities with in the society (WHO-RHB, 1996). According to the joint position paper, Community Based Rehabilitation (CBR) is to demystify the rehabilitation process and give responsibility back to the individual, family and community. This idea implies that the goal of CBR is that for rehabilitation to be perceived as part of community development where by the community seeks to improve it. To elaborate the concept of CBR further, Helander (1989) says once the community takes on the responsibility of rehabilitation for persons with disabilities, then the process could truly be called community based rehabilitation. Thus, in such process, rehabilitation becomes one element of a broader community integration effort. The essence of CBR clearly shows that CBR promotes the right of people with disabilities to live with in their communities; to enjoy health and well being; and to fully participate in educational, social cultural, religious, economic and political activities. It also indicates that CBR is aimed at joint multi-sectorial action at the level of the community to provide assistance and support to the disabled people to reduce the effect of disabilities.

2.4. Theoretical Assumptions and Principles of Community -Based Rehabilitation

The theoretical conceptions and practices of Community Based Rehabilitation are based on a number of assumption and principles. Unfortunately, distinction between assumption and principles is rarely made in the literature. For example, Kotze (1987:30)"treats the issue of community needs as an assumption while Watts (1990:78) treat needs as a principle of community development".

The philosophy and principles of CBR are very persuasive, but the challenge now is to translate philosophy of CBR to practice. It is better to raise some important questions that are

raised by Riscos Divine. According to Riscos (1988), the following major questions are important and paraphrased to indicate the philosophy and principles of CBR.

- Is community and persons with disabilities empowerment can be a realizable when people are engulfed in poverty?
- How can the community be mobilized to take responsibility for the prevention, rehabilitation and care of socially disadvantaged disabled people in their particular community?
- Is the concept of working with the volunteers any more a romantic notion or is it practical within the poverty-stricken community?
- How can the cooperation among public services in health, education and labor exist within the community?

The above questions illustrate the magnitude of the challenge to be faced while introducing CBR programs in relation to its principles and philosophy within the community. For the most part, based on the questions raised by professionals above, the following theoretical conceptions and principles about CBR are briefly discussed here below.

According to Chitire (1994), the primary principle of CBR model is encouraging participation of persons with disabilities and their families as a key factor in the rehabilitation process. Lisk (1989) "argues that local participation is first needed because it permits mobilization of local community for rehabilitation and development purposes. This indicates that participation permits growth of local capacity, which develops out of partnership between development agencies; community and disabled people themselves (Chitire, 1994). Accordingly, the assumption is that working with target community instead of working for them is an essential strategy used in CBR model (IDC, 1996). This can be more elaborated in that deciding and doing things for persons with disabilities deprives them of the chance to learn and gain experience by making decisions.

According to O'Toole (1989) the key success of CBR is measured by active participation of the community. The community must realize that the lives of its disabled members must be improved and that the community itself has the capacity to do it. Thus, the principles of "involvement" refers to making as many members of persons with disability as possible aware

of their needs and stimulating their desire to do something about the needs (Wilden, 1988). And, the principle of "cooperation" emphasizes the need for collaboration of efforts between or among as many members of a group of a community as possible in resolution of their problems (Batshaw, 1987). In this regard, empowerment of persons with disabilities is very crucial. An empowered disabled person or group of persons with disabilities may be enough to bring to the attention of the community; their needs and what should be done about them (WHO-RHB, 1996). According to this report, empowerment of persons can be practical through:

- “Awareness of one's rights and the right to have those rights
- Getting education and access to information
- Transforming the passive roles that persons with disabilities (PWDs) play more active and valued roles”(Ibid: 17).

The other assumption relates to the resource needed for the improvement activities of persons with disabilities. The community mobilizes and uses its own material, labor and monetary resources (Cowley, 1987). The most important resources for CBR activities are the local community, with in which lay the people, the institutions, the materials and the money, which enable CBR to function and grow.

These include:

- “Human resources (persons with disabilities, parents extended family, peers, professional people, religious and business people).
- Institutional resources such as local schools, health clinics, vocational training’s and clubs.
- Local natural resources financial resources and other services”. (UNESCO, 1994:8)

According to the consultation paper of WHO (1996), some of the strategies for community mobilization are using multiple strategies, inter community assistance, using the multiplying factor, involving marginalized group, building optimism, education to change the attitudes of target population and so forth. However, to make the approach more effective a mixture of strategies is required.

The philosophy of CBR also embraces both rehabilitation and education (UNESCO, 1994). Community Based Special Education is a component of CBR, but it is distinct from CBR. Community-Based Special education is an approach to the provision of services for disabled

people within their local community that involves the community in a spirit of partnership and Co-operation (UNESCO, 1994). The concept and practice of CBSE has been developed because if education of children with disabilities is placed under CBR with the emphasis on the ultimate goal of rehabilitation then disabled children are being educated to be rehabilitated (Ibid.). O'Toole (1994) elaborates that special education rehabilitation must be offered as a process in which all the participants are actively involved. Thus, an essential ingredient of CBR is the involvement of schools and the community in the planning, implementation and evaluation of the program.

CBR model aims at changing community attitude by assisting the families and communities understand causes, effects and treatment of disability and to accept people with disability (Helander, 1993). CBR also aims at reducing stigma and dependency on the part of persons with disabilities. In relation to the above issues, the philosophy of CBR is integration of disabled people in to societal mainstream rather than creating special environment for them (cited in Adugna and etal 1996 stated by UNESCO 1994). Therefore, participation tends to reduce alienation that prevents persons with disabilities from identifying themselves with their communities. Rehabilitation institutions in this case are viewed as important in supporting the CBR activities, but the role of such institutions would be a helpful to handle sophisticated rehabilitation services up on referral from communities (MOM, W. and Koenig, 1992).

The other approach of CBR model is that it is cheaper than the institution-based model of rehabilitation and makes rational use of scarce resources (Helander, 1989). In this case, the CBR model attempts to reach more people with disabilities compared to IBR model with low cost.

According to Helen Jackson (1993) the CBR model promotes early detection of health problems, as families and communities become more aware of cause of disabilities. Helen Jackson's CBR model asserts that effective prevention and rehabilitation of disabilities could be possible through community participation and involvement.

To ensure sustainability of the CBR with in the community, the CBR model also encourages the selection of the Rehabilitation workers to be from the local community (Barnes, 1993). The debating issue here is that some professional recognizes the CBR workers on volunteer

bases. But, others prefer on payment basis rather than on voluntary bases. According to O'Toole (1991), in Philippines where CBR was impractical to introduce through the primary health care structure, volunteers were effectively used. O'Toole had also found out that volunteers prove to be effective over the 18-months life of the Guyana CBR project. In this regard, the major innovations in CBR have been through other volunteer or primary health care initiatives. On the other hand, Barnes (1993) encourages the idea of payment bases for rehabilitative workers rather than on volunteer bases to increase stability and continuity in the work force and a trained senior worker should guide their work. Although the issues of volunteer bases versus payment bases are debatable, the philosophy of encouraging the rehabilitation workers to be from the local community is unquestionable (Helander, 1993).

As indicated in WHO 1989 and cited by Aduagna and et al (1996), the CBR model assumes that if rehabilitation is to reach all those in need, then there must be a large scale transfer of knowledge about disabilities and skills in rehabilitation to the people with disabilities, their families and members of the community. There fore, the concept of CBR is built on the observation that family members are usually the resource to handle the daily training and care of persons with disability.

Last but not the least, CBR model emphasizes on that people with disabilities have the same rights as other people (Helander, 1989). Therefore, for rehabilitation to be successful, communities must recognize and accept the issue of equalization of opportunities and social integration of people with disabilities by brining attitudinal changes. So, communities can accept and recognize that people with disabilities have the same rights as other people if and only if communities themselves take on the task of rehabilitating their members who have disabilities.

2.4.1 Issues of Participation /Involvement / in CBR Activities

In this part of the paper I look at ways in which CBR program actively involves members of the community, disabled children and their families in meeting the needs of disabled children and in helping them find a meaningful place in the community in relation to the principles of CBR.

a) Community and targets Involvement

As mentioned in the above part of this paper, the institutional based approach is a top- down model of service delivery. It has been found out that social service programs for rural communities as well as marginalized urban areas have been planned and implemented by bureaucratic institutions with out the involvement of beneficiaries and the community at large (ILO, 1988). However, people currently realize this that if targets of rehabilitation do not participate actively in the rehabilitation process, change will be impossible. Hence, the active participation of persons with disabilities and the community at all phases of rehabilitation process is essential and has to be facilitated. It is well known that the key success of CBR is measured by active participation of the community and persons with disabilities. Participation or involvement of the community can be practical when the community realizes that the lives of its disabled must be improved and that the community itself has the capacity to do it. The social, cultural and economic context with in which CBR to be introduced needs to be considered very carefully. According to Batez (1984), community participation has become a new catchword. The challenging reality of translating laudable principles in to action is not often appreciated because communities are divided and stratified societies (O'Toole, 1991). This indicates that involvement of the community in identifying problems, planning, implementation and evaluation of the CBR program requires a well-organized awareness and sensitization mechanisms.

To introduce a new and effective innovation to the community, it requires media coverage, seminars and trainings at different times at different levels and stages. This would help and enhance persons with disabilities and community members the feeling that they are part of an important project. This type of involvement can be advocated by the announcements concerning the project in place of worship places, health centers, schools and community organizations.

For example, in Guyana, community awareness was enhanced by CBR:

- Column in the Sunday newspaper that ran for long months, and the participants to schools, village meetings, public festivals and video training presented series of puppet shows.

In Srilanka, committee members who composed of village elders and persons with disabilities (Kgosana, 1984cited in O''Toole, 1991) monitor a CBR project. O'Toole pointed this project as a practical example where community members have been deeply involved in rehabilitation processes. The Burma experience also shows that there was a high degree of local involvement through a process of effective dialogue with the village leaders and

extensive propaganda (WHO, 1982, O'Toole, 1991). Involvement of the community in CBR program is some times unpractical due to poverty and negative attitude of community towards persons with disabilities. Therefore, in introducing CBR projects one needs to be aware of the great range of socio-economic conditions and should be worry of proposing a plan. So, in considering which targets are suitable for CBR approach, practical community involvement at a grassroots level is quite important.

b) Family Involvement

In developing countries, fundamental material improvement may be relevant for parents to participate in their child's intervention. Poverty, severe social stress, unemployment, overwork and tensions hamper parental involvement in rehabilitation process (Batez, 1984). In such cases the disabled child's progress or determination in all aspects may be the least of the parent's worries for practical reasons of unemployment or poverty or negative attitudes. There are families where involvement is unrealistic. However, for each of these cases there are as many others who are eager to become involved once they are given the necessary support, information and guidance (WHO, 1996:).

In the process of involvement, parents consistently emphasize on the need for practical information, support and advice. According to (Helander, 1993) satisfying parents emotional needs may be a vital first step in helping the parents come to terms with the way they feel. Similarly, O'Toole (1991) expressed that parents stress the need to have some one to talk with to overcome the feelings of shame and guilt. In this context, the characteristics response of deep emotional upset, extreme isolation, disbelief, denial, grief and depression have to be taken in to consideration for practical parental involvement (Drew, 1989). According to O,Toole (1991, UNESCO 1994) report at least three prerequisite skills needed to be examined to know the relevance of parental involvement to the context of developing countries.

- “Understanding the child: an appreciation that children develop skills in an ordinary sequence that is relatively universal.
- Belief in teaching the belief that child development can be accelerated by intervention and that parent can play a key role in this respect
- Opportunities for teaching: the acceptance by the parents changing the environmental or their approach could help the disabled child to learn” (UNESCO, 1994: 26).

These skills indicate that parents would come for higher involvement in the educational process that are willing and eager to offer individual teaching and play sessions to their child. In addition to this, arranging some existing opportunities for teaching and understanding the disabled child could assist parents to involve easily in the rehabilitation process.

For the disabled child to function effectively in well-integrated family unit, the family has to be systematically addressed. In the process of parental involvement, encouraging a mother to behave like a teacher may destroy the very contribution which is most important for her to make and could add stress to a parent-child case, mothers are being pressured into adopting perceptions, expectations, and behaviors which may be psychologically damaging to themselves (WHO, 1996, training package No. 15).

The danger of pushing parents further apart by focusing on the mother-child relationship should be noted as another problem in parental involvement. Many study shows that father's role is traditionally limited in the life of his child with disabilities in developing countries (OToole, 1991). Thus, by concentrating only on the mother-child unit to the exclusion of other family members, the intervention may only serve to increase the father's isolation emphasize the differentiation between parents regarding their respective roles. This implies that in the process of rehabilitation parents may well already have a role division with which they are both contents to involve.

In this regard, before encouraging involvement of parents in rehabilitation, an appreciation of the different ways that families lead their life is necessary. If that is so Community-Based-Rehabilitation (CBR) may be no more effective than the previous approaches in meeting the family's needs. The goal therefore, is flexibility in responding to the needs of each family rather than prescriptions of developing services on one model.

2.5 Experiences of Community-Based Rehabilitation program

Community-Based Rehabilitation model has been experienced in different developing countries such as Kenya, Ethiopia, Zimbabwe, Ghana, Zambia, Tanzania, Indonesia, Philippines, Swaziland and so forth. In this review of literature, some of the experiences are cited below.

Kenya

Community-Based rehabilitation program in Eldoret and Kitale of Kenya has served more than one thousand and two hundred children and people with disabilities with different kinds of disabilities and now this people are on the road to good rehabilitation (Hutchinson, 1998).

The survey conducted in the Diocese of Eldoret by co-coordinators of CBR program reveals that causes of disabilities in the area of Nandi shows that congenital anomalies, infectious diseases, neurological disorders and traumas including deformities are the major ones among others (Ibid.). In CBR program, community members with churches have played a significant role in rehabilitating children with physical Disabilities in Kenya (Percia, 1997). Percia's study reflects that the focus of CBR program in the area is mainly on physically disabled people including those with sight and hearing impairments. Similarly the report shows that the CBR project in Eldoret served over one thousand and six hundred people that have received treatment or referral services. This report also shows that out of the above-mentioned figures, more than one hundred fifty of them have received corrective surgery services by the assistance of local physiotherapists and doctors.

The experience of CBR in Kenya in general and in Diocese of Eldoret project in particular is quite encouraging. However, the community based rehabilitation projects in Kenya in most cases are based on external donors. Therefore, their financial viability depends mainly on funding from external donors and international NGOs. Except few projects, they do not yet have income generating schemes. As seen in different literatures, the other problem of Kenya CBR is lack of volunteers' involvement. Volunteers and local teachers were used as the home visitors. However, the number of youth involved in CBR activities without payment at the initial stages reduced drastically as time progressed (Hutcherson, 1998). There fore the problem of payment was reported as one of the causes for the dropout of volunteer workers.

Gahanna

In Gahanna, the CBR program has brought important changes in families of children with disabilities. The study conducted in one CBR project of Gahanna shows that 30% of volunteer mothers and 73% of nursery mothers who participated in the CBR project played major role in facilitating the CBR program (OToole, 1991).

In Ghana, Ministry of employment and social welfare initiated a community-based rehabilitation program for people with disabilities in 1992 (UNESCO, 1994). This project

was initiated in collaboration with the Ministry of Health, Ghana Education services, the ministry of Local Government, non-governmental organizations of persons with disabilities. According to the UNESCO 1992, cited in O'Toole 1994, it is estimated that over one million of the country's 15 million people are disabled. To improve the conditions of these persons with disabilities the following activities were undertaken through CBR at individual, community and national level. As stated by O'Toole in one of the UNESCO's (1994) article the major activities are the following:

- Strengthening of social infrastructures, human resource development and other services were carried out
- Net working was established between service providers in health, education, community development and social welfare at district level
- Training in the community for people with disabilities
- Mobilization and support for communities within their respective district.

In addition to this, local people have managed to erect school buildings to facilitate the education of children in the community. Before the CBR program was initiated in this community, children were used to walk a distance of 5KMs to attend a school (Ibid). A committee also has been constituted at the national level in Ghana. The committee plans for the program to include the introduction of CBR in the curriculum of the school of social work, and a component on the education of children with special educational needs in the teacher's training colleges.

Philippines

CBR in Philippines was established as a complete departure from institutional approach and it was operating in six regions of the country, each of which was reaching more clients annually than all the residential services in the country combined (O'Toole 1991). In this country, volunteers from selected communities were trained to start income generating activities or disabled members with support and services of the community (UNESCO, 1994). Generally, the volunteers were encouraged and supported to go in to profitable income generating activities to support CBR programs at community level.

Jordan

In Jordan, some useful lessons are learnt regarding CBR program. The Holy Land institute for the deaf entered a CBR program in 1983 (Andrew, 1994 cited in UNESCO report, 1994). According to Andrew the work of the institute includes:

- The provision of wheelchairs and braces,
- Helping to develop services for physically disabled people
- Developing special education units for children with learning difficulties.

This institute runs in service training for teachers of special educational need children. Many of the trainers were involved in CBR work on a voluntary basis and turn over is high, which can make it difficult to achieve a good result.

In Jordan, some of the problems encountered CBR services are paraphrased below.

Attitude of the community Majorities of the community rely on more its local institutional services

Some potential CBR workers have become used to institution-oriented thinking and find it difficult to consider alternative patterns of provision, the concept at the heart of CBR.

CBR is development oriented and operates on the basis of partnership. However, charity oriented approaches are a major problem for CBR to become more successful. Therefore, training is essential to become development oriented rather than charity oriented (UNESCO, 1994).

Ethiopia

According to MOLSA (1992) the idea of community-based rehabilitation in Ethiopia was first introduced by Rehabilitation Agency for Disabled (RAD) in collaboration with UNDP and ILO in early 1980's.

In the 1990s, NGOs and Rehabilitation Agency are engaged in a community based rehabilitation project (CBR) for the disabled in different parts of the country including Addis Ababa, Assela, Nazareth and Bahirdar (MOLSA, 1996). Projects that were undertaken by NGOs and government organizations have four major components.

- Vocational training for the disabled
- Basic rehabilitation and education
- School children and youth awareness program

- Basic community health education is mentioned in different annual reports and assessments of MOLSA and NGOs.

The mission of CBR among NGOs in Ethiopia is to contribute to the efforts made by government, NGOs and community organizations to assist disabled people to obtain health, educational training, employment opportunities and other services that are needed to improve lives. Cheshire Home CBR, Voluntary Council for Handicapped (VCH), CBR, Catholic Church rehabilitation service and Redd Barna CBR program are some of the major CBR initiatives undertaken by NGOs in the country. According to Tigabu (1998), some of the Cheshire home's CBR activities include providing education about health, nutrition, vaccination, safety and family planning with in the major objective of preventing disabilities in the communities. Non governmental Organizations and governmental organizations in Ethiopia are undertaking CBR program not only for persons with disabilities but also include parents' of children with disabilities, children in kindergartens, primary and secondary schools, neighbors of families and community members in the project areas (Ibid.).

In Ethiopia, efforts made by government, NGOs and other Agencies are very inadequate compared with the magnitude of the problem (VCH, 1998). Similarly there is lack of mechanisms to coordinate the limited efforts made by different agencies to assist and promote the interests of the disabled in the country (RAD report, 1996). RAD's report also shows that, in some cases humanitarian or philanthropic services have aggravated the sense of dependency and helplessness in the disabled people due to poor planning and in appropriate approaches in to the problems.

As indicated by VCH report of (1998) some of the limitations observed regarding CBR in Ethiopia are:

- Lack of capacity building, lack of support for CBR workers, Lack of community ownership and poor management of CBR committee.
- Majorities of the CBR programs carried out in Ethiopia were purely dependent on external donors to undertake project activities in the past.
- In some areas, phasing out strategies of the project is not yet in place. In addition, CBR programs to mobilize the community to make CBR programs sustainable and vibrant program are not making significant efforts.

In conclusion, CBR programs in developing countries in general and in Ethiopia in particular have an opportunity to extend their responsibilities in to their local communities. By working in partnership with persons with disabilities and non-disabled members of the community, to reach the millions of those who are still deprived of the opportunity of rehabilitation, it needs more involvement of parents and community members in CBR activities. Local communities and disabled people in developing countries were and have been involved in CBR activities. However, experiences in developing countries show that local communities often lack the necessary awareness and sensitization about people with special needs. Therefore, educating communities about the special needs of its disabled members has paramount importance.

2.6. Rehabilitation of Children with Physical Disabilities

2.6.1 Definitions, causes and types of physical Disabilities (Physical disability)

Children with physical disabilities or health impairments are large and diverse group that ranges from asthma, a comparatively mild condition to a cerebral palsy, which may involve neurological impairment that affects mobility and other functional skills (Sharon and et al, 1996). According to USA's public law 94-142 cited in Reynolds (1987) physical disability is classified in to two i.e., Orthopedic and Health impairments. However, the focus of this paper is only on orthopedic impairments, which is usually and interchangeably used with physical disability.

The Arizona special Education department (ASE, 1997: 18) defined orthopedic impairment as follows:

" Orthopedic impairment means one or more motor disability and includes those that are caused by congenital anomaly, disease, and other causes, such as amputation, cerebral palsy and adversely affect a child's performance in the educational environment". In this regard, orthopedic impairment and motor disability are synonymous and have the same meaning. Examples of motor disability that may be caused by birth defects are clubfoot and absence of one or more limbs and on the other hand motor disability that may be caused by disease include polio and arthritis (Sharon and et al, 1996). Other causes of motor disability may include cerebral palsy, amputations, and fractures that cause stiff or immovable joints called contractures (Ibid). .

Accordingly, ASE (1997) elaborates orthopedic impairment or physical disabilities may not only interfere with child's coordination and mobility, but also affect their ability to communicate, learn and adjust. The aforementioned definitions show that motor disability is an impairment that substantially limits a person's participation in one or more life activities such as home, school or work activities.

Taylor, Strenberg and Richards (1995) conclude the definition of physical disability in two commonalties. In the first place, a physical disability will affect one's interaction with the environment and in the second place physical disability will require special services.

There are different types of physical disabilities /Motor disabilities/. The major types of physical disability are polio, cerebral palsy, contractures, muscular dystrophy club feet, juvenile arthritis, spina-bifida, leprosy, amputations, burn deformities and so forth (Werner, 1994). Among these types of physical disabilities polio, cerebral palsy, clubfeet and amputation are considered under this topic.

a) Prevalence of Children with Motor Disability

In USA, approximately 52,000, or 1.1 percent of all children receiving special needs education services are categorized as having motor disability annually (Sharon and et al, 1996). As indicated in US office of Education cited in Encyclopedia of special Education (1987) indicates that the greatest percentage of those identified as physically disabled were individuals who have cerebral palsy. About 500,000 to 700,000 Americans have some degree of cerebral palsy with about 5,000 to 7,000 infants born with cerebral palsy (3/1000 infants) per year (Sharon, 1996).

On the other hand, Kaffuma and Halahun, (1988) estimated that 0.5 percent of school aged children have physical disabilities in USA. Taylor and his colleagues (1995) pinpointed and support the estimation given by federal government of US in 1988 that is cited in Kaffuman and Hallahun.

A survey study conducted by Tirusew and et.al (1995) reveals that persons with physical disability (walking sitting and eating) constitute 30.9% in Ethiopia. According to this survey among other types of disability physical disability stands first.

2.6.2. Educational program and other related Rehabilitation Services for Children with Physical disability

According to Yesseldke and Algozzine (1995) educational intervention of today is a complex system directed to meet the diverse learning needs of children with disabilities. Three basic principles in accommodating students with physical disabilities are explained by Bigge, J. (1991). These basic principles in accommodating students with physical disability are:

- Using others as resources such as expertise of the student, parents, other school personnel as well as student's classmates.
- Be flexible in instructional planning and changing the plan in response to day-to-day condition and readiness to learn.
- Be ingenious and creative. One of the greatest rewards from working with the students is helping them to discover their strength and ways to demonstrate them.

The aforementioned idea shows that in interdisciplinary teaming, all members of the teamwork together view the students as a whole instead of working only on their specialty area. It shows that all team members are aware about the student's goals and observe each other as they work with the student so that they can share and generalize successful techniques and strategies in rehabilitation process.

Locally made assertive technological devices are particularly useful for increasing mobility, communicating better performing daily living skills, enhancing learning's and manipulating and controlling the environment (Batshaw, 1992).

In addition to the necessary accessibility modifications, Sharon & etal (1996) discuss three types of environmental modifications:

" Changing in location of material and equipment so that for example students in wheelchair can reach items independently, work surface modification (e.g. raising a desk so that a wheelchair fits under it). Manipulation aids (e.g. using a page-turner to reduce dependency on others "(Sharon, 1996:21).

According to Werner, D. (1994) some of the best design improvements in aids and equipment for children with physical disability to meet the child's needs many writers take in to

consideration different important things. As many children with physical disability grow and develop, his/her needs keep changing. Therefore, frequent reevaluation is necessary to find out if an aid should be changed or is no longer needed. This means that asking the child what he/she wants is important. For instance, a device that was appropriate at the age of two may not be appropriate at latter age.

In addition, a simple, low cost-aid that is designed and made to meet the needs of a particular child often works better than an expensive commercial one (Batshaw, 1992). This issue is also indicated in Werner (1994), commercial wheelchairs are often too big for children, and hard to adapt to their positioning needs, repairs are difficult and expensive. On the other hand, a simple wood chair can be easily made to fit the child's size and positioning needs. Therefore, considering the economic limitations of the family and adapting equipments to the local culture and way of life is very imperative.

WHO training package Manual 9 (1996) reveals that growing children will frequently need larger size of aids such as leg braces, artificial limbs, and special seating. So, using either aid that is cheap enough to replace often or that can be easily made bigger is very important for disabled children. For example, poor families sometimes spend as much as a year's earnings on expensive, modern braces, with knee and special shoes. When the physically disabled child out grows, the family cannot afford to repair or replace it. Hence, the child goes back to crawling and may never walks again. For this reason, adjustable home and locally made braces should have arranged to be cheaply replaced. Generally, before deciding if a child needs special aids, braces, surgery or equipment, and what kind, considering the needs of the child carefully in his/her family and community should have to get due attention.

2.6.3. Rehabilitating Children with Cerebral Palsy, Poliomyelitis, Amputee and Clubfoot

Among different types of physical disabilities cerebral palsy (CP), poliomyelitis, amputee and clubfoot will be discussed under this sub topic. According to Werner (1994) polio and cerebral palsy are the most common types of disability in developing countries like Ethiopia respectively.

2.6.4.1. Rehabilitating Children with Cerebral Palsy (CP)

Kaffuman and Hallahan (1989) defined a cerebral palsy as a condition characterized by weakness, in coordination of muscles or other motor dysfunction due to damage to the child's brain before matured. Cerebral palsy is caused by damage to one or more specific areas of the brain, usually occurring during fetal development before, during, or shortly following birth (Health-Link-USA, 1991). In its general sense, "cerebral " refers to the brain and "palsy" to disorder of movement or muscle weakness (UCPRE, 1997). Cerebral palsy itself is not progressive (i.e., it does not get worse) however, secondary conditions can develop which may get better over time, get worse, or remain the same (Werner, 1994). Although Cerebral palsy is not " curable" in the accepted sense, training and therapy can help to improve the child's situation. (WHO, 1996).

According to UCPREF, there are three types of cerebral palsy. These includes:

- “Spastic-stiff and difficult movement
- Athetoid-involuntary and uncontrollable movement
- Ataxic-disturbed sense of balanced and depth perception”(UCPREF, 1997:12).

Cerebral palsy can be caused by damage to the brain, genetic disorders, injury or disease (Sharon, 1996). Premature birth, low birth weight, infection of the mother with German measles or other virus diseases in early pregnancy, child bearing process, accidents, falls, brain infection and child abuse are risk factors for cerebral palsy (UCPREF, 1997).

The whole brain is not damaged, only parts of it, mainly parts that controls movement is damaged, and once damaged, the parts of the brain do not recover, nor do they get worse (Werner, 1994). In this regard, the movements, body positions and related problems can be improved or made worse depending on how we treat the child and how damaged his or her brain happen to be (Health Link-USA, 1997). This implies that the earlier we start rehabilitation, the more improvement can be made.

In many developing countries, cerebral palsy is the most frequent cause of physical disability and about 1 out of 300 babies are born with or develop cerebral palsy (Werner, 1994). Werner also explains that the damaged part of the brain cannot be repaired, but often the child can learn to use the undamaged parts to do what he/she wants to do.

Families can do a lot to help CP children learn to function better. Families and rehabilitation workers need to learn from one another. The rehabilitation workers can help families know

where to start with their child. It is best to start with activities that the child can do and build his success and follow the stages of development (WCFP, 1993).

According to Werner (1994), rather than trying to treat the symptoms of cerebral palsy, parents and rehabilitation workers can do more for the child if they help the child with development of movement, communication, self-care, and relationship with others. As mentioned by Rye, H and Miriam (1989) facilities used for managing cerebral palsy child's daily living and educational materials include simple ramp, ample space in class room, walking aids, correct seat, simple writing materials, reading aids and so forth. Simple aids available in the area make it possible for the child with cerebral palsy to follow the curriculum and manage the social activities in the best way possible as many as other students. As it was discussed in the previous part of this paper, simple aids reduce the practical difficulties, cost and also will increase the child's independence and self-reliance.

In conclusion, the intervention and rehabilitation process, the involvement of the family members, teachers, peers, rehabilitation workers and the community at large have valuable importance for the well-being and integration of a child with cerebral palsy to the community.

2.6.4.2. Rehabilitation of Children with paralysis of Polio

In many developing countries, poliomyelitis is still most common cause of physical disability in children (Werner, 1994). In Ethiopia for example, at least one of every 100 children may have some paralysis from polio (MOH Population Handbook, 1995). However, after vaccination program become effective, polio has been greatly reduced. As indicated by Tirusew (1998) and cited in Vergson (1993) "poliomyelitis (polio) is an acute disease that inflames nerve cells of the spinal cord or brain stem and leaves a residual paralysis or muscular atrophy which resulted in many individuals with physical disabilities.

In areas with poor hygiene and lack of latrines the polio infection spreads when the stool of sick child reaches the mouth of a healthy child (MOH, Hand book, 1995). Polio is not inherited or familial and does not affect ability to have children. So persons with polio can have normal children (Werner, 1994). Studies show that all children paralyzed by polio can be helped by certain basic rehabilitation measures such as exercise to keep a full range of motion in the affected limbs. However, each child has a different combination and severity's

of paralyzed muscles, and therefore will have his/her special needs. For some children, normal exercise and play may be needed like non-disabled children. Similarly, others may require special exercise and play materials still others may need braces or other aids to help them move about better, do things more easily, or keep their bodies in healthier and more useful positions (Ibid).

Based on the principles of community-based rehabilitation and special needs education, every child needs to be carefully examined and evaluated in order to meet his/her particular needs. This implies that the earlier you evaluate a child's need, and take steps to meet them, the better. However, Werner (1994) found that in most areas where polio is still common, community rehabilitation programs do not exist or are just beginning to help many adults and children who have been paralyzed for a long time already have severe deformities and joint contractures. In principle, often this must be corrected before a child can use braces or begin to walk. In such cases, problems of a polio child become complicated and need some rehabilitative measures to be taken early.

According to Werner, (1994) the changing needs for aids and assistance for the progress is important, if the following measures are carried out.

- Exercise to keep full range of motion, starting within days after paralysis appears and continuing through out rehabilitation
- Active exercises with limbs supported, to gain strength and maintain full motion
- Exercise in water walking, floating and swimming, with the weight of the limbs supported by the water
- Rendering locally made wheel board or wheelchair with supports to prevent or correct early contractures
- Render Crutches modified as walker for balance and extra support.

The above types of aids and support indicate that applying these activities may prevent complications that can appear after, due to lack of proper rehabilitation support. Though there is lack of rehabilitation services in many areas, CBR workers should have to teach families to do a lot of things to help their children with polio to learn and function better.

2.6.4.3 Rehabilitation of Amputee and Clubfoot Children

An amputation is the loss of some parts of the body. And rarely, children are born without one or both hand or feet (Adams, 1995). More often children loss an arm or leg because of accident, or limbs must be cut off because of advanced bone infections (Werner, 1994). Some of the types of amputation, included missing both hands, missing one hands, an amputation below the knee, one leg amputated above the knees and both legs amputated above the knees (Ibid.).

Deciding what to do for a child with amputation depends on a number of things, including the age of the child at the time of amputations, the amount of amputations, and above all, what the child and parents want and accept. Hooks, artificial limb (if the child born that way), artificial leg as soon and after the amputation as possible or by one year age are some of the most important assistance that should be facilitated for an amputee child (Ibid.). Children with very high amputation of legs may do best in wheelchairs. Children's living with amputation often requires equipment to aid in mobility, seating, and standing and activities of daily living. Children who have lost a limb, or are born without a limb require the services of physiotherapist and rehabilitation workers (RCC, 1997). The team consisting of a surgeon in the local health center, CBR workers and physiotherapist work with the child and family to assess the need for limb replacement should have to be in place.

All amputee children like other children need to be talked and listened to. Some families over protect their child who is amputated. They do too much for him/her. So, he/she will not learn to do things for himself. According to the WHO (1996) No.8, training manual for children with moving difficulties, families and rehabilitation workers need to learn from one another to teach the amputee child in all aspects. The same guideline of No. 11 indicates that training in observing and assessment of the limb, instruction in the care and use of the prosthesis should have to be provided for family members. In addition to medical treatment, braces, crutches, wheelchair, special education or appropriate schooling have a paramount importance in the rehabilitation of amputee children.

Regarding clubfoot, about 3 out of 1000 children are born with a clubfoot or feet and some times clubfoot runs in the family, but usually the cause is unknown (Werner, 1994). The feet may also gradually become deformed in to a "club foot" position, because of cerebral palsy, polio, arthritis, or spinal cord damage (Ibid.). Correction of clubfeet should begin soon after

the child is born if possible, in the first two days. This can be done by locally training physiotherapists or trained parents of the child. At birth, baby's bones and joints are still soft. As the child gets older, his/her bones get harder and become less flexible to correct it by locally trained physiotherapist (RCC, 1998). This implies that good correction without surgery only possible in the first year of life and in an older child it takes longer, and surgery is more often needed for good lasting results. The study conducted at PRJIMO CBR center on correction of clubfoot with casts shows that 60% of clubfeet can be effectively straightened with out surgery in 6 to 8 weeks, using casts (O'Toole 1991). Generally, early intervention and rehabilitation measures could help to bring changes in health and functioning of movement in clubfoot children.

CHAPTER THREE: METHODOLOGY

3.1. Instruments of Data collection

Implementation of Community-Based Rehabilitation program for children with physical disability requires the study to be multifaceted necessitating the use of both qualitative and quantitative methods. Accordingly, three methods of data collection were employed in this study.

1. Focus Group Discussion

One of the tools used for qualitative method was a focus group discussion. Discussions were held with small representative group guided by the investigator to get information about ideas, beliefs and behaviors of CBR program participants. It was carried out with children with physical disabilities, their parents, and rehabilitation workers.

2. Questionnaire and Interview

The data collection instrument for the quantitative information was a closed and open-ended questionnaire. This consisted of two parts. Part one was administered to children with physical disability and part two was designed to interview parents of children with physical disability and CBR coordinators. The questionnaire and interview questions were used to complement the focus group discussion method.

3. Secondary data or written descriptions

In addition to focus group discussion and the questionnaire, secondary data on CBR and children with physical disability was analyzed. In this regard, general information about the children with physical disability including numbers of children in different age groups, family size and type, housing, economic activities of parents and types of CBR services were carried out in the area are briefly treated. Annual reports and unpublished surveys were the basic resources for secondary data analysis. Finally, secondary data was analyzed to complement a focus group discussion method.

3.2. Sample Selection and Target groups

In order to make the sample significant, 62 percent of the total number of children with physical disability and their parents were included in the sample. Thus, a total of 104 respondents were interviewed. The following steps were followed in the sample selection. Fifty-eight children with physical disabilities above the age of 12 and below the age of 18 were randomly selected out of 95 children those who received CBR services in the past 6

years. They were also interviewed by using questionnaire A. In addition, 46 parents of children with physical disability were selected from 74 parents and interviewed by using questionnaire B. For focus group discussion method, a purposive random sample was used and four focus group discussions sessions were held.

Six to nine people or children were in each category for Focus Group Discussion (FGD).

These include:

- CBR workers 6
- Children with cerebral palsy and club foot 8
- Polio and amputee children 7
- Parents 9

3.3 Procedures of Data collection and Analysis

In data collection, questionnaire and guiding questions were initially prepared in English and then translated in to Amharic language (the Ethiopia working language).

Approval was obtained before conducting this study from East Showa zone Labor and Social Affairs department and WACT. Rehabilitation workers either in the participant's home or in a conference room scheduled by the investigator conducted interviews with parents and their children. A total of four rehabilitation workers were selected to conduct an interview by using the questionnaire. After selecting the most experienced rehabilitation workers, the investigator gave orientation for the interviewers about the questionnaire and interview was carried out. As far as a focus group discussion was concerned, one person assisted the investigator. Then a focus group discussion was conducted based on the guiding questions. Probes were used to clarify what was said. Each focus group discussion session was lasted from one and half-hours to 2 hours.

During the focus group discussion, notes were taken and discussion was tape-recorded. The investigator had the discussion taped and has an assistant taking notes. The result of the discussion was transcribed and responses were classified by themes and analyzed. Some pictures are also attached to the ends of the pages to support the findings of the focus group discussion regarding CBR programs so far under taken in the past.

The information collected from secondary data was also used to supplement the qualitative data as well as data gathered by the questionnaire. Responses collected by the questionnaire

were grouped and tallied in a format designed for this purpose. The data was then analyzed by using simple percentages and descriptive statistics. The simultaneous collection and analysis of data by a questionnaire helped to complement the results obtained by a focus group discussion.

CHAPTER FOUR: ANALYSIS AND FINDINGS OF THE STUDY

4.1 Background Characteristics of the study Population

Under this part sex, age, prevalence, occupation and education of parents and children are presented. The questionnaire was distributed to a total of 58 children and 46 parents respectively.

4.1.2. Age and Sex of children with Physical Disabilities

Table 1. Children with Physical Disabilities by age and sex

Types of Disabilities	M	F	T	%	Mean Age	Median Age	S.D
Polio	16	9	25	43	15.4	15	1.61
Cerebral palsy	12	5	17	29.3	15.41	15	1.23
Amputee	8	4	12	20.7	16.3	16.8	1.62
Club foot	2	2	4	7	15.5	15	1.5
Total	38	20	58	100	15.5	15	1.49

In this study, 62% of the subjects were selected from 95 children with physical disabilities. As indicated in table 1 above, the population constitutes four groups of children, namely: polio (43%), cerebral palsy (29.3%), amputee (20.7%) and clubfoot (7%). Thus, the total subjects are 38 male and 20 females within the chronological age of 12 to 18 years. Mean age, median and standard deviation values were 15.5, 15 and 1.49 respectively. In this case, there is no remarkable age difference and there is a smaller proportion below the age of 14. Table 1 also shows that out of the total population, 65.4% of them are male and the prevalence of children with physical disabilities is higher among male than female. As indicated in the same table, polio prevalence was 16/25 (64%) and 9/25 (36%) for male and females respectively. However, with such small sample, it is hard to speak of statistical significance, but it is important to note that male children with physical disabilities have higher rate of cerebral palsy and polio than female with a much lower rate. In this study

although the majorities of the respondents are males, the number of females cannot be undermined for any interpretations.

In addition, such a combination of sexes and living areas of the informants could help me to draw a reasonable conclusion from my finding. The profile of these children also shows that the incidence of physical disability is highest (26.3%) in age category from 11- 25 ages and the next highest falls between the ages of 26-40(Rehabilitation Agency, 1995). In this profile, the incidence of disability by sex reveals that males constitute 64.7% and females make the remaining 33.3%. This secondary data shows that there are more males than females across the two sexes.

4.1.3. Socioeconomic Characteristics

Table 2. Educational level of Children with physical disability

Educational level	M	F	Total	%	Total Mean	Total S.D
Never attended	2	1	3	5.2	-	
Attended school for some time but drop out	1	1	2	3.5	-	
Grade 1-6	18	8	26	44.8	-	
7-12	16	7	23	39.8	-	
Above 12	2	2	4	6.9	-	
Total	38	20	58	100	5	2.3

❖ *Source: Results obtained by Questionnaire-A*

The educational level of the children ranged from elementary to high school, i.e.; grade 3 to 12 ($x= 5$, S.D. 2.3). More than eighty four percent (84.6%) of the children are enrolled to primary school over the past six years after their parents were involved in Community Based Rehabilitation program. Before the commencement of CBR project, majorities of the informants were with out any education. As it can be obtained from the secondary data of RA- CBR program, out of 95 children with physical disability in 1994, there were only three children enrolled to school. Therefore, the net primary enrollment ratio for children with physical disabilities increased from 12.6% to 84.6 between 1994 to 1999. It has been also

observed that three children with cerebral palsy were not ever enrolled to school and two attend school but they were dropouts for some reasons including parental problems.

Table 3. Family members with whom children live

<i>Family members</i>	<i>No</i>	<i>%</i>
With Mothers and fathers	9	15.5
With Mothers only	38	65.5
With Fathers only	4	6.9
With Sister /Brother	2	3.4
With Other extended family	5	8.6
Total	58	100

❖ *Source: Profiles of Physically disabled Children RB-CBR, 1998*

The current living status of children with physical disability was assessed from profiles and record sheets of CBR projects. The result of this file shows that 38 target children or 65% are living with their mothers only. Nine children (15.5%) are living with their both parents. Seven (12%) children are living with sisters and others are with extended families. There are an increased number of children living with their mothers than fathers due to divorce of parents as a result of their child's disability.

• **4.1.3. Parents' Educational Status**

Table 4 Educational status of parents as given by children

Educational status	No	%
Illiterate	14	24
Read and write	24	41.4
Primary school	11	19
High school	6	10.5
Diploma	1	1.7
Degree	1	1.7
Unknown	1	1.7
Total	58	100

As indicated in table 4 above, out of 58 children's parents, two parents only attained degree and diploma level of education. The data strongly indicates that 65.4% of the parents either had not gone to school or they were only able to read and write.

In addition, the background of participant involved in a focus group discussion shows that among nine parents only two of them have an educational level of grade 5 to 6. The rest can only read and write. In addition to this, six community based rehabilitation workers were also participated in a focus group discussion. All CBR workers were completed grade 12 and have one-year training on the issues of CBR for dpersons with disabilities. Among seven CBR workers, two of them are polio cases 32 and 37 years of age. While the rest are "non-disabled" and aged 34-42 years with the mean age of 34.6.

4.1.4.Occupational Status of Parents

Table 5 Occupational status of parents' Pre and Post CBR program

N o	Types of occupation	Pre CBR –1994		Post CBR 1995-1998)	
		No	%	No	%
1	Civil servant	6	10.3	6	10.3
2	Daily laborer	15	25.8	3	5.2
3	Pensioner	2	3.4	2	3.4
4	Self employed and petty traders	6	10.3	36	62.2
5	House maid	16	27.7	8	13.8
6	Dependant on relatives	7	12.2	2	3.4
7	Others	6	10.3	1	1.7
Total		58	100	58	100

❖ *Source: Redd Barna Nazareth annual reports 1998.*

As it is shown in table 5, before 1995, majorities of the parents were housemaids (27.7%) and daily laborers (25.8%) respectively. However, the occupations of parents were drastically changed in five years. In this regard, 62.2% of the parents occupation become petty traders or self-employed. Thus the number of parents engaged in housemaid activities was decreased from 27.7% in 1994 to 13.8% in 1998. On the other hand, self-employed petty traders increased by 51.9% with in five years. In the context of this study, majorities (73.5%) of the parents are said to be employed in that they are involved in formal and non-formal services currently.

4.2. Causes of physical disabilities as perceived by parents and Children

Table 6. Parent's belief about the causes of Physical disability before and after the commencement of CBR program

No	Causes	Parents belief before CBR		Parent's present beliefs	
		No	%	No	%
1	Cursesfrom God (Religious beliefs)	24	52.2	2	4.4
2	Lack of vaccination	-	-	8	17.4
3	Complication during pregnancy & at birth	4	8.7	8	17.4
4	Disease	2	4.4	9	19.5
5	Premature birth	4	8.7	4	8.7
6	Alcohol/drug	-	-	1	2.2
7	Accident	2	4.4	6	13
8	Unknown causes	8	17.4	8	17.4
	Total	46	100	46	100

❖ *Source: Results obtained by Questionnaire-B*

As shown in table 6, curse from God was highly manifested as a cause for physical disability among 24 (52.2%) of the parent's before they were involved in CBR program. However, at present, majorities of the parents reflected that the causes for physical disability are lack of vaccination (17.4%), complication at birth (17.4%), accident (13%) and disease (19.5%) respectively. Unknown causes were mentioned by 8 (17.4%) of the parents. I have conducted an interview with RA CBR coordinator about parents' belief concerning the causes of cerebral palsy before and after the intervention CBR program. In this regard, he stated his opinion as follows:

“In Adama town and the surrounding community, we have many types of physical disabilities including children with cerebral palsy (CP). Cerebral palsy is common in our town especially in rural and slum areas of the town where traditional and untrained birth attendants deliver most babies at home. Sometimes, when labor is very long the baby’s brain does not receive sufficient oxygen and is damaged, thus causing cerebral palsy. As a CBR workers team, we tried to prevent such damage by encouraging mothers to deliver at hospitals or health stations where help is available if labor become difficult. Our team is also concerned that their families do some times not accept children with CP. In the past, many parents believe that CP is witchcraft or a burden from God. We tried to overcome these ideas by talking to mothers about CP and how it is caused. Those mothers who understand the cause go on to explain the cause to others, by helping to reduce negative attitude and prejudice to create community acceptance.” Thus, this opinion shows that the causal attribution of physical disabilities at present differs from that of the previous ones.

Those who ascribe the cause as a curse from God (4.4%) may not show any effort for treatment at present. In this case, parents believe that their children’s fate is already predetermined. As indicated in table 6 above, before the commencement of CBR, more than 52% of the parents believe that the cause of physical disability could be attributed to superstitious beliefs. However, after six years of CBR intervention, 95.6% of parents believe that the cause of physical disability could be attributed to accidents, disease and unknown reasons. In connection to this, one CBR worker mentioned, “ parents those inclined to believe that physical disability is possessed by evil spirit resort to the holy water or to other traditional medicines than medical treatments or CBR interventions.”

On the other hand, a mother of child with CP in a focus group discussion reflected that:

“I know about the cause, I gave birth while I was 16 years old, the baby was born with very small kg. He was born with a premature age. And I had identified that some obvious signs such as strabismus eye and inability to suck a breast were reflected right after his birth.”

Similarly, it is indicated in table-6 that premature birth represents 4(8.7%) of the causes among the total sampled population. Parallel with other causes of physical disabilities, train accident was not a minor issue as mentioned by children with physical disability.

In a focus group discussion with amputee children, a 15 years old boy expressed about the cause of his disability and his past feelings as follows:

" I was amputated as a result of train accident while I was 10 years old. It was because my mother was leading our family life by selling some home made bread and "Kolo" (toasted grain) to passengers during train hours since the train station is very closer to our home. I walked with her and reached to sell some "Kolo" to assist my mother through the train window when I slipped under the train and lost my two legs. After my knee replacement, I felt that I improved often dramatically. I had restored my movement".

One locally made shoe user of 16 years old clubfoot girl also replied in a focus group discussion that:

" I was born with club feet legs. In fact, my problem was not diagnosed until I was 9 years old; however, after it was diagnosed and that they told me I have had it since I was born I aggressively responded. But now I feel very much more comfortable and I can walk and move".

In a reply to a question of what new knowledge gained about the causes of physical disability, a focus group discussion held with parents of clubfoot and CP children made the following suggestions:

"In the past, we thought that cause of cerebral palsy and club foot was the punishment from God for our personal wrong doing like committing sin and disobedience to churches' rules. However, currently we understood that cerebral palsy and clubfoot are not caused by supernatural powers. Instead, the causes are associated with premature birth, disease, accidents and other factors", they replied.

In relation to this, the following was reported from a focus group discussion held with CBR workers. They remarked:

"We have observed that superstitious beliefs about the causes of physical disabilities are still wide spread among both Christian and Muslims in the town. However, traditional belief of parents on religious attitudes has been largely changed to possible causative factors in Adama in the past five years. We think that our CBR program promoted awareness among parents by teaching them about the tangible causes and treatment of physical disability."

4.3. The Effectiveness of Community-Based Rehabilitation program as perceived by Children with Physical disability

In this part, the investigator has tried to analyze the way children with physical disability viewed their disability in relation to the rehabilitation service they have received in the past. The analysis was purely made based on the issues raised by children those participated in a focus group discussion during three sessions. At present, the perceived characteristics of children with physical disabilities by the majorities of the informants can be more or less characterized as having desirable attitude towards themselves. To this effect, a focus group discussion was held with polio, cerebral palsy, clubfoot and amputee children. In this regard, five polio cases said: " We saw ourselves as " normal " even though there were hard times at dealing with exercise." Another polio child remarked: " I am exclusively healthy except using braces." The same polio case added that " I felt great and doing just great like non-disabled children in all activities"

Polio children were also asked in retrospect about their self-perception by comparing their previous and current situation. For this reason, the following responses were obtained. Three of the participants replied that, "during our post corrective measures we were "doing nothing", unable to walk, we were unable to go to school, we were unable to visit friends, and no play which we are doing as well now." Participants in a focus group discussion (polio and clubfoot) also said, "we recognized the significant role played by our mothers and CBR workers in providing support". These children also referred their mothers as their better nurturers than their fathers in dealing with their effective rehabilitation. Another clubfoot girl (15 years old) "commented on the tremendous support she gets from her "peers". She also said, "the CBR workers are very considerate in giving counseling services".

In relation to this, another information was gathered from those informants participated in the same focus group discussion.

"I had an orthopedic prosthesis and locally made shoes. Until I had a treatment, I was crawling. I wondered after a treatment, it is like I am born all over again. I can control my life...the caliper and shoes are made in our CBR project.... Not in some manufacturing industry, said 16 years old clubfoot boy.

Responses from focus group discussion with clubfoot polio, cerebral palsy, and amputee children indicate that some coping strategies such as "not thinking about it, keeping active and looking at the positive aspect of their disability" were stated. In this regard, a 17 years old child with cerebral palsy stated "I dealt with my disability by not thinking about it and keeping busy". One participant girl in the same focus group discussion also said "I had not given it much thought or attention." Another FGD participant boy replied, "I try not to think about it." A 15 years old amputee also stated: "I never thought myself as having a disability after treatment." It was just something I had a scar on my body part," a surgically corrected clubfoot boy said. Thus, a focus group discussion participant spoke of the positive aspect of their polio paralysis, amputee and clubfoot after treatment.

Children's current Self-Perception and future Vision

Regarding the attitude of other children towards him, a 16 years old amputee boy in a focus group discussion suggested the following in relation to the rehabilitation services he had received.

"I stopped going school for more than two years before I was assisted by CBR program. After I have received appliances and crutches free of charge I joined school but children on the way call me "bale arat egir" four legs for my crutches. Some other calls me "Koriti"(amputee). However, after the establishment of "disability club in our school" many of them stopped such nasty names. Currently, they included me in games in which I can participate. So, I started to advise those children annoy me. Some accept my advice while others do not accept."

Through the questions raised about their self perception in comparison with non-disabled children, a club foot girl said, "I choose to look on the positive side of my life, seeing my braces and appliances as equal to others leg and I have a faith and trust of my parents, peers and CBR workers".

Children were also asked about their current self-acceptance and future visions in a focus group discussion. A 15 years old clubfoot boy said, "before I was able to get support from the CBR center, I thought that it was hard for a person like me to plan ones own future when basic survival is a question. However, it is important to have hope that the future will be better. My future aim is to first improve my own life and then to help other disabled children like me."

In the same session, a polio case reported that:

During the past five years I received much moral and material support from CBR workers and I realized that being disabled was not the end of life. What I can say to my disabled colleagues is that it is not the end of life to become a disabled person anywhere. We persons with disability must be strong, we must work hard to survive, and we must be happy for the lord who created every one."

On the other hand, two Hemiplegic (CP) children involved in a focus group discussion stated: "We managed to adjust to a growing body which was weak on one side. In fact, we did not overcome most of our problems like clubfoot children. It is hard to be poor with a disability.... We needed more training than the secondary school education that we were able to complete. We needed another special training to be self-reliant in spite of our handicap. Our aim and future vision is to acquire proper rehabilitative measures like clubfoot children to feel confident in our self and to rely on our self. But to fulfil this aim, we need more training and treatment so that we can cope and overcome disability and poverty in the future."

Contrary to this, a 17 years old clubfoot girl is highly interested in CBR program and she said:

"Today, I own my business by the loan that I have received from CBR project. In addition to my business, I learned how to make crutches, braces and other orthopedic materials. At present I am a volunteer in CBR workshop on my part time." Regarding her future plan she also added, "all my life I must work for those disabled children. I hope that one day the world will change and be better. People will be together without fighting, they must love each other and defend rights of children with disabilities." My goal is to help children with disabilities in giving education and vocational training which has been started by our community based rehabilitation program." In general, majorities of the children believe that their previous misconception about themselves is quite changed to positive attitudes with good vision."

4.5. Participation and Involvement of Parents, Children & community members in CBR program

Table 7.Participation of both parents as perceived by children

Involvement	High		Medium		Low	
	No	%	No	%	No	%
Fathers' involvement	4	6.9	6	10.3	48	82.8
Mothers' Involvement	53	91.4	4	6.9	1	1.7

Source: Results obtained by Questionnaire- A

In table 7 above, 82.8% of children with physical disability responded that their fathers' involvement and role in rehabilitation process is minimal. On the other hand, 91.4% of the respondents said, mothers in CBR program welcomed the role of grater involvement in their child's rehabilitation.

In a focus group discussion, mothers' were also asked whether their children with disabilities could be helped by their fathers to achieve certain developmental tasks such as being able to walk, eat, and feed on their own at early age. Most of them agreed and remarked that:

“... At present, our children could be helped to achieve different self-care activities. However, the roles and involvement of fathers is too demanding and they are not deeply involved in the rehabilitation of their children.”

In addition to this, in a focus group discussion held with 8 children with cerebral palsy and clubfoot, five of them explained about their fathers and mothers as follows:

“Our father’s do not have the belief that we can be taught to acquire early developmental skills. However, our mothers played a key role in teaching us how to eat, dress, walk, talk and use crutches”. Regarding the negative attitude of his father towards him a CP child who participated in a focus group discussion remarked the following proverb that is always said by his father in Afaan Oromo. “Supheen caabaan matii gargaaree hinbeeku”. Which means, " a broken pot cannot serve the

family". This word always irritates me and my father also insists me to beg in the street to generate income for my family," said the child.

4.5.2. Participation of the Community in CBR program

Table 8. Major areas of community participation

N=46

Responses	Responses (parents)	
	No	%
Planning	1	2.3
Donating money	3	6.5
Advice	19	41.3
Labor	6	13
Local materials	14	30.4
Monitoring and evaluation	3	6.5
Total	46	100

❖ *Results obtained by Questionnaire-B*

The above table shows that most of the participation is manifested in providing local materials (30.4%), Labor 13% and advice 41.3% respectively. On the other hand, the donation of money to the project was (6.5%), while that of evaluating and planning stands at the lowest end of the scale 6.5% and 2.3% respectively. In connection to this, a CBR worker described, "Some of the community participation in CBR activities included the CBR volunteer selection, health committee members, construction of pit latrine, and announcing polio vaccination campaigns." By extending his responses the informant also said, "the principal community members participated in CBR activities were the volunteers, health committee members, persons with disabilities associations, teachers and students."

Regarding the issue of cooperation with Kebele administration and "Idirs", an Idir leader remarked the following:

"Six years ago we heard that Keble 09/16 were selected by Redd Barna CBR program. House visits were done and a general meeting was held. Committees were formed... I have lived for 27years and have seven children. Among my seven

children one boy is a polio case. For this and for my personal interest, my contribution in CBR program is fully voluntary. I simply want to help the poor. When the people elected me for Idir chairperson and for CBR task force committee member, I was very happy, how can I disappoint them? I know that RBE-CBR program is leaving (phasing out) now. For this reason, we have started to prepare ourselves...It is our responsibility and we are determined to make this project sustainable. We are not going to let them down and we are very grateful to the people of Redd Barna CBR workers. He continued and said, the Kebele accepted bribery. Therefore, we consult the kebele people to follow the same pattern as RBE- CBR program. When we have a problem with the kebele and CBR program members, we arrange the coordinating task force committee meet to discuss and resolve problems.” In addition, a CBR workers were discussed about the role of volunteers in a CBR program implementation whether volunteers could be expected to provide unpaid services on long term basis or not. In this regard, a CBR co-ordinator participated in an interview stated:

“...Despite the belief that volunteers should serve their community and children with disabilities voluntarily, volunteer service with out salary cannot be sustained on long term basis as they require money for necessities". This was also stated by most of the CBR Workers as follows:

“In our long period experience we believe that the provision of incentives to volunteer workers has to get considerable attention and it needs to be carefully examined in terms of long term involvement in CBR activities and program sustainability.” Rehabilitation workers were also asked about the contribution of volunteers in the implementation of CBR program. For this question, they replied that in the past six years the major roles of volunteer includes:

“... Creation of social awareness, counseling services for children and parents, home visit, identification of the key problems of children with physical disabilities, developing linkages between the disabled and CBR workers, mobilization of community resources and facilitation of contribution of materials, training in schools and out side schools.” They extended their answers and said, “...due to the aforementioned reasons and other factors in Adama, the CBR project has increased attendance and support given to children with physical disabilities and their families. This has lead to a positive impact regarding their possibilities to survive, develop and participate in any activities.” In addition to this, a CBR

coordinator said, “the impact of using various awareness raising strategies increased their knowledge on the rights of children with physical disabilities by children themselves and by the members of police and the community at large.”

Table 9. Parents' means of communications with CBR workers and community members

Response	No	%
Discussion and meetings	19	41.3
Visits and conferences	4	8.7
Letters and telephones	2	4.3
Parents' committee meetings	20	43.5
Others	1	2.2
Total	46	100

Source: Results obtained by Questionnaire-B

Asked which means of communication parents used, 43.5% of the respondents indicated that parents' committee meetings were the major ones. Further more, discussions and meetings comes to the second rank with 41.3%, while visits, letters and conferences appear towards the end. Some parents in the focus group discussion also proved that there are other informal means of communication "such as at "Idir", "Ballitina", and weeding ceremony times. This informal meeting can be imagined to open a better understanding between parents, CBR workers and community members as well.

CBR workers involved in a focus group discussion similarly noted that:

“... Communication between parents’ and our CBR program was not only with our initiatives. Parents' were paid a visit to out office, occasionally in order to know more about their child's progress and to get counseling.” The same group also explained, "...We visit parents' home monthly in order to investigate the child's health history, interest, parents' expectations, attitudes and educational progress.”

4.4. Major Strategies used for Community Mobilization in the Implementation of CBR Program

4.5.1. Awareness Raising

Table 10 strategies used to raise awareness of the community and parents

Strategies	Very good		Good		Not good		Total
	No	%	No	%	No	%	
Advocacy by Associations of persons with disabilities	20	43.5	5	10.9	21	45.6	100
Participation of persons with disabilities in workshop/seminars	32	69.5	5	10.9	9	19.6	100
Child-to-child interaction/peer/	37	80.4	9	19.6	-	-	100
Parents meetings	41	89	5	10.9	-	-	100
Marking persons with disabilities day (drama, games, sport and music)	44	95.6	2	4.4	-	-	100

❖ Results Obtained by Questionnaire-B

Various strategies have been found to be effective in mobilizing communities for the implementation of CBR program. As shown in table 10 above, 95.6% of the respondents rated *marking persons with disabilities dates* as the major information dissemination strategy, while 89% of parents ranked regular meeting of parents as a second important strategy used for community mobilization purposes. The most third and fourth important strategies in raising awareness of the community were *peer discussion* (80.4%) and *workshops* (69.5%) respectively.

In addition to this, some important means that were effectively used was identified. As mentioned by CBR workers, “traditional and community support groups including mutual social associations *Idir*, *meredaja* and financial cooperative societies *Ekub* were used as an important strategies for mobilization of the community in the implementation of CBR activities.

4.5.2. Involvement of Children in the implementation of CBR Program

Table. 11. Number of children involved in awareness raising activities

Types of involvement	No	%
Working as a Volunteer	2	6.9
Working in CBR committee members	3	5.2
Involved in Disability club and community education	21	36.3
Involved in coordination of peers	6	10.3
Not involved at all	22	37.9
Participated in persons with disabilities organization (DPO)	4	6.9
Total	58	100

❖ *Results obtained by Questionnaire*

The number of children with physical disabilities involved in creating awareness about disability issues and CBR activities in the area is indicated in the above table. The table indicates that majorities of the children (62.1%) were involved in different CBR activities such as serving as a *volunteer* and community educator in the areas of disability. Among 62.1%, 36.3% of them were involved in community education. The data also reveals that more than 37.9% of children with physical disabilities were not totally involved in creating awareness about disability issues and CBR program.

4.5.3. Net working with local institutions

Redd Barna's Rehabilitation workers those who were participated in a focus group discussion pinpointed net working with local institutions as a best intervention strategy to attain their program strategies. As related to their service provisions to children with physical disabilities, three government departments were identified namely: Department of labor and Social Affairs, Education and Health departments. In this regard, the rehabilitation workers mentioned the cooperation they have made with each department in the past.

They were asked to express the importance of net working as a strategy to implement CBR program. They explained it as follows:

“As far as department of Labor and Social Affairs (DLSA) is concerned, cooperation and support programs such as conducting training for physiotherapists, production of appliances and braces, awareness raising for community members were undertaken.” In addition, the project cooperation programs with department of education were mainly focused on revitalizing the previously neglected special needs education. Regarding this issue one CBR worker said: "construction of ramps in four primary schools, provision of appropriate appliances and wheel chairs, play materials and counseling have been some of the activities undertaken to assist children with physical disabilities in collaboration with department of education in the area". The same informant replied, “Community health education, environmental hygiene, vaccination, family planning, and HIV/AIDS prevention were some of the activities carried out with zonal department of health.”

Moreover, the cooperation between department of labor and social affairs and Redd Barna CBR project was also explained by the informants participated in a focus group discussion. They said, “Redd Barna-Nazareth branch CBR project has made a considerable effort to support activities of labor and social affairs orthopedic workshop in a more sustainable manner. Local materials such as wood and iron casting used for the production of adoption chairs, parallel bars, crunches have been provided to rehabilitate particularly children with physical disability." The participants also further explained that materials and machineries provided to DLSA served for cutting, smoothing and welding of iron bars and bending equipment have been supplied as part of package to strengthen artificial device production for children with physical disabilities.”

In general, the focus group discussion participants stated that the intervention strategies undertaken in collaboration with local government departments has helped and increased participation of children in schools social and leisure activities remarkably.

4.5.4. The Relationship between CBR program and Schools

Table 12 CBR program and schools relationship as perceived by parents and children

Responses	Respondents				%
	N=46 parents		N=58 children		Average Total
	No	%	No	%	%
High	17	36.9	34	58.8	47.8
Medium	21	45.6	16	27.6	36.6
Low	2	4.4	4	6.8	5.6
No relation ship	6	13.1	4	6.8	9.9
Total	46	100	58	100	

As shown in the above table, an attempt was made to know the level of relationship between CBR program and schools in Adama town. Thus, 36.9% and 58.8% of parents and children respectively indicated that the relationship was high, while 45.6% of parents and 27.6% of children have perceived it to be medium. Average of 5.6% in both groups still witnessed the relationship is to be low. On the other hand, 13.1% parents and 6.8% of children indicated that there is not any sort of relationship between parents, community and schools. In a focus group discussion with CBR workers they remarked: " the current relationship between primary schools and CBR program is very high. However, the relationship between parents and schools is limited to the sending and receiving of their children to schools only.

In addition to the above figures, CBR workers stated:

" Before the commencement of CBR program in Adama, families and schools appear to be as having independent "*islands*" of their own that may have affected the children's progress as well. But after CBR program has been implemented in the area, the ties and relationship between the two groups become high. Relationship programs such as visiting schools and initiating commonly operating committees were established in four schools."

Concerning the importance of relationship between CBR program and schools, a 16 years surgically corrected clubfoot girl in a focus group discussion said:

“The CBR project constructed a ramp in my school and has renovated, and furnished the school with necessary materials. At the initial stage it was difficult to me to go to school and enter class with out the help of my peers. Significant changes have been observed on my personality and necessary attention is given to me from my teachers and guardians after awareness creation workshop about disability has given to the school community. At present, I do not have any problem to discuss and play with able ones. Non-disabled children don't call me" *mankiya Egri*" spoon legged" as they do before. All these paramount changes were created due the establishment of conducive relationship between CBR program and my school community.”

There is evidence that the CBR intervention has had a positive impact on school attendance for children with physical disabilities in Adama town (Report from Adama Woreda Education Department, 1998). This report shows that many children with disabilities are admitted to school after 1995. The RA CBR coordinator has also informed me about the current relation ship between schools and CBR programs in Adama town. In his response, he explained that, “the CBR program in its education component has involved the provision of infrastructure in the form of school construction or extensions to the existing schools and provisions of school materials and school fees in certain private schools where school fees should be paid.” He also stated, “training has been provided to teachers in the areas of community mobilization and introduction of productive projects to generate income for support to disability clubs were introduced to four schools.” Similarly, a father of a polio case who is a CBR task force committee member was interviewed on the relationship between schools and CBR program. And he said, “ Two kindergartens were constructed by CBR project in collaboration with parents and school community members. One special unit and three primary schools were also renovated and supplied with teaching and learning materials. Five children with physical disabilities were admitted to the kindergartens.”

4.5.6. The Role of CBR workers in supporting children with physical disabilities in Schools and Family atmosphere

In this section, an attempt has been made to investigate the role played by rehabilitation workers in child's schooling. In the first place, the CBR workers were asked how they could train and teach parents and children at home to send their children with physical disability to primary school.

A CBR worker participated in a focus group discussion stated the importance of stimulation for CP children before schooling. He remarked:

“ Stimulation is important to prepare children with physical disabilities for preschool or primary school as well as it gives them the extra skills they need to develop their abilities. Before the child starts school, we tell the family what they can do at home to help with the child's schooling. We make arrangements for these children to be brought to school and taken home by family member, by other school children or neighbors”.

In relation to this, in a reply to a question of what should be the role of rehabilitation workers in training children who have difficulty of moving after admitted to school, two rehabilitation workers participated in a focus group discussion stated as follows:

“ Some children who have difficulty of moving may need to use sticks, crutches or locally made frames to walk. Others may have to be carried. So, we have arranged for these children to be able to move around easily in school. We arranged for some of them to have the space they need in class in collaboration with teachers.”

A CBR worker who participated in the same focus group discussion session stated:

“In Hawas primary school, two CP children who have difficulty of using their hands were encouraged to write more easily by using their toes or mouths. One CP boy was successful in writing by using his toes. This was done with the great efforts of a CBR workers and some teachers.”

The following description of what CBR workers do for prevention and rehabilitation of physical disabilities refers to their work with in community based rehabilitation program. They were asked about their roles in retrospect. Three guiding questions were in place to

collect information in the focus group discussion. Though the questions seem that they include all types of disabilities, participants of the focus group discussions were asked to refer their role and experiences only concerning prevention and rehabilitation of children with physical disabilities. In the first place, the probing questions were addresses about " How to inform and educate children with disabilities and their parents?" A young CBR worker has explained his experience and roles as follows:

“Before all, I observe the child carefully, if the impression of delayed development persists, and there are medical doctors available to do assessment of the child, I refer the child to the hospital. In most cases, I take the responsibility to guide and encourage the mother to stimulate the most normal development possible. For example if the child has impaired movement, I used to teach the mother how to position the child, and how to move the limbs each day in order to prevent deformities and improve mobility.”

CBR workers also agreed and said that children and adults who have physical disabilities were benefited from the advice offered by us. Our advice includes information about methods of positioning to prevent deformities, general modifications to be made in the home, such as rearrangement of seats, bed or appliances.

In facilitating attitudinal changes of children with physical disabilities, one CBR worker remarked: “... I know many people with similar disabilities; some have a very active life while others do not, so I used to bring all of these individuals together so they learn from each other. I did the same with many mothers of children with physical disabilities and this in turn give assurance and encouragement for children as well as their parents.”

In expressing about their role, a 37 years old CBR worker stated:

“I have served as educator, advocator, facilitator, team member, counselor and home visitor in the past six years. He also explained that child with cerebral palsy took longer to learn to do things. From my experience such problems made his family not to stimulate and reward him. I know some families over protect their children who have cerebral palsy. They do too much for him/her. So, I learned from experience that working effectively with the CP child and his/her family is essential in the rehabilitation process.”

4.6. Obstacles encountered in implementing a CBR program in the area

In a focus group discussion with Community Based Rehabilitation workers some obstacles that hinder the implementation of CBR program were discussed. Discussions were focused on the ways and means of identifying obstacles in order to turn them in to opportunities for growth. Some of the obstacles mentioned by CBR workers were personal obstacles, socio-cultural barriers, policy issues, management and training problems. Under these four basic issues, informants expressed their opinion as follows. Regarding personal obstacles, the rehabilitation workers mentioned that: "Children's and parents' negative attitude to wards themselves, unrealistic expectations from the community, lack of skills in use of appliances, emotional problems and dependency syndrome of children with physical disabilities were some of the obstacles that hindered CBR program."

As far as socio-cultural barriers were concerned, rehabilitation workers also agreed and suggested the following:

"Negative attitude of families towards their children, isolation and abandonment by families and communities, negative attitude by some government departments towards the issues of CBR activities, and cultural beliefs" are major obstacles so far mentioned by informants.

Rehabilitation workers suggested the following obstacles in connection to policy issues as a barrier in implementing CBR program.

- "Government policy is not in place regarding the implementation of CBR program.
- There is lack of collaboration between NGOs and government organizations
- Limited availability of resources for the implementation of the CBR program.
- High demands from donors and government officials for quick impact."
- Lack of local fund raising and dependency on external funds."

In addition, CBR workers were asked about the management and training's undertaken in the past six years. CBR workers replied that sustainability might be hindered for the following reasons:

" Inadequate involvement of persons with disabilities and children in program planning, inadequate training of CBR personnel and lack of community participation were cited as some of the major barriers in implementing Community Based rehabilitation program."

4.5 Measures taken by CBR Program to Rehabilitate children with physical disability

After the Rehabilitation Agency and Redd Barna's project intervention, several activities were implemented to rehabilitate children with physical disability in Adama. In a focus group discussion, CBR workers stated, " types of interventions may vary based on the nature of motor disability, and active role of parents, role of rehabilitation workers as well, in inquiring either temporal, radical or intermediate solutions." The major intervention areas that have been undertaken since the last six years were:" surgical assistance, counseling services, health education, mobility training provision of devices and physiotherapy services."

Table 13 Types of rehabilitation measures under taken

Type of measures	No	%
Surgical corrections	27	46.6%
Medical assistance	56	96.5
Health education/Environmental Health	46	79.3
Mobility training	24	41.4
Provision of devices	36	62.1
Physiotherapy services	28	48.3
Counseling services	52	89.6

❖ *Results obtained by Questionnaire-A*

Accordingly, the above table shows that 46.6% of children with physical disability had undergone effective surgical corrections. Almost all (96.5%) benefited from medical assistance and 89.6%of the children have received counseling services. Mobility training is also given to 41.4% of children. More than 62.1% of children with physical disabilities benefited from provision of all types of devices. 48.3% of children are benefited from physiotherapy services in the past six years. Environmental or health education was also given for 46 (79.3%) of children. In addition, mobility of children with physical disability has also shown a significant improvement through provision of devices, mobility training and counseling services on simple physical exercises using parallel bars and walking frames. This is clearly shown in table14 below.

4.7.1. Mobility Changes

Table 14 Mobility Improvements observed as a result of CBR intervention

Changes	No	%
Mobility improvements with devices/appliances	27	46.6
Mobility Improvements with out devices/appliances (Surgical correction)	24	41.4
Complaining about changes	2	3.4
No significant improvements	5	8.6
Total	58	100

From a total of 58 children with physical disability, the finding of this report indicates that 27 (46.6%) children have shown improvement of mobility with the help of appliances and devices. On the other hand, twenty-four (41.4%) of the children have shown mobility improvements changes with out help of appliances, i.e., through training and surgical correction only. Five (8.6%) children with motor disabilities are cerebral palsy cases that did not shown any significant changes on their physical mobility. Two (3.4%) children are also CP cases complaining of minor mobility problems.

In addition, an amputee boy was interviewed and he told me about his personal history and access to wheelchairs as follows:

“ I am 18 years old boy living in Keble 09 of Adama town. Eight years ago, I had a train accident that left me severely disabled. I cannot move and I spend most of my days sitting in armchair looking from the window of my parents’ home. It is several years since I last went out side. Although I have never committed a crime, I feel like a prisoner. Before 1995, there is almost no opportunity for me to work or to study. Without money, I cannot receive good medical services and I cannot find a suitable medical rehabilitation service. Moreover, I become a volunteer CBR program worker in 1995. Currently I am grateful since I have obtained a wheelchair from CBR program. Even though I am grateful to obtain a wheelchair, I also know from my own experience that a wheelchair in itself can be a big problem for a person with disabilities. For example, I still have to find a wheelchair that is right for my needs together with devices that can fits with the existing infrastructures in our town. Most

of all, I am interested in information about the rights of persons with disabilities to combat discrimination, on raising awareness about disabilities in Nazareth and another areas of my country.”

4.7.2.Changes Observed as a result of Parents Involvement in Income generating Activities

This study sought to determine what, if any increases or changes had occurred in the areas of local income generation. Redd Barna and RAD-CBR projects have started a revolving fund in 1994 to help families of children with disabilities in the town. The income generation strategy is focusing on the household and could potentially benefits the child in keeping with the CBR services. It is also used as a strategy, which targets mothers predominantly, and this is consistent with the aim of Redd Barna CBR program to target children with disabilities. Concerning women’s saving and credit associations, CBR project coordinator was interviewed. This informant replied that “ the main benefits seen by the groups and parents in all income generating projects included reduced dependency on money lenders, low interest on credit, leading to their ability to buy goods and food items. He also said, the earnings are generally enough for clothes and school materials for children.”

Based on this, a focus group discussion was also held with parents to investigate the substantial increases obtained on parents as well as their children's livelihood as a result of their involvement in saving and credit scheme.

Regarding income generating activities, a mother of a club foot child said:

“When they (Redd Barna-CBR workers) came to help us we thought it was one of the numerous of empty promises. However, this project started in transforming our well being relatively to a better life. When has government come to our aid like this? Ever since the founding of this town, I never had it so good like this project”. She also said that before joining CBR program, my family and I lived in one straw roofed house. When it rained water leaked through the roof and we used to collect the rainwater in utensils and later throw it out. In rainy season, I used to fill my children's ears with cotton before they went to bed, so that rainwater could not get in during the night rains. However, after I involved in CBR income generating activities, I live in rented iron corrugated roofed living houses. Recently, I bought some bricks with which I have planned to build additional one room.”

Another mother who involved in the same focus group discussion sessions stated:

“ Before joining CBR's income generating scheme, I had no savings. But after I have received a loan from CBR's income generating program, I have more than 2000 birr savings in my account last year. However, I spent this money on my daughter's marriage. At present, even though I had no money of my own at hand, there is 1000 birr loan which I borrowed from RB-CBR and now I have intended to buy a milk cow.” Regarding the change she has obtained, a mother of a CP child who trained in poultry production skill remarked as follows: “I feel proud because many neighbors respect me and seek my advice and suggestions regarding poultry production. Many of these people who need my advice were from families who initially opposed me when I joined a CBR program and those who annoy me due to my child's disability. These days I planted the CBR seed in my "Kebele" I hope it grew in to a tree, and began to grow leaves and have now gave fruit at present. I think that a CBR project has changed my families and my child's life in many ways. Now, community members respect me as my income increased and my child's mobility improved,” she said.

As far as the attitude and the status of parents in the community are concerned, except one mother, most of them said, “Our status in the community has increased due to our involvement in Income generating activities.”

In relation to her income and improvement in status, a 42 years old mother of an amputee child remarked:

“Before I was involved in CBR activities, some of my neighbors call me “Yekomata Enat" which means " mother's of a leper. However, at present I feel that their attitude is drastically changed at present, because my activity in income generating scheme is acknowledged as an example among my neighbors. All my children including the amputee child joined school. So, I feel that my status within the community has increased due to my involvement in CBR activities.”

On the other hand, a mother of a CP child who has not benefited from CBR income generating activity noted:

“I feel that it was mainly due to my illness that I did not benefited from CBR_IGA as I found my self unable to make saving deposits or pay my loan installments. Now, I

have no saving. I also feel that being in CBR did not make any difference for me. My status with in and outside my family has remained the same before and after my involvement in CBR. In fact, many people have improved their living condition through their involvement in CBR. It was just my bad luck that my child and I could not do so to ourselves.”

Regarding the use of their income derived from income generating activities, most of the parents said that we spent most of our income for consumption purpose and use for other needs as medical treatment, or important social obligations such as marriage and for holidays. In addition to this, a CBR worker who organizes the saving and credit scheme said, “in most cases the family borrows money on behalf of their child with physical disability. In one case, a brother and sister of polio cases were given credit. Their father used the credit investing on stock to set up small business in their names. This in turn increased the income of the family and raised the status of the brother and sister with in the family.” In relation to this, CBR workers remarked that loans are used in many ways “...buying animals for rearing, setting up small businesses, purchasing grains for business and food and money was used for social obligations.” In general, this finding shows that parents' involvement in income generating activities has changed parents' livelihood and their children's well being.

CHAPTER FIVE: DISCUSSION

In this chapter, the result of the finding will be discussed and interpreted in relation to the research questions and theoretical assumptions. To qualify the result some implications were drawn. Therefore, major thematic contents are presented based on the findings.

5.1. Causes of Physical disability and some related prevailing factors

As the causes of physical disability varied, its prevalence also varies due to the differences in educational level and socio-economic status of the families of children with physical disabilities (Ingested and Whyte, 1995). Levene, Malcom (1986) also said, the incidence of congenital malformation increases as socioeconomic status falls. In addition to this, Redd Barna Ethiopia (1995) found that malnutrition, poor environmental sanitation, disease, accident, premature births of the children and inadequate health services are the major factor that causes physical disabilities in Adama town. The present study also indicated that prior to the commencement of CBR program in the town parents' beliefs and perceptions about the causes of physical disability corresponds to parents' low level of awareness. In this regard, before the commencement of CBR, (52.2%) of the parents said that perception about the causes of physical disabilities was a curse from the God. However, parent's present perception about causes of physical disability showed that lack of vaccination, accident, disease, unknown causes and birth complication constitutes more than 78%. This implies that parent's awareness about the causes of physical disability has significantly changed from superstitious belief to possible factors after the intervention of community-based rehabilitation service has been introduced in the area.

Similar result was obtained in a focus group discussion held with parents. One mother remarked: "In the past, I thought that the causes of polio was curse from God for my wrong doing and disobedience to saint Gebriels church rules. However, at present I realized that the causes of my child's problem is associated with disease and lack of vaccination". One can infer from this that, initially polio was thought and related to curses from God and other religious beliefs. But due to measures taken by CBR program parents' belief was changed.

In addition, of 58 children with physical disabilities in the present study, all received some kinds of rehabilitation services. This may include surgical correction, counseling, education,

health and training. As a result, majorities of the parents believed that having a child with physical disability is a result of some problems rather than sin of the family or religious factors.

A study conducted by Hutcheson (1998) in Kenya Nandi Village reflected similar findings with the current study. Hutcheson's study showed that Nandi village community's belief about the cause of cerebral palsy is shifted from total religious belief to the real causative factors through long efforts of rehabilitation health workers. Here also after intervention of CBR program, except few parents and children, almost all respondents attached possible causes to different problems appeared before and after birth.

In relation to this, I found some views of children with physical disability about the possible causes of physical disabilities. For instance, a polio girl remarked her view about the possible cause of her disability as follows:

“ I became disabled because of poliomyelitis when I was 3 years old. My mother told me that I suffered very much. She first took me to the traditional physiotherapist " Wogesha" and churches. There was no improvement. And, later she took me to " Dukuman Dirijit" (Rehabilitation Agency) while I was ten years old. I received physiotherapy and caliper at the center. I think the services I had received from the orthopedic center changed my life than the traditional treatments. So, I believe that the possible cause of my problem is lack of vaccination during my earlier age” she replied.

Similarly, there appears to be a relationship between sex and prevalence of physical disability. The study showed that more boys were found to be suffering from cerebral palsy and polio than girls are. In connection to this, Werner (1994), most of the polio attacks babies from 8 to 24 months and a little more affects boys than girls. A hospital based report from Hailemariam Mamo hospital (Adama) also showed about clubfoot children that there is a prevalence of 67% of male to 33% female. Again, I have found a valuable study conducted by Bischoff and et al (1996) in Botswana Mushupa Village. In Bischoff's survey, the prevalence of children with physical disabilities under 16 years of age was found to be six per 100 out of 180 subjects. The most frequent diagnosis was cerebral palsy followed by polio. In Bischoff's survey, male infantile CP children were greater than female CP cases in number. Since either the above-mentioned reports or the present study are not a triangulated inquiry or

a representation of the sample of the large population, it may be hard to make a general comparison or conclusion. However, the present study and what literatures have been said are significantly matching each other. For example, all rehabilitation workers in this study confirmed that the number of male children with clubfeet are greater than number of clubfoot female children in the town.

On top of this, some socio-economic factors such as lack of sanitation, poverty and low educational levels and the prevalence of physical disability may have relationship. The overall investigation of CBR program in Adama indicated that parents interviewed and participated in a focus group discussion fall under the category of poor in Ethiopia standard. In this case, the study showed that daily laborers and housemaids form the majority of people involved in the study before CBR intervention. In connection to this, (MOH, Hand book, 1995) has stated that in areas with poor hygiene and lack of latrines, the polio infection spreads when the stool of sick child reaches the mouth of healthy child. So, polio is related to low socioeconomic status of the community and poor sanitation.

Besides the above findings, a baseline survey was carried out by Redd Barna- Ethiopia in 1993 in collaboration with community based rehabilitation workers of Rehabilitation Agency in Nazareth town. In this base line study, the analysis on food intake by disabled children under five years of age indicated that the majority of children with disabilities (89%) are from families of lower educational and economic level. As a result, majorities of them are fed unbalanced diet only corn meal. Redd Barna's base line study also showed that most mothers found difficult to include meat, beans and vegetables in their children's regular diet. Therefore, this would mean that unless proteins are regularly provided to substitute for meat, the diet of children might suffer from protein deficiency.

In general, when we review the causes of physical disabilities and the prevailing beliefs in retrospect, most of the causes are recognized by parents as the result of infection, lack of health services, communicable diseases (polio), ignorance and poverty than superstitious beliefs. Regarding educational attainment of children majorities of children with physical disabilities i.e. 84.6% had only attained primary education level while their age mean is 15.5. Only nine children had reached the junior secondary level of education. So, this trend is alarming since it seems to indicate that physical disability has adversely affected the educational attainment of the children due to the problem of mobility. However, as it will be

discussed in this paper, parents are strengthened by community based rehabilitation services through family income generation activities, rendering counseling, orthopedic appliances and medical services which in turn helped children not to stop their lessons.

5.2. Participation of Community members, Parents and Children with Physical disability in CBR program.

5.2.1. Community participation / Involvement/

The main strategy of community based rehabilitation program is to secure rehabilitation services to the maximum possible number of persons with special needs at their local communities with least possible expenses (WHO, 1996). According to Gajaynke(1993), the active involvement of the people is governed by the conditions of the context in which the community based rehabilitation program takes place. Further more, participation varies according to the nature of community-based rehabilitation projects. This study has found that in Adama CBR project, people's participation in project lies on a continuum ranging from a high level of participation to nominal participation. The study also showed that the variation of community as well as parents participation depends on many factors, including the model of project development, style of management, personal and socio -cultural obstacles prevailing in the area.

This study showed that the CBR program in Adama mainly focused on helping children with physical disabilities, parents and the community by participating them in education, economic, social and community development while maintaining their dignity and self-worth. My informants reported that CBR accomplished this goal by net working, coordinating and facilitating with local institutions and volunteers. The study also showed that community involvement was low in CBR activities in three areas namely: planning, decision making and evaluation. In addition, focus group discussion participants revealed that there was low involvement in decision-making, donating money, and planning. In spite of low community involvement in CBR services in the area, fairly high coverage of active volunteer workers involvement was achieved. It suggested that volunteer's active involvement in CBR program is so important in community mobilization, social awareness and home visits. As it is discussed in chapter four respondents reported that " to ensure sustainability of the CBR program with in the Adama community, rehabilitation workers were selected from the town and surrounding areas". In this regard, for long-term sustainability of CBR program, respondents suggested payment for volunteer CBR workers.

In relation to this, Helander (1993) had stated that even though the issue of volunteer bases versus payment bases for volunteers is debatable, the philosophy of encouraging rehabilitation workers to be from the local community is unquestionable. This implies that selection of CBR workers has to be from the CBR project's operational area since they know the social beliefs and cultural values of the community.

In countries such as Philippines and Jordan, volunteers were effectively used and actively involved in CBR activities (O'Toole 1999). However, since local communities in developing countries like Ethiopia often lack necessary awareness about disability issues, volunteer service from the community is minimal (Voluntary Council of Handicapped Ethiopia, 1997). This is also because majorities of community based rehabilitation program implementers were not acquainted with the philosophy of CBR approach. In connection to this, since volunteer services hampers employment and other opportunities, volunteer service is discouraged in the area. What so ever it is, the Adama CBR program encouraged and has under taken the selection of the rehabilitation workers from the local community on payment basis.

Moreover, to introduce a new and effective CBR innovation to the community, it needs strategies such as media coverage, seminars and training at different level and stages (O'Toole, 1991). Various strategies have been used for community mobilization in the implementation of community based rehabilitation program in Adama. From the findings of this study, it is easy to understand that the majority (88.3%) of the respondents have rated "*observing dpersons with disabilities day,*" *parents meetings and peer- education* as effective information dissemination strategy to mobilize the community for the implementation of CBR program. In addition, traditional community organizations such as "*Idir*", "*equib*", "*mahiber*", and "*meredaja*" were also used as effective means to mobilize the community in the past six years. To this effect, CBR workers informed me, "the *Awra Godana* community *Idir* is a very dynamic, progressive and well organized indigenous organization which initially contributed 750Eth. birr for the payment of the volunteer workers to implement the CBR program. This shows that there is a positive attitude towards persons with disability among community members. The CBR project was lucky in that apart from the contribution of the *Idir* members, some members contributed in kind especially the acquisition of a 4-hectare site for CBR office, kindergarten and orthopedic workshop construction in collaboration with the town municipality. Furthermore, Redd Barna's 1998 report shows that

the achievements of Adama's CBR project intervention strategy were accomplished at community level under three categories. The first strategy was used in information dissemination and awareness creation among the community on the major causes of disability, and the second category encompassed rehabilitation measures by organizing and sponsoring seminars, workshops through formal and non-formal groups. In the third places, community members were motivated and involved in the establishment of facilities such as water points, play ground and communal latrines though it was very minimal. In this explanation, a CBR program has tried possible alternatives to realize the principles of participation and involvement of the community in CBR activities to assist persons with disabilities in general and children with physical disabilities in particular.

To bring attitudinal changes among the community and to rehabilitate children with physical disabilities, working with the existing local institutional services helped the CBR workers to achieve the objectives of CBR program. In connection to this, the CBR program in Adama town had used networking strategy with government local institutions such as health, social affairs and education departments. CBR workers in collaboration with local institutions undertook provision of appliances and awareness raising activities. In relation to the above ideas, CBR workers in a focus group discussion stated:

“Our CBR project has collaborated its activities with governmental and non-governmental organization to implement the program by using the resources and expertise of the institutions for effective rehabilitation of children with physical disabilities”.

This implies that involvement of local institutions in rehabilitation process, helped the CBR project in utilizing resources such as the existing services, skills and knowledge of expertise and care givers as an essential instruments for the implementation of CBR program.”

5.2.2. Involvement of Children in CBR Activities

With regards to children's involvement in CBR program, the results of the study indicated that (62.2%) of children with physical disability were involved in community education and school disability clubs. Similarly, this finding was in agreement with the principles of CBR model that says promoting participation of persons with disabilities in rehabilitation process enhanced their self-confidence and self esteem (Chitre, 1994). It was also agreed among all participants of the focus group discussion in that involvement of children in all phases of rehabilitation such as needs assessment, project planning and project implementation requires

patience, commitment and willingness of community based rehabilitation workers, parents and teachers. This shows that involving children with physical disabilities in project implementation activities is not an easy task without joint efforts and commitments of the stakeholders.

In this study, an attempt was made to investigate the importance of children's participation in implementation of CBR program. CBR workers stated that participation of children in CBR program“ has *enhanced their self-esteem and self confidence, reduced feelings of isolation, reduced depression and dependency.*” CBR program has also encouraged participation and paved an avenue of communication between CBR program implementers and children with physical disabilities. In relation to the above issues, the CBR model showed that participation of children with disabilities in CBR activities reduced isolation from the community and promoted their social integration in societal mainstream (Helander, 1993). The assumption behind social isolation is that sometimes getting disabled child may lead some parents and members of the community to the rejection of the child. In this case, a mother of a child with cerebral palsy explained her child's problem as follows:

“My child has experienced social isolation which was caused by his father. He also encountered rejection by his peers during his day-to-day interactions. His father hides him behind the door for a long period of time and his father don't allows him to participate in daily events such as participating in play activities, in recreational and household activities. These physical and emotional barriers frustrated the child. However, after I had started involving in rehabilitation services, I have benefited from the advice offered by rehabilitation workers. As a result, I encouraged my child to participate in all activities such as play, attending social events, religious ceremonies and other activities appropriate to his age”. These days, my child is successful in performing all social activities with his age mates.

According to the mother of this child, the participation of CBR workers in family rehabilitation approach is very useful for the rehabilitation and social integration of her CP child. It indicates that the CBR worker helped the mother to better understand the situation faced by her child in home and communities. Therefore, such appropriate assistance enhanced the child's participation in social activities.

The findings of this study also indicated that children with physical disability were asked to explain their perception about CBR program in relation to their present status. Furthermore, most of the children explained that their perception about CBR services has been changed through time. They also replied that they have received much moral and material support from CBR program and realized that they have started looking on the positive sides of their life. For example, one polio case said, *"I see my braces and appliances as equal to able bodied legs."* It seems that this child has built self-esteem and self-confidence after she was involved in CBR intervention activities. In addition to this, most of the children's self-perceptions seem to be an expression of self-confidence. Thus, this finding seems to be similar with what is mentioned by WHO (1996) that persons with disabilities adjust successfully by being loved, valued, treated and trained by their family as well as rehabilitation workers. This implies that encouragement and participation has promoted the over all psychosocial well-beings of children with physical disabilities.

As far as empowerment of children with physical disability is concerned, CBR workers noted some indicators. An empowered person with disabilities or group of persons with disabilities may be enough to bring the attention of the community to their needs and what should be done about them (WHO, consultation report, 1986). In this regard, the present study showed that the passive roles those children with physical disability played pre- CBR program was transformed to more active and valued roles. To qualify this idea, the result of focus group discussion showed that " many children with physical disabilities were participated in activities such as dance, sport, musical activities and different school clubs". Similarly children were participated in a child-to-child committee to advocate their rights and the right to have education, health and rehabilitation services stated it.

This effort has made CBR program as a stepping-stone to empower children with physical disabilities and such efforts have increased the visibility of children with physical disability among the community. More over, participants of this study reflected that children themselves often led social advocacy and different activities. This effort in turn also has improved their status and increased their value and image.

5.2.2. Parental Involvement

At present, it is recognized that many of the social and emotional needs of parents can best be met by participation in an informal voluntary association with other parents of children with

special needs (O'Toole, B; cited in UNESCO, 1994). As indicated in this finding almost there was high level of mothers' involvement than fathers in CBR activities.

For example, 91.4% of children with physical disability responded that their mother's involvement in rehabilitation process was high whereas 82.8% of them said those their fathers' role and involvement in their care and rehabilitation was very minimal.

A study conducted in Philippines (Ibid.) showed that involvement of parents could be influenced by sex with mothers tending to be more involved in rehabilitation of their children with special needs. In addition, father's role is limited in the life of his child with disabilities in developing countries. This is because variables such as rejection, lack of nurturing role, searching for jobs from place to places and educational level of fathers were some of the social indicators commented in the literature as affecting fathers involvement in rehabilitation of their children with physical disabilities (WHO, 1996). Effective parental participation was carried out by different means. Most of the parents (85.8%) indicated that mothers' committee meeting and discussion were the major means of communication that parents used to interact with the community members and with other parent's of children with special needs. Similarly, informal traditional community organizations assisted to open a better relation ship between parents and community members for the implementation of CBR program.

5.3. The Relationship between educational and community-Based rehabilitation Services.

Education of children with physical disability is part of rehabilitation and educational activities. As indicated in the literature part, CBR embraces both rehabilitation and education and it seeks a democratization of the provision of services but their implementation is quite different (Carpetier, 1994). The finding of this study indicates that the level of relationship between schools and CBR program was very low before the commencement of CBR project. However, majorities of the parents (58.8%) said that the relation ship between the two organizations is high while only 13% of the respondent said that the relationship is low at present.

On top of this, CBR workers explained that "parents and school relationship was quite very low and they appeared as two independent entities pre-CBR project. Such trend was also measured in those majorities (84.2%) of children under study were enrolled to school after

the commencement of CBR program. In this case, the profile of children with Physical disabilities shows that their mean age is 15.5 while they are attending primary school with mean of grade 5 at present. This shows that their chronological ages don't correspond with their grade level. So, the essence of this study is that the ties and relation ship between the two organizations improved in meantime. Some parents, especially fathers have tended not to send their children with cerebral palsy to school with the belief that their children are useless and unproductive.

Adama CBR programs assisted four schools by classroom materials reflecting disability perspective e.g. drawing materials, ramps for children with physical disabilities, disabled children posters, and materials with disability components. With regard to this, the result of this study indicated that some schools are renovated, ramps are made in some schools and significant changes have been observed on the personalities of children with physical disabilities in schools. In connection to this, Rye, H. and Mariam (1989) have stated that some simple aids available that may reduce the practical difficulties totally or partly compensate for the CP child's functional disabilities. Therefore, the aforementioned issues imply that adaptation and creating of special aids for children with CP assisted and enabled them to be more functional in schools.

In reducing difficulties that children with physical disabilities encountered in schools, CBR workers mentioned some of the strategies that they have undertaken in the past as follows:

" Some children who have difficulty of moving may need to use sticks, crutches, or locally made frames to walk. Others may have to be carried. So, we have arranged for some of the CP children to have the space they need in class in collaboration with teachers. And, we have arranged ample space around the child to be able to move without hindrance in the class room."

From the above CBR workers description, it is clear to understand that CBR workers served children with physical disabilities in the school by actively involving in school rehabilitation activities. This was achieved through the partnership created between schools and CBR program.

In addition to this, traditionally, regular or special schools have been service providers; the specialists and teachers are providing help for disabled children (Thorburn, 1994). However, CBR is not a charity-oriented approach. Instead it is an involvement of schools and the

community in development-oriented approach operating on the basis of partnership is the core element of CBR program in the rehabilitation of children with disabilities. Thus, the findings of this study show that both schools and CBR program are operating on partnership bases. This study also showed that teachers have very little reservation about meeting children with physical disability in the ordinary classroom if they are provided with necessary support from CBR program and parents.

In this regard, by realizing the inconvenience appealing to school environment, Redd-Barna and RA CBR projects implementation showed that the number of children with physical disabilities increased to 54 at present from that of 7 at the commencement of the CBR project. In this report, three CP children with multiple disabilities were transferred from special unit to regular schools by extensive follow-up of teachers and CBR workers.

From the finding of this study, it has been found out that the establishment of links with local institutions like schools helped to create effective partnership and helped to bring physically disabled children those remained at the back of the school to classes to meet their specific needs. This also implies that, for CBR to be effective a strong partnership needs to be strengthened with schools and other institutions to support children with physical disabilities.

5.4. Obstacles and Threats that CBR program Encountered

Respondents in implementing community based rehabilitation program in Adama area have mentioned different strategies to overcome obstacles. In addition, informants in focus group discussion as well as interview respondents pointed some essential changes observed so far. Respondents remarked that mixtures of strategies are required. In this study, involvement of parents, community members and children with physical disability in implementation of CBR program were indicated as essential & imperative strategy. Similarly, net workings, partnerships with local institutions were another points noted by informants. Social support networks both traditional and non-traditional formal and non-formal strategies have paramount importance as stated by CBR workers to address obstacles and threats of CBR program. In implementing the CBR program in the area CBR workers identified four basic obstacles and threats. These obstacles were categorized as, personal obstacles, socio-cultural barriers, lack of policy issues and management problems.

Moreover, the following detail obstacles and threats were identified and noted by rehabilitation workers during a focus group discussion. These were:

- Due to lack of awareness some difficulties in involving community in planning and implementation of the CBR projects.
- Interference and lack of support from some governmental organizations such as discouraging volunteer services, not allowing the NGOs to invest on disability issues.
- Lack of incentives for volunteer rehabilitation workers.
- There is high degree of dependency on external funding agencies for project implementation.
- Lack of skills in use of appliances, dependency syndrome and frustration on the part of children with physical disabilities.
- Fragmentation among CBR program, funding agencies and governmental organizations or lack of net working.
- Lack of clearly formulated social welfare policy to mobilize resources locally.
- Perceptions that non-governmental organizations involved in rehabilitation of persons with disabilities provide less quality and those workers are corrupted.
- Children and parent's negative attitude towards them selves and unrealistic expectations from the community were some of the obstacles, which hinder the implementation of CBR activities.

From the above CBR workers explanations, one can understand how different obstacles affected CBR program as a model for meeting the needs of children with physical disabilities and other group of persons with disabilities. Therefore, collaboration with multi-sectorial approach between and among different groups and stakeholders are required. All the mentioned problems of CBR program call a collaboration of all individuals, GOs, NGOs and beneficiaries in the identified community.

5.5 The Effect of CBR Intervention on Children, parents and community members

In this part, in addition to the numerical results some tangible feelings and hopes of children and parents were examined. Similarly, the children's needs and progresses were briefly reviewed in the context of their particular disability.

In this study, 46.6% of children with physical disability have undergone through effective surgical corrections and physiotherapy. More than 62.1% of children with physical disabilities benefited from mobility training and provisions of all types of devices. The study also showed that mobility of children with physical disability has increased significantly. Concerning the change observed a mother of a polio child noted the following.

“ ... My little boy had polio when he was 9 months old. He was unable to walk, and he had to continue crawling. Due to the effort of community-based rehabilitation, my little fellow was able to stand with aid of crutches and braces when he was 10 years old. At present, he is in grade four. He is also learning leatherwork. Moving around the village is unthinkable for this boy before the commencement of CBR project.”
(See the annexed picture).

Similarly, a clubfoot boy expressed his self-satisfaction and improvement in the following manner:

“I had an orthopedic appliance and locally made shoes.... Look! These shoes are made in our CBR orthopedic workshop center not in some manufacturing industry. Until I had a treatment I was crawling. After a treatment, it is like I was born all over again. I wondered. I realized that it is not the end of life to be a disabled person any where.”

The above findings indicate that positive results were obtained. Children had received emotional and psychological satisfaction from the rehabilitation services undertaken in the area. In this study, Werner (1987) noted that 60% of the clients were judged to have clearly benefited from the CBR program of Projimo project while 40% had also progressed but in more subtle ways.

Furthermore, this study also shows that from 58 children with physical disability, 46.6% children have shown mobility changes with the help of devices whereas 41.4% of them have shown mobility changes without the help of appliances, but through proper training.

By comparison, 41% of the cases in Philippines benefited from the CBR program. In the present study, although majorities (78%) of the parents said that their attitude about causes of disability is changed, there are some parents who still think the cause of disability is curse from God. This implies that illiteracy led them not to accept and participate in a lot of sensitization and awareness raising programs conducted so far.

On the other hand, the analysis of secondary data from Redd Barana - CBR project (1998) show the following achievements in the past six years concerning children with disabilities. In education, school enrollment of children increased from 27% to 84% and use of latrine by target families is increased from 24% to 65%. It indicates that these changes have been achieved as a result of various workshops; seminars and training that have been carried out to sensitize parents and the community.

Therefore, the notion of this study indicates that the program had a tangible effect on mothers' attitude about their children with physically disabilities. This in turn can change their negative conception towards a community. The study conducted in Guyana CBR program has a similar result with this study. Guyana's project study shows that all of the mothers working with CBR workers and half of the mothers working with nursery teachers saw important changes in themselves as a result of the project, feeling more relaxed, less depressed, happier, more confident and more aware of their child's potential (O'Toole. 1991).

During the past six years, 10 types of income generating activities have been planned and executed by the CBR program. The document from RAD-CBR project shows that the IGA assistance provided by the project varied from simple provision of start up capital or starter goods for the initiation of petty trade activities to the formation of saving and credit association. This report noted that as a result of IGA, monthly income of parent's of children with physical disabilities increased to Eth. birr 135 from that of 55 birr in 1994 (Redd Barana-CBR, 1998).

Similarly, a mother of a CP child who involved in a focus group discussion stated:

" Before the CBR's income generating scheme began, I had no savings. But after I have received a loan from CBR's IGA, I have more than 1800 Eth birr savings in my account last year. However, I spent this money on different social obligations. At present, there is 1200 birr loan which I borrowed from CBR-IGA and I intended to buy sheep for rearing."

As the above statements show, due to their involvement in CBR-IGA, parents have begun to acquire positive self-perception of their own personal interests. These self- perceptions allowed them to an opportunity to send their disabled children to school and arrange marriage for older siblings. It is also apparent that " many fathers have been to appreciate the benefits of having their wives and children involved in income generating activities. " Said a CBR worker. This finding also indicated that parents have an independent source of income, and they no longer need to serve as a house made in others home as they do prior to 1995.

For children's mobility, it is also clear that IGA involvement has had positive impacts in that many parents afford money their children for transportation to go to school or other far places. Many children never even ventured out side their own neighbors prior to CBR-IGA involvement, let alone travel to schools, and recreational areas. This implies that parents involvement in CBR-IGA has given their children opportunities to communicate with the out side world and at the same time has helped them to over come their fear and low- self-esteem in dealing with strangers and peers.

These are the over all changes those parents and children experiences as a result of being involved income-generating activities. This also indicates that CBR program initiation at community and family level helped to improve the awareness and income level among families of children with physical disabilities in this regard. In this connection, (Instegad and Whyte, 1995) stated that CBR intervention, apart from changing the lives of parents and children it has also played an effective role in bringing about changes in the wider community.

CHAPTER SIX: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

To generalize from these findings, the number of cases considered in this study seems to be small. However, based on the results of this study one may tentatively conclude the following only for the area understudy.

The goal of community based rehabilitation is to influence people, their perception, attitudes and behavior. In this study, the focus was not on the structures of the organizational change. Rather, it focuses on special needs of children with physical disability as a point of entry. Thus, CBR has been successful in reaching some of the poorest families and their children with disabilities by making daily life better with valuable, practical skills, devices, creating integration and lessening discrimination and social integration in Adama town.

In this case, parents who were previously not involved in any income generating activities have now begun showing improvement in rendering rehabilitation devices for their children with physical disabilities. Parents' awareness about the causes of physical disability is significantly changed from religious beliefs to the possible causes as a result of CBR program intervention. This is true because in the process of transferring knowledge and skill, CBR workers have promoted parent's emotional, social and cultural values to the existing realities. Parents have developed positive expectations to their children with physical disability with regard to their educational performance and active participation at family and community levels.

There appears to be a relationship between gender and the occurrence (prevalence) of physical disabilities in that in the study more boys than girls particularly in CP and polio cases. There is also a relationship between educational levels of parents, poverty and the prevalence of physical disabilities in this study.

High level of parental involvement in CBR services is related to a high level of function of rehabilitation workers as evidenced by parents. Therefore, the involvement of parents and CBR workers as a key rehabilitation figures at the planning and implementation stages often helped to avoid some of the potential obstacles of CBR program perceived as joint ventures

rather than the idea of one person or a group of persons. Conversely, low level-involvement of fathers in CBR activities is attributed to father's lack of awareness about disability, high expectations to their children, and family crises. However, mothers' participation in an informal voluntary association with other parents of children with special needs was very effective in rehabilitating their children and they found the meeting helpful in realizing that they were not alone with the problem. In addition, parental involvement in traditional organizations assumed to have an advocacy role.

Except in few cases, community involvement in planning and decision making of CBR program is very minimal. However, some practical strategies and suggestions are offered concerning how to work with the community in promoting the process of social integration and the rights of children with physical disability. Though it was not as anticipated, the CBR program has tried some possible strategies to mobilize the community by sponsoring formal and non-formal groups. Thus, community involvement was observed in establishment of infrastructure than directly involving in rehabilitation of children with special needs.

Volunteer base CBR program implementation has done a lot to increase community awareness and parents by sensitizing them to the needs of children with physical disability for rehabilitation and integration in to both family and community activities. In addition, volunteer CBR workers are selected from the local community. But, the idea of payment base for CBR workers than with out payment was highly pronounced and recommended to ensure sustainability of CBR projects.

In mobilizing and using local resources needed for rehabilitation of children with physical disabilities, the CBR program under study showed minimal efforts in fund raising locally. Rather, the program was highly dependent on external funds.

Participation of children with physical disability in CBR activities seems better than community participation. In this regard, participation of children in CBR activities has enhanced their self-confidence and reduced feelings of isolation and dependency. In relation to this, participation in rehabilitation process helped children to transform their prior passive role to active and valued roles of the community.

In conclusion,

- There appears to be a relationship between gender and the prevalence of physical disabilities in that in the sample under study more boys were found to be suffering from polio, clubfoot, cerebral palsy, and amputee than girls are. Similarly, there is a relationship between poverty of parents; their educational levels and prevalence of physical disabilities in that occurrence of disability may aggravate poverty in the family.
- Study found some direct relationship between effective involvement of CBR workers in rendering rehabilitation service for children, and high enrollment of children to primary school after rehabilitation services have been carried out. This indicates that children's improvement in mobility has increased their school enrollments.
- There was high level of relationship between schools and CBR program activities in rehabilitating children with physical disabilities.
- An increase in the parents' awareness about issues of disability and an increase in income of the parents were found to have a positive effect on children and parents' social status in the community. In other words, study found that parental involvement in CBR's income generating activities has increased parents as well as disabled children's social integration with in the community.
- Children with physical disabilities have clearly benefited from CBR program in that their self-reliance has developed and their mobility has getting well.

6.2. Recommendations

The implementation of community based rehabilitation program calls for methods of empowering children with disabilities in their community, the use of community resources and methods for ensuring cooperation between persons with disabilities, local communities, NGOs, traditional community organizations and government support. In this regard, the following recommendations become apparent:

1. Those who can contribute most to the rehabilitation of children with physical disability especially those with severe CP cases are parents, siblings, rehabilitation workers and teachers. They are the one who spend their most time with those children, know them best and are in the best position to understand them, interact and communicate and develop empathy with them. So, this is important for CBR program implementers to

- make special efforts to increase the active involvement of such group to increase the living situation of these children.
2. CBR workers, teachers, family and community members have to be oriented to produce simple, cost effective and locally made appliances with a technical support of orthopedic workshop workers.
 3. Rather than depending only on external donor's resources a strategy must be designed in which ideas, skills, experiences and resources are pooled from various groups to lead a CBR program to success and future sustainability. Sustaining the CBR program needs continued involvement of all partners starting from the initial stages of CBR program. Therefore accessing the existing wealth from individuals, institutions, government and business sectors is an alternative way for resource mobilization.
 4. The role of indigenous NGOs for the development and expansion of CBR program in the area has a paramount importance for the rehabilitation of children with physical disabilities. NGOs have to believe and able to communicate to the society that their organization pursue a mission and perform functions that are valuable to persons with disabilities.
 5. The existing mothers' association should have to be supported and encouraged to involve fathers to under take rehabilitation measures effectively at family level.
 6. The emotional and social values are strongly bounded to culture. So, in rehabilitation process, implementers of the CBR program must be careful not to impose their religious and cultural values on children those who are receiving help. Rather they should have to teach the locally accepted and valuable values and religious beliefs.
 7. The present developmental social welfare policy in use has not properly incorporated strategies of the implementation of CBR programs. Thus, the policy under question has to create a ground in which the major roles and responsibilities of the government and that of NGOs and the community are well articulated.
 8. More researches need to be conducted on the implementation of CBR program the in the future.
 9. Findings of this study should have to be shared to CBR implementers, concerned authorities, community representatives and beneficiaries in Adama town.

APPENDIX-A

Glossary

1. English

Amputee--- is a person who has had one or more limbs removed by amputation

Amputation--- Loss of part of the body /hands or legs caused by disease, accident or congenitally.

Appliances--- a device especially designed for persons with disabilities

Ataxic--- Unsteady shaky body movement or poor body balance

Brace--- An appliance or device used for holding two arms to stand and move

Cerebral--- a brain or part of the brain

Cerebral Palsy--- Disorder of movement due to damage in some parts of the brain

Clubfoot--- Deformity of the foot or the feet that born with or its cause is not well known

Congenital anomaly---- A physiological or structural abnormality that develops before birth

Diplegia--- is a type of cerebral palsy when legs are affected more than arms or when arms are slightly clumsy

Functional body--- When a disabled part of the body is useful, or serving some purpose for day-to-day life it is said to be functional.

Hemiplegia---- a type of cerebral palsy when arms and legs of the child is affected on one side only

Limb--- an arm or leg

Palsy--- refers to disorder of movement

Perception---The process of viewing or understanding some thing as basic component in the formation of concepts.

Polio (Poliomyelitis)--- an infectious viral disease occurring chiefly in children and in its acute forms attacking the central nervous system and producing paralysis, muscular atrophy and deformity.

Spastic--- means stiff or tight muscle

2. Amharic

Enat--- Mother

Egir---Leg

Idir--- a traditional community based mutual organization mainly serving for mourning purpose

Komata--- Leper or amputee with negative connotations

Koriti--- amputee

Mankiya--- Spoon

Wagesha--- A traditional physiotherapist

2. Afaan Oromo

Cabaa--- broken

Citaa--- amputee

Gargaree--- Served or helped

Hinbeeku--- I don't know

Jaalaa---Bent (not strait)

Mattii--- family

Nafaa--- Crippled

Namalee--- with out me

Suphee--- Any type of material made from clay (e.g. Pot)

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After CBR Intervention



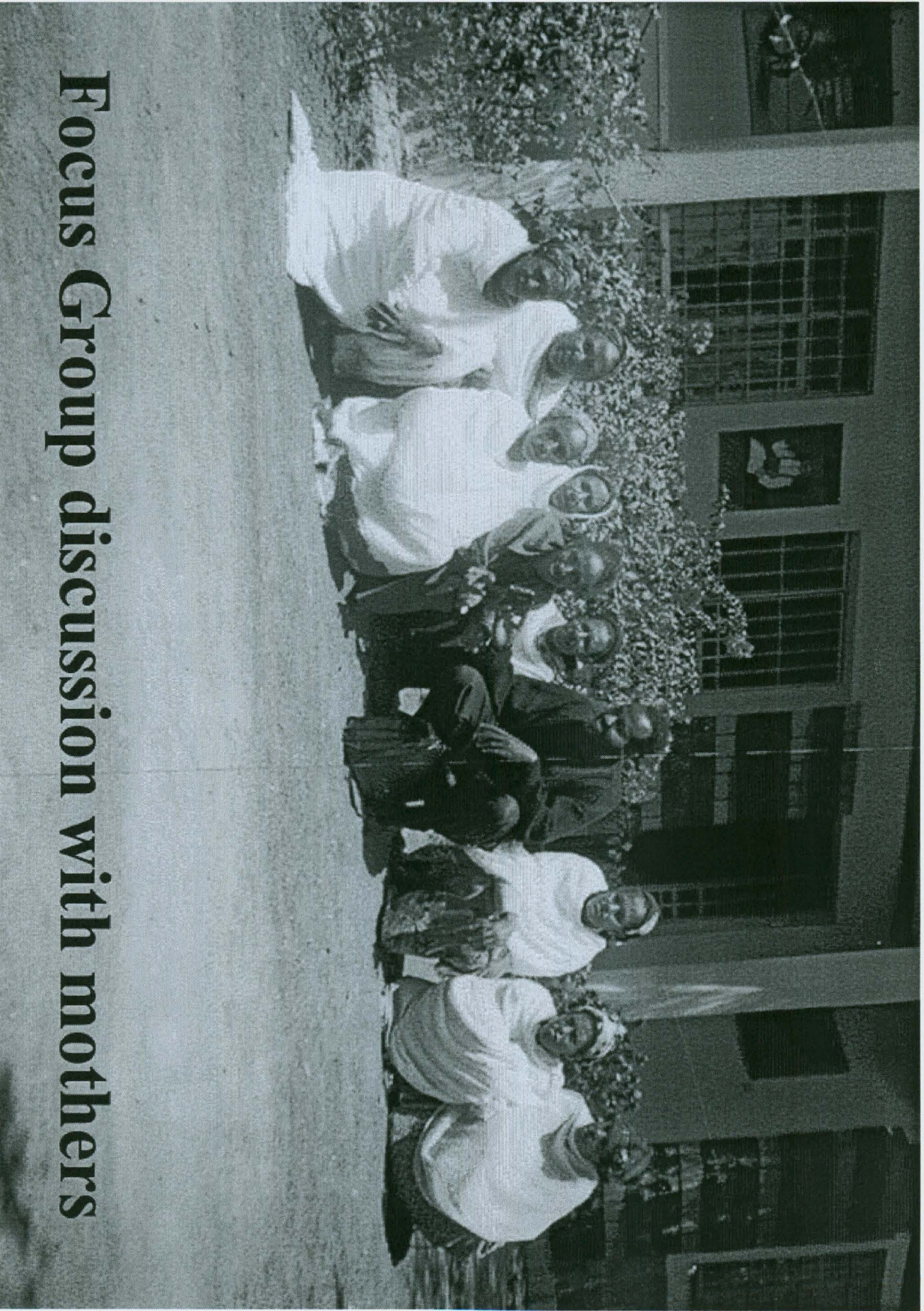
After CBR Intervention



**Involved in income
generating activities**

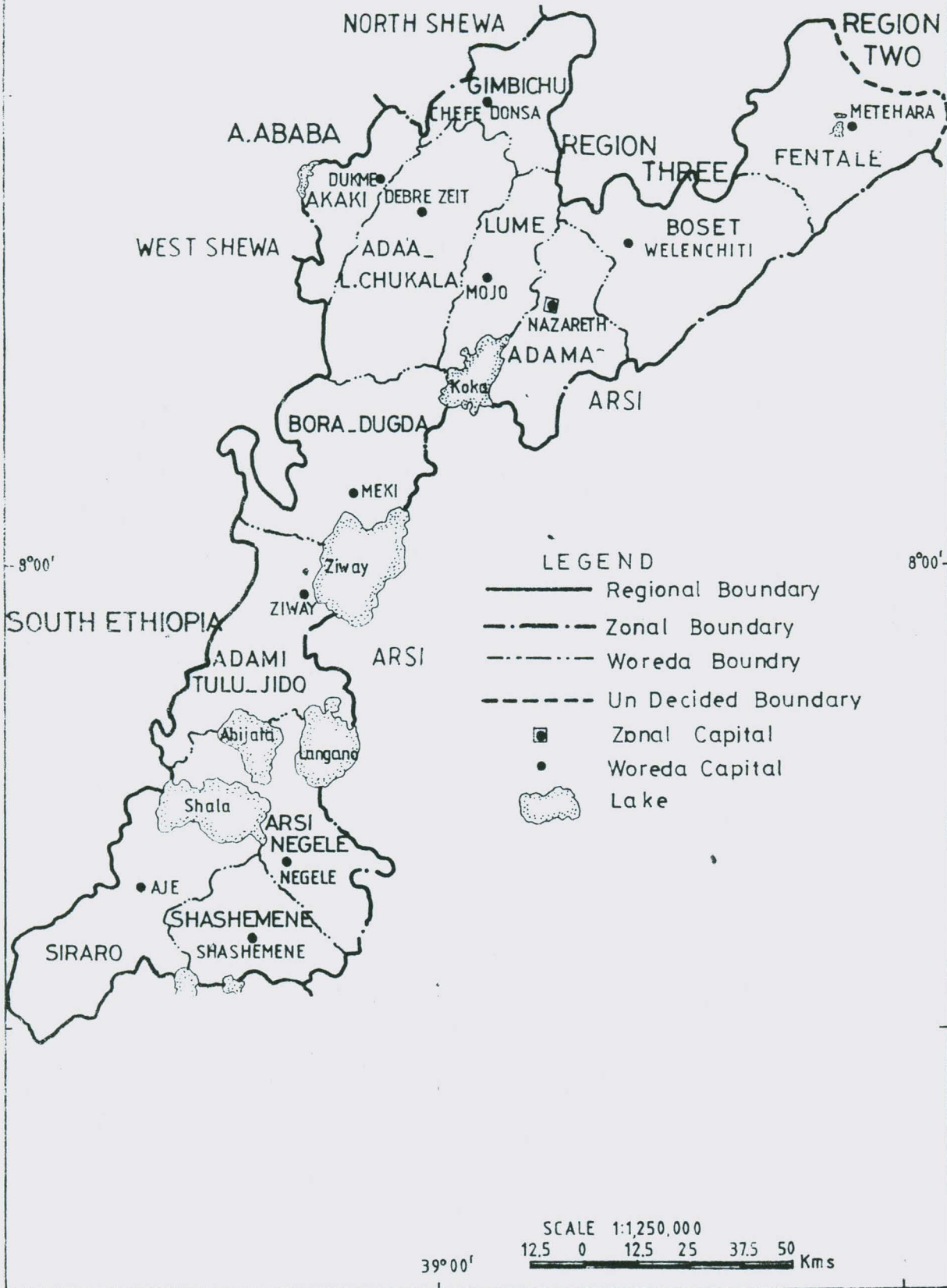


Volunteers and Employed CBR workers



Focus Group discussion with mothers

EAST SHEWA ADMINISTRATIVE ZONE



LEGEND

- Regional Boundary
- - - Zonal Boundary
- · - · Woreda Boundry
- - - - Un Decided Boundary
- Zonal Capital
- Woreda Capital
- ☼ Lake

SCALE 1:1,250,000

12.5 0 12.5 25 37.5 50 Kms

የጉልበት ሠራተኛ

ሌላ -----

የገቢ መጠን በአማካይ

- > ከ100 ብር በታች
- > 101- 300
- > 301-500
- > 501-1000
- > ከ1000 ብር በላይ

II ቤተሰብ አባላት ብቻ የሚመለስ

2.1 የቤተሰብዎ አባል የሆነው/ችው የጉዳት ዓይነት

- > የመራመድ ችግር
- > የመቀመጥ ችግር
- > የመንቀሳቀስ ችግር
- > የእጅ ችግር
- > የእግር ችግር
- > ሌላ -----

2.2 የአካል ጉዳተኛው የጉዳቱ መንስኤ ምን ይመስልዎታል?

- > ከወሊድ በፊት ያገጠመው ችግር
- > በወሊድ ጊዜ ያጋጠመው ችግር
- > በህፃንነቱ አደጋ ስለደረሰበት/ባት
- > በሽታ
- > ሌላ-----

በመግህበረሰብ ተሃድሶ አገልግሎት ያገኘኛሉ አዎ አልተሃተፍኩም
አገኘኛለሁ ካሉ -----

2.3 የግህበረሰብ ተሃድሶ አገልግሎት ማግኘት ከጀመሩ በኋላ ጊዜዎት ነው?

- > 2 ዓመት
- > ከ4 ዓመት በላይ
- > ከ6 ዓመት በፊት
- > ሌላ -----

2.4 በግህበረሰብ ተሃድሶ አገልግሎት ሥራዎች ይሳተፋሉ?

አዎ አልሳተፍም

2.5 አዎ ካሉ እንዴት ወይም በምን ሁኔታ?

2.6 ከማህበረሰቡ ተሃድሶ ፕሮግራም ለአካል ጉዳተኛ ቤተሰብዎ አባል ወይም ለራስዎ ያገኙት የመልሶ ማቋቋሚያ አገልግሎት ምን ምን ናቸው?

- የአካል ድጋፍ
- ትምህርት
- የጤና አገልግሎት
- ፊደላት
- ምክር
- የገቢ ማስገኛ ብድር
- ምንም
- ሁሉም
- ሌላ _____

2.7 የትኛው የማቋቋሚያ አገልግሎት በጣም ጠቃሚ ይመስልዎታል?

- የአካል ድጋፍ
- ትምህርት
- የጤና አገልግሎት
- የምክር አገልግሎት
- የገቢ ማስገኛ ብድር
- ሁሉም
- ሌላ _____

2.8 ከማህበረሰብ ተሃድሞ ስራዎች በጣም የረኩበትን ቢገልፁልን?

2.9 በማህበረሰብ ተሃድሶ ፕሮግራም በመካሄዱ ምን ለውጥ ያገኙበት ይመስሎታል?

➤ የአካል	ጉዳተኛ	ቤተሰብ	የታየ
ለውጥ-----			

➤ በኅረግ ት፣ ጓደኛ፣ ዘመድና ነዋሪ አካባቢ የታየ ለውጥ

2.10 የቤተሰብዎ አካል ወይም ልጅ የሆነው አካል ጉዳተኛ በቤተሰብ ዕለት ተዕለት ተግባራት ይሳተፋል/ለች?

አዎ አይሳተፍም
> ይሳተፋል ካሉ በምን በምን ሥራ ይሳተፋል

2.11 ልጅዎ ወይም የቤተሰብ ዓባል የሆነው የአካል ጉዳተኛ ከጎረቤትና ከማህበረሰቡ ጋር በምን በምን ይገኛል? ይገለጹልን

2.12 በአሁኑ ወቅት የአካል ጉዳተኝነት መንስኤ እንዴት ይመለከቱታል?

- > የእግዚአብሔር ቁጣ መሆኑን
- > የማህበረሰብ ሠራተኞች ባስተማሩን ዓይነት
- > መንስኤው የማይታወቅ መሆኑን
- > ሌላ -----

2.13 የማህበረሰብ አገልግሎት ከማግኘትዎ በፊት አካል ጉዳተኛውን በምን መልኩ ይረዱት ነበር?

- > ጠበል በመውሰድ
- > ሀኪም ቤት በመውሰድ
- > የሀገር ሽማግሌና በወጪ
- > በመደበኛ
- > ሌላ-----

2.14 አሁንስ በምን መልኩ እየረዱት ነው?

- > በህክምናና በማህበረሰብ ሠራተኞች ምክር
- > ከበሬቱ ለውጥ የለም
- > ሌላ-----

2.15 በማህበረሰብ ተሃድሶ ከመሳተፍዎ በፊት አካል ጉዳተኛ ልጅዎ ት/ቤት ትሄድ/ይሄድ ነበር?

አዎ አይሄድም
የማይሄድ ከሆነ ምክንያቱን ቢገልጹልን

2.16 ከማህበረሰብ ተሃድሶ አገልግሎት ወዲህ አካል ጉዳተኛ የቤተሰብዎ አባል ወደ ት/ቤት ይሄዳል/ትሄዳለች? አዎ አይሄድም

2.17 ት/ቤት የሚሄዱ ከሆነ ስንቶቹ?

- > ሁሉም

> ወንዶች ብቻ

> ሴቶች ብቻ

> ሌላ-----

2.18 ፕሮግራሙ ከመጀመሩ በፊት ልጆቹን ያስከትባሉ? አዎ አላስከትብም

2.19 አሁንስ? አስከትባለሁ አላስከትብም

አዎ ካሉ ለውጡ ከምን የመነጨ ይመስልዎታል?

2.20 የማህበረሰብ ተሃድሶ አገልግሎት ከመጀመሩ በፊት ስለቤተሰብ ምጣኔ ያውቁ ነበር?

አዎ አላውቅም

አዎ ካሉ በምን ዘዴ ይጠቀሙ ነበር?

2.21 በአሁኑ ወቅት የቤተሰብ ምጣኔ ይጠቀማሉ?

አዎ አልጠቀምም

አዎ ካሉ በምን ዘዴ ይጠቀማሉ

2.22 የሚከተሉትን ጥያቄዎች ለማህበረሰብ ተሃድሶ ተጠቃሚ በመሆኑ የታየ ለውጥ ካለ አዎ በሚለው ለውጥ ከሌለ ግን የለም በሚለው ምልክት በማድረግ ያመልክቱ::

ሀ. አካል ጉዳተኛ የሆነ ሰው በስራ መሳተፍ ይችላል አዎ የለም

ለ. የአካል ጉዳተኛ ልጅ ከሌላው ጋር መማር ይችላል አዎ የለም

ሐ. አካል ጉዳተኛ የአካል ጉዳተኛ ያልሆነ ሰው ጋር መጋባት ይችላል አዎ የለም

መ. አካል ጉዳተኛ በማህበራዊ ህይወት/በሠርግ በሀዘን / እንደማንኛውም እየተሳተፈ/ች ነው::

አዎ የለም

ሠ. ማህበረሰብ ተሃድሶ በመጀመሩ

> የቤተሰብዎ የዓመት ገቢ ተሻሽሏል አዎ የለም

> የቤተሰብዎ አመጋገብ ከበፊቱ ተሻሽሏል አዎ የለም

> የአካል ድጋፍ በብዛት ተሰጥቷል አዎ የለም

> የህክምና አገልግሎት ተሻሽሏል አዎ የለም

> የህብረተሰቡ አመለካከት ተለውጧል አዎ የለም

ክፍል ሁለት -

2. በአካል ጉዳተኞች የሚሞላ

1. የቅድመ ሁኔታ መረጃ

ሀ. ያታ----- ዕድሜ-----ሀይማኖት-----

ለ. የመኖሪያ ቦታ

ከተማ-----

ገጠር -----

ሐ. የጋብቻ ሁኔታ

ያገባ -----

ያላገባ -----

ሌላ -----

መ. በቤተሰብ ውስጥ ያለዎት ሃላፊነት

ባል -----

ሚስት -----

ልጅ -----

ሌላ -----

ሠ. የቤተሰብ ብዛት -----

ረ. የትምህርት ሁኔታ

ምንም ያልተማረ -----

መሰረተ ትምህርት -----

አንደኛ ደረጃ -----

ሁለተኛ ደረጃ -----

ዲፕሎማና ከዚያ በላይ -----

ሰ. ሥራ አለኝ የለኝም

ሸ. ሥራ ካለዎት የመንግስት ሠራተኛ

➤ ሌላ-----

2.9 የማህበረሰብ ተሃድሶ ሠራተኞች በሚሰጡት አገልግሎት ችግር ያለባቸው ይመስልዎታል
አዎ የለም

2.10 ችግር አለባቸው ካሉ በምን ይመስልዎታል?

➤ ተገቢውን አገልግሎት አለመስጠት

➤ ፈቃደኛ አለመሆን

➤ ክትትል አለማድረግ

➤ በቤተሰቤ ተቀባይነት የላቸውም

➤ ሌላ-----

2.11 በማህበረሰብ ተሃድሶ ቆይታዎ ት/ቤቶችና ማህበረሰብ ተሃድሶ ፕሮግራም ያላቸውን
ግኑኝነት በገልጹልን

2.12 ተጨማሪ አስተያየት ካለዎት
ይግለጹልን-----

- የአካል ድጋፍ
- የመጓጓዣ መሳሪያ
- የዕለት ተዕለት ምክርና ትምህርት
- የትምህርት ዕድል
- የጤና አገልግሎት
- የስራ ዕድል
- የሙያ ስልጠናና የገቢ ማስገኛ አገልግሎት
- ሁሉንም
- ሌላ-----

2.5 በማህበረሰብ ተሃድሶ ፕሮግራም በመሳተፍ ለርስዎ ምን ለውጥ ያስገኛልዎት ይመስላል?

- በራስ የመተማመን ስሜት ዳብሯል
- በፕሮግራሙ በሚሰጡ አገልግሎቶች ሙሉ በሙሉ እሳተፋለሁ
- ገቢዬ/የቤተሰቤ ገቢ/ጨምሯል
- ምንም ለውጥ አላየሁም
- ሌላ-----

2.6 የአካል ጉዳተኝነት መንስኤ በአሁኑ ወቅት እንዴት ያዩታል?

- የማህበረሰብ ተሃድሶ ሠራተኞች በአስተማሩን ዓይነት
- የእግዚአብሔር ቁጣ ያመጠብኝ መሆኑን
- ሌላ-----

2.7 በአሁኑ ወቅት በቤተሰብዎና በህብረተሰቡ ውስጥ ያለዎት ተሳትፎና ሚና ከሚከተሉት በየትኛው የኅላ ይመስልዎታል?

- በቤተሰቤ ውስጥ የነበረኝ ተሰሚነት ጨምሯል ትክክል ትክክል
አይደለም
- ወደ ት/ቤት ለመሄድ በቅቻለሁ ትክክል ትክክል
አይደለም
- የአካል ጉዳት ከሌላቸው ሰዎች ጋር የመነጋገርና የመገናኘት ዕድል ከፍ በሏል ትክክል ትክክል አይደለም
- በራስ የመተማመን ባህሪ ጨምሯል ትክክል ትክክል
አይደለም
- በሁሉም ለውጥ አሳይቻለሁ ትክክል ትክክል
አይደለም
- ኑሮዬ ተሻሻሏል ትክክል ትክክል
አይደለም

የቡድን ውይይት /Focus group/

1. በአካባቢው ለተቋቋመው የአካል ጉዳተኞች / የመራመድ፣ የእጅ፣ የእግር፣ ችግር ያለባቸው/ ማህበር የሚቀርቡ ጥያቄዎች

1.1 በአካባቢዎ ያሉ አካል ጉዳተኞች ፍላጎት ዋና ዋናዎቹን ቢጠቅሱልን

1.2 እዚህ አካባቢ ያለው የማህበረሰብ ተሃድሶ ፕሮግራም ከላይ የጠቀሱትን የማህበረሰቡን ፍላጎቶች ለመቅረፍ ምን ያህል ተንቀሳቅሶታል?

1.3 የርስዎ ማህበርና የማህበረሰብ ተሃድሶ ፕሮግራም ያለውን ግንኙነት ቢጠቅሱልን

1.4 በማህበረሰብ ተሃድሶ ፕሮግራም የአካል ጉዳተኞች ተሳትፎ ምን ገፊነት አለው?

1.5 የማህበረሰብ ተሃድሶ ፕሮግራም በአካል ጉዳተኛ ተጠቃሚዎች ላይ ያመጣውን ለውጥ ተጠቃሚ ካልሆኑት ጋር በማናጸፀር ቢገልፁልን?

2. የማህበረሰብ ተሃድሶ ፕሮግራም አባል ለሆኑ መምህራን የቀረቡ ጥያቄዎች
2.1 አካል ጉዳት ያለባቸው ህፃናትን አካል ጉዳተኛ ካልሆኑት ጋር ቀላቅሎ ማስተማር ጠቀሜታ አለው ብለው ይገምታሉ አዎ የለውም አለው ካሉ በምን መልኩ

2.2 በት/ቤትዎ የተቋቋመው የአካል ጉዳተኞች ክበብ አስተዋፅኦ ያለው /ያበረከተ/ ይመስሉዎታል? አዎ አይደለም
አስተዋፅኦ አበርክተዋል ካሉ በምን በምን እንዳበረከተ ይግለፁልን?

2.3 የሕፃናት ለሕፃናት ትምህርታዊ አቀራረብ የአካል ጉዳተኝነትን በመለወጥ ምን ለውጥ እንዳበረከተ ይግለጹልን-----

2.4 የማህበረሰብ ተህድሶና የት/ቤት ሥራ ምን ግንኙነት አለው?-----

3. ለማህበረሰብ ተህድሶ ሠራተኞች

3.1. ለማህበረሰብ ተህድሶ ሠራተኝነት የተመረጡት ከዬት ነበር?

- ከት/ቤት
- በማስታወቂያ ከሌላ ቦታ ተቀጥሬ
- ከማህበረሰቡ ተመርጬ
- ሌላ

3.2. የመራመድ፣ የመንቀሳቀስ፣ የእጅና የእግር ችግር ያለባቸውን አካል ጉዳተኞችን ከሌሎቹ ጋር ሲያነፃፅሩ ከማህበረሰብ ተህድሶ ምን ያህል የተጠቀሙ ይመስሎታል?

3.3. የአካል ጉዳተኞችን ቤት በምን ያህል ጊዜ ይጎበኛሉ

- በየቀኑ
- በየሳምንቱ
- በየወሩ
- ሌላ

3.4. ከማህበረሰብ ተህድሶ ሥራዎች ለውጥ በማምጣት የትኛው ወጤታማ እንደሆነ ይግለጹልን

የግል ድርጅት ሠራተኛ

የጉልበት ሠራተኛ

የግብርና ሠራተኛ

የቤት ሠራተኛ

ሌላ -----

የገቢ መጠን በአማካይ

ከ100 ብር በታች

ከ101 - 300

ከ301 - 500

ከ501 - 1000

ከ1000 ብር በላይ

2.1 የአካል ጉዳትዎ ዓይነት?

➤ የመራመድ ችግር

➤ የመቀመጥ

➤ የመንቀሳቀስ

➤ የእጅ

➤ የእግር

➤ ሌላ -----

2.2 የጉዳቱ መንስኤ ምን ይምስልሃል/ ይመስልዎታል?

➤ ከወሊድ በፊት ያጋጠመኝ ችግር

➤ በወሊድ ጊዜ ያጋጠመኝ ችግር

➤ በህፃንነቴ አደጋ ደርሶብኝ

➤ በበሽታ ምክንያት

➤ ሌላ -----

2.3 የማህበረሰብ ተሃድሶ አገልግሎት ማግኘት ከጀመሩ/ርክ ምን ያህል ጊዜ ሆኖት?

➤ 2 ዓመት

➤ ከ4 ዓመት በፊት

➤ ከ6 ዓመት በፊት

➤ ሌላ -----

2.4 በማህበረሰብ ተሃድሶ ስራዎች ይሳተፋሉ? አዎ አልሳተፍም

2.5 አዎ ካሉ በምን መልኩ ይሳተፋሉ?

2.6 በማህበረሰብ ተሃድሶ በመሳተፍዎ ምን እገዛ አግኝተዋል?

3.5. የማህበረሰብ ተህድሶ ከተጀመረ ወዲህ በተጠቃሚዎች ላይ ያመጣውን ለውጥ ቢገልፁልን

3.6. ማህበረሰብ ተህድሶ ፕሮግራም የህብረተሰብ አመለካከት በመለወጥ ምን አስተዋፅኦ ነበረው?-----

4. በማህበረሰብ ተህድሶ ፕሮግራም ለተሳተፉ የኅብረተሰብ የወካዮችና ለጎረቤት የሚቀርቡ

ጥያቄዎች:

4.1 በማህበረሰብ ተህድሶ ፕሮግራም መሳተፍ ከጀመሩ ምን ያህል ጊዜ ሆነዎት?-----

4.2 የማህበረሰብ ተህድሶ ፕሮግራም በአካል ጉዳተኞች ህይወት ላይ ያመጣ ለውጥ ካለ ቢገልፁልን

4.3 የመንቀሳቀስ፣የእጅና የእግር የአካል ጉዳት ያለባቸው ሠዎች ለራሳቸውና ለህብረተሰቡ ምን አስተዋፅኦ ያበረክታሉ ብለው ይገምታሉ?-----

4.4 ሌላ አስተያየት ካለዎት

ለጋራ ውይይት የሚቀርቡ የመነሻ ጥያቄዎች

መመሪያ (guiding questions for focus group discussion)

እነዚህ ለጋራ ውይይት የሚቀርቡ የመነሻ ጥያቄዎች [REDACTED]

- ለተወሰኑ አካል ጉዳተኞችና ቤተሰቦቻቸው
- ለማህበረሰብ ተሃድሶ ሠራተኞችና ለመምህራን
- ለአካል ጉዳተኞች ኮሚቴ አባላት የሚቀርቡ ናቸው

1- ቁልፍ ሃሳቦች

- የማህበረሰብ ተሃድሶ መሠረተ ሃሳቦችና ተግባራት፤
- የአካል ጉዳተኞችና ቤተሰቦቻቸው ተሳትፎ፤
- የህብረተሰቡ አመለካከት፤
- የታዩ ለውጦችና መሻሻሎች ቁልፍ ሃሳብ ይሆናሉ።

2- የውይይቱ አካሄድ

- አስቀድሞ ቦታና ከ8-10 ሠዎችን ማዘጋጀት፤
- ራስን ማስተዋወቅ፤
- ተወያዮቹ ራሳቸውን እንዲያስተዋውቁ ማድረግ፤
- ስለማህበረሰብ ተሃድሞ ፕሮግራም ሂደት ሃሳብ መለዋወጥ፤
- ሁሉም በሚነሱት ሃሳቦች በየተራ ሃሳብ እንዲለዋወጡ ጋባኸ / አነሳሽ/ ጥያቄ ማንሳት፤
- ከተወካዮቹ የሚቀርቡት ሃሳቦች መመዝገብና በካሴት መቅዳት ወ.ዘ.ተ.

3- ናሙና የመንደርደሪያና የመወያያ ጥያቄዎች

- በአካባቢው የአካል ጉዳተኛ /የመንቀሳቀስ ችግር ያለባቸው/ ችግርና ፍላጎት ምን ያህል ትኩረት ያገኘ ይመስልዎታል?
- በማህበረሰብ ተሃድሶ መረሐግብር የአካል ጉዳተኞችና የቤተሰብ አባላት ተሳትፎ

ምን ይመስላል?

- በፕሮግራሙ ህብረተሰቡን ለማሳተፍ ምን ምን ዘዴ አገልግሎት ላይ ውሏል?
- የማህበረሰብ ተሃድሶ ፕሮግራም ከት/ቤቶች ጋር ምን ግኑኝነት አለው?
- በአካል ጉዳተኞች አጠቃላይ ሁኔታ ላይ የታዩትን ለውጦች መግለጽ ይችላሉ?

* አካል ጉዳተኞች የሚለው ቀል የመንቀሳቀስ፣ የእጅ፣ የእግርና የመሳሰሉትን የአካል ጉዳት ዓይነቶችን የሚተካ መሆኑ ይታወቅ።

Declaration

I, the undersigned, declare that this thesis is my original work and has not been presented for a degree in any other university and that all sources of materials used for the thesis work have been duly acknowledged.

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Signature 

Date June 16, 2000

Approved By:

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