

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

**ADDIS ABABA UNIVERSITY
SCHOOL OF GRADUATE STUDIES
COLLEGE OF EDUCATION AND BEHAVIOURAL STUDIES
DEPARTMENT OF SPECIAL NEEDS EDUCATION**

**SOCIAL AND ECONOMIC CHALLENGES OF SERVICE
PROVIDERS TO CHILDREN WITH INTELLECTUAL DISABILITIES: THE
CASE OF MEKANE-EYESUS CENTER FOR MENTALLY CHALLENGED
CHILDREN.**

BY : KALKIDAN SHIMELIS TIRUNEH

JUNE, 2015

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i

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Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Abstract

Ethiopia is one of the countries in which a number of service providers as well as children with intellectual disabilities exist. However, the issue of social and economic challenges of service providers to children with intellectual disabilities remains less researched. Therefore, the present study has examined how the service providers to children with intellectual disabilities were influenced economically and socially while giving and receiving special needs services. Qualitative research method was used along with tools, such as interview, FGD, observation and document review to collect the relevant information. Thematic framework was used to analyze the study. It was conducted in Mekane Eyesus Center for Mentally Challenged Children, in the region of Addis Ababa, in the sub-city of Nifas Silk Lafto, wereda2, with a total of nineteen research participants; and purposive sampling technique was used. The research participants were composed of service providers (social workers, teachers, physiotherapists, and who were working in the Center), and key informants who had a direct experience about the center service providers to children with intellectual disabilities. In this study, the Key informant was the center executive director. Finally, the study recommended the need for salary increment, respecting and supporting the work on children with intellectual disability, strengthening social interaction, and coping strategies, should also be enhanced.

Key words: children with intellectual disabilities, service providers, social and economic challenges.

Social and Economic Challenges of Service Providers to Children with
Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally
Challenged Children.

<i>Table of Content</i>	<i>Page No.</i>
<i>Acknowledgement</i> _____	<i>iv</i>
<i>Abstract</i> _____	<i>v</i>
<i>Acronyms:</i> _____	<i>viii</i>
 1. Chapter One:	
1.1 Introduction: _____	<i>1</i>
1.2 Statement of the Problem _____	<i>3</i>
1.3 Research Questions: _____	<i>4</i>
1.4. Objectives of the study _____	<i>5</i>
1.5 Significance of the Study _____	<i>5</i>
1.6 Limitation of the Study _____	<i>6</i>
1.7 operational definition of Terms _____	<i>7</i>
1.7.1 conceptual definition of terms-----	<i>7</i>
 2. Chapter Two	
2.0 Literature Review _____	<i>9</i>
2.1 Definition and nature of ID-----	<i>9</i>
2.2. General Overview of ID _____	<i>9</i>
2.3. Causes of ID _____	<i>22</i>
2.5 Classification of ID-----	<i>24</i>
2.6 Prevalence of ID _____	<i>30</i>
2.7. Prevention and Treatment of Intellectual Disability	
2.8 Challenging Experience of Service Providers in Caring for Children with ID _____	<i>31</i>
2.9 Coping Strategies. _____	
2.10. Family Based Care _____	<i>40</i>
2.11. Bronfenbrenner's Ecological Model _____	<i>41</i>

Social and Economic Challenges of Service Providers to Children with
Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally
Challenged Children.

3. Chapter Three

3.1 Research Method	48
3.2 Study Area:	48
3.3. Source of Data:	49
3.4 Sampling Technique	49
3.5. Data Collection instruments:	50
3.6 Pilot study	
3.7. Data Analysis	53
3.8. Ethical Considerations	54

4. Chapter Four

4. RESULT	57
4.1. General Background of Research Participants	57
4.2. Social challenges:	58
4.3. Economic challenges:	67
4.6. Coping strategies:	70

5. Chapter Five

5.1. Discussion of result	71
5.2 Economic challenges of service providers:	82

6. Chapter Six

6.1 Conclusions	91
6.2 Recommendations	92

Appendices.

Appendix-1 Informed Consent Form(including itsAmharic translation)	xiii
Appendix-2 Interview Guide for Service Provider(including itsAmharic translation)	xv
Appendix-3 FGD Guide for parents(including itsAmharic translation)	xvi
Appendix-4 Observation Check List	<i>Error! Bookmark not defined.</i>

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Acronyms:

AAMR_____ American Association Mental Retardation

AAIDD_____ American Association on Intellectual and Developmental Disabilities

CSA_____ Central Statistics Authority

FGD_____ Focus Group Discussion

MCMCC_____ Mekane Eyesus Center for Mentally Challenged Children

ID_____ Intellectual Disability

MoE_____ Ministry Of Education

UN_____ United Nations

UNICEF_____ United Nations International Children Emergency Fund

WHO_____ World Health Organization

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Chapter One

1.1 Introduction:

The early experience of the world has shown that children with intellectual disabilities (ID) were forgotten and labeled in society at all. There was stigma and discriminatory activities for instance, children with ID were thought to be dumped to segregated places like child care institution for long care and support for the reason that they were considered to be burden on their families as well as a country as a whole. The issue of intellectual disability (ID) has also been influenced by political, legal agendas, social, economic, attitudes, psychological and educational practice (Smith et al., 1994)., children with intellectual disabilities (ID) were stigmatized as follows , some of the common terms used throughout the literature include such as feeble-minded, moron, mental retardation, intellectual handicap, mental disability.

These terms were vary offensive (Smith et al., 1994).

Similarly, in Ethiopia, children with intellectual disabilities (ID) have not been obtained access to early identification, early intervention, education, training and employment; it is mainly due to the negative attitude, lack of knowledge, stigmatization, and discrimination towards children with intellectual disability (ID) (Tirussew, 2005).

Consequently In the past, the extended families were only available to provide services for the children with intellectual disabilities (ID). It simplified the burden of care expected from the nuclear family. However, in recent times, there is a shift from extended family to nuclear family. This is because over the past two decades, family units have become smaller and the rate of marriage break down was exceeding because of their children intellectual disability(Raina et

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

al., 2004). The level of stress is also more and more when the care giving is depending only on the family and it affected the quality of service (Susan, 2011).

That means the problems of children with intellectual disability (ID) was considered only the challenges of their families. As a result, , the severity of the children with intellectual disability (ID) becomes more and more. Because of lack of early stimulation and their dependency; the care giving responsibility of parents becomes lifelong. Since parents and their children with ID have reciprocal relationship; who affects each other (Bronfenbrenner, 1979).

Today the magnitude of the responsibility is not only depend on the family units but also looks for the help of different service providers such as teachers, counselor, social workers, nurses, and therapists to support the children with intellectual disabilities (ID) (WHO, 2011).

In now days, the given Assistance and support is complex for children with intellectual disabilities , because the service is provided by different service providers, funded in different ways, and delivered in different locations with out coordination. For instance, Special needs services are supplied by informal care givers like neighbors and friends; formal services are provided by government, and non-governmental organizations (WHO, 2011). how ever, there is high interest on service providers to support children with developmental disability especially when they become children with ID (Margaret, et al., 2011).

Service providers confront with social and economic challenges while they are providing services for children with intellectual disabilities (ID). Among these challenges like lack of financial support, inadequate human resources, poor payment and inadequate training, absence of policies, negative attitudes, discrimination, and no conducive working environments remarkably refrain from offering quality services for children with ID in formal organizations (WHO, 2011).

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Further more, the researcher has engaged on child focused work for 6 years in Addis Ababa, so the researcher has observed multi-dimensional challenges of the service providers to children with ID confront with, while providing special need services for children with ID. Even though the social and economic challenges are multi-dimensional, there is no sufficient research which conducted on this issue in Ethiopia to alleviate social and economic challenges of service providers to children with ID (parents of children with ID , social workers, teachers, and physiotherapists who involved in caring for children with ID) so that it made the researcher initiate to conduct a research on this issue.

1.2 Statement of the Problem

Evidence suggested that there are considerable challenges in providing services for children with ID. Many studies have sought to qualify the association between care giving, social and economic outcomes of service providers (Raina et al., 2004). Contextual factors such as socio-economic status, child factors such as child behavior problems, severity of disability, coping strategies, and social supports have been associated with social and economic outcome of service providers (Haan et al., 1989). However, in reviewing these issues, the literature appears to be limited by using traditional analytic approach to examine the relationship between factors and outcomes. In developed countries, research findings revealed that the social and economic challenges of service providers and children with ID are inconsistent. Some studies argue that there is the occurrence of stress and social maladjustment in service providers whom are working for children with ID (Featherstone 1981; Friedrich & Friedrich, 1981; Krahn 1993).

Several studies was conducted on this issue; for eg, wich was reported in America that no differences in the level of service providers' stress or anxiety, social maladjustment and

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

economic instability among service providers, children with ID, and children without ID (Kazak 1987; Dyson 1991;). Others showed significant variability in service providers' responsibility to the interest of care giving and range of variables contribute to challenges encountered by service providers. These include the difficulty of completing care-giving tasks (Gallagher, et al, 1983; Leyser, 1996), the time taken in completing tasks (Erickson & Upshur 1989), the presence of difficult behavior of a child with ID during tasks (Floyd & Gallagher, 1997), and the level of a child's disability (Beckman, 1991).

Some research has been conducted on the social and economic challenges of service providers to children with ID. For instance, in developing countries, a study conducted in Tanzania showed that service providers of children with ID had a great responsibility to care and support them, but who was appeared to be stigmatized and discriminated by community. Besides this, it affected the social and economic wellbeing of service provider; as a result, it also influences the quality of service providing (Margaret & David, 2011).

In Ethiopia, social and economic challenges of service providers to children with ID is multi-dimensional directly or indirectly. However, it was not also well studied in organized way with a primary intention of addressing the social and economic challenges of service providers to children with ID while providing and receiving various special need services and finding solution for a better social and economic adjustment.

Therefore, conducting this research may set foundation for future course of study.

1.3 Research Questions:

1.3.1. What are social challenges encountered by service providers to children with ID

(parents, social workers, teachers and therapists)?

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

1.3.2 What are economic challenges faced by service providers to children with ID while providing and receiving special need services?

1.3.3. What is the impact of social and economic challenges of service providers to children with ID on service delivery?

1.3.5. What kinds of coping strategies used by service providers to overcome challenges?

1.4. Objectives of the study

1.4.1 General objective of the study

The major aim of this study is to investigate social and economic challenges of service providers to children with ID while providing special need services in Mekane Eyesus center for Mentally Challenged children.

1.4.2 Specific objectives

In line with the above objective; this study was intended to achieve the followed specific objectives.

1. To examine social challenges encountering service providers and children with ID
2. To explore economic challenges of service providers to children with ID
3. To assess how service providers for mentally challenged children cope with social and economic challenges.

1.5 Significance of the Study

This study has been conducted to assess social and economic challenges of service providers while they are delivering special need services and while children with ID are receiving services in Mekane Eyesus Center for Mentally challenged Children Addis Ababa project.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Thus the significance of this study has been stated as followed:

1. It might serve as a base - line to set out better coping strategies in order to have positive relationship between service providers and children with ID.
2. It might give hint as to what sorts of strategies should be employed for the effectiveness of service provision in order to meet the need of children with ID.
3. It might indicate to enrich the standard of service delivery of the program and subsequently result in developments of qualified service delivery to children with ID in GOs and NGOs as a whole.
4. The study might help to understand social and economic challenges of service providers to children with ID in order to come up with suggestions.
5. It might also provide basic information to concerned bodies like GOs and NGOs to realize and overcome obstacles against the special need of children with ID.
6. It might serve as a way forward for further research on this issue.

1.6. Limitation of the Study

In order to make this study manageable in all aspects; it was very essential to determine span of the study. An attempt was made by the researcher to point out a wide range of analysis on social and economic challenges of service providers to children with ID as a whole; however, it has made the study unmanageable due to limitation of adequate reference materials, study area, time, resource and participants.

So the research is limited to city government of Addis Ababa specifically in Mekane Eyesus center for Mentally Challenged Children. The study has been conducted mainly with purposively selected service providers and children with ID in relation to social and economic

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

challenges. That means the study was carried out in such a way that special attention was given to the above particular issues.

1.7 Operational definition of Terms

Social challenges : refers to the influence or negative perception of others on service providers and children with ID while giving and receiving special needs services.

Economic challenge : refers to the condition in which a service provider to children with ID are negatively influenced by resource scarcity such as financial, man power, teaching aids while there is giving and receiving special needs services.

Service providers: refer to teachers, social workers, therapists, and parents of ID who provide special need services for children with ID by using their expertise with maximum effort in Center for mentally challenged children.

Parent: stands for both the father and mother or a person who has a parental responsibility for the care and upbringing of the child with ID.

Children : refers to human beings whose age ranges between eight and twelve.

Coping strategy: refers to a strategy used by service providers to deal with or solve the problem associated with the child's disability.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

1.7.1 Conceptual definition

Disability: The Americans with Disabilities Act (2008) defines a disability as "a physical or mental impairment that substantially limits one or more of a child's major life activities (walking, speaking, seeing, hearing, breathing, learning, working, self-care); or a record of such impairment; or being regarded as having such impairment."

Social and Economic Challenges of Service Providers to Children with
Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally
Challenged Children.

Chapter Two

Literature Review

This section presents a review of literature related to the present study done by the researcher in Ethiopia and elsewhere. Initially, the definition and general overview of intellectual disability is stated in this chapter. followed by nature of children with ID, after that mental health in Africa, causes of ID, next Prevention and Treatment of Intellectual Disability, proceeded by classification of ID, prevalence of ID, Challenging Experience of Service Providers in Caring for Children with , Coping Strategies of Service Providers, family based care, and finally Bronfenbrenner's Ecological Model would be reviewed in detail.

2.1 Definition and Nature of ID

Many scholars have defined ID in their own perspectives. That means the definition differs from one professional discipline to another. The definitions may be medical, psychological, and behavioral (Kirk and Gallagher, 1986). ID is an abnormality that has enormous social effects; it not only affects the people who suffer from it but also the family and society as a group.

According to the tenth revision of the WHO (2011), ID is a disorder defined by the presence of incomplete or arrested mental development, principally characterized by the deterioration of concrete functions at each stage of development and that contribute to the overall level of intelligence, such as cognitive, language, motor and socialization functions; in this anomaly, adaptation to the environment is always affected. For ID, scores for intellectual development levels must be determined based on all of the available information, including

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

clinical signs, adaptive behavior in the cultural medium of the individual and psychometric findings.

On the other hand, the American Association on Intellectual and Developmental Disabilities (2007), indicates that in addition to a significantly sub-average intellectual functioning, concomitant limitations are observed in two or more areas of adaptive skills, and the disorder presents itself before the age of 18. During the first half of the twentieth century, two definitions of ID, one developed by Tredgold and the other by Doll, were frequently employed (Smith et al., 1994). According to him, ID is defined as:

A state of incomplete mental development of such a kind and degree that the individual is incapable of adapting him/herself to the normal environment of his /her fellows in such a way to maintain existence independently of supervision, control, or external support.

Doll (1941,) also defined ID and state six criteria by statement or implication have been generally considered essential to an adequate definition and concept. These are (1) Social incompetence (2) due to mental sub-normality, (3) which has been developmentally arrested, (4) which obtains at maturity, (5) is of constitutional origin, and (6) is essentially inscribable.

One can understand that the main focus of early definitions incorporate several criteria characteristic of the times (intellectual inadequacy, developmental, immaturity, deficit in adaptive behavior, and incurability, and stressed the concept of stressed. From Dolce's definition, it can be understood that most of the criteria listed are still considered as important concepts describing ID.

Social incompetence together with deficits in intellectual ability is an integrated issue that occurs from earlier definitions through subsequent definitions to the most current (David, 1997).

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

The concept of social incompetence should be considered in the light of cultural relativism. This is because of the interpretation of social incompetence varies from culture to culture and from society to society. If we consider a child who is socially incompetent in Japan, where social integration needs more mental ability, may not be evaluated equally incompetent in Ethiopia, where physical ability is more needed to integrate in society.

From Doll's definition, ID originates during the developmental period. According to his definition ID has a constitutional origin and is essentially incurable. However, incurability and its constitutional origin are not functional in the contemporary definitions of ID. Current studies showed that ID is not only caused by constitutional origin but also by environmental variables. Moreover, ID is no longer considered to be an incurable condition (David, 1997). That means through the provision of appropriate educational support it is possible to improve the life situation of children with ID. In current definitions of ID, adaptive behavior becomes a very important element.

In 1961, the AAMR introduced a manual that replaced the older terms, such as "feeble mindedness", "idiocy" and "mental sub-normality" with the term "mental retardation" which was universally adopted (Greenspan and Switzky, 2003 cited in Harris, 2006). The 1961 definition of AAMR is as follows: "Intellectual disability refers to average general intellectual functioning that originates during the developmental period (age 16) and is associated with impairment in adaptive behavior."

The 1973 AAMR definition of ID stated that ID refers to significantly sub average general intellectual functioning existing concurrently with deficits in adaptive behavior, manifested during the developmental period. The 1961 definition of ID explained that mental

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

retardation [sic] refers to sub average general intellectual functioning, which originates during the developmental period and is associated with impairment is adaptive behavior. The 1983 AAMR definition of intellectual disability refers to significantly sub average general intellectual functioning resulting in or associated with concurrent impairments in adaptive behavior and manifested during the developmental period.

The AAMR (1992) definition of ID stated that intellectual disability refers to substantial limitations in present functioning. It is characterized by significantly sub average intellectual functioning, existing concurrently with related limitations in two or more of the following adaptive skill areas: communication, self-care, home living, social skills, community, use self-direction, health and safety, functional academics, leisure and work. Mental retardation manifests before age 18 AAMR, 1992). For the application of the 1992 AAMR definition, the following four assumptions are essential. These are:

Valid assessment considers' cultural, linguistic diversity, as well as differences in communication

The existence of limitations in adaptive skills occurs within the context of community environments typical of the individual's age peers and is indexed to the person's individual needs for supports. Specific adaptive limitations often co-exist with strengths in other adaptive skills or other personal capabilities.

With appropriate supports over a sustained period, the life functioning of the person with ID will generally improve (AAMR, 1992).

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

According to this definition, ID can be seen as having three components (Intellectual limitations, problem of adaptive skill areas, and age of onset before 18). Smith et al. (1994) also defined ID as:

Intellectual disability generally refers to substantial limitations in present level of functioning reflected in delayed intellectual growth, and manifested in inappropriate or immature reactions to one's environment and below average performance in the academic psychological, physical, linguistic and social domains.

In general, ID is characterized by significant limitations in intellectual functioning and adaptive behavior the latter expressed as conceptual, social and practical adaptive skills.

AAMR (2002) defines ID that "mental retardation is an intellectual disability characterized by significant limitations, both in intellectual function and adaptive behavior expressed in conceptual, social, and practical adaptive skills. The disability originates before age 18." The definition includes standard deviation criteria for intellectual and adaptive behavior components and a fifth dimension of participation, interactions, and social roles. It proposes that adaptive behavior includes conceptual, social, and practical skills. It also provides a framework of assessment and describes how to assess supports and intensity of support.

In recent years, there has been an effort to replace the term "mental retardation" with "intellectual disability" (AAIDD, 2007). The Centers for Disease Control have made this change changing the term mental, as has the American Association on Mental Retardation (AAIDD, 2007). In addition, the President's Committee on Mental Retardation has also adopted the change and renamed the President's Committee for People with ID (PCPID, 2007), past two decades, moving away from the previously dominating concept of mental retardation to the current

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

concept of ID. Previous definitions made assumptions about the disability existing with in the person, specifically with in the mind; it was looked up on as a defect.

The redefinition of the concept in to ID involved a shift in perspective to wards perceiving the disability as an impairment in “the fit between the person’s capacities(implied in that is limited capacity as a function of neural impairment) and the context in which the person functioned” (America Disabilities Act 2008). This change of concept may be seen as an action to change how with disabilities and their families tend to be perceived, which may in turn affect transactions on all levels of the ecological system and to be less offensive to people with disabilities (Schalock et al.,2007).Other reasons for changing the concept from mental retardation in to ID were to adjust to the changes in the disability concept made by the AAIDD and World Health Organization, (World Health Organization 2011). However, mental retardation is still listed as a diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR, American Psychiatric Association 2000)*.

2.2 General Overview of ID

A documented history relating to ID is rather brief, struggling only about the last 200 years (Smith et al., 1994). Before the 18th century ID was growing from its gravest level to be taken care of the religious organization and the families. According to Smith et al., (1994), , before 17 century, if any service was provided to individuals with special needs, it was protective in nature and usually offered in monasteries. In addition to this, little evidence exists that structured programs of training or services delivery were available. The era of the 18th century brought changes following Renaissance thinking that encouraged a Philosophy of humanism,

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

principally concerned with peoples worth, as human features of this era were the advent of sensationalism and the revolutionary changes in Europe and America (Beirn-Smith et al., 1994).

According to Smith et al. (1994), the first part of the 19th century can be described as a time of dedication for working with people who had various disabilities. In addition to this, the recognized birth of special education and systematic services for individuals with disabilities occurred in Europe in the early eighteen's century. The field of special education was dramatically influenced by Jean-Mark Itard (1774-1838), a medical doctor who became quite interested in a feral child who was found in a wooded area near Aveyron, France, in 1799. Itard named the boy Victor from a state of wildness to a state of civilized behavior (Humphrey and Humphrey, 1962; as cited in Smith et al., 1994).

At the end of the 19th century, disappointment began to take on more reactionary tone. A change from concern to caring about individuals who had special needs to one for protecting society from them was evident (Smith et al., 1994). During this time training institutions were changed to new custodial role, and many citizens were now afraid that people with ID were dangerous to society. The prevailing perceptions during this time is stated as: The mental defectives were viewed as a threat to civilization, discouraging at home, and burdens to the school, sexually promiscuous, breeders of feebleminded offspring, victims and spreaders of poverty, danger, crime, and disease. Consequently, there was a cry for the segregation of all mental defectives, with the aim of purifying society, of erecting a solid well between its contaminators (Konner, 1964 as Cited in Smith et al., 1994).

The practical means of gathering people with mental defectives included various forms of segregation, an extreme example of which was sterilization. The eugenics movement was

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

another scare interested in controlling the number of “feeble-minded” persons through selective breeding. In 1869, Sir Francis Galton, the follower of Charles Darwin, espoused the idea that individual traits, most notably genius, were inherited and he advocated the genetic control of mental defectives (Smith et al., 1994).

During this time Immigration Restriction Act and the testing movements are developed. In 1905 Alfred Binet developed psychometric tests and Theodore Simon developed an instrument (known as Intelligence Quotient (IQ) test) to be used in French schools to screen those students who were not benefiting from the regular classroom experience and who might need special education. It is interesting to realize that Binet was concerned that this instrument might be mis-used (Harris, 2006). From this one can understand that this instrument might not be used as a guide for identifying children who were in need of help.

During the 1930 two major trends emerged in the treatment of individuals with disabilities. (1) The generation of a new attitude supportive of a public welfare system and 2) the affirmation of responsibility to those in need (Harris, 2006). When the World War 2 (WWII) was over, many families, and the nations as a whole, felt the realities of disability and also created increased employment opportunities in war related industries for individuals who were with ID. At that time, one of the greatest discoveries in medical history, the issue of mental deficiency [sic] appears respectable as a legitimate field of research in the biological sciences through the contribution of Clemens E. Bonda. According to Smith et al., (1994), in 1935 and 1949 the Vineland Social Maturity Scale (VSMS) and Wechsler intelligence scale for children (WISC) developed respectively.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

In 1950, the National Association for Retarded Children (NARC) was established known as the ARC (Association for Retarded Citizens).

In 1961, President John F. Kennedy of USA issued a statement calling for a national plan in the field of ID: “we as a nation have too long postponed an intensive research for solutions to the problems of ID; that failure should be corrected” (Kennedy, 1961 cited in Harris, 2006). Issues ranging from the need for scientific research on etiology and prevention of civil rights were going to be addressed by the president’s panel on ID appointed (Harris, 2006).

The Community Mental Health Centers Act of 1963 became law and facilitated the development of such centers throughout the United States and finally, academic medicine became fully involved with other specialties, community organizations and develops habilitation and prevention programs (Harris, 2006). In the mid-1960s, the Elementary and Secondary Education Act (P.L.89-10) and its amendments in the following five years initiated funds for education of children and youths with disabilities. In the 1970’s, additional progress was made in improving the lives of persons with disabilities such as the 1971 Intermediate Care Facility as part of Social Security Act on constitutional right to treatment and the 1973 on Rehabilitation Act in Section 504 (Silver Stein, 2000 cited in Harris, 2006). In 1975, the Education for All handicapped children Act (P.L.94-142) was enacted (Broddock, 1986 cited in Harris, 2006). In 1986, it was amended to mandate services for pre-school Children (P.L.99-457). Such legislations with the provision of Education of the Handicapped Act Amendments of 1990 (P. L. 101-476), became known as the individuals with Disabilities Education Act (IDEA). According to Harris (2006), this legislation guarantees children and youth with disabilities to get a free, appropriate public education.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

According to Roberts (1989) cited in Harris (2006), the four core principles for those in independent living were self-determination, self-image, public education, and individual and system advocacy (individual access and removal of community barrier for independent living). Hence, all barriers to full participation must be removed and the provision of rehabilitation service for person with ID like social, nutritional, medical, educational, vocational assistance, and technical aids must be available.

2.3 Mental health in Africa

According to World Psychological Association (2002), It is estimated that world-wide up to 20 % of children suffer from debilitating mental illness. Mental disorders that pose a significant concern include learning disorders, hyperkinetic disorders (ADHD), depression, psychosis, pervasive development disorders, attachment disorders, anxiety disorders, conduct disorder, substance abuse and eating disorders. Living with such children can be very stressful for caregivers in the family. Therefore, determination of challenges of living with these children is important in the process of finding ways to help or support caregivers to provide proper care for their children. The purpose of this study was to explore the psychological and emotional, social, and economic challenges that parents or guardians experience when caring for mentally ill children and what they do to address or deal with them.

Caregivers of mentally ill children experience various psychological and emotional, social, and economic challenges. Professional assistance, public awareness of mental illnesses in children, social support by the government, private sector, and non-governmental organizations

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

(NGOs) are important in addressing these challenges. Retrieved from on 1st July,2015 from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3390284/>

The WPA recognizes a number of constraints to the development of mental health programs in Africa:

- Lack of awareness of the magnitude of the problem.
- Lack of a reliable information system. Information on the efficiency and cost of various forms of intervention is needed to permit enlightened planning and allocation of resources. Questions about the prevalence in communities of common disorders of childhood or old age, or about substance use, or about factors associated with the HIV/AIDS pandemic are largely unanswerable in most African countries. Also in the allocation of scarce resources, prioritization is essential. Research is needed to determine the best policy for the particular country concerned, prevailing social and cultural circumstances, the main constraints, and the options for a viable model of care within them.
- Insufficient human and financial resources.
- Absence of national mental health policies.
- Shortage of specialized personnel.
- Constant brain drain.
- Widespread civil strife and violence. Wars and internecine strife disrupt social and community life and spread hunger, disease and homelessness. Psychological morbidity usually accompanies and outlasts the physical morbidity of war.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Although most African societies are fortunate in still being able to draw on the support of families for the care of the mentally ill, urbanization is becoming more widespread and the system of extended families is breaking down, depriving mental patients from a traditional source of support.

Another challenge in African countries is the role played by traditional healers. Many of them are strongly against any medication intake and therefore constitute an obstacle rather than an asset to mental health care provision. In many cases traditional treatments are characterized by injurious methods. In Nigeria about 20% of patients with mental disorders had previously consulted a traditional healer before consulting a general practitioner or psychiatrist; the corresponding percentage in Egypt is 70% (5). How could this be turned from a challenge to an asset? A policy of integration ought to have among its goals an examination of the nature of traditional practices and a process of isolating and improving the more efficacious and safe components of this form of care. WHO has training packages specifically designed for primary care workers, focusing on such conditions as depression, anxiety, somatization disorders and substance abuse. An equivalent tool for traditional healers could be considered.

In view of the above-mentioned challenges and the ambitious endeavors for the future, African leaders of psychiatry have agreed to create the African Association of Psychiatry and Allied Professions, in an attempt to coordinate and join efforts in analyzing, planning and promoting the situation of mental health and mental health care in Africa. All the participants in the above-mentioned meeting in Cairo agreed about the importance of initiating this Association, despite the difficulties existing, especially in communication. It was considered

Social and Economic Challenges of Service Providers to Children with
Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally
Challenged Children.

essential:

- to create a network for collecting and disseminating relevant information in the fields of psychiatry and mental health;
- to make contacts with policy makers (especially ministers of health) with the help of WHO;
- to associate French and Portuguese speaking African psychiatrists and to encourage regional meetings in West Africa;
- to maintain close liaison with the respective ministers of health, especially before they go to Geneva for the World Health Assembly;
- to collect information about national mental health programs and legislation, with the help of the World Bank (mapping mental health needs in Africa);
- to support training activities, especially by disseminating WPA educational programs;
- to encourage the creation of national psychiatric associations and their affiliation to the WPA (Kenyan, Sudanese, and Ethiopian associations are willing to join the WPA);
- to organize scientific meetings within regional and international scientific activities to bring forward the mental health concerns of the continent;
- to find contacts with expatriate African psychiatrists, especially if they have an association, in order to help their counterparts working in the country of origin;
- to encourage the help given to academic libraries in Africa;
- to encourage and facilitate the attendance of African psychiatrists in African meetings.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1489826>

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

2.4 Causes of ID

Knowing the etiological factors in ID, facilitate multi-disciplinary communication, are an essential element of professionalism, and are important in giving professionals the ability to make accurate information available to parents (Kolstoe, 1972 cited in Smith et al.,1994). That is why educators, psychologists, and other behavioral scientist spend time on the study of causation of ID. Studies have shown that ID can be caused by organic factors such as chromosomal, metabolic disorder or environmental deprivation. That is, it happens by any condition that may impair the development of brain during prenatal, perinatal or postnatal period (especially during infancy and early childhood) (Beirne - Smith et al. 1994).

In addition to these, etiological information can contribute to accurate diagnosis. Causal factors related with ID are multiples and can be classified as follows: Genetic, acquired (congenital and developmental), environmental and socio-cultural (Katz and Lazcano, 2008).

A) Genetic conditions: This result from abnormalities of genes inherited from parents, errors when genes combine, or from other disorders of the genes caused during pregnancy by infections, overexposure to x-rays and other factors. There are many genetic diseases associated with ID. Some examples include PKU (phenylketonuria), a single gene disorder. Due to a missing or defective enzyme, children with PKU cannot process a part of a protein called phenylalanine. Without treatment, phenylalanine builds up in the blood and causes ID. Down syndrome is an example of a chromosomal disorder. Chromosomal disorders happen sporadically and are caused by too many or too few chromosomes, or by a change in structure of a chromosome. Fragile X syndrome is a single gene disorder located on the X chromosome and is the leading inherited cause of ID.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

B) Acquired factors: can be further classified into congenital and developmental. The congenital cause can be grouped as follows: (1) Metabolic such as neonatal and hypothyroidism; (2) Toxic such as lead poisoning, fetal alcohol syndrome, prenatal exposure to substances abuse and (3) Infectious such as rubella, Cytomegalic Inclusion Body Disease, syphilis, toxoplasmosis, simple herpes. The developmental cause occurs during the prenatal period, possible pregnancy complications exist, such as toxemia and uncontrolled diabetes, intrauterine malnutrition, vaginal hemorrhages, placenta prevail and umbilical cord prolapsed. During the perinatal period, there are common birth complications: prolonged fetal suffering with neonatal anoxia, asphyxia related with suffocation, inadequate application of high forceps or a poorly applied Kristeller maneuver. During the postnatal period, complications are observed such as encephalopathy from hyper-bilirubinemia (kernicterus), encephalic traumatism and infections (encephalitis and meningitis).

C) Environmental and socio-cultural factors: Epidemiological studies have consistently reported a notable link between poverty and ID. The available evidence suggests that this connection reflects two distinct processes. The first establishes that a relation exists between poverty and exposure to a wide range of environmental and psychosocial factors; the second indicates that families with members who suffer from ID have an increased risk of catastrophic expenses that considerably affect poverty levels. These factors are direct causes of the disproportionate increase in the incidence of ID in developing countries. Interactions have been reported between scarcity and poor prenatal, perinatal and postnatal health care, adolescent maternity, family instability, poor natal health care due to multiple and inadequate caregivers and health professionals, low level of stimulation and education, in addition to infant mistreatment.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

According to Chernet (1999), causes of ID and related developmental disabilities have traditionally been divided into two categories: biological and (or psychological) and environmental (or psychological and sociological). In addition, in Ethiopia many people think that ID comes as a result of Curse from God (Cherinet, 1999, Tirussew, 2000), most probably as a result of some sin that the parents might have committed.

ID can be caused by any condition that impairs development of the brain before birth, during birth or in the childhood years. Several hundred causes have been discovered, but in about one-third of the people affected, the cause remains unknown. The three major known causes of ID are Down syndrome, fetal alcohol syndrome and fragile X syndrome (Katz and Lazcano, 2008).

The most prevalent general groups of biological causes of ID are genetic transmission of traits (i.e. genetic disorders) and chromosomal abnormalities. The genetic transmission includes dominant transmission, recessive transmission, sex-linked inheritance, and polygenic inheritance. The chromosomal deviations also include Down syndrome fragile-x syndrome, Klinefelter syndrome, Turner syndrome (Smith et al., 1994). The other biological causes of ID are cranial malformations (micro-anencephaly, cephalo and hydrocephaly), congenital factors (maternal disease and substance exposure), prematurity prenatal concerns, and postnatal biological concerns (head injuries, child-abuse, nutritional deficiencies (Smith et al. (1994).

2.6 Classification of ID

In the past, children with ID were categorized into one of four subtypes based on their IQ. This practice was abandoned in *DSM-5* for three reasons. First, the developers of *DSM-5* wanted to give equal importance to IQ and adaptive functioning in describing children with ID, rather

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

than focus exclusively on IQ alone. Second, children's IQ scores were less helpful than their level of adaptive behavior in determining their need for support and assistance at home, at school, and in the community. Third, IQ scores tend to be less valid toward the lower end of the IQ range.

Consequently, in *DSM-5*, clinicians specify the severity of ID based on the person's level of adaptive functioning. Adaptive functioning can be assessed using standardized rating scales, clinical interviews, and observations at home and school. Children with mild deficits in adaptive functioning (i.e., standard scores 55-70) in only one domain would presumably need less support from caregivers than children with profound deficits in adaptive functioning (i.e., standard scores <25) across multiple domains. Furthermore, by specifying the domains most in need of support, clinicians can begin to plan interventions to improve children's adaptive functioning or compensate for deficits that might be less responsive to provide a general overview of children's adaptive functioning at each level of severity.

Mild ID (Adaptive Functioning Scores 55-70): *As infants and toddlers*, children with mild ID usually appear no different than other children (Jacobson & Mulick, 1996). They achieve most developmental milestones at expected ages, learn basic language, and interact with family members and peers. Their intellectual deficits are usually first identified when they begin school. Teachers may notice that they require more time and practice to master academic skills, such as letter and number recognition, reading, and math. As they progress in school and their schoolwork becomes more challenging, these children fall further behind and may repeat a grade. Some children grow frustrated with traditional education and display behavior problems in class. By middle school, these children master basic reading and math but seldom make

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

further academic progress. After school, they typically blend back into society, perform semiskilled jobs, and live independently in the community. They usually require only occasional support from others to overcome their intellectual deficits. For example, they may need help for completing a job application, filing a tax return, or managing their finances.

Moderate ID (Adaptive Functioning Scores 40-55): *Children with moderate ID* often show signs of their intellectual and adaptive impairments as infants or toddlers (Jacobson & Mulick, 1996). Their motor skills usually develop in a typical fashion, but parents often notice delays in learning to speak and interacting with others. These children often seem less interested in their surroundings compared to their age mates. They are often first identified as having ID as toddlers or preschoolers, when they show little or no language development. Instead, they rely mostly on gestures and single word utterances. By the time they begin school, these children usually speak in short, simple phrases and show self-care skills similar to typically developing toddlers. However, they display problems mastering basic reading, writing, and mathematics. By adolescence, these children are able to communicate effectively with others, have basic self-care skills, and have simple reading and writing abilities. They may continue to have trouble with reading a newspaper, performing arithmetic, or handling money. As adults, some may perform unskilled jobs if they are given training and supervision. They usually live with family members or in residential care facilities.

Severe ID (Adaptive Functioning Scores 25-40): *Children with severe Intellectual Disability* are usually first identified in infancy (Jacobson & Mulick, 1996). They almost always show early delays in basic developmental milestones, such as sitting up and walking. They also usually show one or more biological anomalies that are indicative of a genetic or medical

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

disorder. These children often have health problems, are at risk for long-term motor disorders, or have seizures. They require ample supervision from parents and caregivers. By the time they begin school, they may be able to move on their own and perform some basic self-care skills, such as feeding, dressing, and using the toilet. They may communicate using single words and gestures. As adults, their speech continues to be limited and difficult to understand, although their ability to understand others is often better developed. They are usually unable to read or write, but they may be able to perform simple daily living tasks under close supervision. They typically live with family or in residential care.

Profound ID (Adaptive Functioning Scores <25): *Children with profound ID* are first identified in infancy (Jacobson & Mulick, 1996). They almost always show multiple biological anomalies and health problems indicative of neurological damage. By the time they reach school age, their skills are similar to those of typically developing one-year-olds. They may be able to sit up, imitate sounds, understand simple commands, and recognize familiar people. About half of the children with profound ID will continue to require help from others throughout their lives. The other half will show slow development of adaptive skills. They may learn to walk, develop some communication skills, and be able to perform some self-care activities. As adults, they usually continue to require constant support and supervision from family.

The most prominent classification which is based on the severity of the ID have four levels such as (with the additional requirement that adaptive behavior deficits also be present), mild (IQ range of 50 -55 to approximately 70), moderate (IQ range from 35 - 40 to 50-55), severe (IQ range from 20 - 25 to 35 -40), and profound (IQ below 20 or 25) (Taylor et al., 1995; Ysseldyke & Algozzine, 1995; Gearheart et al., 1988).

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

The other most familiar classification system is based on an individual's educational expectation. The educators' system (which parallels the AAMR system) include educable mentally retarded (EMR) with IQs between 75- 70 and 50, trainable mentally retarded (TMR) with IQs between 50 and 25, severely and profoundly retarded with IQs below 25 (Hallahan & Kauffman, 1991; Taylor et al., 1995).

Mild ID: Children with mild ID are generally "normal" in appearance with no pathological signs of disease or injury. They show a wide diversity in academic and behavioral performance. For example, they learn at a rate of one - half to three - quarters that of "normal" children. But, generally children with mild ID have the capacity to develop in three areas: academically (at primary and advanced elementary grade levels), socially (to be able to live independently in the community) and vocationally (to be partially or total self- supporting as an adult). That is, they can develop and employ adequate social, personal and communication skills (Winzer et al., 1987; Taylor et al., 1995; Kirk et al., 1993). School programs for these students usually stress the basic academic subjects - reading, writing, and arithmetic during the elementary years. The emphasis shifts to vocational training and work-study programs in junior or high school. Thus, as adults, many are not recognized as adult with ID outside school or after they finish school (Heward & Orlansky, 1988). Moreover, as stated in Winzer (1990), youngsters with mild ID show more similarities to other children than differences except that of their intellectual limitations. They feel, think, hope, play, have fun, and find mischief just like everyone else.

Moderate ID: Individuals classified as moderately retarded or trainable mentally retarded comprise up to 32% of all individuals labeled as intellectually disabled (Patton, Payne

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Beirne - Smith, 1990, cited in Eichstaed and Lavay, 1992). Most individuals with Down syndrome are found in this group as in Eichstaedt & Lavay, (1992).

Unlike children with mild ID, most children with moderate retardation show significant delays in development during the preschool years. They are more easily identified because of their lower intellectual, physical, and social functioning and their tendency to be more dependent. As they grow older, discrepancies generally grow wider between children with moderate ID and their mate with non-disabilities. However, this is in contrast to persons with mild Id whose condition become less obvious in adulthood. Moreover, additional handicapping conditions and physical abnormalities are more common in individuals with moderate id than in individuals with mild ID (Heward & Orlansky, 1988; Winzer, 1990; Eichstaedt & Lavay, 1992).

Generally, children with moderate ID are not ready for academic work until their early teens. Their deficits in adaptive behavior are clearly observed in their interpersonal relationships, social concepts, emotional instability, and communication (Winzer et al., 1987; Winzer, 1990). However, despite all these problems, children with moderate id can achieve a degree of adult social responsibility, learn basic academic skills, and acquire some vocational skills. These children are capable of learning self-help skills (dressing, undressing, toileting, eating, etc.) of protecting himself or herself from common dangers in the home, neighborhood, and school; of learning to read signs and to count; and of working in a sheltered environment or in a routine job under supervision (Kirk et al., 1993).

Severe and profound ID : Individuals with severe and profound ID are almost always identified at birth or shortly afterwards. Most of these children have significant central nervous system damage. Thus, many of them have other handicapping conditions (Heward & Orlansky,

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

1988). In addition, maladaptive behavior is common in both populations. The in appropriate behaviors might include aggression toward people and objects, tantrums, self-injury, and strategic behavior such as meaningless repetitive movements, rocking, and hand weaving. Less common behavior might include vomiting and rumination, pica (eating inedible objects, including faces, stealing and materials hoarding (Whitman & Scibak, 1979, cited in Winzer et al., 1987).

2.7 Prevalence of ID

Out of seven billion of the global population, which was suggested, today, there are approximately one billion people with disability in the world. As populations worldwide are living longer, and as chronic diseases such as cancer and diabetes are increasing even in the developing countries, the prevalence of disability will also continue to rise (WHO, 2011). Children and adolescents constitute 200 million of those with disabilities (about 10% of the world's youth), and about 80% of these live in the developing countries and experience physical, sensory, intellectual or mental disabilities(United Nations Disability Fact Sheet, 2006 as cited in UNICEF, 2007, p. 3). In addition, 93 million children aged 0-14 in the world have moderate to severe disabilities (WHO, 2011, p. 36 cited in Tirussew, 2005).

In developing countries, it is difficult to find accurate figures on prevalence and number of disabilities for most developing countries, including those in Africa, partly due to the hidden nature of the problem, and partly because of the low levels of attention given to data on disability by actors in various fields (Shemelis, 2011). However, little statistics by Worldwide Program Development on People with Disability (2010) shows that, in African countries, at least one person out of 10 is disabled by physical, mental or sensory impairment and at least 25

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

percent of any population is adversely affected by the presence of disability. Regarding the prevalence rate of disability in African countries, it ranges between 5 % and 5.5 %; and the prevalence of ID it ranges between 0.2 % and 0.4 % ((Milter, 1993 as cited by Shemelis, 2011).

In the report presented to the African Child forum by Shemelis (2011), despite the large number of children with disabilities in Africa, these children are absent from, or referred to only marginally in, public law and policy documents, health, education and social development plans, and/or poverty reduction programs. National Plans of Action for children in African countries sometimes make reference to children with disabilities, but suggest little action to meet their needs (Ramson 2006, as cited by Shemelis 2011). This situation exacerbates the neglect of these children's economic, social, cultural, civil and political rights (Shemelis, 2011).

According to available survey results from the 2006 census, of a total population in Ethiopia of more than 73 million, there are 805,535 (or 0.8 million) persons with disabilities. Among these 31 % are children with disability and out of these 6.5% are children with ID (CSA, 2006 cited in Tirussew (2005). As Hiwot (2011) pointed out, in Addis Ababa there are only 10 schools that have special and inclusive classes; but as she indicated referring the (2007-2008) survey of Central Statistical Agency (CSA) of Ethiopia which indicates that there are 4,310 persons with intellectual disability in Addis Ababa So, when it is compared, the number of schools available to children with ID in Addis Ababa, which shows a clear disparity between the demand and supply (Hiwot, 2011 p.12)

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

2.8 Prevention and Treatment of Intellectual Disability

Knowing the causes of ID helps for prevention and treatment. In addition, Graham and Scott (1988) cited in Smith et al., (1994), have developed and distinguished three levels of comprehensive model of prevention: primary prevention-risk conditions can be eliminated so that a condition never comes into existence; Secondary preventive efforts reduce or eliminate the effects of an existing risk factor; and tertiary intervention assists a child who has a disability.

Preventive measures are taken at different time, such as, during preconception period, during gestation period, at delivery time, and during early childhood period. As Smith et al. (1994) noted, preventive measures taken before conception can avert hereditary innate, congenital, and other constitutional disorders. One basic tool is genetic counseling, an attempt to determine risks of occurrence or recurrence of specific or chromosomal disorders. The tool of genetic counselor includes the family history and personal screening.

According to Smith et al., (1994), there are two appropriate approaches to prevention during gestation or pregnancy period. These are prenatal care and analysis for possible genetic disorder. Adequate nutrition, fetal monitoring, and protection from disease are certainly the functions of prenatal care. Avoidance of teratogenicity substances resulting both from exposure (e.g., radiation) and from personal consumption (e.g., alcohol and drugs) also relate specifically to this period. Analysis of fetus for the possible presence of genetic or chromosomal disorders is a key component of genetic counseling and the analysis include amniocentesis, chorionvillus sampling, ceroscopy, fatal biopsy, and ultrasound (smith et al., 1994).

Prevention at delivery is based on anticipating possible problems involving very young or older mothers, mothers' of low socio-economic status, drug exposure during pregnancy, and a

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

history of previous children with genetic disorders. Intensive intervention can begin almost immediately for premature and other infants identified as having a particular difficulty.

During early childhood, several types of interventions are important. Even if proper nutrition is critical throughout childhood, particularly during the first six months is fundamentally critical time specifically breast-feeding is important. Avoidance of hazardous in the child's environment can prevent brain injury and avoidance of exposure to substances such as, lead are mandatory to proper development. Other interventions have reduced the chance of ID, such as removing lead from the environment reduces brain damage in children. Preventive interventions such as child safety seats and bicycle helmets reduce head trauma. Early intervention programs with high-risk infants and toddlers have shown positive effects on intellectual functioning.

Finally, early comprehensive prenatal care and preventive measures prior to and during pregnancy increase a woman's chances of preventing ID. Dietary supplementation with folic acid, taken before and during pregnancy, reduces the risk of neural tube defects. Women who have phenylketonuria (PKU) should be counseled to go on a restricted phenylalanine diet three months prior to pregnancy to prevent intellectual disability in their baby.

The health of a baby can depend on how healthy a mother is before pregnancy. Ideally, the mother should obtain a general health assessment six months before pregnancy that includes: updating immunizations; reviewing use of medications; reviewing diet and vitamin supplementation, including folic acid; considering genetic counseling; and stopping use of alcohol, cigarettes or other tobacco forms, illegal drugs, and legal drugs not approved by the doctor. In addition to these, prenatal care should begin as soon as the mother suspects she is

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

pregnant. During pregnancy, a woman can protect the developing fetus by getting plenty of rest and sleep; eating nutritious meals; avoiding alcohol, cigarettes and drugs; avoiding people who are sick; wearing seat belts in a car; and not lifting heavy objects (Smith et al., 1994).

2.9 Challenging Experience of Service Providers in Caring for Children with ID

There is a powerful societal discourse that devalues people with disabilities in Western society (Green, 2007). Expectations tend to be low about the contribution that can be made to society by children with ID, and their rights to receive care and to have a place in society is sometimes questioned (McKeever & Miller, 2004). In addition to the adverse effects that such negative perceptions may have impact on children with ID, they also create problems for parents of children with ID, as they have been considered as a pity by others and perceived as burdened by their child. According to many parents, their experience does not correspond with one another (Green, 2007).

How close the relationship is between caregiver and care recipient appears to be important. Parents and spouses tended to be more positively involved in care giving than did adult offspring in the Victorian Careers Program research (Schofield et al., 1998). Intimacy and love in the relationship between caregiver and care recipient have been associated with lower levels of minor psychiatric symptoms and burden (Braithwaite, 2000), and the quality of the relationship between a caregiver or parents and a care recipient may have an influence on the ability to be satisfied with family functioning (Carruth, Tate, Moffatt, & Hill, 1997). It has also been suggested that depressive symptoms, anger and bitterness may be experienced by caregivers in very close or enmeshed families if they have taken on the care giving role to conform to family rules (Carruth et al., 1997).

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

In Africa specifically in Tanzania some studies conducted that service providers and Caregivers of children with ID experience psychological, social, and economic challenges. Ambikile and Outwater (2012).

2.9.1. Psychological and emotional challenges

Depression occurs when the caregiver feels overwhelmed, alone, blaming herself for not doing better, and feeling the situation is hopeless. The perceived inability of the caregiver to provide the care needed is the most common cause of depression. Caregivers who verbally express a great deal of negative emotion to children with ID they are found more stressed than those who learn positive communication styles. (S.S. Datta, P.S. Russell & S.C. Gopalakrishna, 2002 cited in Edith Henderson, 1995).

Including being stressed by caring tasks and having worries about the present and future life of children with ID, they have feelings of sadness, bitterness and, grieve due to being ID of children. They also experienced some communication problems with their children with ID due to children's inability to talk.

2.9.2. Social Challenges

There were inadequate social services for their children, stigma, discrimination, burden of caring task, providing special need services, lack of public awareness of ID, lack of social support, and disruption in social life.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

2.9.3. The economic challenges

Those were poverty, childcare interfering with various income generating activities in the family, and extra expenses associated the children with ID such as inability to cover school expenses (Ambikile and Outwater, 2012).

In Ethiopia, intellectual disabilities are wrongly perceived by the society as punishment from the God for the wrong doing of a family (Tirussew et al. 1995). As a result families are liable to keep their children with ID behind the door, which further exaggerates the severity of the problem. Because, lack of stimulation by itself is considered to be cause of ID, for which the "Wild Boy" (See Dolce, 1994)

The majority of individuals with ID are raised in homes where there is no stimulation, parental care or protection. Even, within a family of children with ID are often isolated and neglected, and are similarly kept away from schools

2.10. Coping Strategies of Service Providers (Parents, Teachers, Therapists, social workers

Smart (2001) provided a useful definition of coping:“The term coping refers to the things people do (acting or thinking)to increase a sense of well-being in their lives and to avoid being harmed by stressful demands”(p.11).

Coping strategies are considered to be goal-directed, emphasizing on positive steps such as relying on social support, obtaining treatment and rehabilitation, redefining life goals, and seeking information (Smart, 2001). She also added that defense mechanisms are different from coping strategies in that defense mechanisms are an effort to avoid anxiety and reality, and most often, the individual is not aware that he or she is using it. Mostly service providers reinforce coping strategies, but challenge the use of defense mechanisms. Hodapp (1998) described that any family’s capacity to cope with the child with ID depends on external resources such as money as well as internal resources such as the parents’ confidence in their ability to teach the

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

child, their problem solving skills, their attitudes toward life, and their religious beliefs. Moreover, the counseling that parents received from different sources was also seen to have helped them positively cope with their children with ID. In relation to this, Drew et al., (1992) said, “by finding and capitalizing on the positive attributes of the child, the professionals can assist the parents in realizing the child’s worth and can guide them towards acceptance. Coping strategies and functioning are mediated by protective factors in the ecological systems within which parents interact. Some of these protective factors include a supportive social network, sufficient emotional support from friends and others, favorable attitudes to and perceptions of disability in the larger society (Bailey and Smith, 2000; Moor and Moor, 2003).

Parents of children with developmental disorders encounter a variety of severe hardships in caring for themselves and their children’s needs and coping with the challenge. Research by Heiman (2004) cited in Chawla (2007) sheds light on the nature of their personal hardship and explores the coping mechanisms parents call upon to deal with their children’s everyday functioning. also added that the majority of parents, despite their initial perception of a personal tragedy, expressed a strong belief in the child and in his or her future, an optimistic outlook and realistic view and acceptance of the disability.

According to Olsen and Fuller (2007), there are three sources of support and central factors, which affect the parents’ ability to cope and to reduce feeling of hardship and stress and contribute to strengthening parental functioning. The first is a positive bond between parents, the second is cooperation, discussion and consultation of parents with family; and the third is using the available services for diagnostic treatment counseling and training for the child and the family. It is very important to use effective intervention programs for parents. These researchers said, “Parents have to be in a good support group from special organizations and from other parents who have the similar situations to cope with problems. Families have also to learn to effectively implement strategies and techniques that best fit their family’s goals and objectives.”

Psychosocial impact of disabilities will increase stress on the child, the child’s parents and siblings. The parents of children with disabilities are going through many stages. These parents may be going through the marital conflicts, emotional imbalance and self-discrimination. Many parents have reacted to the disability with adaptive fear for their own children’s futures.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Parents have to remember that they shouldn't be afraid of their children disabilities. Effective parents then are likely to be aware of the feeling of pity (Chawla, 2007). According to Chawla (2007) parents view their role as helping the child to become a worthwhile member of the community and expect a child to learn appropriate social rules of behavior. These parents need support in achieving more positive ways of thinking about the child, the parenting rules and the belief in the disability not being a tragedy.

The family improvement occurs whether or not the standard intervention was enhanced with additional parent support and coping skills programs. The child must feel secure to explore the world. Parents have to teach the child to "fit" in the social world. The social rules include being friendly, looking people in the eyes when you talk or listen to them, or verbally responding so others know you're listening. These actions are translated into having good social skills. This is work for the parents. The parents could do all of that only after they cope with the problems in their families' lives.

The two types of coping for parents are differentiated by intention. First, there is helping individuals to deal with their problems through cognitive or motivational changes, such as learning the new skills. Second, emotion-focused coping is directed at modifying one's own emotional response to a problem and includes such strategies as seeking emotional support, extracting value from negative situations, distractions, and minimization (Lazarus & Folkman, 1984, cited in Felicity et al., 2006). These researchers added that special needs parenting needs superhuman patience, energy, communication skills, sense of humor, a positive attitude in a different situations, and huge commitment to seeing a child's potential as well. Parents of children with ID experience more stress, guilt, and other negative emotions than those with typically developing children; and this parents consistently report positive as well as negative perceptions and experiences of raising children with developmental disabilities when asked about positive experiences (Felicity et al., 2006). These researchers also reported that families were most likely to report that children with disabilities contributed positively to the family as a source of happiness and fulfillment, strength, and family closeness. In addition to this, Stainton and Besser (1998) cited in (Felicity et al., 2006) identified nine positive impacts of having a child with ID in the family as reported by parents. These are: (1) source of joy and happiness, (2)

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

increased sense of purpose and priorities, (3) expanded personal and social networks and community involvement, (4) source of increased spirituality, (5) source of family unity, (6) source of increased tolerance and understanding, (7) source of personal growth and strength, (8) positive impacts on others and the community, (9) interaction with professionals and services. There is a great variance in the timing and in the broad reactions of parents in each stage. While most parents eventually accept their child with ID and develop strong bonds of attachment, the sequence of stages can vary and parents can periodically revert to earlier feelings (Wikles, Wassow, and Hatfield, 1981) as cited by Haveman et al., (1997). This implies that, some parents remain in the stage of disorganization, resulting in chronic sorrow, depression or early out-of-home placements, while other families reach the stage of active and positive acceptance of their child with ID.

Risk factors for poor parental adaptation have included having a child with more severe ID, maladaptive behavior, and worse physical health (Haveman et al., 1997). having insufficient support services (Heller & Factor, 1993) as cited in Haveman et al., (1997). According to these researchers, the impact on family life and service needs is likely to be different for families of a child with mild ID compared to families with a child with severe or profound ID. This means families of children with more severe ID also have to deal more with problems of co-morbidity, adaptive skill functioning, and challenging behaviors.

In Ethiopia, many parents are also reported to hide their child with ID behind doors to avoid the ridicule because of the child and attacks made against the child (Tirussew, 2000). The rejection of the child with ID in many cases is a function of severity of the disability (Smith et al., 1994). If the child significantly misbehaves and hence that makes him/her attack/ insults other people and/or is not able to control his/her saliva, the likelihood of being accepted by other people is less. This shows that this parent's problems are not valued by their neighbors. In relation to this, Smith et al., (1994) said that one of the supports that parents of children with ID need is a social support system that allows them to feel that they and their problems are valued by others. Drew et al., (1988) on his part said, "Parents of children with ID must have their own needs and feelings recognized and understood by each other, friends, family and professionals."

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

2.11. Family Based Care

Recent investigations show that the most critical factor in a child's education is the parents. The home is the first training place and parents are the first teachers. In addition, parents often have insights regarding the characteristics and needs of their children that can be helpful in devising treatment and educational programs. Thus, the establishment of a parent-school partnership is crucial to the continuous and optimal development of the children with disability (Schulz, 1987; Haring et al, 1994; Hallahan and Kauffman, 1991).

Several factors were pointed out in an investigation of the relationship of the home environment to the social and personal adjustment of children with ID. Out of which the harmony and quality of parenting, the degree of available educational and cognitive stimulation, and emotional support and parental approval for learning were the most important (Nehir, Mink, and Meyers, 1981, cited in Schulz 1987).

Effective parental participation in the intervention activity for children with ID depends on establishing a positive parent-professional relationship and providing training for parents and teachers as needed (Hallahan and Kauffman, 1991; Schulz, 1987)

Virtually all family theorists agree that the key thing to working and involving parents is through establishing positive and collaborative relationship between parents and professionals (Hallahan and Kauffman, 1991). To this end, different formal and less formal ways of collaborative communication can be used. Informal letters from the teacher to the parents, telephone calls and travelling notebooks or logbooks which accompanies the child to and from school every day in which the parent, teacher and other professionals can write messages to one another concerning the child's progress are less formal once (Winton & Lumball, 1981 cited in

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Haring et al, 1994). Among the formal ones are cooperative problem-solving between parents and the school, formal events such as assessments or planning conferences (parent-teacher conference) (Haring et al, 1994; Schulz, 1987; Hallahan and Kauffman, 1991). Parent education programs are the realization of joint concern for the optimal development of the students with disability. Educating parents is based on the premise that the typical context for learning generally occurs in the home through interaction with family members (Rosenberg, Robinson and Beckman, 1984, cited in Schulz, 1987). "The more treatment and educational programs take into account the relationships and interactions among family members, the more likely they are to be successful." (Hallahan and Kauffman, 1991, P. 458).

Models for educating parents of children with disability are parent workshops (which gives parents the opportunity to relate to a group of people who have common concern), home based programs (teach parents to teach their children), and school based models (which gives opportunity for parents to meet professionals, and to meet and gain support from other parents (Schulz 1991).

2.11. Bronfenbrenner's Ecological Model

Human development and behavior cannot be understood independently of the social, cultural, environmental and historical context in which it occurs (Bronfenbrenner, 1979; Hornby, 1995). This understanding implies that the social context or social environment influences the family system and its function. This in turn can have a significant influence on each member of the family, including the development of a child with ID and the belief of family members towards the child. As Hornby (1995) explained the effects on parents of caring for a child with any kind of special need (e.g. a child with ID) are strongly influenced by the social environment

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

in which they are living, including extended family, services available and community attitudes. This means the social environment has a significant influence on parents social and emotional well-being and the beliefs and values towards a child with ID; which in turn affects the attention, stimulation and services provided for parents and thereby the overall development of the child. It is important to consider the reciprocal influences and how a family is functioning from the point of view of Bronfenbrenner's ecological model (Hornby, 1995). This model explains how different systems such as the micro system, the meso-system, the ecosystem, and the macro system in society influence each other and how they all influence the family and service providers (Bronfenbrenner, 1979).

Microsystems: The Microsystems is the complex of relations between the developing person and the environment in the person's immediate setting, i.e., the person's home, school, day care, etc. family and day care service providers of a child with ID can be considered as micro-system. A micro system is made up by the developing person's closest surroundings like home, the day care centers, the kids in the courtyard, and classmates at school, hobby club members or close relatives (Saarinen et al., 1994). Harkonen has in a number of studies pushed off Bronfenbrenner's theory of development while pondering over the issues of education. The example here is the so-called contextual growth model from the point of view of the child growing up in family and day care centers. Other examples may include the neighborhood or the religious setting (Sage, 1998; Penn 2005, 45cited in Ulla Harkonen, 2007).based on Bronfenbrenner's theory, Harkonen (2007) has made up a family system model where the child is the target. In this case the purpose is to show the child's relations to Mother, Father, brothers and sisters, the other family. All this makes up the child's micro system. In the model there should be

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

arrows and words explaining, whether there is also an intention to the reciprocal relationships between the mentioned persons and parties who surround the child.

Speaking about a daycare centers, it is necessary to be distinct as to what is the object of study, whether it is a kindergarten, what is the age distribution and the group's other properties, or is it a family day care with its specific properties. The properties must be specified distinctly and carefully.

The school class can also be a micro system for the child. Sometimes he have seen in the students initial plans such an approach that only home is the micro system and any system further away is either the meso- or exosystem, especially if they are away from home. Yet, the idea behind Microsystems is not geography but the person's degree of participation in any system at all. In his micro system definition, all environments, in which the developing person is an active participant, are his/her microenvironments.

Sage (1998) has on the Bronfenbrenner theory basis made up a classroom system model where the child is the target. In this case the target is the relation of the child to the teacher, the teaching intern, classmate 1 and classmate 2. All this makes up one child's micro system. The model would need arrows or words to explain whether there is an intention to also study the reciprocal relations between the aforementioned persons and parties around the child.

Tonttila (2006) stated descriptions of four Microsystems: family, kindergarten, school and immediate environment. In all Microsystems an articulated picture is given reciprocal relations between the persons in interaction. This model is a fine example of how the same model can expose all the desired Microsystems and the interaction of the persons in them, using arrows for that purpose.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

All the above mentioned examples describe the child Microsystems. Quite often a student, a developmental psychology or an education major, will run into a situation where there is a need to handle a child or a schoolchild point of view. It must be noted that a study may focus on any one developing person like mother, father, grandma, grandfather, a teacher, a decision maker - anybody.

Sage (1998), who has on the basis of the Bronfenbrenner theory drawn a classroom system model (the teacher is the target. Tonttila's (2006, 11) chart clearly includes four micro-systems in the same model, but it must be remembered that one model can only include one person's micro-systems, not the systems of different persons at the same time. They must each have their own systems model. In this connection, it may also be asked how to use this theory and models to articulate the groups' development process or shall we always eventually come to an individual psychological point of view.

Bronfenbrenner (1979).cit. 11) figure might do with some fine adjustment because the family here is called the ecological reference framework, even though it is the child with disability's point of view and the family is just one micro system by the side of three others. The entire family is not pictured as participating in all Microsystems, mother and father are but not brothers and sisters. It would suffice here to change the title of the figure. It is also important to notice that figures and titles must correspond to each other, as well as these and the entire study must be in line.

The Bronfenbrenner theory based models are mostly circles or ovals one inside another, equipped with names or arrows. Even a researcher may be surprised finding unorthodox figures in the internet (Paquette & Ryan 2001). In this case micro system is the human body, inside

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

which there is an emotional system, a cognitive system and biology (apparently these in interaction as well, even if not pointed out in the model). This model points towards a renewed appearance of the Bronfenbrenner theory, the bio-ecological systems theory that referred to at the beginning of the article (Henderson1995). At the first glance at least, reading the arrows and telling the circles in the figure apart seems to take some time. Henderson (1995) has noticed that especially the understanding of the meso-system and its relaying into models and all the other interaction cause quite often problems. In this system there are the parents of a child with ID, siblings and extended family. These family members are interacting and communicating each other in their daily life. In Ethiopian context, for example, members of the family are powerful and very important for the developing child. What happens to the child can affect members of the family and again the child can be influenced by the rest of the family members (Hornby, 1995).

Mesosystem: The mesosystem is a set of interrelations between two or more settings or microsystem in which persons in question are active members. It can include home, extended family, neighborhood, Church, Mosque, School day care centers, Idir, Mahiber, etc. Families of children with ID can have interaction with one or more of these social settings. These social settings play a significant role in maximizing or minimizing the psychosocial problems parents encounter. In addition to this, it also plays a role in shaping the beliefs of day care service providers in general and teachers, social workers, therapists, rehabilitation specialists, nurses, counselors and so on, in particular towards children with ID.

Exosystem: The exosystem is an extension of the mesosystem embracing other specific social structures, both formal and informal that does not contain the developing person but

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

impinge upon or encompass the immediate settings in which that person is found, and there by influence, delimit, or even determine which goes on there (Hornby, 1995). These structures include such social institutions as mass media, welfare services, employment, etc. Even though family members do not directly involve themselves in ecosystems, still it can, indirectly, influence the beliefs and values of members of the family. For instance, the beliefs of friends at work place towards disability can affect the belief of the father towards his child with intellectual disability which, in turn, could affect the beliefs of other members of the family. The school special need guide line can affect the belief of special need education teachers, which also affects the belief of family towards a child with ID (Bronfen Brenner 1979).

Macrosystem: The macrosystem is the overarching institutional patterns of the culture or subculture, including the economic, social, educational, legal, and political systems, of which micro, meso, and exo systems are the concrete manifestations. All these institutional systems can play a significant role in influencing the parents' psychosocial well-being and beliefs towards children with ID. For example, economical problem happen at National level will affect the ecosystem (e.g. the welfare services of the community and employment condition) and this will affect the economic situation of the family. The family's economic situation, in turn, plays an important role on parents' perception towards their children with ID. In addition to this, inadequate educational services for children with disabilities in the country could affect the expectations of day care service providers to children which again lead parents and day care service providers to develop wrong beliefs towards these children. Moreover, culture and religion can affect parents' perception and other people in the community about causes of ID and the selection of ways of improving the child's condition. These perceptions and values play an

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

important role on the child's overall development and on service providers' and parent's 1 psychosocial values (Bronfen Brenner 1979).

Social and Economic Challenges of Service Providers to Children with
Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally
Challenged Children.

Chapter Three

Research Method

3.1 Research Design

A research design is a plan that explains the how, when and where data are to be collected and analyzed (Parahoo, 2006). Hence, The researcher selected the most appropriate design to meet the objective of the study. Sandelowski (2000) asserted that a research design can involve a quantitative design or qualitative design. Accordingly, the researcher employed qualitative method. The study was conducted to investigate the social and economic challenges of service providers to children with ID who were encountering in Mekane Eyesus Center for Mentally Challenged Children Addis Ababa project. The researcher decided that qualitative approach is suited to this study since, qualitative research is a broad term, it used to describe research that is focused primarily on human experience through exploring attitudes, beliefs, values and experiences (Whitehead, 2007).

3.2 Study Area:

Mekane Eyesus Center for mentally challenged children is non-governmental organization; it is found in the sub-city of Nifas-silk Lafto wereda 2. It was established in 1987 in Kasanchies and it was moved to Mekanisa in 1994 sponsored by MekaneEyesus church. It is also a kind of specialized setting. The researcher has chosen the study site specifically because this was the only center with long years' experience providing special need services for children with ID and having larger population.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

3.3. Source of Data:

The study was conducted with both primary and secondary data to obtain relevant information that is required to carry out this research. Primary sources were collected through in-depth interview, observation, and focus group discussion. Secondary sources of data were document review government policy documents, international instruments, books, and journal. Both primary and secondary data were carried out to strengthen methodological as well as argument basis of the present study.

3.4 Sampling Technique

According to this study, The purpose of sample is to attain data from a smaller particular sample which in turn increases reliability to generalize about the whole specified population (Polit & Beck, 2010). In this study, the researcher has chosen to use purposive sample for the following reason. Purposive sample is predominantly used in qualitative research so that the researcher intentionally selected participants to strengthen the reliability of the data. The focus of this study was service providers (teachers, physiotherapists, and social workers).

The researcher has selected nineteen sample respondents who met the selection criteria. The selection criteria included those service providers currently working in full time arrangement in the day care center for children with ID; who are involving in direct child care ; and having at least 3 years working experience. Parents were selected on the basis of having children with ID, becoming the primary care givers of their children with ID, and receiving services from the center more than three years. Governmental organization experts were also selected as a stake holders to the center. And the center executive director was selected as key informants since she had sufficient knowledge and experience about the research problem. Based on the criteria set;

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

four teachers, 1 social worker, 2 therapist, 9 parents of children with ID , two experts from governmental organizations, and one MCMCC executive director were also included. In addition, home visit was carried out to triangulate the data obtained from service providers in relation to their economic challenges. In this regard, 5 workers were randomly selected and consent was also obtained from participants for home visit.

3.5. Data Collection instruments:

Qualitative research relies on methods that permit researchers into the personal lives of the participants. To facilitate this process, flexible and various data collection instruments are required (Parahoo, 2006). Accordingly, the researcher used to collect data through interview, observation, focus group discussion and document review as instruments to uncover the reality of the research problem posed. The interview and FGD were conducted with respondents through tape recording and the researcher also took field notes on her daily field work experience. Then the study was carried out to review document of children with ID, profile that has already been recorded by the center. Followed the completion of data collection, audio materials were first transcribed and translated in to English then corrections was made by a senior English expert since interview guide items and focus group discussion guide items were prepared in Amharic primarily based on the researcher's experience with the problems, after a senior Amharic expert and further improvement was done by the researcher's advisor.

Interview

In -depth Interview is a common method of data collection in qualitative research, each questions become clear to the respondent, free of suggestion and use correct grammar (Whittemore & Grey, 2006). Accordingly, the researcher administered in-depth interview

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

through interview guide, and the interview guide comprised open-ended and with Semi-structured questions those were driven from research questions. It allowed the researcher to have a framework in which necessary open-ended questions were posed to encourage the participants to talk freely about their experiences in their own words. And the researcher carried out open-ended and semi-structured questions to obtain detail information from respondents about the research problem posed.

It was administered for 9 service providers (3 parents of children with ID ,3 teachers, 1 social worker, 2 therapists and it was included four experts of government organizations such as one expert of Bureau of Labor and Social Affairs, 1 coordinator of Sub-city Labor and Social Affairs,)to gather information regarding to social and economic challenges in which service providers were encountering in providing and receiving different intervention activities in MCMCC. The researcher audio recorded all interviews in the study; since The audio tape record is common in qualitative research to enable the researcher to pay full attention to the participant and non-verbal behavior and a word for word transcript for analysis (Newman, 2004).

3.5.2 Focus Group Discussion

It refers to group discussion providing a rich and detailed set of qualitative data based on group interaction; focus group discussion (FGD) is commonly used as a research method for conducting research with parents of children with ID (Polit and Beck, 2010). Therefore, in this study, focus group discussion (FGD) was one of the qualitative data collection methods that the researcher conducted the study. FGD was carried out through FGD guide. It was made constitute six parents of children with ID.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

FGD was employed by the researcher to get more insight through FGD guide about social challenges of service providers to children with ID; economic challenges of service providers to children. and coping strategies used by service providers. Since FGD is relatively naturalistic about exchange of idea of group members based on personal experiences in their own words of participants on the topic thereby providing insight that cannot be obtained from other data collection instruments (Polit and Beck, 2010).

3.5.3 Observation:

It is the scientific data collection instrument and an important source of data in many areas of investigation and serving for a useful purpose in adding knowledge to fields researchers intended to carry out observation method systematically through non participant group observation so as to investigate research participants' behavior and their usual actions. It was administered by the researcher through observation check list. It was also done by researcher for 15 days to examine the service provision of the center as a whole and the situation of service providers to children with ID.

The researcher carried out observation with her three friends who have special needs education background in order to strengthen the reliability of the data. and the researcher thought that group observation reduces a researcher bias. Accordingly, the researcher observed the situation of service providers like what they dressed, eat, and talked with persons in the center and service providers give services for children with ID on adaptive skill areas such as self-care, communication, social skills and functional academics. As the purpose of observation checklist was for academic research; the researcher has carried out observation to gather information for

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

the dissemination of data effectively. In addition, home visit was carried out to collect data particularly on their economic condition.

3.5.4. Document Review:

Since document review is one of the instruments of data collection, and it is the evidence on written form to enforce participants' conversation. Document review was conducted by taking information regarding to the case files of the Educational background of service providers and children with ID' level of disabilities was taken from their medical certificates. Which was found in the center so as to increase reliability of the data. That is why, the researcher included in her present study.

3.6. Pilot Study

The pilot study was conducted to check whether the instruments which was adopted appropriately to investigate social and challenges of service providers to children with ID in Mekane eyesus Center for Mentally Challenged Children. For this reason, five parents of children with ID and four teachers were selected as a sample for a pilot study. Thematic analysis was used to describe the instruments. Based on this, the researcher decided that the items were appropriate for the present study.

3.7. Data Analysis

The data was analyzed qualitatively and used thematic analysis. The findings was logically organized or categorized according to the basic frameworks on the research questions, such as social and economic challenges. Based on these categories, concerning each case, the findings were independently presented in a description form. Then, the findings on social and economic challenges of service providers to children with ID were discussed in detail.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Since qualitative data are collected in the form of text, written words or phrases in social life, its analysis is less standardized unlike its counterparts the quantitative analysis. Accordingly there is no clear agreement in the process and rule of qualitative data analysis (Newman, 2004). Nevertheless, for this particular study thematic framework was employed to analyze the data for proper management of analysis of the data and to establish coherent flow of ideas.

With regard to the structure of analysis, the data collected from the interviews, focus group discussion and document review has been categorized thematically. This was then broken down into sub-themes and concrete concepts. After it has been identified major themes and sub themes; category numbers was given to each raw data. The raw data was then distributed to the already identified thematic areas based on similar contents and finally it was summarized the data. It was by drawing on these major themes finally, the researcher carried out the analysis.

During analysis, all major themes and sub themes were discussed in detail in line with objective of the study. The researcher attempted to maintain consistency throughout the entire thesis by organizing the main themes in to three , i.e., based on objectives and the sub themes under their respective major themes. In doing so, the researcher made a continuous visit and revisit to the original raw data to see new clues and check if there were missed themes. Finally, conclusions and recommendations of this research were made based on the discussion.

3.7. Ethical Considerations

Since this study covered the social and economic challenges of service providers and children with ID; the researcher made a considerable care to ensure that the research was compiled with the necessary ethical responsibilities. For this particular research all participants were made aware in advance of the purpose and objective of the study. They were informed that

Social and Economic Challenges of Service Providers to Children with
Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally
Challenged Children.

the research was carried out for educational purpose; it did not involve any remuneration for taking part of in it as research participant.

Primarily, all research participants were asked their willingness to participate in the research including the possible use of tape recorder while in the process of administering the interview and the focus group discussion. They were also informed the confidentiality of information given for this particular undertaking. Respondents were asked to give their oral consent, nevertheless. The researcher wanted to inform to the readers of this thesis that the names mentioned in the entire thesis became pseudo names for the purpose of confidentiality as per agreement with the research participants. The researcher listened attentively to the participants' questions, it was phrased in a caring manner and probing questions was only used when it was necessary. In general, the research did not include any potential harm to anyone involved in this research; in assurance this, research participants were filled out a consent form. The researcher also provided an opportunity for the participant to say any concerns regarding the proposed study.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

4. Chapter Four

RESULTS

As this study was qualitative research, it was made to look in to social and economic challenges of service providers to children with ID in the study area. And the analysis was done thematically. Hence, this chapter presented the aforementioned above core and major research objectives or research questions of the study. For this purpose, research participants were asked their different experience about social and economic challenges of service providers to children with ID were encountering while providing various special needs services.

Based on this, research participants were enquired on social challenges faced by service providers to children with ID. In which the study examined how social challenges affects social interaction of service providers to children with ID. Then research participants were asked on economic challenges those service providers were encountering. Then the study investigated their economic status and its connection with giving quality services for children with ID. Participants were also asked about how service providers were affected by social and economic condition while providing services for children with ID. In this regard, the study explored the efforts made for children with ID in order to make them lead their own daily life activities. Finally, participants were asked to explain about coping strategies. Accordingly, the study examined their resilience of service providers while encountering social and economic challenges in relation to their occupation.

The overall profiles of research participants; secondly, the in-depth analysis of social and economic challenges in relation to service providing respectively. Thirdly,

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

4.1. General Background of Research Participants

Table 1

Participants' general information

No	Participants	Sex		T	Age		Qualification				
		M	F		25-35	36-45	MS C	BA/B ED	Dipl oma	Prim ary	Un ed uca te
1	Head of the center		1	1			1				
2	Physiotherapist		2	2		4			2		
	Teacher		4	4		4			4		
3	Social worker		1	1					1		
4	Experts	2	-	2	1	1		2			
5	Parents	2	7	9	2	7	-	-			

As it is shown on table 1 above, 84.2 % of service providers were between ages 46-45 and all service providers except the head of Mekane Iyesus center for mentally challenged children, were diploma holders.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Unit of analysis for this study at hand were the service providers to children with ID. Based on this, the study was conducted for the purpose of academic research; so that the names of participants of this study were not mentioned for any one. The researcher used quotation to indicate the direct speech of the research participants.

4.2. Social challenges:

4.2.1. Social interaction of service providers with parents and children with ID:

All participants of this study were asked that what their social interaction of service providers looked like with their parents and their children with ID.

Participant three who was the teacher explained that “I have poor social interaction with some children with ID and their parents because, the parents of children with ID thought me as the cruel woman not giving appropriate services and as I mistreat their children with ID in stead of showing empathy to them; parents also blame me for not improving their children’ ID. their thought makes me nervous and I don’t want to have close interaction with them since they didn’t understand my maximum effort. “

Participant five (who was the teacher), she explained that she had no positive interaction with some parents of children with ID . For the reason that, some parents of children with ID were not willing to accept their children as having ID . At that time, I advise them but some of them didn’t want to discuss about their children condition instead, they burst in to tears and blamed their fate and God. Then those parents shouted at her, and they told her not to say something to them and they talked her to give any service without talking about their children condition. And they left all activities as her obligation like a care giver not a teacher, so that they

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

wanted to be cleaned and controlled their personal hygiene. She also explained that because of this, her interaction with some parents of children with ID became poor. Participant 1 (who was the physiotherapist), she replied, “I have served children with ID about twenty five years though the work is very complex, still I am very happy to perform this kind of work; I believe that God has assigned me to work diligently so I am always ready to serve children with ID whenever they need assistance from me. Some time, when I reach my home, I feel tired in my work. “She also added that , She also added that “when I observed children with ID daily; Some time the situation made me become full of anxiety and sadness In this case, I take some time to come up with solution in discussing about their children situation with me and it also made me get stress about the situation of children. She also said, she was not herself rather than she was for them because, the work requires commitment the whole day until it reaches off time from the work. For instance when I has eaten lunch, or during break time, children with ID needme help from me , and I am happy to assist them. For example, if a child was hungry, I made her/him take break-fast by buying from my pocket or I make get food that was prepared by the center. I also encouraged parents to repeat the lesson what she taught to children with ID in cooperating with parents of children with ID; although the work demands professional competency and commitment to satisfy needs of children with ID, I have interest and respect to my occupation.”.

In addition to this, some of Research participants (who were teachers), pointed out when parents of children with ID had brought their children with ID to the center; they didn't have awareness how to care and support their children with ID. In this case, they were not ready to prepare balanced diet and buying dipper to control children with ID's waste things because there

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

were many children with ID who were unable to make sense whether urine became full of concentration or not. Due to negligence and low level of income of parents of ID; the other reason is, some of them has lived on the street, they got shortage off water due to this, and they got of sanitation problem; so that they expected all the needed materials to be fulfilled by the center. At that time, it created misunderstanding among some parents and the service providers; for the reason that, their expectation was beyond the center capacity; as a result it made develop negative relationship among them; in this case, that child with ID might not obtain special need services based on the child needs for a time being until they resolve their own conflict with the service providers of the center.

On the other hand, some other research participants (who were the physiotherapists) explained, some parents brought their children with ID with the needed materials like diaper without complaining which was expected from them; then it helps to be their relationship very well between them .

As majority research participants explanation, (who were service providers) “we try to make parents of ID strong in their spirit to accept their children with ID and we tell them not feel bad situation instead we attempt to make them think of presence of God with them so that it is better praying to God so as to help them having consolation; and we advise them to make their children exercise at home whatever we taught in the center and we ensure that as parents of children with ID will see the improvement of their children with ID’s condition. some times, even we shocked too much when we saw children with ID with additional disability and coming to the center to get intervention. In the meantime, we cried with parents of children with ID but many parents considered us as aggressive and who quarrel with us .”

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

On the other hand, Participant eleven (who was the parent), she showed that many service providers were reluctant to have social interaction with many parents of children with ID; Because, some service providers were aggressive and they didn't have good heart to help children with ID. she also added that they were not exerting maximum effort to help children with ID function their daily activities. Instead the service providers shouted at children with ID while they were teaching them. That means the service providers didn't understand the condition of children' ID. And they didn't give love and treatment. Therefore, she thought that many service providers were not sociable. Participant thirteen who was also the parent, She also explained that some service providers didn't afraid of bad actions on children with ID. For instance, she observed some service providers reacted to beat and insults. At that time, She felt sad in their wrong action. And she recognize that as there were some service providers who missed professional ethics and their social interaction was very weak. Participant nine who was expert from BOLSA, he said that he contacted with many teachers and physiotherapists monthly for the purpose of monitoring and evaluation of the activities of MCMCC, some of teachers and some physiotherapists were not appeared to have smile face at all, he thought that they have had burden in their work, they concentrate only on their work, who forgot how they interact with people. He also added that even they didn't greet him properly. On the other hand, in focus group discussion, parent one pointed out, " I think, many service providers such as teachers and therapists have good relationship with we parents and our children with ID, but some times some of them ignore us and even they don't want to see us in the center". Parent five also indicated that " majority teachers, therapists and social workers are cooperative, and they count for my children like themselves. If there is problem with my children with ID; they tell me frankly, I

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

also saw them approach all children with ID equally .” parent seven also pointed out “ I never close the teachers freely because, they don’t respect me, in stead of it, they neglect me and my child with ID. So, they are not sociable for me.” The other research participants in FGD and in interview showed that majority service providers were not extrovert to approach parents of children with ID. That means they have limited interaction with parents and their children with ID.

4.2.2. social interaction of service providers with community:

Participants two (who was the therapist) she said that in now days, still there appeared stigma and discriminatory activities in society. there was negative attitudinal problem about the work of service providers. even some people insulted service providers when they talked and went with children with ID to the somewhere and center; service providers that means (teachers, physiotherapists, social workers) were considered to b insane and to be cursed by God. Most participants of this study believed that as it needs to be created awareness to community starting from their surrounding about work of service providers have great value . Some of them believed that social interaction is required to be started from the center; as to the center is responsible for the work. in contrast, parent two explained that some teachers were not committed to their work rather than they became fade up and complained about shortage of human resources. She also added that they simply shout at parents of children with ID parent four also said, “ some of service providers didn’t respect their own work, they felt inferiority and who murmured to God to make them help resigning the work . she also added that even they didn’t want to explain about their work and communicate them at all, when guests came to visit the center . parent five also pointed out some service

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

providers like therapists blamed parents and society for not to be valued their work. They cursed their luck to be engaged in this work. Majority research participants of the interview pointed out, some service providers were appeared not to have good relationship , because, they could not over come social challenges encountered by community.

Participant three (who were the teacher) she got difficulty to have intimate interaction with them because her neighbor consider her as notorious and valueless woman , because she engaged in the work of giving services for children with ID. She tried to involve herself in community based organization; such as idir equb, and coffee ceremony but, her surrounding community didn't accept her because, the neighbors thought that since her work was on children with ID, she might be like children with ID moron and foolish. So, her neighbors considered her as not add value on social interaction, rather than they preferred to stigmatize her not to talk with her at any time. She also added that even they deny of greetings or "yeegziabher selamta" some in this case, she had limited interaction with her neighbor and with her surrounding community.

Participant six who was the teacher) also she indicated that "in my surrounding, my neighbors don't like me and they have not srust on me to involve me in social life activities, because, they believe that as I am not wise woman rather than they consider me foolish woman for the reason that I am working on children with ID so, I have no positive interaction with them."

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

4.2.3. professional support and cooperation:

In terms of professional support and cooperation, all research participants were asked that what kind of professional support the service providers obtained from the center. Participant 2 (who was the physiotherapist) said that she got training on therapy and the center encouraged her morally to work hard. Participant four (who was the teacher) she also said that “ as a teacher, I expected much things to do for me, but there is not much support is done by the center. I got only three times on special needs training.” Participant six (who was the teacher) explained that “some times, I obtain training on special needs; but the center didn’t promote the work of service providers through mass media and by organizing consultative meeting with community and stake holders to make be recognized the value of work of service providers due to reducing social challenges of service providers.

According to participant seven (who was the social worker) some trainings has been given to service providers, those trainings were made involve external trainers in addition to internal trainers how ever, the the center didn’t facilitate for them like to get update information, experience, and trip. She also added that the given trainings were assisting the service providers to have positive interaction towards children with ID and it enable them to overcome social challenges they encountered in society.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

The majority participants of this study (the service providers and some parents) explained that the given special needs trainings were not continuous and also much attention was not given by the center enabling to update their knowledge and to give for them additional expertise so as to make them deliver quality services on basis of needs of children with ID. They also indicated that the service providers were not gaining much professional support from the center and government .

4.2.4. social interaction of service providers with their family:

Regarding to social interaction of service providers with family, Research participants were interviewed that what they discussed with their family about their own occupation.

Participant 2 (who was the physiotherapist) she said, “I have discussed with my family about my occupation; previously, my mother refused me not to work for children with ID because, my mother considered them as the cursed person from God; after I discussed with her again and again; now she and my family has accepted my occupation and who have positive attitude towards children with ID. They have empathy to children with ID and also they attempt to help them where ever they meet children with ID. as much as possible.

Participant 1 (who was the physiotherapist) also pointed out, “I have good relationship with my husband and my daughter, for instance, my husband encourage me not to lose my endurance and my daughter said to me, “you want to be a business woman, but you are wishing that everybody can work; this is the special and blessed occupation God gave to you so you have to know as you are selected to do this work for spiritual purpose and for your survival on this world.” “ That means my daughter accepted my work to have value to make children with ID

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

productive, if a lot of effort is done to encourage them so as to lead independent living; in the meantime, I was so much impressed by my daughter reflection; I had been touched from the bottom of my heart and I begged God to apologize me and I regret so much in my wrong thought.” participants three (who was the teacher) she replied that her family have no good relationship with her; because they believed that her work didn't have value they have fear of her not become moron like children with ID; they didn't realize that as ID happens with in a fraction of second on everybody. They majority interviewee (the teachers, and the social workers) pointed out their relationship was not good. Their family believed that the service providers waste their time simply working on children with ID. Then their family nag them to resign the work. in this case, some teachers and social workers fought with their family.

4.2.5. Interest of service providers to their occupation

In terms of their interest to the occupation, Research participants were asked that how they expressed their interest to the occupation. Participant 2 O(who was physiotherapist) replied that she liked the work even though it has had much social challenges and it requires to be devoted full time without rest.

According to participants 4 explanation, (who was the teacher) “although there are several challenges to be encountered in my work, I like the job since I believe that it is the way to enter my soul in to heaven; I always thank God a lot for facilitating this work to be done by me; because, God bless me whenever I make sin”.

Some of them explained, they have had good intension towards their occupation although they came across negative societal attitude to be disappointed in their occupation, because children with ID were appeared by community to be unwanted and valueless person to perform

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

their daily activities and who couldn't contribute to their community instead, it was thought that children with ID were left to institution for lifelong services, since they were not considered as productive citizen for a country; their fate was counted only to be dependent on their family and country.

Moreover, the community had not also inserted in to consideration the professional commitment of service providers (physiotherapists, teachers, and social workers). However, the service providers attempted to cope up the social challenges of the work such as insults, stress, murmuring, sadness, tiresome, grieve; by considering it in spiritual aspect.

Majority research participants also explained that they liked the job since it enable them to contribute improving the condition of children' disability; consequently it has moral satisfaction to do so.

4.3. Economic challenges:

4.3.1. Satisfaction of service providers in their salary:

In relation to satisfaction, participants of this study were interviewed that how they described their level of satisfaction in their salary. Participant 3 (who was the teacher) elaborated, "I have been paid a small amount of salary but I have always told to myself as I am also working for my soul to be saved by God in doing so properly this kind of praised work; I think that it was so difficult to be satisfied for me if I were paid much salary and I talk with myself as the work has moral satisfaction when the condition of children with ID is improved; indeed, the more you have, the more you want." Participant five (who was the teacher) also pointed out "as you know, the living condition of our country comes worse at present time, it is impossible to afford my daily subsistence so I didn't have a satisfactory salary; I realize that my

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

salary is blessed by God and since God is always with me.” Participant two (who was the physiotherapist) also illustrated that “I am the single and I have four children; I raise them alone since I am widowed woman; some times I attempt to work over night in other organization. But still I am in serious problem to fulfill the whole need of my family, such as cloth, food and nutrition, and school fee.” Participant seven (the social worker) she indicated that “the salary is not sufficient for my daily subsistence, additional benefits is not given for me and other service providers.”

She also added “even though there is burden on my work, I am devoted to the work; but, there is very difference between the work and the salary I am played.” Participant 10 (the sub city coordinator) he replied, “of course, their salary is lower I think, the center didn’t give much attention towards the burden of the service providers and their commitment, though the center have budget scarcity, it needs to look for additional donors other wise, the center might lose the existing hard workers, so, it needs to think over it” participant eight (who was the center executive director) she demonstrated that she recognized that as the monthly salary of the service providers was very low. But, it was very difficult to obtain additional donors. She also added that still she was in maximum effort to come up with solution.

4.3.2 Home observation of service providers

The home observation was mainly targeted to get data on economic condition of service providers. In this regard, out of 8 service providers,5 were taken based on their home's proximity to Mekane Iyesus center for challenged children. Two teachers, one therapist and one social worker was included in the observation schedule. Except one teacher, the residence of 4 service providers was far from their work place in Saris Abo,Bole bulbula and Bethel area. The

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

observation was carried out on two married, two divorced and one single service providers for mentally challenged children. All service providers were female since the entire number of service providers in Mekane Iyesus center for mentally challenged children were female. On the basis its similar nature, the researcher opted to categorize the home observation in to two. The first group constitutes houses of very poor quality made of mud and wood. They were not cemented, very narrow in size to put house hold furniture and even they have bed room.

Their furniture was too old and broken. These are the residents of two teachers of Mekane Iyesus center for Mentally challenged children. In general their housing condition indicates their low living condition.

The second group constitutes therapists house which was relatively better than the former service providers. It was cemented and the furniture was relatively good with bed rooms. Of course they have also lacked kitchen and shower. In general from my home observation, I realized that service providers were in difficult condition economically.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

4.4. Coping strategy: in terms of coping strategies among service providers

The research participants were asked how the service providers cope with each other the encountered social and economic challenges. Participant one (who was the physiotherapist) she pointed out that she insist cope with the encountered challenges by considered the work in to spiritual aspects. For example, when she feel tired too much and when she clash with some colleagues, she took rest by informing the situation to her boss; or she preferred to read bible by sitting in her office. Then she told to her other colleagues to make reconcile with persons she already quarreled before. Participant three (who was the teacher)she said that many times she felt tired because, the work was too hard for her to perform easily. At that time, her behavior became destructive, so, she tried to resolve her problem by not talking with any one in the center. her colleagues understood her behavior, so, any conflict was not occurred. She also attempted to work per-time in other organization in her profession to maximize her level of income. Participant seven (the social worker) she pointed out, most of times, she didn't quarrel with her colleagues. When it happened, she cried out loudly by closing her office room. After that she became very happy.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

4.4.2. Coping strategies of service providers with parents of children with ID: participants one (who was physiotherapist) explained that “some parents of children with ID misunderstood my tiresome instead they annoyed at me for their child’ problem, at that time, I attempted to control my emotion swiftly; sometimes, I resolve the conflict through discussion with the parents.” participant five (who was the teacher) she illustrated that when some parents of children with ID offend her; she became silent not to hurt their feeling aggressively. Many times some children with ID didn’t give attention to what she has told them rather than they disterve in the classroom; in the mean time, she often preferred to leave the class until they became stable. Because, she recognize that the children with ID didn’t want to stay on some activities. They fade up easily, and they shoed restlessness. The other service providers indicated that although the service providers told the parents repeatedly, some parents of children with ID were not willing to make their children with ID exercise at home what the children with ID has already learned by teachers and physiotherapists. The service providers also added that there were many children have had destructive behavior and children with multi disabilities. For the reason that some service providers became nervous and they were not unable to manage the situation. In the mean time, they preferred to pray to God, until they solve the problem through discussion, consultation, and cooperation with the parents. In contrast, the service providers added that there are some parents of children

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

with ID who were making effort to improve the condition of their children. and there were some children with ID who made very glad in their talent during holiday celebration.

On the other hand, in the focus group discussion, parent 2 said that some teachers and physiotherapists didn't listen to what she told her problem. She added that she raised her child with ID alone. And she was daily laborer. She didn't have time to make her child exercise at home. In this case, she became nervous, and many times, she quarreled with them. Parent four explained that she preferred not to depart from her child with ID in the center. She lost her occupation for sake of her child. So, she agreed with all service providers. In addition to this, she accepted that the service providers advised to her. Parent six replied that some service providers said to her child with ID immoral words like "duruye" for her child's misbehavior. Then she cried loudly and she insulted them. The remaining FGD participants (parents) indicated that specially, some teachers considered only their problem. They didn't concentrate on their problems. They also added that although the service providers came across challenges; it was not more than the challenges of the parents. The parents also added that some service providers needed to remember their work has spiritual value not working for them. That didn't mean, all service providers were not generous to children with ID.

4.4.3. Coping strategies of service providers to community:

Participant four (who was the teacher) she explained that she was stigmatized and she encountered discrimination by her neighbors from social activities; and her neighbors considered her as the so called abnormal woman by

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

working on children with ID. They also assumed her as she has had arrogant behavior. So that she preferred to be neutral from any social activities. In addition, she prayed to God enabling her to have tolerance to her neighbor's discriminatory activities. Participant seven (who was the social worker) she replied that in her surrounding community, she came across discrimination; but, she tried to make discussion with neighbors and her family about children with ID during coffee ceremony by being present there even if they didn't invite her. She had hope on them to bring about change towards her career. The other service providers replied that They handle the social challenges through praying to God; informal discussion with community.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Chapter Five

Discussion of the Results

In this study, the socio-cultural or the ecological perspective framework seems to provide a helpful conceptualization to interpret the results. Bronfenbrenner's (1979) ecological framework is helpful to understand the themes in terms of how people represent their everyday environments as well as in the broad range of situations encountered in their homes, schools, neighbors, and communities.

The social experiences of the service providers implies a serious need to increase their personal networks. Bronfenbrenner's ecological model is applied to the social system of Ethiopian society. The traditions of Ethiopian society can be agents of change. In order to change the Ethiopian society's prevailing beliefs and negative expectations for children with ID, the traditional institutions might be encouraged to use strategies such as organizing service providers and parents meetings for experience sharing, workshops, conferences as well as spreading information through leaflets and school media. By working within the cultural traditional institutions of Ethiopia (e.g., utilizing traditional social institutions like "*Idir*", "*Equb*", "*Mahiber*", and "coffee mornings and after noon's" parents' perspectives as well as the attitudes of the larger society can be changed from the stigmatized negative stereotypes that seem to pervade the society's reference to and treatment of children with ID towards a more strengths-based perspective. Consequently it enables to minimize the social challenges of service providers (teachers, physiotherapists, and social workers).

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Coffee ceremony programs are good opportunity where service providers and neighbors meet and discuss social issues while drinking their coffee. In many cases, the main thing is not the coffee but the meeting itself because service providers discuss different issues and find solutions for their problems. Therefore, service providers such as teachers, physiotherapists, and social workers could join these neighborhood meetings to explain about ID, treatment, expectations, and so on. They could participate coffee ceremony themselves, thus facilitating social interaction among community on behalf of service providers . They could organize neighborhood discussion groups to learn about disability issues and then go out to teach others about the value of the work of service providers. In this way, members of the community or neighbors can be made to change their perception towards ID and their neighbors whose children have ID. When the society changes its negative perception, then the service providers' challenges would be minimized.

In relation to this, Coleridge (2000) stated that, "If there is no awareness how ID is perceived in the target culture, programs on ID doesn't become applicable or sustainable. This implies that, especially in Ethiopian communities where people from a variety of cultures and beliefs are living together, without the prior understanding of how the communities and families perceive those with a disability, it is very unlikely that any intervention programs can become effective without some adaptation to the traditional customs. Traditional mediators of the society (e.g., the priests and community leaders) must understand the service providers (social workers, teachers, and physiotherapists) situation and attitudes, their values and life situations. They can ally themselves with the service providers to form partnerships, provide information and new understanding about children with ID.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Based on this theory, The major findings of the research were discussed and interpreted thematically. Those themes were social challenges of service providers; economic challenges of service providers, and coping strategies.

5.1 social challenges of service providers (teachers, physiotherapists, and social workers). in this primary section, the followed sub themes were discussed thoroughly. Those were, social interaction among service providers; social interaction of service providers with parents of children with ID; social interaction of service providers with their families; professional support and cooperation; interest of service providers towards their own occupation:

A. social interaction among service providers:

According to Bronfenbrenner's (1979) even though parents are the primary care givers to their children with ID and they have reciprocal relationship among them i.e., they are not seen to live separately one another; service providers have also a great role in protecting right and wellbeing of all children specifically children with ID to satisfy their special needs proceeding to their parents. He also added that if the relationships break down in the immediate microsystem, the child will not have other alternatives to explore other parts of his /her environment. So, a child looks for the affirmations that should be present in the child/parent or child/other important adult) if relationship looks for attention in inappropriate places, These deficiencies will show themselves especially in adolescence as anti-social behavior, lack of self-discipline, and inability to provide self-direction (BronfenBrenner, 1979). This theory seems to enable looking in to discrepancy of the practice of teaching. Knowing about the breakdown occurring within children's homes, it is expected from schools and teachers to provide stable, long-term relationships. Yet, Bronfenbrenner believes that the primary relationship needs to be with

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

someone who can provide a sense of caring that is meant to last a lifetime. This relationship must be fostered by a person or people within the immediate sphere of the child's influence. Service providers fulfill an important secondary role, who can contribute to provide the complexity of interaction that is provided by primary care givers. Bronfenbrenner also stated that the problems of students and families are caused by the conflict between the workplace and family life not between families and schools. Schools and teachers should work to support the primary relationship and to create an environment that welcomes and nurtures families. Bronfenbrenner's ideal of the creation of public policy that makes easier the work of service providers conflict (Henderson, 1995). It is in the best interest of entire society to lobby for political and economic policies that support the importance of service providers' roles for children with ID development.

The theory was supported by almost all research participants explanation of this study, who indicated that the service providers requires to work together cooperatively for fulfilling special needs of children with ID effectively. Moreover, it is used to their children with ID getting more treatment from service providers by understanding the intensity of children' condition from their parents.

Otherwise if some parents of ID are not willing to have social interaction with teachers, physiotherapists and social workers because of lack of awareness about the value of social interaction; the condition of their children with ID may become worse.

Besides this, based on the finding of this study showed that majority researchparticipant pointed out , many parents of children with Id suffered from negative perceptions and discriminatory activities of society daily. As a result of this, parents of children with ID became with full of grieve, disappointment and full of tears. So that until they have had trust for service

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

providers; they were not open to any body including service providers to have social interaction and discussing about their children' condition and different challenges they encountered from day to day. For that reason when parents of children with ID contacted with service providers for the first time, they considered service providers to have negative attitude and discrimination like other society. That means parents of children with ID didn't realize as majority professionals might have positive perception and expertise about disability specifically children with ID.

On the other hand, some participants of this study indicated that, even if service providers have awareness about children with ID; some service providers became in full of stress and feel tired, in this case, they were appeared to be irresponsible for children with ID in office hours.

In relation to this, Some researches revealed that the presence of difficult behavior of a child with ID during tasks; it is the major reason service provider to be stressed and tired consequently it limits their interaction among service providers, parents of children with ID and their children with ID (Floyd & Gallagher, 1997), and the severity and profound level of a child's disability become another factor refraining from providing different intervention (Beckman 1991).

In this regard, the researcher suggests that that means no need of any intervention to children with severe and profound ID. However, it seems to contrast the sign of professional competency instead various interventions need to be given for a child with ID without disappointment in order to address their special needs appropriately.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

B. Social interaction of service providers with parents of children with ID:

This research finding indicated that majority Research participants emphasized that, it was not thought a child with ID finished a task in short period of time, although, it depends on level of disability; they needed more time to learn an activity than children with non-disability. Majority research participants added that it requires extra time to complete a task; in the meantime, most of the teachers have had patience and giving their own time to repeat a task again and again for instance, teaching how to dress their clothes, teaching to call their own names, washing their own face and hands, tying their shoes and so on.

Likewise, according to Erickson & Upshur (1989), it takes time to accomplish tasks like for teaching a child with ID to call her/his name; that means repetitive exercise is required to enable them calling.

That means it demands maximum effort of service providers to give various intervention to children with ID.

On the basis of this research finding, majority of the research participants reported that, "During teaching and learning time, the teachers face hard time in teaching them in class. For example, when the children are out of class for break or sport, it is hard to keep them in. In the class itself, once the children focus on one thing they do not respond to the teacher, it is hard to get their attention. So, to attract the children's attention the teachers said, " We let them sing a song all together and then tell them to stop, after we could get their attention".

Teaching children with ID need great patience and effort. If the teachers do not teach only what is interesting for the children, they do not like to attend to the teacher. The teachers

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

said, "Once the children hate a lesson, you cannot teach that lesson, you have to change." The children completely hate academic education. They, also, hate and do not understand abstract things. Thus, they like every lesson in concrete form supported with teaching aids and organized in a form of play. In this case, they usually like new teaching materials otherwise they dislike learning with the old once. Moreover, what is boring for the teachers as well as the students is that since the children with ID do not understand easily and forget quickly, the teachers have to repeat a week lesson or a single concept for months. In addition, there is great work load. In explaining the work load the teachers said, " Since the Children Salivate on themselves and some children with ID urinate on themselves, we have to clean all these. We act like teachers as well as caregivers."

Regarding the children's behavior, they are not cooperative; they are shy and hate forceful instruction. The children become fidgety easily, they cannot learn for longtime. Rather, they push and bit each other in the class. Furthermore, since some children have sinous and epilepsy behavioral problem, interruption in the middle of a lesson or training is common.

The participants of this study also added that the teachers complain about the lack of support from parents. That is, parents don't let the children practice at home what they have learnt in the center.

In this regard, the research finding indicates that there could be different reasons for the above statement; most probably, parents of children with ID were not well oriented how to make their children with ID exercise various activities at home those intervention activities have already given by service providers in the MCMCC; and parents of children with ID engaged themselves in small business activities to afford their own family's daily subsistence. In addition,

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

they got lack of assistance at home to support their children with ID. Therefore, most of the time, they have not sufficient time to make their children with ID exercise what their children with ID have already learnt in the center.

C. Social interaction of service providers with their families:

Based on some research participant explanation, their families said that, serving children with ID is a blessing occupation by God, and it is a unique work having moral satisfaction and spiritual value rather than other occupation which have already been done. As Majority research participants indicated, some of their family perceived, it is not comfortable to provide services for children with ID for the reason that they perceived that children with ID are foolish and who don't understand what they have learnt again and again.

In contrast to this, as stated in the statement of the problem of this study, according to Gallagher, et al., (1983) and Leyser (1996), most of time, A given task is not broken in to small tasks for children with ID to perform it easily in limited period of time. That is why, it is thought the given tasks are very difficult to accomplish in fixed time. In this case, , their family devalues the occupation of service providers in relation to children with ID in all aspects. And also, children with ID are considered not to succeed in academics that mean no need of sending them to school. Moreover, it can be said that still much effort is not done by government and persons with disability organizations to change the negative perception of society towards the occupation of service providers to children with ID as a whole.

Similar to this, According to Bronfenbrenner (1979), societal attitudes should be fostered to give value work done on behalf of children with ID at all such as parents, teachers, social workers, physiotherapists, school administrator.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

E. interest of service providers towards their occupation:

Majority research participants indicated that service providers have carried out with interest without complaining its difficulty by considering it in spiritual aspect. For example, they thought serving children with ID has value, and that is given by God in order to approach to heaven since it is the blessed work. Some service providers of this study perceived that it is very difficult to work on children with ID, as a result, it makes stress and disappointment; in addition, there is no sufficient special needs educators to simplify the work so as to provide interventions for children with ID cooperatively. so that some of them were working for gaining their daily subsistence in the center until they get better occupation.

This indicates that effective special needs trainings were not given to all service providers in order to enhance their professional competency and to maximize quality service delivery. in other words, MCMCC is expected to equip all staff service providers to acquire sufficient knowledge on special needs education and to have good interaction each other and with children with whom received services and then it requires to exert their maximum effort to give quality services for children with ID.

5.2. Economic challenges of service providers:

In this theme, the sub themes was discussed in detail. That is, assessing the level of satisfaction of service providers in their salary.

Interms of Assessing the level of satisfaction of service providers in their salary

The service providers of children with ID can be categorized in middle level of income since they are able to afford their daily subsistence (World Bank, 2011). In the contrary, The majority

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

research participants elaborated that it is less likely to say the paid salary is sufficient to fulfill the entire needs of their family except their subsistence. . However, they believed that the salary of service providers was blessed by their creature God. They always considered its spiritual value instead of thinking of the amount of salary that is obtained from the center. Some participants of this study explained that because of the dissatisfaction in their salary, who were working in another organization per time to fulfill their own family need. . And also the salary makes refrain from serving children with ID exhaustively. And some time it made service providers lead to stress and murmuring to resign the work.

5.3. Coping strategies: in this theme, sub themes were included As follows. There were, coping strategies among service providers; coping strategy used by service providers to parents and their children with ID; coping strategies used by service providers to community; and coping strategy used by service providers to economic challenges.

5.3.1 A. Coping strategy used among service providers:

According to Smart (2001) stated that coping strategy is the goal directed and making effort coming in to positive action to overcome challenges. Based on this, the finding of this study indicated that when there was conflict among them, the service providers persisted social challenges in different ways. Such as praying to God, discussion, crying, blaming to God, and tolerating each other. So, they work to be blessed by God not to praise by human beings. In other words, It is the spiritual work for them. As participant three (who was the teacher) reported that when she got misunderstanding with her colleagues, she preferred to blame to God for making her engaged in this work to resolve the conflict. In relation to this, some literatures stated that discussion and faith is some of coping strategy among service providers to be developed (Moor

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

and Moor, 2003). From the above statement it can be understood, some service providers didn't use coping strategies like other their staff colleagues; Such as faith, moral value, sharing experience. That is why, some of them got misunderstanding in their social interaction. And not to be devoted for their given work. This contradicts the literature "service providers of children with ID must have their own needs and feelings; which is recognized and understood by each other, friends, family and professionals." In this study, the discussions that most service providers of children with ID held with neighbors, friends, and others were not to the extent of meeting the needs and feelings of their own (Drew et al., 1988).

5.3.2. Coping strategy used by service providers to parents of children with ID:

The finding of this study indicated that some service providers got difficulty to have positive interaction with parents of children with ID. This shows that most service providers had used limited coping strategy. Coping strategies and functioning are mediated by protective factors in the ecological systems within which parents interact. Some of these protective factors include a supportive social network, sufficient emotional support from friends and others, favorable attitudes to and perceptions of disability in the larger society (Bailey and Smith, 2000; Moor and Moor, 2003). The finding of this study showed that most parents used faith, searching for information, coordination as positive coping strategies. Reliance on faith or religion helped some service providers to maximize interest of working with child with ID. Moreover, it helped them to deal with social interaction thus seemed to empower them to better cope with the situation. As participant 1 (who was the physiotherapist) , "We continue to pray to God and he will lead us to the solution." In relation to this, it is also inspiring to note that the physiotherapist in participant 1 stated, "I think I have learned a lot and become strong after I work with these

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

children. Even, my ability of solving problems in my working environment has increased. I always say that God gave me this work just to increase my knowledge and to make me strong.

Pertaining to this, (Felicity et al., 2006) identified the positive impacts of having a child with ID in the family as reported by service providers. These are: source of increased spirituality, source of family unity, source of increased tolerance and understanding, source of social interaction and strength, and interaction with parents of children with ID and services. On the other hand, blaming themselves & God, and attempting to resign the work was some of the negative coping strategies.

In addition, most service providers reported that they took care for the children with ID more than their 'normal' children. As to service providers of two & five said that , caring for children with severe and profound ID is more complicated and difficult. This is because it needs close supervision and longer time. However, the parents of this research believed that they have had a role to improve their child's condition; while others believed that God can improve their child's condition. In addition, most parents believed that the conditions of their children can be improved through holy water and some of them believed vocational training can improve the child's condition. This shows that parents who are in similar conditions could develop a belief that the situation of ID is beyond human capacity and ability to change. As a result, this may lead parents to the belief that they have no role to play in improving the living condition of their children. This contradicts the explanation of Chawla (2007); which stated that parents view their role as helping a child to become a worthwhile member of the community and expect a child to learn appropriate social rules of behavior. Similar to this, Most parents are responsible for their child's suffering with ID and many parents felt regret in that they haven't done

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

something for the improvement of their child's ID. Rejection of behavior, and neatness of the children (Tirussew, 2000). In this study, most parents reported that the improvement of their child's condition would be possible best through external agents, particularly by government and NGOs. This is because almost all participants of this study (parents) reported that it is beyond their pocket to afford the medication fee and scholarstic materials. In relation to this, they have no time to take to school and to come to home due to their engaging in small business and some parents are daily laborers. In relation to this research finding, some studies revealed that in their economic status, most parents can be categorized in low-income class according to World Bank (2011) which includes those who have inability to obtain the basic needs and services necessary for survival with dignity, low levels of health and education, poor access to clean water and sanitation, inadequate physical security, lack of voice, and insufficient capacity and opportunity to better one's life. In addition, educational support services are provided to children with ID by the government. However, most parents, particularly those in developing countries find it difficult to raise a child with disability especially if the family is in the lowest economic bracket (Amakelew et al., 2000). Parents with economic problems find it difficult to afford the medical, educational and other costs incurred by the child's disability. Due to these problems government as well as non- governmental organizations should provide help and other related assistance (Chernet et al., 2007).

And most parents also reported that they beat their children when they commit mistakes than explaining what they did is wrong. parents also worried about what happens to their children If they are no longer available to provide care and support. . That means who will care their children if they pass away. In line with this, what most worries of the parents is what the

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

future holds for their child (Tirussew, 2000). Some parents (e.g., the parent6) wished his child's death than suffering for the unchanged health condition of the child.

In relation to this Drew et al., (1992) explained that in some instance parents may react to the birth of a child with ID with death wishes. In other words, Most parents were enthusiastic to make their children with Id independently By improving condition of their child emmediately with help of service providers. In the mean time the service providers cope with these challenges through discussion, consultation, and cooperation with parents of children with ID. In relation to this, Drew et al., (1992) said, "by finding and capitalizing on the positive attributes of the child, the professionals can assist the parents in realizing the child's worth and can guide them towards acceptance."

The service providers and the FGD participants (parents) reported that there was holidays celebration among service providers, parents of children with ID, and their children in the center.

The researcher also observed while the center was celebrating the holidays like New Year and Christmas. For instance, during new year, In the meantime, there was opening time by the center executive director, and then talent show; song and poet were presented by children with ID. Then there were parents of children with ID comment and reflection time; piece of advice was given to parents finally, the closing time has been done. At that time, the researcher has seen smile face on service providers, parents and their children with ID. it was really a cheerful holiday to them. The researcher also understood from the report of service providers and parents, as it was one of coping strategy for them to strengthen their social interaction.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

C. Coping strategy used by service providers:

the finding of this study indicated that the service providers encountered social challenges by society. according to Corrigan and et al., (2003), the service provider have often reported being subjected to discrimination and exclusion due to their work association with a disability (e.g. The findings of the study also reveals that their social experience showed that they got insufficient social support, poor social network or interaction due to the children with ID intensive demands of time for caring. In addition Inwards of service providers participant three reported that she faced to stigma and discriminatory activities in her surrounding in her work, and when she went on the road with children with ID together. In line with this, According to Breener (1979), the work of service providers are not given value by society. hence, the service providers suffer by negative reaction of society. In this case, their social interaction is minimized. Parent 6 explained that, some her neighbors believe that children with ID couldn't bring change through education; rather, they believe that service providers work on the children with ID searching for money from the center than seeking for the child's improvement. This shows that these service providers' challenges and effort are not valued by their neighbors. In relation to this, (Moor and Moor, 2003) said that one of the supports that service providers of children with ID need is a social support system; that allows them to feel that they and their challenges are valued by others.

The discussion of service providers depends on the following three factors. The first factor is the neighbors' life style, attitude and willingness to discuss on the issue, and conception of neighbors towards their child with ID and themselves. In the cases of participant one, three, and four, most of their neighbors are busy to win their bread and had no attention to such an

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

issue. Related to neighbors, particularly participant one said, “everybody begins to bother when he / she faces the problem, otherwise, it is none of their business to discuss on such an issue.” The second factor is the physical environment and intimacy of neighbors and friends. That is the physical proximity of neighbor’s house has its own role for discussion. In addition to this, intimacy has great roles for discussion on the child’s development. In the case of participant one, discussion with her intimate job colleagues has brought her in conflict. In the case of participant 5, she discussed with her neighbors about value of the work on children with ID. The third factor is the service providers’ perception towards the child with ID. It may brought change or development in a crucial point for discussion with others that can provide valuable information or support. If service providers become hopeless about the child’s improvements, they become reserved not to discuss with others. In addition to this, for hopeless service providers , having discussion with others is just considered as a fruitless exercise. This also affects the social activities of them outside the center; and isolates them from social gatherings (this is true in the case of participant three and five).

Regarding to this, the service providers made effort to include themselves in coffee ceremony, community based organization. Such as edir, and Mahiber in order to maximize their social interaction with their surrounding community and to make them aware about the value of the work on children with ID through discussion. It is possible to bring change on society. discussion with neighbors, friends, professionals, religious leaders, and relatives help service providers of children with ID to be given value for their work and minimize their challenges. if government and NGOs work coordinately to encourage service providers to devoted more in their work.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

D. Coping strategy used by service providers to economic challenges:

based on this research finding, the service providers got lower satisfaction in their income., because they earned not much salary. In this study, most participants reported that the payed salary and the burden of the work is not suited.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Chapter Six

6.1 Conclusions

Based on the findings of the research, the researcher has reached the following conclusions. This study has examined how service providers to children with ID were influenced by social and economic challenges while giving and receiving different interventions. Specifically, this study reflected up on social interaction among service providers, parents of children with ID and society. secondly, the level of satisfaction of service providers in their job, income, and also investigates their coping strategies.

In this study, some research participants reported that, some service providers have had limited interaction with other service providers, parents of children with Id and society due to social and economic challenges of service providers in their work since children with Id didn't show improvement immediately; due to the repetitive exercises and devotion. The other reason was, some parents were also reluctant to approach service providers and at afraid of approaching to service providers to work in collaboration for their child's development. The other point is that some service providers became fade up and felt tired in their work because they faced social and economic challenges and there was no adequate human resources in MCMCC.

Some service providers believed that their level of income has had negative impact on their working environment; in this case, the salary didn't satisfy their own needs and their entire family. As per their beliefs, even though their work requires more commitment; great variation was occurred between their work and their salary. As a result it leads to loose commitment to their work. Some of the other serviced providers believed, no need of thinking of monthly salary,

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

instead it requires to think about its spiritual aspects; because, the salary has been always blessed by God. They also considered the work as the means of approaching to God.

Parents of this study had limited social supports and poor social network or interaction. All service providers of this study need support from MCMCC and government. This is because most service providers were living with low socio-economic status and mostly they did not benefit from their monthly salary.

Most service providers didn't get much support from the center and government as well . The Service providers of this study used as coping strategies faith, discussion, consultation, cooperation, moral value, information, support, coordination and some of the service providers used negative coping strategies such as, blaming to God, and attempting to resign the work on children with ID.

generally, In this study, service providers of children with ID need multi-dimensional support like social and economic (salary increment, social interaction and emotional supports).

6.2 Recommendations

Based on the conclusions described above, the researcher forwarded the following Recommendations.

1. Recreational areas should be facilitated for service providers, parents and their children with ID by Mekane Iyesus Center for Mentally Challenged Children in order to strengthen their social interaction.
2. The salary of service providers should be suited to the burden of their work.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

3. Government, non-governmental organizations, and community based organization like *Idir* and religious institutions should make a bridge to the society so that the work on children with ID could be respected and supported by the society.
4. The government and Mekane Iyesus Center for Mentally Challenged Children should focus on social and economic challenges of service providers in setting out strategies to minimize the challenges and to encourage them so that service providers can exert maximum effort in delivering quality services for children with ID.
5. The government and the church should plan capacity building for service providers and opening additional branches for mentally challenged children to address the entire children who are not getting the service.

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

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Social and Economic Challenges of Service Providers to Children with
Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally
Challenged Children.

Social and Economic Challenges of Service Providers to Children with
Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally
Challenged Children.

Appendix. 1.

Informed Consent Form

My name is Kalkidan Shimelis, a student pursuing my Master's Degree in the discipline of Special Needs Education at Addis Ababa University. I have undertaken research as part of my MSNE program. The main objective of my study was to investigate social and economic challenges of service providers and children with I D encounter while providing and receiving special needs services in Mekane Eyesus center for mentally challenged children. It also aimed at exploring the solutions to minimize the negative impacts and maximize positive impacts of service provision of service providers and children with I D. For the successful completion of the study, the cooperation of those who experienced the impacts and capable of providing necessary data is crucial.

For this study, I have collected information from the teachers, children with ID, physiotherapists, social workers and parents of children with I D in the day care center. The service providers should be ones who have had three years working experience and still who were working as service providers in the day center for the same purpose at the time of the study. In addition, the research also only targeted the service providers and children with I D. The participants also must be already involved in day care center and alive at the time of the study. The researcher recorded the voice of voluntary interviewees. All data collected from participants has been kept confidential and respondents have the right to refuse responding to some questions or quitting participation in general.

Social and Economic Challenges of Service Providers to Children with
Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally
Challenged Children.

The data process has been facilitated by open-ended interview guides which were
responded by the participants. The researcher clarified any unclear question by signing this form;
I agreed to participate in this research, under the provided conditions.

Name of participant (pseudonym) _____

Place _____ Date _____ Signature _____

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Appendix-2-

Interview Guide for Service Providers

Respondents' General Characteristics

Age: _____

Sex: _____

Marital status: _____

Employment Status/ source of income _____

Work experience in the center _____

Educational Background: _____

General Research Questions

The following questions listed down below were used as a spring board, to begin a discussion and a number of other, but related questions were raised in the course of the discussion through probing.

Social Challenges: how do you interact with children with ID?

how do you support the children with ID when they need your help

Do you talk about your occupation with your family and friends? If yes, what they say?

Do you have interest to your work? If yes or no explain about it. Do you get special needs training? If yes or no explain it.

Economic Challenges:

Are you satisfied in your salary? Yes or no, and why?

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

Appendix-3 -

FGD Guide to parents of children with intellectual disability

1. Respondents' General Characteristics

Age: _____

Sex: _____

Marital status: _____

Level of education _____

Occupation _____

Employment/source of income _____

Number of your children _____

Other children with disabilities _____

Disabilities history of the spouse's family _____

1) Services those are already provided to Children with ID

1. Do you get any financial support or any kind of support for the child with ID near your locality? If yes, from where and how much?
2. What kind of training you got from professional that helped you for caring your child with ID in the Centre?
3. Is there guide line concerning intellectual disability developed by the centre? If yes, explain about it.
4. What kind of services available for children with I D in the Centre? List it.
5. How did you overcome social challenges among service providers?

Social and Economic Challenges of Service Providers to Children with Intellectual Disabilities: the Case of Mekane-Eyesus Center for Mentally Challenged Children.

6. How did you overcome economic challenges with parents of children with intellectual disabilities?
7. How did you overcome challenge from the community?
8. How did you cope up economic challenges?

2. Coping Strategies of service providers

- A. How did service providers overcome social challenges among service providers?
- B. How did service providers overcome economic challenges with parents of children with intellectual disabilities?
- C. How did service providers overcome challenge from community?
- D. How did service providers cope up economic challenges?
- E.