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The State of Community Based Rehabilitation Approaches for Children with Disabilities in Kilte Awlaelo Wereda, Tigray

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June, 2010

Addis Ababa

The State of Community Based Rehabilitation Approaches for Children with Disabilities in Kilte Awlaelo Wereda, Tigray

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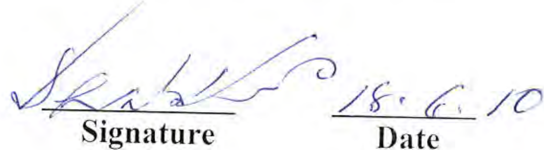

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Table of content

Page

Acknowledgments---------- I
Table of contents ---------- II
List of tables ---------- V
Acronyms and Abbreviations ---------- VI
Glossary ---------- VII
Abstract ---------- VIII
CHAPTER ONE: INTRODUCTION---------- 1
1.1 Background of the study ---------- 1
1.2 Statement of the problem ---------- 4
1.3 Research questions ---------- 5
1.4 Objective of the study
General objectives ---------- 5
Specific objectives ---------- 5
1.5 Significance of the study ---------- 6
1.6 Delimitation of the study ---------- 6
1.7 Limitation of the study ---------- 7
1.8 Operational definitions ---------- 7
CHAPTER TWO: REVIEW OF LITREATURE---------- 8
2.1 The concept of disability ---------- 8
2.1.1 Types of disabilities ---------- 10
2.1.2 Causes of disability ---------- 11
2.1.3 Prevalence of disability in Ethiopia ---------- 12
2.2 An Overview of rehabilitation ---------- 14
2.2.1 Medical rehabilitation ---------- 15
2.2.2 Educational Rehabilitation ---------- 16
2.2.3 Social Rehabilitation ---------- 17
2.2.4 Vocational Rehabilitation ---------- 18
2.3 Institutionally Based Services and their Challenges ---------- 19
2.4 Community Based Rehabilitations ---------- 20
2.4.1 Components of Community Based Rehabilitation ---------- 21
2.4.2 Principles of Community Based Rehabilitation ---------- 23
2.5 Community Involvement ---------- 24
2.6 Partnerships in Community Based Rehabilitation ---------- 26
2.7 The Role of Family Members in CBR ---------- 27
2.7.1 Family Reaction ---------- 27
2.7.2 Families Involvement in CBR ---------- 28
2.8 The Role of Professionals ---------- 28
2.9 Challenges in Implementing CBR Programmes ---------- 29
2.10 Experiences of Different Countries ---------- 30
CHAPTER THREE: METHODOLOGY---------- 35
3.1 Research Design ---------- 35
3.2 Sampling Area ---------- 36

3.3 The Participants and Sampling Techniques ---------------------------------- 36
3.3.1 Participants -- 36
3.3.2 Sampling Technique -- 36
3.4 Instruments for Data Collection -- 39
3.4.1 Interviews -- 39
3.4.2 Focus Group Discussion -- 40
3.4.3 Observation --- 40
3.4.4 Review of Documents -- 40
3.5 Procedure of the study -- 41
3.6 Data analysis -- 41
CHAPTER FOUR: FINDINGS OF THE STUDY -------------------------------------- 43
4.1 Introduction -- 43
4.2 Background Information about CBR Tigray ---------------------------------- 43
4.3 Background information of children with disabilities- ---------------------- 44
4.4 Interview results of children with disabilities ------------------------------- 45
4.4.1 Situation of children with disabilities before rehabilitation 45
4.4.1.1Social situation -- 45
4.4.1.2 Psychological situation ------------------------------- 46
4.4.1.3 Educational situation --------------------------------- 46
4.4.1.4 Medical situation -------------------------------------- 47
4.4.2 The state of CBR services -- 48
4.4.3 The effect of CBR on children with disabilities --------------- 49
4.4.4 Community mobilization in the implementation
of CBR program --- 50
4.4.4 .1 Awareness raising ----------------------------------- 50
4.4.4.2 Involvement of CWDs, parents, and community --- 50
4.4.4.3 Partnership with local institutions ------------------ 51
4.5 Background information of parents --- 52
4.6 Interview results of parents -- 53
4.6.1 Beliefs of parents on the causes of
Impairment before rehabilitation ----------------------------- 53
4.6.1.1 Beliefs on causes of impairment --------------------- 53
4.6.1.2 Family reaction -- 53
4.6.1.3 Treatment given to children with disabilities ------- 54
4.6.1 .4 Challenges faced by having a child with disabilities-- 55

4.6.2 Beliefs of parents while the rehabilitation going on ------------ 55
4.6.3 The state of CBR services for children with disabilities ------ 55
4.6.4 Involvement of parents and their children in the program --- 57
4.6.5 Challenges of CBR -- 58
4.7 Interview results of the program coordinator --------------------------------- 59
4.8 Focus Group Discussion Results --- 62
CHAPTER FIVE: DISCUSSION --- 66
5.1 Types of rehabilitation services -- 66
5.2 Involvement of children with disabilities, families, community members, and professionals in CBR program -- 69
5.2.1 Involvement of children with disabilities in the program ------ 70
5.2.2 Involvement of parents in CBR program ------------------------- 71
5.2.3 Involvement of community in CBR program -------------------- 72
5.2.4 Role of professionals in CBR program------------------------- 73
5 .3 Beliefs of parents before, and while the CBR program is going on ------- 74
5.3.1 Beliefs of parents about the causes of disability ------------- 74
5.3.2 Parents reaction -- 74
5.3.3 Treatment given to children with disabilities ----------------- 75
5.4 Attitude of the community towards children with disabilities ---------------- 76
5.5 Challenges of CBR program -- 77
CHAPTER SIX: SUMMARY, CONCLUSIONS AND RECOMMENDATIONS
6.1 Summary --- 79
6.2 Conclusions -- 82
6.3 Recommendations -- 83
References --
Appendices--

List of tables

Page

Table 1 Prevalence of disabilities in Ethiopia in percentage-------------------------- 13

Table 2 Prevalence of disability in terms of age-- 13

Table 3 Summary of number of respondents --- 38

Table 3 Back ground information of children with disabilities----------------------- 44

Table 4 Back ground information of parents of children with disabilities---------- 52

Acronyms and Abbreviations

BOLSA- Bureau of Labor and Social Affairs
CBM- Christofol Blind Mission
CBR- Community Based Rehabilitation
CRC- Convention on the Right of the Child
CWDs- Children With Disabilities
EFA- Education For All
FGD- Focus Group Discussion
GCBRP- Guyana Community Based Rehabilitation Programme
HNAC- Handicap National Action for Children with Disabilities
IBR- Institution Based Rehabilitation
ILO- International Labor Organization
MOE - Ministry of Education
MOLSA- Ministry of Labor and Social Affaires
NDA - Nepal Disabled association
NGOs- Non Governmental Organizations
PWDs- Persons with Disabilities
SHIA- Swedish Organization of Disabled Persons International Aid
UNDP- United Nation Development Program
UNESCO- United Nations Educational, Scientific and Cultural Organization
UNICEF- United Nations Children's Fund
WHO- World Health Organization
WVE- World Vision Ethiopia

Glossary

Tabia – *The lower most administrative district consisting of 10,000 people on the average*

Wereda – *Second higher administrative district consisting of ten Tabias in the average.*

Seftinate - *Public participation on water and soil conservation work in the form of food for work.*

Ashenda - *A Cultural festival of girls.*

Hoyahoye and Ayankla – A cultural festival of boyes.

Abstract

The purpose of this study was to investigate the state of community based rehabilitation approaches for children with disabilities in Kilte-Awlaelo wereda, Tigray. In this study a qualitative method of study was employed with the participation of four children with disabilities, eight parents of children with disabilities, two community rehabilitation workers, two teachers, two community leaders and the program coordinator. In addition, these sources of data were selected based on purposive and available sampling techniques. Regarding children with disabilities, they are four in number and they are selected using the criteria, age 10-18years, from different categories of disabilities, from both sex, and who are included in the program; four parents of the children already selected and other four parents of children with disabilities who were willing to participate; the community rehabilitation workers these who are working with the children and parents of children with disabilities; teachers of the children with disabilities, and community leaders of the village in which the children live in. The study also used data gathering instruments such as individual semi-structured interview guides, focus group discussion guide, observation guides and document review list. The data were collected using interview from four children with disabilities, six parents, and the program coordinator; the data collected using focus group discuss was from two parents, two teachers, two community rehabilitation workers, and two community leaders. The major findings include that the CBR program provide effective medical and educational services for children with disabilities, and that there is an attitudinal change of parents and the community towards children with disabilities as the result of the awareness raising activities done by the center. Even though the CBR-Tigray has brought a significant change in the quality of life of children with disabilities, there were underachievement regarding vocational rehabilitation of children, income generating activities of parents as well as in involvement of children with disabilities, parents, professionals and the community in planning and monitoring the CBR program activities. There were also different manmade and natural obstacles on the on-going rehabilitation program. In order to enhance the quality of life of children with disabilities, The study

recommends that CBR-Tigray should include other components in its program such as vocational training and income generating services, and involvement of parents, children, professionals and the community in planning and monitoring of the program activities.

CHAPTER ONE: INTRODUCTION

1.1 Background of the study

When a child is born, there are usually doubts and apprehension in relation to the baby's health, life and future. These feelings lead to disappointment when parents are finding that they had a child with disability. In this situation, parents often face hard times because of emotional factors and intense frustration (Conceição, 2007).

Children with disabilities constantly experience barriers to enjoyment of basic human rights and inclusion in society. Their abilities are overlooked, there capacities are underestimated and their needs are given lower priority, yet the barriers they face are more frequently a result of the environment in which they live than as a result of their impairment (UNICEF, 2007).

Children with disabilities like other children without disabilities deserve special attention, protection, and assistance from their families, as well others who could support their upbringing. Hence the 1989 convention on the right of the child (CRC) is the first binding instrument in international law to deal comprehensively with the human rights of children with disabilities (UNICF, 2007). CRC refers to the obligation of states parties and recognizes that "… a child with mental or physical disabilities is entitled to enjoy a full and decent life in conditions that ensure dignity, promote self reliance and facilitate the child's active participation in the community" (Article 23).

Hence, in order for children with disabilities to participate in community activities the role of community based programs is vital. With the global human rights movement becoming prominent, many changes have followed in the field of disability rehabilitation all over the world, including Ethiopia (Tirussew, 2006).

Institutionally Based Rehabilitation, adopted in many countries, delivers services to people with disabilities(PWDs) primarily through special institutions and centers which could reach only few and insignificant proportion of the PWDs Daniel (n. d.); in this approach persons with disabilities are moved to a special setting where there are limited

opportunities for interacting with the wider community. Isolation of the people with disabilities from their families and community is believed to have a negative effect on their proper growth and development (Ibid).

Wegayehu (2004) indicates that IBR programs have noticeable limitations, they are center based rather than rehabilitant need based and these center based institutes used imported technology which is costly. IBRs have lack of flexibility as they need to fulfill the preset objectives of the program instead of the clients need and want.

IBR services are generally established in cities or towns where there are better public facilities and utilities. On the other hand PWDs are scattered all over the country and far from where IBRs exist. These settings make them inaccessible for people with disabilities. As IBR centers are too few, they cannot cope with the large number of persons with disabilities (Ibid). Tigabu (2008) disclose that, in Ethiopia, rehabilitation services provision institutions could address only to a 1% of the total rehabilitation needs of persons with disabilities. He also stressed that, in addition to the minimum capacity it had, the intervention strategy employed had worst consequences-entrenched negative attitudes towards PWDs, disempowered PWDs themselves and people around them, and, perpetuated harmful traditional practices in the general communities.

As a result of these factors, a new approach to providing rehabilitation services known as community based Rehabilitation (CBR) was introduced and has become popular for three decades. Today, CBR is being implemented in many developing countries and has evolved into an effective comprehensive multi-sectoral strategy in creating access to health care, education, livelihood opportunities and participation/inclusion (WHO, 2005).

As compared to institutional rehabilitation, which is said to be costly and hence difficult to implement, CBR has become popular and acceptable particularly by developing countries. Many countries have rightly recognized its advantages and hence and are using it for the purpose of rehabilitating children with disabilities (HNAC, 2005).

There are several reasons to assume that CBR is a better strategy than IBR for developing and delivering effective rehabilitation services in Ethiopia. The most important reasons that Wegayehu (2004) identified are:

- CBR mobilizes and activates local resources and empowers PWDs.
- CBR encourages learning from experience and innovation.
- CBR respects indigenous beliefs and practices.

In general, the most important reason to accept this assumption is because rehabilitation process of CBR is convenient for PWDs, because it is also economical (Ibid).

According to Thomas and Thomas (2001) as cited in (Tirussew, 2006) CBR entails the enhancement of the daily life and activities of persons with disabilities, the creation of awareness in the community, the provision of a barrier–free environment, and the utilization of local resources, as well as the active participation and inclusion of PWDs in community activities.

CBR needs coordinated efforts of relevant government sectors, community organizations, non governmental organizations and society at large (O'Toole and Mc Conkey, 1995) as cited in (Yirgashewa, 2004)., In addition to this O'Toole (1995) as cited in Yirgashewa (2004) disclose that the mobilization and initiation of the family members and the community is the only best way in CBR services.

The rehabilitation of persons with disabilities involves the provision of medical, psychological, educational, social and vocational services. In Ethiopia, there are both governmental and non-governmental services which attempt to cater for the special needs of PWDs. However, among the millions of people facing various degrees of disabilities only few are beneficiaries of the rehabilitation services (Tirussew,1993). Wegayehu (2004) also indicated that, the few rehabilitation services that exist in Ethiopia are mostly located in Addis Ababa and a few major towns, and thus can not serve people with disabilities who live far away from the service deliverers.

Recipients of CBR services also misunderstand the service of CBR. Daba (2000) explains that, some people see CBR only as a service for delivering prosthetic and orthotics

appliances. However, it should be known that CBR programs do much more, than the few services stated above. CBR services can fully or partially or in co-operation with other centers provide all types of rehabilitation services including medical, vocational/educational and social rehabilitation.

1.2 Statement of the problem

Children with disabilities in poor and developing countries like Ethiopia face numerous difficulties, linked to poverty and social barriers. In many traditional cultures, a child with a disability is seen as a bad omen, bad luck, or a result of poor lineage. With regard to the families having a child with disability is considered as a shame. As a result of this, children with disabilities and their families are very far from social integration.

Due to social isolation and discrimination, children with disabilities and their families are excluded from engaging in most socio economic programs. In addition to this, poverty, overwork, and sever social stress make parental involvement difficult in rehabilitation programs.

Regarding the provision of rehabilitation services for children with disabilities and their families there are a limited number of CBR programs rendering their services in urban and rural areas of Ethiopia, CBR-Tigray is the one working with the provision of rehabilitation services to people with disabilities in rural areas of Tigray National Regional State. The efforts so far made by CBR-Tigray in providing rehabilitation services are very limited in relation to the demand of rehabilitation and the magnitude of the problem.

Hence, the anticipated, progress on the life of children with disabilities may not be realized, and the rehabilitation services rendered to children with disabilities assumed to be less effective. It is therefore important to assess the state of the CBR program approach for children with disabilities.

1.3 Research Questions

Keeping the above statements in mind, this study tries to investigate the state of community Based Rehabilitation approaches for children with disabilities. Thus, the study attempts to find answers for the following questions.

1. What was the social, psychological, educational and health situation of children with disabilities before the commencement of CBR program and while it is going on?
2. What is the state of CBR services for children with disabilities in Kilte Awlaelo Wereda?
3. Does the CBR program actively involve families, community members, children with disabilities and professionals in its overall activities?
4. What beliefs do parents of the children with disabilities have about the causes of disability before the commencement of CBR program and while it is going on?
5. Do CBR services contribute towards changing beliefs of the community about children with disabilities?
6. What are the challenges faced in running a CBR program effectively for children with disabilities in the wreda?

1.4 Objective of the study

General objectives

The general objective of the study is to investigate the state of community Based rehabilitation approaches for children with disabilities in Kilte Awlaelo Wereda.

Specific objectives

- To examine the social, psychological, educational and health situation of children with disabilities before the commencement of CBR program and while it is going on.
- To examine the situation of the services offered by CBR Tigray for children with disabilities.

- To explore the involvement of parents, children with disabilities, community members, and professionals in the CBR program.
- To investigate the beliefs of parents on the causes of disability before the commencement of CBR program and while it is going on.
- To examine the change occurred on beliefs of parents and the community towards children with disabilities due to the rehabilitation.
- To investigate problems that affect the effectiveness of the CBR program in providing services for children with disabilities.

1.5 Significance of the study

CBR as a new approach of rehabilitation has been employed in Ethiopia during the last two decades. However, studies in the field are limited and data pertaining to effectiveness of CBR approaches in this country are very few in number. The study is thus significant for the following reasons.

1. Design effective and successful intervention strategies for children with disabilities.
2. Make concerned bodies and policy makers aware of the existing gap between the need for the rehabilitation of children with disabilities and the nature of the service being given to meet these needs.
3. Suggest and recommend possible ways and procedures in which strategies for community based rehabilitation program can be designed.
4. The study serves as a springboard for other researches to be undertaken in the future.

1.6 Delimitation of the study

This study focuses on investigation of the state of CBR approaches for children with disabilities in Kilte Awlaelo wereda. Currently CBR-Tigray is actively involved in giving services in four rural weredas of Tigray. This present study focuses on Kilte Awlaelo wereda rural Tabias (Kebele).

1.7 Limitation of the study

As this study aims at assessing perceptions of persons with disabilities concerning the situations of CBR programme, the use of qualitative enquiry method was employed. Given the nature of qualitative enquiry, fair generalization are not free of limitations.

1.8 operational definitions

Belief – Is defined as parents' or community members feeling, trust or confidence in something or the things they accept as true or real. Belief in this study includes perceptions and knowledge of parents and the community.

Child- Any person under the age of 18 years old level (Obdigo:1999 cited in Aschalew, 2001)

Community Based Rehabilitation- CBR is a strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all people with disabilities *(ILO, UNESCO and WHO, 2004).*

Community Based Rehabilitation approaches – The service offered by the CBR program in order to enhance the quality of life and physical wellbeing of children with disabilities.

State – The situation or condition in which the CBR program exists.

CHAPTER TWO

2 Review of Literature

2.1 The Concept of disability

There are different views for defining the concept of disability. The charity model of disability regards people with disabilities as 'unfortunate', 'tragic' or 'helpless' people who deserve pity and charity (WVE, 2008). The focus on such model is to provide people with disabilities with supports, such as food or clothing. This model considers people with disabilities as long term recipients of welfare and support. According to Sovolainon(1995), this model is a construct created by religious and cultural societies.

The medical model perceives disability as a problem located in the individual with disability, and assumes that working to 'fix' or 'cure' individual can solve it (WVE, 2008). This model largely replaces and in effect extends the charity model. According to Sovolainon (1995) it has its origin in biomedical understanding of impairments; hence disability is visually seen as lack of competence, due to a dysfunction in an individual's mind and body.

Both, the charity and medical model perceive disability as a problem located in the individual with disability. The true nature of disability is neither an individual's mere functional limitations nor the difficulties of performance which arise from such limitations. But it is oppression, discrimination, social exclusion and the restriction of participation. This view of disability as a social construct is called the social model of disability (Kuno, 2009). This perception removes the focus from the individual with disability as being the problem and shifts the onus on to society to remove the barriers which prevent full inclusion and participation of people with disabilities (Ibid).

ILO also stresses that 'disability is not natural, but a social fact.' Persons with disabilities are forced to carry the consequences of collective societal imposition and decisions,

hence it concludes that, as society is responsible for putting all the burdens that persons with disabilities are forced to carry, so also it is responsible to, "eliminate the exclusions that turn an impairment into a disability" (ILO, 2002 cited in Wegayehu, 2004).

The acceptance of the concept of disability as a social construct has become a popular notion and has achieved the endorsement of United Nations bodies (Wegayehu, 2004).

However, literatures clearly indicated the definition of disability from various angles. According to Smart (2001) the Americans with Disabilities Act (ADA) defines disability by providing three general guidelines all of which are necessary;

1. The presence of physical, cognitive, intellectual or psychiatric condition or combination of conditions.
2. Pervasive impairment in social and occupational functioning.
3. Individuals with these impairments are the target of prejudice, discrimination, stigma, and reduced opportunities.

So, it can be seen that disability is a combination of the condition, limitation in functioning, and societal prejudice and discrimination.

As there is no single definition of disability, which can be used in all social legislation, there is no standard terminology. Therefore, various terms, such as 'disabled persons' and 'handicapped person' seem to be used in discriminately. Hence words such as 'disability', 'impairment' and handicap' appear in various legislative texts interchangeably (Feruz, 2006).

The following distinction is made by the World Health Organization in the context of health experience, between impairment, disability and handicap (WHO, 1994).

Impairment: - Any loss or abnormality of psychological, physiological or anatomical structure or function.

Disability: - Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the rang considered normal for a human being.

Handicap: - A disadvantage for a given individual, resulting from an impairment or disability, that, limits or prevents the fulfillment of a role that is normal, depending on age, sex, social and cultural factors, for that individual.

Handicap is therefore a function of the relation ship between person with disability and their environment. It occurs when they encounter cultural, physical or social barriers which prevent their access to various systems of society that are available to other citizens (WHO, 1994).

2.1.1. Types of Disability

Different literatures categorize disability in different ways using different methods. According Smart (2001), categorization of disabilities could be organized using symptoms and causes of the disability. But defining or categorizing disability by the etiology or pathogenesis would be difficult because:

1. For many disabilities, the cause is not known.
2. For some disabilities, there are multiple causes.
3. Clinicians may change their hypothesis concerning the cause of specific disabilities.

Hence, Smart categorizes disability into four major groups these are physical, intellectual, cognitive, and psychiatric, all of which are based on symptoms.

- Physical disabilities includes: - visual impairment, hearing impairment, dual sensory loss, mobility impairment, and health disorders.
- Intellectual disability includes:- mental retardation
- Cognitive disabilities includes: - traumatic brain injury and learning disability.
- Psychiatric disabilities includes: - mental illness, autism, chemical and substance abuse (Smart, 2001).

2.1.2 Causes of Disability

The cause of impairment varies through out the world, as do the prevalence and consequences of disability. The variations are the result of socioeconomic circumstances and of the different provisions that each society makes for the well being of its members.

The World Health Organization (WHO), based on studies conducted in 29 countries reported that the foremost cause of disability was infectious disease such as tuberculosis, trachoma, otitismedia, meningitis and parasitic disease. The second major cause of disability was war, trauma or accident (primary road accidents). The third most common cause of disability was congenital and non infectious diseases such as epilepsy (WHO, 2003). The poor quality of perinatal care results in disabilities such as cerebral palsy (Helander, 1993).Other cause of disabilities include malnutrition due to Vitamin A, iron and iodine deficiency (Durkin, 2002); and chronic medical conditions such as rheumatic disease and diabetes (Cameron, D.; Nixon. S. ;Parnew. P. and Pidsodny. M., 2005).

According to Tirussew (2000), the presence of diversified pre, peri, and postnatal disabling factors (like infectious diseases, difficulties contingent to delivery, under nutrition, malnutrition, civil strife's and periodic episode of drought and famine) and absence of early primary and secondary prophylactics in Ethiopia at large has brought a phenomenal increase and the problem still remains to be a challenge. In addition to the above causes, the main causes of disability in the country can be by and large, attributed to two sources, namely poverty and ignorance (Tirussew, 1993).

According to Tirussew (2005), in Ethiopia the cause of disability is wrongly perceived as:

1. A curse
2. A consequence of a sin or wrong doing or evil deeds by parent's; ancestors, the persons with disability themselves.
3. Other supernatural presence.

Tigabu (1997) has further reported the belief of a rural community in Ethiopia on the causes of disability as follows:

> *"Children can acquire a disability through the possession of an evil sprit when they play alone under a hot sun; while they are swimming far from their friends; when they heard cattle in the forest, alone; or when they play where ashes and garbage are dumped."*

2.1.3 Prevalence of Disability in Ethiopia

Disability has always been part of the human condition. Many individuals are born with impairment, while others acquire a disability later in life due to a multiplicity factors. It is estimated that 300 to 500 million people world wide, live with a significant disabling condition. Of these, according to WHO 120 to 150 million are children, adolescents and youth (UNICEF, 1999).

According to Tirussew (2000), data pertaining to the incidence, prevalence and the situation of persons with disabilities in Ethiopia are fragmentary, incomplete and sometimes misleading. Hence the survey made at different time has its limitations. According to the report made on base line survey on disabilities in Ethiopia by Tirussew, T., Savolinen, H., Agdew, R., & Daniel, D. (1995), the prevalence amounts 2.95%. The finding of this study further reveals the proportion of specific disabilities as shown in table 1 below.

Table 1 Prevalence of disabilities in percentage

N0	Types of disability	Percent (%)
1	Persons with motor disorder (those with physical disabilities and with chronic crippling health conditions which leads to inability to walk, to sit, to eat and drink	41.2
2	Persons with visual impairment (weak sighted and blind)	30.4
3	Persons with hearing impairment (hard of hearing and deaf)	14.9
4	Persons with intellectual disability (refers to mild, moderate and profoundly mentally retarded)	6.5
5	Persons with speech and language disorder	2.4
6	Persons with multiple disabilities	2.0
7	Persons with behavioral disorders	2.4

A further analysis of the prevalence of disability in terms of age revealed the following.

Table 2 Prevalence of disability in terms of age

N0	Age in years	Percent (%)
1	1-14	15.9
2	15-25	23.3
3	26-39	17.7
4	40-54	14.4
5	55 and above	28.6

Table 2 indicates that, above 56.9% of the incidence occurs during child hood, adolescence and early adult hood period in the life span (Tirussew, 2000).

2.2 An Overview of Rehabilitation

Rehabilitation as human service philosophy is designed to attend to the physical, mental emotional, spiritual, social, and vocational aspects of life. Its goal is to facilitate productivity and independent living as well as community integration of a wide variety and substantial population of persons who otherwise may be functionally and societally limited in fully realizing their potential (Maki and Rigger, 1997).

According to Banja (1990) cited in Maki & Rigger, (1997) Rehabilitation is defined as " A holistic and integrated program of medical, physical, psychosocial, and vocational interventions that empower a person with disability to achieve a personally fulfilling, socially meaningful, and functionally effective interaction with the world." In this case, the philosophy of rehabilitation is premised in a belief in the dignity and worth of all people. It values independence, integration and the inclusion of people with and without disabilities in employment and in the communities. Rehabilitation represents the philosophy that whenever possible person with disability will be integrated into the least restrictive environment (Maki & Rigger, 1997).

According to Adugna(n.d) Rehabilitation refers to all measures taken or to be taken to reduce the impact of disabling conditions, and the other way round enable people with disabilities achieve social integration. In this case rehabilitation services and facilities are generally directed to minimize impairments and negative attitudes in the society and to facilitate adaptation to the new life style.

When it says that, rehabilitation is helping people with disabilities, it does not mean rehabilitation is charity (Wegayehu, 2004). He explains that 'as the Helen Keller Foundation stressed, people with disabilities do not want charity, they need supportive

assistance to activate their own capacities. If they are given the opportunity, they could be an effective as any person in many spheres of social life.' Rehabilitation builds the strength of the rehabilitant.

In other words the goal of rehabilitation is to help children or persons with disabilities to enjoy the best quality of life possible by enhancing the 'disabled persons' natural abilities in the natural environment Daba (2000). Enhancing natural abilities in natural environments refers to the type of service to assist children with disabilities in their own communities by sharing information by transferring knowledge and skills to care givers. This indicates that the type of rehabilitation that provides service in the child with disability's natural environment is very effective, and children who have access for effective and comprehensive rehabilitation can show progress in their development, they can be productive, independent, emotionally strong and stable. Yirgashewa (2004) also stresses that any rehabilitation services would be effective if it is provided in early ages than later age.

Thus, rehabilitation of children with disabilities focuses on medical, educational, social and vocational training.

2.2.1 Medical Rehabilitation

Rehabilitation is the restoration of the 'handicapped' to the maximum physical and mental utilization of which they are capable. In rehabilitation we need to focus on the individual's abilities than the disabilities. In other words the 'disabled' is helped to live within the limit s of his or her disabilities but to the fullest of his or her capabilities (Minilik, n.d).

Children with disabilities can benefit from medical professional supportive services starting from diagnosis. According to Winzer (1990) Diagnosis is the art of identifying disease or difficulty from its symptoms and signs. Since the cause of disabilities, the type

of handicap and specific interventions are different in different people medical rehabilitation implies the involvement of medical workers such as Pediatricians, psychiatrists, ophthalmologists, the ear; nose and throat specialists, and neurologist.

Since children with disabilities have difficulties to resist disease, medical follow up is essential to protect them against further health-related dangers. In medical rehabilitation, the people with disability may require access to expensive specialist equipment, professional expertise or drugs (Ndawi, 2002).

2.2.2 Educational Rehabilitation

The aim of educational rehabilitation is to enable persons with disabilities to become self reliant using knowledge they acquire by creating as equal opportunities as any other citizen in regular and non regular educational program (MOLSA, 1999).

In the area of educational rehabilitation, the debate on inclusion versus segregation appears to have occupied the minds of academics more than other issues. However, legislations should be put into place to support and safeguard the right of people with disabilities to access education, since free "education for all" should be included all citizens including children with disabilities (Ndawi,2002).

The framework for action on special needs education adopted at the world conference on special needs education (1994) stresses that integrated education and community based rehabilitation represent complementary and mutually supportive approaches to serving those with special needs (Daniel, n.d).

Inclusive education for children with disabilities is the concept through which the goal of equal educational opportunities for children with disabilities should be realized. All children, without any exception, are the responsibility of the regular school system. With very few exceptions it is possible to organize good educational opportunities for children

with special needs in the context of the regular school. Naturally, new schools must be built with accessible classroom and other facilities for children with physical disabilities. Adequate support systems must be provided, and must be based on the actual needs of children. Curriculum flexibility is required in order to cope with the special educational needs of some children. Teachers must be adequately informed and prepared so that they are able to meet the needs of children with different forms of disabilities and other special needs. These measures must be present in a school system designed for all (Lindqvist, 1999).

Educational intervention is a complex system directed to meet the diverse learning needs of children with disabilities. Yessldyke and Algozzine (1995) have defined three types of support services which are considered as important for children with disability:

- Direct services: - are these services provided by directly working with the children with disabilities themselves to correct, remediate or enrich or accelerate the progress they are making in their learning performance.
- Indirect or consultative services: - are services that are provided to teachers and others who work with children with disabilities to help them meet needs of the children.
- Related services: - are those services provided by the specially trained personnel directly to the child in the need or indirectly to those who work with the child. They may include assessment or testing, counseling, occupational therapy, adapted physical education, school health services, and the like. The provision of communication aids, for instance, is often considered as a related or support service.

2.2.3 Social rehabilitation

Social rehabilitation is concerned with integrating the people with disability into society with maximum possible adjustment, to cope with normal social demands as well as the extra demands placed on them by their disability (Ndawi, 2002). The ultimate goal of

social rehabilitation is to allow people with disabilities to have the same sense of well being in society, as people without disabilities.

Social rehabilitation is a process, the aim of which is to attain functional ability. This ability means the capacity of a person to function in various social situations towards the satisfaction of his/her needs and the right to achieve maximum richness in his/her participation on society (Miles, 2004) as cited in (Alhamdu, 2006).The attitude of the person with disability, families, neighborhood and the community also makes a great change on rehabilitation area. Hence social rehabilitation of children with disability should include family members, peers, neighborhood and all others who are significant for these target children.

Social rehabilitation also calls for the community to institute measures that make life easier for people with disabilities. Aspects such as easy access to buildings and toilets, voice aided traffic controls and removal of hazards from busy paths to protect people with disabilities from injury, are very important and may need enforcement by the law. Ensuring that people with disabilities are represented at all levels of local government, best facilitates efforts of this nature (Ndawi, 2002).

For person with disabilities the social environment is more disabling than their physical disability. This affects the effective functioning and adjustment of the person and reflects how challenging and sever the social environment is for persons with disabilities (Tirussew, 2000). In case of this the approach of rehabilitation is recently changing from rehabilitation of the disability to the rehabilitation of the community Daniel (2000) as cited in (Yirgashewa, 2004). The main argument of this idea is that the life of children with disability is dependent up on the way others treat and look at them.

2.2.4 Vocational Rehabilitation

According to ILO the definition of vocational rehabilitation is as follows;

'That part of the continuous and coordinated process of rehabilitation which involves the provision of these vocational services, e.g. vocational guidance ,vocational training

and selective placement, designed to enable a person with disability to secure and retrain suitable employment.' The purpose is to 'further a person with disability integration into society.' (ILO, 1996 as cited in Damenech, 2005. pp-21).

According to Mapande (1986), vocational rehabilitation is a preparation for work and placing people with disabilities in suitable jobs. The government and private institutions may recruit people with disabilities impart vocational skills to them, but they will also need to be placed into jobs for vocational rehabilitation to be complete. The training can be conducted with in the community or at external institutions (Ndawi, 2002).

Vocational training gives people with disabilities a sense of equality when competing for employment particularly in urban areas. Traditionally, the training takes place in separate special centers in an urban setting. People with disabilities from rural areas are either recruited, or are attracted to these training centers (Campos, 1995).

In rehabilitation services people are often seen and classified by the single dimension of their disability and certain procedures are automatically prescribed, rather than considering people as individuals with a varying range of characteristics and skills (Ibid).

2.3 Institutionally Based services and their challenges

The Institutionally Based Rehabilitation (IBR), adopted in many countries, delivers service to persons with disabilities primary through special institutions and centers which could reach few and insignificant proportion of the 'disabled' population only. In this approach isolation of persons with disabilities from their families and community is believed to have a negative effect on their proper growth and development (Daniel, n.d). Institutions bring groups of children with disabilities, young people or adults to a place where resources, buildings and expertise are located and provision is centralized (Helander, 1995).

According to Wegayehu (2004) institutionally based programs would have difficulties in conducting advocacy because of the nature of their establishment as separate institutions run by special interested groups who are generally less enthusiastic to challenge state officials on disability matter. In addition to this institutionally based rehabilitation is based on custodial care of people with disabilities, they are established in cities or towns, and it is costly.

As compared to institutional rehabilitation, which is said to be costly and hence difficult to implement in low income countries, Community based rehabilitation has grown popular and acceptable particularly by developing countries (HNAC, 2005).

2.4 Community Based Rehabilitation

Community Based Rehabilitation is recognized as best practice in addressing the needs of people with disabilities. The definition recognized by the ILO, UNESCO, WHO describes CBR as follows;

> *"CBR is a strategy within general community development for the rehabilitation, equalization of opportunities and social inclusion of all people with disabilities. CBR is implemented through the combined efforts of people with disabilities themselves, their families, organizations and communities, and the relevant governmental and non governmental health, education, vocational, social and other services." (ILO, UNESCO and WHO, 2004, pp-2).*

The definition stressed that CBR is a strategy within community development, and it embedded CBR in community development without giving a direction to this development. Equalization of opportunities and social inclusion of people with disabilities became touchstones in the appreciation and evaluation of community development. The basic principle appeared to be that people with disabilities should take part in, and benefit from, community development (Finkenflugel, 2004).

The goal of Community Based Rehabilitation is to demystify the rehabilitation process and give responsibility back to the individual, family and community. Rehabilitation then becomes one feature of community development whereby the community seeks to improve itself. Once the community takes on the responsibility for the rehabilitation of people with disabilities in their community, then the process could truly be called 'community-based'. In such a process, rehabilitation becomes one element of a broader community integration effort (O'Toole,1995).

The leading concepts in the definition are 'rehabilitation', 'equalization of opportunities', and 'social inclusion of all people with disabilities', social inclusion appears to be the aim of CBR, and rehabilitation and equalization of opportunities are the condition to reach this aim (Ibid).

CBR programmes seem to have initiated change processes in social norms and values, which are essential for the further development of quality of life of persons with disabilities. And its primary objective is the improvement of the quality of life of persons with disabilities. In order to achieve this, CBR programmes focus on:

- Eliminating stigma and increasing the recognition of persons with disability as resourceful members of family and society.
- Making the environment and existing service delivery systems accessible.
- Supporting persons with all types of disabilities (SHIA and WHO, 2002).

The same ideas are reflected in the revised joint position paper on CBR from the UN agencies. In this paper emphasis is given to aspects of human rights and community participation.

2.4.1 Components of Community Based Rehabilitation

In recent years a multi sectoral (or multi disciplinary) concept of CBR has evolved. This concept emphasizes working with and through the community to create positive attitudes towards people with disabilities, to provide assistance to people with disabilities and to

ways of preventing disabilities. Another important area of disability prevention is the detection of disability in young children and intervention early in their development, to minimize the effect of impairment.

7. **Management, Monitoring and Evaluation:** - the effectiveness and efficiency of all CBR programme components, both in the community and in the area of service delivery outside the community, depend on effective management practices. The impact of programme activities must be measured on a regular basis. People must be trained in effective management practices. Data must be collected, reviewed and evaluated to ensure that programme objectives are met. In this way the success or failure of a CBR programme can be honestly measured.

2.4.2 Principles of Community Based Rehabilitation

CBR is recognized as best practice in addressing the needs of people with disabilities. According to WHO (2007), the principles of CBR are the following.

Inclusion: - CBR works to remove all kinds of barriers which block people with disabilities from access to the mainstream of society. Inclusion means placing disability issues and people with disabilities in the mainstream of activities.

Participation: - CBR focuses on abilities, not disabilities. It depends on participation and support of people with disabilities, family members and local communities. It also means the involvement of people with disabilities as active contributors to the CBR programme, from policy – making to implementation and evaluation, for the simple reason that they know what their needs are.

Empowerment: - Local people and specifically people with disabilities and their families ultimately may make the programme decisions and control the resources. This requires people with disability taking leadership roles within programmes. It means ensuring that CBR workers, service providers and facilitars include people with disabilities and that all are adequately trained and supported. Results are seen in restored dignity and self- confidence.

Equity: - CBR emphasizes equality of opportunities and rights-equal citizenship.

when the community realizes that the lives of its people with disabilities must be improved and that the community itself has the capacity to do it (Daba, 2000).

The social, cultural, and economic context within which CBR to be introduced needs to be considered very carefully. According to Kuipers and Harknett (2008) the value of community participation is linked to two values, which are key to CBR;

i) Cultural appropriateness: - employing local human resources is more likely to result in culturally appropriate practice (e.g. language, religion), and lead to the use of locally available materials.

ii) Cost effectiveness: - the use of family and community volunteers reduces the dependence on external professionals which decrease service costs and promotes sustainability.

Community participation is heavily reliant upon the commitment and active involvement of informal local leaders to whom others naturally turn for advice, support and leadership (Zakus and Lysack, 1998). In addition to this O'Toole (1991) explains that in Burma a high degree of local involvement in CBR program was achieving through a process of effective dialogue with the village leaders and extensive propaganda.

Therefore, community members should be involved in CBR programmes at all levels because they already know the local environmental conditions, the local economy, the local political situation and how to work with them. They also know about the accessibility, availability and effectiveness of locally available rehabilitation services; who in the community cares enough about other people to become a programme leader or worker; and, which community members have the knowledge and skills for training others in micro-economic activities. They are the people most likely to want to live, work and stay in the community. Community involvement usually requires the agreement and approval, both formal and informal, of the community leaders (UNESCAP, 2009).

Coordinating Committee, where ministerial staffs as well as representatives of Disabled People's Organizations (DPOs) are represented.

GUYANA'S CBR PROGRAMME (WHO and SHIA, 2002)

The Guyana Community-based Rehabilitation Programme (GCBRP) was started in 1986. It is a nongovernmental national organization with its headquarters in Georgetown. The organization is managed by a National Committee of nine members elected by the Regions, an Executive Committee, a part-time National Advisor and National staff at the headquarters. Operations in the regions are guided by Regional Committees. Regional Coordinators are responsible for the programme, including the management of Community Resource Units (CRUs).

There are two types of members in the organization — Ordinary Members and Supporting Members. The former consists of persons with disabilities and their family members; while the latter includes any person who is committed to the philosophy of the GCBRP.

Since 1989 the Amici di Raoul Follereau (an Italian NGO) and the European Union have been the main providers of funds to the programme.

GCBRP started as a small project and expanded to seven of the ten administrative regions of Guyana. The CBR programme aims at involving the community and the family in addressing the rights and needs of children with disabilities. It works with children with disabilities in four main areas: vision; hearing and speech; movement; and learning and focus on development of self-esteem and self-reliance of children with disabilities and their integration into the mainstream of society.

NEPAL'S CBR PROGRAMME (WHO and SHIA, 2002)

The CBR programme in Nepal is implemented by the Nepal Disabled Association (NDA), an organization founded in 1969 with the mission of enabling persons with disabilities to lead a life of dignity and self-respect. The CBR programme is one of five

separate programmes undertaken by NDA. The others are: Special Education and Vocational Training; Ryder Cheshire Home; SOS Children Village; Nepal Orthopedic Hospital.

The SHIA funded CBR programme started in 1991 and it is one of many CBR programmes in Nepal. The main programme initiatives are:

- To provide persons with disabilities medical, vocational, educational, economical and social rehabilitation services in their own community.
- To support persons with disabilities to become functionally literate.
- To provide persons with disabilities with assistive devices, mobility and sign language in accordance with their needs.
- To raise public awareness on disability prevention and rehabilitation.
- To assist persons with disabilities in improving their community life through leadership training and counseling.
- To encourage disabled persons to form their own organizations.
- To train community people to implement CBR programmes on their own by using local resources.
- To orient and train CBR resource persons to ensure sustainability of the CBR programme.

The implementation is carried out through the formation of CBR Committees in the villages where there is a willingness to start a CBR programme. The committees consist of local leaders and professionals who work out plans and proposals and suggest a CBR local supervisor and a CBR fieldworker to be employed by the programme.

Tanzania's CBR (Cameron et al., 2005)

Comprehensive Community Based Rehabilitation Tanzania (CCBRT) is an example of a nongovernmental organization that provides a continuum of health care services to children with disabilities and their families in Tanzania. These services include CBR projects in the cities of Dares Salaam and Moshi. The primary population served is children, particularly those with neurological, visual and/or auditory impairments.

Community rehabilitation workers provide integrated home-based services under the supervision of rehabilitation professionals. These home-based services consist of early detection, referral, therapy and monitoring. Each program has two or three rehabilitation professionals and 10 to 20 community rehabilitation workers. The community rehabilitation workers live and work in the local communities of the children they service. Under the supervision of rehabilitation professionals, they carry out individual rehabilitation plans at no cost to the families.

Experience of Zimbabwe (Daniel, n.d)

The community leaders involved in the CBR projects reported that they were very pleased with the projects and appreciated the help they received for people with disabilities in their community. Also they reported that they were more aware of the role that people with disabilities can play in community activities. They also recognized that the community has to accept and support people with disabilities.

The experience of CBR initiatives in Zimbabwe indicate some problems encountered in the implementation of the projects. The number of people who volunteered at the initial stage reduced drastically as time progressed. The problem of transportation was reported as one of the causes for the drop out of the volunteer workers. Evaluation of the projects by the Rehabilitation Unit of Health in Zimbabwe indicates that it is unrealistic to expect people from poor rural communities to continue to work for nothing and remain actively interested in the projects over a long period of time.

Experience of Ethiopia (Daniel, n.d)

The idea of community based rehabilitation in Ethiopia was first introduced by Rehabilitation Agency for the Disabled (RAD) in collaboration with UNDP and ILO in early 1980's. The initial survey for starting CBR projects in the country was done by a project team composed of two UNDP/ILO experts and four national counterparts.

Two pilot CBR projects were started in nineteen Weredas around Nazreth and Assela with a total of twenty community rehabilitation workers. The major activities of both projects include community awareness activities, educational and vocational training, placement services, medical and paramedical services production and distribution of low cost aids and devices.

The community skills training centers which were basically establishment by the Ministry of Education were extensively used for the CBR activities. Farmers cooperative also supported the CBR projects by employing a total of seventy-five community rehabilitation assistants for some time in the nineteen districts. Quite significant number of people with disabilities benefited from the pilot projects.

Cheshire CBR which functions in wereda 25 and wereda 28 in the capital is another initiative. The project has been working since 1994 predominantly on house-based activities for people with disabilities. Some of the Cheshire CBR activities include providing education about hygiene, nutrition, vaccination, safety and family planning with the major objective of preventing disabilities in the communities. Positive and encouraging results were achieved.

According to CBR- Network Ethiopia (n.d), by now there are more than nineteen Governmental and Non Governmental CBR implementing organizations in different area of the country.

CHAPTER THREE

METHODOLOGY

To realize the objectives of the study which are mentioned in section 1.4, the following methods: research design, study area, the participants and selecting techniques, instruments of data collection, and method of data analysis were selected.

3.1 Research Design

This study deals with the investigation of the state of community Based rehabilitation approaches for children with disabilities in Kilte-Awlaeo Wereda. Hence, the methodological approach that was employed in this research was qualitative. As Holliday (2002) explained the philosophical assumption of qualitative research is constructivism where reality is multiple and individuals create the social world. Creswell (2003) mentioned that knowledge is located in the meaning people make of it and can be acquired through communication about their meaning. In order to achieve this qualitative research is expected to establish a close relationship with the research participants. This demand has gone to the natural setting of subject understandably. In strengthening this idea Creswell (2003) states that qualitative research has to keep the research design open, flexible and emerged and take him/her self as a primary research tool.

For the purpose of this research, among the qualitative research designs case study design was employed. According to Creswell (2003) Case study is a strategy of inquiry in which the researcher explores in-depth a program, an event activity, a process, or one or more individuals. Merrian (1988) as cited in Bogdan and Biklan (1992) also explained that case study as a detailed examination of one setting, or single subject, a single depository of documents, or on particular event.

3.2 Sampling Area

The study was conducted in Kilte-Awlaelo Wereda which is one of the forty-six weredas of Tigray National Regional state. Wereda Kilte-Awlaelo is located in Eastern zone Tigray National Regional State north of Addis Ababa at a distance of 829 kilometers. The wereda consists of 18 Tabias. Wukro Kilte-Awlaelo, the capital city of the study wereda is located along the main road to Adigrat at 45 kilometers north of Mekelle town. The total area of the wereda is 1017.46 square kilometers. The wereda is also one of the four rural weredas that get services from CBR-Tigray. The wereda is also a model wereda in different governmental sectors such as health, education and agriculture.

According to the population and housing censes, the total number of human population of the district was 99,688. According the survey made by CBR-Tigray there were about 2003 people with disabilities, from these 524 have an age > 21 years, and 89 children with disabilities in the wereda are getting services from CBR-Tigray.

CBR-Tigray undertakes its CBR program in all Tabias of the wereda. There is no other institution in the area whose integral focus is on disability.

3.3 The Participants and selection Techniques

3.3.1 The Participants

To enhance the reliability of the data in methodological triangulation data for the research was collected from different participants; hence the participants of the study were four children with disabilities, eight parents of children with disabilities, two community rehabilitation workers, two community leaders, two teachers and one CBR coordinator; totally there were 19 participants.

3.3.2 Sampling technique

Qualitative research naturally recommends purposive sampling method, and hence purposive sampling method is applied in this study to select the participant of the study.

The research study includes four children with disabilities, which are available in the study area, based on the following criteria:

1. age 10-18 years which could be able to describe the situation
2. From different categories of disabilities, i.e., physical impairment, hearing impairment, and visual impairment.
3. from both sex
4. Who receives service from CBR-Tigray

In addition to these children, eight parents from which four of them are parents of the children already selected, two parents of children with intellectual disabilities and two other parents who have willing to participate in the study, two community rehabilitation workers who work with the selected children, two community leaders in the village where the children live in, two teachers of the children and the CBR coordinator of the region were included.

A. Children with disabilities

The four children with disabilities are received a rehabilitation service from the center since the establishment of the program, and they are from different categories of disabilities.

B. Parents of children with disabilities

Including parents of children with disabilities in the study is crucial to have reliable data or information about the study that is not gained from the children, and also it is important to include parents of children with intellectual disabilities and other beneficiary of the CBR services to gain more response about the rehabilitation. The six parents were included in the interview and the remaining two were included in focus group discussion.

C. Community rehabilitation workers

The selected community rehabilitation workers are those who have been working with the selected children with disabilities, and they participate in Focus group discussion.

D. Community leaders

The community leaders are selected from the village where the participant children with disabilities and their parents live in. Both participants were participating in different training of the program. They participate in the focus group discussion.

E. Teachers of children with disabilities

The participant teachers were, teachers of the children with disabilities those are included in the study and they are also leaders of the special needs club in the school, and they were participate in focus group discussion.

F. The CBR program coordinator

Since the program is monitored by TBOLSA, including the program coordinator in the study is crucial to have a reliable data. Therefore, the CBR-Tigray program coordinator selected as data source and she is participated in the interview.

The number of participants is summarized below in table 3.

Table 3: Summary of number of the respondents

Data collection method	Participants						
	CWDs	Parents	CRWs	Community Leaders	Teachers	Program coordinator	Total
Interview	4	6	-	-	-	1	11
FGD	-	2	2	2	2	-	8
Total	4	8	2	2	2	2	19

3.4 Instrument for data collection

To secure reliable and adequate information, four basic instruments were used. These were in-depth interviews, focus group discussion, observation, and document analysis.

3.4.1 Interviews

The interview is one of the most widely used methods for obtaining qualitative data, such as subjects', opinions, beliefs, and feelings about the situation in their own words (Ary et al., 2002). In addition to this Best and Kahn (1999) explained, an interview is a kind of oral and face to face conversation, it is a specific form of human interaction in which knowledge evolves through a dialogue. Based on this interview was the primary data collection technique used in this study. Thus, interview guides are prepared and in-depth interviews were undertaken with three different parties(children with disabilities, parents of children with disabilities, and the program coordinator) in the form of one-to-one encounters by using semi-structured interview questions (see from appendix I-IV). They were mainly open ended that intended to provide opportunities to discuss issues in more detail manner, and they were also pertinent to the major research questions stated.

The interview guide used in the research was developed by the researcher based on the research questions. And the questions were designed to include the situations of children with disabilities, the rehabilitation services offered to CWDs and involvement of different stockholders in the activities of the program.

All the interviews were carried out in Tigrigna language, which was the preference of the subjects, focusing on the main themes of the study. While interviewing the interviewees, the responses were recorded in a tape recorder. The interviews were carried out as conversations lasting between one and two hours. All individual interviews have taken place in the home and school of the interviewed person. The recorded responses were transcribed to written notes in Tigrigna, and then translated in to English language for analysis.

3.4.2 Focus Group Discussion

Focus group discussion guide helps to understand issues with consensus and variation among the members of the discussion are available as means for validating statements and views (Punch, 2000). According to Yin (2003) the interaction among the participants stimulate them to state feelings, perceptions and beliefs that they would not express if interviewed individually. Hence, it was employed to enrich the data gathered by interviewing the children with disabilities, parents of children with disabilities and the program coordinator. It was conducted with community leaders, community Rehabilitation workers, teachers and parents who were selected for the study.

The focus group discussion guide contains five items and basically focused on services offered by the program, involvement of the community in the program and challenges faced to the program on running up its activities.

3.4.3 Observation

Observation enables to provide first hand information by observing phenomenon as they occurred in their natural settings. So, direct observation were done during children's interactions and participation with their family, neighborhood and community members at home and school; The participation of the community, professionals, and parents on the activity involved on CBR program.

It was guided using observation checklist. These guide lines are developed from literature based on key concepts focusing on social, educational, mobility and communication ability of the children in school and at home. Accordingly, the actual situations was observed and cross checked with the interview responses.

3.4.4 Review of Documents

In qualitative research, written documents are quite useful to gain knowledge of the phenomenon under study. Different written materials that were thought to provide the

necessary information were properly consulted. Therefore, documents such as training manuals, broacher, and report papers were used to enrich the study.

3.5 Procedure of the study

First of all, the problem was identified while the researcher was holding informal discussion with the program coordinator of the rehabilitation service in her office. Then, relevant literature was reviewed, based on the review literature and other relevant information, data collection instruments were devised.

Data collection instruments devised based on the research questions in English language and submitted to advisor for approval, after he made some corrections in the language and the content of the instruments he allowed the researcher to use it. Translation from English to Tigrigna was done by the researcher, and then both versions were given to Tigrigna language expert for correction.

At the center selected for the main study, first contact was made with the program coordinator and the purpose of the study was explained. Following this activity the researcher has gone to the research area with the program coordinator to which the available participants are found. Then the identification of children and parents were made according to the criteria set up for selection by the researcher. After this, necessary arrangements were made and data collection were undertaken using the aforementioned data collection instruments with CWDs, parents, CRWs, community leaders, teachers and the program coordinator in a given time schedule.

3.6 Data Analysis

Data analysis is a process where by researchers systematically search and arrange the data in order to increase their understanding of the data and to enable them to present what they learned to others (Ary et al., 2002). In this study, three steps were involved in the data analysis procedure i.e. organizing, summarizing, and interpreting the data. So after the relevant data were collected from different data sources through the major data collection instruments, they were categorized in to the major themes and sub themes

based on their communalities and pertinence to the stated basic research questions in a way that helped to summarize and interpret the data effectively. Then after, an attempt was made to investigate exhaustively what was there in the data and to summarize the relationships among the categories. At last, the data organized and summarized were interpreted carefully. Interpretations have involved in reflecting the words and acts of the data sources, and the researcher's personal judgments also inculcated to evaluate the cases relying up on his actual experience. More ever, some documentary evidences were used to strengthen the findings.

In general, the researcher presented the whole findings and analysis in the next chapters with the help of long and short direct questions and narrative statements.

CHAPTER FOUR

4 FINDINGS OF THE STDUY

4.1 Introduction

The purpose of the study is to investigate the on going situation of community based rehabilitation services for children with disabilities. The study was conducted in Kilte Awlaelo wereda. Kilte Awlaelo wereda is one of the forty six weredas of Tigray National Regional State, and it is also one of the four rural weredas that get service from CBR-Tigray. As indicated in chapter three, the researcher has collected data from 19 participants.

In this process, four children with disabilities, six parents, and the CBR coordinator were involved in the interview; whereas the remaining eight respondents participated in focus group discussion.

4.2 Background Information about CBR-Tigray

CBR-Tigray was established in 2004 as a project, when it was established its services were 0ffere on a very small scale, where focus has only been concentrated on a particular component of the CBR activity that is socio economic empowerment activities. CBR-Tigray is governmental initiative organization that managed by Tigray Bureau of Labour and Social Affaires (TBOLSA). The major objective of the organization is to ensure the provision of opportunity in all aspects of life including health, education, awareness raising and skill training of people with disabilities and the community. Hence CBR-Tigray has been working based on CBR matrix in the area of prevention of disability, rehabilitation and integration of people with disabilities.

The primary beneficiaries of CBR program are children with disabilities. This time the organization works in four selected rural weredas of Tigray, namely kilte Awlaelo, Dega Tembien, Enderta and Hintalo Wajrat. To achieve its goals CBR-Tigray works in collaboration with other departments of the government such as health, education, and

agriculture. Due to this collaboration the community rehabilitation workers are the Health package workers.

4.3 Background Information of Children with Disabilities

Table 4 Background information about the children with disabilities

Case No	Sex	age	Grade level	With whom he/she lives	Type of disabilities
Child-1	F	13	6th	Father & mother	Physical disability
Child -2	F	16	7th	Father & mother	Hearing
Child -3	M	12	5th	Mother	Hearing
Child-4	M	12	4th	Grandmother	Visually impairment

As indicated in table 4 the respondent children have different types of disabilities i.e., child-1 with physical impairment, child-2 and child-3 with hearing impairment, and child-3 with visual impairment. All of the four children with disabilities included in this study are attending school. The age of the children ranged from 12 to 16 years. Among the four children included in the study, two of them are females and the remaining two are males. The current living status of the children show that two of them live with their parents, one with his mother and the remaining one lives with his grand mother.

4.4 Interview Results of Children with Disabilities

4.4.1 Situations of Children with Disabilities before Rehabilitation

4.4.1.1 Social Situation

All the children were asked about their participation in cultural festivals, and then they explained that, they participate in all traditional chants of holidays and ceremonies with their peers without disability.

Regarding their participation in the traditional chants of holiday's child-1 and child-2 explained that, they are participating in cultural festivals. For instance child-1 stated as follows: *"Even I can not move far places; I can play with my friends here around our village in epiphany and ashenda ceremonies."*

'Ashenda' is cultural festival that is held annually in August 22-24, and it is a song ceremony; girls in group sing songs going to or wandering around different homes and they earn money.

In addition to this, male children participants also argue that they participate in a festival that concerns them. Regarding the participation child-4 explains as:

> *"I take part on ceremonies such as 'hoya-hoye' and 'ayankla' with my friends, they guide me when we wander around the village I also sing songs, I am a good singer could I sing for you?"*

Both *'hoya-hoye'* and *'ayankla'* are traditional chants of holidays of male children that are held in September and on the week of Easter respectively.

They added that they have play mates or friends whom they play with, and they are able to perform daily activities independently like other children without disabilities. Regarding working independently, Child-4 explained that, he can feed, dress, wash and

toilet himself, the only problem that he stated is the problem of the road towards his school that it is full of stone and bumpy, hence he needs help when he walks to school.

Finally, the respondents explained that they do not participate in any public activities, such as youth association before the rehabilitation because of their age.

4.4.1.2 Psychological Situation

When the children were asked about their feeling, concerning their disabilities, they replied that they do not feel any thing. This is because; in all children the impairment is acquired below the age eight. For instance child-4 explains as follows:

> *"I feel nothing, because I did not believe that I will be blind forever. One thing which makes me worry about is that I become inferior to my class mates."*

The respondents were also asked either they are being teased or are being insulted by other children with out disabilities in the school or not, and their responses are different according to their types of disabilities. Child-1 with physical impairment has not been teased or insulted by others. Child-2 and child-3 have been insulted by their peers. Regarding this child-2 states as:

> *"My class mates insults and teases me, using derogatory words, such as 'tsemam'*,and/or *'armam'. When I read a book in a class room, and answer questions, they laugh at me when I speak."*

'Tsemam', 'armam', means one that does not understand what some one tells him/her.
Child-3 also replied that he quarrels with his class mates because they pluck his cloth or throw a stone and beat him in order to call him. He added, that his peers consider him as an aggressive child and he was about to leave school.

4.4.1.3 Educational Situation

When the respondents were asked whether they had attended a school before the rehabilitation or not, they stated that all of them had started learning before the rehabilitation. Regarding this, child-1 and child-4 explained that their impairment happened when they were at school. Child-2 and 3 also explained that, even if the

impairment had occurred before they started attending school. They have been at school with other students without disabilities before the rehabilitation.

Furthermore, the children were asked about their participation in co curricular activities and whether are they able to perform school tasks independently. All the respondents except child one have disclosed that they do not participate in different co-curricular activities. Whereas child-1 explains her participation as follows:

> *"I am participating in different co-curricular activities such as girls club and health and sanitation clubs. Even I am a leader of the girls' club tutorial team."*

Meanwhile, the children reported that, they can perform school tasks independently and with the help of their classmates; Child-1 and child-2 explained that they take notes and do home works independently. While child-3 needs help from his peers in order to understand the lessons being taught. Regarding this he states as:

> *"I do not hear even a word; I understand the lessons through reading books and written notes. In addition to this my class mates elaborate what the teacher says in a class."*

This idea has been also strengthened in classroom observation of the researcher.

4.4.1.4 Medical Situation

The respondent children were asked about the medical treatment they have ever taken. In this case most of the respondent took medical treatment in a neighboring clinic and in hospitals out side their wereda. Regarding this child-1 explained that, her parents have been treating her in her village using herbal medicines. The remaining respondents are also taken to "*may-tselot*" which means '*holy water*' and then to medical treatment.

When the respondents were asked whether they have been treated using specialists or not, they responded that after trying herbal medicines their parents took them to specialists. Regarding this child-3 describes:

> *"Having taken many religious treatments here in our village, my father took me to specialists of ear in Addis Ababa."*

When the children were asked, whether they ever received any assistive devices or not, they reported that they don't get any device from the hospitals or health centers they went.

4.4.2 The State of CBR Services

The children with disabilities were asked about the services they are provided by the center. The respondent children explained that the services they receive from CBR-Tigray are different types of rehabilitation according to the types of their disabilities. Hence referral, educational support, social rehabilitation (awareness rising) and support of devices are some of the services they receive.

Child-1 explains regarding referral service as:

> *"... first when I become wounded on my leg, my parents repeatedly took me to herbal medicine, but it couldn't cure my wound; instead it aggravated and prevented me from walking. The community rehabilitation workers sent me to referral hospital, by now I am being treated there and I am able to walk with slight problems."*

Another type of service the children receive from the center was an educational rehabilitation. And they explained that, in academic year 2008/2009 all teaching materials including uniform was covered by the center. Regarding this child-4 reports as follows:

> *"I got teaching materials such as Braille, stylus and slate from the center. Before I got these materials I used to sit in a class and attend orally what a teacher says, I was not able to write and read."*

In addition to the services mentioned above, the awareness raising given to all students in a school is an effective work of the center. According to the responses of the children with disabilities, there is a discussion in a flag ceremony concerning the causes of disabilities, how to help children with disabilities in a school and at home, and children without disabilities should not insult children with disabilities everywhere.

Child-4 reported that, in addition to the teaching materials that he receives from the center he has got an assistive device such as white cane. Regarding this he explains as:

> *"I have been using simple stick for guiding, and it was difficult for me to cross vehicle roads. After I got a white cane I easily cross without any support, and it is easy to carry or handle it."*

4.4.3 The Effect of CBR on Children with Disabilities

The children were asked about the changes occurred on their life as the result of rehabilitation, and they reported that they are benefited from the services such as medical, educational, and social rehabilitation. Regarding this, child-1 explains as:

> *"If I had not got the medical rehabilitation I would have amputated my leg, because I was treat using traditional medicines before the rehabilitation. My parents also send me to learn far from them because they understand that children with disabilities can learn like their peers without disabilities from the rehabilitation."*

Child-4 also disclosed that, he was not able to read or write using Braille before rehabilitation, but after rehabilitation since he got educational materials he is able to read and write.

When the children were asked about the changes brought in health, education, and communication skills; they stated that, they have an improvement in all cases. Regarding this, child-3 explains as:

> *"My communication skill with peers and families has been improved due to the awareness raising made in school and at home. I easily understand what my mother told me and she also understand me what I want."*

This idea is also strengthened by the researcher's observation at school and at home. Generally, the respondents reported that their life has been changed because of the services they get from the center.

4.4.4 Community Mobilization in the Implementation of CBR Program

The data regarding community mobilization in the implementation of CBR program has been presented and analyzed on three domains. These are awareness raising, involvement of children with disabilities; parents; and community, and partnership with local institutions.

4.4.4 .1 Awareness Raising

When the children were asked about activities accomplished awareness raising for the community, they reported that, awareness raising have been done in different ways in the community. Some of these methods by which it was done were in Tabia meeting, in school in the form of drama and poem at a flag ceremony, home to home education given by the community rehabilitation workers, and education given by agricultural extension workers in a '*seftinat*' work. Regarding this child-2 explains as follows:

> *"Before rehabilitation my parents was try to stop my school. But, the awareness raising ideas made by teachers in parents meeting and the community rehabilitation workers lessons at home have convinced them not to prevent me from school."*

4.4.4.2 Involvement of Children with Disabilities Parents, and Community in CBR Program

During the interview children were asked about themselves, their parents and the community involvement in the rehabilitation program, and they reported that, their participation was preparing drama and poem on the issues of disabilities to teach others. In addition to this, they participate in sport festival which is prepared by the name of 'people with disabilities day'. Concerning the involvement of children in CBR program child-1 said:

> *"We, members of special needs club in conjunction with our teachers are preparing different types of drama and poem that can serve as awareness creation for students and their families. "*

In relation to this, in a replay to a question 'do you and your parents take part in planning and evaluating the rehabilitation program or not?' child-4 states as:

> *"I do not know what is planning and monitoring of a program means, hence I do not participate on such activities. We do what our teachers and the rehabilitation workers tell us to do. Even if my mother does not know anything about the program activities, she only participates on parents' meeting."*

Even the remaining participants disclose that they do not participate in such conditions more than they participate in their school as mentioned before. And they do not perceive their parents participation in the program on the above mentioned activities.

4.4.4.3 Partnership with Local Institutions.

The children were asked about the relation between their school and the CBR program, and child-2,3 and 4 stated that any educational material which is given to them by the center is being used by the school and even they mentioned that they know the CBR center only when it participate in a school. Regarding this child-4 states as:

> *"I got the teaching materials from school; teacher 'A' brought the materials to me. So our school serves as a bridge between the CBR program and we, students with disabilities."*

On the other hand, child-1 states as:

"I know that there is a relation between our school and the CBR program, the CBR program coordinator visits our school and help our club."

4.5 Background Information of Parents of Children with Disabilities

Table 5 Background information about the parents

Parent No.	Age	Family relation with the child	Level of education	Occupation	No. of children	Current Marital status
Parent-1	55	Mother	Pre-literate	Farmer	5	Married
Parent-2	49	Mother	Pre-literate	Farmer	4	Married
Parent-3	34	Mother	7th	Farmer	4	Divorce
Parent-4	75	Grand Mother	Pre-literate	Daily laborer	4	Widow
Parent-5	50	Mother	Pre-literate	Farmer .	3	Widow
Parent-6	47	Father	7th	Trader &farmer	7	Married

From the respondent parents of children with disabilities, four of them were the parents of the children who participated in the study and the remaining two are parents of other children with disabilities those are not included in the study. As indicated in table 5 the age of the parents vary from 34 to 75. Among six, four of the parents are mothers of children with disabilities, one father and the remaining one is grand mother. In analyzing the educational level of the interviewee parents, two of them have completed grade six while the remaining four did not attend school. The occupation of four parents was farming, one trader as well as farmer, and the remaining one is daily laborer. The number of children in the family varies from 3 to7. The current marital status of the parents indicates that, three of them married, one was divorced, and two are widows.

4. 6 Interview Results of Parents

4.6.1 Beliefs of Parents on the Causes of Impairment before Rehabilitation

4.6.1.1 Beliefs on Causes of Impairment

When the parents were asked, either their child's disability is congenitally or acquired, Parent 2, 5 and 6 are responded that their children are congenitally impaired while the remaining three children have been impaired after birth. The researcher asked them about the causes of disabilities of their children and the respondents reported that they perceived the cause as 'tiezaz Fetari' which means the willing of God, it happens by God.

Parents-6 also reported that, the cause of the impairment could be the problem created in his wife delivery time, he states the situation as:

> *"When my wife given birth her first child she was at home and the delivery time took her two days and nights and this long delivery time must be the cause of my child's disability."*

While parent-4 stated the cause as: *"ኣብ ውዬቕተ ፀሐይ ዝወዬቐ ነገር ክእርዩ ነበ ገሐፍ ከዩዩ ማንዮት ኣማንዩወ ከሰተ ወዩነ ተረምሰሰ" which means at mid day when there was scorching sun he went to search garbage things and an evil sprit beat him."*

4.6.1.2 Family Reaction

When the parents were asked about their feeling after having a child with disability, they have reported that, they experienced different feelings of denial or disbelief, sadness, anger, and hopelessness after they have had such child.

Parent-2, 5, and 6 experienced feeling of denial. This is because they didn't expect such a child with disability. For instance Parent-6 states as:

> *"Since he was my first child, I didn't believe that he would be a child with disability. I wouldn't accept the truth; even I was angry and attempt to kill myself. When the pediatricians told me about my child's disease at that time they told me that he became sick due to malnutrition called kwashiorkor, but I*

do have enough property which can feed my child. Due to this I have been quarrel with them. I lost my appetite; I didn't eat any food for more than two days."

The reaction of parents towards having a child with disability is different according to their experience of parenting, since the children of parent-6 and parent-3 are their first son, hence they felt hopelessness.

4.6.1.3 Treatment Given to Children with Disabilities

When the parents were asked about the treatment they have taken to improve their children with disabilities, they responded that they tried different types of treatment which was available in their village starting from traditional to scientific medicines. For instance parent-1 states as: *"When my daughter was wounded at her leg, what I did was I took her to traditional healers. After this when it was not improved I took her to holly water, and then finally to medical treatment."*

Regarding the treatment of their children all parents used the *'holy water"* treatment as the first alternative treatment. They explained that around their village there are more than five religious places in which other persons came to be treated there. The existence of such practices made them to use traditional treatment, and also they believe that they are the best solution for such children.

Parent-5 also believed that the best treatment of her child could be get from *'deftera'* and she has visited different 'defteras' in her village and out side the village.
Finally the parents reported that after they tried their best looking for all possible traditional treatments that are in their surroundings, they had gone to health centers and hospitals and they got the solution from these.

4.6.1 .4 Challenges Faced by Having a Child with Disabilities

The parents were asked about the challenges they faced due to their children's disabilities; they reported that they faced different type of problems. Regarding the problem parent-5 explains as:

> *"I could not do my work outside my home, I couldn't leave him alone at home, because our home is precipitous hence for fear that he might fall down, so I isolate myself in public activities in order to watch him."*

She also added that she is parted from public participation such as burial.

Parent-4 also explains that she is afraid of her child might fall down on the way to school or when he play with his friends, hence she was watching him while he is playing and took him to school so she spent most of her time with her child at spare time of her age.

4.6.2 Beliefs of Parents while the Rehabilitation go on

The parents were asked about their beliefs on causes of disability, treatment of children with disabilities and their reactions towards their children while the rehabilitation go on. They reported that they have a change of idea concerning the cause of disability, for instance parent-5 explains as follows:

> *"Before I had taken such type of lessons I thought the cause is in relation to God willing. But after the community rehabilitation workers told the possible causes of my child's disability, I know that it is lack of vaccination."*

Parent-1 also states that she is tired of searching traditional healers on finding a cure for her child's impairment, and she did this one believing that they are best healers, but she didn't get a solution and finally she has come to know that medical treatment is the best that can be a solution for her child's impairment after rehabilitation.

4.6.3 The State of CBR Services for Children with Disabilities

When the parents were asked about the services the CBR-Tigray provided to children with disabilities, they explained that the services were in the form of medical

rehabilitation, i.e. free medical check up in Health Centers and Hospitals; educational rehabilitation, in the form of educational material support and creating conducive atmosphere of learning for their children; social inclusion of their children with the community, regarding this parent-5 explains: *"My child receive an assistive device which is used to move."* In addition to the above mentioned services the main advantage that they receive from the service is the knowledge of handling or treating such a child with disability. Regarding this parent-5 states as:

> *"I have learned from the community rehabilitation workers and volunteer how to communicate with the child and how to keep him clean and stretch his hands and legs to make them move."*

When the parents were asked about public awareness concerning disability issues, they reported that the community can be viewed in two ways concerning the disability issues: first from the age of the people and secondly from their educational level. As parent-5 explains,

> *"Older people are collaborative because they have an empathy outlook they saw a child with disability like their own child. But younger people have a thought of carelessness, they consider themselves like those are free of disability encounters."*

In the second condition educated people know the cause. Hence, they can identify which diseases can be transmitted by contamination and which can not. While most of the illiterate people do not know the cause, so they assume any disease is contaminating so they need to be far from people with disabilities.

The parents were asked about the program either it satisfy the children's need or not, they reported that even if it does not fulfill all the needs of the children it has a good starting in some aspects such as medical and educational situations. In relation to this the researcher asked the parents about the economical empowerment of the parents themselves. Parent-3 responded as:

"The 'Tabia' administrator and the community give us a chance to get any support in the wereda prior to other people. The medical treatment for our children is also given free of charges in governmental health organizations."

4.6.4 Involvement of Parents and Their Children in the Program

When the parents were asked about their role in the program, they reported that they implement what they are told by community rehabilitation workers, teachers, and the community health care volunteers. They participate in parents' meeting at school monthly with teachers and discuss about the education of their children. When the researcher asked why they do not participate in planning and evaluating the program, they responded that they are not well organized and the program is at its initial stage it didn't invite them for such condition. Regarding this parent-6 states as:

"We do what the rehabilitation workers and teachers tell us to do, and participate in parents' meeting at school to fulfill our children's need, beyond that I myself do not participate in any planning and monitoring activities of the program."

They were also asked if their children participate in the activities of the program, they reported that because of their age their involvement is not seen clearly out of school participation. Regarding this parents-5 and 6 stated that their children do not know about the program, but they are simple beneficiary of the program.

Finally the parents were asked about the role of professionals in the program and they responded that, the professionals such as teachers and health workers are involved in such a program. Even the parents know the presence or availability of the program by these professionals. The education gave by teachers make to bring children with disabilities to schools. Regarding this parent-5 stats as: *"My child does not attend school but I participate in parents meeting at school due to the invitation of the school director and teachers."*

Hence, teachers are core participants. She also added that there is lack of speech therapy. Besides, out of the existing professional in rural areas, the involvement of agricultural extension workers is limited than others in disability issues.

When an observation is made in the involvement of parents in implementing CBR program, the mothers are highly involved than fathers in the rehabilitation of their children.

4.6.5 Challenges of CBR

Parents reported that their poverty restricted them from participating in all activities of the program. Poverty affects children's education and health. Hence all parents except parent-6 think about their children's daily food rather than rehabilitation. For instance parent-4 states as:

> *"I have three grand children who are children of my son. Their parents are dead; I do not have enough wealth to feed them. In addition to this I am old I couldn't work. Hence, poverty influence my children's livelihood so I can't only think about the rehabilitation of a single child with disability, I should be responsible for all of my children."*

The other challenge is the physical environment of the surrounding which restricts the children from school and other activities. Parent-5 states that: *"The road from our house is rugged and it has a problem in moving a wheel chair. So I take my child even to clinic by carrying on my back."*

The respondent also reported that their level of education has prevented them in effective rehabilitation of their children. Regarding this parent 1, 2, 4, and 5 explain that their level of education has prevented them from attending training given by the program and that they do not attend effectively the lessons given by the community rehabilitation workers and the volunteers concerning their child. In addition to their level of education their ages

also has influence on their participation, regarding this parent-4 states as follows: *"I can not participate in any activities of the program because I am old enough."*

4.7 Interview Results of the Program Coordinator

A twenty three years old female graduate of University who has a service of two years in the field was interviewed about the services provided to children with disabilities at the center. She reported that the services that they are being offered to children with disabilities were according to CBR matrix; hence they deal with Health, Education, Livelihoods, Social and Empowerment. Concerning the service she states as follows:

> *"The services rendered for people with disabilities are according to CBR Matrix; hence we deal with Health, Education, Livelihoods, Social and Empowerment. Therefore, there are priorities of work, hence medical, educational and social activities are services rendered from the center. Medical services are given in the form of referral by the health package workers who are also community rehabilitation workers and medicines are given to children with epilepsy in our center clinics and hospitals freely. Educational services are given as in the form of helping teaching materials such as exercise books, pens, uniform, (Braille, slate and stylus for blind students) for children with disabilities. We have also strengthened collaboration with schools in establishing special needs education club that can create awareness among students and teachers. In awareness raising of the community we trained community rehabilitation workers and community health care volunteers in order to teach the community in disability issues."*

When the program coordinator was asked about the involvement of families, professionals and communities in the program she responded that Community members are participating being volunteers. She added that:

> *"These volunteers have been selected by the community as community health care volunteers, and they are trained and then participate in implementing the*

activities of the program in collaboration with other governmental sectors such as health, education, and 'Tabia' administration."

In addition to this she stated that the involvement of professionals such as teachers and health workers have been positive, while as the involvement of parents and children with disabilities was limited.

However, the involvement of the community which is represented by community leaders has a positive outcome on mobilizing the community. Community leaders have been trained in order to mobilize the community and to participate in the program and to fund resource to the program.

In a replay to a question 'which services are effective?' The program coordinator states as: *"The medical rehabilitations and educational rehabilitations are the most effective works done in the wereda."*

She also added that, the wereda administration provides medicines themselves for people with epilepsy, and this indicates that the community is the owner of the program.

The program coordinator was asked about public awareness of disability issues before the commencement of the rehabilitation program and while, the rehabilitation going on, and she explains as follows:

> *"Before rehabilitation, parents had locked their doors for their children with disabilities; there was a discriminatory attitude towards people with disabilities and their parents. But now parents send their children to school and the community has a positive attitude towards children with disabilities and their families, due to the activities accomplished by community rehabilitation workers, teachers and the community health care volunteers in awareness raising."*

When the program coordinator was asked about the partnership with other institutions in supporting the program she discloses that:

"Partnership among different sectors of the government enhances the work of CBR. Although Bureau of Labour and Social Affaires of Tigray is leading the program, the other department of governmental sectors i.e. Health, Education and Agriculture are working together in fulfilling the objective of the program."

She added that the role of health organization was given a great emphasis on allocation of community rehabilitation workers those who are health package workers. The teachers bring children with disabilities to schools and play great role in awareness rising in and out side school. The agriculture sector is also working on economic empowerment of people with disabilities and their families.

Moreover, the CBR program has close working relation with service providers such as Mekelle ortho-physio center, with different governmental and non governmental hospitals and clinics, and vocational training centers in Mekelle. This idea has also strengthened from the report made by the CBM representative of CBR program in the region.

Lastly, the program coordinator was asked about the challenges facing the program, and then she stated that there are many challenges. Among these problems, poverty of the people is the most obstacle in running the program, i.e. poverty prevent parents and people with disabilities from involvement in the program. She also adds that:

"Shortage of skilled man power is another challenge; there are two community rehabilitation workers in one Tabia, which are very few to cover all rehabilitation tasks and activities."

In addition to their limited number there are ability differences among themselves. The social affaire in Wereda is also represented by single person. Thus, he/she can't cover to supervise or evaluate all activities of the program in the wereda.

Another challenge which was mentioned by the program coordinator is that the attitude of regional officials towards the program.

4.8 Focus Group Discussion Results

In focus group discussion there were eight participants; two community leaders, two community rehabilitation workers, two teachers and two parents of children with disabilities. Hence, in the group discussion the participants were asked about the services of CBR being offered to children with disabilities, and they responded that the services are medical in the form of referral; educational mobilizing and support of teaching materials and social inclusion of people with disabilities are some of the services that are rendered by the center.

A community rehabilitation worker in the group discussion expressed her idea concerning the service as:

> *"There are different types of services that are provided by the center. The services are medical in the form of referral, we have a referral pad when we believe that an individual should have to visit medical doctors we give it and send him/her to hospitals. We teach parents of children with disabilities how to handle such child and for blind children we teach mobility training. We also discuss with the community about the causes of disabilities, prevention of diseases, family planning and inclusion of people with disabilities in any community participation."*

In addition to the services mentioned above, there is also support of devices for children that couldn't able to walk or to sit without support; the materials are like wheel chairs, crutches, special chairs and corner chairs.

They were asked about families, children with disabilities, teachers and the community involvement in the rehabilitation program. They replied that families are involved in their children rehabilitation programs by participating in community awareness raising activities on different occasions such as 'seftnet' work, Tabia meeting, and parents meeting in school. The children with disabilities are also involved in awareness rising at school being member of special needs club and demonstrating dramas in the school.

In addition to this, one of the community leaders states community involvement as:

> *"The communities have been participating in the rehabilitation program as community health care volunteer since rehabilitation began, these volunteers are from the community who participate in all issues of health concerning the community, and they give emphasis for children with disabilities and their families. Teachers are also part of the community that plays an important or vital role in mobilizing the community towards the education of children with disabilities."*

They were also asked about attitude of the community towards children with disabilities and their parents before the commencement of the program and while it is going on. They replied that before the commencement of the program there were negative attitudes which imply social stigma attached to disabilities. This was due to lack of awareness about impairment and its causes. After the beginning of the rehabilitation program, the attitude of the community is changed. Regarding this in the focus group discussion a mother of a child with hearing impairment states as:

> *"My child was hired as a herdsman and the owners were not allowed him to learn while their children were learning, but now they have allowed him and he is learning in grade two."*

One of the community rehabilitation workers stated that the attitude of the community has been changed from social stigma to collaborative and social inclusion and this is manifested in including people with disabilities in a 'seftinat' work. They also share the work payment for people with disabilities and parents of children with disabilities with out participating in the work.

In addition to this the attitudinal change of the community after the commencement of the program was stated by one of the teachers participated in a focus group discussion as:

> *"In the school and out side of the school the attitude of community towards children with disabilities has become positive, for instance in a school children with out disabilities have been using derogatory terms such as "tsemam,*

armam" which is an insult, changed to euphemism "mismae ztesano" which means 'who can't hear a sound'. Before, Students with different types of disabilities were hiding their impairment, but now, they are registered in the special needs club themselves."

They also discussed on the observable changes on children with disabilities due to CBR services. They replied that there are tangible changes in the children's health and education as well as on the awareness of the community.

They were asked about challenges that affect the effectiveness of the program. They replied that there are different obstacles on the on going program. Some of the obstacles mentioned by one of the community leaders were *"poverty, lack of qualified personnel, and policy issues."* Regarding poverty, the community leaders mentioned that their village has been hit by drought for many repeated years. Hence the community has shortage of resource contribution to the program. In addition to this people with disabilities and parents of children with disabilities are concentrated with fulfilling their livelihood instead of participating in the program. Even the volunteers do not devote their time on the program.

Regarding the shortage of qualified persons a teacher who is leader of special needs club mentions as follows:

> *"Students with hearing impairment are taught by teachers who do not know sign language; hence the educational rehabilitation of such children has a problem."*

A community rehabilitation worker also mentioned that there is a shortage of qualified persons; she added that the rehabilitation tasks and activities accomplished by them as an additional work and they don't have enough knowledge of rehabilitating children with disabilities.

In addition to this a community leader suggested that there are obstacles concerning the policy issues, the obstacles are:

- Transfer of workers from place to place with out accomplishing a given task, for instance the community rehabilitation workers.
- There is work load for a single person at wereda level, for instance the social affaires of wereda has many over loaded works.
- There is no concerned body towards rehabilitation like that of wereda social affaires in Tabias.
- The new structure of administration in regional level, i.e. BOLSA and Youth and Sport Affaires are merged to one bureau hence there is an overlapping of work.

CHAPTER FIVE
DISCUSSION

In this chapter, the results of the findings have been discussed in relation to the research questions and the theoretical framework as presented in chapter two. Therefore, major thematic contents are presented based on the findings.

5.1 Types of Rehabilitation Services

Rehabilitation is a holistic and integrated program of medical, physical, psychosocial, and vocational interventions that empower a person with disability to achieve a personally fulfilling, socially meaningful, and functionally effective interaction with the world (Maki & Rigger, 1997). In this case, different service providers render services to people with disabilities and their families which are directed to minimize impairments and negative attitude in society and their effects; and to facilitate adaptations to the new life. The rehabilitation in such a way includes different components.

In this regard CBR-Tigray is undertaking rehabilitations with its major objective to ensure the provision of opportunity in all aspects of life including health, education, awareness raising and skill training of people with disabilities and the community. According to Thomas and Thomas (2001), the main objective of community based rehabilitation are: The enhancement of the daily life and activities of persons with disabilities, the creation of awareness in the community, the provision of barrier free environment, the utilization of local resources as well as the active participation and inclusion of persons with disabilities in the community.

Therefore, CBR-Tigray offers different type of rehabilitation services for children with disabilities and the community based on CBR matrix. Some of the services that are being rendered by the center are limited to medical rehabilitation, educational rehabilitation, and social rehabilitation.

A. Medical Rehabilitation

Since the service rendered by CBR-Tigray is based on CBR matrix, medical rehabilitation in the form of referral is the first and for most useful type of rehabilitation for children with disabilities. Child-1 explains regarding the referral service that she got from the center as:

> "*...The community rehabilitation workers send me referral to hospital, by now I am taking medical services there and I am able to walk with slight problem.*"

Furthermore, the community rehabilitation workers also mentioned that they give a referral service to children with disabilities by visiting their home. Hence all children are beneficiaries of such services.

B. Educational Rehabilitation

Educational rehabilitation is one component of CBR that is strongly prioritized in the rehabilitation of children. In child oriented CBR education has more school based focus on literacy and socialization than academic activities. The educational goal is awareness building in the community. Children with disabilities those who had been learning before the commencement of the program and those who were not at school have been benefited from educational rehabilitation of the program.

Both types of children have been provided with educational materials such as exercise book, pen, pencil, and uniform by the center. Children with visual impairment have also been provided with materials such as Braille, stylus and slate by the center.

Children, who had not attended school before, start to learn with the help of the program. Regarding this, a mother of hearing impaired child expresses her idea as:

"My son has been attending here in nearby school with children with out disabilities after the commencement of CBR program. Hence I am happy now."

On the other hand, the establishment of special needs club in the school encourage children with disabilities to participate in different co-curricular activities, and expose children with hidden disabilities to participate in rehabilitation program. Regarding this in a focus group discussion one of the teachers explain that:

"...Number of members of special needs club has increased from 29 to 49 in this academic year. This is because of the educational rehabilitation done in the school. I hope that for the next year the number of members will increase."

C. Social Rehabilitation

Social integration is very important in the rehabilitation of children with disabilities and it is one of the essential components of the program. In social rehabilitation, different types of activities have been undertaken for several times for social inclusion of children with disabilities into society. This is because the attitude and beliefs of the community affect the social well being of people with disabilities specially these children. Hence working in social acceptance of children with disability is one of the most important parts of rehabilitation.

Social rehabilitation is a process the aim of which is to attain functional ability. This ability means the capacity of a person to function in various social situations towards the satisfaction of his/her needs and the right to achieve maximum richness in his/her participation on society (Miles, 2004 cited in Alhamdu, 2006). In order to let children with disabilities participate in societal issues, the attitude and beliefs of the community should be changed. To change such attitude and beliefs an awareness raising must be done in the society.

Disability awareness raising activities have been undertaken by the center in different situations. The awareness raising program has been undertaken by community rehabilitation workers, teachers, agricultural extension workers, community health care volunteers, community leaders and children with disabilities themselves in different occasions.

The awareness raising program undertaken by CRWs and community health care volunteers are carried out in home to home visits and discussions. And that of teachers and children with disabilities are carried out at school in flag ceremony sand monthly at parents' meetings. The agricultural extension workers and community leaders also undertake an awareness raising activities at Tabia (kebelle) meeting and on sefitinat work.

Regarding the service in awareness raising and its effect on the change of students and teachers' parent-6 mention as follows:

> *"I was frightened to send my son to school, because I was afraid of pupils in the school, they may insult him or kick him, but by now due to the awareness raising activity carried out in the school, all teachers and students treat him and show him friendly attitudes and now he is learning in grade three."*

5.2 Involvement of Children with Disabilities, Families, Community members, and Professionals in CBR Program

Community based rehabilitation started as strategy for delivery of primary rehabilitation services to persons with disabilities in their communities with least possible expenses (SHIA and WHO, 2007). Since CBR is done in the community, there would be involvement of different stakeholders such as people with disabilities, families, professionals, and the community in overall activities of the program in different occasions. According to Tirussew (2005), community based rehabilitation and early intervention programmes involve family members, children with disabilities, teachers and

mainstream learners as well as community leaders. This study has found out that the involvement of different stakeholders in the program is indicated from simple beneficiary of the program to an active participant on the program.

5.2.1 Involvement of Children with Disabilities in the Program

Since community based rehabilitation is part of community development, it should be able to participate members of the community in meeting the needs of children with disabilities, and helping them find a meaningful place in the community. Active participation of persons with disability in all phases of CBR, starting from need assessments to implementation of program activities, is considered as key factor and necessary for the success of the program.

With regard to children's involvement in CBR program, the result of the study indicates that children with disabilities are involved in education and awareness raising activities in a school in form of special needs club.

People with disabilities should be involved in program planning, implementing, monitoring and evaluating. To do such activities, the participants should have commitment and knowledge to do so. Hence from the finding of the study, children with disabilities have a commitment to involve in all activities of the program, but their age and knowledge do not allow them to carry out activities such as planning, monitoring and evaluating. They only take part in implementing the activities. Regarding the involvement of children with disabilities in program implementation, a teacher of the children mentions:

> *"The special needs club in the school is guided by children with disabilities themselves and they prepare different awareness creation literature and present on mini media."*

This indicates that children with disabilities are implementing activities of the program.

5.2.2 Involvement of Parents in CBR Program

Parents or primary care givers involvement in CBR program is critical to successful early intervention. Families have the primary responsibility for caring all of their members. They are the first line of support and assistance for people with disabilities at local level. Thus, families must be included in CBR programme activities. Where an individual with a disability is not able, for whatever reason, to speak by himself or herself, a family member should represent him or her and should be considered as a legitimate member of people with disabilities organizations.

As the study indicates the involvement of parents in different activities of the programme, mothers are vital participants in their children's rehabilitation. A mother of child with disability mentioned that she is participating in parents meeting at school with other parents of children. She explains as: *"My son does not learn, but I participate on parents meeting in school concerning the education of children with disabilities by representing my child."*

This indicates that parents are representing their child those who are not able to speak in implementation of CBR activities.

A study made in Indonesia, Nepal, and Vietnam indicates the involvement of families is limited in implementation of some field activities of the program (WHO, 2002). This study also indicates that the involvements of families in the program activities such as deciding the priorities for the CBR program and in evaluating the program activities which are not exist. Hence the parents' involvement is limited in implementation of the program.

The above mentioned reality shows that the poor living standard of parents of children with disabilities has played its own part in limiting their active involvement in the rehabilitation program. Regarding involvement parent-5 states as:

"I do have three children, their father is not alive. Hence I have the responsibility of feeding them, so I have to work; therefore, my involvement in the CBR program is limited only to parents meeting in the school."

Parents obviously have very different degrees of capability, time, and energy in dealing with their children; and there are for whom greater involvement may be unrealistic – whether because of unemployment, poverty, or ingrained attitudes, or because of other circumstances (O'Toole and Halls, 1994).

5.2.3 Involvement of Community in CBR Program

It is important to recognize communities as the primary resource available for rehabilitation. Communities understand the problems that arise. They have access to resource and can provide long term support (WHO, 2007). This study shows that the CBR program does not involve the community on the activities such as planning, decision making and evaluation. These things have been carried out by the regional officials. The theory of participation is that the community should be involved in the planning, implementation, management and evaluation of the program. The reality, however, is usually that the community passively accepts external decisions (O'Toole, 1991).

The only participation demonstrated by the community is reflected as being volunteers. The involvement of the community in resource contribution is also seen as giving priority in supporting parents of children with disabilities. Regarding this a community leader states as:

"...the community give priority to families of children with disabilities in a 'seftinat' (food for work) and in other aids. For the future we discuss with World Vision Ethiopia to construct a shop which is used for people with disabilities and their parents as means of income."

5.2.4 Role of Professionals in CBR Program

Involvement of professionals in CBR program is very important in helping children with disabilities. According to Hertly, Nganwa, and Kisanji (2002), professionals are classified in two as 'high states professionals', these are specialists; they are mostly man, and the second are named as 'low status professionals', these types of professionals tend to work in environments, which are diverse, complex, dynamic and uncontrollable. They are generalists, they look at things holistically, and they include nurses, teachers and therapists. They are more likely to be a woman. In countries like Ethiopia there is a shortage of 'high status professionals'. CBR-Tigray has rendered its service in rural Weredas, in such situation the existing professionals are of 'low status professionals', and the role of such professionals in implementing the CBR program activities is essential.

In this study, an attempt was made to investigate the involvement of professionals in implementation of CBR program. And the findings indicate that the involvement of 'high status professional' is limited on the form of referral at regional level. While the involvement of 'low status professionals' in implementing the CBR activities is an encouraging work. In this case, the program coordinator explained that involvement of low status professionals as:

> *"The community rehabilitation workers who are the executor of the CBR activities are Health package workers; they visit children with disabilities home to home; they train mobility for blind children and they train parents how to communicate with their children, this is done parallel to their regular work. Teachers are also involved as therapists at school for children and parents in monthly parents meeting."*

The study also indicates that, there is shortage of community rehabilitation workers, and there is an ability difference among them. Teachers are participating in implementation but they don't have any training regarding the rehabilitation of children with disabilities.

5.3 Beliefs of Parents before, and while the CBR Program is going on

5.3.1 Beliefs of Parents about the Causes of Disability

The cause of impairment varies through out the world, and beliefs of the community and parents on causes of impairment also vary due to the difference of culture and religion of the community. This study shows that the belief of children with disabilities and their parents on acquired disabilities were possessed by an evil sprit while the children play at a garbage place at noon. For instance parent-4 explains the cause of her child's impairment as: *"My child has been beaten by Satan when he was playing at the garbage on mid day."*

Thus, the findings seems to be similar with what is mentioned by Tigabu (1997) that children can acquire a disability through the possession of an evil sprit when they play alone under a hot sun.

The study indicates that the cause of disability perceived by parents who are educated and those who are illiterate differently. Parent-6 who attended a school up to grade seven, explained that the cause of his child's impairment is a long delivery of his wife. While an illiterate mother, explains the cause as discussed above.

After the commencement of rehabilitation the belief of parents has been changed due to the lessons or training they receive by community rehabilitation workers and teachers in home to home visits and parents meeting.

5.3.2 Parents Reaction

When a child is born, there are usually doubts and apprehension in relation to the baby's health, life and future, such feelings get stronger when parents are told that they had a child with disability. In this situation parents often face a hard time because of emotional factors and intense frustration (Conceicao, 2007).

In this condition, all parents expect differently of the kind of baby they will have. This expectation is also high for parents those who have a first child, they wish that the baby will be free of any unwanted characteristics. When they have a child with unwanted characteristics they feel negatively. This type of feeling is common in parents those who have a child with disability at birth. These negative beliefs have been exercised in this study on parents who have a child with congenital disability, for instance parent-6 explains his feeling as:

> *"Since he is my first child, I didn't believe that he would be a child with disability. I couldn't accept the truth; even I was angry and attempted to kill myself. When the pediatricians told me about my child's disability, I lost my appetite; I couldn't eat any food for more than two days."*

Thus, the findings seems to be similar with what is mentioned by Wilknson (1995) that parents experienced grief with behavioral concomitants such as weight loss, loss of sleep and appetite. Conflict with in the family was described, with feelings of over-protectiveness on the one hand and feelings of anger and resentment at the disruption of their lives on the other hand.

Another mother of a congenitally disabled child expresses her feeling as follows: *"I was ashamed, of my child; 'ኣብ ቅድመ ህዝበ ኣፈይ መሰኣ ክፀውይ ኣይክኣለን' which means I was not able to speak in front of people confidently."*

Such kind of belief leads parents to hide their children with disabilities at home.

5.3.3 Treatment Given to Children with Disabilities

Treatments of children with disability are given by parents in different ways where the parents expected that it is a best solution for their children's disability. The religion and education of the society determines the type of treatment that parents undertake. All of the respondents' mothers had beliefs that the primary solution of children's treatment was

'may-tselot' which means 'holy water'. For instance parent-2 explained the type of treatment that she had undertaken before the commencement of rehabilitation as follows:

> *"I had a belief that the solution for the treatment of my child was only may-tselot, hence I took her to different religious places here and far from here and she washed "kilte shewate" which means two weeks a shower of holy water."*

This is also similar with the concept of Tirussew (2005) he mentioned that the role of the Ethiopian Orthodox has been considered the center for remediation of different forms of impairments. The traditional healers who use herbal medicine seem to attract a lot of clients from both urban and rural dwellers.

In addition to the religion, the educational level of parents also determines the treatment they give to their children, hence parents-3 and 6 had tried medical treatment starting from clinics in the village to higher specialists in Mekell and Addis Ababa Hospitals before the commencement of rehabilitation.

After rehabilitation the parents believe has been changed with the knowledge of the causes of disabilities.

5.4 Attitude of the Community towards Children with Disabilities

As it is mentioned in chapter two there are different categories of disabilities. Thus, the attitude of parents and the community is varied. The study shows that children with sever disabilities have been locked and isolated from social inclusion While children with hearing impairment and physical impairment have been integrating with the community. For instance, parent-5 explains her child's isolation as:

> *"Since he does not speak and move I didn't use to take him any where out side home. I have been locking him when I went to work because I didn't have any alternative; his siblings are also students and they are not interested in watching him."*

This was also observed by the researcher while I visit the home of the child.

In other situation parent-2 and 3 stated that, they used to take their child where ever they went and the children also played with other children with out disabilities. The community in the village has also a positive outlook to such children.

Thus, the findings seem to be similar with what is mentioned by Kisanji (1995), attitudes towards people with disabilities have been a mixture of persecution as well as tolerance. However, the tolerance has been paternalistic. And (Tirussew et al., 1995) indicates that there are three sorts of parental attitudes towards children with disabilities, and they are:

1. Inconsistent behavior involving careful provision for necessary physical care, together with resentment at the burden entails;
2. Out right rejection of the child; and
3. Over protection of the child.

After rehabilitation, the attitude of parents and community has been changed due to the efforts made by community rehabilitation workers, teachers and community health care volunteers due to awareness raising. This is also mentioned by Daniel (2000) as cited in Tirussew (2005), despite all the misconceptions and resistance to changing attitude on the part of parents of children with disabilities as well as community members, the CBR project appear to have positive result in Ethiopia.

5.5 Challenges of CBR Program

Poverty and shortage of CBR personnel are the main obstacles that affect the effectiveness of rehabilitation program in the Wereda. The study indicates that, most of parents of children with disabilities interest are to feed their children rather than to give attention to the rehabilitation of their children with disability.

The other problem of CBR program as mentioned by different respondents is that the limited number of community rehabilitation workers. Since the rehabilitation workers are paid by ministry of health they consider the rehabilitation work as secondary work. In

addition to this their number in Tabia is reduced to two which is insufficient. Hence the effectiveness of the program is limited to specific area where they live.

The program coordinator suggested that the number of Social Affaires civil servant in Wereda is limited to a single person. Thus, he/she can't cover supervising or evaluating all activities of the program existing in all Tabias of the wereda. Hence, there is an overlapping of work. In relation to this, the attitude of the regional officials towards the program is not encouraging. They do not consider the issue of disability as their responsible task.

Finally the community leaders mentioned the following obstacles on the on going programme effectiveness.

- Transfer of workers from place to place without accomplishing a given task, for instance the community rehabilitation workers.
- There is no concerned body towards rehabilitation like that of Wereda social affaires in Tabias.
- The new structure of administration in regional level, i.e. BOLSA and Youth and Sport Affaires are merged to one bureau hence there is an overlapping of work.

From the above community leader explanation, one can understand how different challenges or obstacles has affected CBR program as a model for meeting the needs of children with disabilities.

CHAPTER SIX
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 SUMMARY

The main objective of the present research study was to investigate the state of CBR approaches for children with disabilities in Kilte-Awlaelo wereda. In order to meet its objective data was collected from four CWDs, eight parents of CWDs, two CRWs, two community leaders, two teachers and one program coordinator. The instruments used in the study were interviews, FGD, observation and document analysis.

Among the participants four CWDs, six parents and the program coordinator were reserved for interview and the remaining participants for FGD. The interview guide, FGD guide and observation guide were developed based on research questions and reviewing literature. The interview guide line and the FGD guide line were focused on the situation of rehabilitation services for children with disabilities, involvement in CBR program and challenges of the CBR program.

The data collected was analyzed by using qualitative analysis method based on the results, discussions on the findings were made and consequently, the conclusions and recommendations are forwarded on the basis of the research outcome.

The findings of the study reveal that children with disabilities received different types of service from CBR-Tigray. These services consist of children's medical, educational and social rehabilitations. Thus, CBR has been successful in reaching some of the children with disabilities by making them receive health follow-up and illness treatment services provided in collaboration with hospitals and health centers. In addition to this children have been benefited with education. Children these had not enrolled in school due to the previous attitudinal barriers and lack of teaching materials, but after rehabilitation they are at school in their locality with their peers in an inclusive school.

With regard to awareness raising, there are different programs of training the community on disability issues. Thus, the community rehabilitation workers, teachers, children with disabilities and their parents and community health care volunteers have played a vital role on awareness raising in different occasions. Among these awareness raising carried out by children with disabilities and their teachers as well as the home visit of community rehabilitation workers and community health care volunteers have been effective tasks and activities carried out by the program in attitudinal changes of the community.

Other CBR components such as vocational training and income generating activities of parents did not include in the CBR program; because of shortage of skilled manpower and the center give more emphasis on health of children with disabilities. The program also gives emphases only on the aforementioned experiences of CBR, and this has made the program incomplete.

Any program that does not involve the community at all levels and in all stages, is considered as irrelevant and may not have significant impact on the community or for people with disabilities. Therefore, involvement of parents, low level professionals in the community and the community contribution to the planning and implementation stages often helped to avoid some of the potential challenges of CBR program.

However, the involvement of parents, children with disabilities, teachers and the community is limited only on implementation of the program. They are not involved in planning and monitoring the activities of the program.

The parents have been thought differently in the causes of disability. These differences arise from the educational level of the parents. Those parents who are educated are considering the cause as possible causes of disabilities, while the illiterate people consider the cause as sin or punishment by the God.

In case of treatment, based on the parent's religion and educational background they had been search for different types of treatments in which they expected as a solution. Among these treatments are holy water, traditional healer and 'deftera', and at last they visited medical doctors.

There are different obstacles facing the CBR program, and these are: first, poverty of the parents, which hinder them from involvement. Secondly, there is shortage of concerned skilled manpower in different administrative levels such as Wereda and Tabia. Thirdly, attitude and interest of regional officials towards rehabilitating children with disabilities is too low. Fourthly, there is a transfer of rehabilitation workers from place to place with out accomplishing their work which they started on a particular place.

6.2 Conclusions

Based on the objectives of the study, the research questions and the findings the following conclusions have been drawn:

- The main focus of the CBR program is on health and educational services of children with disabilities, and it has not gone through all CBR components.
- Children with disabilities have benefited from both medical and educational rehabilitation.
- There is no involvement of parents, children with disabilities, low status professionals and the community in planning and monitoring of the program.
- The attitude of the community towards children with disabilities has been changed from negative to positive thinking after rehabilitation.
- Beliefs of parents about the causes of disability had been varied according to the educational level of parents before the commencement of the rehabilitation program.
- Parental beliefs towards the causes of impairment have been changed from religious thinking to possible causes as a result of rehabilitation.
- Parents' reaction towards having a child with disability varies among who have a first born child with disability and those who had other children before. And Parents those who never had other child before have a feeling of hopelessness and they have passed through some stages of shock, disbelief and anger.
- Poverty, shortage of skilled man power, structure of the administration and attitude of regional officials are some of the obstacles facing to the CBR program.

6.3 Recommendations

In the light of the findings of the study, the following recommendations are forwarded:

- To enhance the quality of life of children with disabilities CBR-Tigray should include other components of CBR such as vocational training and income generation services for children and parents of children with disabilities.
- The existing health committee in Tabias should be re organized in the form of CBR committee in order to enhance participation of the community in different stages of the program.
- In addition to the health package workers who serve as community rehabilitation workers, the program should also use teachers as community rehabilitation workers through training them.
- The existing parents meeting held in the school should be supported and encouraged; and it should be expanded its magnitude even out side of school.
- On changing the attitude of community and parents towards children with disabilities, collaborative work among community rehabilitation workers, teachers, agricultural extension workers and community leaders should be strengthened and encouraged.
- There should be counseling services for parents of first born children about reactions on having a child with disabilities.
- Since the structure of the administration is decentralized; and the program is implemented at the root level, CBR program should able to use the existing resources in Tabias and weredas rather than asking the good will of regional officials.
- In order to have a sustainable CBR program, the rehabilitation program should involve parents, professionals and the community in its activities such as planning and monitoring.
- Further researches need to be conducted on the state of CBR services in the future to make wide scale investigation.

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APPENDICES

Appendix I

I Semi-structured interview guide for children with disabilities

1. Background information

Sex________ Age________ Religion________________
Grade__________ Type of impairment___________________
With whom he/she lives: Father and mother___ Mother only___
Father Only___ other relative____

2. Situation before rehabilitation

2.1 Social situation

- Were you participating in cultural festivals and recreational activities with other children without disabilities?
- Do you have friends (play mates) from children with out disabilities?
- Were you being able to perform daily activities independently?
- Do you participate in public activities?

2.2 Psychological situation

- What did you feel by having impairment?
- What do you feel when you are not able to perform other children without disabilities able to?
- Have you been teased or been insulted by children in the school?

2.3 Educational situation

- Did you attend school before joining this program?
- Did you able to perform school works independently?
- Did you participate in co curricular activities?

2.4 Medical situation

- Did you follow medication in the surrounding clinic?
- Did you get any referral treatment?
- Have you received any assistive device?

3. About the rehabilitation services

- What type of services have you been getting from the center?
- How has your life changed as a result of receiving CBR services?
- What are the most important changes brought about by CBR in the community?
- Has CBR improved your access to health services rehabilitation, assistive devices and equipments?
- Has CBR helped you in improving your education? How?
- Have your communication skills and personal participation in family and community increased as a result of the services?
- In what condition did you involve in CBR program?

Appendix II

II. Semi-structured interview guide for parents of children with disabilities

1. Background Information

Sex________ Age________ Religion________________
Relation ship of the caregiver to the child_______________
Martial status___________ Education background ________
Occupation___________ Number of children Male____ Female____
Total___

2. Regarding the Child with Disability

- When did the impairment occur to your child?
- What was your reaction after having a child with disability?
- What treatment was given to your child?
- What services did your child receive from the program?
- What do you think the cause of the impairment before you joining the program? What about now?
- Could you describe the challenges you have faced by having a child with disability?
- What changes do you observe on your child development after the rehabilitation service?
- How do you rate public awareness of disability issues, before launching and while the CBR program going on?

3. Regarding participation

- What is your role in the program?
- Did your child participate on the activities of the program?
- What expectations do you have about the role of professionals on the program?
- Did the program satisfy your child's needs?
- What are the challenges faced by the program?

Appendix III

III. Semi- structured interview guide for the program coordinator

1. **Background information**
   Sex_____ Age______ Educational back ground__________
   Work experience: A) In the field____ b) In other field______

2. **About the Rehabilitation**

   - In what areas does the center provide services for children with disabilities?
   - Can you tell me about the involvement of families, professionals and community in the program?
   - What changes do you observe on the children wellbeing while the rehabilitation going on?
   - From the services that the center offered to children with disabilities what services do you think effective? Why?
   - How do you rate public awareness of disability issues, before the commencement of the program and while it is going on?
   - How do you describe public attitude towards children with disabilities, before the commencement of the program and while it is going on?
   - How do you describe the participation of various institutions and organizations in supporting the program?
   - What are the challenges faced by the program?
   - What is your thought of the future?

Appendix IV

IV. Focus Group Discussion Guide

- The state of CBR services for children with disabilities.
- The involvement of families, children with disabilities, teachers, health workers and the community in the program.
- Attitude of the community before the commencing of CBR program and while it is going on.
- Any observable changes due to the provided CBR service.
- Challenges that affect the effectiveness of the program.

Appendix V

V. Observation guide

Social aspect

- participation in family activities
- Does house hold activities
- Participate in community activities

Educational aspects

- Goes to school
- Participate in class room
- Plays with others

Mobility

- sits and stands
- walking using assistive device

Communication

- Communicate with family members
- Communicate with teachers and peers

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

Name: Kahsay Tareke

Signature:

Date: June 11, 2010

This thesis has been submitted for examination with my approval as a university advisor.

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Date: June 18, 2010