# AN ASSESSMENT OF REHABILITATION APPROACHES FOR PERSONS WITH MENTAL AND PHYSICAL DISABILITY IN MOROGORO REGION

BY

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## ABSTRACT

More than half a billion persons are disabled as a result of mental, physical or sensory impairment. Tanzania is estimated to have 3,346,900 people with disabilities, and the majority of whom live in rural areas. Tanzania, like other countries, provides rehabilitation as a right to the disabled, but there are very few institutions that provide rehabilitation in Tanzania. Morogoro Region is one of the Regions in Tanzania that have a number of people with physical and mental disabilities. A cross sectional study on comparative assessment of Institutional Based Rehabilitation (IBR) and Community Based Rehabilitation (CBR) approaches for persons with disabilities in Morogoro, in terms of their suitability and effectiveness under Tanzanian conditions was done. The study conducted in Morogoro Region, involved a total of 60 respondents, 30 respondents from Institution Based Rehabilitation and 30 respondents from Community Based Rehabilitation. The data were analysed using Statistical Package for Social Science (SPSS) computer software program. It was found that there are different services provided in different institutions in Morogoro. And the Effects of the services provided show that 67.7% have experienced changes and the remaining 33.3% had no changes due to staying too far from the centre, poverty, and severe disability. Advantages of CBR are: - interactions, familiarisation of the environments, get love from the parents, and develop the mind. Advantages of IBR are to live independently, creating understanding, vocational skills and avoiding sexual abuse. The study concludes that service provided to these institutions that have different approaches have shown slight differences. Approaches for both IRB and CBR need to be the same in terms of quality and quantity service provided, because both rehabilitate persons with mental and physical disability to live independently and provide skills to them according to their interests.

## DECLARATION

I, LUCY EUGEN MBAMBE, do hereby declare to the SENATE of Sokoine University of Agriculture that, this dissertation is my own original work, and has not been submitted for degree award in any other university.

.....  21/07/2008

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The above declaration is confirmed

.....  21/7/08

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## DEDICATION

To my beloved parents, Mr and Mrs Eugen Gabriel Mbambe who, through their love and dedication, gave me solid guiding principles, with which to determine my own path.

# TABLE OF CONTENTS

## LIST OF TABLES

## LIST OF APPENDICES

## LIST OF ABBREVIATIONS

| | | |
|---|---|---|
| CBR | - | Community Based Rehabilitation |
| IBR | - | Institutional Based Rehabilitation |
| ILO | - | International Labour Organization |
| MDGs | - | Millennium Development Goals |
| SNAL | - | Sokoine National Agricultural Library |
| SPSS | - | Statistical Package for Social Sciences |
| SPSS | - | Statistical Package for the Social Sciences |
| UN | - | United Nations |
| UNESCO | - | United Nations Educational Scientific and Cultural Organization |
| URT | - | United Republic of Tanzania |
| WB | - | World Bank |
| WHO | - | World Health Organisation |

# CHAPTER ONE

# INTRODUCTION

## 1.1 Background information

More than half a billion persons are disabled as a result of mental, physical or sensory impairment. No matter in which part of the world they are, physical or social barriers often limit their lives. Approximately 80 per cent of the world's disabled population lives in developing countries (UN, 2003-2004). The United Nations Population Information Network estimates that there are almost 800 million people living in Africa, 50 million of who are disabled (Adedoyin, 2001). This means that there is one disabled person for every 16 Africans. This group forms the highest proportion of Africa's disadvantaged population, and only 2% have access to any form of rehabilitation; 90% of children with mental disability die before age 5; and 70% of disabled adults are unemployed and live in poverty (Adedoyin, 2001).

The causes of disability in Africa, like anywhere else in the world, are not farfetched: they are chiefly malnutrition, communicable diseases, occasioned by poverty and war. Though there is little information about the prevalence and incidence of disabling diseases in Africa, it is clear that much of the disability stems from poor nutritional status, communicable diseases and low inoculation and immunization rates (Adedoyin, 2001).

In bringing about positive impact on the situation of people with disabilities, two approaches have been practiced, that is: Institutional Based Rehabilitation (IBR), and Community Based Rehabilitation (CBR). While the rehabilitation gap can't be closed in any quick or easy way, CBR is considered to be one of the most practical and efficient rehabilitation approaches (Handojo, 1991).

CBR is a system that envisages using existing resources of manpower and material within the community to promote integration of disabled people in all spheres of life and activity (Thomas and Thomas, 1997), while Institution Based Rehabilitation (IBR) is generally used to refer to services provided by institutions to individuals where they provide full support to the disabled.

Tanzania is estimated to have 3 346 900 people with disabilities, majority of who live in rural areas; and this is caused by unfavourable economic situation that has affected the availability of services such as health, education and employment opportunities (URT, 2004). Tanzania like other countries provides rehabilitation as a right to the disabled. It has introduced two approaches that are Institution Based Care and Community Based Care, but there are very few institutions that provide rehabilitation in Tanzania (URT, 2004).

Morogoro Region is one of the Regions in Tanzania that have a small number of people with physical and mental disabilities (URT, 2003). There are about five institutions that provide care to people with disabilities; two of these institutions are for medical rehabilitation that is the Regional Hospital and the Teresian Capuchin Sisters rehabilitation centre at Kihonda, while the remaining institutions provide different services. Services provided in different institutions in Morogoro are prevention, identification and assessment of disability, medical rehabilitation, pre- school training, education, vocational rehabilitation, and social rehabilitation, depending on the institution. These institutions are Bethlehem at Ifakara in Kilombero District, Amani Centre at Chamwino and Mihayo at Mazimbu in Morogoro Municipality.

### 1.2 Problem statement

Rehabilitation to disability in developing countries shows that institutional based care is not conducive to the disabled who are in rural areas, due to the reason that most of the institutions are located in towns where the minority lives (Handojo, 2001). Tanzania is estimated to have 80% of people with disabilities living in rural areas (URT, 2004). This implies that the government needs to spend more resources to establish a wide coverage of institutional centers for rehabilitation; unfortunately this can not be achieved given budgetary and institutional constraints. Therefore, Community Based Rehabilitation (CBR) was introduced as a solution to this problem. This approach is viewed as the appropriate method to increase coverage in developing countries (Thomas and Thomas, 2002).

Yet the introduction of Community Based Rehabilitation may not be a panacea to the problems of the disabled. There is no information indicating which of the two is more effective. There is a need therefore, to compare between Institution Based Care and Community Based Care in order to determine their relative strengths, weaknesses and suitability under Tanzanian conditions.

### 1.3 Problem justification

The study will generate information to the public and private sectors that provide rehabilitation to people with disabilities. Reliable information is an important tool in the provision of services to persons with disabilities. Unfortunately there is a serious lack of data and information in this service area (URT, 2004). In addition, the study is in line with the government policy (Act No. 3 of 1982 Disabled Persons Care and Maintenance). Therefore, there is a need to compare the services provided and suitability of these two approaches (Institution Based Rehabilitation and Community Based Rehabilitation) under

Tanzanian conditions. Such information is not readily available to institutions and families that live with disability.

## 1.4 Objectives of the study

### 1.4.1 General objective

To make a comparative assessment of Institution and Community Based Rehabilitation approaches for persons with disabilities in Morogoro, in terms of their suitability and effectiveness under Tanzanian conditions.

### 1.4.2 Specific objectives

i) To Examine how different services aimed at persons with disabilities are provided in different institutions.

ii) To assess effects of different services provided to persons with disabilities.

iii) To evaluate the relative advantages of Institution and Community Based Rehabilitation for persons with disabilities in Morogoro Region.

# CHAPTER TWO

# LITERATURE REVIEW

## 2.1 Definition of disability

By definition, disability is a physical or mental impairment that substantially limits or restricts the condition, manner, or duration under which an average person in the population can perform a major life activity, such as walking, seeing, hearing, speaking, breathing, learning, working, or taking care of oneself. An impairment or diagnosis, in and of itself, does not necessarily constitute a disability: it limits these activities (WHO, 2002).

Intellectual disability or mental disability also referred to as cognitive disability, developmental disability, or mental retardation, is a disability that begins in childhood. People with intellectual disability have limitations in their mental functioning and in their ability to communicate, socialize, and take care of their everyday needs. Some cases of intellectual disability can be prevented with proper medical care (Rocha, 2006).

## 2.2 Causes of intellectual disability

Mental retardation can be caused by any condition that impairs development of the brain before birth, during birth or in the childhood years. Several hundred causes of intellectual disability have been discovered, but many are still unknown. The most common ones are (Rocha, 2006).

### 2.2.1 Genetic conditions

These result from abnormalities of genes inherited from parents, errors when genes combine, or from other disorders of the genes caused during pregnancy by infections, overexposure to x-rays and other factors. There are many genetic diseases associated with

mental retardation. Some examples include PKU (phenylketonuria), a single gene disorder. Due to a missing or defective enzyme, children with PKU cannot process a part of a protein called phenylalanine. Without treatment, phenylalanine builds up in the blood and causes mental retardation. Down syndrome is an example of a chromosomal disorder. Chromosomal disorders happen sporadically and are caused by too many or too few chromosomes, or by a change in structure of a chromosome. Fragile X syndrome is a single gene disorder located on the X chromosome and is the leading inherited cause of mental retardation.

### 2.2.2 Issues during pregnancy

Use of alcohol or drugs by the pregnant mother can cause mental retardation. In fact, alcohol is known to be the leading preventable cause of mental retardation. Recent research has implicated smoking in increasing the risk of mental retardation. Other risks include malnutrition, certain environmental toxins, and illnesses of the mother during pregnancy, such as toxoplasmosis, cytomegalovirus, rubella and syphilis.

### 2.2.3 Problems at birth

Premature and low birth weight predicts serious problems more often than any other conditions. Difficulties in the birth process such as temporary oxygen deprivation or birth injuries may cause mental retardation.

### 2.2.4 Problems after birth

Childhood diseases such as whooping cough, chicken pox, measles, and Hib disease that may lead to meningitis and encephalitis can damage the brain, as can injuries such as a

blow to the head or near drowning. Lead, mercury and other environmental toxins can cause irreparable damage to the brain and nervous system.

### 2.2.5 Poverty and cultural deprivation

Children growing up in poverty are at higher risk for malnutrition, childhood diseases, exposure to environmental health hazards and often receive inadequate health care. These factors increase the risk of mental retardation. Also, children in disadvantaged areas may be deprived of many common cultural and educational experiences provided to other youngsters. Research suggests that such under-stimulation can result in irreversible damage and can serve as a cause of mental retardation.

## 2.3 Symptoms of intellectual disability

Symptoms appear before a child reaches 18 years and vary depending on the degree of the intellectual disability. Symptoms include:

- Learning and developing more slowly than other children of the same age
- Difficulty in communicating or socializing with others
- Lower than average scores on intelligence (IQ) tests
- Trouble learning in school
- Inability to do everyday things like getting dressed or using the bathroom without help
- Difficulty in hearing, seeing, walking, or talking , and
- Inability to think logically (Rocha, 2006)

## 2.4 Perceptions, disparities and stereotypes

Disability is associated with stigma. When a person becomes disabled or a disabled child is born, the individual and family enter into a new world about which they know next to nothing and about which they have a lot of stereotyped notions. They are influenced by religions that see disability as a curse or the manifestation of sin and disgrace in the family, and alms given to the disabled beggar are a means of obtaining spiritual grace and forgiveness for the non-disabled person (Shakerspeare, 1998).

Disabled people are often excluded from school or the workplace, and often end up depending on others in the family and community for physical, social and economic support. In addition to being vulnerable to exclusion, "disabled people are disproportionately poor, and poor people are disproportionately disabled." The World Bank studies have revealed that Ugandan households with a disabled head are 38 percent more likely to be poor than households headed by a person without a disability (World Bank, 2005).

In Tanzania the widespread prejudice and negative attitude towards disability and persons with disability in our society is mostly culturally motivated. The birth of a child with disability is associated with superstitions or some misfortune. Negative attitude of the community towards disability and persons with disability is one of the major barriers against the integration and equal participation of disabled persons in the life of the community. Often, disability is perceived as a problem and a person with disability as unable and dependent (URT, 2004).

## 2.5 Poverty and disability

People with disabilities in developing countries are over-represented among the poorest people. They have been largely overlooked in the development agenda so far, but the recent focus on poverty reduction strategies is a unique chance to rethink and rewrite that agenda.

Poverty causes disabilities and can furthermore lead to secondary disabilities for those individuals who are already disabled, as a result of the poor living conditions, health endangering employment, malnutrition, poor access to health care and education opportunities. Together, poverty and disability create a vicious circle (World Bank, 2006).

There is a strong correlation between disability and poverty. Poverty leads to increased disability, and disability in turn leads to increased poverty. Thus, the majority of people with disabilities live in poverty. Studies show that they have higher rates of unemployment compared to non-disabled people even in industrialized countries. In developing countries, where the majority of people with disabilities live, their rates of unemployment and underemployment are undoubtedly higher. Lack of access to health care and rehabilitation, education, skills training, and employment contributes to the vicious cycle of poverty and disability. In 2000, the UN Member States adopted the Millennium Declaration and set eight Millennium Development Goals (MDGs) to guide the implementation of the Declaration. All the goals are relevant to disability and three goals are of particular concern to people with disabilities and their families:

1. Eradicate severe poverty and hunger.
2. Achieve universal primary education.
3. Promote gender equality and empower women.

With regard to poverty reduction, countries were invited to develop strategies relevant to their needs and capabilities and to request assistance from international banks, donors and aid agencies (WHO, 2004).

### 2.6 Millennium Development Goals for disabilities

A world with less poverty, hunger and disease, greater survival prospects for mothers and their infants, better educated children, equal opportunities for women, and a healthier environment; a world in which developed and developing countries work in partnership for the betterment of all. This vision took the shape of eight Millennium Development Goals, which are providing countries around the world a framework for development and time-bound targets by which progress can be measured.

United Nations (UN, 2006) released its own goals for the Millennium, the inclusion of International Millennium Development Goals, to ensure that people with disabilities are not forgotten in global efforts to improve the quality of life in developing and transition economies. The MDGs provide recommendations for developing inclusive policies and programmes in education, maternal and child health, poverty reduction, human rights, gender equality, HIV/AIDS and global partnerships to promote the inclusion of people with disabilities worldwide. These are as follow:-

#### 2.6.1 Eradicate hunger and poverty

Disabled people are significantly poor in developing countries, and more so than non-disabled counterparts. Eradicate Extreme Poverty for People with Disabilities and their Families: By 2015, people with intellectual disabilities and their families will live free of poverty and discrimination (The Arc, 2005).

### 2.6.2 Achieve universal primary education

Very often, children with disabilities are not recognized, get frustrated with schooling and so drop out. By 2015, all children with intellectual disabilities will receive good quality, inclusive education with appropriate supports to ensure that each child reaches their highest educational potential.

### 2.6.3 Promote gender equality and empower women

Disabled women are more likely to be victims of sexual abuse. Violence against women causes psychological and other disabilities. Promote Gender Equality for Women with Disabilities: By 2015, social, economic and political discrimination against women and girls who have a disability and their mothers will be eradicated.

### 2.6.4 Reduce mortality of children with disabilities

Reduce the Mortality of Children with Disabilities: By 2015, the mortality rate of children who are born with disabilities or become disabled in the early years will be reduced by two-thirds.

### 2.6.5 Achieve the rights of children and families

Achieve the Rights of Children and Families: By 2015, the rights of children with disabilities, as outlined in the UN Convention on the Rights of the Child, will be respected; mothers will receive adequate pre- and post-natal health care to ensure the well being and healthy development of all children; families will get the help they need for the care and support of their members with a disabilities.

### 2.6.6 Combat HIV/AIDS, malaria and other diseases

Combat HIV/AIDS, malaria and other diseases: By 2015, the spread of HIV/AIDS in the community of people who have a disability will begin to be reversed and children with disabilities who have been orphaned will be supported and cared for in the community

### 2.6.7 Environmental sustainability

Ensure Environmental Sustainability: By 2015, achieve significant improvement in the lives of people who have an intellectual disability and their families who live in extreme poverty.

### 2.6.8 Develop a global partnership for development

Develop a Global Partnership for Development: By 2015, global efforts to promote good governance and global partnerships will contribute to the human rights of people with intellectual disabilities, including citizenship and economic rights (UN, 2006).

## 2.7 Rehabilitation for persons with disabilities

In the 1940s and 1950s the United Nations was active in promoting the well-being and rights of persons with physical disabilities through a range of social welfare approaches. The United Nations provided assistance to Governments in disability prevention and the rehabilitation of disabled persons through advisory missions, workshops for the training of technical personnel and the setting up of rehabilitation centers. Seminars and study groups were means of exchanging information and experience among experts in disability. Fellowships and scholarships were awarded for trainers. As a result of initiatives from within the community of disabled persons, the 1960s saw a fundamental re-evaluation of

policy and established the foundation for the full participation by disabled persons in the society (UN, 2003-2004).

Therefore these discriminations to the people with disabilities from societies, led to Government and private sectors to come up with a policy on rehabilitation, and for coordinating different approaches to deal with the disabled in order to reduce their disability from primary to secondary disability.

The Government of Tanzania in 1982 came up with a law (Act No. 3 of 1982 Disabled Persons Care and Maintenance). According to the Act:

i) The Government through local authorities and in collaboration with non-governmental organizations shall provide institutional care to eligible people with disabilities.

ii) The government in collaboration with non-governmental organizations shall put in place mechanism for awareness creation amongst families and the society in general on their responsibility to provide care to relatives with disabilities.

**2.8 Institution Based Rehabilitation**

The term institutional care is generally used to refer to services provided in the institutions to individuals with functional disabilities. These services provide full support to the disabled that include nursing, medical care, such as administering intravenous medications that were previously done only in hospitals. Institutional care is also provided on a long-term basis to assist people in pre-schooling training, education, vocation rehabilitation and social rehabilitation [www.din.ne.jp.com].Institutional care services in Tanzania are inadequate and lack essential amenities and qualified personnel. Government decision to

place institutional care under Local Authorities and Non-governmental Organisations brings these services, not only closer to the recipients but also provides a good chance for their improvement (URT, 2004).

In the life of every society there are individuals who for some reason cannot lead independent lives and have no one to fend for them, however institutional care for people with disabilities should be the last resort. Institutional care of people with disabilities has the following disadvantages:

i) It reaches fewer people.

ii) It uproots people from their areas of usual domicile.

iii) It separates people with disabilities from mainstream community life, and

iv) It evokes negative attitude.

This institutional care targets fewer people and leaves the majority aside especially those from rural areas. The government of Tanzania has, therefore, come up with a policy statement that: "The government shall take measures to insure that Community Based Rehabilitation (CBR) is adopted as a strategy and method of service delivery to people with disabilities" (URT, 2004).

**2.9 Community Based Rehabilitation**

In 1994 the International Labour Organization (ILO), United Nations Educational Scientific and Cultural Organization (UNESCO) and World Health Organization (WHO) produced a Joint Position Paper on CBR in order to promote a common approach to the development of CBR programmes. WHO, ILO and UNESCO view CBR as a strategy that can address the needs of people with disabilities within their communities in all countries.

The strategy advocates community leadership and the full participation of people with disabilities and their organizations. It promotes and supports community needs and activities, and collaboration between all groups that can contribute to meeting its goals (World Bank, 2006).

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 (WHO, 2004).

The term home care is generally used to refer to services provided in the home or in the community to individuals with functional disabilities and to their families. These services can range from home support, such as a few hours a week of simple housekeeping, to full nursing and medical care, such as administering intravenous medications which were previously done only in hospitals. Home care is also provided on a short-term basis to assist people who are discharged from acute care hospitals. In addition, home care can provide palliative care, respite care and other related services to those in need (Thomas and Thomas, 2005).

This approach calls for children with mental or physical disabilities to be given the opportunity to participate in all activities and opportunities of community life at home, and allows the disabled children to integrate with normal children. This leads to children with disabilities to learn important personal and social skills that they might not otherwise learn in Institution Based Care and children who do not have disabilities to benefit by improved

self-concept, growth in social cognition and decreased fear of human differences (World Bank, 2005).

Integration is the degree of participation of people with disabilities in the life of the community. The concept of integration presupposes the use of the same institutions used by the non-disabled to serve people with disabilities (URT, 2004).

It is acknowledged that Community Based Rehabilitation programmed work is an effective strategy towards the empowerment of people with disabilities living in low-income countries because it has the basic interrelated key components that it:

- Provides the basic "rehabilitation" needs of both the people with disabilities and their families
- Develops capability of people with disabilities, families and community as a whole
- Creates opportunities for livelihood, health, education and participation of self-help groups of people with disabilities
- Presents collaboration among multidisciplinary sectors
- Involves the whole community, local governments and leaders (Thomas and Thomas, 2005).

CBR promotes the rights of people with disabilities to live as equal citizens within the community, to enjoy health and well being, to participate fully in educational, social, cultural, religious, economic and political activities.

It is essential that national strategies to address the MDGs and tackle poverty include measures to ensure the participation of people with disabilities. CBR itself can be viewed as a poverty reduction strategy within community development. Efforts at community level to ensure education for children with disabilities, employment for youth and adults

with disabilities, and participation of people with disabilities in community activities can serve as a model for national strategies and policies for development.

Agencies and organizations that work to reduce poverty have recognized the importance of specific programmes for women, who contribute significantly to the health, education and welfare of their children. But these specific programmes do not routinely include women with disabilities. CBR programmes can be effective in promoting the inclusion of women with disabilities in programmes aimed at poverty reduction among women in general.

Rehabilitation services should no longer be imposed without the consent and participation of people who are using the services. Rehabilitation is now viewed as a process in which people with disabilities or their advocates make decisions about what services they need to enhance participation. Professionals who provide rehabilitation services have the responsibility to provide relevant information to people with disabilities so that they can make informed decisions regarding what is appropriate for them.

**2.10 Decline of extended families threat Community Based Rehabilitation**

The changes that have occurred in family life are seen as a threat to the quality of community life since strong families are the foundation of strong communities. Marriage and family formation are seen as important life transitions in this respect. Marriage embeds individuals within a network of extended family and friends, and child bearing and home ownership are associated with greater levels of neighbourhood attachments and involvement.

These changes are marriage, divorce, single-parent families, and increased rates of female workforce participation. It is argued (Hughes and Stone, 2003) that these changes in family life have weakened family bonds and the quality of relationships within families. Divorce leads to household disruption and mobility, as well as financial strain, and these factors may in turn impede individuals' capacity to engage in their communities. Women's increased workforce participation may be linked to "community decline" because the time constraints associated with paid employment may make other forms of community participation and voluntary activity more difficult (caring the family).

Therefore falling marriages, increased rates of divorce and separation, may lead to lower levels of community engagement and attachment, and a decreased trust of people generally. Where the family is seen as the key site for the development of behavioural norms, it follows that if people don't experience cooperative relationships in their family life, they are less likely to have cooperative relationships with others in the community. Similarly, if individuals do not learn how to take responsibility for others within the family say, as parents or providers it will block their transition into responsible adulthood (Gillies, 2003).

# CHAPTER THREE

# RESEARCH METHODOLOGY

## 1.1 Description of the study area

The study was conducted in Morogoro Region, focusing on three Districts, Morogoro, Mvomero and Kilombero, specifically Mazimbu ward in Morogoro Municipality, Turiani in Mvomero District and Ifakara in Kilombero District. The Districts and Wards were selected purposively since they host institutions that provide care to those with physical and mental disabilities, characterised by two approaches that is Community Based Rehabilitation (CBR) and Institution Based Rehabilitation (IBR).

Morogoro Region is one of the 20 Regions in Tanzania mainland. The Region lies between latitude 5° 58" and 10° 0" to the south of the equator and longitude 35° 25" and 35° 30" to the east. It is bordered by seven other Regions: Arusha and Tanga Regions to the north, the Coast Region to the east, Dodoma and Tanga to the west, Ruvuma and Lindi to the south (URT, 2003).

## 3.2 Economy of the study area

The economy of the Region is dominated by agriculture and the allied activities. The major activities include small scale farming (food and cash crop production and subsistence farming), cattle keeping (mainly indigenous livestock), plantation and estate (sisal and sugar cane) agriculture (URT, 2003).

## 3.3 Research design

A cross- sectional survey that allowed data to be collected at a single point in time was used (Bailey, 1994). The survey involved interviewing parents of disabled children and

workers of institutions that provide care to the disabled. According to Bailey (1994), the is design uses minimum time and resources.

### 3.4 The Sample

The sampling units were the families of children with disabilities, and teachers in the institutions that provide care for disabled children that were selected. The families and teachers are appropriate units of measure when assessing the level of development to disability.

#### 3.4.1 Sample Size

The population of the disabled in Morogoro Region is estimated to be 3,123 where the mentally and physically handicapped are 624 (females 226 and males 398), and their ages range from 5- 30 years (URT, 2003). Mental and physical disabilities are those mental and physical impairments that limit the disabled to fulfil the major life activities. The sample size was at least 5% (30 disabled) of the total numbers of families having disabled children/ individuals; the same was applied to the institutions. The sample of 30 disabled ranged from 5-20 years, where they got services for 5 to 10 years from the centre.

#### 3.4.2 Sampling technique

The institutions were purposively selected. These institutions are Amani Centre in Mazimbu Ward and Upendo at Turiani in Mvomero ward which provide Community Based Rehabilitation (CBR) and Bethlehem at Ifakara in Kilombero ward and Mihayo in Mazimbu Ward that provide Institution Based Rehabilitation were selected. Disabled children/ families were randomly selected.

### 3.5 Data collection

#### 3.5.1 Primary data

The main instrument that was used in collecting primary data in this study was the structured questionnaire containing both closed and open-ended questions focusing on various services provided to the disabled. Open-ended questions were used to get in-depth information from respondents.

Interviews with the disabled from institutions as well as observations were used. A checklist guided the inquiry. Effectiveness, cost, time, convenience, methods on teaching and culture were measured in comparing the two approaches (IBR and CBR). To ensure validity and reliability, the first draft of the questionnaire was pre-tested in the families having disabled children. Necessary changes were made on the basis of pre-testing results before administering the final questionnaire.

#### 3.5.2 Secondary data

Secondary data on rehabilitation of persons with mental and physical disability was collected from literature, SNAL and the Internet.

### 3.6 Data analysis

The collected quantitative and qualitative data were coded and analysed using Statistical Package for the Social Sciences (SPSS) computer software. Likert scale was used to determine the scores of the services/methods provided between Community Based Rehabilitation (CBR) and Institution Based Rehabilitation (IBR). Descriptive statistics such as frequencies, percentage and means were determined and cross tabulations involving chi-square tests were used to test the suitability of services provided by

Institution Based Rehabilitation and Community Based Rehabilitation to the welfare of disabled in Morogoro. Cross-tabulations are both a powerful way of communicating information and commonest form of data presentation (Kothari, 2004). In both chi- square and t-test, the level of statistical significance used was 5%.

# CHAPTER FOUR

# RESULTS AND DISCUSSION

## 4.1 Overview

In this chapter the results of the study are presented and discussed. First, the background characteristics of the respondents are presented followed by sources of disability and condition of the child before being identified, rehabilitation of the child in the identified institution which was determined through observation. This is then used to measure services provided in the institution, changes after having rehabilitation in the institution, and lastly, advantages of the service provided, problem and challenges.

## 4.2 Background characteristics of the respondents

The study covers the characteristics of the 60 persons with mental and physical disability included in this study. These characteristics are age, sex, marital status and occupation. The summary of the background characteristics is presented in Tables 1 and 2.

### 4.2.1 Sex

Age and sex are important parameters in social analysis. The results in Table1 show that out of the 60 disabled persons, 51.7% were girls and 48.3% were boys; therefore the girls are more compared to the boys even though there is no biological relation to sex, in the general population women are more than men.

### 4.2.2 Age

The results showed that 61.7% of the 60 disabled persons were 8-17 years old and 38.3% were 18-30 years old.

**Table 1: Sex and Age of the disabled (N=60)**

| Categories | Frequency | Percent |
|---|---|---|
| **Sex** | | |
| Female | 31 | 51.7 |
| Male | 29 | 48.3 |
| Total | 60 | 100.0 |
| | | |
| **Age (years)** | | |
| 8-17 | 37 | 61.7 |
| 18-30 | 23 | 38.3 |
| Total | 60 | 100.0 |

### 4.2.3 Marital status

The results show that out of 60 parents of disabled children interviewed, 58.3% were married, 25% were divorced, 11.6% were widows/widowers and 5.1% were single. This study shows that half of the families with a disabled child live in marriages. The observations show that the disabled children are not the first borne in their families; either they are second/third born and so on. While with divorced families their disabled children were the first born, so the man abandoned his disabled child and wife, married another woman. This applies to the single families as well, where a girl gets pregnant before marriage, and has a disabled child the man abandons her to avoid responsibilities, because disability is associated with a stigma in the society (Adedoyin, 2001).

### 4.2.4 Occupation

The results show that among the 60 respondents (parents of disabled children) interviewed, 60% were peasant farmers, 13.3% were petty traders, 10% were employed and 6.7% had other activities (e.g. house wives). The results show that most of the disabled and families with children with disability live in poverty. The UN Millennium Goals is to eradicate poverty to the disabled and families with children with disabilities by 2015 (Bowie, 2004).

**Table 2: Marital status and occupation of parents of the disabled children (N=60)**

| Marital status | Frequency | Percent |
|---|---|---|
| Married | 35 | 58.3 |
| Single | 3 | 5.0 |
| Divorced/Separated | 15 | 25.0 |
| Widow/Widower | 7 | 11.7 |
| Total | 60 | 100.0 |
| | | |
| **Occupation** | | |
| Peasant | 33 | 55.0 |
| Petty business | 10 | 16.7 |
| Employed | 9 | 15.0 |
| Other activities | 8 | 13.3 |
| Total | 60 | 100.0 |

### 4.3 Source of disability

The results in Table 3 show that 40 of the disabled persons that is 66.7%, were disabled due to disease (chronic malaria), and the remaining 20 respondents which is 33.3%, were congenital. In Tanzania children under five years have high risk of contracting malaria disease (De la Rocha, 2006), and this leads to disability.

### 4.4 Who takes care of disabled children

The majority of the disabled (73.3%) were taken care of by parents, and out of these, 31.7% were single parents, which means one of the parents died, divorced or abandoned the family, 15% by their grandmother/father and 11.7% by other relatives (sister, aunt or uncle). Most of the relatives take care because the parents either died or they are not able to take care of their disabled children (Table 3).

**Table 3: Source of disability and who takes care of disabled children (N=60)**

| Source of disability | Frequency | Percent |
|---|---|---|
| Chronic malaria | 40 | 66.7 |
| Congenital | 20 | 33.3 |
| Total | 60 | 100.0 |
| | | |
| **Who takes care** | | |
| Parents | 44 | 73.3 |
| Grandmother/father | 9 | 15.0 |
| Other relatives | 7 | 11.7 |
| Total | 60 | 100.0 |

### 4.5 Rehabilitation from the institution identified and conditions of the child before being identified

All the 60 respondents interviewed, get rehabilitation from the institution identified. The results show that more than 50% of the disabilities identified and who get rehabilitation from IBR were mild disabilities (Table 4), where they were able to help themselves, and live independently, compared to the CBR who include also severe disability. Because in the IBR it is difficult to take care of severe disability due to the demand for human resource, generally, it needs one matron for every three children (URT, 2004), compared to the CBR, where parents can take care of such children at home.

**Table 4: Condition of the child before being identified by the institution**

| Condition | CBR (n=30) | | IBR (n=30) | |
|---|---|---|---|---|
| | Frequency | Percent % | Frequency | Percent % |
| Help by himself | 13 | 43.3 | 23 | 76.7 |
| Able to hold an object | 18 | 60.0 | 25 | 83.3 |
| Able to speak a single world | 17 | 56.7 | 22 | 73.3 |
| Slept well | 28 | 93.3 | 27 | 90.0 |
| Interact with others | 14 | 46.7 | 22 | 73.3 |
| Gets bath by him/herself | 11 | 36.7 | 19 | 63.3 |
| Gets dressed without support | 9 | 30.0 | 20 | 66.7 |
| She/he used to speak often | 9 | 30.0 | 18 | 60.0 |
| She/he likes to use a sign | 7 | 23.3 | 7 | 23.3 |
| She/he can speak a short sentence | 9 | 30.0 | 19 | 63.3 |
| Able to hear | 24 | 80.0 | 28 | 93.3 |
| Saliva dropped from the mouth | 12 | 40.0 | 3 | 10.0 |
| Medicine used | 11 | 36.7 | 3 | 10.0 |
| Able to walk | 22 | 73.3 | 28 | 93.3 |

### 4.6 Services provided at the centres and at home

The services provided are as shown in the Table 5 below, where there is a slight difference in services provided in the CBR and IBR, and this is the house skills in the IBR where the child learns to participate in different activities together with other children where in CBR this service is not provided and it is left to the child to learn at home. Also, the services provided in the CBR are for a short time. from 8.00 am-12.00 noon, compared to the IBR. Also for CBR there is no vocational training. Vocational training is very important to the disabled due to the competitive markets and self reliance.

**Table 5: Services provided at the centres and at home**

| | Homes (n=30) | | Centres(n=30) | |
|---|---|---|---|---|
| **Categories** | Frequency | Percent | Frequency | Percent |
| Food | 25 | 83.3 | 30 | 100.0 |
| Pre-primary | 19 | 63.3 | 23 | 76.7 |
| Physiotherapy | 4 | 13.3 | 3 | 10.0 |
| Medical | 16 | 53.3 | 28 | 93.3 |
| Vocational training | 0 | 0.0 | 17 | 56.7 |
| Primary education | 2 | 6.7 | 0 | 0.0 |
| Sports | 17 | 56.7 | 26 | 86.7 |
| Counselling | 14 | 46.7 | 9 | 30.0 |
| Any other | 10 | 33.3 | 0 | 0.0 |
| **Services provided throughout the week** | | | | |
| Classes | 0 | 0.0 | 18 | 60.0 |
| Cleanliness | 0 | 0.0 | 28 | 93.3 |
| Cooking | 0 | 0.0 | 9 | 30.0 |
| Handcraft | 0 | 0.0 | 15 | 50.0 |
| Daily living activities | 0 | 0.0 | 29 | 96.7 |
| House care | 0 | 0.0 | 27 | 90.0 |

### 4.7 Changes after having rehabilitation from the institution

The results show that 66.7% of the respondents experienced positive changes after having rehabilitation from CBR, while the remaining percent 33.3% showed no changes, (Table 6). This is because most of them stay far from the rehabilitation centres, and due to

poverty they can't manage to travel to and from the centre to get education. Others had severe disability, what they had was 1kg of maize flour or a bar of soap if available from the centre, once per month after paying a visit to them, so they miss education and interaction that can develop the understanding. In the IBR centres all experienced changes after having rehabilitation from the centres. All disabled children stay at the centre and get behaviour modification during and after class hours, which leads them to change after a short period of time.

**Table 6: Changes after having rehabilitation (N=30)**

| Categories | Frequency | Percent |
|---|---|---|
| **CBR** | | |
| Yes | 20 | 66.7 |
| No | 10 | 33.3 |
| Total | 30 | 100.0 |

### 4.8 Satisfaction with the services provided

The results show that with CBR, 60% of respondents were satisfied with services provided while 40% of respondents were not satisfied with the services provided. Some of the respondents said that assistance like a bar of soap or 1kg of maize flour per month is not enough for the family or disabled child her/himself, while others said what they have was not enough for their children to change or to improve understanding because the time spent at the centre to get education and go back home was not enough (Table 7), let alone behaviour modification, home skills, vocation training, and physiotherapy. There were also those who said that their children were severely disabled such that they can't change so what they needed was more support like food to avoid malnutrition that could lead to secondary disability.

With IBR all 30 respondents, said there are changes to the disability because they stay at the centre and they learn different things from class and home skills where they learn how to live independently and to participate in the different activities at the centre, and at home when they go back.

**Table 7: Satisfaction with the services provided (N= 30)**

| | CBR | | IBR | |
|---|---|---|---|---|
| **Categories** | **Frequency** | **Percent** | **Frequency** | **Percent** |
| Yes | 18 | 60 | 30 | 100 |
| No | 12 | 40 | 0 | 0 |
| Total | 30 | 100 | 30 | 100 |

**4.9 Advantages children have when receiving rehabilitation at home**

One of the advantages children have when receiving rehabilitation at home was familiarisation with the environment where 21.1% of respondents agreed that children understand the environment, and challenges of the surroundings, like ability to go to school and get back home without escort, where 10.3% said they get love from their family rather than patron/matron who takes care of them in the IBR (Table 8). Another advantage was interaction with other children in the surrounding areas who play with them so they develop their minds and learn from them (14.7%). Another advantage was to be close with their families rather than to stay in the institution far from their home, at the end they forget their parents and think that the centre is where they were born. (30.9%) Also they get self management (daily living activities) at home they learn from the family activities when they are at home (21.1%).

**Table 8: Advantages children have when receiving rehabilitation at home (N = 30)**

| Advantage | Frequency | Percent |
|---|---|---|
| Familiarization with the environment | 15 | 21.1 |
| Get love from his/her family | 7 | 10.3 |
| Interaction with other children | 10 | 14.7 |
| Be close and remind her/his family | 21 | 30.9 |
| Self management (daily living activities) | 15 | 21.1 |

### 4.10 Advantages children have when receiving rehabilitation at the centre

One of the advantages mentioned was to live independently. They used to learn behaviour modification when they came to the centre where 14.4% of the respondents agreed with the statement (Table 9); they create understanding and help different activities at the centre from the outside environments up to the dormitories where they slept, these where 22% and 12.7% of the respondents, others were vocational skills and interaction with other children (11.9% and 22.9%). Disabled learn different skills according to their ability and interests where at the end they are able to provide income to their families. Another advantage was education, the disabled get education according to their ability, and if they show improvement they are introduced to primary education, when they reach 18 years old they start vocation training (13.6%). Lastly was avoiding sexual abuse as when a child stays at the centre there is security compared to staying at home where there is risk of sexual and drug abuse (2.5%).

**Table 9: Advantages of children to staying at the centre (N=30)**

| Advantage | Frequency | Percent |
|---|---|---|
| Live independently | 17 | 14.4 |
| Create understanding | 26 | 22.0 |
| Help different activities at the centre | 15 | 12.7 |
| Vocation skills | 14 | 11.9 |
| Interacting | 27 | 22.9 |
| Education | 16 | 13.6 |
| Avoiding sexual abuse | 3 | 2.5 |

### 4.11 Problems children have when staying at home

Stigmatisation is one of the problems the disabled face when they stay at home, even today some of the communities stigmatize disabled people where 56.7% of respondents agreed that stigmatisation of their disabled child was a problem (Table 10), 16.7% of the respondents mentioned the risk of sexual/drugs abuse to their children. There are some cases at Amani Centre where some girls were raped and got pregnant and remained single parents. Another 20.0% of respondents complained that they could not work they stay at home to look for their disabled children to avoid missing/abuse, whereas 13.3% of respondents mentioned the problem of children missing at home and needing close supervision for the whole day.

**Table 10: Problems children face when staying at home (N=30)**

| Problem | Frequency | Percent |
|---|---|---|
| Stigmatization from the society | 17 | 56.7 |
| Sexual/drugs abuse cases | 5 | 16.7 |
| Have grand daughter/sons who have no father | 1 | 3.3 |
| Not able to work | 6 | 20.0 |
| Child missing often | 4 | 13.3 |

### 4.12 Problems children have when staying at the centre

The results from the field showed that 10% of those staying at the centre have a problem in communication which means that they are not able to speak/pronounce well so communication and understanding each other is a problem to them (Table 11). At the same time, 2.7% have a problem of beating other children and 46.7% of the disabled are slow learners. These were big problems for most of the children at the centre. Lastly, were those who are not able to work independently which was 3.3% of the group.

**Table 11: Problem children have when staying at the centre (N= 30)**

| Problem | Frequency | Percent |
|---|---|---|
| Communication not able to speak | 3 | 10.0 |
| Beating others | 2 | 6.7 |
| Slow leaner | 14 | 46.7 |
| Not able to work independently | 1 | 3.3 |

### 4.13 Acceptability by neighbours of disabled children

The results show that out of 30 parents of disabled children 76.7% said that their neighbours perceived their disabled children positively whereas the remaining 23.3% perceived their children negatively, due to the following reason; - that they were different from the others (6.7% of respondents), it was a curse to have disabled children (3.3%) and others said that they were dirty so they didn't like them which was 3.3% of the respondents.

### 4.14 Preference of the parents on rehabilitation of their disabled children

The results from the field show that 43.3% of parents who stay with their disabled children, prefer their children to have rehabilitation at home rather than at an institution (Table 12). This is because they want to be close with their children and give love to them; also they need to have rehabilitation from the family. The remaining 56.7% like their disabled children to have rehabilitation from an institution, because they can have close rehabilitation from the institution to avoid stigmatisation from the surrounding society and they can be free to work. This is contrary to the WHO, UN and Tanzania government policy for disability that promote CBR for persons with mental and physical disabilities.

**Table 12: Preferences of parents on rehabilitation of their disabled children (N=30)**

| Preference | Frequency | Percent |
|---|---|---|
| Rehabilitate at home | 13 | 43.3 |
| Rehabilitate at the centre | 17 | 56.7 |
| Total | 30 | 100.0 |

### 4.15 Reasons for the children to be rehabilitated at the centre

The children were rehabilitated at the centre and not at home due to the following reason: their parents died which was 13.3% of respondents; no one to take care (6.7%) of respondents; to get close rehabilitation (26.7%); to avoid stigmatisation from the society (3.3%); and because there were no rehabilitation centres near home (43.3%).

### 4.16 Charges for services that children have from the centre

The results showed that 76.7% of respondents said the service they receive with CBR is free of charge and the remaining 23.3% said they have to contribute 20kg of maize per year (Table 13). In fact for the service provided in CBR institution they have to contribute food every year.

For IBR they have to pay Tshs. 10, 000 per year for Mihayo Centre at Mazimbu, and in Bethlehem they have to pay Tshs. 250, 000 per year and for those who do not pay they have to wait until they have the fee, except those who fund raise for the Centre.

**Table 13: Charges from the services that child have from the centre (N=30)**

| | CBR | | IBR | |
|---|---|---|---|---|
| **Charges** | **Frequency** | **Percent** | **Frequency** | **Percent** |
| Free of charge | 23 | 76.7 | 10 | 33.3 |
| Not free of charge | 7 | 23.3 | 20 | 66.7 |
| Total | 30 | 100.0 | 30 | 100.0 |

### 4.17 Challenges faced in caring for a disabled child at home

The results show that challenges facing the disabled children at home are as follows (Table 14): Parents are not able to work because they have to stay at home and take care of disabled children (36.7%), where as 20% of respondents said it is difficult to take care of the disabled children especially mentally disabled child, because this needs love and

patience, others, 23.3%, said it is challenging to watch/care for a disabled child like a baby for the whole life, and 40% of respondents said nowadays disabled children were the victims of sexual/drug abuse especially the girls. It was a challenge to the parents to watch after them. Lastly, the majority of respondents (90%), said poverty is a big challenge for them since it limits the education and health level of their children which often leads to secondary disability to their children.

**Table 14: Challenges faced in caring for children at home (N = 30)**

| Challenges | Frequency | Percent |
|---|---|---|
| Not able to work | 11 | 36.7 |
| Need love and patience to stay with disabled | 6 | 20.0 |
| To watch her/his as a child for the whole life | 7 | 23.3 |
| Poverty | 27 | 90.0 |
| Sexual/ Drug abuse | 12 | 40.0 |

### 4.18 Challenges the centres face in their work

The results show that 23.3% of respondents said teachers got stigmatized from the society by calling them "matahira" or "walimu wa mataahira" in front of people. About 66.7% said there was no cooperation from the parents, if you call a meeting few of them respond, and participate, most is left to donors, meaning they are not responsible to take care of the disabled children, little cooperation from the government which was 53.3%. Private institutions have no support from the government like grants, teachers, facilities, materials for disability etc, where 50% of the institutions have a challenge of sexual abuse to the disabled so they have to take care of them when they are at the compound and during the holidays. Lastly, 40% mentioned that there was no curriculum for mentally disabled children, so each institution has to teach according to what donors want (Table 15).

**Table 15: Challenges the centres face in their work (N = 30)**

| Challenges | Frequency | Percent |
|---|---|---|
| Teachers get stigmatisation from the society | 7 | 23.3 |
| No cooperation from the parents | 20 | 66.7 |
| No cooperation from the government | 16 | 53.3 |
| Sexual abuse to disabled | 15 | 50.0 |
| No curriculum for mentally disabled children | 12 | 40.0 |

### 4.19 Teachers' education level

The results reveal that teachers' qualified to teach the disabled in these institutions have different levels of education from standard seven which is 28.6% and they teach by experience of taking care of children, 28.6% have secondary education while another 28.6% have certificate in Montessori and 14.3% have a diploma in special education. This was not enough to address the majority of disabilities in the institutions.

### 4.20 Teachers' preference of the services provided in the institutions

The results were given different scores using a Likert Scale, in which the highest score was 35 and lowest score was 5 to each of the services provided in the institutions, the highest scores show the preferences of the teachers on the methods of teaching and services needs to be provided in the institution as shown on in Table 16 below:

**Table 16: Teachers score on the services provided in the institution**

| Categories | Score |
|---|---|
| Provide cancelling | 34 |
| Identification of talents/hobbies of the individual | 34 |
| Conducting tours as a part of study to disabled | 34 |
| Mixing normal and disabled children | 34 |
| Medical rehabilitation | 34 |
| Sports | 34 |
| Using pictures than words | 34 |
| Food and Nutrition | 33 |
| Income generating to disable families | 33 |
| Physiotherapy rehabilitation | 33 |
| Social rehabilitation | 33 |
| Identification and assessment of disability | 32 |
| Vocation training | 32 |
| Independent living | 32 |
| Pre-primary | 31 |
| Prevention of disability/secondary disability | 30 |
| Habit of visiting each other | 29 |
| Primary education | 25 |
| Mixing together mildly and severely disabled children | 17 |
| Staying in a confined environment | 14 |
| No involvement in different activities to avoid accident | 13 |
| Beating a disabled as a method of understanding | 10 |

The highest scores (34), means teachers preferred that method of teaching as the method that should be used on teaching disabled children in the institutions, and the lowest score was 10 which means not preferable as a method of teaching in the institutions.

### 4.21 Teachers' opinions on the service being provided by institution

The results reveal that even though the services provided were enough to make the disabled self reliant but facilities are not enough to fulfil the target provided. Also, teachers need training often to make them up to date on handling mental disabilities, lastly there was need to introduce projects or income generating activities in the centres in order to be self reliant and not donor dependant.

# CHAPTER FIVE

# CONCLUSIONS AND RECOMMENDATIONS

This chapter presents the conclusions and recommendations on the findings of the study. The conclusions and recommendations are based on the objectives of the study with the view of providing information on approaches that can be taken for caring persons with disabilities under Tanzanian conditions.

## 5.1 Conclusions

Based on findings the following conclusions are made.

### 5.1.1 A comparative assessment of IBR and CBR.

- It was found that the two approaches are different in that IBR puts emphasis on how to live independently and to acquire skills, while CBR puts emphasis on understanding and living at home.

- CBR in Morogoro performs poorly compared to the strategies of CBR that are known globally, for it tends to put emphasis on education (day care) alone rather than eradicating poverty to the disabled and their families. Furthermore there is no participation of the disabled and community in their programmes.

### 5.1.2 Services aimed at persons with disabilities

- Services provided in CBR include: pre-education (day care), counselling, health or medical and sports, this is insufficient for what CBR needed to provide, while services provided in IBR include: pre-education (day care), counselling, health or medical, sports, vocation training, behaviour modification and house care.

- Institution Based Rehabilitation (IBR) tends to rehabilitate those with mild disabilities and who can help themselves compared to the Community Based Rehabilitation (CBR) that provides rehabilitation for both severe and mild disabilities. For severe disabilities, CBR tends to provide assistance at home, food, clothes, and pay visits to the disabled children either once per month or once after two months depending on the distance from the centre.

### 5.1.3 Effects of different services provided to persons with disabilities

- The disabled from the rural areas tend to have inadequate or poor rehabilitation compared to the disabled in towns. This is because most of the centres are located in town, and provide rehabilitation in the rural areas, so what they provide to them is poor services and the remote villages tend to have no rehabilitation at all for their disabled.

- There are changes for those disabled children who attend the day care at the centres and go back home in terms of understanding and interaction, but there are no changes for those who have been provided that service at home with community workers, since what they provide is greeting, aid like food or a bar of soap and this is once per month or once after two months.

- All disabled in the Institution Based Rehabilitation show changes in what they like and dislike and participate in different activities at the centre, compared to when they are at home.

### 5.1.4 The relative advantages of CBR and IBR

- The advantages children have when receiving rehabilitation at home (CBR) are familiarisation with the environments and challenges of the surroundings, self management (daily living activities) and to stay close with their families while advantages that children have when receiving rehabilitation in the institutions (IBR) are to live independently, behaviour modification, vocational skills, social interactions and avoiding sexual abuse.

- The stigmatisation of disabilities and sexual abuse to mentally disabled, girls is a problem for children who stay at home. While in IBR communication, slow leaning and habits of beating each other is a problem.

- There is no support or cooperation from the government, and no curriculum for education for the disabled in Tanzania, every institution provides education according to donor preferences.

- There is no good cooperation between parents of the disabled children and institutions that provide rehabilitation. Parents believe that the institutions are responsible 100% to take care of their children, because they get fund from the donors.

- Most of the teachers in the institutions are not qualified for the job; they just use an experience of rearing the children as an advantage.

## 5.2 Recommendations

- Approaches for both IRB and CBR need to be the same, in terms of quality and quantity of services provided, because both aim at making the disabled independent and to acquire skills according to their interests.

- CBR approaches should aim at meeting Millennium Development Goals, that is to eradicate poverty for the disabled and their families, and should involve the community nearby in the issues of disability, especially on their rights.

- CBR should be implemented in the rural areas, and to identify where the disabled live and should provide services to them according to their needs rather than to be implemented in towns and only occasionally provide service in the rural areas and areas near towns.

- All mentally and physically disabled have a right to get rehabilitation from the institutions regardless of the severity of their disability, therefore, IBR has to include both severe and mild disability.

- CBR is preferable for people with disabilities who stay in the rural areas, for those who stay far away from the institutions and for severe disabilities who have no ability to work or help by themselves.

- Vocation skills should be included in CBR, not only for familiarisation with the environment, but also to get skills according to their interests.

- Sensitization on the rights of disability is needed in the community, that disabled children have rights like normal children, to get love from the society, not to be segregated and to live alone in the institutions.

- Disabled people should be protected from sexual and drug abuse especially the mentally disabled, and every person in the community has a responsibility for the protection of the disabled against sexual or drug abuse.

- The government should cooperate with non governmental institutions by training and providing professional teachers, and paying their salaries, also provide grants to the non governmental institutions, this will reduce the cost of running the centres, and therefore, the fees will be affordable to the poor families especially for the IBR.

- The government should make follow ups on the implementation of activities in CBR especially for those in rural areas.

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# APPENDICES

**Appendix 1: Questionnaire for Community Based Rehabilitation**

Questionnaire for parents or relatives who take care of disabled child or children, getting Rehabilitation at home.

**Study area** **Date** _____

District_____Division_____Street/village_____

**A. Backgrounds information**

1. Name of the child_____2. Age_____yrs 3. Sex_____
4. Religion
   - i) Christian
   - ii) Moslem
   - iii) Others, specify
5. Where was your child born?
   - i) Within the Municipality_____
   - ii) Outside the municipality/town, specify_____
6. What is your marital status?
   - i) Married
   - ii) Single
   - iii) Divorced/ Separated
   - iv) Widow/widower.
7. What is your occupation?
   - i) Peasant
   - ii) Petty business
   - iii) Employed
   - iv) Other activities.

**B. General over view on disabled children**

8. Is the disability of your child congenital i) Yes ii) No
9. If No. How did he/she get disability_____
10. Who takes care of this disabled child _____
11. Is he/ she identified by any institution that deals with disability? i) Yes ii) No
12. If yes, which institution_____
13. Does he/she get rehabilitation from the institution identify? i) Yes ii) No
14. If yes, which services are provided?
    - i) Food
    - ii)Pre-primary
    - iii) Physiotherapy
    - iv) Medical

v) Vocation training
vi) Primary education
vii) Sports
viii) Counselling
ix) Any other (specify)_____

15. How often do they visit your child per week?

i) Once per week.
ii) Twice per week
iii) Three times per week
iv) Every day
v)Any other (specify)_____

16. What was the condition of your child before being identified by the institution?

| Condition | Yes | No |
|---|---|---|
| 1. Help by him/herself | | |
| 2. Able to hold an object | | |
| 3. Able to speak single world | | |
| 4.slept well | | |
| 5.Interact with others | | |
| 6. Get bath by him/herself | | |
| 7. Get dressed without support | | |
| 8. She/he used to speak often | | |
| 9.She/he likes to use a sign | | |
| 10.She/he can speak a short sentence | | |
| 11. Able to hear | | |
| 12. Saliva dropped from the mouth frequently | | |
| 13. Medicine used | | |
| 14. Able to walk | | |
| 15. Others (specify)..... | | |

17 How long has your child obtained services from institution mentioned? _____

18. Have you observed any changes after having rehabilitation from the institution?

i) Yes
ii) No

19. If yes which changes?

| Changes | Yes | No |
|---|---|---|
| 1. He/she identified an object | | |
| 2. Able to connect that object | | |
| 3. She/he can identify numerical 1-5... 5-10 | | |
| 4. Able to identify numerical in wealth | | |
| 5. To identify consonants | | |
| 6. To write a vowel | | |
| 7.Eat by him/herself | | |
| 8. Walk | | |
| 9.help by him self | | |
| 10. Live independently | | |
| 11. Able to create an object | | |
| 12. Able to help in different activities at home | | |
| 13. Able to speak | | |
| 14. Able to identify and differentiate things | | |
| 15. Others specify ---------- | | |

20. Do you think the services your child is getting are satisfactory? i) Yes ii) No

21. If No why_____?

22. What need do you prefer your child to gate from the centre_____?

23. What advantages does your child have in receiving rehabilitation when he/she is at home?

i) ------- ----- iii) ----------
ii) ---------- iv) ----------

24. What problems do you face when this child stays at home?

i) ---------- iii) ----------
ii) ---------- iv) ----------

25. Do your neighbour perceive positively/negatively to your disabled child?

i) Yes ii) No

26. If no why? (Explain)_____

27. Will you prefer your child to stay at home rather than in institution? i) Yes ii) No

28. If Yes why (Explain)_____

29. If no why (Explain)_____

30. The service that your child has from the centre, is free of charge? i) Yes ii) No

31. If no how much do you pay per year as a fee?

32. What challenges do you face in caring for your child at home?

i) _____ iii) _____
ii) _____ iv) _____

**Appendix 2: Questionnaire for Institutional Based Care**

Name of the centre_____ Date_____

**A. Background information**

1. Name of the child_____ **2. Age_____ yrs 3. Sex_____**

4. Religion

i) Christian iii) Others, specify_____

ii) Moslem

5. Where was this child borne?

i) Within the Municipality

ii) Outside the municipality/town, specify_____

**B. Back ground information about parent (Mother/Father)**

6. What is the marital status?

i) Married iii) Divorced/ Separated

ii) Single iv) Widow/widower

7. Occupation of his/her parent

i) Peasant iv) Employed

ii) Trader v) Other activities_____

iii) Petty business

8. His/her parent alive i) Yes ii) No

9. If no who was taking care before she/he came here to the centre_____

**B. General overview of the disabled children**

10. Is he/she identified by the centre? i) Yes ii) No

11. If no explain _____

12. What is the condition of the child, before being identified?

| Propose Conditions | Yes | No |
|---|---|---|
| 1. Help by him/herself | | |
| 2. Able to hold an object | | |
| 3. Able to speak single world | | |
| 4.sleep well | | |
| 5.Interact with others | | |
| 6. Get bath by him/herself | | |
| 7. Get dressed without support | | |
| 8. She/he used to speak often | | |
| 9.She/he likes to use a sign | | |
| 10.She/he can speak a short sentence | | |
| 11. Able to hear | | |
| 12. Saliva dropped from the mouth frequently | | |
| 13. Medicine used | | |
| 14. Able to walk | | |
| 15. Others (specify) ---------- | | |

13. How long has the child stayed at the centre? ----------

14. What services does the centre provide to this child?

i) Pre-primary
ii) Counselling
iii) physiotherapy
iv) Health/ medical
v) Sports
vi) Vocation training
vii) Any Other

15. What services are provide throughout the week?

16. Have you observed any changes after having rehabilitation from the centre

i) Yes ii) No

17. If yes which changes

| Changes Proposed | Yes | No |
|---|---|---|
| 1. He/she identified an object | | |
| 2. Able to connect that object | | |
| 3. She/he can identify numerical 1-5... 5-10 | | |
| 4. Able to identify numerical in wealth | | |
| 5. To identify consonants | | |
| 6. To write a vowel | | |
| 7.Eat by him/herself | | |
| 8. Walk | | |
| 9.help by him self | | |
| 10. Live independent | | |
| 11. Able to create an object | | |
| 12. Able to help you different activities at home | | |
| 13. Able to speak | | |
| 14. Able to identify and differentiate things | | |
| 15. Able to interact/cooperate with others | | |

18. If No, (From Qn 16) Why? _____

19. Does she/he pay any fee for this services I) Yes ii) No

20. If yes How much_____

21. If No why_____

22. The services provided by the centre, are preferable for rehabilitation to this disabled child? I) Yes ii) No

22. If no why? _____

23. Is the disabled child used to interact with normal children? i) Yes ii) No

24. What problem will the child face when he/she stays at the centre _____

25. What is advantage having this child to stay at the centre? _____

26. Why is the child not being rehabilitated at home? _____

27. What challenges does the centre face in their work?

i) _____ iii) _____

ii) _____ iv) _____

**Appendix 3: Questionnaire teachers in the centres**

1. Age _____ 2. Sex _____

3. Level of education_____

4. Do you have the professional qualifications to teach physically and mentally disabilities children i) Yes ii) No

5. Which are the following services provided by the centre?

| **Services** | **Yes/ No** |
|---|---|
| 1. Provide cancelling | |
| 2. Food and Nutrition | |
| 3. Medical rehabilitation | |
| 4. Pre- primary | |
| 5. Primary education | |
| 6. Vocation Trainings | |
| 7. Habit of visiting each other | |
| 8. Sports | |
| 9. Independent living | |
| 10. Identification and assessment of disability | |
| 11. Prevention of disability/ secondary disability | |
| 12. Social rehabilitation | |
| 13. Income generating to disabled families | |
| **Methods of teaching** | |
| 14.Mixing together mildly and severely disabled children | |
| 15. Mixing normal and disabled children | |
| 16. Using pictures than words | |
| 17. Beating a disabled as a method of understanding | |
| 18. Staying in a confined environment | |
| 19. Identification of talents/hobbies of the individual | |
| 20. Physiotherapy rehabilitation | |
| 21. Conducting tours as a part of study to disabled | |
| 22. No involvement in different activities to avoid accident. | |

6. Likert scale to find the opinions of teachers on the services /methods of teaching in the institutions that deals with disabilities.

| Opinions | Strongly disagree (1) | Disagree (2) | Undecided (3) | Agree (4) | Strongly Agree (5) |
|---|---|---|---|---|---|
| 1. Provide cancelling | | | | | |
| 2. Food and Nutrition | | | | | |
| 3. Medical rehabilitation | | | | | |
| 4. Pre- education | | | | | |
| 5. Primary education | | | | | |
| 6. Vocation Trainings | | | | | |
| 7. Habit of visiting each other | | | | | |
| 8. Sports | | | | | |
| 9. Independent living | | | | | |
| 10.Identification and assessment of disability | | | | | |
| 11. Prevention of disability | | | | | |
| 12. Social rehabilitation | | | | | |
| 13. Income generating to disabled families | | | | | |
| **Methods of teaching** | | | | | |
| 14.Mixing together mild and severe disabled | | | | | |
| 15. Mixing normal and disabled Children | | | | | |
| 16. Using pictures than words | | | | | |
| 17. Beating a disabled as a method of understanding | | | | | |
| 18. Staying in a confined Environment | | | | | |
| 19.Identification of talents/hobbies of the individual | | | | | |
| 20. Physiotherapy rehabilitation | | | | | |
| 21. Conducting tours as a part of study to disabled | | | | | |
| 22. No involvement in different activities to avoid accident. | | | | | |

5. Your pinions for the centres, that take cares to disabilities?_____

**Appendix 4: Questions to the manager of the centre**

Name of the centre._____

1. Name of the officer_____ Title _____

2. Age_____ 3. Sex _____

4. Education level

   i) Primary education  iii) Post secondary

   ii) Secondary education

5. For how long have you been working with disabled children_____?

6. Have you ever worked in other centres apart from the one you are working now?

   i) Yes  ii) No

7. How do you identify the children?

8. Which services are offered by the centre?

9. Why do you think the parents prefer their children to stay at the centre rather than at home?

10. What are the problem facing your centre?

11. What is the source of fund for running this centre?

12. Which support do you get from the government in dealing with the disabled?

13. What is your future plan in dealing with mental and physical disabilities?

14. What is your advice for taking care of the disabled?

i) Government  ii) Parents  iii) Community