

**MIDLANDS STATE UNIVERSITY
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**CHALLENGES AND OPPORTUNITIES FOR DISABLED CHILDREN'S RIGHTS
IN ZIMBABWE: AN ANALYSIS OF THE EDUCATIONAL AND HEALTH
RIGHTS OF CHILDREN WITH CEREBRAL PALSY IN HARARE'S HIGHFIELD
HIGH DENSITY SUBURB**

BY

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ABSTRACT

This study examined the extent to which the educational and health rights of children with disabilities (Cerebral Palsy) are being met in Zimbabwe, in general, and in Harare's Highfield Suburb, in particular. The study was motivated by the fact that, in most parts of Africa children with disabilities and their families constantly experience barriers to the enjoyment of their basic human rights and to their inclusion in society. Objectives of the study were to examine the adequacy of legal framework for ensuring access to education and health by children with disabilities, in general, and those with Cerebral Palsy, in particular, to establish if there are appropriate institutional structures for promoting the educational and health rights of children with Cerebral Palsy in Highfield High Density Suburb in Harare, and to establish if schools in Highfield High Density Suburb have appropriate facilities to cater for children with Cerebral Palsy. Other objectives were to establish if there are appropriate health institutions and facilities to cater for the health needs of children with Cerebral Palsy, and to propose options for enhancing the educational and health rights of children with Cerebral Palsy. The study was significant to children with Cerebral Palsy. The research was being done in order to promote the educational and health rights of children with Cerebral Palsy. Moreover, the study aimed to add to the existing body of knowledge on the rights of children living with disabilities. Findings of the study, if adopted, could advance the body of knowledge on the rights of children with disabilities. The study also provides a platform for on-going research on how the rights of children with disabilities can be realised. There was review of literature on Cerebral Palsy, what it is, its types, and causes. Focus was also on a review of literature on children's rights to education and health, and the legal framework. The study also reviewed literature to access to education by children with disability, in general, and with Cerebral Palsy, in particular. There was also a discussion on the right to health by children with Cerebral Palsy. In this study, the research design used was a survey. The population consisted of educational, health practitioners, and parents/guardians in Highfield High Density Suburb. Purposive sampling was utilised to select 100 participants from four residential areas. Data for this research was collected using key informant interviews and focus group discussions. The study found out that has a negative attitude towards people with disability. It therefore, becomes difficult for policy makers to enact appropriate legal framework to cater for the health and education need of children with Cerebral Palsy because the policy makers are also part of society. Even the parents of children with Cerebral Palsy have negative attitudes towards the education of their own children most probably as a result of traditional beliefs that create non-supportive parental behaviours. This could be a result of an educational system that is far removed from societal issues and problems. It was recommended that the needs of children with Cerebral Palsy be met through mainstream programmes and services. In addition to mainstream services, children with Cerebral Palsy may require access to specific measures, such as rehabilitation, support services, or training. There is also a need for a national rehabilitation strategy. The need to improve human resource capacity was another recommendation. Moreover, there is a need to provide adequate and sustainable funding of publicly provided services. In addition, it is vital for all stakeholders to translate policy into action.

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CHAPTER I

THE PROBLEM AND ITS SETTING

1.1 Introduction

This study examines the extent to which the educational and health rights of children with Cerebral Palsy are being met in Zimbabwe, in general, and in Harare's Highfield Suburb, in particular. This chapter highlights the following features of the research, that is, background to the study, statement of the problem, research objectives, and research questions. It also focused on the significance of the study, delimitation of study, conceptual framework, research limitations, and definition of key terms.

1.2 Background to the Study

The year 2014 marked 25 years or silver jubilee anniversary on the adoption of the United Nations Convention on the Rights of the Child (UNCRC). According to United Nations Children's Fund (UNICEF, 2007), the African Charter on the Rights and Welfare of the Child (ACRWC) was born out of the feeling by African member states to the United Nations that the drafting of the CRC missed important socio-cultural and economic realities of the African experience. The African Charter stresses on the need to include African cultural values and experience whenever discussing or considering issues pertaining to the rights of the child in Africa. The ACRWC was adopted by the Assembly of Heads of States and Government of the African Union in 1990 and Zimbabwe signed

this Charter in January, 1992. By ratifying both the UNCRC and the ACRWC, the Government of Zimbabwe committed itself to implement the provisions of both instruments (Munemo and tom, 2013).

In addition, the UNCRC and ACRWC are efforts to ensure that children, as human beings, are guaranteed their basic human rights. Human rights are inalienable fundamental entitlements given to a person simply because she or he is a human being. Human rights are rights inherent to all human beings, whatever their nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. People are all equally entitled to human rights without discrimination. Human rights are often expressed and guaranteed by law, in the forms of treaties, customary international law, general principles and other sources of international law. International human rights law lays down obligations of Governments to act in certain ways or to refrain from certain acts, in order to promote and protect human rights and fundamental freedoms of individuals or groups (Human Rights Watch, 2012). All human rights already apply to all people, irrespective of disability. For instance, the United Nations Universal Declaration on Human Rights (UDHR) declared that every child has a right to education, to ensure their growth and development, to fulfil their individual potential (UN, 2009).

Moreover, rights of children are applicable to all young persons, irrespective of whether they are disabled or not. Accordingly, in 2006, the UN General Assembly adopted the Convention on the Rights of People with Disabilities (CRPD). A wide range of

stakeholders, including persons with disabilities and their representative organisations, representatives of governments and the UN participated in its development and continue to advocate for universal ratification. By March 2009, 139 States had signed the convention and 50 had ratified it while 82 States had signed the optional protocol and 29 had ratified it. The CRPD entered into force on 3 May 2008.

In addition to ratifying international protocols, efforts to guarantee rights of disabled persons have been made at the level. The Constitution of Zimbabwe (2013) provides that resources should be availed to ensure that people with disabilities realise their full mental and physical potential. The Zimbabwe Education Act (Chapter 25:04 of 1987) outlines the fundamental right of every child to education regardless of their physical, social and economic status. The Disabled Persons Act (Chapter 17:01 of 1992) also lists the responsibilities of the National Disability Board as “to give effect to any international treaty or agreement on welfare or rehabilitation of persons with disabilities”. However, there are limited financial resources for the establishment of facilities to cater for the needs of disabled children. Measures to be put in place include providing special facilities for education of people with disabilities. The Disabled Persons Act (2001) also provides for equal opportunities for people with disabilities.

However, irrespective of various international and legal frameworks, UNESCO’s Global Monitoring Report on Education for All (EFA) published in 2007 estimated that 77 million children (aged 6-11 years) do not attend school and that approximately one-third

of these out-of-school children are disabled. The other two thirds are said to be children from poor families who live in poor households and whose mothers have no education. The estimated 1 billion people who live with a disability face a multitude of barriers to participating equally in society (Walker, 2011). In particular, their right to education is often not realised, which in turn hinders their access to other rights and creates enormous obstacles to reaching their potential and effectively participating in their communities. Globally, an estimated 93 million children, or 1 in 20 of those aged up to 14 years of age, live with a moderate or severe disability. In most low and middle income countries, children with disabilities are more likely to be out of school than any other group of children. Children with disabilities have very low rates of initial enrolment. Even if they do attend school, children living with disabilities are often more likely to drop out and leave school early. In some countries, having a disability can more than double the chance of a child not being in school, compared to their non-disabled peers (Save the Children Sweden, 2009).

In addition, according to the Zimbabwe Education Act (Chapter 25:04 of 1987) all children have the right of education. The Act provides that there should be no discrimination in the provision of primary education in Zimbabwe. However, the Act fails to articulate the provision of education to persons with disability. The education of persons with disability has been left to be addressed by the Disabled Persons Act. However, effective implementation seems to be a major challenge. At the same time Zimbabwe opted for inclusive education as a policy that would lead to the avoidance of

discrimination in schools when it accepted the provisions of the CRC, the Copenhagen Declaration on Social Development, the Salamanca Statement and Framework for Action and the Dakar Framework for Action (Hapanhengwi-Chemhuru, 2009). All children must be able to go to schools nearest them or schools of their choice without impediments being put in their way. However, the continued existence of specialised, that is, segregated schools for people with disability precludes inclusivity. At the same time very few teachers in ordinary schools have the necessary skills to be able to work with pupils with special educational needs.

However, it is very difficult to ensure equal opportunities for all if children with disabilities do not receive adequate education. According to Munemo and Tom (2013), a stroll in the streets of urban centres in Zimbabwe reveals that there are many people with disabilities either begging or doing nothing at all. The same scenario applies in rural areas where people with disabilities are a source of pity and are idle most of the time.

Education is important in a person's life. Attending school and formalised education in nonschool spaces provides continuity and social interaction for all children, with or without disabilities. Children with disabilities have gifts and weaknesses, as do children without disabilities. The role of education should be to try to reinforce the abilities of all children and strengthen and support all children's potential for learning (Langam, 2005). Equal opportunities mean that children with disability should have an equal right to attend school. Education is a basic right and making education inclusive can improve

access and quality for all, within low resource levels. It is not an expensive luxury. For example, in school, teachers commonly believe that they need specialist skills to teach children with disabilities whereas in practical terms this is not necessarily the case (Filmer, 2008).

Moreover, just like education, health is a basic human right. Accordingly, the CRC provides that state parties shall recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. In addition, state parties shall pursue full implementation of this right and, in particular, shall take appropriate measures to diminish infant and child mortality. Member countries also need to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care, and to combat disease and malnutrition, including within the framework of primary health care (UNICEF, 2007).

However, children with Cerebral Palsy have special health needs. They require specialized treatment and facilities in order for them to lead 'normal' lives. Nevertheless, developing countries like Zimbabwe may lack the necessary institutions and facilities to cater for the health needs of children with Cerebral Palsy.

In the light of the preceding arguments, this study analyses the extent to which the educational and health rights of children with Cerebral Palsy (disability) are being met in Harare's Highfield High Density Suburb. According the preliminary results of the Living Conditions for People with Disability Survey (Commissioned by UNICEF and Ministry of Health , Rehabilitation Services Department (2013) Cerebral Palsy is the most common motor disability in young people, this has been corroborated by the Children's Rehabilitation Unit (Harare Hospital) which has a database of children with disabilities in Harare (61% of 12386 Children). Cerebral Palsy comprises of a group of conditions, heterogeneous in causation and manifestations, grouped together. Cerebral Palsy is not one condition. Rather, the term describes a wide range of disorders and developmental disabilities that can arise from damage to a child's developing brain before, during or shortly after birth. The damage occurs in a region of the brain that controls muscle functions. Therefore, people with Cerebral Palsy might have problems with motor skills (control of muscle movement), muscle tone (abnormally stiff or loose muscles), muscle weakness, reflexes, and balance (Himmelman, 2005).

According to Odding, Rowbroeck, and Stam (2006), key risk factors for the development of Cerebral Palsy are low birth weight, intrauterine infections, multiple gestations and trauma to the head during birth. Griffiths and Clegg (1988:11) defined Cerebral Palsy as; "a persistent but not unchanging disorder of posture and movement, caused by damage to the developing nervous system, before or during birth or in the early months of infancy." Stokes (2004) stated that the different classifications of Cerebral Palsy are based on two

things, the impairment and the distribution of this impairment. The impairment can be 'spastic', 'dyskinetic', or 'ataxic'. Spastic Cerebral Palsy is caused by damage to the cortex, the child will be stiff in one or more limbs and may have involuntary movements. Dyskinetic or athetoid Cerebral Palsy is caused by damage to the basal ganglia or cerebellum, the main symptom is low muscle tone resulting in one or more floppy limbs. Lastly, ataxic Cerebral Palsy is caused by damage to the cerebellum and results in shakiness and random movements (Stanton, 1992). However, regardless of the classifications, all people with Cerebral Palsy will have a degree of decreased mobility. Children with Cerebral Palsy are significantly weaker than their able bodied counterparts (Murphy and Carbone, 2008). In addition, they often have deformities at the joints. Stanton (1992) stated scoliosis (distortion of the spine) is the most common deformity in children with Cerebral Palsy followed by hip deformities. Therefore, children with Cerebral Palsy have special needs in terms of educational facilities.

In addition, some children with Cerebral Palsy experience cognitive difficulties because the damage has affected multiple areas of the brain. Muscle-tone and motor-skill impairments can also affect cognitive development. If a child has trouble moving independently, it might be difficult to participate in some of the typical childhood activities that foster learning (Murphy and Carbone, 2008). Accordingly, special facilities are required if the children are to realize their basic human right to education.

Furthermore, Cerebral Palsy affects people from all social backgrounds and ethnic groups. According to a United States (US) based organization that provides care for people with Cerebral Palsy, Gillette Children's Specialty Healthcare (2010), about 0.2% (2 in every 1,000) of children born in the US has Cerebral Palsy. In the United Kingdom (UK), statistics show that 0.25% (one in every 400) children is affected by Cerebral Palsy. The statistics from UK is means about 1,800 babies are diagnosed with Cerebral Palsy in the UK every year (Gillette Children's Specialty Healthcare, 2010).

Cerebral Palsy cannot be cured but treatment will often improve a child's capabilities. Many children go on to enjoy near-normal adult lives if they receive early intervention services and their needs are properly managed. Also, it is important to understand that no two children with Cerebral Palsy are alike, just as no two children without disabilities are alike. These strategies have been shown to be effective with many children with Cerebral Palsy, but certainly not with all children. Individualization should be paramount when creating strategies and plans for instruction. There could be early intervention services (services that begin before a child is 3 years old) children have a greater chance at overcoming some of the symptoms of Cerebral Palsy, as well as learning new ways to accomplish challenging tasks. Physical and occupational therapy, speech therapy, braces and other orthotic devices, wheelchairs and rolling walkers, and communication aids such as computers with attached voice synthesizers, should all be therapies to explore in order to support a child's development. After provision of early intervention services, there is need for the provision of accessible classroom activities (ACA). This study shall mainly

focus on ACA, which is about making sure that a child with Cerebral Palsy has access to their classroom environment.

According to Gillette Children's Specialty Healthcare (2010), ACA is critical to creating an inclusive classroom setting. Rearranging the furniture so that a child using a walker or wheelchair can maneuver in and out of learning centers; making sure that items can be reached by all children; and modifying classroom activities to meet the unique needs of your students are all essential to creating a supportive and accessible environment for children with Cerebral Palsy. Moreover, fatigue is a factor in many medical and physical conditions, including Cerebral Palsy. If a child shows signs of fatigue it is important to exclude an underlying medical condition, such as anaemia. The school may need support in identifying the correct rest/exercise balance to ensure that they are supporting the child appropriately. All those involved with the child should contribute to the overall physical management plan, which should be reviewed regularly. In addition, some children with Cerebral Palsy may suffer from memory difficulties, so lessons planned well in advance can ease the learning journey for the child. Planning ahead is a fact of teaching life, with the year planned in advance and the lesson details planned six to 12 weeks ahead. This commitment to planning allows teachers and parents to consider in advance any particular needs a child may have with memory difficulties and how to tackle them. When planning, many factors regarding the child should be taken into account (Gillette Children's Specialty Healthcare, 2010).

The preceding paragraphs showed that children with Cerebral Palsy have special requirements in order for them to be able to learn. Access to education for children with Cerebral Palsy entail provision of tailor made facilities like furniture, walkers, wheelchairs, and that the pace of learning is slow. Financial resource limitations could compromise the provision of adequate facilities for children with Cerebral Palsy. Accordingly, despite the existence of legal framework, children with Cerebral Palsy could be failing to access educational and health facilities, a contravention of their basic rights as human beings. The study seeks to assess the extent to which the educational and health rights of children suffering from Cerebral Palsy in Highfield High Density Suburb are being met.

1.3 Statement of the Problem

In most parts of Zimbabwe children with disabilities and their families constantly experience barriers to the enjoyment of their basic human rights and to their inclusion in society. Their abilities are generally overlooked, their capacities are underestimated and their needs are given low priority. In particular, their rights to education and health are often not realised, which in turn hinders their access to other rights and creates enormous obstacles to reaching their potential and effectively participating in their communities. People with disabilities often find themselves excluded from the development agenda, according to The Living Conditions for Persons with Disability Survey (2013) puts that 7% of Zimbabwe's population (13 million people) are living with disabilities of which more than 600 000 of them are children, leaving 7% of the population out of the

development agenda is a travesty. Education and Health service provision `make the most basic indicators of development, a country's development is of often negatively affected by lack of service delivery to minorities like persons with disabilities. In the case of Zimbabwe lack of access to health and education by persons with disabilities deprives 7% of the population of the basics of development. Disability then becomes inextricably interwoven with the development discourse. In the same respect Zimbabwe has adopted legal frameworks for ensuring the rights to health and education for persons with disabilities including children and has ratified the international conventions dealing with children's rights like the CRC. Therefore, this study analyses the extent to which the educational and health rights of children with Cerebral Palsy are being met in Highfield High Density Suburb in Harare. The study shall evaluate the implementation of the legal framework for realisation of the educational and health rights of all children, irrespective of disability.

1.4 Research Objectives

Objectives of the study are as follows;

- To examine the adequacy of legal framework for ensuring access to education and health by children with disabilities, in general, and those with Cerebral Palsy, in particular.
- To establish if there are appropriate institutional structures for promoting the educational and health rights of children with Cerebral Palsy in Highfield High Density Suburb in Harare

- To establish if schools in Highfield High Density Suburb have appropriate facilities to cater for children with Cerebral Palsy
- To establish if there are appropriate health institutions and facilities to cater for the health needs of children with Cerebral Palsy
- To propose options for enhancing the educational and health rights of children with Cerebral Palsy

1.5 Research Questions

- To what extent is the legal framework for the realisation of educational and health rights of children with disabilities adequate?
- Does Highfield High Density Suburb have appropriate institutional structures for promoting educational and health rights of children with Cerebral Palsy?
- Do schools in Highfield High Density Suburb have appropriate facilities to cater for children with Cerebral Palsy?
- Do health institutions in Highfield have appropriate facilities to cater for the health needs of children with Cerebral Palsy?
- What measures can be adopted to enhance the educational and health rights of children with Cerebral Palsy?

1.6 Significance of the Study

1.6.1 Significance to Children: This study is being done in order to promote the educational and health rights of children with Cerebral Palsy. Access to education and

health would make it possible for children, when they reach adulthood, to lead ‘normal’ lives.

1.6.2 Policy Influencing: The study could influence public policy and indicate possible measures that may be employed by government to ensure realisation of educational and health rights for disabled children. The research could provide a good platform for policy refinement to ensure that children with disabilities enjoy their rights to education and health.

1.6.3 Significance to Literature: The study will add to the existing body of knowledge on the rights of children living with disabilities. Findings of the study, if adopted, could advance the body of knowledge on the rights of children with disabilities. The study also provides a platform for ongoing research on how the rights of children with disabilities can be realised.

1.6.4 Information for Planning: The study will provide information to stakeholders in the education and health sector including government departments and non-governmental organisation to plan and come up with responsive programs and policies for children with Cerebral Palsy

1.6.5 Information for children with Cerebral Palsy, parents and caregivers: Perhaps the most important benefactors of the research are the children with Cerebral Palsy themselves and their parents and caregivers. The research will provide information on

available legal framework, services and hence better able to access services and to lobby responsible authorities in cases where the service is not available or is unsatisfactory

1.6.6 Significance to National Development Agenda

The study will amplify the rights of persons with disabilities in the national development discourse, this will have a net effect of improving service delivery to 7% of the population which is constituted by persons with disabilities including children.

1.7 Theoretical Framework

Approaches to disability can be summarised into four models, the charity model, the medical model, the social model, and the human rights model. This study is based on the social and human rights models. According to Carson (2009) the social model assumes that the problem is not the person with the disability, but rather the society in which that person lives. Thus, it is recognised that society does not provide for the needs of persons with Cerebral Palsy (inaccessible buildings, furniture and lack of sign language interpreters). Thus society disables the person by not allowing for her or his inclusion. In the social model the challenge rests with society to remove barriers that prevent adults and children with disability from full and effective participation in society on an equal basis with others. It recognises that a change of attitude in society is necessary and critical if people with disabilities are to achieve equal status (Filmer, 2008). The Union of the Physically Impaired Against Segregation (UPIAS UK) who are the major proponents of the social model of disability argued that, “in our view it is society which disables

physically impaired, disability is something imposed on top of our impairments, by the way we are unnecessarily isolated and excluded from full participation in society.

The human rights model is similar and complementary to the social model but goes further by placing the social model in a legal framework, which recognises that adults and children with disabilities must enjoy certain freedoms and have access to certain entitlements and rights on an equal basis with others in order to live a life in dignity. Consequently, the environmental and attitudinal barriers identified under the social model amount to discrimination. The human rights model requires monitoring of the extent to which freedoms and entitlements are enjoyed without discrimination and requires the State to provide remedies when rights are abused (Freeman, 2007). These two models stress that society creates and exacerbates disability and society must change its attitude towards adults and children with disability rather than focusing on the particular condition of an individual.

1.8 Delimitation

This study focuses on the educational and health rights of children with Cerebral Palsy in Harare's Highfield High Density Suburbs. There is a review on the adequacy of legal and institutional frameworks for the realisation of the rights. The researcher shall collect information from key informants and residents in the Highfield High Density Suburbs. The area was chosen because it is one of the oldest and largest high density suburbs in Harare.

1.9 Limitations of Study

The researcher could face a number of limitations during the study. The following are some of the potential limitations.

- **Time Resources:** The first limitation could be that of time. To overcome this limitation, the researcher would focus on Highfield High Density Suburb.
- **Availability of Respondents:** Another limitation could be that some respondents, especially government employees (key informants) and community leaders may not be readily available for interviews due to work commitments. In order to interview selected participants, appointments will be made in advance so that interviews will take place once the participants have confirmed their availability.

1.10 Definition of Key Terms

- **Cerebral Palsy:** Cerebral Palsy is not one condition. Rather, the term describes a wide range of disorders and developmental disabilities that can arise from damage to a child's developing brain before, during or shortly after birth. Cerebral Palsy stems from an injury to the brain or abnormal development during the brain's formation. It affects people in many different ways
- **Child:** Every human being below the age of 18 years is a child

- **Child Well-Being:** Child well-being measures the quality of children's lives. However, there is no unique, universally accepted way of actually measuring child well-being. Some of the indicators of child-well being include access to basic needs like education, health, clothing, and shelter.
- **Children with Disabilities:** Those who have long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others.
- **Disability:** The World Health Organisation (1996) defines disability as 'any restriction or lack of ability to perform an activity in a manner or within a range considered normal for a human being' (WHO, 1996). The 1982 National Disability Survey of Zimbabwe came up with a working definition of disability as 'a physical or mental condition, which makes it difficult or impossible for the person concerned to adequately fulfil his or her normal role in society' (Zimbabwe Department of Social Services, 1982).
- **Human rights;** These are inalienable fundamental entitlements belonging to a person simply because she or he is a human being. Human rights are rights inherent to all human beings, whatever their nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. People are all equally entitled to human rights without discrimination. Human rights are often expressed and guaranteed by law, in the forms of treaties, customary international law, general principles and other sources of international law.

International human rights law lays down obligations of Governments to act in certain ways or to refrain from certain acts, in order to promote and protect human rights and fundamental freedoms of individuals or groups (Human Rights Watch, 2012).

1.11 Conclusion

This chapter presented the problem and its setting. Focus was on background to the study, statement of the problem, research objectives, research questions, and significance of the study. The chapter also presented theoretical framework, delimitation of the study, research limitations, and definition of key terms. The next chapter looks at literature review.

CHAPTER II

LITERATURE REVIEW

2.1 Introduction

In this chapter, there is a discussion on Cerebral Palsy, what it is, its types, and causes. Focus is also on a review of literature on children's rights to education and health, and the legal framework. The chapter shall also review literature to access to education by children with disability, in general, and with Cerebral Palsy, in particular. There is also a discussion on the right to health by children with Cerebral Palsy.

2.2 Cerebral Palsy

The term Cerebral Palsy (Cerebral Palsy) represents a group of heterogeneous conditions. neurological as well as psychological and educational. Neurologically the condition is usually defined as a permanent impairment of movement and posture resulting from a non-progressive brain disorder, due to events during pregnancy, delivery, the neonatal period or the first years of life, or hereditary factors (Bax and Hagberg, 2005).

2.2.1 Types of Cerebral Palsy

Cerebral Palsy is classified according to clinical neurological signs. The types are as follows;

- **Spastic Cerebral Palsy:** This is the largest group. The most salient neurological symptoms are marked rigidity of movement and inability to relax their muscles. The degree of handicap varies from only one arm or leg being affected, to both arm and leg on one side, or affection of all four limbs or more or less the whole body. About 75 percent of Cerebral Palsy children show spasticity as their main neurological symptom (Healy, 1983).
- **Athetoid Cerebral Palsy:** In this group the main neurological symptoms are seen as involuntary movements, which interfere with voluntary normal ‘movements of the body, for example writing, walking and speaking are often affected. About 10% have athetosis (Hagberg, 2005).
- **Ataxic Cerebral Palsy:** The dominating syndrome in this group is in coordination of voluntary movements frequently resulting in unsteady gait and poor body balance: often eye-hand coordination is affected. About 5% of children with Cerebral Palsy show these symptoms, a condition which is comparatively rare (Hagberg, 2005).
- **Mixed forms of Cerebral Palsy:** This group represents about 10% of children with Cerebral Palsy. The children show mixture of the symptoms described above (Hagber, 2005).

In addition, as already stated, Cerebral Palsy is associated with a myriad of dysfunctions. Although a definition of Cerebral Palsy focusing on disorders of movement and posture may be useful from a medical diagnostic standpoint, it leaves out a number of associated

dysfunctions or deficits that are common and have to be properly addressed in order to ensure an optimal development and habilitation. Among the dysfunctions frequently described are visual defects, hearing loss, other sensory defects, disorders of comprehension, or the expressive use of language, and cognitive dysfunctions. In addition seizures and orthopedic problems are commonly found (Healy, 1983). While motor disabilities are important factors with regard to the potential development towards leading a meaningful, independent life, locomotion is but one single consideration. Ability to communicate and mastery of daily living, including transportation, which is essential to personal independence and obtaining employment, are probably more important to the outcome. In order to understand more completely the function of cerebral palsied people, it is not enough to identify the effect of isolated additional dysfunctions; the interaction of multiple dysfunctions in each individual person's mastery and adjustment must be appreciated (WHO, 2009). Some of the more frequently associated dysfunctions are discussed below.

- **Visual dysfunction:** The most common visual disturbance associated with Cerebral Palsy is strabismus (approximately 50%), nystagmus, visual field cuts, refractive errors and other oculomotor defects are frequently found. Children with Cerebral Palsy often demonstrate an inability to interpret visual symbols. Visual processing dysfunctions may be responsible for inability to identify letters, but at other times the difficulty may be due to cognitive dysfunctions. The educational implications of visual dysfunctions may easily be underestimated, and it is

therefore important that visual abilities in children with Cerebral Palsy are assessed as early as possible. In addition, many children with Cerebral Palsy demonstrate problems with matching shapes, distinguishing shapes that appear similar, seeing a drawing as separate from its surrounding background and differentiating between varying directions of lines or forms, for example distinguishing 'b' from 'd'. Other children may have normal perception of forms, but great difficulties in drawing and writing, completing puzzles and building with blocks, and bricks. These problems are known as visual-motor dysfunctions, and are more often found in children with spastic than athetoid Cerebral Palsy. This kind of dysfunction is also frequently found in children without diagnosed motor, visual or cognitive problems, and are considered to be due to central cerebral dysfunctions that mainly manifest themselves in activities demanding a high level of coordination (Healy, 1983).

- **Auditive dysfunctions:** Hearing impairment is frequently found in populations with Cerebral Palsy. Significant hearing loss may easily be overlooked in children with speech defects and/a cognitive disability. If educationally significant hearing loss is not diagnosed at an early pre-school age and proper educational help given, eventually combined with a hearing aid, the language development may be seriously affected (WHO, 2009).

- **Sensory impairment:** Any child with significant left-right asymmetry is at risk for sensory impairment. Among cerebral palsied children sensory impairment is more prevalent in children with hemiplegia. The dysfunctions often reported relate to stereognostic perception (e.g. tactile-kinesthetic perception of objects), two point discrimination, sense of position, sharp-dull discrimination, pain, light touch and temperature sense (Shapiro et al., 1983). Assessment of the sensory functions mentioned above may have great implications for educational measures as they are of significant importance for children's ability to explore the environment.
- **Communication disorders:** To many children with severe Cerebral Palsy the communication problem is more handicapping than the inability to walk. In addition to the problems related to hearing loss, speech disorders and language disorders are often serious obstacles to communication. These dysfunctions are not independent and may coexist in the same child, so that when improvement in, for example, hearing does not always lead to more advanced speech. Many speech defects relate to reduced control of facial and respiratory muscles, or the muscles of the tongue or lips. The articulation problems may range from minor difficulties to a complete absence of speech. Lack of speech may be due to a combination of factors that in addition to articulation defects also may include language dysfunction and impaired intelligence. Language dysfunction seems to be a frequent problem in communication disorders in children with Cerebral Palsy. This is an important factor to take into account when treatment of speech

and language disorders is planned. When deficits in central processing of language are present. It is unlikely that articulation therapy alone will be effective or sufficient to secure a satisfactory improvement of communication. Children with central processing deficits need an educational approach suited to extend their knowledge of concepts as well as their use in meaningful communication. Even communication by alternative means may be difficult for children with severe central language dysfunction (Healy, 1983).

- **Emotional and behavioural problems:** Children with severe Cerebral Palsy grow up in a life situation that is very different from that of other children. They are already from the beginning hampered in their exploration of the environment, in communication and interaction with family and peers, and in developing a sense of competence and self-confidence. When children with brain damage are reported to develop behavioral disorders four to five times more often than children without brain damage. This may well be related first of ailment to the fact that brain damage often reduces the ability to learn from experience, to solve problems and overcome obstacles in daily life, and to be able to adjust to new situations in a flexible way. Their reactions are, however, normal reaction in relation to the frustrations they experience because of their disabilities. The idea that emotional and behavioral problems in children with brain damage are in principle different from problems in children without brain damage is not supported by modern research (Hagberg, 2005). Emotional and behavioral

problems affect a child's ability to learn. However, although Cerebral Palsy may affect a child's mental ability to understand and solve problems originating in the interaction with others, it is in many cases clear that the emotional disturbances are secondary to difficult situations. Examples of situations demanding new adjustments could be communication difficulties, hospitalization, surgery, entering school, change of school, puberty and adolescent concerns about feeling isolated, developing sexuality and a wish to become independent while experiencing continued dependence because of motor and other handicaps. Professional support and guidance as well as close co-operation with teachers could probably diminish the secondary emotional disturbances often noticed in children with Cerebral Palsy.

- **Cognitive dysfunction:** One of the most commonly associated deficits of Cerebral Palsy is cognitive dysfunction. Although there certainly are exceptions to the general finding that the children with greatest physical handicaps also have the poorest mental functioning, there seems to be a systematic relationship between the extent of the brain damage and the development of intelligence at the group level of research. Subtle dysfunctions in central processing are difficult to assess however, especially in young children, and although most surveys report that approximately 40 to 50% of cerebral palsied children are of subnormal intelligence. More than 25% cent are functioning well within the normal ranges, and many of these are able to pursue academic education. A proper assessment of

strengths and weaknesses in cognitive abilities is essential for developing an appropriate educational programme and expectations. This is essential to avoid frustrations for child, teacher and family (WHO, 2009).

- **Impairment, disability and handicap:** The process towards handicap starts with impairment, which may lead to disability and which again may lead to handicap. Impairment refers to any loss or abnormality of psychological, physical or anatomical function or structure. Disability is any lack or restriction of ability, caused by an impairment, to perform an activity in the manner or within the range considered normal for a human being. Handicap is a disadvantage caused by a disability that prevents or limits an individual's fulfillment of a role that is normal, depending on age, sex, and social and cultural factors (Healy, 1983).

James and Adams (2007) said that the hallmark feature of Cerebral Palsy is impaired social interaction. As early as infancy, a baby with Cerebral Palsy may be unresponsive to people or focus intently on one item to the exclusion of others for long periods of time. A child with Cerebral Palsy may appear to develop normally and then withdraw and become indifferent to social engagement.

Children with Cerebral Palsy may fail to respond to their names and often avoid eye contact with other people. They have difficulty interpreting what others are thinking or feeling because they cannot understand social cues, such as tone of voice or facial

expressions, and do not watch other people's faces for clues about appropriate behavior, and they lack empathy (Gallagher et al; 2008) .

More so, many children with Cerebral Palsy engage in repetitive movements such as rocking and twirling, or in self-abusive behavior such as biting or head-banging. They also tend to start speaking later than other children and may refer to themselves by name instead of "I" or "me." Some children with Cerebral Palsy do not know how to play interactively with other children. Some speak in a sing-song voice about a narrow range of favourite topics, with little regard for the interests of the person to whom they are speaking. Boyle et al (2007)

Children with characteristics of Cerebral Palsy may have co-occurring conditions, including Fragile X syndrome (which causes mental retardation), tuberous sclerosis, epileptic seizures, tourette syndrome, learning disabilities, and attention deficit disorder. About 20 to 30 percent of children with Cerebral Palsy develop epilepsy by the time they reach adulthood (James and Adams; 2007).

In addition, as Timothy et al (2010) pointed, Cerebral Palsy varies widely in severity and symptoms and may go unrecognized, especially in mildly affected children or when it is masked by more debilitating handicaps. Very early indicators that require evaluation by an expert include;

- No babbling or pointing by age 1

- No single words by 16 months or two-word phrases by age 2
- No response to name
- Loss of language or social skills
- Poor eye contact
- Excessive lining up of toys or objects
- No smiling or social responsiveness.

Later indicators include;

- Impaired ability to make friends with peers
- Impaired ability to initiate or sustain a conversation with others
- Absence or impairment of imaginative and social play
- Stereotyped, repetitive, or unusual use of language
- Restricted patterns of interest that are abnormal in intensity or focus
- Preoccupation with certain objects or subjects
- Inflexible adherence to specific routines or rituals.

James and Adams (2007) pointed that health care providers will often use a questionnaire or other screening instrument to gather information about a child's development and behavior. Some screening instruments rely solely on parent observations, while others rely on a combination of parent and doctor observations. If screening instruments indicate the possibility of Cerebral Palsy, a more comprehensive evaluation is usually indicated. A comprehensive evaluation requires a multidisciplinary team, including a

psychologist, neurologist, psychiatrist, speech therapist, and other professionals who diagnose children with Cerebral Palsy. The team members will conduct a thorough neurological assessment and in-depth cognitive and language testing. Because hearing problems can cause behaviours that could be mistaken for Cerebral Palsy, children with delayed speech development should also have their hearing tested.

2.2.2 Incidence of Cerebral Palsy

Estimates of the incidence of Cerebral Palsy have varied considerably, mainly due to differing techniques of case finding, differing definitions of Cerebral Palsy and changing demographic trends and social conditions. According to studies carried out in some developed countries (Lagergren, 1981; Glenting, 1986; and Healy, 1983). The incidence of Cerebral Palsy is about 2 per 1000 live births or slightly lower. With regard to the incidence of Cerebral Palsy in developing countries, detailed surveys are lacking. The existing sources of information are mainly the estimates made by medical or health experts in developing countries, and not based on systematic surveys. The variations in estimated incidence or prevalence rates vary for reasons that relate as much to the organization and availability of services as to the actual numbers of handicapped people.

2.2.3 Causes of Cerebral Palsy

Handicapping conditions that affect children may have their origins in the prenatal period (25%), commonly defined as the time up to the 27th week of the gestation period. Others have their onset around the time of birth or in the prenatal period (48%) from the 27th

week of gestation through the first week after birth, and still others may acquire Cerebral Palsy during the postnatal period or the first years of life (6%), (Hagberg, 2005). A number of aetiological factors originating pre, peri or postnatal stages are associated with increased risk for Cerebral Palsy. Prenatal risk factors such as congenital malformations, lack of oxygen (asphyxia) and infection are associated with Cerebral Palsy, while premature births, prolonged labour, breech presentation, jaundice and lack of oxygen may represent increased risk at the prenatal stage. During the postnatal period infections such as meningitis and encephalitis, excessive jaundice, rubella, and head trauma can increase the risk for Cerebral Palsy. There is, however, rarely a single cause to Cerebral Palsy, in most cases it is caused by a combination of contributing conditions. Maternal characteristics such as adolescent pregnancy, low socio-economic status and poor health are associated with increased risk of Cerebral Palsy in children. In only a small percentage of families have more than one child affected, and hereditary causes are therefore considered rare. Although a great deal is known about the causes of Cerebral Palsy, in as many as 25% of affected cases no definite cause or aetiological factor can be pin-pointed (Margulec, 2006).

Furthermore, although prevention of impairment should be a main objective of social and health services in any country, impairments seem unfortunately inevitable throughout the world, and even more so in developing than in developed countries. Given this situation, what can very often still be done is through interventions, such as early home training programmes, preschool education, schooling, and training for maximum of independence

and meaningful activity. The goal is to prevent impairments and disabilities from becoming handicaps, or to reduce the handicapping impact (Hagberg, 2005). Although it is possible to list many of the problems that are common in children with severe Cerebral Palsy, as done above, it is evident, however that different etiological factors, inherited characteristics and environmental circumstances must lead to widely differing resources and developmental capacities, physical as well as mental. Despite the fact that the descriptions of development and the characteristics of children with biologically-based delays must remain general, it is possible, however, to describe some patterns that are similar to many of them. Examples include difficulties in interactions between caregivers and children, delay in speech and language development which may easily lead to a mismatch between the parents' way of communicating and the children's capacities. Another problem is lack of adequate control of attention and effective use of the social and physical environment, and delayed or deficient ability to learn systematic strategies in problem solving tasks (UNICEF, 2010).

Moreover, children with severe Cerebral Palsy also show extraordinary difficulties in establishing reciprocal social relationships of some duration, problems that may be rooted in comprehensive physical disabilities, communication disorders, mental delays or very limited experience in social exchange. Whatever developmental theories are used in order to conceptualize development in children, a common central denominator with regard to preconditions for early development is the ability and opportunity for interaction with people and objects. Theories about bonding and attachment as well as theories about

cognitive development are based on the notion of the need for early interaction with caregivers as well as experience with the material environment. The traditional approach focusing on etiological factors and disabilities may easily lead to a reduction of understanding the development of handicap in impaired children as a result of limited ability to explore and experience the social and physical environment, and not just the result of a pathological or disturbed brain function. The extent to which the social and material world takes on meaning to a child depends on personal experience. An extremely limited interaction with the environment means reduced ability to understand and adapt to new experiences and less shared understandings with family, peers and the wider community. In order to develop meaningful, reciprocal social relationships, it is necessary to form attachments, to develop empathy with others, to learn the meaning of common concepts and to develop insights into other people's situations and the ability to act in a flexible and reciprocal way (WHO, 2009).

In addition, conceiving of how young children learn about the world, especially taking into account the theories of cognitive development of Jean Piaget, a theoretical framework also used in early education programmes (Hohmann. Banet and Weikart, 1979). It becomes evident that how to make 'active learning' become a reality to severely handicapped children is the crucial question. Today the terms 'active learning' and 'child initiated learning' are recognized as indicators of an educational approach that puts children's own activity in the centre of the learning process.

The question of how society can provide opportunities for severely handicapped children that allow an optimal development of abilities to discover and construct their own personal knowledge of the world is a challenging one for teachers as well as parents. The experience of active learning is essential to mental development in all children, for children who did not have this opportunity when younger, the provision of situations encouraging active learning are of central importance. In order to be able to know what to do in assisting a child's learning in the best way possible, it is necessary to know about the child's actual abilities. Knowing a child's abilities helps to establish contact and communicate, the possible ways the child can convey his or her interests or wishes, and how to influence the situations of daily life (in the classroom as well as at home) and what kind of toys, things, tools and learning aids, etc.' a child can use in a controlled way. To obtain this information, a comprehensive assessment is necessary, covering the child's physical condition and needs, as well as mental functioning, home environment and needs for personal and practical support at home as well as at school (UNICEF, 2010).

In many places even in the affluent parts of the world, the necessary facilities for comprehensive assessments, counseling and follow-up of children and their families that should be based on regular assessments are not available. Naturally this is even more the case in developing countries, where the scarcity of professional assistance, especially in the rural districts and the urban slums, is the normal situation. In practical terms, this means that many handicapped children grow up in families left to manage on their own

as best they can, without counseling or advice from professionals such as pediatricians, psychologists, special educators, and social workers. In such situations the opportunities for growth and development rest mainly on the resources of the families, the parents' understanding of handicapping conditions, their attitude and conception of upbringing of children, available time and energy for interacting with and assisting the children, and the family or community network to support children and parents (UNICEF, 2010).

2.2.4 Prevention of Cerebral Palsy

Timothy et al (2010) argued that although the entire mystery of what has caused the Cerebral Palsy epidemic has not yet been solved, based on emerging science and parents reporting what specific treatment have improved (or in some cases recovered) their children, there are some strong clues regarding Cerebral Palsy prevention and treatment. Causation theories range from: it must be due to better diagnosis, (rather than a real increase) to maternal age at the time of conception to the more likely scenario suggesting genetic predispositions plus environmental factors (including an explosive increase in the number of vaccines given before the age of 5) are to blame. The problem is that more children are being negatively impacted by this condition. In the meantime, moms of affected children who want to get pregnant with another child and women who have never conceived ask what can be done to increase the chances of having a healthy baby.

Cerebral Palsy Research Institute (2011) revealed abnormal patterns and metabolic dysfunctions in the Cerebral Palsy population that include gastrointestinal dysfunctions

(constipation, diarrhoea, reflux, increased permeability), decreased blood flow to certain parts of the brain, abnormal brain size, and hormonal disturbances (including increased cortisol production, disorders of serotonin and dopamine).

As parents and clinicians work feverishly to address these abnormalities by assessing the individual issues each child presents with, and attempt to normalize or correct these various disturbances, children are improving (speech, behaviour, cognition, attention, general health etc) and in some instances they are even recovering. But this is tremendously difficult and expensive work. Since some of these biochemical abnormalities may be preventable, more and more parents are working to optimize their health prior to conceiving. James and Adams (2007) provided the following as a possible preventive measure;

- If a woman is considering becoming pregnant, one of the best things she can do is give herself six months to a year to improve her diet and make better lifestyle choices. She should consume organically grown grains, vegetables, fruits, nuts, and lean sources of protein.
- Laying the foundation for a healthy pregnancy by putting herself in optimal shape prior to conceiving will go a long way in minimizing the chance of miscarriage, or developing other complications of pregnancy and delivery.
- Reduction or elimination of alcohol and caffeine and eliminate tobacco.
- Exercise
- Minimizing consumption of large fish

- Improving indoor air quality by opening the windows and creating cross ventilation.

2.2.5 Health Services for Children with Cerebral Palsy

Health services for children with disabilities in Zimbabwe are designed to capture children who are at risk at birth or soon after birth , the Department of Rehabilitation and the Maternal Health Department in the Ministry of Health and Child Care (MoHCC) have an early identification programme nationally named the “At Risk Programme”. This makes the use of stickers on Maternal Health Cards (, this starts with the birth process, when a child doesn’t respond normally or when the delivery process is complicated e.g. prolonged labour or scores low on the Apgar Scale (Rapid test done soon after birth to establish new-born’s physical condition). If the child has any of the above symptoms, a green sticker is placed on the card with the letters AR (at risk) and referred to the nearest rehabilitation department for further assessment. Once established that the child has a disability a red sticker with the letter R (child has a disability) is placed on the card to alert all health service providers working with the child that the child has a disability and needs special care and monitoring.

Medical Rehabilitation services for children in Zimbabwe are made of two major referral Children’s Rehabilitation Units(CRUs) in Bulawayo and Harare. The CRU in Harare at Harare hospital serves the country’s Northern Region and the CRU in Bulawayo serves

the Southern Region. The CRUs also provide services to the two major cities in Zimbabwe thus Harare and Bulawayo. While the two serve the regions as referral centres there are provincial medical rehabilitation centres at all provincial hospitals and rehabilitation units at some district hospital.

2.3 The Right to Education

The CRC provides that states parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity (UNICEF, 2007). Due to the fact that there are economic, cultural and family factors that can negatively affect access to education by children, like disability, UN member countries were encouraged to;

- Make primary education compulsory and available free to all;
- Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;
- Make higher education accessible to all on the basis of capacity by every appropriate means;
- Make educational and vocational information and guidance available and accessible to all children; and
- Take measures to encourage regular attendance at schools and the reduction of drop-out rates.

Moreover, Article 28 of the Convention on the Rights of the Child establishes the child's right to education. This must be achieved "on the basis of equal opportunity", reflecting the fact that huge numbers of children suffer discrimination in access to education, particularly girls, children with disabilities, minorities and children from rural communities. Education is expensive and elements of the right may need to be achieved "progressively" (Committee on the Rights of the Child, 2001). However, article 28 states the core minimum: free, compulsory primary education for all, and different forms of secondary education and vocational guidance "available and accessible" to all. Higher education must be accessible "on the basis of capacity". The article also addresses the form of education, in so far as States must take measures to reduce school drop-out rates and to ensure that school discipline respects the child's rights. It also encourages international cooperation on education, which should be readily forthcoming, given education is both a core human right and an engine for economic growth.

Moreover, the Human Rights Watch (2012), the 1948 Universal Declaration of Human Rights states, "everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory. Technical and professional education shall be made generally available and higher education shall be equally accessible to all on the basis of merit".

However, children, the world over, seem not to have access to better educational facilities and family set up and poverty are some of the causal factors (Save the Children Sweden,

2005). The 1990 World Summit for Children declared “At present, over 100 million children are without basic schooling, and two thirds of them are girls. The provision of basic education and literacy for all is among the most important contributions that can be made to the development of the world’s children.” The World Summit set a goal: “By the year 2000, universal access to basic education and achievement of primary education by at least 80% of primary school-aged children”. That goal was not achieved. A decade later, noting that at least 113 million children were still out of school, world leaders set a new goal: “to achieve universal primary education”.

The United Nations Millennium Development Goals Report 2006 report shows there has been some progress towards this goal: “Net enrolment ratios in primary education have increased to 86% in the developing world, ranging from 95% in Latin America and the Caribbean to 64% in sub-Saharan Africa. Although the sub-Saharan region has made significant progress since 1990/1991, in Burkina Faso, Djibouti, Eritrea, Ethiopia, Mali and Niger, fewer than half the children of primary school age are enrolled in school. Faster progress will also be needed if Oceania and Western Asia are to achieve universal education. Southern Asia, in contrast, has made great strides, especially over the period 1999-2004, when enrolment rose from 72 to 89%, largely as a result of progress in India” (The Millennium Development Goals Report 2006, United Nations, 2006).

2.4 The Right to Health

Just like education, health is a basic human right. Accordingly, the CRC provides that state parties shall recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. State parties shall strive to ensure that no child is deprived of his or her right of access to such health care services. In addition, state parties shall pursue full implementation of this right and, in particular, shall take appropriate measures to diminish infant and child mortality. Member countries also need to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care, and to combat disease and malnutrition, including within the framework of primary health care (UNICEF, 2007).

Moreover, UNICEF (2007) pointed out that member countries needed to respect for the views of the child needs to be built into health care and into the design of health services (article 12 of CRC), and respect for children's evolving capacities (article 5 of CRC) underlines the need for full consideration of adolescent health issues. In addition, article 24 paragraph 3 requires action to abolish traditional practices "prejudicial to the health of children", drafted because of particular concern over female genital mutilation and requiring a review of all potentially harmful practices. Paragraph 4 asserts the importance of international cooperation (reflecting the general provision found in article 4) in achieving full realization of the right to health and health care services (UNICEF, 2007).

Furthermore, the CRC's health provisions developed from provisions in the Universal Declaration of Human Rights and the two International Covenants, on Civil and Political Rights and on Economic, Social and Cultural Rights, and from the formulation of definitions and principles by international organizations, in particular the World Health Organization (WHO) and UNICEF. (UNICEF 2007)

2.5 The Legal Framework for Ensuring Children's Rights to Education and Health

The study examines the adequacy of various protocols aimed at ensuring the rights of children with disabilities. These include the CRC, adopted in 1989. The CRC is believed to be the most comprehensive treaty which provides economic, social, cultural, civil and political rights of children and establishes the obligations of the government to protect promote and fulfil the rights of all children.

The CRC provides a holistic framework of comprehensive and binding principles which should underpin the treatment of children throughout the world. It establishes a set of universal minimum standards of entitlement for all children. According to UNICEF (2007), in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration. The CRC and the African Charter on the Rights and Welfare of the Child (ACRWC) are the main legal instruments for realization of the educational rights of children.

The CRC provides that state parties should undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her. The Committee on the Rights of the Child (2001) highlighted article 3(1), that the best interests of the child shall be a primary consideration in all actions concerning children, as one of the general principles of the Convention on the Rights of the Child, alongside articles 2, 6 and 12. The principle was first seen in the 1959 Declaration of the Rights of the Child. Interpretations of the best interests of children or use of the principle cannot trump or override any of the other individual rights guaranteed by other articles in the Convention. The concept acquires particular significance in situations where other more specific provisions of the Convention do not apply. Article 3(1) emphasizes that governments and public and private bodies must ascertain the impact on children of their actions, in order to ensure that the best interests of the child are a primary consideration, giving proper priority to children and building child-friendly societies.

The Committee on the Rights of the Child (2001) has developed its interpretation of the principle in relation to various issues in its successive general comments. Within the Convention, the concept is also evident in other articles, providing obligations to consider the best interests of individual children in particular situations in relation to;

- **Separation from parents:** The child shall not be separated from his or her parents against his or her will. States must respect the right of the child to

maintain personal relations and direct contact with both parents on a regular basis “except if it is contrary to the child’s best interests”. However, in polygamous marriages, divorces are common and children may be separated from parents against their will and not in BIC.

- **Parental responsibilities:** Both parents have primary responsibility for the upbringing of their child and “the best interests of the child will be their basic concern”. In a polygamous marriage, both parents may not be responsible for the upbringing of their children.

Moreover, the concept of the “best interests” of children has been the subject of more academic analysis than any other concept included in the Convention on the Rights of the Child. In many cases, its inclusion in national legislation pre-dates ratification of the Convention, and the concept is by no means new to international human rights instruments. The 1959 Declaration of the Rights of the Child uses it in Principle 2: “The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration” (UNICEF, 2007).

In light of the need for legal framework for the realization of educational rights of children, it is vital to note that Africa is the only continent with a region-specific child

rights instrument. The African Charter on the Rights and Welfare of the Child (ACRWC) is an important tool for advancing children's rights (UNICEF, 2007). The ACRWC was adopted by the Heads of State of the then OAU in 1990 and came into force in 1999 by which time it had the requisite 15 ratifications. It lays out the responsibilities of the state, the family, the community and the individual in the protection and promotion of the rights of the child and is rooted in other human rights treaties, including the African Charter on Human and Peoples' Rights (ACHPR) and the CRC.

Moreover, while building on the same basic principles as the UN Convention on the Rights of the Child, the AU Children's Charter highlights issues of special importance in the African context. In particular, it challenges traditional African views that conflict with the rights of the child such as attitudes concerning child marriage, parental rights and obligations towards their children and children born out of marriage. The Children's Charter also gives express recognition to the idea that children have responsibilities depending on their evolving capacities (UNICEF, 2007).

In addition, the ACRWC has a provision on harmful social and cultural practices. Article 21 ACRWC, deals with them from a broad perspective which includes health but also discrimination, dignity and development. It is in line with Article 24(3) of the CRC that approaches harmful social and cultural practices from the perspective of their impact on the right to health. Furthermore, according to United Nations Children's Fund (UNICEF, 2007), the African Charter on the Rights and Welfare of the Child (ACRWC) was born

out of the feeling by African member states to the United Nations that the drafting of the CRC missed important socio-cultural and economic realities of the African experience. The African Charter stresses on the need to include African cultural values and experience whenever discussing or considering issues pertaining to the rights of the child in Africa. The ACRWC was adopted by the Assembly of Heads of States and Government of the African Union in 1990 and Zimbabwe signed this Charter in January, 1992. By ratifying both the CRC and the ACRWC, the Government of Zimbabwe committed itself to implement the provisions of both instruments (Munemo and Tom, 2013).

In addition, the CRC and ACRWC are efforts to ensure that children, as human beings, are guaranteed their basic human rights. Human rights are inalienable fundamental entitlements give to a person simply because she or he is a human being. Human rights are rights inherent to all human beings, whatever their nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. People are all equally entitled to human rights without discrimination. Human rights are often expressed and guaranteed by law, in the forms of treaties, customary international law, general principles and other sources of international law. International human rights law lays down obligations of Governments to act in certain ways or to refrain from certain acts, in order to promote and protect human rights and fundamental freedoms of individuals or groups (Human Rights Watch, 2012). All human rights already apply to all people. For instance, the United Nations Declaration on Human Rights declared that

every child has a right to education, to ensure their growth and development, to fulfil their individual potential (UN, 2009).

In addition, according to the Zimbabwe Education Act (Chapter 25:04 of 1984) all children have the right of education. The Act provides that there should be no discrimination in the provision of primary education in Zimbabwe. At the same time, Zimbabwe opted for inclusive education as a policy that would lead to the avoidance of discrimination in schools when it accepted the provisions of the CRC, the Copenhagen Declaration on Social Development, the Salamanca Statement and Framework for Action and the Dakar Framework for Action (Hapanhengwi-Chemhuru, 2009). All children must be able to go to schools nearest them or schools of their choice without impediments being put in their way. Attending school and formalised education in nonschool spaces provides continuity and social interaction for all children. The role of education should be to try to reinforce the abilities of all children and strengthen and support all children's potential for learning (Langam, 2005).

The legal instruments complement and reinforce each other in a powerful way. There is need for development practitioners to influence the state parties to respect, protect and fulfill the rights enshrined in the ACRWC and they can work closely together with children and communities to translate the Charter into positive practice in daily life (UNICEF, 2007). Moreover, consideration of best interests of the child (BIC) must embrace both short- and long-term considerations for the child. Any interpretation of best

interests must be consistent with the spirit of the entire CRC, and in particular with its emphasis on the child as an individual with views and feelings of his or her own and the child as the subject of civil and political rights as well as special protections. States cannot interpret best interests in an overly culturally relativist way and cannot use their own interpretation of “best interests” to deny rights guaranteed to children by the CRC, for example to protection against traditional practices and violent punishments (UNICEF, 2007).

Furthermore, the Convention on the Rights of People with Disabilities (CRPD) provides a clear focus and detailed elaboration of government obligations and the measures in ensuring that the rights of children with disabilities is protected, promoted and realised. In countries like Ireland, there is the National Disability Strategy (NDS). (UNICEF 2007)

2.6 Access to Education by Children with Disabilities

2.6.1 All Disabilities

Educational options for children with disabilities include inclusive education in mainstream schools, special classes in mainstream schools and special schools. Other supports include special needs assistants, assistive technology, home tuition and the Visiting Teacher Service (VTS). According to Walker (2011), globally, 93 million children, or 1 in 20 of those aged up to 14 years of age, live with a moderate or severe disability. As noted by the 2011 monitoring report of the Convention on the Rights of the

Child, children with disabilities are “one of the most marginalized and excluded groups in respect of education. There is very little accurate information available on the extent and nature of disability among children globally, and even less on the degree of exclusion from education faced by children with disabilities. However, the data that is available undeniably shows that disabled children have far poorer educational opportunities, compared to non-disabled peers. For example, the 2004 World Health Survey found that respondents with a disability had significantly lower rates of primary school completion and on average fewer years of education than respondents without a disability.

At national level, the Constitution of Zimbabwe (2013) provides that resources should be availed to ensure that people with disabilities realise their full mental and physical potential. Measures to be put in place include providing special facilities for education of people with disabilities, furthermore the Zimbabwe Education Act provides that all children including those with disabilities should have access to education, the act provides for the formation of the Department of School Psychological Services which assesses children and places in appropriate schools and to go further to ensure that the school provide an enabling , nurturing and stimulation for children with disabilities through maintaining properly equipped classes with qualified and able staffing. However, it should be realised that while situations and ways of measuring success vary greatly, it is clear that children with disabilities have a far greater chance of being out of school than their non-disabled peers. A disability can more than double the chance of a child not being in school in some countries.

Moreover, children with disabilities require special needs education. Special needs education means the educational arrangements that are in place for children with special educational needs. Special needs education is provided in mainstream settings as far as possible. Children who have been diagnosed with a disability may get special needs assistance from resource teachers and perhaps other specialists such as speech and language therapists or educational psychologists. Learning support is the help given to children who may lag behind other children in school perhaps because of learning difficulties, behavioural problems or undiagnosed disability. Special needs assistants (SNAs) work with children who need non-teaching support perhaps because of a physical disability or behavioural difficulties. Pupils' needs could range from needing an assistant for a short period each day, for example, to help feed or change them or bring them to the toilet, to requiring a full-time assistant (Walker, 2011).

2.6.2 Children with Cerebral Palsy

Children with Cerebral Palsy will require treatment and need education at school. It is important for the teacher to understand the therapy needs just as it is essential for the therapist to understand the practical implications of the child's day in the class room. The child's will to learn will not be taught at the classroom desk nor discovered on the floor of the therapy room; it will be established progressively by the child's awareness of achievement This will come from mutual co-operation by all concerned, including the home. Techniques have been developed, adequate equipment and aids to communication

produced and teachers trained in this field. However, at the same time attitudes towards severe disability have also changed. According to UNICEF (2007), the fact that it is now established that children with Cerebral Palsy have the same aspirations to an education as their peers and the fact that disability is no longer regarded as something to be hidden away have combined to demand a new approach to the education of children with disabilities (children with special needs).

Traditionally, it was not surprising to find that education in special institutions was regarded as an unacceptable approach and the past two decades have been marked by the search for a more acceptable alternative, one that does not isolate the disabled child from her/his peers. Thus, many of those countries which pioneered special schools in 1980s now insist on full integration of disabled children in ordinary schools. Inevitably the dialogue continues; there remain excellent arguments in support of special schooling and the lobby in favor of integrated education has strong emotional arguments in support of their concept. How successful integrated education really is has yet to be fully tested, so much will depend upon such factors as the training of staff, the availability of the right equipment and the willingness of teachers to learn about the problems of disability. What is clear, however, is that what disabled children might lose by their attendance at an ordinary school will be more than offset by their gains in integration within the community in which they will spend most of their lives (UNICEF, 2010).

2.6.3 Options for Enhancing Access to Education by Children with Disabilities

According to Save the Children, Sweden (2009), learning environments should be accessible in terms of the physical space, and be considerate of the child's need, for example, being close to the blackboard, or, to have better light by sitting next to a window. These small changes may make the difference between a child with a visual disability getting value from a lesson or being labelled backward and missing out completely. Other children, including those with disabilities, may simply need more time to express themselves, or may need to have a ramp to enter the classroom. Developing inclusive communication and teaching methods such as using visual cues, clear slow speaking or child participation, will benefit all children. There may be some children who need assistive devices to have full access to education, such as adapted furniture and classroom equipment, and teachers may benefit from support in problem solving, but these are very rarely insurmountable problems (WHO, 2011).

A number of measures need to be taken to enhance the educational rights of children with disabilities. These include physical access. Depending on the nature of a child's disability, a parent may need to check with the principal that the school is accessible to the child (playgrounds and toilets as well as classrooms and assembly areas). The school may apply for a grant to make the premises accessible by, for example, putting in ramps or accessible toilet accommodation. There are also special transport arrangements, including escorts and safety harnesses, for children with disabilities attending school

(UNICEF, 2007). In addition, education in a special school is another option that parents may wish to explore for children with disabilities.

2.7 Access to Health by Children with Cerebral Palsy

The Universal Declaration of Human Rights includes the right to care as part of everyone's right to "a standard of living adequate for the health and well-being of himself and of his family", adding: "Motherhood and childhood are entitled to special care and assistance. All children, whether disabled or not, shall enjoy the same social protection" (UN, 2005).

The International Covenant on Economic, Social and Cultural Rights, in article 12, provides;

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for the reduction of infant mortality and for the healthy development of the child;
3. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The Committee on Economic, Social and Cultural Rights adopted a General Comment in 2000 on the right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights). The Committee has

also adopted General Comments on the right to adequate housing, the right to adequate food and the right to water; article 11 of the Covenant sets out the right of “everyone” to an adequate standard of living, including adequate food, clothing and housing. Both the Universal Declaration and the International Covenant also assert the right to Life. However, due to poverty and lack of access to basic social services, more than 10 million children under five years of age, nearly half of them in their neonatal period, die every year of preventable diseases and malnutrition (UNICEF, 2009). The situation is worse for children with disabilities, who require special facilities. Also, WHO (2012), pointed out that complications related to pregnancy and childbirth and maternal anaemia and malnutrition kill more than half a million women and adolescents each year, and injure and disable many more. More than one billion people cannot obtain safe drinking water; 150 million children under five years of age are malnourished; and more than two billion people lack access to adequate sanitation.

To ensure access to health facilities by children, the World Health Organization developed the “Strategic Directions for Improving the Health and Development of Children and Adolescents” in response to a global call for renewed and intensified action to promote and protect the health and development of the 0-19 years age group. The United Nations General Assembly’s special session on children called attention to the uneven progress that had been made in the achievement of the goals adopted in the 1990 World Summit for Children. The adoption of the development goals of the Millennium

Declaration (MDGs) in 2000 provided further impetus to the need to develop a “road map for action”. The Strategic Directions were endorsed unanimously during the Fifty-sixth World Health Assembly, in May 2003. However, there seem to be no special arrangements for children with Cerebral Palsy. The next section discusses the health care requirements for children with Cerebral Palsy.

Online publication by Holmes (2005) shows evidence of how early intervention is of great help. This is because of fact that there is no cure for Cerebral Palsys. Therapies and behavioural interventions are designed to remedy specific symptoms and can bring about substantial improvement. The ideal treatment plan coordinates therapies and interventions that meet the specific needs of individual children. Most health care professionals agree that the earlier the intervention, the better. The following are some ways of treating Cerebral Palsy.

Educational/behavioural interventions: Therapists use highly structured and intensive skill-oriented training sessions to help children develop social and language skills, such as Applied Behavioural Analysis. Family therapy by Social Workers for the parents and siblings of children with Cerebral Palsy often helps families cope with the particular challenges of living with a child with Cerebral Palsy.

Medications: Doctors may prescribe medications for treatment of specific Cerebral Palsy-related symptoms, such as anxiety, depression, or obsessive-compulsive disorder.

Antipsychotic medications are used to treat severe behavioural problems. Seizures can be treated with one or more anticonvulsant drugs. Medication used to treat people with attention deficit disorder can be used effectively to help decrease impulsivity and hyperactivity.

Other therapies: There are a number of controversial therapies or interventions available, but few, if any, are supported by scientific studies. Parents should use caution before adopting any unproven treatments. Although dietary interventions have been helpful in some children, parents should be careful that their child's nutritional status is carefully followed.

Consequently, James and Adams (2007) conducted a study on biomedical treatment of Cerebral Palsy. Biomedical treatments will not help every child, but they have helped thousands of children improve, sometimes dramatically. The following summarises some of the biomedical treatments.

Improve Diet: Humans need certain essential nutrients for their bodies to function, including vitamins, minerals, essential fatty acids, and amino acids (from protein). A balanced diet rich in vegetables, fruits, and protein is important to help provide those key nutrients.

Food Allergies: Many children with Cerebral Palsy have food allergies, due to abnormalities in their digestive and/or immune systems. If food is not fully-digested into individual sugars, amino acids, etc., then the partly digested food can pass from the gastrointestinal tract into the bloodstream, especially if the child has a “leaky gut” due to inflammation. The immune system recognizes those foods as foreign, and may launch an immune response to those foods, resulting in an allergic response.

Vitamin/Mineral Supplements: In order to be classified as a “vitamin” or “essential mineral”, many studies were conducted that showed that the lack of that vitamin or mineral resulted in disease or even death. The RDA is the minimum amount required to prevent disease, but may be less than the amount needed for optimal mental and physical health. Most people in the US consume less than the Required Daily Allowance (RDA) of one or more vitamins and minerals. For example, many women lack enough calcium and iron, leading to osteoporosis and anemia, respectively.

2.8 Conclusion

This chapter presented a review of literature related to educational and health rights for children with disabilities. The chapter also reviewed literature on Cerebral Palsy, its causes and types. There was also a review of literature on education and health as basic rights of children. There was also a discussion on the legal framework for ensuring children’s access to education and health. Review of literature on access to education and

health by children with Cerebral Palsy was also done. The next chapter discusses research methodology.

CHAPTER III

RESEARCH METHODOLOGY

3.1 Introduction

Each research requires a specific methodology that is best suited to answer the question under study. This chapter focuses on the methodology that the researcher will utilize in undertaking the study. Areas of focus include the population, sample, sampling procedures and the research instruments and data collection procedures. A summary will also be provided on the issues discussed in the chapter.

3.2 Research Philosophy

Research philosophy refers to the structure of an enquiry undertaken to ensure that the evidence collected enables the researcher to answer study questions or test hypotheses as unambiguously as possible. There are basically two views to the research process that dominate literature, namely positivism (quantitative) and phenomenology (qualitative).

Positivism is a philosophy that states the only authentic knowledge is knowledge that is based on actual facts and figures (quantitative). In positivism, knowledge only comes from affirmation of theories through strict scientific method where metaphysical speculation is avoided (Leedy and Ormrod, 2010). On the other hand, phenomenology

provides that knowledge is subjective. It argues that people attach subjective meanings to reality. People differ in perception and interests are not objective (Simon, 2011).

Qualitative research takes the view that it is very difficult for researchers to stand back and be objective, since they are really part of the research process. Saunders et al (2012) contend that one may argue that the world of social sciences is too complex to lend itself to theorizing by definite laws in the same way as physical sciences. According to Kato (2002), greater insight can often be obtained when collecting data under a qualitative research framework through such methods as observation, interview, and document and media analysis thereby facilitating the understanding of the phenomenon from various aspects. Therefore, this study applies the qualitative approach.

Moreover, this study applied the phenomenology paradigm because people's perceptions regarding disability and the educational rights of disabled children may. There could be divergent views on the influence of disability on the realisation of the BIC (education and health) and there may be no facts to support the arguments. In addition, 'social studies' is a 'value loaded' discipline and it is difficult to be objective.

3.3 Research Design

Research design is the overall plan for obtaining answers to the research questions and testing the research hypothesis (Saunders, Lewis and Thornhill, 2012). Kothari (2004) notes that a research design provides a framework for collection and analysis of data and

subsequently indicates which research methods are appropriate. Kato (2002) define research design as all the issues involved in the planning and execution of a research project from identifying the problem through to reporting and publishing the results.

.Henning (2004) argued that surveys are means of gathering data from a sizable number of elements. The design will major more on qualitative methods than quantitative methods. The qualitative paradigm was grounded with the experiences of the respondents in relation to access to education and health by children with Cerebral Palsy.

3.4 Population

Population consists of all units, or the universe- people or things possessing the attributes or characteristics in which the researcher is interested (Yin, 2003). In light of the above, with regards to the study in question the population consisted of of government employees (teachers, health practitioners, and officials in the department of social welfare) and parents with children who have Cerebral Palsy in Highfield High Density Suburb.

3.5 Sampling Technique

A sample, in simple terms, is a subset of the population (Saunders et al., 2012). Kothari (2004) defines a sample as a set of elements selected in some way from a population. It is virtually impossible to collect data from the wholesome target population in Highfield High Density Suburb, to the financial and time resources the exercise would require. For

this reason sampling is utilised in which a small and manageable proportion of the population is interviewed for the purposes of this study and is assumed to be a representation of the target population.

Sampling is the process of systematically choosing a sub-set of the total population one is interested in interviewing. Parajares (2007) states that, 'sampling is critical to validity'. Validity is the extent to which interpretations of the results of the study follow from the study itself and extent to which results may be generalized (Parajares 2007).

The sampling procedures in this study are non-probability sampling techniques which are not based on probability theory but on obtaining sample subjects on the basis of opportunity, researcher's judgment and referrals. Purposive sampling and convenient sampling were used in this study. Purposive sampling was utilised because it involves the deliberate selection of key informants who possess particular information about the disability and Cerebral Palsy in Highfield High Density Suburb. Key informants are defined by Bloor and Wood (2006) as research subjects in ethnographic studies that have disproportionate weight and role in the conduct and outcome of the research.

Purposive sampling is a technique in which the investigator selects participants because of their characteristics good informants/participants are those who know the information required, are willing to reflect on the phenomena of interest, have the time and willing to participate (Saunders et al., 2012). With reference to the above, key informants in this

study included teachers, health officials, social welfare workers, parents and caregivers whose children have Cerebral Palsy, Non Governmental Organisation (NGO) officials, and local government officials. Bloor and Wood (2006) note that key informants may provide particularly important understandings to the researcher because they have a rich knowledge of the collectivity through their seniority or through their specialist roles in the setting. Convenience sampling is also known as opportunity or accidental sampling. Sullivan (2001) notes that convenient sampling the researcher places into sample whichever elements are readily available to him/her. The samples in convenient sampling are especially popular and appropriate for research in which it is difficult or impossible to develop a complete sampling frame (Sullivan 2001).

The researcher also used a sample size of 100 respondents from four residential zones surrounding Machipisa Shopping Centre in Highfield (Canaan, Egypt, Lusaka, and Engineering). The Machipisa Shopping centre is a transport network node comparable to any busy terminus in the country and is linked to most suburbs in Harare and surrounding towns such as Chitungwiza, Ruwa and Norton. Each residential zone provided 25 participants, comprising of 5 educational professionals (teachers), five health workers, and 15 parents. Identification of parents or caregivers for the survey was made using the Harare Children's Rehabilitation Unit database to identify and locate parents of children with disabilities, their zones and proximity to Machipisa Shopping Center. Bringing the parents and caregivers together for focused group discussions was made easier because parents and caregivers of children with Cerebral Palsy have support groups supported by

the Harare CRU and The J.F Kapnek Trust, the support groups meet weekly .The respondents' selection was based on the which by their proximity and accessibility to the researcher. The sample size was intended to be inclusive of all representation in terms of sex and age. In this regard the researcher was in control of the sample composition by employing convenience sampling. Bloor and Wood (2006) say that convenience sampling helps to gather data and information that would have not been possible using probability sampling techniques which require more formal access to lists populations, with a few rules governing it is easy to carry out and it is relatively fast and inexpensive. The accessibility and proximity of respondents make convenience sampling relatively fast and inexpensive thus suitable for researcher in this study.

3.6 Research Instruments

Research instruments are basically the tools that are employed to collect data. Data for this research was collected using key informant interviews and focus group discussions.

3.6.1 Key Informant Interviews

Key informant interviews are used as a tool to explore related issues and problems associated with a given topic, a key informant interview involves talking to persons such as extension workers, farmers, local government officials, traders and community leaders who know the area or certain aspects of the problem (Saunders et al., 2012). Marshall (1996) says that, the key informant technique is an ethnographic research method in which these key informants because of their personal skills, position within society are

able to provide information and a deeper insight into what is going on around them. Key informant interviews also allowed the researcher to collect quality data in a short period in comparison to the time that in depth interviews can require. Teachers, health practitioners, and ministry officials were the key informants.

3.6.2 Focus Group Discussions

Focus group discussions are a small, temporary community formed for the purpose of collaborative enterprise of discovery (Kato, 2002). For the purposes of this study, considering the sample size of 15 parents from four residential zones, at least four focus group discussions were carried out ,one in each residential zone (Canaan Egypt, Lusaka, and Engineering). These consisted of a representation of both male and female respondents since researcher assumed that disability affected both males and females.

In this study, the use of focus group discussions allowed the researcher to gain the research domain quickly from the respondents. By using focus group discussions, the researcher was provided with unique insights of the communities understanding of food aid and how it has affected them. This process generated rich answers from the respondents. The researcher was also allowed to probe further as responses from respondents were presented to him the discussion progresses. Kato (2002) noted that focus group discussions make use of open ended questions and this allows respondents to reveal what is on their mind as opposed to what the interviewer suspects is on their mind. In light of the above statement, the use of focus group discussions for this study provided

the insights and understandings of the community itself and not the researcher's opinion on the subject matter.

3.7 Data Collection Procedures

The data collection was initiated by the compilation of the key informant interview guide and the focus group discussion guide. The data collection procedure began by the researcher travelling to the area of study or site of research, which was Machipisa Shopping Centre. Focus group discussions were conducted with a minimum of 6 people and maximum of 15 people. Both males and females had to be, at least, equally represented in a given session. At least four focus group discussions were carried out in each of the four zones (Canaan, Egypt, Lusaka, and Engineering). The discussion session lasted approximately between one and one and a half hour. The researcher had to lay down a few ground rules for the discussion session to ensure order and progress such as being the chairperson and to view opinion on issue under discussion. The researcher also had to use a language that was best understood by the respondents and in this cases their local language Shona.

Teachers, health practitioners, and social welfare officials were the key informants. The researcher visited five schools in each ward and interviewed the most senior teacher at each school. The researcher also made an effort to interview five health practitioners in each ward. The first step in the interviews was to identify and introduce oneself to these

key informants. The key informant interview were intended to last for not more than an hour as these people were likely to be busy individuals.

3.8 Ethical Considerations

Ethics define the right and wrong conduct in research. According to Saunders et al (2009), ethics of research include informed consent, confidentiality, protection of privacy, protection against harm, and protection against identity.

Ethical considerations were observed when participants were informed about the study and verbal consent is given. Participants were also told not divulge their names during key informant interviews and focus group discussions and this ensured anonymity. In addition, participants were informed that data collected is to be used for academic purposes only and that information collected would be treated as confidential.

3.9 Data Presentation and Analysis Procedures

The research conducted was qualitative in nature and, therefore, quantitative data analysis was difficult due to the use of open-ended questions. Open-ended questions produce a multi varied and multi diverse response(s) from interviewees. O' Leary (2004) says that for qualitative data thematic analysis is suitable. This involves an analysis of words, concepts, literary devices and or non verbal cues. Findings from the research of similar nature were, therefore, grouped together.

3.10 Summary

Chapter three on methodology discussed the appropriate methodologies or research techniques that the research utilised to collect data. The target population was outlined, the sampling procedure and sample size was presented. The researcher highlighted specific tools used and these were focus group discussions and key informant interviews. The chapter ended with a brief discussion on how the data collected was analysed. The next chapter looks at data presentation, analysis, and discussion.

CHAPTER IV

DATA PRESENTATION, ANALYSIS, AND DISCUSSION

4.1 Introduction

This chapter focuses on data presentation, analysis, and discussion. The data presentation, analysis and discussion of data are in line with the objectives of the study. There were four main objectives, which are;

- To examine the adequacy of legal framework for ensuring access to education and health by children with disabilities, in general, and those with Cerebral Palsy, in particular.
- To establish if there are appropriate institutional structures for promoting the educational and health rights of children with Cerebral Palsy in Highfield High Density Suburb in Harare
- To establish if schools in Highfield High Density Suburb have appropriate facilities to cater for children with Cerebral Palsy
- To establish is there are appropriate health institutions and facilities to cater for the health needs of children with Cerebral Palsy
- To propose options for enhancing the educational and health rights of children with Cerebral Palsy

The chapter starts by providing the response rate and demographic characteristics of participants. Response rate and demographic characteristics help in validating the findings of the study.

4.2 Response Rate and Demographic Characteristics of Participants

4.2.1 Response Rate

The researcher obtained a good response from participants. Table 4.1 illustrates the response rate.

Table 4.1: Response Rate

Category of Participants	Sample Target	Response	Response Rate
Health Officials	20	16	80%
Educationists	20	18	90%
Parents/Guardians	60	60	100%
Total	100	94	90%

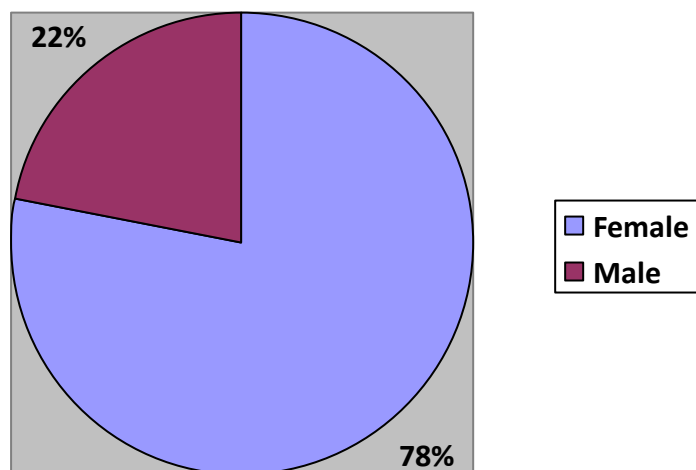
From table 4.1, the researcher obtained a response rate of 90%. The response rate was very high considering that Saunders et al (2009), recommended a minimum rate of 67%. Appointments were made in advance, and interviews and focus group discussions were conducted when participants had confirmed availability. The response rate was assisted by the fact that the researcher works with the parents, caregivers, educationists and social

welfare officers in Highfield as a Social Worker for The J.F Kapnek Trust and the Harare CRU. Health official and educationists were the key informants and the researcher visited schools and health centers in order to interview participants. Focus group discussions were conducted with parents/guardians. There were four focus group discussions, one in each of the following residential zones, Canaan Egypt, Lusaka, and Engineering. Each focus group discussion was attended by 15 parents/guardians.

4.2.2 Demographic Characteristics of Participants

Information about personal details of participants was obtained. The gender of participants was recorded and participants also provided their ages. Female domination was observed in the study as 78% of the participants were female. Therefore, findings from this study were mainly views of females. Figure 4.1 show findings on gender of participants in the study.

Figure 4.1: Gender of Participants



Participants were asked to indicate their age groups. Table 4.1 shows findings on age.

Table 4.1: Age Groups

Age Group (Years)	Number of Participants	% of Participants
18<30	14	14.9
30<40	58	61.7
40<50	16	17
<50	6	6.4
Total	94	100%

From table 4.1, it can be seen that 16 participants (14%) were between 18 and 30 years, 61.7% were between 30 and 40 years, while 22% were above 40 years of age. The data in

table 4.1 shows that the majority of were old enough to appreciate the issue of access to health and education and by children with Cerebral Palsy.

The study also found out that 30 out of the 60 parents/guardians have children or relatives with Cerebral Palsy. The other parents were not very much familiar with the disability. However, all the 34 professionals (16 health practitioners and 18 educationists) were aware of the disability by virtues of interacting with patients and students affected they the condition.

4.3 Status of Health and Education in Highfield

4.3.1 History of Highfield High Density Suburb

Highfield is a high-density suburb to the southwest of Harare. Highfield was founded on what used to be Highfield Farm; the farmhouses and the gates can still be seen at, and have become the Rutsanana Clinic and Municipal buildings in what is now Glen Norah territory, near St Peters Kubatana High School. Highfield is bordered by Glen Norah to the southwest, Waterfalls to the southeast, Willowvale and Southerton spanning northeast to northwest. Highfield is the second oldest suburb (township) in Harare, established in 1930. It was established for black settlement during the colonial era. The first High Density Suburb is Mbare (Harari) which gave its name to the Zimbabwe capital Harare. Highfield was primarily set up by the white settler colonial government to provide labour to the Southerton and Workington industrial areas that border it; this was in a similar

fashion to how Harari (Mbare) had been set up to provide labour to Workington and Graniteside.

Highfield is divided into two main zones, Old Highfield and New Highfield. Old Highfield was established in the 1930s, and it comprises four distinct areas, namely the '2 Pounds', '5 Pounds', '12 Pounds' and 'The Stands'. The most affluent parts of Highfield are the two areas of Old Highfield; 'The Stands' and the '5 Pounds'. The Stands are so named because when first sold, the area was a greenfield and residents had to build houses of their choices; this is in comparison to the other areas of Highfield where the government had built low-cost basic housing for the natives and sold it at reflective prices. Historically, the yards here are very large and the houses, flamboyant and indulgent to reflect the affluent status of the black Rhodesians who settled here. Black Rhodesians who even if they afforded could not buy properties outside African designated areas naturally settled here. New Highfield was established in 1956 and comprises Lusaka (named after the Zambian capital), Egypt, Jerusalem and Canaan (named after biblical places), Engineering; Cherima (Dark Zone, used to be off the electricity grid; Zororo (place of rest); and Western Triangle. The newest area of Highfield is Paradise (1996) which is located at the southern end and borders Lusaka; it connects Highfield to nearby Glen Norah suburb to the South and part of it is in Glen Norah. Parliament of Zimbabwe (2006)

Highfield has remained a poor suburb despite the regeneration in other areas after 1980. Most of its successful residents choose to move out of the area (in a similar pattern to other high-density areas) rather than invest and set up in the area. It also remains a primary destination (like most high-density areas in Zimbabwe) for rural to urban migrants, who find it easier to pay for accommodation here and commute to work. They are also attracted by the easier opportunities to start up home businesses/industries at Machipisa and Gazaland Home Industry areas. It thus remains heavily populated, with high unemployment and is socially deprived. Parliament of Zimbabwe (2006)

4.3.2 Provision of Educational and Health Services in Highfield

There are 13 primary schools in Highfield. All of the 11 are state owned schools, managed through the Harare City Council. There are nine High Schools, of which four of them are private owned institutions. Health services are provided at two council clinics and several private surgeries at Machipisa and Gazaland Shopping Centres.

4.3.3 Knowledge about Cerebral Palsy

Thirty six parents/guardians (60%) indicated that they did not know the causes, effects and prevention of Cerebral Palsy. Those who had consulted traditional healers were made to believe that the disability was as a result of witch craft or evil spirits, one parent outlined “ *mushure mekunge mwana azvarwa akanzi aneCEREBRAL PALSY ndakarambwa nemurume achiti ndiri muroyi* (after my child was diagnosed with Cerebral Palsy my husband dumped me accusing me of being a witch. Another issue that

emerged was that the disability was associated with demons and bad omen. Thus these beliefs provided meaning for their experiences with disabled children and hence it affected how they responded to disability issues. The remaining 40% of parents believed that the disability has a natural cause and hence the children with Cerebral Palsy need a special place for good care (rehabilitation) as early as possible. These are the parents who consulted medical doctors for the rehabilitation of their children at an early stage.

The study, therefore, revealed that the majority of Zimbabwean population is generally not aware of Cerebral Palsy. With the exception of education and health workers, people came to know about Cerebral Palsy when they have experienced it. There is limited or no information dissemination on the problem of Cerebral Palsy and the disease is highly misunderstood, the symptoms or impairments associated with Cerebral Palsy are often interpreted as mental illness or weakness on the part of the mother (*ane musana wakaipa*)

The study revealed some observable signs and symptoms of Cerebral Palsy. Parents with Cerebral Palsy children revealed that children experience delays in speaking, have limited social skills, experience difficulties in conversations, and have unusual use of language. Other signs include inability to socialise (few or no friends) and poor eye contact. These findings are in line with what Timothy et al (2010) observed. Timothy (2010) provided that Cerebral Palsy varies widely in severity and symptoms include no babbling or pointing by age 1, loss of language or social skills, and poor eye contact.

All health workers in the study said that they have knowledge about Cerebral Palsy and check for its signs and symptoms during postnatal visits. It means that medical practitioners are aware of the problem of Cerebral Palsy. The problem is lack of information dissemination and health workers are keeping their knowledge to themselves. The researcher believes that there is need to create public awareness on Cerebral Palsy, just the same way other diseases like malaria, tuberculosis, and HIV (AIDS) are treated.

The study revealed that most primary school teachers are aware of Cerebral Palsy. However, participants said that there are no 'school specific' programmes to deal with Cerebral Palsy. There are no resources, in terms of books that educate people about Cerebral Palsy. Accordingly, Cerebral Palsy is not being viewed as a serious problem in Zimbabwe. It can be argued that more priority is being placed on the killer diseases like malaria, tuberculosis, cholera, and HIV (AIDS).

4.4 The Adequacy of Legal Framework for Ensuring Access to Education and Health by Children with Cerebral Palsy

All participants said that they were aware of national policies that seek to promote attainment of basic rights by all Zimbabwean citizens. One of the legal frameworks is the Constitution that guarantees human rights to all Zimbabweans. Also, some participants, particularly educationists and health workers, were aware of the Zimbabwe Public Health Act and the Education Act, that seek to ensure that all children have access to education and health services. A few professionals were privy of the provisions of the CRC, CRDP,

and the Disabled Persons Act. The few who were aware of the Disabled Persons Act were not privy of its provisions. This demonstrated that the proliferation of the legal framework guiding health and education issues for children with Cerebral Palsy was poor in caregivers and professionals alike. This also goes further to highlight the weakness of the legal framework as an elitist set of documents with little purpose in serving those whom they were created for, that is, children with Cerebral Palsy

However, it was pointed out that there were no legal frameworks dealing with Cerebral Palsy in particular. Therefore, the legal framework is inadequate. It seems as if society was not worried about Cerebral Palsy the same way it is about diseases. Participants outlined that there was need for laws that guarantee minimum survival standards for children with Cerebral Palsy. There is need for explicit laws that are focused on people with Cerebral Palsy especially children. It was pointed out that disability in general is a difficulty to parents of children with disabilities, there has to be a law that obligates government to assist with education and health of children with Cerebral Palsy since these are intermittent and recurrent expenses that come by merely having a child with Cerebral Palsy, they are incurred throughout the lives of most children with Cerebral Palsy.

In addition, the researcher noted that although in theory the government promotes an inclusive education policy, in practice, it supports a system of segregated resource classes designated for children with disabilities in mainstream schools and separate schools for

deaf, blind and children with physical and intellectual disabilities. While it takes time to transition from resource classes and special schools to a fully inclusive education system, the government has not done enough to ensure that children with disabilities attend school and that the education system is accessible, appropriate, and of good quality for children with disabilities, particularly those with intellectual disabilities. Furthermore, the government's inclusive education policy does not appear to be serious since there is no clear plan for the integration of children with disabilities, particularly intellectual or developmental disabilities, into mainstream schools.

The researcher also noted that, despite national policies on inclusive and "child-friendly" schools, the government of Zimbabwe is failing to make the school environment accessible for children with disabilities as evidenced in Highfield where there are little provisions in the health and education system for children with Cerebral Palsy, this in many cases effectively denies these children their right to education. One educationist outlined that even in new schools and on new blocks being constructed at schools there are no access ramps and rails, these things take a simple circular to inform all school authorities to include these on new buildings. This further shows a lack of seriousness on the part of government to meet the educational needs of children with Cerebral Palsy. He went further to give an example of how the famous circular 37 led to the regularization of corporal punishment

Furthermore, the researcher found that though there was a level awareness of the right to education among parents, most of them noted that education for a child with Cerebral Palsy was much more difficult, they noted that firstly there was the issue of getting the child assessed by the Department of School Psychological Services (DSPA) for placement in appropriate schools and procurement of assistive devices to enable the child to learn, these may include hearing aides and wheelchairs, while the government helped with assessments, the needs after the assessment are left to the peril of the already struggling parents, for example procurement of a wheelchair. Secondly the parents outlined that there might come a recommendation from the assessment that the child be sent to a special school, again all the government does is assess and leave the parent or caregiver to pay the exorbitant fees demanded by special schools. The parents and caregivers also lamented that there are government provisions to pay fees for children with disabilities like the Basic Education Assisted Module (BEAM), these have failed to assist children with Cerebral Palsy as in most cases the government has failed to honour its promises. The same applies to the Public Assistance offered by the Ministry of Labour Public Service and Social Welfare (MPSLSW) through the Department of Social Services, this includes procurement of prosthetics and assistive devices, this process has failed to assist children with Cerebral Palsy as the process leaves sourcing for quotations to parents and even in cases the parents have acquired the quotations the government rarely has the money to buy the devices, this further exposes the porousness of the legal framework as many children are falling through the above cited loopholes

Inadequately trained teachers, lack of appropriate teaching materials, inaccessibility of classes and long distance to schools, lack of funds for transportation, and negative parental attitudes about the learning capabilities of their children. The study showed that there are significant unmet needs for people with disabilities in general, particularly among low to middle income earners where health service infrastructure, education and public awareness are lacking. From a global health perspective, the appropriate means of promoting the participation/social inclusion of disabled persons is dependent on local needs (both country and region-specific) and the availability of resources. Freeman (2007)

Moreover, there is absence of social acceptance of Cerebral Palsy in Highfield, most families who have children with disabilities are shunned and accused of witchcraft, sorcery or African wealth enhancement magic, this has seen them being excluded from community initiatives which in other words is an opportunity for integration of the families and the children into communities. This also makes it difficult for policy makers to realize the plight of the children and the caregivers alike since their predicament since they are subjugated to the interests of the majority. A ‘family-centered’ approach in providing health and education services offers great opportunities of children with Cerebral Palsy and their parents in Highfield, since it is apparent that the existence and wellbeing of children is tied to parental care and parental wellbeing, it is important therefore that parents be integrated into all services provided to children. Transition from childhood to adulthood for children with Cerebral Palsy in Highfield is not supported by

appropriate planning and coordination by the health, education and social services including attention to housing, vocational and recreational opportunities. Children with Cerebral Palsy are left to navigate the transition on their own. This transition often occurs when children are still in the education system, since the children have different needs from other children and often find themselves comparing themselves with other children, the failure of the legal framework to capture the unique needs of children will result in them dropping out of school.

Moreover, there is limited health provision to children with Cerebral Palsy in Highfield and there are no policies to ensure that the affected children enjoy their basic rights. The aim of health care for people with Cerebral Palsy is to enable activities and participation by promoting efficient movement, limiting deformity, reducing pain, and employing cognitive and/or behavioural strategies. These objectives may sometimes conflict, for instance when strategies to limit deformity temporarily hinder activities. Thus, the rationale for any intervention should be shared with the individual with Cerebral Palsy and the family to enable them to make an informed decision with the professionals, to prioritise goals and to plan management regimens. The situation has remained the same for years as there is no mechanism in the existing legal framework to make stakeholders accountable.

The researcher found out that it is difficult to formulate an idea legal framework due to societal values and beliefs around disability in Zimbabwe. In traditional African society,

the birth of a child with any form of disability brings a lot of emotional stress to family members as a result of the stigma attached to such a condition. Focus group discussions with parents revealed that, traditionally, disability was regarded to be the work of mythical Gods or the presence of the evil and witchcraft. Some parents believed that disability is a punishment from the ancestors for having transgressed the spiritual or moral values of society. The findings are also supported by literature. According to Zindi (1997), assumption of traditional African philosophies is that the birth of a child with disability is a bad omen or an act of bewitchment. This is so because the disabled child is viewed as someone who will not bring fortune into the family as argued by Sanders (1985) in Kapp (1994). From a Zimbabwean cultural perspective, the child was and is still seen as an important asset for the family. Having a child fulfills societal expectations of procreation and helps to strengthen the clan and nation. For some parents, the child has always been seen as a source of income, as well as financial gain through the payment of lobola for their daughters. Thus a disabled child, especially one with Cerebral Palsy may not marry or work for the family and in such situations, the parents often respond negatively to the situation. Very few parents have been able to handle the trauma that comes with the birth of a disabled child. However as pointed out by Levitz (1991) the adjustment and reactions that those parents of children with disabilities experience do not necessarily manifest at the same degree in all parents, but do manifest in most of them. In some families a child with a disability is regarded as a demon, possessed by a demon or bad omen to the entire clan. The situation is perceived as a punishment from God for the evil doings committed either by parents or by their ancestors, hence some parents

actually think it is shameful to have a disabled child around (Chimedza and Peters 2000). In some instances the occurrence of the condition has often led to divorce, propelled by the belief that such children are unclean, inferior and unworthy for an education (Chimedza and Peters 2000). Yet some families do regard disability as a problem that can be solved although they may exhibit disbelief, shock, rejection, mourning, anger, embarrassment and frustration as argued by Sello (1995), though of course the parents' reactions may differ from culture to culture. In some African cultures parents' reactions depend on the size of the family, the sex of the child, religion and the degree of severity of the child's ability. These reactions provided some assistance in the understanding of parental attitudes to children's disabilities as is the case of children with Cerebral Palsy.

Moreover, even at the international level, it is difficult to come up with an ideal legal framework. Culture also affects international policies on disability. The researcher also noted that a significant number of families have their roots in Malawi and Zambia, their forefathers came to Zimbabwe (then Rhodesia) as migrant workers looking for employment in Southerton and other surrounding industrial sites, and the fusion of cultures has somehow resulted in a highly superstitious society. The perception of disability discussed earlier is also evident from the biblical times and other ancient civilizations, and with the universal influence of Christianity, this has resulted in a negative feedback mechanism into the African traditional beliefs. People in biblical times commonly viewed those with disabilities as sinful, demon-possessed, separate from the rest of humanity, and "unclean." Within this moral model, the place of disability has

been displayed as manifestation of sin or of God's displeasure, a test or challenge for nondisabled people, an opportunity for nondisabled people to achieve salvation through serving disabled people, and an aberration in nature's harmony (Mackelprang 2010). Hence charity and ostracism have been used as typical mechanisms to assist and to control people "afflicted" with disabilities (Mackelprang 2010). Historically then, people with disabilities have been stigmatized, stereotyped, and discriminated against (Garner & Joe, 1987; Livneh, 1994 in Treloar 2000).

Policy design does not always take into account the needs of people with disabilities, or existing policies and standards are not enforced. For example, for inclusive education policies, a review of 28 countries participating in the Education for All Fast Track Initiative Partnership found that 18 countries either provided very little detail of their proposed strategies to include children with disabilities in schools or did not refer to disability or inclusion at all (Mackelprang 2010). The common gaps in education policy include a lack of financial and other targeted incentives for children with disabilities to attend school as well as a lack of social protection and support services for children with disabilities and their families. There are other challenges that hinder promulgation of effective policies to guarantee educational and health rights of children with Cerebral Palsy. These are;

- **Negative attitudes:** Beliefs and prejudices constitute barriers to education, employment, health care, and social participation. For example, the attitudes of

teachers, school administrators, other children, and even family members affect the inclusion of children with disabilities in mainstream schools. Misconceptions by employers that people with disabilities are less productive than their non-disabled counterparts, and ignorance about available adjustments to work arrangements limits employment opportunities.

- **Lack of provision of services:** People with disabilities are particularly vulnerable to deficiencies in services such as health care, rehabilitation, and support and assistance. Data from four Southern African countries found that only 26–55% of people received the medical rehabilitation they needed; 17–37% received the assistive devices they needed; 5–23% received the vocational training they needed; and 5–24% received the welfare services they needed. Research in Uttar Pradesh and Tamil Nadu states of India found that after cost, the lack of services in the area was the second most frequent reason for people with disabilities not using health facilities ((Mackelprang 2010).
- **Problems with service delivery:** Poor coordination of services, inadequate staffing, and weak staff competencies can affect the quality, accessibility, and adequacy of services for persons with disabilities. World Health Survey data from 51 countries revealed that people with disabilities were more than twice as likely to report finding health care provider skills inadequate to meet their needs, four times more likely to be treated badly and nearly three times more likely to be denied needed health care. Many personal support workers are poorly paid and

have inadequate training. A study in the United States of America found that 80% of social care workers had no formal qualifications or training (WHO, 2013).

- **Inadequate funding:** Resources allocated to implementing policies and plans are often inadequate. The lack of effective financing is a major obstacle to sustainable services across all income settings. For example, in high-income countries, between 20% and 40% of people with disabilities generally do not have their needs met for assistance with everyday activities (WHO, 2013). In many low-income and middle-income countries governments cannot provide adequate services and commercial service providers are unavailable or not affordable for most households.
- **Lack of accessibility:** Many built environments (including public accommodations) transport systems and information are not accessible to all. Lack of access to transportation is a frequent reason for a person with disability being discouraged from seeking work or prevented from accessing health care. Reports from countries with laws on accessibility, even those dating from 20 to 40 years ago, confirm a low level of compliance. Little information is available in accessible formats, and many communication needs of people with disabilities are unmet. Deaf people often have trouble accessing sign language interpretation: a survey of 93 countries found that 31 countries had no interpreting service, while 30 countries had 20 or fewer qualified interpreters. People with disabilities have significantly lower rates of information and communication technology use than non-disabled people, and in some cases they may be unable to access even basic

products and services such as telephones, television, and the Internet (WHO, 2013).

- **Lack of consultation and involvement:** Many people with disabilities are excluded from decision-making in matters directly affecting their lives, for example, where people with disabilities lack choice and control over how support is provided to them in their homes.
- **Lack of data and evidence:** A lack of rigorous and comparable data on disability and evidence on programmes that work can impede understanding and action. Understanding the numbers of people with disabilities and their circumstances can improve efforts to remove disabling barriers and provide services to allow people with disabilities to participate. For example, better measures of the environment and its impacts on the different aspects of disability need to be developed to facilitate the identification of cost-effective environmental interventions.

4.5 Appropriateness of Institutional Structures for Promoting the Educational and Health Rights of Children with Disabilities

There study found out that Highfield did not have appropriate health and educational institutions to cater for the needs of children with Cerebral Palsy. In terms of education, there were no special schools in Highfield and children go to mixed schools where there are no adequate resources in the Disability Resource Classes (DRCs). Also, only 4 of the 13 primary schools have Disability Resource Classes.

In addition, though special institutions available in neighbouring Southerton, many parents of children with Cerebral Palsy in Highfield are not able to access them because of poverty. They are unable to send their children to expensive schools that can provide a conducive environment to nurture and rehabilitate their children. Some of them are unable to meet the high travelling expenses to and from the school since such children would need special transport. Generally poverty prevents parents in Highfield from participating in school activities aimed increasing opportunities for their children to learn better, they view this as an extra burden since time in school allow them a breathing space and time to do other economic activities like vending .This inevitably creates a negative attitude towards the education of children with disabilities. An important emerging issue was that children with Cerebral Palsy require a lot of financial support for their rehabilitation. This was causing a lot of financial strain in the families of all parents interviewed. This led to the evident manifestation of negative attitudes towards the child with Cerebral Palsy. Another issue that came up is that of discrimination. The parents did not see it as discrimination but the practice confirms it so. For example, preference for the payment of school fees is given for children without disabilities before those living with the disability. Although the explanation is to pay for those whose fees is cheaper first, this really amounts to discrimination. Eventually this created negative attitudes among the siblings who would see the child with Cerebral Palsy as second class, while at the same time viewing him or her as one who is using more financial resources at the

expense of the welfare of the other children. However all the parents expressed that their children with Cerebral Palsy were an integral part of their families.

It also emerged that in homes where house maids were employed, children with disabilities did not receive proper care, especially when their parents would have gone to work. The child is sometimes left alone, without food or proper care. Children with mobility problems were the most affected and more frustrated. Some parents have ended overprotecting the child and this has affected his/her development of independence. Such treatment disrupts the efforts by the special school. One parent had failed to send her child to school at one point due to financial problems. Other parents indicated that they were not fully involved in what was happening at school or were not sure as to how they could get involved. However, it was also evident that some parents lacked interest in the education of their children with Cerebral Palsy, only interacting with the school only when invited for consultation. Some even failed to go for such consultations. One point worth noting is that most parents complained that the special schools are far away. This is not surprising since children with disabilities are few, it also follows that the schools are few.

4.6 Appropriateness of School Facilities for Children with Cerebral Palsy in Highfield High Density Suburb

The study showed that children with Cerebral Palsy have challenges going to school. One parent said that, “my child’s education is tied to a wheelchair, if he doesn’t have one, he cannot go to school, and I cannot carry him either because he is too heavy”. Also,

children have challenges moving around at the school premises, for example from the class to the library. There are no pavements for wheelchairs at schools, no ramps at the doors, no rails for children who have difficulties moving, and there are no specially designed toilets and commodes for children with disabilities. Moreover, teachers in Highfield are not trained to teach children with Cerebral Palsy. It was held that, sometimes, children are turned away because of their impairments e.g. visual or audio. In some cases, children are referred to special schools outside Highfield, for example Jairos Jiri and Ruvimbo both in Southerton. Children who need respite services are referred to Tose Respite Centre in Sunningdale. The study showed that of all the 13 primary and secondary school in High field none have a special education teacher.

Moreover, it is vital to note that education is expensive as parents have to pay fees, buy uniforms, books, and meet other requirements. Children with disabilities especially Cerebral Palsy need much more, some need assistive devices like hearing aids which are expensive and not readily available in government hospitals, others need wheelchairs and spectacles. Most children with Cerebral Palsy need on ongoing therapy thus physiotherapy and occupational therapy to help them to better adjust to school environment. Schools need special equipment to cater for needs of children especially specially designed desks and chairs, some children with Cerebral Palsy end up having concentration problems because of sitting positions. With economic challenges, there are limited financial resources to cater for the needs of children, children with disabilities are, therefore, in a worse off situation.

The study found out that there is lack of access to school, in terms of physical access (no ramps or disability-friendly toilets), communication barriers negative attitude of teachers, and a curriculum that does not adequately address children with different learning needs. It is vital to note that, under the CRPD, Zimbabwe is required to make the necessary accommodations to the school environment based on the individual needs of children with disabilities to enable them to attend school with others.

Furthermore, most schools in Highfield are often inadequately staffed or understaffed, they have no flexible curriculum and limited teaching materials, leading to an inferior quality of education for children with disabilities, compared to other children. The government provides minimal special education training only to teachers working in special schools or resource classes.

The study also revealed that teachers in the 3 schools in Highfield that have Disability Resource Classes do not have adequate training on how to integrate children with disabilities in their classrooms, thereby undermining the principle of inclusive education that the Zimbabwe Government is trying to promote. As a result, children with Cerebral Palsy in Highfield schools have a greater probability to fail and are more likely to repeat. In other cases children are assigned to “special classes” where they stay stuck for years without any prospect of moving forward.

Generalization of impairment is another problem faced by children with Cerebral Palsy in Highfield, in the name of inclusive education , most schools have created so called “special classes” where children with learning and coping difficulties are accommodated and assisted by untrained ‘special needs education teachers’, most parents however lamented that these “resource classes” have turned into dumping grounds where all children with learning difficulties are left to allow teachers to move with those who can cope. This comes from the common stereotype society and in Highfield specifically that children with Cerebral Palsy are mentally retarded. In this regard the resource classes are manned by teachers with no special needs education qualifications.

Moreover, the economic environment is making it difficult for schools in Highfield to provide adequate facilities for pupils affected by Cerebral Palsy. Economic environment influences available of financial resources in a schools. Holcomb (1995) says that no money, no development because money is a vehicle that drives every plan to success or failure. Schools require financial resources for acquisition of furniture and building of school infrastructure. Maciha (2000) points out that when there is high inflation and high interest rates, it becomes difficult for school administrators to plan for acquisition of required resources. The current economic challenges facing Zimbabwe make it difficult for schools to purchase even textbooks let alone brail paper among other needs of children with Cerebral Palsy. Teachers are also earning low salaries and substantial numbers of qualified teachers have left the work force and unqualified temporary staffs

are being used to fill the gap. Teacher pay, attendance and motivation are low, resulting in weak performance.

4.7 Appropriateness of Health Institutions and Facilities to Cater for Needs of Children with Cerebral Palsy

The study found out that there were two public health centres in Highfield. However, discussions with health professionals showed that these institutions were not able to cater for the needs of children with Cerebral Palsy. In addition, poor families were failing to access the basic services. It is important to note that while the government promises health for all, parents often have to pay for services but many cannot afford. In addition, while health services for children with disabilities are offered free to children under the age of 5 those above 5 have to pay. In cases where the medical care is offered for free, the parents and caregivers of children with disabilities often face intermittent costs like transport to health facilities and buying medication.

The local health facilities in Highfield do not offer any services whatsoever to children with disabilities besides treating common ailments; hence caregivers often have to travel to the Children's Rehabilitation Unit (CRU) at Harare Hospital. Therefore, transport becomes complicated when a caregiver has to travel with a wheelchair bound child using public transport; they have to pay 3 fold (caregiver, child and wheelchair). In addition, the CRU is often congested as it caters not only for Harare but other cases referred for specialist care nationally; this has affected patient specialist ratios hence compromising

the quality of care. One caregiver outlined that one perfect example which shows lack of stakeholder commitment is the Harare CRU itself, located on the first floor of a building only accessible by a flight of stairs, how on earth do children on wheelchairs get there, he went to say that all it takes is a simple swap of departments but commitment to the cause of children with disabilities.

In line with the preceding discussions, the study found out that children with disabilities in Highfield experience barriers in the delivery of appropriate primary and preventive health care. The barriers can be classified into three, sometimes overlapping, categories: financial, structural, and programmatic. In the financial category are problems related to coverage limitations for medications, durable medical equipment, mental health treatment, referrals to specialists, and treatment for chronic conditions. In the structural barrier category are problems related to the architectural characteristics of medical offices (e.g., parking and entrance locations, doorway width, stairs and ramps, and bathroom accessibility). The barriers to access that can be considered programmatic include aspects of how physician offices operate, the accessibility of the equipment utilized for medical examinations, the medical responses of doctors and nurses to patients with disabilities, and the absence of physician and allied health professional expertise regarding the provision of primary care to someone with a disability. The financial and structural access problems are elaborated in a number of studies (Neri and Kroll, 2003 and Drainoni et. al., 2006). Physicians, policy makers, and the public appear to have some grasp of what financial and structural access mean, even if the implementation of solutions lags.

However, Drainoni, et al. (2006) find that while there are financial and structural access problems, a large proportion of the barriers reported to them by people with disabilities involve the processes used to deliver healthcare. These issues of programmatic access appear to be less well-recognized or understood.

In addition to neurological and musculoskeletal problems, children with Cerebral Palsy may require care for multiple impairments of sensation, perception, cognition, communication, and behavioural problems, epilepsy, difficulties with sleeping, drooling and feeding. Health care for people with Cerebral Palsy requires the skills and input from a variety of professions who must work efficiently and collaboratively with the family as a team. Each professional, and the teams involved in managing different issues (e.g. orthopaedic, epilepsy, feeding etc) must understand the range of problems associated with the condition as well as the family goals and priorities. Drainoni, et al. (2006)

Evidence from the research suggests that children with disabilities in Highfield experience poorer levels of health than the general population. Depending on the group and setting, children with Cerebral Palsy may experience greater vulnerability to preventable secondary conditions, co-morbidities, and age-related conditions. Some studies have also indicated children with cerebral have higher rates of risky behaviours such as poor diet and physical inactivity. Children with disabilities also have a higher risk of being exposed to violence. One Child Welfare and Probation Services Official in Highfield outlined that the risk of violence, neglect and abuse becomes increased when a

child has a disability, he further lamented that statistics in the district show that rates of sexual abuse are high among children with disabilities

4.8 Options for Enhancing the Educational and Health Rights of Children with Cerebral Palsy

4.8.1 Educational Rights

Participants said that there is need to put in place policies that recognise the plight of children with Cerebral Palsy and put in place measures to assist them. Training of teachers has to consider needs of children with Cerebral Palsy. Building of new schools has to consider physical challenges of children with Cerebral Palsy. The existing schools need to be better equipped to meet the needs of children with Cerebral Palsy. Moreover, awareness of Cerebral Palsy has to be raised at both school and community level so as to integrate the needs of children with Cerebral Palsy in community planning. Funding has to be availed from government and other stakeholders to build and resource Disability Resource Classes in Highfied's 13 schools.

Participants also noted that, of particular importance is the need to ensure inclusive education. The inclusion of children with disabilities in mainstream schools promotes universal primary completion, is cost-effective and contributes to the elimination of discrimination. Including children with disabilities in education requires changes to systems and schools. The success of inclusive systems of education depends largely on a country's commitment to adopt appropriate legislation; provide clear policy direction;

develop a national plan of action; establish infrastructure and capacity for implementation; and benefit from long-term funding. Ensuring that children with disabilities can have the same standard of education as their peers often requires increased financing. UNESCO (2012)

According to UNESCO (2012) creating an inclusive learning environment will assist all children in learning and achieving their potential. Education systems need to adopt more learner-centred approaches with changes in curricula, teaching methods and materials, and assessment and examination systems, most schools in Highfield use the same curriculum and teaching methods for both normal and special needs children. Many countries have adopted individual education plans as a tool to support the inclusion of children with disabilities in educational settings. Many of the physical barriers that children with disabilities face in education can easily be overcome with simple measures such as changing the layout of classrooms. Some children will require access to additional support services including specialist education teachers, classroom assistants, and therapy services.

Appropriate training of mainstream teachers can improve teacher confidence and skills in educating children with disabilities. The principles of inclusion should be built into teacher training programmes and accompanied by other initiatives that provide teachers with opportunities to share expertise and experiences about inclusive education. In line with this argument, UNESCO (2012) estimates that children with disabilities represent

more than one-third of the 67 million children who are out of school worldwide. In some countries, the chances of a child with a disability not attending school are two or three times greater than a child without a disability.

Inclusion in education is rooted in Article 26 of the Universal Declaration of Human Rights, which provides that “everyone has the right to education.” The Convention on the Rights of Persons with Disabilities obliges States Parties to guarantee an “inclusive education system at all levels.” Specifically, CRPD Article 24 requires States Parties to ensure that children with disabilities “are not excluded from the general education system on the basis of disability” and that they have access to “inclusive, quality and free primary and secondary education on an equal basis with others in the communities in which they live.” The convention goes further by requiring governments to provide reasonable accommodations and the “individual support required, within the general education system, to facilitate their education consistent with the goal of full inclusion.”

The concept of inclusive education is also contained implicitly in article 13, paragraph 1, of the International Covenant on Economic, Social and Cultural Rights and articles 23 and 29 of the Convention on the Rights of the Child (UNICEF 2007)

Inclusive education focuses on removing the barriers within the education system itself that exclude children with special educational needs and cause them to have negative experiences within school. It requires teachers and classrooms to adapt, rather than for the child to change. Support services should be brought to the child, rather than

relocating the child to the support services. In an inclusive classroom, children with disabilities have individual education programs to guide the teacher, parents and student on how to achieve the best educational outcomes for the child. UNICEF (2007)

UNICEF (2007) further states that inclusive education needs to be distinguished from the system of integrated education. The latter focuses on developing the skills of children with disabilities so that they can join a mainstream school, sometimes through classrooms located within the mainstream school itself. However, this model tends to regard the child itself as the problem rather than addressing whether children with disabilities are in fact learning and the system-wide barriers in the education system. Specialized classes within mainstream schools may be beneficial for some students with disabilities to complement or facilitate their participation in regular classes, such as to provide Braille training or physiotherapy. Inclusive education stands in sharp contrast to the special or separate education model, in which children with disabilities are taught in segregated schools outside the mainstream.

4.8.2 Access to Health

Participants said that there was a need to scrape user fees for all disabled persons and government and other private stakeholders have to take some of the burden from the parents. One caregiver pointed out that, “my son will always sacrifice all I have for my

child but I cannot sacrifice what I do not have, in this case the government should meet me halfway” This highlights the high cost health for children with Cerebral Palsy.

The research also found that centralisation of rehabilitation services has seen the caregivers and children with disabilities has resulted in caregivers negating on the health of their children owing to extra costs incurred in the process of accessing a distant services, this has been corroborated by the World Report on Disability (2011) which outlined that, local health centres have to be equipped to meet some of the health needs of Children with Cerebral Palsy. Making all levels of existing health care systems more inclusive and making public health care programmes accessible to people with disabilities will reduce health disparities and unmet need. A variety of approaches have been used in mainstream health care settings to overcome physical, communication and information barriers such as structural modifications to facilities, using equipment with universal design features, communicating information in appropriate formats, making adjustments to appointment systems and using alternative models of service delivery. Community-based rehabilitation has been successful in less-resourced settings at facilitating access for children with disabilities to existing services and in screening and promoting preventive health care services. In high-income countries disability access and quality standards have been incorporated into contracts with public, private, and voluntary service providers. Such measures as targeting services, developing individual care plans, and identifying a care coordinator can reach people with complex health needs and hard-to-reach groups. While children with disabilities should receive services

from primary care teams, specialist services, organizations, and institutions should be available when needed to ensure comprehensive health care. WHO (2011)

Financing options can greatly improve coverage and affordability of health care services for children with Cerebral Palsy in Highfield. These include ensuring that payments for services are affordable for children with Cerebral Palsy and their parents and for those who do not have other means of meeting the cost of services, reducing cash payments, and providing income support to meet the indirect costs can improve the use of health care services, income generating projects being run by a local nongovernmental organization Kapnek Trust for parents of children with Cerebral Palsy is a good example. Partnerships between government, the private sector and service providers to improve services for example the Zimbabwe government can work with Medical Aid Societies to come up with affordable health financing for children with Cerebral Palsy, Harmonised Cash Transfers run by the Ministry of Public Service Labour and Social Welfare in collaboration with UNICEF in some rural districts can be rolled out in Highfield as a way of meeting the cost of service. In

Moreover, there is a need to address bottlenecks to rehabilitation for children with Cerebral Palsy in Highfield, Rehabilitation is a lifelong service that children with Cerebral Palsy will always require, this includes, physiotherapy, occupational therapy,

speech therapy and other allied services, this will go a long way in improving not only the standards of health and education but the standard of living in general.

The researcher also established that policy responses should be focused on early detection and intervention so as to improve the chance for recovery and to maximize the benefits of medical and social interventions.

Furthermore the research found out that in Highfield medical rehabilitation services are not part the mainstream primary healthcare system , while all most medical services like maternity and primary health are available at local health centers , rehabilitation services are not available meaning that caregiver and child have to travel outside the community regardless of other challenges they face, this gives an extra burden to caregivers who are already struggling to meet the child's other needs.

Helping children and caregivers of children with Cerebral Palsy to access assistive technology for children with Cerebral Palsy in Highfield promotes independence, advances participation, and cuts costs which are normally borne by caregivers, the additional resources saved can be used to finance needs in other areas of the child's life. The research also noted dangers associated with the high cost of assistive technologies, there were cases where caregivers had received wheelchairs and prosthetics from well-wishers, this was oblivious of the fact that wheelchair are prescription items, but each child has to be assessed and prescribed according to their condition. Furthermore there is

need for review after the issuing of assistive devices to maximize on improvements and adjust prescription to current conditions

The research also unearthed a lack of rehabilitation professionals in Zimbabwe, given the geographical expanse of Highfield there is no facility health or education that has a rehabilitation professional all needs of children with Cerebral Palsy are referred to Harare Hospital's Children's rehabilitation Unit.

4.9 Conclusion

This chapter presented findings of the research. The study showed that society has a negative attitude towards people with disability. Parents of children with Cerebral Palsy have negative attitudes towards the education of their own children most probably as a result of traditional beliefs that create non-supportive parental behaviours. This could be a result of an educational system that is far removed from societal issues and problems. The next chapter presents summary, conclusions, and recommendations.

CHAPTER V

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter concludes the research. It presents the overall summary of the study, the main findings, and recommendations.

5.2 Summary

This study examined the extent to which the educational and health rights of children with disabilities (Cerebral Palsy) are being met in Zimbabwe, in general, and in Harare's Highfield Suburb, in particular. The study was motivated by the fact that, in most parts of Africa children with disabilities and their families constantly experience barriers to the enjoyment of their basic human rights and to their inclusion in society. Their abilities are generally overlooked, their capacities are underestimated and their needs are given low priority. In particular, their rights to education and health are often not realised, which in turn hinders their access to other rights and creates enormous obstacles to reaching their potential and effectively participating in their communities. This is despite the fact that Zimbabwe has adopted legal frameworks for ensuring the rights to health and education and has ratified the international conventions dealing with children's rights like the CRC. Therefore, this study analysed the extent to which the educational and health rights of children with Cerebral Palsy are being met in Highfield High Density Suburb in Harare.

Objectives of the study were as follows;

- To examine the adequacy of legal framework for ensuring access to education and health by children with disabilities, in general, and those with Cerebral Palsy, in particular.
- To establish if there are appropriate institutional structures for promoting the educational and health rights of children with Cerebral Palsy in Highfield High Density Suburb in Harare
- To establish if schools in Highfield High Density Suburb have appropriate facilities to cater for children with Cerebral Palsy
- To establish if there are appropriate health institutions and facilities to cater for the health needs of children with Cerebral Palsy
- To propose options for enhancing the educational and health rights of children with Cerebral Palsy

The study was significant to children with Cerebral Palsy. The research was being done in order to promote the educational and health rights of children with Cerebral Palsy. Access to education and health would make it possible for children, when they reach adulthood, to lead 'normal' lives. In addition, the study could influence public policy and indicate possible measures that may be employed by government to ensure realisation of educational and health rights for disabled children. The research could provide a good platform for policy refinement to ensure that children with disabilities enjoy their rights to education and health. Moreover, the study aimed to add to the existing body of

knowledge on the rights of children living with disabilities. Findings of the study, if adopted, could advance the body of knowledge on the rights of children with disabilities. The study also provides a platform for ongoing research on how the rights of children with disabilities can be realised.

There was review of literature on Cerebral Palsy, what it is, its types, and causes. Focus was also on a review of literature on children's rights to education and health, and the legal framework. The study also reviewed literature to access to education by children with disability, in general, and with Cerebral Palsy, in particular. There was also a discussion on the right to health by children with Cerebral Palsy.

In this study, the research design used was a survey. The population consisted of educational, health practitioners, and parents/guardians in Highfield High Density Suburb. Purposive sampling was utilised to select 100 participants from four residential areas. Data for this research was collected using key informant interviews and focus group discussions.

The study found out that has a negative attitude towards people with disability. It therefore, becomes difficult for policy makers to enact appropriate legal framework to cater for the health and education need of children with Cerebral Palsy because the policy makers are also part of society. Even the parents of children with Cerebral Palsy have negative attitudes towards the education of their own children most probably as a result

of traditional beliefs that create non-supportive parental behaviours. This could be a result of an educational system that is far removed from societal issues and problems.

5.3 Conclusions

The study came up with the following conclusions, in line with each research objective.

5.3.1 The Adequacy of Legal Framework for Ensuring Access to Education and Health by Children with Cerebral Palsy

The study found out that the legal framework was inadequate. Society had a negative attitude towards people with Cerebral Palsy and this affected the enactment of appropriate laws. There was absence of knowledge about Cerebral Palsy by the ordinary citizens. It seems as if society was not worried about Cerebral Palsy the same way it is about diseases. Therefore, participants said there was need for laws that guarantee minimum survival standards for children with Cerebral Palsy. There is need for explicit laws that are focused on people with disabilities especially children. It was pointed out that disability in general is a difficulty to parents of children with disabilities, there has to be a law that obligates government to assist with education and health of children with Cerebral Palsy since these are intermittent and recurrent, they are needed throughout the lives of most children with Cerebral Palsy.

5.3.2 Appropriateness of Institutional Structures for Promoting the Educational and Health Rights of Children with Disabilities

The study found out that Highfield did not have appropriate health and educational institutions to cater for the needs of children with Cerebral Palsy. In terms of education, there were no special schools in Highfield and children go to mixed schools where there are no adequate resources in the Disability Resource Classes (DRCs). The health institutions were not able to cater for the need of children with Cerebral Palsy and patients were referred to Harare Central Hospital.

5.3.3 Appropriateness of School Facilities for Children with Cerebral Palsy in Highfield High Density Suburb

The study showed that children with Cerebral Palsy have challenges going to school. Also, children have challenges moving around at the school premises, for example from the class to the library. There are no pavements for wheelchairs at schools, no ramps at the doors, no rails for children who have difficulties moving, and there are no specially designed toilets for children with disabilities. Moreover, teachers in Highfield are not trained to teach children with Cerebral Palsy. It was held that, sometimes, children are turned away because of their impairments for example visual or audio. In some cases, children are referred to special schools outside Highfield, for instance Jairos Jiri and Ruvimbo both in Southerton. Children who need respite services are referred to Tose Respite Centre in Sunningdale. The study showed that of all the 13 primary and secondary school in Highfield none have a special education teacher.

5.3.4 Appropriateness of Health Institutions and Facilities to Cater for Needs of Children with Cerebral Palsy

The study found out that the two public health centres in Highfield were not able to cater for the needs of children with Cerebral Palsy. In addition, poor families were failing to access the basic services. In cases where the medical care is offered for free, the parents and caregivers of children with disabilities often face intermittent costs like transport to health facilities and buying medication. The study found out that people with disabilities experience barriers in the delivery of appropriate primary and preventive health care. The barriers can be classified into three, sometimes overlapping, categories: financial, structural, and programmatic.

5.3.5 Options for Enhancing the Educational and Health Rights of Children with Cerebral Palsy

Educational Rights: The study pointed out that there is need to put in place policies that recognise the plight of children with Cerebral Palsy and put in place measures to assist them. Training of teachers has to consider needs of children with Cerebral Palsy. Building of new schools has to consider physical challenges of children with Cerebral Palsy could also help. The existing schools need to be better equipped to meet the needs of children with Cerebral Palsy. Moreover, awareness of Cerebral Palsy has to be raised at both school and community level so as to integrate the needs of children with Cerebral Palsy in community planning. Funding has to be availed from government and other

stakeholders to build and resource Disability resource Classes in Highfied's 13 schools. Of particular importance is the need to ensure inclusive education.

Access to Health: There was a need to scrape user fees for disabled persons. Also, the local health centres have to be equipped to meet some of the health needs of Children with Cerebral Palsy. Making all levels of existing health care systems more inclusive and making public health care programmes accessible to people with disabilities will reduce health disparities and unmet need. A variety of approaches have been used in mainstream health care settings to overcome physical, communication and information barriers such as structural modifications to facilities, using equipment with universal design features, communicating information in appropriate formats, making adjustments to appointment systems and using alternative models of service delivery. Community-based rehabilitation has been successful in less-resourced settings at facilitating access for disabled people to existing services and in screening and promoting preventive health care services.

5.4 Recommendations

Recommendation 1: Enable access to all mainstream systems and services

Children with Cerebral Palsy have ordinary needs, for health and well-being, for economic and social security, to learn and develop skills. These needs can and should be met through mainstream programmes and services.

Mainstreaming is the process by which governments and other stakeholders address the barriers that exclude persons with disabilities from participating equally with others in any activity and service intended for the general public, such as education, health, employment, and social services. To achieve it, changes to laws, policies, institutions, and environments may be indicated. Mainstreaming will not only fulfill the human rights of children with Cerebral Palsy, it also can be more cost-effective.

Mainstreaming requires a commitment at all levels – considered across all sectors and built into new and existing legislation, standards, policies, strategies, and plans. Adopting universal design and implementing reasonable accommodations are two important approaches. Mainstreaming also requires effective planning, adequate human resources, and sufficient financial investment – accompanied by specific measures such as targeted programmes and services (see recommendation 2) to ensure that the diverse needs of children with Cerebral Palsy are adequately met.

Recommendation 2: Invest in specific programmes and services for children with Cerebral Palsy.

In addition to mainstream services, children with Cerebral Palsy may require access to specific measures, such as rehabilitation, support services, or training. Rehabilitation – including assistive technologies such as wheelchairs or hearing aids – improves functioning and independence. A range of well-regulated assistance and support services in the community can meet needs for care, enable these children with Cerebral Palsy to

live independently and participate in the economic, social, and cultural lives of their communities. Vocational rehabilitation and training can also open labour market opportunities.

While there is a need for more services, there is also a need for better, more accessible, flexible, integrated and well coordinated multidisciplinary services, particularly at times of transition such as between child and adult services. Existing programmes and services need to be reviewed to assess their performance and make changes to improve their coverage, effectiveness and efficiency. The changes should be based on sound evidence, appropriate to the culture and other local contexts, and tested locally.

Recommendation 3: Adopt a national disability strategy and plan of action which includes children with Cerebral Palsy

A national disability strategy sets out a consolidated and comprehensive long-term vision for improving the well-being of children with Cerebral Palsy and should cover both mainstream policy and programme areas and specific services for these children. The development, implementation, and monitoring of a national strategy should bring together the full range of sectors and stakeholders.

The plan of action operationalizes the strategy in the short and the medium term by laying out concrete actions and timelines for implementation, defining targets, assigning responsible agencies, and planning and allocating needed resources. The strategy and

action plan should be informed by a situation analysis, taking into account factors such as the prevalence of Cerebral Palsy, needs for services, social and economic status, effectiveness and gaps in current services, and environmental and social barriers. Mechanisms are needed to make it clear where the responsibility lies for coordination, decision-making, regular monitoring and reporting, and control of resources.

Recommendation 4: Involve children with Cerebral Palsy

Children with Cerebral Palsy often have unique insights about their disability and their situation as the old adage says “he who feels it knows it” . In formulating and implementing policies, laws, and services, children with Cerebral Palsy should be consulted and actively involved. Disabled people’s organizations dealing with children with Cerebral Palsy may need capacity building and support to empower these children and advocate for their needs.

Children with Cerebral Palsy are entitled to control over their lives and therefore need to be consulted on issues that concern them directly – whether in health, education, rehabilitation, or community living. Supported decision-making may be necessary to enable some individuals to communicate their needs and choices.

Recommendation 5: Improve human resource capacity

Human resource capacity in rehabilitation and special needs education can be improved through effective education, training, and recruitment, the Zimbabwe government needs

to come up with specific policies to ensure that training colleges churn out enough professionals to sustain the health and education needs of all people with disabilities. A skills audit to review the knowledge and competencies of staff in relevant areas and identify training gaps and capture emerging issues can provide a takeoff platform for developing appropriate systems. . Relevant training on disability, which incorporates human rights principles, should be integrated into current curricula and accreditation programmes. In-service training should be provided to rehabilitation and education practitioners official responsible for service provision.

Recommendation 6: Provide adequate funding and improve affordability

The government should partner with the private sector to provide sustainable financing of services in public institutions and come up with mechanism to make sure the services are offered to intended beneficiaries. Creating other innovative services outside public institution can hold decongest facilities and guarantees quality service. The development of the national disability policies and related action plans should be tied to the affordability and sustainability.

To improve the affordability of goods and services for children with Cerebral Palsy and to offset the extra costs associated with disability, consideration should be given to expanding health and social insurance coverage, ensuring that poor and vulnerable children with Cerebral Palsy benefit from poverty-targeted safety net programmes, and

introducing fee-waivers, reduced transport fares, and reduced import taxes and duties on durable medical goods and assistive technologies.

Recommendation 7: Increase public awareness and understanding

Some of the problems being faced by children with Cerebral Palsy are merely due to attitudes, using existing systems in the health and education sectors, the government should launch an aggressive campaign to change perceptions of communities and service providers alike, the services being provided should be structured in such a way that demystifies Cerebral Palsy and provide ordinary members of society a window to understand and appreciate the services and consequently the needs of people with disabilities, this can be achieved through community based rehabilitation programs and decentralizing services for children with Cerebral Palsy from Central Hospitals to local clinics. Therefore it is vital to improve and change public perceptions of Cerebral Palsy, confront negative thoughts and demystify Cerebral Palsy. Information collection on public understanding, beliefs, and attitudes about Cerebral Palsy can help point out gaps in popular understanding that can be changed through education and information dissemination. The media is an important pillar in influencing public opinion and perception, its involvement in attitude changing has a higher chance of yielding desired results.

Some methods for increasing awareness about Cerebral Palsy include;

- Awareness on national TV, radio and press

- Posters all over like what is done with HIV(AIDS)
- Include a module for special education to teacher programs for all teachers
- Workshops for nursery schools staff
- Have children screened by professional on entering pre-school, grade 0 and grade 3 so that they catch the condition early since it is possible for it to manifest by 4 years.
- Outreach programs at hospitals and clinics
- Include a module to pediatric and health programs
- Encourage medical staff to check for signs when mothers visit wellness centres
- Set up centres for Cerebral Palsy awareness and screening in every province

Recommendation 8: Suggestions on parental attitudes towards children with Cerebral Palsy

Through the research, teachers managed to make several suggestions to affected parents. Firstly, parents should be committed to their children's education. They should be compelled to visit the school regularly so as to create enabling conditions for the acceptance of their children in special schools. Teachers also encouraged parents to accompany their children during class/ school outings. This would enable a seamless effort in standardising the caring and handling of the children at both home and school. Such a scenario would be possible if the child attends the nearest special school.

Teachers and social workers and rehabilitation technicians also recommended that psychosocial support to both parent and child is vital should success be achieved, home visits for children with Cerebral Palsy should be made an integral part of the education and health delivery process for children with Cerebral Palsy, this helps to coordinate efforts for child wellbeing on the home, health and education front. Lastly parents should shun away cultural values that see children with Cerebral Palsy as bad omen in their lives.

Recommendation 9: Improve disability data collection

Zimbabwe like many other countries needs to come up with an integrated process of collecting data on children with Cerebral Palsy, the data can be collected in both health and education terms, this enables the government to be better able to plan and integrate services for children with Cerebral Palsy, disaggregated demographic data enables policy makers to place services where they are needed and to identify certain types of disability like Cerebral Palsy which need specific services. Data gathering also enables government to identify new needs and to compare performance of institutions say annually. Data also needs to be disaggregated by population features to uncover patterns, trends and information about subgroups of children with Cerebral Palsy.

Dedicated disability surveys can also gain more comprehensive information on Cerebral Palsy characteristics, such as prevalence, health conditions associated with Cerebral Palsy, use of and need for services, quality of life, opportunities, and rehabilitation needs.

Recommendation 10: Translating policy into action

The Government of Zimbabwe need to commit itself to implement the recommendations of the CRPD including finalisation of the National Disability Policy, other stakeholders also have important roles. The following highlights some of the actions that the various stakeholders can take.

Governments can:

- Review and revise existing legislation and policies for consistency with the CRPD; review and revise compliance and enforcement mechanisms.
- Review mainstream and disability-specific policies for children with Cerebral Palsy, systems, and services to identify gaps and barriers and to plan actions to overcome them.
- Develop a national disability strategy and action plan, establishing clear lines of responsibility and mechanisms for coordination, monitoring, and reporting across sectors.
- Regulate service provision by introducing service standards and by monitoring and enforcing compliance.

- Allocate adequate resources to existing publicly funded services and appropriately fund the implementation of the national disability strategy and plan of action.
- Adopt national accessibility standards and ensure compliance in new buildings, in transport, and in information and communication.
- Introduce measures to ensure that children with Cerebral Palsy are protected from poverty and benefit adequately from mainstream poverty alleviation programmes.
- Include Cerebral Palsy in national data collection systems and provide Cerebral Palsy disability-disaggregated data wherever possible.
- Implement communication campaigns to increase public knowledge and understanding of Cerebral Palsy as a disability.
- Establish channels for people with disabilities and third parties to lodge complaints on human rights issues and laws that are not implemented or enforced.

United Nations agencies and development organizations can:

- Include disability in development aid programmes, using the twin-track approach.
- Exchange information and coordinate actions – to agree on priorities for initiatives, to learn lessons and to reduce duplication of effort.
- Provide technical assistance to countries to build capacity and strengthen existing policies, systems and services – for example, by sharing good and promising practices.

- Contribute to the development of internationally comparable research methodologies.
- Regularly include relevant disability data into statistical publications.

Disabled people's organizations can:

- Support children with Cerebral Palsy and their caregivers to become aware of their rights, to live independently, and to develop their skills.
- Support children with Cerebral Palsy and their families to ensure inclusion in education.
- Represent the views of their constituency to international, national, and local decision-makers and service providers, and advocate for their rights.
- Contribute to the evaluation and monitoring of services, and collaborate with researchers to support applied research that can contribute to service development. Promote public awareness and understanding about the rights of persons with disabilities – for example, through campaigning and disability-equality training.
- Conduct audits of environments, transport, and other systems and services to promote barrier removal.

Service providers can:

- Carry out access audits, in partnership with local disability groups, to identify physical and information barriers that may exclude persons with disabilities.

- Ensure that staff is adequately trained in disability, implementing training as required and including service users in developing and delivering training.
- Develop individual service plans in consultation with disabled people, and their families where necessary.
- Introduce case management, referral systems, and electronic record-keeping to coordinate and integrate service provision.
- Ensure that people with disabilities are informed of their rights and the mechanisms for complaints.

Academic institutions can:

- Remove barriers to the recruitment and participation of students and staff with disabilities.
- Ensure that professional training courses include adequate information about disability, based on human rights principles.
- Conduct research on the lives of persons with disabilities and on disabling barriers, in consultation with disabled people's organizations.

The private sector can:

- Facilitate employment of persons with disabilities, ensuring that recruitment is equitable, that reasonable accommodations are provided, and that employees who become disabled are supported to return to work.
- Remove barriers of access to microfinance, so that persons with disabilities can develop their own businesses.

- Develop a range of quality support services for persons with disabilities and their families at different stages of the life cycle.
- Ensure that construction projects, such as public accommodations, offices and housing include adequate access for persons with disabilities.
- Ensure that information and communication technology products, systems, and services are accessible to persons with disabilities.

Communities can:

- Challenge and improve their own beliefs and attitudes.
- Promote the inclusion and participation of disabled people in their community.
- Ensure that community environments are accessible for people with disabilities, including schools, recreational areas, and cultural facilities.
- Challenge violence against and bullying of people with disabilities.

People with disabilities and their families can:

- Support other people with disabilities through peer support, training, information, and advice.
- Promote the rights of persons with disabilities within their local communities.
- Become involved in awareness-raising and social marketing campaigns.
- Participate in forums (international, national, local) to determine priorities for change, to influence policy, and to shape service delivery.
- Participate in research projects.

5.5 Areas for Further Study

The researcher recommends further research on the problem of Cerebral Palsy. Resource and capacity constraints forced the researcher to look at a sample of participants in Highfield High Density Suburb. A more encompassing study by a research institute can yield more information on the matter.

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APPENDIX I

INTERVIEW GUIDE AND FOCUS GROUP DISCUSSION

My name is Peter Chinamora, a student studying towards Masters in Development Studies with Midlands State University. As a partial fulfilment for the requirements of the programme, I am conducting a study on the challenges and opportunities for disabled children's rights in Zimbabwe: an analysis of the educational and health rights of children with Cerebral Palsy in Harare's Highfield High Density Suburb. I would like to assist me by providing answers to a few questions. The information you give me is going to be used for academic purposes and names of participants are not required so that anonymity and confidentiality are ensured.

Section 1: Personal Details

1. Gender of respondents
2. Age of respondents
3. To record highest educational qualification
4. To record occupation of respondents
5. To establish whether respondents have children with Cerebral Palsy
6. To establish whether respondent has a relative or friend whose child have Cerebral Palsy

Section 2: Legal Framework for Ensuring Access to Education and Health by Children with Disabilities

1. Are you aware of policies that promotes the educational and health rights of children with Cerebral Palsy?
2. What is your comment on the adequacy of the legal framework?

Section 3: Access to Education

1. What is your understanding of education as a basic human right?
2. Given comment on access to education by children with Cerebral Palsy
3. What factors influence access to better educational facilities by children with Cerebral Palsy?
4. Are there appropriate institutions to ensure educational rights for children with Cerebral Palsy?
5. Do the institutions have adequate facilities to cater for the educational needs of children with Cerebral Palsy?

Section 4: Access to Health

1. What is your understanding of health as a basic human right?
2. Given comment on access to health by children with Cerebral Palsy?
3. Does the health institutions have appropriate facilities to cater for children with Cerebral Palsy?

Section 5: Options for Enhancing the Educational and Health Rights of Children

- What can be done to ensure that children with Cerebral Palsy have access to better educational facilities?
- What can be done to ensure that children with Cerebral Palsy have access to better health facilities?

Thank you for your time and effort