

KNOWLEDGE AND EXPERIENCES OF CHILD CARE WORKERS REGARDING CARE AND MANAGEMENT OF CHILDREN WITH SPECIAL NEEDS IN FOUR INSTITUTIONS OF THE DEPARTMENT OF SOCIAL DEVELOPMENT IN TSHWANE METRO, SOUTH AFRICA.

by

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RESEARCH DISSERTATION

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DECLARATION

I declare that the work on which this mini-dissertation is based, hereby submitted to the University of Limpopo, for the degree of Master of Public Health has not previously been submitted by me for a degree at this or any other university, that is my work in design and execution, and that all material contained herein has been duly acknowledged.

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ABSTRACT

Children with chronic health conditions spend more time outside their family in the institutions. These children need access to the services of the child care workers. Care givers are often reluctant to accept children with disabilities in child care setting because they feel inadequately trained to care for a child with a disability. They have fears and misconceptions resulting from insufficient information and experience. The aim of the study was to determine the knowledge and experiences of care and management for children with special needs in four institutions of the Department of Social Development in Tshwane Metro. The study was conducted among 253 participants. Self-administered questionnaires were used to collect data from the participants. Data were then analysed using software STATA version 10.

The results showed a low level of knowledge about children with special needs. The majority of the participants (67.35%) indicated that they needed training in care and management of children with special needs. Over half the participants (57.31%) experienced feeling of frustration after working with children with special needs. Lack of training, resources, children's level of disability and behaviour were the major cause of child care workers feeling frustrated.

Conclusion and Recommendation

Care and management of children with special needs can be physically and mentally challenging if it is performed by child care workers who lack the knowledge to care and manage children with special needs. Little or no emphasis is being placed on care and management of children with special needs. Child care workers feels inadequately trained to care and manage children with special needs. Low self-perceived knowledge about children with special needs has been reported amongst child care workers who care and manage children with special needs in this study. Levels of frustration and stress after caring for children with special needs were reported: A need for training in care and management of children with special needs was indicated by the child care workers. In order to manage children with special needs, child care workers are required to have patience, knowledge,

special skills and a lot of effort in order to effectively care for children with special needs. A system of care to assure safe, quality service for children with special needs is therefore paramount if one has to care and manage children with special needs.

CHAPTER 1

BACKGROUND AND INTRODUCTION

1.1 BACKGROUND

The rights of children with special needs in general are paramount above and beyond any other process. Children with special needs in Gauteng continue to face barriers that prevent them from enjoying their complete civil, political, economic, social, cultural and developmental rights. This is largely due to the ignorance and prejudice prevalent in society as well as the failure of some legislation to protect the right of children with special needs (Department of Social Development, 2005). The challenge is to promote access for children with special needs to a wider range of services. This means the removal of all cultural, physical, social and other barriers that prevent children with special needs from entering, using or benefiting from the various social systems that are available to other children. Children with special needs are heterogeneous populations having in common the need for specialised health care services (Zetlin, 2006). These are children who have a broad range of disabilities or chronic illness, handicaps, health related educational needs and behavioural problems diagnosed at any time during their childhood (Torado et al, 1993). Such chronic conditions may necessitate adaptations for daily functions.

Disability, according to The American Heritage Dictionary of the English Language, is defined as "a disadvantage or deficiency, especially a physical or mental impairment that interferes with or prevents normal achievement in a particular area, or something that hinders or incapacitates (Sinclair, 2003)." The definition of disability contained in the Individuals with Disabilities Education Act reads: "A physical or mental impairment that 'adversely affects a child's educational performance.'" In other words, an individual cannot learn because of his/her disability. Disabled person means – an individual whose prospects of securing and retaining suitable employment are substantially reduced as a result of physical or mental impairment (Child Care Act, 1983).

According to the Integrated National Disability Strategy (1997), disability is defined as having a physical or mental impairment which is long term or recurring and which substantially limits one's prospects of entry into, or advancement in all social activities.

The most common forms of disabilities are:

- Physical disabilities - damage to muscles, nerves, skin or bone that leads to difficulties in moving about, in performing activities of daily living.
- Paraplegia- a substantial loss of function on the lower part of the body.
- Quadriplegia-a substantial loss of function in all limbs.
- Hemiplegia - a substantial loss of function on one side of the body, often due to a stroke or as a result of epilepsy.
- Cerebral palsy - resulting from damage of the brain, which causes muscle in coordination.
- Post polio paralysis - weakness in some muscles and under development of some limbs.
- Visual disability - the loss of sight and may be total or partial
- Blind - a person experiencing difficulty in moving around and knowing where things are.
- Hearing disability - hearing loss may be mild , severe or total
- Deaf-hearing loss usually results in difficulties in learning a spoken language, following verbal instructions.
- Mental disability - include cognitive, psychiatric and learning disabilities as well as physical head trauma. Particular attention needs to be given to the right of people with mental disability to advocates for their own rights and not to always be spoken for.
- Intellectual disability - children with intellectual disabilities find it difficult to learn and retain new information, and often to adapt to new information.
- Psychiatric disability - people living with a psychiatric or mental illness often experience difficulties in perceiving or interpreting reality, coping with some aspects of daily life.
- Multiple disability- it means having two or more of the disabilities for example people who have a hearing and visual disability
- Epilepsy and albinism are not usually regarded as a disability. Epilepsy often causes physical or mental disabilities.

- Albinism is an inherited condition where a person is unable to produce normal colouring of the skin, eyes and hair. Most people with albinism identify with other disabled people due to the nature of discrimination they experience.

Defining which children have special health and care need is difficult. Batshaw (1993) states that such a child has an illness with a biological basis that is certain to last at least one year and requires continuing treatment, or has some functional disability. A special need is an umbrella underneath which a staggering array of diagnoses can be wedged (Batshaw, 1991). Children with special needs may have mild learning disabilities or profound mental retardation, food allergies or terminal illness, developmental delay that catch up quickly or remain entrenched, occasional panic attacks or serious psychiatric problems. The designation is useful for getting needed services, setting appropriate goals, and gains understanding for the child and stressed family.

Studies reviewed indicated that many child care workers have a negative attitude towards children with special needs (Landis, 2007). These workers are reported not to have the necessary skills or training in how to deal with these children. According to Sinclair (2003) a care worker is a person whose work involves looking after people who cannot look after themselves for example, old people, disabled children, children with special needs, children with health care needs etc.

A Child Care Worker according to the Child Care Act (1983) means a person who cares for children who are either normal or abnormal (disabled) who are placed in an institution due to many reasons e.g. neglected, abused or abandoned. These child care workers give 24 hour care to the children like any child that will be cared for at home by their biological parents. The child care worker is a professional in the field of managing, assessing and treating vulnerable children and youth. According the Child Care Act (1983) there are six steps in which the role of child care worker can be categorised in the child's stay at the institution which are: admission, management, care, assessment treatment and discharge.

Nature of work of child care work

- Nurturing, teaching and caring for children.
- Supervising children before and after school.
- Playing a role in children's development by caring for them when their parents place their children in care to help them socialise with other children.
- Attending to children's health, safety and nutrition.
- Organising activities and implementing curricular that stimulate children's physical, emotional intellectual and social growth.
- Helping children explore individual interests, develop talents and independence.
- Helping in building children's self-esteem; teaching them how to get along with other children and preparing them for more formal schooling.
- Responsible for bathing, dressing and feeding children, supervising children at play, putting children to bed and waking them, involving children in educational games, and taking them for doctor's visits.
- Performing a combination of basic care and teaching duties, but the majority of their time is spent on care giving activities.
- Spending most of their day working with children and keeping records of each child's progress.
- Keeping children healthy by serving nutritious meals and teaching them good eating habits and personal hygiene.

Place of Safety according to the Child care Act (1983) is any place established under section 28. It includes any place suitable for the protection of a child into which the owner, occupier or person in charge thereof is willing to receive a child. While children's home means any residence or home maintained for the reception, protection, care and bringing up of more than six children apart from their parents, but does not include any school of industries or reform school.

In South Africa, children in the age group birth to 18 years represent 9.9% of the country's total population, according to the latest census data (2001). This is a significant number of children in their early childhood years. Different approaches and strategies are needed that will ensure their optimal growth, development and protection. The Department of Social Development believes in the potential and

capacity of each parent and in the absence of a parent, a primary caregiver, to provide care and support interventions that will ensure the well-being and optimal development of each child. However, the Department of Social Development also recognises that there are a significant number of young children in the country whose well-being are impacted upon by poverty, unsafe social condition, HIV and AIDS as well as other factors that require care support and protection intervention from outside the family cycle (Department of Social Development, 2008).

The Department of Social Development's vision and mission provides a solid starting point for the department's role in terms of early childhood care and development. The vision of the department provides for a "caring and integrated system of social development services that facilitates human development and improves the quality of life". The mission expands on the vision as it states "to ensure the provisioning of comprehensive social protection services against vulnerability and poverty within the constitutional legislative framework and creating an enabling environment for sustainable development".

1.2 PROBLEM STATEMENT

The researcher was concerned that children with special needs are taken care and managed by child care workers whom some of them have a qualification in child care while others have not received training. From what the researcher gathers about prospects of the Diploma in Child Care is that it concentrate more on early childhood development specifically normal development rather than abnormal development (children with disabilities or special needs). Caring for children with special needs includes handling, feeding, and bathing, dressing and communicating. These activities are executed by child care workers who are not trained in managing children with special needs. The researcher was concerned about the level of knowledge and experiences that the child care workers have with regards to care and management of children with special needs.

1.3 SIGNIFICANCE OF THE STUDY

The researcher is a qualified occupational therapist working under the sub directorate named "children with special needs" under the Gauteng Department of Social Development. The researcher renders services in different institutions that cater for children with special needs. During her rotation in the different institutions she noticed that most of the child care workers who give care to children with special needs constantly complained that they were not trained to manage these children. This state of affairs made the researcher to wonder how such workers cared and managed children with special needs without training.

1.4 JUSTIFICATION OF THE STUDY

Given the critical role that child care workers play in determining the efficiency, effectiveness in the care and management of children with special needs, it is paramount to understand what drives, motivates child care workers and to what extent they are faced with challenges when performing their work. Management of children with special needs is an essential part of ensuring quality care.

It is therefore crucial to understand what motivates the child care workers to continue caring for these children without knowledge, experience and training in special care needs. Having information about knowledge and experiences of child care workers with regards to care and management of children with special needs would improve child care services because the findings of the study will be utilised to improve work allocation procedures. The researcher, during her literature search, found that there were few studies related to care and management of children with special needs, especially in South Africa. That limitation of literature motivated her more to conduct this study.

Given the noticeable lack of studies addressing care and management of children with special needs in South Africa, this study will attempt to address the gap in the literature. The information obtained will hopefully assist in identifying skills that child care workers require in caring and managing children with special needs.

1.5 RESEARCH AIM

The aim of the study therefore is to determine the knowledge and experiences of care and management for children with special needs in the four institutions of the Department of Social Development in Tshwane Metro.

Brown (1995), as quoted by Mogorosi (2002), defines aims as the broad condition or outcome that is designed by a community of interest. Objectives, on the other hand, refer to those more specific changes in the policies or practices that are believed to contribute to the broader goal.

1.6 RESEARCH QUESTIONS

The researcher phrased the questions as follows:

- What is the knowledge of care and management for children with special needs among child care workers?
- What is the experience of care and management for children with special needs among child care workers?
- What are the challenges that child care workers experience regarding the care and management of children with special needs?

Mogorosi (2002) views the research question as an issue to be resolved. It is a question to be answered at the end of the investigation. However, the research at hand focuses on determining the knowledge and experience of child care workers in caring and managing children with special needs.

1.7 RESEARCH OBJECTIVES

The objectives of the study are as follows:

- To describe the knowledge of care and management for children with special needs among child care workers.
- To describe experiences of care and management for children with special needs among child care workers.
- To describe the challenges regarding care and management of children with special needs.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

De Vos (1998) states that conducting a literature review involves planning narratives and comparing the findings with existing theories and previous research report. The purpose of this exploration is to compare research findings with literature regarding the establishment and feasibility of care and management of children with special needs. This chapter will explore literature links with the findings.

Children with special needs include children through age twenty-one who have a broad range of disabilities or chronic illnesses diagnosed at any time during childhood, including the prenatal period, handicaps, health-related educational, physical or sensory impairments, learning difficulties and those whose behaviour cannot readily be contained in regular schools (Ross et al, 2010). These children need special educational provision over and above what regular schools offer. According to Skweyiya (2008) children with special needs are those who have visual, hearing, developmental, physical, special health care needs, social and psychiatric disorders. Such chronic conditions may necessitate adaptation for daily functioning, prolonged or periodic hospitalisation or special services in an educational setting.

There are about 650 million people with disabilities worldwide (Gauteng, Department of Social Development, 2005). This accounts for 10% of the global population and constitutes more than 20% of the world's poorest people. Children with special needs, disabilities and health care problems experience stigma from birth and they are more prone to exclusion, concealment, abandonment, abuse and institutionalisation (Skweyiya, 2008). According to UNICEF (2003), about 985 of children with special needs, disabilities and health problems in developing countries do not attend school. A step toward recognising people with disabilities as equal and active members of society has been made through the United Nations Convention on the Right of Persons with Disabilities (CRPD) and this came into force in May 2008. The CRPD calls for enjoyment of all human rights and fundamental freedom by children and adults with disabilities, and points to the importance of early intervention as well as inclusion in the

education system from an early age. It further argues that early childhood care and education is a powerful means of nurturing diverse abilities and overcoming disadvantages and inequalities.

According to Maternal and Child Health Bureau, children who have the potential for chronic illness, disabilities, handicaps, and health-related educational or behavioural problems are considered to be children with special needs (Brown, 2005). There are approximately 10-15 million children who have a chronic health condition with 1 to 2 million being characterized as severe (Landis, 2007). These are children who are technology-dependent and rely mainly on life sustaining medical technology and require daily complex care. For example, one of the studies that were conducted during a school in service, an assistant indicated that she was completing a gastrostomy tube feeding for a child every day. When she was asked about training she replied that she just observed the mother doing it a couple of times, and she started doing it herself. This demonstrates the need for a training system which includes steps to manage the health needs, levels of training and expected competencies for care providers of children with special care needs.

Children with chronic health conditions spend more time outside the family in institutions (Ross et al, 2010). These children need access to child care workers services. Therefore, training of child care workers is critical in developing a system of care of children with special needs. This training would include training of child care workers for emergency situations to deal with chronic illness and disabilities. Caldwell et al (1996) also reports that as technologies and philosophies develop and change, child care providers require education and training to update their knowledge and skills.

2.2 The following information may be useful in determining whether a child has a special need (Sloper, 2006).

2.2.1 Visual Disability (Blind)

Children with visual disabilities are often delayed in their physical and motor skills. In many cases they are unable to locate or pick up small objects that have been dropped. Helping these children to understand about space and size will improve their development.

Characteristics

- These children sometimes or always cross one or both eyes.
- They blink or rub their eyes constantly.
- They avoid bright light.
- They stumble or fall a great deal, tripping over small objects.
- They cover one eye.
- They tilt head to side or to front.
- They squint or frown a great deal.
- They complain of dizziness, headaches or nausea after doing intense work.
- They are unable to locate and pick up small objects that have been dropped.
- They may turn their face away when being addressed.
- If partial vision is possible, they may be able to see shadow forms, colour or large pictures.
- They hold books or objects very close to their face.

2.2.2 Hearing Disability (Deaf)

Children with hearing disability means they have an impairment which is so severe that they are unable to process linguistic information through hearing, with or without amplification, resulting in adversely affected educational performance (Meyen & Skrtic, 1998). These are children who have difficulty hearing or learning how to listen and speak. It is important to provide these children with activities that encourage communication and language development. These children can develop important language skills with practice (Sloper, 2006)

Characteristics

- Child does not respond when spoken to.
- Child does not startle at loud noise.

- Child does not wake up in response to sound.
- Does not talk very much or at all.
- Talks, but it is impossible to understand.
- Leaves out many sounds when talking.
- Talks in a monotone voice.
- Seems unable to follow verbal direction, often says "huh" or "whoa" and requires repetition.
- Interrupts conversation.
- Seems unaware that others are talking.
- May hold head so that one ear is turned towards speaker.
- Alert and attentive to things that can be seen, disinterested in those he is expected to hear.
- Talks in a very loud or very soft voice.

2.2.3 Mental Disabilities

A mentally handicapped person is one whose level of development, for example mental age is less than that expected at his/her chronological age (Zetlin, 2006). We can also speak of mental handicap being a state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning.

Mental retardation refers to significant sub-average general intellectual functioning resulting in, or associated with concurrent impairments in adaptive behaviour and manifested during the development period (Meven & Skrtic, 1998). Zetlin (2006) clarifies this disability by showing that it is a delay or slowness in a child's mental development and such the child learns more slowly than other children of his/her age.

2.2.3.1 Mild Mental Retardation

Children with mild mental retardation have great difficulty in coping with formal school work (Kupinsel, 1999). They cannot be expected to achieve more than approximately standard 2 levels and can only do that with specialised help. Many, however, can learn simple repetitive tasks which equip them for sheltered or protected workshop employment.

2.2.3.2 Moderate Mental Retardation

Children with moderate mental retardation are often termed trainable, which means that they cannot benefit much from ordinary schooling, but can be taught to care for their personal needs: to perform simple domestic duties and to do simple work in protective workshops (Kupinsel, 1999).

2.2.3.3 Severe Mental Retardation

Severely retarded children require special training to teach them the rudiments of hygiene, speech and other basic skills. Most of these children require constant supervision and care throughout their lives.

2.2.3.4 Profound Mental Retardation

Children with profound mental retardation need constant care in order to survive (Hudson, 2002). They seldom develop beyond the level of small babies or very young children. In South Africa trainable children are those whose IQ level is between 30 and 50, untrainable children are those whose IQ level is less than 30 and children requiring special education those having their IQ level between 50 and 80. These are important terms, as 'untrainable' children are the responsibility of the Department of Health, while 'trainable' children are the responsibility of the Department of Education.

Children with mental disabilities generally will go through typical developmental stages but at a much slower rate (Hudson, 2002). Characteristics vary with disabilities, but few approaches can be applied to all kinds of disabilities.

Characteristics

- Short attention span, easily distracted.
- Difficulty with transitions.
- Prefer to play with young children.
- Afraid of trying new things.
- Difficulty in problem solving.
- Does not remember things well.
- May not be able to transfer learning to a new situation.
- Stumbles and falls because of poor body control.
- Speaks and uses language like a much younger child.

- May repeat same movement over and over.
- Frustrated with change and transitions.

2.2.4 Children with emotional or behavioural disorders

According to Ross (2010), emotional and behavioural disorders are degrees of freedom an individual has in choosing from among alternative types of behaviour with emotional disturbance inferred from inflexible behaviour patterns. Children with emotional disabilities often display one of three types of extreme behaviours such as withdrawal, aggression or hyperactivity (Brown, 2005). Each type of behaviour may require a different type of response. These are conditions exhibiting one or more of the following characteristics over a long period of time and which, to a marked degree, adversely affects educational performance.

Characteristics

- Inability to learn; this cannot be explained by intellectual, sensory or health factors.
- In ability to build or maintain satisfactory interpersonal relationships with peers and teachers.
- Inappropriate types of behaviour or feelings under normal circumstances.
- A general pervasive mood of unhappiness or depression.
- A tendency to develop physical symptoms or fears associated with personal or school problems.

2.2.5 Conduct Disorders

Conduct disorders include repetitive and persistent patterns of antisocial behaviour that violates the rights of others (Dendy, 1995). Conduct disorders are very common particularly among boys. Parental attitudes and family socioeconomic status appear to be the major correlation factors. Research has demonstrated links between conduct disorders and learning disability disabilities.

2.2.6 Affective Disorders

These are children with a disturbance in mood accompanied by cognitive, psychomotor and inter-personal difficulties (Reisner, 1998). Affective disorders in children are often diagnosed in conjunction with adjustment disorders. Depression, whether related to

another psychiatric disorder or associated with a medical diseases is the most commonly reported affective disorder in children. Jacoby (2002) in his discussion of illness reported that children who are diagnosed with affective disorder have disturbances in self-esteem, motivation and interpersonal relationships.

2.2.7 Adjustment's and identity disorder

According to the literature, the main cause of adjustment conflicts was found to be the failure to adequately process challenges, resulting in development lags (Smith, 1992).

2.2.8 Substance abuse

Statistics indicate a surprisingly high rate of substance abuse among school-aged and adolescent children, leading to these children being vulnerable because of their need for peer acceptance and engagement (Paquette et al, 1995). The range of substances includes alcohol, nicotine, marijuana and cocaine.

Characteristics

- Use aggressive behaviour to deal with most situations.
- Withdrawals or stays quiet and pervasive most of the time.
- Shows excessive activity, restlessness or inability to stick with something.
- Regresses to babyish behaviour whenever stress occurs.
- Cries a great deal, seems depressed, unhappy and seldom laughs.
- Shows extreme fear and anxiety.
- Does not seem to recognise basic feelings of happiness, sadness, anger or fear.
- May not want to be touched.

2.2.9 Psychiatric Disorders

According to Ross (2010) in one year, about 5 to 15 percent of all children and adolescents will have a psychiatric disorder. Many psychiatric disorders have their origins in early childhood, ideally before the start of formal schooling. Children with psychiatric disorder are those who are diagnosed for example, with Attention Deficit Hyperactively Disorder (Dendy, 1995). The essential features are the presence for at least six months of development in appropriate degrees of attention, impulsiveness and hyperactivity with the onset occurring before the age of seven years. These

children have difficulty in awaiting turn, difficulty in sustaining attention or finishing tasks or play, shifting from one uncompleted activity to another, talking excessively or playing loudly, interrupting or intruding on others. The disorder is more common in boys. Such children show low self-esteem, mood liability, poor frustration tolerance, soft neurological sign and perceptual motor difficulties.

2.2.10 Disorders of Mood

The most commonly occurring mood disorders are pre-pubertal depression. The essential features of a major depressive episode are the onset of their depressed mood or loss of interest in former pleasurable activities lasting for a period of at least two weeks accompanied by increased or decreased motor activity, difficulty concentrating with fall off in school work, feeling of worthlessness, somatic complaints and suicidal thoughts.

According to Dendy (1995) depressed mood is not reported by children and therefore this disorder may remain undetected in many cases. Depression may present with somatic symptoms such as stomach or headaches, cognitive symptoms such as forgetfulness or poor concentration. However, a depressed mood in older children is usually obvious when looked for and if the child is sensitively questioned. Depressed mood in pre-school children may only be expressed non-verbally in angry, aggressive and destructive behaviour while in infants it is expressed in severe apathy and irritability.

2.2.11 Learning Disability

Means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which may manifest itself in imperfect ability to listen, think, speak, read, write, spell or do mathematical calculations (Paquette et al, 1995). The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, development aphasia and dyslexia. This does not include children who have learning problems which are primarily due to the results of visual, hearing, motor handicaps, mental retardation or emotional disturbance caused by environmental, cultural or economic disadvantage (Meyen & Skrtic, 1998).

Characteristics

- Inability to communicate through language, spoken or written or by sign.
- Inability to read, spell or produce motor movement required for handwriting and performing mathematical functions.
- Inability to discriminate direction, in space or dimensions of time and inattentiveness or lessons in class.
- Has immature social behaviour.
- Poor body and self-image.
- Fear of failure.
- Need instructions repeated many times.
- Seems disorganized.
- Inability to follow a sequence of two or more directions which other children of same age can follow.

2.2.12 Epilepsy

Epilepsy is a convulsion disorder caused by excess firing of electrical discharge in brain cells (Reisner, 1988). It is manifested in a seizure that is loss of control over specific muscles in the body. Three major forms of epileptic seizures include:

Grand mal seizure is manifested by loss of consciousness and postural control, with muscle rigidity (tonic phase) that progress to jerking reaction. There is also suspended breathing, loss of bowel and bladder control. A frothing of saliva often occurs. The grand mal seizures is often preceded by an aura, a warning sign that seizure is coming. Auras may take the form of an unusual taste, smell or sound, dizziness, weakness, sensation of fear, numbness and tingling.

Petit seizure may appear to be daydreaming. There may be a twitching of the eyelids or minimal head or extremity movement. No warning precedes these little seizures. The child maintains postural control and may not even be aware of the seizure; contact with the environment is lost for 5 – 30 seconds. The seizures may recur many times during the day, interrupting attention span, memory and thought process in general.

Psychomotor seizures are variant forms of petit mal seizure where the child experiences sudden loss of muscle tone, falling and sudden involuntary muscular

contractions limbs and trunk, in that order. The child does not lose consciousness, and the seizures are brief but frequent (Gurainick, 1994).

Epilepsy affects individuals throughout the world irrespective of age, ethnicity, sociological economic class or geographical location. Male and female are equally affected. The prevalence of epilepsy increases with age and generally, it is between 5 and 9 per 1000 population (Christianson et al, 2000). It is notably high between birth and puberty, during which period the morbidity of the condition is potentially at its highest level, especially in terms of the neurological and psychosocial development of the individuals concerned (Hauser, 1995).

The prevalence rate of epilepsy in childhood varies worldwide from 3.4/100 in Japan, to 11.2/1000 in Mexico (Mouton, 1996). No information is currently available on the prevalence of epilepsy in rural South African children (Christianson et al., 2000). Approximately 50% of the epilepsy cases have been shown to have their onset of seizures before the age of 5 years and 75% have their onset before the age of 20 years (Mouton, 1996)

In school, peers perceive the epileptic child as different. This perception may influence the quality of social interactions of the child. The learning process of the child may also be adversely influenced. Some of the children with epilepsy have residual brain damage, inevitably leading to poor performance at school. It can also be due to the effect of medication on them. Some of the medications cause them to be drowsy and not alert, making learning to be difficult for them.

2.2.13 Physical Disabilities

Children with physical limitations have specific needs depending on their particular disability (Albrecht, 1995). Playmates are usually eager to assist the children with disabilities. A child with physical disabilities needs encouragement to do as much as possible independently. These are children with delay in motor development, muscle stiffness, involuntary movements, flabby muscles, uncontrollable movements or a combination of these traits and paralysis in one or more of the limbs.

Characteristics (small motor)

- Poor developed hand or finger coordination.
- Difficulty in picking up small objects.
- Difficulty in drawing or writing.

Characteristics (large motor)

- Stumbles and trips frequently.
- Difficulty walking or running, jumping or climbing.
- Poor balance.
- Difficulty in bouncing, catching or throwing balls.
- May be unable to release objects voluntarily.

2.2.14 Health Impaired

Health impaired includes autism manifested by severe communication and other developmental and educational problems or having limited strengths, vitality or alertness due to chronic or acute health problems (Brill, 1994). In many countries, the education system has traditionally excluded individuals perceived to be different. This has created marginal structures for those who did not meet the expected standards. This was based on a medical model that learning difficulty was a symptom of a deficit that could be treated by a specialist's placement. The aim of putting children with disability together in separate groups was to provide the best possible treatment by the specialist teachers. There was little need therefore for teachers in ordinary classes to give consideration to pupils with special needs (Brill, 1994).

Many children with mild and moderate difficulties attended ordinary classes and no extra help was provided for them. They ultimately fell back and dropped out of school, a situation which is still quite common in many countries (Mouton, 1996). The children with extensive need of help have usually been categorised as disabled or handicapped and the extra help given has made these children to be referred to as children with special educational needs. To most people, special educational needs has become synonymous with the education of the blind, deaf, mentally retarded and physically disabled pupils. This limited view led to the creation of small and more or less parallel school system with special schools and institutions which have not been of any significant relevance to the rest of the education system (Birbeck, 2000). Today there

is a general acceptance that experiencing difficulty in learning is a normal part of schooling rather than an indication that there is something wrong with the child. Every child is unique and every child needs help in developing and adjusting to life. In that respect, all children are special and emphasis should now be put on individual needs, curriculum flexibility and a common responsibility for all pupils in a classroom.

Disabilities often are not recognised at birth, but become noticeable as a child exhibits some type of developmental delay over time (Smith, 1992). Parents and child care providers are often the first to notice that there might be a developmental delay. The Disability Rights Charter of South Africa is a charter that reflects demands from the people with disabilities. It aims at promoting equal opportunities for all disable people. It focuses on the right of all disabled people to live independently in a safe environment in a society free from all forms of discrimination, exploitation and abuse. The charter is important as it highlights the fact that people with different disabilities experience discrimination in different ways, thus calling for a comprehensive and integrated approach of addressing disability issues in South Africa.

According to Charter 2 of the Constitution of South Africa (1996), all the citizens are guaranteed fundamental rights. It includes, in section 9 of the Constitution, the equality clause, and the right to freedom from discrimination based on a number of social arterial. Discrimination based on disability is specifically the right to be treated equally and to enjoy the same right as all other citizens (Constitution of South Africa, 1996).

The Americans with Disabilities Act (1992) is a civil rights legislation designed to protect people with mental or physical disabilities from discrimination based upon that disability. It states that it is illegal to discriminate against someone with disability and that public accommodation must make reasonable modifications in policies, practices and procedures in order to accommodate individuals with disabilities. Children with special need benefit greatly from being with other children and from receiving consistent care from an adult. Children with special needs are like all other children. They need to be physically comfortable, feel secure and have opportunities to play (Education White Paper 6, 2001).

2.3 EDUCATIONAL INCLUSION

Child care providers, child and disability right advocates have long recognised that barriers to inclusive child and after-school care exist for children with disabilities and special health care needs (Landis, 2007). Yet, the voices of families have been missing from efforts to document the scope of the problem. According to the United State Census Bureau (2000), about 300.000 children under the age of five have a physical or mental disability. Experts further report that there is a possibility that the figures might probably be higher because many disabilities are not diagnosed until the children reach school age.

The philosophy of inclusion supports the rights of all children regardless of their diverse abilities, to participate actively in natural setting within their communities. A report compiled by the Maryland Committee for children in 1995 made some recommendations to improve the state of children with disabilities, access to community, and to maintain child and after school care programmes. This report was developed by a panel of families, child care and disability professionals in order to train child care providers in licensing child care centres to make it easier to accommodate children with disabilities. According to UNICEF (2003) families of children with special needs continue to have difficulties accessing and maintaining quality child and after care programmes.

The survey that was conducted by the Maryland Committee for children in 2001 with child care providers relating to the availability and quality of child care for children with disabilities and special health care, found that 74% of family care providers were concerned with safety factors such as lifting larger children and using medical equipment. This was reported to be mainly as a result of lack of training which was reported by the care givers. Almost two-thirds (65%) of family care providers reported that children with aggressive behaviours like social or emotional problem could not receive the attention they needed in a typical child care setting. Eighty-two percent of family care providers reported that there were many liability issues with regard to caring for children with special needs or disabled. About 77% of family care providers however reported that care providers did not have sufficient knowledge about

disabilities and about 59% of family care providers reported that providers were uncomfortable diapering or assisting children with special toileting needs (Burry, 1999).

Another study conducted in 2002 by the Coalition for Inclusive Child Care Committee together with the Maryland Committee for Children reported attitudes of providers as a major problem. It was reported that child care providers saw inclusive child care as one of the larger barriers. It was further reported that many child care providers did not want to care for children with disabilities or special health care needs usually because of incorrect assumptions about the child, disability and the effect on their work load or child care setting. Lack of knowledge was also found to be a problem among child care providers (Righton, 2000). It was reported that child care providers needed basic disability awareness training in order to reduce stereotypes, and to provide training on developmentally appropriate care, specific disabilities, and successful strategies to include children, positive behaviour support, and information on community resources.

2.4 LEVELS OF STRESS BY FAMILIES OF CHILDREN WITH SPECIAL NEEDS

Children with special needs affect not only the individual, but the family and the society (Kessner, 2001). The individual having special care need is faced with many challenges which may affect their normal state of living. Quality of life, family functioning and social support affect children who need special care. Children with special needs and those who have chronic diseases have a significant impact on family members. These children are mostly accompanied by emotional disturbance than other childhood diseases (Kessner, 2001). Siblings often experience feeling of guilt and stigmatisation for having a "disabled" brother or sister and later assume parental roles. Many children who need special care are denied schooling either because the school insists the child stays at home or because the parents are worried that the child will not be accepted by other children at school (Jacoby, 2002).

Families of children with special needs are frequently burdened by extensive caretaking, the unpredictable nature of behavioural changes, high cost of medical care and lost days at work (Leonard et al, 1999). Lindsten et al (2002) were able to show that the impact of children with special needs in the family is not only physical, but financial, moral, social, psychological and emotional. The parents of children with

special needs may go through stages of grief similar to those proposed by Kubler (1998) affecting death and dying. Ross & Deverell (2000) point out that parents of children with special needs grieve for the normal child that they will never have or have lost through a catastrophic event or illness. Some parents may experience guilt from the fact that the child might have inherited the problem from someone within the family. In some cultures, children who have special needs are regarded as outcasts. They are not accepted in the community (Ross & Deverell, 2000).

In the African family setting, especially within the extended family, caring for a chronically ill member of the family goes beyond the nuclear family. At times, depending on the family and in communities where consanguineous marriages are common, an ill person may have family attachment with almost every other family in the village (Doherty & Campbell, 1998). This means everybody in the village rallies around to take care of such a person. This, in essence, can be summarised thus: "There is no way to intervene in an individual's life and not affect his/her family and the whole community" (Doherty & Campbell, 1998).

In many societies, it is believed that children with special needs, especially those who are disabled, their disability is caused by supernatural powers. Others believe that it is due to witchcraft by people who were jealous or envious of the victims or his/her parents and by spirits and ghosts of departed ancestors (Cresswell, 1994). It is not surprising then that accusations of demon possession and witchcraft as well as actual social deprivation and ostracism are frequent in children with special needs, especially the disabled. These children are also subjected to negative attitudes when it comes to marriage, sharing accommodation, schooling and even physical contact.

It has been well documented that the parents of children with special needs or disabilities experience chronic stress. The nature of stress has been shown to span over several aspects of family life such as daily care demands, emotional distress, interpersonal difficulties and adverse social consequences (Dale, 1996). Stress experienced by the families is influenced by child severity of the problem and strategies such as acceptance of the child diagnosis and perceptions of stigma associated with the disorder (Cresswell, 1994). Additional stress is also created due to mental conflicts associated with learning of the handicapped child, extra financial

burdens to obtain the necessary services and fatigue and loss of leisure time due to the care-taking responsibilities (McAndrew, 1976).

Not only do the child's characteristics influence parental stress level, but negative reaction from others can also serve as a source of stress for the families (Mason, 2002). Parenting of children with special needs increases stress among care givers. Family members living with children with special needs are also affected. Many tensions are created within the family if members do not cooperate in dealing with children with special needs (Brill, 1994). These tensions may lead to illness or symptoms in other family members from the stress of caring for an ill family member. It may also be a way of competing for attention and care. Siblings will also have trouble coping as more and more attention is given to the child with special needs. According to Burton (2008) dysfunctional children make parents dysfunctional. Therefore, if this problem is left unaddressed it can cause conflict within the family.

2.5 PARENTAL ATTITUDES TOWARDS CHILDREN WITH SPECIAL NEEDS

An enormous amount of research has been done to explore the stressors associated with caring for a child with special need and the deleterious effects these stressors have on parents' wellbeing. Research evidence shows that family attitude contributes to the prognosis. Family stresses associated with limited financial resources, lack of appropriate service and insufficient support systems are some of the risk factors that can contribute to poor prognosis (Dunbrack, 2003). Emotional instability, constant grief, psychological ill health and unsatisfactory social health are extreme stressors that families of children with special needs experience and have to endure. Some parents have also reported loss of friendship as a result of having a child with special needs, and that other parents of children with disabilities and caring health professionals are their primary members of their new friendship networks (Redding, 2000). The majority of literature has highlighted the stresses and the subsequent negative consequences in caring for children with special needs. Many researchers have found that the families of children with special needs report more stress than other families (Smith, 1992).

On the other hand, in a multicultural and multilingual society, a lack of awareness of the diverse cultures, beliefs and attitudes may hinder the outcome of rehabilitation, leading to misunderstanding between professionals and clients (Valentine, 2001). Understanding of different cultures can assist health care professionals to realise why and how families make decisions concerning health care and rehabilitation. A study conducted in the Western Cape (South Africa) which aimed at investigating the knowledge, attitudes and beliefs of society relating to children with physical disability in different cultural groups found that attitudes of society towards children with disabilities were varied. About 50% of the respondents felt that the society did not care.

2.6 PSYCHOLOGICAL IMPACT ON CHILDREN WITH SPECIAL NEEDS

The most fundamental characteristic of special care for children with special needs is that they are long term and have profound influence on the lives of sufferers. This influences people at home and work (Guralnick, 1994), 1995). Families of children who experience illness and disability are enormously influenced by the dominant culture and the larger health systems embedded in this prevailing culture (Grinnel et al, 1997). The family and each of these members face the formidable challenge of focusing simultaneously on the present and future, mastering the practical and emotional tasks of the immediate situation while charting a course for dealing with the complexity and uncertainties of their problem in an unknown future. Family members also draw on prior multigenerational experiences with illness and loss and core family beliefs to guide them.

Children with special needs can place intolerable strain on the family due to the need for high levels of physical care and support (Ross et al, 2004). Even where the family members are willing and able to provide assistance, the child who has a special need may feel that he/she is a burden to the family and may refuse the assistance that is needed. In some instances, both the individual and the family become isolated from the wider community.

Many chronically sick people are involved in a constant struggle to lead valued lives and maintain definitions of self that are positive and worthwhile. This balance can be difficult to achieve due to cultural acceptance of disability which may devalue the

individual, undermining his/her sense of self-worth. Quality of life can be compromised by low self-esteem, fear and dependency (Leonard et al, 1999). The presence of a child with a special need may have an adverse effect on the marital relationship. The emotions that arise from having a child with a disability or chronic illness are usually very intense and tend to disrupt the organisation of the family structure (Cain, 1991). A child with special needs may precipitate a number of changes in the family structure.

Caring for children with special needs is extremely demanding, and this includes a consideration for the social, cultural and psychological situation of the child. The experience of caring for children with special needs affects families in profound ways such as how well the family adapts to all the challenges that come with the caring of these children (Cain, 1991). The effects on families may lead to disintegration of some families and on the other hand, some families may derive solitude in the situation leading to increased family togetherness. However, the family needs to participate actively in the care of children with special needs. Families of children with special needs usually have change in role structure and task allocation. This adjustment of role structure among the family members may make some feel neglected while others may feel overburdened.

2.7 SOCIOECONOMIC IMPACT ON CHILDREN WITH SPECIAL NEEDS

The socioeconomic impact of children with special needs varies widely. Children with special needs are still subjected to legal discrimination, particularly with regard to employment. This situation remains considerably worse in developing countries. Studies have shown that people in developing countries suffer considerably in both social and economical terms (Fehrsen, 1995). This includes medical costs as well as lost wages from unemployment and underemployment. Some people with special needs can do some jobs and perform just as well as those without special needs, provided of course that there is proper matching of the job and the individual (Buboltz & Whiren, 1984).

2.8 SPECIAL NEEDS AND EDUCATION

Children with special needs receive significantly less education than their sex matched siblings (Birbeck, 2000). These children are deprived of education based on the impact

of their disorders. In school, peers perceive children with special needs as different, hence influencing the quality of social interactions of the child.

Parents also play an important role in the academic attainment of children with special needs. Many parents due to fear of discrimination; never allow their special needs children to attend school. Parents may decide to remove the child from school to avoid embarrassment, especially when they believe that the child may not be strong enough to cope (Howell, 2006). Some of the parents due to the stigma may fail to inform the teachers about the condition of the child and this, makes it impossible for the teacher to be of assistance to the child.

Based on the findings of the study that was conducted in the Western Cape (South Africa) in 2000, it was reported that about 60% of the respondents did not agree that disabled children should not attend school, while 72% of the respondents agreed that disabled children should have their own school. Some of the reasons advanced were that, the children were better off in their own school where they are accepted and respected. It was also reported that in the normal school the other children and teachers mocked these children, calling them names and refusing to help them when assistance was required. Therefore, mainstreaming of children with disabilities into regular day care setting would reduce the unfounded fears about misunderstandings many children, providers and parents have about children with special needs.

Teachers play an important role in the academic attainment of these children. It was found that many teachers did not understand the multiple problems that affect the quality of life of children with special needs (Howell, 2006). This was not intentional, but it was because of lack of knowledge about children with special needs. Teachers are expected to empathise with these children and be able to show love and care for them. Some teachers were reported to resent children with special needs (Dale, 1996). The attitudes of teachers make the learning process difficult for children with special needs. As a result, children with special needs are at risk as far as achievement is concerned. On average they tend to be some years behind the expected reading level. They also tend to repeat grades more often. It is also reported that teenagers end up dropping out of school.

2.9 SPECIAL NEEDS AND STIGMA

Stigmatisation poses two interrelated problems for children with special needs or disability. Managing the impact of stigma upon their self-conception and identity and managing their social interaction with other people. Children and young adults with special needs face a difficult task as they are stigmatised as being possessed by evil spirits. The stigma or negative attitudes that often are attached to having a child with special needs can significantly affect the quality of life of those children and can also lead to social isolation (Valentine, 2001).

There is ample evidence that parents of children with special needs undergo prolonged periods of stress than parents with typically developing children. Like any other child, the family and environmental systems also affect a child with disabilities. A negative attitude towards children with special needs from family members, relatives, friends or the society at large not only impacts the child directly, but also adds on to the existing stress level of the family. Lack of public awareness about the potential of children with special needs, often acts as a barrier to their acceptance and participation in society (Cain, 1991).

2.10 FOSTERING FAMILIES FOR CHILDREN WITH SPECIAL NEEDS

Parents who foster children with special needs may experience particular challenges and as a result would require additional resources in order to function in the same way as a family caring for a child without special needs (Buboltz & Whiren, 1984). One of the great concerns to foster parents caring for children with special needs is lack of knowledge on the specific disability of the child in their care. Burry (1999), reported that specialised training of fostering for children with disabilities influences the attainment of skills and knowledge about the child's needs. In addition to that, foster parents report frustration due to lack of organised communication between the agency, the medical system, the education system and the various programmes offered for children with disabilities (Cain, 1991). Vig & Kaminer (2002) recommend counselling as a helpful service for parents fostering children with special needs. On the other hand, Hudson & Lavasseur (2002) report crisis intervention and support as one of the most important services needed by foster families caring for children with special needs. He goes

further to suggest that regular time away from the children for physical, emotional and social reasons would be very crucial.

2.11 FINDINGS OF OTHER RESEARCH

According to Hudson & Levasseur (2002), foster parents caring for children with special needs reported that relevant training regarding special needs would be very helpful. Few studies that were conducted to understand the perspective on the experiences of foster parents of children with special needs reported that most of foster parents emphasize the value of training, communication with professionals, counselling services and peer support as aspects which will be beneficial to them. Support groups were also reported to be very beneficial to parents fostering children with special needs. Some of the reported benefits included feeling of being understood by others, learning new parenting skills, being able to express their feeling and concerns with people who understand their position and learning to empathise with the child's biological family (Redding et al, 2000).

Foster parents also report great benefits from resources designed to help them find specialised medical and recreational services. These include potential physicians for their foster children, information on special education programmes, mental health services and transportation services available in their area (Reddings, 2002). In addition, peer support groups, transportation services, specialised recreational services and specialised education programmes were reported to be beneficial for parents fostering children with special needs (Cain, 1991 & Redding et al, 2000). According to Buboltz & Whiren (1984) families with children with special needs require additional financial resources in order to add effective care for their children with special needs. It is very important to recognise the range of support these families need.

The study conducted in 2002 by the Maryland Development Disabilities Council to document the experiences of families of children with disabilities and special health care needs support what the advocates for children with disabilities have known for years, that there are significant gaps in the availability and more importantly quality of

child and after school care opportunities for children with disabilities and special health care needs. Anecdotal evidence showed that many child care providers including employers supported facilities which do not accept children with disabilities due to lack of knowledge and training on types of disabilities (Vig & Kaminer, 2002). Families of children with disabilities continue to have difficulties accessing and maintaining quality child and after-school care.

The data gathered in 2003 by the Maryland Developmental Disabilities council regarding child care for children with disabilities indicated that when parents were asked if they had difficulties in finding, obtaining or keeping child care, 83% of the respondents said "yes". When they were asked the reasons for these difficulties, the families indicated a wide variety of problems including the unwillingness of child care providers to accept the child, child care providers' lack of knowledge, behavioural issues and toileting problems. Data indicate that finding quality child care for children with disabilities and special health care is almost impossible. These gaps even widen as the number of children with disabilities and significant health care needs continue to rise worldwide. Even though the Americans with Disabilities Act of 2002 established equal rights for people with disabilities in employment, state and local public service, public accommodation including preschool, child care centres and family child care home, the situation remains unsolved for the most part. Parents who have children with special needs are still faced with a big problem.

In South Africa, however, an understanding of disability as a human rights and development issue leads to a recognition and acknowledgement that people with disabilities are equal citizens and should therefore enjoy equal rights and responsibilities. This implies that the needs of every individual are of equal importance, and that needs must be made the basis for planning. It further implies that resources must be employed in such a way as to ensure that every individual has equal opportunities for participation in society. Understanding a disability as a human rights and development issue also means that people with disabilities should have equal obligations within the society and should be given the support necessary to enable them exercise their responsibilities.

Restricted participation in mainstream society, discrimination, prejudice and lack of access to essential services not only affect individual disabled persons and their families, but also impact on the economic and social development of the broader society where a significant reservoir of human potential often goes untapped. This realisation led to the inclusion of disability issues in the South African Constitution of 1996 and the subsequent establishment of the Office of the Status of Disabled Persons (OSDP). As a result of the efforts of the OSPD in cooperation with government departments, disabled people's groups, civil society organisations and human rights activists, the White Paper titled Integrated National Disability Strategy was formulated into a Bill in 1996 and endorsed by the South African parliament in 1997. The White Paper emphasises the importance of disabled persons enjoying equal rights and responsibilities and a good quality of life.

The Maryland Committee for Children (1995) reports that finding appropriate child care is challenging for most families and exceptionally difficult for families that have a child with special needs. It was reported that families with children with special needs are in contact with many different agencies and professionals. Many families report problems in understanding what services are available for children with special needs, and how to access them (Sloper, 1999). Care givers are often reluctant to accept children with disabilities in child setting because of concerns about insurance, liability, environmental and programme accommodation and the cost of care. Many care givers feel inadequately trained to care for a child with a disability. They have fears and misconceptions that emanate from insufficient information and experience (Birbeck, 2000).

The Maryland Committee for Children reported that mothers of children with special needs work an average of 100 hours less per year than their counterparts with no children with special needs. The earnings of these mothers are estimated to be 20% lower than average as a result of their special needs children. Therefore, by providing child care that includes meeting the special needs of children with special needs can enable many of these parents to work, thus reducing the financial burden on government.

The survey that was conducted by the Maryland Committee for Children in January 1991 to determine if the child care providers accepted children with special needs found that only 1,881 out of 10,293 day care providers said they would accept children with special needs, while another 1,092 said they would consider accepting children with special needs depending on their getting more information about the child from the parents. Only 300 children care centres out of the 987 surveyed said they would accept children with special needs.

A survey conducted by in Lansdale found that only 8 to 13 of 250 child care providers offered specialised care and facilities for children with special needs, while 25 were equipped to accept children with special needs and 125 would consider accepting children with special needs.

Another survey that was conducted for the California Department of Education found that 159,000 children with special needs have working parents of whom about 80,000 of the employed mothers of the children with special needs child needed care. It was also reported that parents of children with special needs had no alternatives with regard to placing their children; as such they had to settle for whatever arrangement they could find.

According to Susan Graig a coordinator of a project called the Successful Integration of Infants and Toddler with Handicaps, Nanning, is one of the most important components of providing quality day care for children with special needs. She also supported the training of child care workers which she said should focus on physical environment, safety promoting health and nutrition, physical development, cognitive development, communication, social development and preventing abuse among children with special needs.

According to Righton (2000) the human qualities which are required of a child care worker are emotional stability and resilience that is not readily shaken but also open to learning from experience, a capacity to manage stress in self and others, a sense of the work of oneself and work. They should not be arrogant but have a solid belief that whatever they have to provide the children with special needs will benefit the child.

Children with special needs are unable to develop their potential maximally forcing them to become dependent on family members. Little or no emphasis is being placed on care and management of children with special needs as is being done for other chronic illnesses such as HIV and AIDS. Many families are being disrupted and many learners drop out of school. Therefore, a system of care to assure safe, quality services for children with special need is necessary.

It is important to start intervention at an early age if one is to help a developmentally delayed or physically disabled child to progress; otherwise they develop secondary problems such. It is important therefore to provide a stimulating environment to promote development as part of the intervention strategy. The purpose of stimulation is to hasten progress and help the child develop his/her maximum potential as well as to prevent the development of secondary problems (Singer, 1993).

A team approach is essential. The primary facilitators are the child, the parents, caregivers and teachers. These provide stability, nurturing and education and are the people who need to be directly involved in the stimulation of the child and the decision making processes. They need to be supported by the secondary facilitators who are the doctors, social workers, therapists etc. These people provide support in their particular areas of expertise. Team members need to work closely together and there must be freedom within the team to discuss problems and work towards solutions.

2.12 DEVELOPMENTAL PROGRESS

Children learn new skills in a step manner, meaning that they usually learn one skill before progressing to another. Sometimes when a child is developmentally delayed they skip a stage or they appear to be stuck on one stage. It must be remembered that every child is unique and progresses differently. Children with special needs particularly do not progress in the same way or at the same rate as others or even each other.

A child with cerebral palsy or developmental delay has a slower rate of progress in one or several areas of development. The term maximum potential also differs from child to child, as some will be striving to achieve basic skills while others will be able to achieve

scholastic skills and work skills. What is important is to never give up on the child, but at the same time to be realistic about a child's potential.

Children go through different stages of development for example, sitting stage or the crawling stage, standing and walking. Some children due to the severity of the disability sometimes remain in a particular stage and may need the support of a wheelchair for the rest of their lives. Others may progress to using a standing frame or a walker, crutches or even walking. The goal therefore is to help each child reach his/her maximum potential and also to act preventatively to avoid deterioration where possible. Unfortunately, it is important to note that deterioration happens at a quicker rate than progress.

2.12.1 Here are some areas of development from an Occupational Therapy perspective

- Motor development – refers to movement and balance.
- Language development – refers to listening, communicating and speaking skills.
- Social and emotional development – refers to how the child relates to adults and children socially and deals with emotions.
- Play development – refers to how a child plays.
- Cognitive development – refers to thinking, learning, memory and problem solving. Children who are delayed in this area are sometimes referred to as “slow learners” in the schools, although there are other terms such as cognitive or intellectual impairments which are now current.
- Sensory development – refers to learning step by step using the different senses, eyes (vision), ears (hearing), nose (smell), tongue (taste) and skin (touching and feeling) as well as sense of movement and body position (joint and muscles).
- Early intervention of the developmentally delayed child is absolutely vital. It is essential to stimulate each child to assist him/her to reach full potential, even if it is just to help such a child hold his head steady or communicate basic needs. Care providers also need to share ideas, motivate one another and resolve problems with the aim being to offer the best care for the child. Societal

attitudes and practices that discriminate against the right of each child to develop to his/her full potential should be avoided at all costs.

2.12.2 The visually impaired

From infancy the blind or low vision child and his family need early professional services that focus on how the child learns about his world. How parents understand and help with learning, the impact of loss of vision on early development, and how parents feel about having a child with a disability. Research has estimated that up to 90% of what every child learns in his first three years is learned visually, primarily through imitation. Vision is the sense that enables us to integrate all of the things we learn about the world.

- Place sound making objects (clocks, wind chimes, radio) in different parts of the house to help the child learn his/her way around.
- Encourage the child to find and sense different textures throughout the house.
- Look for toys and books with raised numerals, letters or designs that children can touch and explore.
- Provide activities with sensory experiences. Children with visual disabilities learn through hearing and touch.
- Read aloud stories that have a predictable story line.
- Follow up descriptions with concrete experiences.
- Cut out symbols, shapes, letters and numbers from sandpaper or cardboard. Guide the child's hand over these shapes as you discuss them.
- Show the child how to make rubbings by colouring over an interesting texture.
- Be sure that play areas are well lit so that children with limited vision can see well.
- Establish specific areas for play activities. Help the child become familiar with your room arrangement. In case of any changes made in the house, the child needs to be reoriented to the new room arrangement.
- Provide toys and materials in colours that children with visual disabilities can see well.
- Arrange the house for safe and free movement. Keep doors and cabinets closed

- Teach non disabled children to identify themselves and describe their art activities or building constructions in words to children with visual disabilities.
- Teach them also to call the child with visual disabilities by name to get his attention and to use specific words to describe objects such as a phone, hat or car rather than this, it , or that.
- Expand the child's learning by talking to him through an activity. Use a descriptive word such as long, short, over, under, big and little. Whenever possible, provide concrete experiences that illustrate these important concepts.
- Encourage children to build with blocks horizontally. Children can feel shapes and lay them end or in different patterns without the frustration of falling blocks.

2.12.3 Hearing disabilities

Early diagnosis is essential for treatment and proper development of speech. All babies should, therefore, be given a screening test for hearing around the age of 2 – 6 months, with particular attention to those that are on the risk level. The complaints of primary givers should be treated very seriously as they are seldom wrong unless the child is mentally retarded. In understanding the deaf child one has to realise that the normal child has to learn to hear, the first year of life being crucial for this. The ability to learn auditory discrimination diminishes as the child grows older. Delays cause diminished capacity for hearing and the consequential impairment for speech is viewed as the most severe form in the deaf mute. Total deafness is exceptional in most cases.

Ongoing support for the family is vital after initial diagnosis. Information about loss implications, audiograms, hearing tests, amplifications and allowance needs to be provided as well as advice on the impact of deafness on language, social and emotional development. Different methods of communication need to be discussed. For the first 1 -2 years of life, auditory training will be given by the primary care giver who should be taught how to handle the child so as to bring sound to him. Speak close to the child's ears, repeating sounds so that he/she can learn auditory discrimination. Background noise should be kept to a minimum.

A hearing aid should be fitted in at the earliest age at which will accept it, particularly when he/she starts to crawl as the child at this stage will no longer be close to the caregiver for full instructions. The aid should be doubled since two ears are better than

one and must be worn continuously. The child should be kept in a normal environment so that he/she is able to listen to speech all day long. His capacity to hear measured by audiometry improves with auditory. Reading should be taught in order to fill any gaps in his hearing. Sign language must be discouraged as the last resort. Slow down speech rate; allow the child more time to think, talk and repeat if necessary. Use visual aids whenever possible. Do not assume, ask if in doubt. Be patient and flexible.

- Cut down on background noise from the radio when you are doing an activity.
- Make eye contact before you start speaking. A gentle tap on the shoulder usually will get the child's attention.
- Talk in normal tone. Use gestures and facial expressions to clarify your message.
- Provide earphones or set up a special area where a tape recorder can be played at a higher volume.
- Teach children in your programme to use gestures and sign language
- Encourage the child to talk about what he/she is doing. Provide children with visual cues. For example, label shelves with pictures of toys to facilitate easy cleanup. Use pictures to illustrate the steps of a recipe during cooking activities.

2.12.4 Mental disabilities

- Keep verbal instructions simple.
- Break activities into small steps and give one instruction at a time.
- Practise activities over and over.
- Select activities that match the child's mental age and abilities.
- Show and tell the child how to do something by guiding hands and body through the motions of the activity.
- Provide opportunities to play near a child who is doing a similar activity. This can give the child with mental disability some ideas on how to use and explore the same materials.
- Make sure there are obvious differences in size, shapes and colour when sorting or classifying objects. Subtle differences between red and maroon or circles and ovals can be confusing.
- Limit the number of art materials or toys to avoid overwhelming the child with choices.
- Give plenty of warning when an activity is about to change or end.

2.12.5 Behavioural disabilities

- Invite a withdrawn child to join others in an activity by watching others. As the child becomes more comfortable, demonstrate how to play with materials or toys.
- Watch for signs of aggressive behaviour and intervene quickly. Teach problem solving skills.
- Provide developmentally appropriate activities that are not overly difficult and that will help the child feel capable.
- Avoid activities that can be done only a certain way.
- Watch for periods when children are less excitable and in control. Use these times to present a new activity that requires some concentration.
- Keep stories and group activities short to match attention spans. Seat the child near you and away from distractions such as a nearby toy shelf.
- Avoid over stimulation. Limit the number of toys or materials you set out at one time.
- Provide adult guidance and structure. Help children to plan or organise an activity.

2.13 EARLY CHILDHOOD DEVELOPMENT

The impact of inaccessible and poor quality early childhood setting goes far beyond early years. The study conducted by the Joint Committee on children (2000), Youth and families recognised the importance of quality early childhood experience with regard to children entering school ready to learn. School Readiness Baseline Information released by the Maryland State Department of Education showed that only 30% of young children receiving special education services were fully ready for normal school as compared to 48% of young children without disabilities. Research shows that access to developmentally- appropriate early childhood curriculum and typical peer's increases children with special needs' academic and social progress and better prepares youngsters with disabilities and special health care needs for school and learning.

2.13.1 Why early childhood care and education

The early years offer a special opportunity to foster development gains in children as 80% of the brain's capacity develop before the age of three. The gains are shown to be highest for those with maximum disadvantage. Early neglect has lasting disabling effects, poor nutrition leads to early childhood stunting, and couple with low stimulation. It contributes to the poor cognitive and educational performance of over 200 million under five children who are not fulfilling the developmental potential (McAndrew, 1976)

Comprehensive early childhood care and education providing care, stimulation, parental support and access to relevant services enhance the effects of intervention for children with disabilities. Early childhood programme allow for child-centre pedagogy and necessary individualized support to effectively address the diverse learning needs and abilities of children with disabilities (ISSA, 2007). Early childhood programme that are responsive to individual needs and respectful of diversity benefit all children and contribute to building the foundation of an inclusive society.

2.13.2 How can early childhood development be more responsive to children with special needs?

It is important that early assessment and intervention among children with special needs are initiated well before children become eligible for preschool and school. Early assessment and intervention should be made available to identify and support young children at risk. It is most effective when families are closely involved in the process, enabling them to seek appropriate diagnostic and therapeutic service to support their child's well being and development.

Through early assessment coupled with intervention, families gain relevant information, especially about what their child can do and about interventions that will optimise his/her learning potential. This increases the chances that children with disabilities can also participate and flourish in inclusive mainstream educational setting. Evidence suggests that one in three infants and toddlers who receive early intervention services do not present later with a disability or require special education in a preschool (Kessner, 2001).

Besides a holistic attention to the earliest years of life, it is critically important for children with special needs to access formal pre-primary education. Yet, only 56% of all young children worldwide have access to any form of pre-primary services. Although data regarding access for children with special needs is lacking globally, they are least likely to be included in such programmes. Out of 100 million children with special needs worldwide, 80% live in developing countries where the provision of pre-primary education and other basic services tend to be insufficient (UNESCO, 2006).

Although the notion of children with special needs entails varied conditions, abilities, difficulties and needs, there is limited consensus on viable means of addressing this diversity in educational provision. Mainstream education systems typically address a narrow band of learning needs and do not reflect the diversity of abilities, interests and language that all pupils bring to the classroom. When pupils with special needs receive education, it is often in segregated classes or schools where valuable physical, medical, behavioural and pedagogical support can be provided. However, the underlying notion of individuals' deficit and persistent discriminatory attitudes often limit their curricular options and perpetuate large scale institutionalisation, failing to offer equal and meaningful education to children with disabilities and exacerbating their isolation in society.

The inability of mainstream education system to recognise and respond to diverse learning needs is the real barrier to learning. To be inclusive, educational systems must offer differentiation, accommodation and modifications within the general curriculum and include early training in orientation, mobility skills and alternative communication (UNESCO, 2006). The early childhood imperative for the right of children with special needs is clear. It is important to ensure that all girls and boys with special needs have access to lifelong learning. If the Millennium Development Goals around universal primary education and eradication of poverty are to be met, it is necessary that the disability bodies address the care, management and inclusion of children with special needs in their early years, as they comprise one third of the 77 million out of school children (UNESCO, 2006).

In conclusion, this chapter has reviewed the literature that exists in the area under discussion. It has highlighted the kind of issues and challenges that children, parents,

care givers and communities face as far as children living with disability or special needs face. The next chapter will look at the research methods employed in gathering data for the present study.

CHAPTER 3

MATERIALS AND METHODS

3.1 RESEARCH

The researcher in her study will adopt a quantitative approach with some few qualitative questionnaires. The researcher will begin by elaborating on quantitative approaches and qualitative methodologies.

De Vos (2002) stated that the quantitative approach is based on positivism which takes scientific explanation to be based on universal law. Its main aims are to test hypothesis and control human behaviour. It is designed to determine quantitative differences by means of objective measurements. On the other hand, Grinnel (1997) mentions the fact that quantitative research tries to study only those variables that can be objectively measured in the real world, not from someone's opinions, beliefs or past experiences.

Qualitative research is not easily defined and yet it does have certain characteristics that tend to distinguish it from quantitative research methods. According to Lincoln (1994), qualitative research is viewed as an interdisciplinary method. Although qualitative research reflects certain approaches to knowledge production, it may be useful to consider qualitative research as any research that uses qualitative data. Qualitative data refer to any information that the researcher gathers that is not expressed in numbers. De Vos quotes Cresswell's (1994) statement that qualitative research stems from an anti-positivistic interpretative approach. Furthermore, Grinnel (1997) states that qualitative research is the study of how people live, how they talk, behave and also what distresses them. The researcher understands the fact that these two approaches are on the same footing, but her study requires her to utilise the quantitative approach.

De Vos (2002) quotes Webster in defining research, stating that it is an inquiry or examination, especially a critical and exhaustive investigation. On the other hand, Babbie (1995) states that research seeks to provide answers to life's enigmas by exploring questions that originate from people. Research is involved with the quest for knowledge that is conducted in a rational way using scientific methodologies.

Furthermore, research has to be based on a certain approach. Therefore, it is essential that the researcher should select an approach relevant to his/her study. The approach assists researchers to develop knowledge for their profession. In this chapter the researcher will discuss the method of data-gathering.

3.2 RESEARCH DESIGN

The researcher has noted that there are different designs or strategies that are employed in qualitative and quantitative methodologies. From De Vos (2002) we can establish that quantitative research comprises the following designs: notational systems, pre-experimental or hypothesis developing or exploratory designs, quantitative-descriptive designs and true experimental/cause-effect/explanatory. De Vos further quotes Cresswell (1994) who says that research strategy is the entire process of research from conceptualising a problem to writing a narrative. In the present study, a quantitative approach and descriptive design were used to explain the knowledge, experiences and challenges of child care workers with regard to care and management of children with special needs.

Mouton (2001) defines a research design as a plan or blueprint of how one intends conducting the research. A research begins with a set of guidelines and instructions to be followed in addressing the problem. The main function of a research design is to enable the researcher to anticipate what the relevant or appropriate research decisions should be so as to minimise the validity of the eventual results through either minimising or where possible, eliminating potential errors.

3.3 STUDY SITE

The study was conducted at the four Tshwane based institutions of the Gauteng, Department of Social Development, South Africa. The Gauteng Department of Social Development has about nine institutions that are responsible for care and management of children with special needs. It means that there are four institutions in the Tshwane Metro, three in the East Rand and two in Soweto Region. These institutions are called places of safety and children's home. The four Tshwane based institutions are Jabulani

Welfare Complex, Tutela Place of Safety, Pabalelo Place of Safety and Magaliesoord Treatment Centre.

Jabulani Welfare Complex

Jabulani Welfare Complex is a multi-purpose centre comprising of two Unit's place of safety and children's home. The complex has been able to offer a home for the abandoned, abused both on a temporary and permanent basis in according to the Child Care Act 74 of 1983. The complex started operating in 1987. It comprises of Tsosoloso Place of Safety which catered for 120 children. In 1990 the complex expanded with the additional of a children's home called Legae La Rona catering for 200 children. The institution has 264 personnel which are divided as follows, 171 Social Axillary Workers, 13 Administrative Staff, 7 Social Workers, 11 Provisioning Administrative Staff, 7 Cleaners, 27 Food Service Aids, 13 Grounds men and 6 Laundry Workers.

Tutela Place of Safety

The institution has been operating for 20 years. It accommodates 90 children who are between the ages of birth and 18 yrs. The children are kept in the institution on temporary basis at least on average 6-12 months while their home circumstances are been investigated by the children's court. After the children circumstances/ situation have been investigated, children can either return home (only if their home situation has changed) or the children can be transferred to another form of substitute care like children's home.

Tutela Place of Safety offer structured leisure-time activities where the children are expected to participate. Depending on the age of the children, the children can be enrolled in either a nursery school or at an appropriate primary or secondary school. These children are placed in different schools depending on their abilities, needs, behaviour and circumstances. The institution has 3 Social Workers, a Professional Nurse, Child Care Workers and Chief Child Care Worker. This team is supported by other Child Care Workers, Administrative Personnel, Kitchen, Laundry Staff, Handyman and a Bus Driver who also maintain the building and the grounds.

Pabalelo Place of Safety

Pabalelo Place of Safety was officially opened in Ga-Rankuwa on the 19-09-2008. The centre renders services that focus on growth and development of children in order to empower them to be successful in the community. They are providing accommodation, food and clothing for orphans and vulnerable children. They also conduct after school sports and educational activities.

Magaliesoord Treatment Centre

The centre caters for children who are dependent on chemical substances. They also care for youth in conflict with the law. These children are either referred voluntarily by the external Social Worker or by court order. The Social Workers compile the psycho social report, a medical certificate and J7 for conflict with the law. These are youth under the age of 18 years who are awaiting trial. The centre renders service that focus on growth and development of children in order to empower them to be successful in the community.

3.4 STUDY POPULATION

In this study the population are the child care workers that provide care and manage children with special needs in the above four mentioned Tshwane Metro based institutions. The study population consisted of all child care workers in all the Tshwane based institutions that were present at the time the study was conducted. The study population was multicultural, with mainly black and few white people. Among the black participants, there were people from different ethnic groups. Most participants were from Pretoria (Tshwane Metro).

Babbie (1995) defines populations as the collection of elements from which the sample is drawn. On the other hand, population can be defined as all possible cases and subjects of what the researcher is interested in studying. De Vos (2002) states that population sets boundaries on the study unit. De Vos further quotes Cresswell (1994) that population is a set of entities in which all measurement of interests to practitioners or researchers are presented.

3.5 STUDY SAMPLING

There are 89 child care workers in Jabulani Welfare Complex, 39 in Tutela Place of Safety, 105 in Magaliesoort Rehabilitation Centre and 22 in Pabalelo Place of Safety. In total there are 255 child care workers in the four Tshwane Metro based institutions. Since the total number of child care workers in these four institutions was small, all the child care workers were included in the study.

Babbie (1995) defines sampling as the process of selecting part of the group being studied. On the other hand, De Vos (2002) quotes Lincoln's statement that quantitative researchers seek out individual groups and setting where specific processes being studied are most likely to occur.

Therefore, convenient sampling was concluded and all child care workers in all the four Tshwane Metro based institution were included in the study sample. The participants were grouped into four shifts in each institution. Questionnaires were delivered by the researcher to the chief child care workers in all these institutions.

3.6 DATA COLLECTION TOOL

A structured self-administered questionnaire was used to collect data from the participants. It consists of two sections. Section A which comprised the socio-demographic characteristics consisting of four items while Section B consisted of questionnaires that the researcher drew based on the literature search following the four headings that the researcher was interested in reviewing. The headings were "knowledge", "experiences", "challenges" and "training needs". The questionnaire consisted of 18 knowledge questions, 17 experience, 8 challenges and 3 training needs statements measured on a (Yes or No, True or False and Agree, Disagree and Not sure) scale. The value of 1 was given to "Yes" and "True", while 2 was given to "No", and "False" and 3 was given to "Not Sure".

3.7 DATA COLLECTION METHOD

The period of data collection was five months, between February 1 and June 31, 2010. Over a five-month period 253 child care workers managed to complete the study questionnaires and return back to their chief child care workers in all the respective institutions.

The researcher was personally responsible for printing all the questionnaires, delivering them to all the chief child care workers in the four Tshwane Metro based institutions and collecting them after all the respective shifts had completed and submitted their forms. Due to the nature of shift work in the institutions setting, the researcher allocated four hours on Fridays to collect the questionnaires. The researcher was controlled by which institution called her to collect the questionnaires every week over the five-month period. Data were then captured electronically for the purposes of analysis.

3.8 GAINING ACCESS TO PARTICIPANTS

The researcher requested permission from the Research Department of the Gauteng Department of Social Development. She also requested permission from the Chief Director and Director of Institutions of the Department of Social Development to conduct this study. She further arranged 4 respective meetings on Friday in October 2009 with the heads of institutions and chief child care workers, to explain her study to them and her expectations from the child care workers. This process was successful since the heads of sections and chief care workers disseminated the information to all the child care workers in their respective institutions. This process was a way of preparing the child care workers for the actual study.

3.9 VALIDITY AND RELIABILITY

To ensure content validity of the instrument, the draft questionnaire was submitted to the supervisor for expert scrutiny regarding the relevance of each item. Pre-testing of the questionnaire was done in October 2009 at Van Ryn Place of Safety in the East of Johannesburg, Benoni where twenty-five self-administered questionnaires were

distributed to participants to comment on the clarity of the questions. About four items from the instrument were found to be asked in the negative, which had the potential to allow different interpretations. These items were subsequently reconstructed to improve clarity.

3.10 ETHICAL CONSIDERATIONS

Ethical clearance and approval to conduct this research was obtained from the research Ethics and publication Committee of the National School of Public Health, University of Limpopo, and the Medunsa Research Ethics Committee, MREC/PH/123/2009: PG (Appendix F)

Permission to conduct the study was requested from the Research Unit of the Gauteng, Department of Social Development and was approved (Appendix A). Permission was further requested from the Chief Director of Institutions and the Director of Institutions (Appendix B).

The ethical considerations took into account the personal and revealing nature of the study, which required that voluntary, informed consent, using the consent form designed for this study, needed to be obtained from the participants. Prior to administering the questionnaires, the aims and objectives of the study were clearly explained to the heads of institutions and chief child care workers in all the respective institutions which was followed by the dissemination of information to all the child care workers of the four Tshwane Metro based institutions. Written informed consent was obtained (Appendix D).

Confidentiality and anonymity were ensured throughout the execution of the study as participants were not required to disclose personal information on the questionnaire. Provisions were made to have participants concerns relating to the study addressed and misconceptions corrected. Participants were informed that their participation was voluntary and that they could withdraw from the study at any time if they wished to do so.

3.11 LIMITATIONS OF THE STUDY

Important limitations are inherent in a survey of this kind, mainly because the study instrument used was a self-reporting measure; the information presented by participants is based upon their subjective perceptions. Although participants were assured of confidentiality, it is therefore possible that they either over or under reported on their levels of knowledge, experiences and challenges they have in managing children with special needs.

Again, even with the high level of participation in this study, the researcher had to work hard to motivate the chief child care workers to make follow up with the child care workers since the researcher was aware of the challenges that the child care workers were faced with during the time of data collection. The child care workers at Magaliesoort and Jabulani Welfare Complex were on strike from April 1 to May. They were protesting against poor service delivery and lack of recognition by the Department of Social Development, whereas at Tutela Place of Safety, the employees were demanding that the head of the institution be removed because of problems they were experiencing with her. Indeed the Tutela head of institution was suspended and moved to Pretoria Regional Office. This development made the process of data collection easier and smoother. Child care workers in Tutela were then willing to complete the study and the participating rate was good. While child care workers in Magaliesoort were still on a go slow.

There researcher therefore acknowledges that the process of data collection was a hectic and rough process and it was by chance and luck that she managed to have almost everyone complete their questionnaires. The hard work was not only done by the researcher, but the chief care workers together with the heads of institutions gave their support. They were willing to motivate their child care workers to complete the questionnaire. The findings of the study may not be generalised to the child care workers in other institutions, as the different environment and circumstances prevailing in other institutions may impact on the level of knowledge experiences and challenges in different ways. It should therefore be noted that the study was conducted at a time when the three mentioned institutions were experiencing challenges and employees

were on strike. However, finally the end the researcher obtained almost all the questionnaires duly completed.

3.12 DATA ANALYSIS

Of the 255 questionnaires printed and distributed about 253 were returned. Of these questionnaires only one was incomplete. Quantitative data from the returned questionnaires were coded and entered into Epi Database. Data were then imported into STATA version 10 to analyse the generated data. Categorical variable Yes or No and True or False were looked at. Frequency distributions were determined per category. Descriptive statistical analyses were employed. Data were also summarised using graphic presentations for the interpretation of findings. Statistics were based on percentages and frequencies. Qualitative variable themes were developed based on qualitative responses. All responses were recorded according to themes, and STATA 10 was used for analysis.

Miles & Huberman (1994) mentioned that, quantitative data provides descriptions that are vivid, nested in a real context and have a ring of truth that has strong impact on the reader. But the strength of this data, they argue, rest with the competence with which the analysis is carried out. Kerlinger in De Vos (2002) reveals that analysis means the categorizing, ordering, manipulating and summarising of data to obtain answers to research questions. The purpose of analysis is to reduce data to an intelligible and interpretable form. On the other hand, De Vos (2002) states that the aim of analysis is to look for trends and patterns that reappear within a single group of participants.

Chapter three discussed the methods that were used to gather data. Quantitative and qualitative methods were both used. The following chapter will analyse results from the data gathered.

CHAPTER 4

RESULTS

This chapter discusses data analysis and interpretation against care and management of children with special needs by child care workers. The level of perceived knowledge, experience and challenges of child care workers in managing children with special needs will be presented. The objectives of the study were:

- To describe the self-perceived knowledge of care and management for children with special needs among child care workers.
- To describe the experience of child care workers in care and management of children with special needs.
- To describe the challenges regarding care and management of children with special needs.

This chapter presents in total five sections as illustrated in the research instruments. Below is the segmentation of the results according to the study objectives. The following results describe the overall findings of the study in descriptive statistics.

4.1. Socio- demographic characteristics of respondents

A total of 253 respondents participated in the study. Table 1 below indicates that the majority of the participants were females (70%) while about one third (30%) were males with a mean age of 42 and a standard deviation of 8 and the range of 39. The minimum age of the respondents was 20 years and the maximum age 60 years. The highest proportion of respondents was between the ages of 31 and 40 years (41.11%). Almost two-thirds (a total of 60.08 %) respondents were married. Under half (a total of 47.83%) obtained certificate/diploma while 37.55 had secondary qualification and only 14.23% had tertiary qualification. The table below indicates the socio-demographic characteristics of respondents.

Table 1: Socio-demographic characteristics of respondents

Variable		n	Percentage
Gender	Female	176	69.57
	Male	77	30.43
Age Mean = 42 Standard deviation = 8 Range = 39	20-30	23	9.09
	31-40	104	41.11
	41-50	90	35.57
	51-60	34	13.44
Marital Status	Divorced	17	6.72
	Married	152	60.08
	Single	78	30.83
	Widowed	6	2.37
Level of Education	Secondary	95	37.55
	Tertiary	36	14.23
	Certificate/diploma	121	47.83
	Other	1	0.4

4.2 Self-perceived knowledge of child care workers in managing children with special needs

The reader should refer to the questionnaire (Appendix C) and the exact phrasing of the statements in order to interpret the results shown in the following tables.

Table 2 shows that nearly three-quarters of the respondents (78.57%) had knowledge and experience of caring for children with special needs or disability, while about

21.43% reported no knowledge. When participants were asked to tick the type of disabilities they have knowledge in, the following results were obtained.

Table 2: Self-perceived knowledge and experience of child care workers in caring for children with special needs

Have you had the knowledge and experience of caring for children with special needs or disability?	n	Percentage
No	54	21.43
Yes	198	78.57
Missing	1	0.10
Total	253	100

Table 3 below indicates the types of disabilities that the participants were asked to indicate whether they have knowledge about types of disabilities.

Table 3: Self-perceived cognitive knowledge

Diagnosis	Percentages	
	Yes	No
Delayed Development/Mental Retardation	77.78	22.22
Down Syndrome/Language Delay	42.42	57.58
Fragile X Trauma Brain Injury	14.65	85.35
Learning Disabled	79.80	20.20

When the participants were asked to show their perceived cognitive knowledge, nearly three-quarters (a total of 77.78%) reported to have knowledge of caring for children with Delayed Development/Mental Retardation while 22.22% reported no knowledge and experience. The results further indicate that a total of 42.42% of respondents had knowledge of caring for children with Down syndrome/Language Delay while 57.58% of the participants indicated no knowledge and experience in this type of disorder. The

majority of the participants (a total of 79.8%) also indicated that they had knowledge about caring for children with Learning Disabilities while 20.2% indicated that they had no knowledge. It was found that with regard to Fragile X Trauma Brain Injury the majority of the participants (85.35%) indicated no knowledge and experience of caring for children with special needs while about 14.65% had knowledge and experience. Table 4 below indicates the self-perceived cognitive knowledge among child care workers.

Table 4: Self-perceived cognitive knowledge

Diagnosis	Percentage	
	Yes	No
Arthritis/ Orthopaedic	7.07	92.93
Cerebral Palsy	39.39	60.61
Hearing /Vision Loss	60.61	39.39
Spina Bifida	10.61	89.39
Muscular Dystrophy	18.18	81.82

Out of those respondents who perceived themselves as having knowledge and experience of caring for children with special needs or disability, only 7.07% of the respondents had self-perceived knowledge about Arthritis/Orthopaedic. The other subjects had no knowledge. Almost forty percent (39.39%) of the respondents perceived themselves as having knowledge and experience of caring for children with Cerebral Palsy while about three quarters (60.61%) had no knowledge. About 60.61% of the respondents perceived themselves having knowledge of caring for children with Hearing/Vision Loss and other subjects did not. A total of 10.61% of respondents perceived themselves having knowledge about Spina Bifida and 18.18% had knowledge about Muscular Dystrophy while the majority of the subjects did not have the knowledge in these disabilities. Table 5 below indicates the self-perceived medical knowledge among child care workers.

Table 5: Self-perceived medical knowledge

Statements	Percentages	
	Yes	No
Apnea Monitor Heart Condition	3.03	96.97
HIV and AIDS	80.3	19.7
Hydrocephalus	4.55	95.45
Cancer Lead Poisoning	3.54	96.46
Colostomy Bags Prematurity	1.01	98.99
Cystic Fibrosis Respirator	3.03	96.97
Diabetes Severe Allergies	35.86	64.14
Drug Addicted	70.71	29.29
Seizure Disorder	9.6	90.4
Feeding Problems	33.84	66.16
Genetic Disorder	17.17	82.83

The results in table 5 show that only 3.03% of the respondents perceived themselves as having knowledge about Apnea Monitor Heart Condition while 96.97 did not. The majority of the respondents (a total of 80.3%) indicated that they had knowledge about HIV and AIDS, while 70.715 perceived themselves as having knowledge about drug addiction. Just about 4.55% of the participants perceived themselves as having knowledge about Hydrocephalus and the other subjects did not. Only 3.54% perceived themselves as having knowledge about Cancer Lead Poisoning, 1.01% had knowledge about Colostomy Bags Prematurity, 3.03% had knowledge about Cystic Fibrosis Respirator, 17.17% of the respondents had knowledge about Genetic Disorders and just about 9.6% had knowledge about Seizure Disorder while the other subjects did

not. Almost two-thirds (a total of 64.14% had knowledge about Diabetes Severe Allergies and just over half (33.84%) had knowledge about Feeding Problems.

Table 6: Self-perceived psycho-social knowledge

Statements	Percentages	
	Yes	No
Adjustment Disorder	45.96	54.04
Asperger Syndrome	2.02	97.98
Attachment Disorder	52.02	47.98
Attention Deficit	61.62	38.38
Hyperactivity Disorder	63.13	36.87
Autism	11.62	88.38
Behavioural Problems	77.78	22.22
Bipolar Disorder	21.21	78.79
Depression	45.96	54.04
Emotional Problems	82.83	17.17
Mood Disorder	49.49	50.51
Obsessive Compulsive Disorder	16.16	83.84
Oppositional Defiant Disorder	10.61	89.39
Pervasive Development Disorder	5.56	94.44
Post traumatic Stress Disorder	35.35	64.65

The results in table 6 show that under half (a total of 45.96%) of the respondents perceived themselves as having knowledge about Adjustment Disorder, while only 2.02% had knowledge about Asperger Syndrome and more than half (52.02%) had knowledge about Attachment Disorder. Two-thirds (a total of 61.62%) perceived

themselves having knowledge about Attention Deficit, while 63.13% had knowledge about Hyperactivity Disorder and 11.62% had knowledge about Autism while the other subjects did not. A large proportion of the respondents (a total of 77.78%) perceived themselves as having knowledge about Behavioural Problems, while 21.21% had knowledge about Bipolar Disorder, under half (a total of 45.96%) had knowledge about Depression and the other subjects did not have that knowledge.

The majority of the participants (about 82.83%) perceived themselves as having knowledge about Emotional Problems, while nearly two-quarters (49.49%) had knowledge about Mood Disorder and a total of 16.16% of respondents perceived themselves as having knowledge about Obsessive Compulsive Disorder, 10.61% of the respondents had knowledge about Oppositional Defiant Disorder, 5.56% had knowledge about Pervasive Development Disorder and 35.35% of the respondents perceived themselves as having knowledge about Post-traumatic Stress Disorder.

Table 7 below shows the summary of results of the self-perceived knowledge of child care workers who care and manage children with special needs; Mean = 11.09, Standard deviation = 5.26, Minimum = 2, and Maximum = 30. The maximum of 30 respondents comes from the aggregated of participants' responses which were used to generate the self-perceived knowledge score from table 3, 4, 5, and 6. The researcher grouped self-perceived knowledge using the criteria indicated below the table (*). The results revealed that the majority (65.22%) of the sample had low self-perceived knowledge about children with special needs, while only few were in the categories of medium (32.20%) and high self-perceived knowledge (1.58%).

Table 7: Summary of self-perceived knowledge on disability

Descriptive	Perceived knowledge
Mean	11.09
Standard deviation	5.26
Minimum	2
Maximum	30
Level of Self Perceive Knowledge	*
Low self-perceived knowledge	165 (65.22%)
Medium self-perceived knowledge	84 (32.20%)
High self-perceived knowledge	4 (1.58%)

*Self-Perceive Knowledge: 1-12 = Low, >12 to 24 = Medium, >24 to 36 = High

Table 8 below indicates the level of accessibility in the institutions and the use of sign language among child care workers.

Table 8: Infrastructure and accessibility of the institutions and the ability of child care workers to understand and use sign language

Statements	Rating	
	Yes	No
Do you currently have wheelchair accessibility in your institutions	23.72	76.28
Do you know sign language	10.67	89.33

Only 23.72% of the participants indicated that they had wheelchair accessibility in their institutions, while majority (76.28%) had no accessibility. Out of all the participants who took part in the study only 10.67% indicated that they knew sign language as

compared to 89.33% who did not. Table 9 below indicates the knowledge of child care workers in managing children with special needs.

Table 9: Knowledge of child care workers with regard to children with special needs

STATEMENTS	PERCENTAGE	
	Yes	No
Children with special needs require special care.	96.05	3.95
Children with special needs are those with disabilities, abnormal behaviour, neglected.	96.05	3.95
HIV/AIDS infected children require special care needs.	88.14	11.86
Children with special needs should not be in school.	7.51	92.49
All children with special needs should receive medication.	31.23	68.77
In school, children with special needs should be in one class.	31.62	68.38
All children with special needs have difficulty in learning.	15.81	84.19
Children with special needs cannot do anything for themselves.	18.97	81.03
Having a special need is a matter of choice.	2.77	97.23
It is the fault of the mother to have children with special needs.	1.98	98.02
Children with special needs should understand things like everyone else.	24.9	75.1
Some children are born with special needs.	35.97	64.03

**Number highlighted in bold is the corrected answer*

Only 2.77% of the participants believed that having a child with special needs is by choice, while 1.98% believed that it is the fault of the mother and the rest of the subject did not agree with these statements. About 35.97% of the respondents indicated that some children are born having special care needs, while 64.03% did not think so. The majority of the participants (96.05%) agreed that children with special needs were those who have disabilities, abnormal behaviours and those who are neglected and that these children require special care. About 88.14% of the respondents indicated

that HIV and AIDS children required special need, while the other subjects did not agree. About (31.23%) of participants reported that all children with special needs should receive treatment, while 68.77% did not agree with the statement. Only 15.81% of the participants believed that all children with special needs have difficulty in learning, while 31.62% thought they should be placed in one class. About 7.51% of the respondents thought these children should not attend school. Only 18.97% of respondents reported that children with special needs could not do anything for themselves, while 24.9% of respondents thought children with special needs should understand things like any other children. The other subjects did not agree with these statements. Figure 1 below shows the criteria used by child care workers to indicate whether a child has a special need.

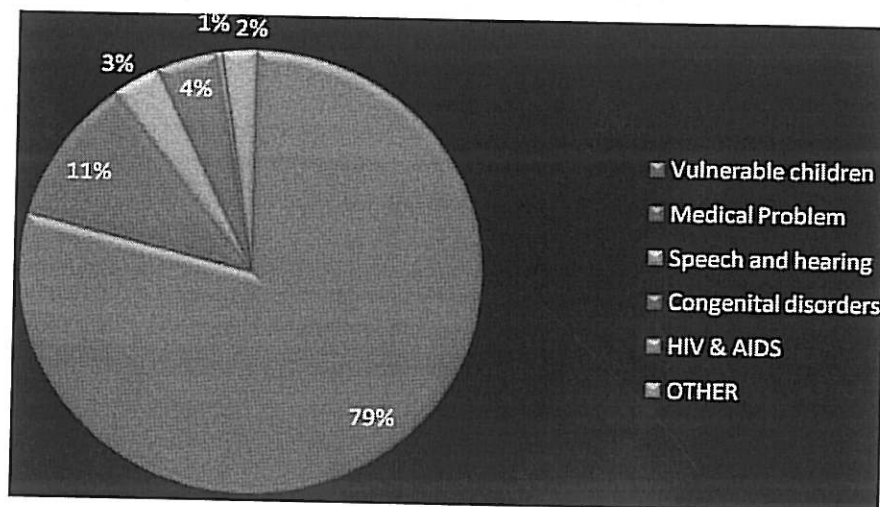


Figure 1: the criteria used by child care workers to indicate whether a child has a special need

Figure 1 shows the responses for the question regard to when will a child be regarded as having a special need. The majority of the respondents (about 79%) indicated that a child is regarded as having a special need when he/she has HIV and AIDS, while 11% indicated that it is when the child has a medical problem. About 4% of respondents indicated that it is when the child has a congenital disorder. About 3% of the participants indicated that it is when a child has speech problem, while 1% indicated that vulnerable children are regarded as children with special needs.

4.3 Experiences of child care workers in care and management of child care workers in managing children with special needs

Table 10 below indicates the attitudes of child care workers in managing children with special needs.

Table 10: Attitudes of child care workers in managing children with special needs

Statements	Percentage		
	Agree	Disagree	Not Sure
Children with special needs require provision of basic skills such as patience, empathy and acceptance (agree = positive)	93.68	4.74	1.58
Children with special needs, requires assistance in order to grow and learn (agree = positive)	95.65	2.37	1.98
Caring for children with special needs is more demanding than caring for other children (agree = positive)	87.75	7.51	4.74
I feel stressed after caring and managing for children with special needs (agree= negative)	84.98	12.25	2.77
Working with children with special needs affects your emotions (agree= negative)	77.87	15.42	6.72
Working with children with special needs requires support from managers and seniors (agree = positive)	90.48	5.95	3.57
I would recommend anyone I know to work with children with special needs (agree = positive)	41.9	13.44	44.66
I like caring for children with special needs (agree = positive)	64.43	13.44	22.13

Table 10 shows that (84.98%) of the participants felt stressed after caring for children with special needs and 77.87% agreed that working with children with special needs affected their emotions, while 15.42% disagreed and 6.72% were not sure. A total of 87.75% of participants indicated that caring for children with special needs is more demanding than caring for any other children. The majority of the participants (a total of 93.68%) felt that children with special needs required provision of basic skills such as patience, empathy and acceptance, and 95.65% agreed that these children required assistance in order to grow and learn, while 90.48% of the participants believed that they required support from the management in order to care and manage children with special needs. About 64.43% of the participants reported that they enjoyed caring for children with special needs, while the other subjects disagreed and some were not sure. Of all the participants who participated in the study, only 41.9% agreed that they would recommend anyone they knew to work with children with special needs, while 13.44% disagreed and 44.66% were not sure. Table 11 below indicates the summary of levels of experience among child care workers.

Table 11: Summary of levels of experience

Descriptive	Experience
Mean	13.55
Standard deviation	2.03
Minimum	6
Maximum	16
Level of Experience*	
Negative Experience	26 (32%)
Positive Experience	226 (89.68%)

Experience: 0 to 8 = negative experience, >8 = positive experience

Table 11 shows a summary of the result of child care worker's levels of experience in managing children with special needs, Mean = 13.55, Standard deviation = 2.03, Minimum = 6, and Maximum = 16. The researcher grouped levels of experience by

using the criteria indicated below the table (*). The results revealed that the majority of child care workers (89.68%) had positive experience towards care and management of children with special needs, while fewer participants (32%) had negative experience. The results indicate that the participants had sufficient experience in care and management of children with special needs.

Figure 2 below shows that just about 61.7% of the respondents reported that working with children with special needs required emotional support and 9.9% of respondents reported that they lacked training. About 0.79% of respondents reported that there was lack of human resources, while 1.97% of participants reported lack of support from management. A total of 5.53% of participants indicated a need for training.

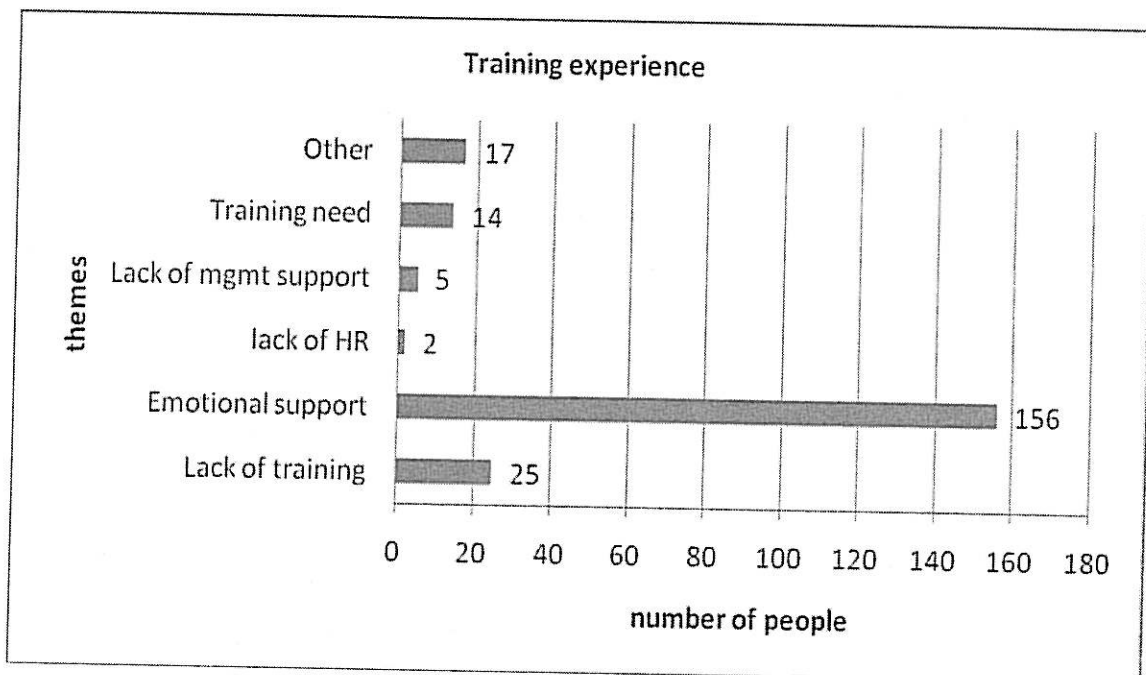


Figure 2: Child care workers' experience of working with children with special needs

The results on table 12 below indicate that about 5.97% of the respondents reported that they would toilet train children with special needs because these children were physical disabled, while 51.24% reported that by toilet training these children they were personally developing them. Almost thirteen percent (12.96%) reported that toilet training children with special needs was a way of showing psychological support, while nearly two-thirds of the respondents (a total of 28.86%) reported that it was the care

workers' responsibility to toilet train children with special needs. Table 12 below indicates reasons why child care workers agreed to help children with special needs with toilet training.

Table 12: The reasons why the childcare workers agreed to help with the toilet training of children with special needs

Why will you toilet train children with special needs?	n	%
Physical disabled	12	05.97
Personal development	103	51.24
Psychological support	26	12.94
Care worker responsibilities	58	28.86
Other	2	01.00
Total	201	

About 53.57% of the participants reported that they would not toilet train children with special needs since they lacked training, while 10.71% would not toilet train these children due to the children's level of disabilities and 7.14% reported due to sexual abuse. About 3.57% of the respondents reported that they needed resources and 17.86% reported a need in general training. Table 13 below indicates reasons why child care workers refused to help children with special needs with toilet training

Table 13: The reasons why child care workers refused to help with the toilet training of children with special needs

Why will you not toilet train children with special needs?	n	%
Need resources	1	03.57
Training need	5	17.86
lack of training	15	53.57
Levels of disability	3	10.71
Sexual abuse	2	07.14
other	2	07.14
Total	28	100.00

Table 14: Child care workers' level of experience in managing children with special needs

Statements	Percentage		
	Yes	No	Don't Know
2. Do you currently have children with special needs or disability in your institution?	48.62	38.74	12.65
3. Do children with special needs or disability in your institution receive early childhood mental or physical health service?	26.48	47.43	26.09
4. Are there children in your care who are receiving early intervention services other than mental or physical health services?	19.76	51.38	28.85
5. Have you ever referred a child or children for early intervention services?	26.98	52.78	20.24
6. Have you ever had to terminate the care of a child due to behavioural problems?	23.02	58.33	18.65

Only 48.62% of participants reported that they had children with special needs or disability in their institutions and about 26.48% of the participants agreed that these children received early childhood mental or physical health services and other subjects did not know. About 19.76% of the participants reported that there were children with special needs in their care who received early intervention services other than mental and physical health services. Only 26.98% of participants indicated that they once referred children for early intervention services, while about 23.03% agreed they have once terminated the care of a child due to behavioural problems in their institutions.

4.4. Training needs for child care workers in care and management of children with special needs

Table 15 below indicates the types of training needs required by child care workers in managing children with special needs.

Table 15: Child care workers' training needs

Statements	Percentage		
	Yes	No	Not sure
Have you attended a course in early childhood development or early childhood education?	39.53	60.47	0.00
Do you think you need special training in caring and managing children with special needs?	87.35	9.49	3.16

Only 39.53% of the respondents attended early childhood development course and 60.47% did not attend, while the majority of the participants (about 87.35%) indicated a need for special training in caring and managing children with special needs.

Figure 2 below indicates the skills that are required by the child care workers in managing children with special needs.

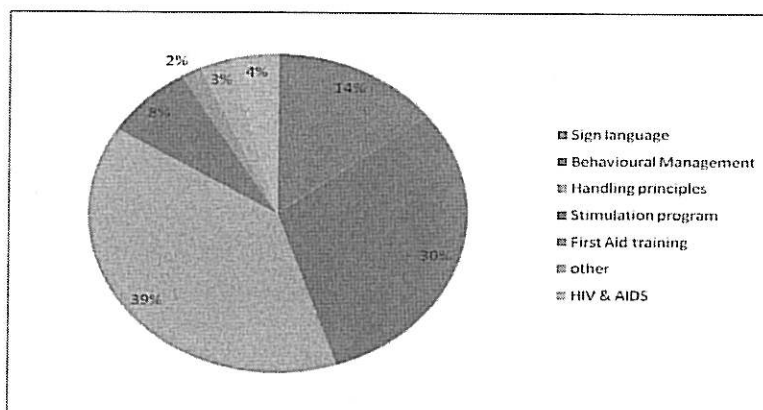


Figure 3: Skills required by child care workers in care and management of children with special needs

Over two-thirds of the respondents (a total of 39%) indicated that they needed skills in handling principles, 30% of the respondents indicated a need of skills in behavioural management, 14% of respondents indicated a need of skills in sign language and 8% of the respondents indicated a need of skills in stimulation programme. Only 4% of the respondents indicated a need of skill in HIV and AIDS, while about 2% indicated a skill in First Aid Training. Table 16 below indicates the child care workers' feeling of frustration and guilty in caring and managing children with special needs.

Table 16: Child care workers' feeling of frustration and guilty in caring and managing children with special needs

Statements		Percentage	
		Yes	No
Do you ever feel frustrated or angry when working with children with special needs or disability?		57.31	42.69
Do you ever feel guilty because you think you should have been able to provide better care, despite all the other things that you have to do?		69.96	30.04
Please indicate what frustrates or angers you	Lack of training	39.84	
	Lack of resources	18.75	
	Psychosocial behaviour	31.25	
	Personal care	3.13	
	Medical condition	1.56	
	Inadequate management support	5.47	

A total of 57.31% of the participants reported feeling frustrated when working with children with special needs, while 42.69% did not feel frustrated by their work. On the other hand, 69.96% of the participants felt guilty that they should have been able to provide better care for children with special needs, while the other subjects had no feeling of guilt. When the participants were asked to indicate what frustrated them,

39.84% indicated lack of training while 18.75% indicated lack of resources, and 5.47% reported inadequate management support. About 31.25% reported feeling frustrated because of the children's psychosocial behaviours, while the other participants would be frustrated by the children's personal care need and their medical conditions.

4.5. Challenges for child care workers in care and management of children with special needs

Table 17 below indicates the challenges that were experienced by child care workers in managing children with special needs.

Table 17: Challenges experienced by child care workers in managing children with special needs

Statements	Percentage		
	Agree	Disagree	Not sure
I wanted to change my job because I have to care and manage children with special needs	20.16	64.03	15.81
After caring and managing children with special needs, I always worry that I will have a child with special needs	13.83	76.28	9.88
I need to wear gloves every time I care and manage children with special needs	41.11	48.22	10.67
I cannot feed children with special needs	8.3	81.03	10.67
I struggle to carry or hold babies with disabilities	13.44	73.52	13.04
It is difficult to communicate with children with special needs	26.88	47.83	25.3

Only 13.83% of the participants became worried that they would have children with special needs from caring for children with special needs, while 76.28% disagreed and about ten percentages of the participants were not sure. About 41.11% of the

participants reported that they needed to wear gloves when working with children with special needs, while 20.16% of the subjects wanted to change their work to where they would not have to work with children with special needs. The other subjects disagreed and some were not sure. Only 8.3% of the respondents reported that they could not feed children with special needs, while the majority of the participants (81.03%) totally disagreed and 13.44% struggled to carry or hold babies with disabilities as compared to 73.52% who disagreed. A total of 26.88% indicated difficulties of communicating with children with special needs, while 47.83% had no challenges and 25.3% were not sure.

This chapter presented the analysis of results. The next chapter will present the findings and will also conclude the study and give recommendations.

CHAPTER 5

DISCUSSION, CONCLUSIONS AND RECOMMENDATION

5.1 DISCUSSION

This chapter presents the findings and discussion of the research on knowledge and experience of child care workers in care and management of children with special needs in the four institutions of the Department of Social Development in Tshwane Metro. The presentation is organised according to the objectives of the research, that is:

- To describe the self-perceived knowledge of care and management for children with special needs among child care workers.
- To describe the experience of child care workers in care and management of children with special needs.
- To describe the challenges regarding care and management of children with special needs.

The findings of the study have limited generalisability and may need to be confirmed by further research in other departments of social development in the other provinces in South Africa. There are nine provinces in South Africa, and this study took place in Gauteng in four Tshwane Metro based institutions. This limited the findings of this study. With this limitation in mind, the study seeks to determine the self-perceived knowledge, experience, challenges and training needs of child care workers in care and management of children with special needs. The results of this study indicated overall lack knowledge and training of child care workers who care and manage children with special needs. These child care workers are also reported to have challenges and stress of managing the children with special needs.

Managing of children with proper attention and care is highly valuable but equally challenging for child care providers, parents and families in general. This task becomes more challenging and at times threatening in bringing up children who have special needs. It requires knowledge, skills, experience and positive attitude primarily on the part of care givers. It requires ability, commitment and hard work. The knowledge and ability to prevent or detect problems and intervene at an early age of the child is also

crucial. Failure to carry out any of these tasks for any reason might lead to multiple problems at different levels.

The results in the preceding section show the experiences of child care workers in care and management of children with special needs and child care workers self-perceived knowledge on types of disabilities. The efforts made by the child care workers, the support system available and the challenges child care workers are faced with are examined.

5.1.1 To describe the self-perceived knowledge of care and management for children with special needs among child care workers.

In this study the results revealed that the majority of the respondents (65.22%) had low self-perceived knowledge about children with special needs. Interestingly, many child care workers were unable identify the types of disabilities in which they had self-perceived knowledge. This indicated knowledge deficit about disabilities among child care workers. The need to educate them on types of disabilities is evident. The need to train child care providers who care and manage children with special needs is also emphasised by many researchers. This training is necessary since the care providers are faced with additional responsibilities and they experience many problems relating to care and management of children with special needs.

In this study the child care workers were found to have low self-perceived knowledge about disabilities. This makes it difficult for child care workers to adequately care and manage children with special needs or disabilities. Anecdotal evidence showed that many child care providers including facilities that support children do not want to accept children with special needs due to lack of knowledge and training of care givers on types of disabilities. Data gathered by the Maryland Development Disabilities Council regarding child care for children with disabilities indicate that child care providers refused to accept children with special needs due to a wide variety of problems, including lack of knowledge, behavioural issues and toileting problems.

The study that was conducted by the Maryland Committee for children in 1995 reported that many care givers feel inadequately trained to care for children with disabilities. Suzan Graig, a coordinator of a project called the Successful Integration of

infants and toddler with handicaps, states that nanning is one of the most important components of providing quality day care for children with special needs. Suzan Graig also supports the need for training of child care workers focusing on physical environment, physical, social, cognitive development and communication based on the critical part of work that care providers play in caring for children with special needs.

From the above results it is clear that the majority of child care workers have lack of knowledge in the types of disabilities of the children they have to care for. It was further mentioned in the literature review that care givers are often reluctant to accept children with disabilities in child care setting because of concerns about lack of knowledge in the types of disabilities. It was also stated that it is difficult to find quality child care for children with special needs and special health care. Children with special needs should be treated equally and should enjoy the same rights as all the citizens. Children with special needs should not be discriminated or refused entry into the child care centres based on their disabilities and challenges.

5.1.2 To describe experiences and challenges of care and management for children with special needs among child care workers.

The results show that 57.31% of the respondents reported feeling frustrated when working with children with special needs. Over two-thirds (a total of 69.96%) of the participants reported feeling of guilty about the services rendered to children with special needs.

Literature search indicates that the parents of children with special needs go through stages of grief in their lives. Furthermore, literature indicates that parents of children with special needs or disabilities experience chronic stress. The stress among child care workers was mainly influenced by the severity of the problem the children had. This stress is also created due to the mental conflicts associated with learning the handicap of the children. The literature has not only highlighted the importance and benefits of care and management of children with special needs, but has also identified numerous barriers which have to be overcome for this to be successful. These include negative attitudes of the child care workers, poor staff to child ratios and insufficient

staff support, limited access to resources and equipment, inadequate staff training and experience in working with children who have a disability (Valentine, 2001)

Hanvey (2002) found that the discomfort level of child care workers increased as the severity of the disability increased. Hastings et al. (2005) reported that child care providers tended to have more negative attitudes about the severity of disabilities in their care. Another study showed that parents with children with disabilities, particularly in severe cases, often undergo psychological crisis. Stress, frustration and hopelessness and feeling of guilt were some of the problems revealed in the study. This, among other things, implies the need to consider counselling whenever services are planned for children with special needs. The counselling services are also to address various psychological problems with children with special needs.

In this study 20.16% of the respondents indicated that they wanted to change their job because of having to care and manage children with special needs. About 77.87% of the participants further reported that working with special needs children affected their emotions. Managing children with special needs requires patience, more knowledge, special skills and a lot of effort from child care workers. External input from professionals is needed in order to support the efforts made by child care workers.

Literature indicates that children with special needs can place a lot of strain in the lives of care providers due to their need of high levels of physical care support and emotional demand.

5.1.3 Training need for child care workers

The study found that the majority of the participants (a total of 87.35%) reported a need for training of child care workers who care and manage children with special needs. Literature indicated that child care providers of children with a disability hold fears about the ability of child care workers to meet the special needs of children (Dunbrack, 2003) and child care workers in this study also harbour doubts about their abilities and believe that more training would be beneficial (Burton et al, 2008).

Literature has shown that the greater the amount of training and experience child care workers have in the area of childhood disability, the more positive their beliefs regarding care and management of children with special needs, and the more likely they are to be willing to work with children who have special needs. The positive attitude towards children with special needs gained through training and experience can also enable child care workers to promote similar attitudes in the children they work with.

5.1.4 Attitudes of child care workers

Literature indicates that child care workers feeling of discomfort and negative attitudes towards children with special needs have been found to decrease after working with these children for a time. Similarly, child care providers who had previous experience working with children with special needs tended to show greater confidence and interest in working with children with special needs in the future (Dale, 1996), although in the Hastings et al. study 40% of the respondents expressed a reluctance to work again with children who have a disability. Attitudes towards future work with children with special needs or disability is likely to be influenced by whether previous experience was positive or negative. Negative attitude of child care workers can be substantial barriers to the care and management of children with special needs.

When participants were asked if they would help toilet train children with special needs, 53.57% indicated that they would not since they lacked training. The survey that was conducted by the Maryland Committee for children in 2001 found that 59% of the family care providers reported that providers were uncomfortable in diapering or assisting children with special needs with toileting. Another study conducted by the Coalition for Inclusive Child Care Committee in 2002 reported attitudes of child care providers as a major problem. Child care providers did not want to care for children with disabilities or special health care needs because of incorrect assumptions about the child, disability and the effect on their work load.

In this study child care workers indicated difficulties in communicating with children who have hearing impairment as a result a need for training in sign language was indicated. According to Tirusew (2008) children with disabilities are undermined, ridiculed and insulted by the care providers and peers. Children with hearing impairment indicated that they were unable to benefit from the support of care

providers because of the lack of sign language. As a result of the lack of sign language, it is difficult for them to communicate with the children.

Attree (2000) found that interpersonal relationships are central to the quality of care for children in need of care. Lau (1996) notes that quality of care is based on the interpersonal relationships of care providers with their children they have to care for. The sign language problem, which hinders interpersonal relationship in managing children with special needs, should be highlighted.

5.1.5 Training Experience of child care workers

The study found that only 39.53% of the respondents attended early childhood development course and 26.48% of the respondents indicated that children with special needs or disability in their institutions received early childhood mental and physical health services. Including children with special needs or disabilities in early childhood programmes sets a precedent for inclusion as the norm, and reduces the possibility of later prejudice and negative attitudes towards children with disabilities. The practice of inclusion encourages children's awareness of individual differences and the great diversity among people (Bailey, 1996). In addition, research has shown that children with disabilities who have attendant inclusive programmes have more positive social interactions and behavioural outcomes than those in segregated programmes (Bailey, 1993). However, a study conducted by Buysse (1993) indicates that the type and severity of the disability may also affect the likelihood of a child being included in an early childhood programme, Bailey (1992) found that discomfort level of child care workers increases as the severity of the disability increases, and Cook (2001) reports that child care providers tended to have more negatives attitudes about severe disabilities.

Research evidence showed that child care providers who manage children with special health care needs and disabilities require basic disability awareness training in order to reduce stereotypes as well as training on developmentally appropriate care, special disabilities, and successful strategies to admit children with special needs, positive behaviours and information on community resources.

5.2 CONCLUSION

Given the critical role that child care workers play in determining the efficiency, effectiveness in the care and management of children with special needs, it is paramount to understand what drives, motivates child care workers, and to what extent they are faced with challenges when performing their work. Management of children with special needs is an essential part of ensuring quality care.

Given the noticeable lack of studies addressing care and management of children with special needs in South Africa, this study attempted to address the gap in the literature. The information obtained will hopefully assist in identifying skills that child care workers require in caring and management of children with special needs.

A quantitative approach and descriptive design were used to explain the self-perceived knowledge, experience and challenges of child care workers with regards to care and management of children with special needs. Self-administered questionnaires were used to collect data from the participants.

The management of children with special needs in general is rather complex and challenging in that the focus is on the management of the individual's disability or multi disabilities as well as on difficult behaviour patterns that may emanate from the disability, particularly in mental health disorders. An understanding in the different categories of disability is imperative if one is to offer an appropriate care management and treatment plan for the child in accordance with needs and situation.

The following are the main findings from this study

1. The study found that the majority of respondents had low self-perceived knowledge about children with special needs.
2. Well over half the participants reported feeling of frustration after working with children with special needs mainly because of lack of resources and training.

3. Almost three-quarters of the participants felt guilty that they should have been able to provide better care for children with special needs.
4. Participants reported feeling of stress when by caring for children with special need.
5. The majority of the respondents indicated that they required management support in order to effectively care and manage children with special needs.
6. Two-thirds of the participants indicated that they had children with special needs or disability in their institution and few of the participants indicated that these children were receiving early intervention services.
7. In this study only forty per cent of the respondent attended early childhood development course.
8. The respondents indicated a need of skills in sign language.
9. The majority of child care workers had positive experience towards care and management of children with special needs, while fewer participants had negative experience.
10. Few participants indicated that they wanted to change their work to where they would not have to work with children with special needs.
11. The majority of the respondents indicated that they needed training in care and management of children with special needs.

Little or no emphasis is being placed on care and management of children with special needs as is being done for other chronic illnesses. A system of care to assure safe, quality services for children with special needs is paramount. It is therefore critical to note that care and management of children with special needs is of a high priority if children with special needs are to enjoy and live as normal as possible.

The place of care can play an important part in assisting children with special needs to develop to their full potential by providing access to early childhood development opportunities, such as a safe physical environment that meets the special needs of these children. Early identification of these needs and timely intervention strategies are particularly important for optimal development of the child.

The services at the child care facilities are ultimately aimed at strengthening and building the capacity and self-reliance of children with special needs. These services include awareness, education, information sharing, advocacy, the right of people, development of resources and disability programmes. Steps to ensure that children with special needs are assisted before more intensive intervention or replacement is required.

5.3 RECOMMENDATIONS

Based on the findings of this study, the following are recommended:

5.3.1 Advanced Training

- Making base line disability training compulsory for all child care training courses including National Diploma in child care.
- Providing ongoing comprehensive training programmes for all child care workers working with children with special needs or disabilities.
- Providing support to child care workers who care and manage children with special needs by giving them continuous information on how to manage children with special needs.

5.3.2 Government Departments

- The Department of Social Development should provide guidelines for the care and management of children with special needs in the institutions that provide care for these children. The guidelines can also be used as a tool to ensure access to fundamental rights and responsibilities for these children. The department should also ensure that specialist training is provided to all staff that care and manage children with special needs.

5.3.3 Legislation

- Few participants indicated that they have wheelchairs accessibility in their institutions and that they lack resources to help them care and manage children with special needs. The government should provide financial assistance so that these centres can acquire the equipment suitable to children with special needs or disabilities.
- There is a need to integrate the needs of children with special needs or disabilities across the departments in sections where the issue of disability is a

concern. This integration will demonstrate the government's commitment to improving care and management of children with special needs or disabilities.

- There is a need to develop positive attitudes and positive knowledge about special needs or disability to child care providers.

5.3.4 Other Researchers

- This study may serve as a base for future studies in the Department of Social Development in the other provinces. The study only focused on the four Tshwane Metro based institutions and not the entire nine institutions in Gauteng Province. The importance of research in the areas of special needs or disability and the prevention of maltreatment of these children is evident. There is a great need for continued research to inform policy makers, planners and service providers.
- Ensuring that professionals are knowledgeable and that services are available is of utmost importance for the promotion of the safety, accessibility and social inclusion of children with special needs.
- More research needs to be conducted into the needs of and provision available for children with special needs.

To sum up this study, the issue of taking care of children living with disability is an important one. Like any other children, these children have the right to be provided with whatever they need. For this to be possible, the government needs to be actively involved in providing policy guidelines and resources. Individuals, businesses and communities must also be involved at all levels. Once this happens children living with disability will enjoy a good and dignified life.

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APPENDIX A

Permission Letter

National School of Public Health

Medunsa Campus

University of Limpopo

Medunsa

23 October 2009

The Research Department

Department of Social Development

69 Commissioner Street

Johannesburg

2001

Dear Sir/Madam,

Application for permission to conduct a Research Project at the four Tshwane Metro based Institutions

I, the undersigned, a Master's student of Public Health at the University of Limpopo Medunsa Campus, hereby wish to apply for your permission to conduct a research study in the four Tshwane Metro based Institutions as part of partial fulfilment for the requirement for the above mentioned programme. A proposal for the study has been submitted to the University of Limpopo ethical and Research Committee for approval. A copy of the ethical committee's approval for the study and the questionnaire are attached.

I will be very grateful if am permitted to conduct this study.

I thank you in advance

Yours faithfully,

Tshitake Ramokone Sylvia.

Signature-----Date-----

APPENDIX B

Permission Letter

National School of Public Health

Medunsa Campus

University of Limpopo

Medunsa

23 October 2009

The Chief Director Institutions and Head of Institutions

Department of Social Development

69 Commissioner Street

Johannesburg

2001

Dear Sir,

Application for permission to conduct a Research Project at the four Tshwane Metro based Institutions

I, the undersigned, a Master's student of Public Health at the University of Limpopo Medunsa Campus, hereby wish to apply for your permission to conduct a research study in the four Tshwane Metro based institutions as part of partial fulfilment for the requirement of the above mentioned programme. A proposal for the study has been submitted to the University of Limpopo ethical and Research Committee for approval. A copy of the ethical committee's approval for the study and the questionnaire are attached.

I will be very grateful if am permitted to conduct this study.

I thank you in advance.

Yours faithfully,

Tshitake Ramokone Sylvia

Signature-----Date-----

APPENDIX C

QUESTIONNAIRE

CONFIDENTIAL

To determine the knowledge and experiences of child care workers regarding care and management for children with special needs in the four institutions of the Department of Social Development in Tshwane Metro.

NB: These are self-administered questionnaires which were developed based on the literature review that supports the study. Kindly answer all the questions by ticking the most appropriate response on the provided spaces. Please note that anonymity and confidentiality will be highly ensured. Please do not write your name.

SECTION A

1. Socio Demographic Information

1.1 Gender male female

1.2. Agein years

1.3. Marital Status single married divorced widowed

1.4. Please indicate the highest level of qualification

Primary education secondary education certificate/ diploma

Tertiary education other.....

SECTION B

2. Self-perceived knowledge of child care workers in care and management of children with special needs

2.1 Have you had experience of caring for children with special needs or disability?

Yes-----

No -----

If yes, please check and tick which disabilities you have had knowledge or experience with.

Self-perceived cognitive knowledge

DIAGNOSIS	Yes	No
Delayed Development /Mental Retardation		
Down Syndrome /Language Delay		
Fragile X Traumatic Brain Injury		
Learning Disabled		

Self-perceived physical knowledge

DIAGNOSIS	Yes	No
Arthritis /Orthopaedic		
Cerebral Palsy		
Hearing/Vision Loss		
Spina Bifida		
Muscular Dystrophy		

Self-perceived medical knowledge

DIAGNOSIS	Yes	No
Apnea Monitor Heart Condition		
HIV and AIDS		
Hydrocephalus		
Cancer Lead Poisoning		
Colostomy Bags Prematurity		
Cystic Fibrosis Respiratory		
Diabetes Severe Allergies		
Drug Addicted		
Seizure Disorder		
Feeding Problems		
Genetic Disorder		

Self-perceived psycho-social knowledge

DIAGNOSIS	Yes	No
Adjustment Disorder		
Asperger Syndrome		
Attachment Disorder		
Attention Deficit		
Hyperactivity Disorder		
Autism		
Behavioural Problems		
Bipolar Disorder		
Depression		
Emotional Problems		
Mood Disorder		
Obsessive-Compulsive Disorder		
Oppositional Defiant Disorder		
Pervasive Development Disorder		
Post-traumatic Stress Disorder		

2.2 Please circle all that apply to your institution:

Currently wheelchair accessible Yes ----- No -----

Know sign language Yes ----- No -----

2.3 Please tick the correct answer between True/False

STATEMENTS	T	F
1. Children with special needs require special care.		
2. Children with special needs are those with disabilities, abnormal behaviour, neglected.		
3. HIV and AIDS infected children require special care needs.		
4. Children with special needs should not be in school.		
5. All children with special needs should receive medication.		
6. In school, children with special needs should be in one class		
7. All children with special needs have difficulty in learning.		
8. Children with special needs cannot do anything for themselves.		
9. Having a special need is a matter of choice.		
10. It is the fault of the mother to have children with special needs.		
11. Children with special needs should understand things like everyone else.		
12. Some children are born with special needs.		
13. In your understanding, when will a child be regarded as having a special need?.....		

SECTION C

3. Experience of child care workers in care and management of children with special needs

STATEMENTS	Agree	Disagree	Not sure
1. Children with special needs require provision of basic skills such as patience, empathy and acceptance.			
2. Children with special needs require assistance in order to grow and learn.			
3. Caring for children with special needs is more demanding than caring for other children.			
4. I feel stressed after caring and managing for children with special needs.			
5. Working with children with special needs affects your emotions.			
6. Working with children with special needs requires support from managers and seniors.			
7. I would recommend anyone I know to work with children with special needs.			
8. I like caring for children with special needs.			

Please tick Yes or No

3.1 Will you toilet train children with special needs or disability?

Yes ----- No -----

If Yes, state why

If No, state why

3.2 Do you currently have children with special needs or disability in your institutions?

Yes ----- If Yes, how many ----- No ----- Don't know -----

3.3 Does a child with special needs or disability in your institutions receive early childhood mental or physical health services?

Yes ----- If Yes, how many ----- No ----- Don't know -----

3.4 Are there children in your care who are receiving early intervention services other than mental or physical health services?

Yes ----- If Yes, how many ----- No ----- Don't know -----

3.5 Have you ever referred a child or children for early intervention services?

Yes ----- If Yes, how many ----- No ----- Don't know -----

3.6 Have you ever had to terminate the care of a child due to behavioural problems?

Yes ----- If Yes, how many ----- No ----- Don't know -----

SECTION D

4. Training needs for child care workers in care and management of children with special needs

1. Have you attended a course in early childhood development or early childhood education? Yes ----- No-----			
2. Do you think you need special training in caring and managing children with special needs?	Yes	No	Not sure
3. What skills do you think you need in order to help you take better care of children with special needs?			

SECTION E

5. Challenges for child care workers in care and management of children with special needs

5.1 Do you ever feel frustrated or angry when working with children with special needs or disability?

Yes ----- No -----

If yes, please indicate what frustrate or anger you

5.2 Do you ever feel guilty because you think should have been able to provide better care, despite all the other things that you have to do?

Yes ----- No -----

5.2 Please tick Agree or Disagree

STATEMENTS	Agree	Disagree	Not sure
1. I wanted to change my job because I have to care and manage children with special needs.	Agree	Disagree	Not sure
2. After caring and managing children with special needs, I always worry that I will have a child with special needs.	Agree	Disagree	Not sure
3. I need to wear gloves every time I care and manage children with special needs.	Agree	Disagree	Not sure
4. I cannot feed children with special needs.	Agree	Disagree	Not sure
5. I struggle to carry or hold babies with disabilities.	Agree	Disagree	Not sure
6. It is difficult to communicate with children with special need.	Agree	Disagree	Not sure

Thank you for your participation

APPENDIX D

Informed consent form

UNIVERSITY OF LIMPOPO (Medunsa Campus) CONSENT FORM

STATEMENTS CONCERNING PARTICIPATION IN A RESEARCH PROJECT

Name of Study

KNOWLEDGE AND EXPERIENCES OF CHILD CARE WORKERS REGARDING CARE AND MANAGEMENT OF CHILDREN WITH SPECIAL NEEDS IN FOUR INSTITUTIONS OF THE DEPARTMENT OF SOCIAL DEVELOPMENT IN TSHWANE METRO, SOUTH AFRICA.

.....
I have read the information on the aims and objectives of the proposed study and was provided the opportunity to ask questions and give adequate time to rethink the issue. The aims and objectives of the Study are sufficiently clear to me. I have not been pressurized to participate in any way.

I understand that participation in this Study is completely voluntary and that I may withdraw from it at any time and without supplying reasons. I know that this Study has been approved by the Medunsa Campus Research and Ethics Committee (MREC), University of Limpopo (Medunsa Campus). I am fully aware that the results of this Study will be used for scientific purposes and may be published. I agree to this provided my privacy is guaranteed.

I therefore give informed consent to participate in the Study with an understanding that confidentiality will be highly maintained through the research.

Name of participant Date.....

Witness..... Date.....

Place:

STATEMENT BY RESEARCHER

I hereby declare that I have explained all matters relating to informed consent to the participants in this research study. I shall fully abide by the approved protocol of the study as given by the Medunsa Research & Ethics Committee (MREC). I agree to answer any future questions concerning the Study as best as am able.

Name of Researcher: Tshitake Ramokone. Sylvia.

Signature..... Date..... Place.....

APPENDIX E

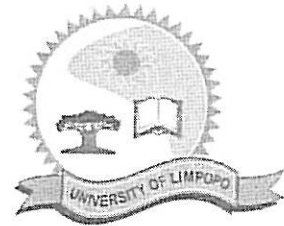
TIME TABLE

Tasks to be completed	Time
Proposal presentation to lecturers and students	02/2009
Proposal submission to supervisor	04/2009
Proposal submission to MREC	09/2009
Pre -Test and pilot study	11/2009
End of data collection	06/2010
Data analysis completion	11/2010
Final draft sent for comment	02/2011
Submission of final research	03/2011

Proposed Budget

Items	Amount
Pre-Test, Pilot	R500.00
Data analysis	R600.00
Stationery	R1500.00
Photocopying	R1000.00
Travelling	R1500.00
Binding	R2000.00
Other logistics	R500.00
Total	R7600.00

UNIVERSITY OF LIMPOPO
Medunsa Campus



MEDUNSA RESEARCH & ETHICS COMMITTEE

CLEARANCE CERTIFICATE

P O Medunsa
Medunsa
0204
SOUTH AFRICA

MEETING: 07/2009
PROJECT NUMBER: MREC/PH/123/2009: PG

Tel: 012 - 521 4000
Fax: 012 - 560 0086

PROJECT :


Title: Knowledge and experiences of child care workers regarding care and management for children with special needs in the four institutions of the Department of Social and development in Tshwane Metro.

Researcher: RS Tshitake
Supervisor: Prof S Pengpid
Department: Social & Behavioural Health Sciences
School: Public Health
Degree: MPH

DECISION OF THE COMMITTEE:

MREC approved the project.

DATE: 03 September 2009


PROF GA OGUNBANJO
CHAIRPERSON MREC



Note:

- i) Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee.
- ii) The budget for the research will be considered separately from the protocol. PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.

African Excellence - Global Leadership