TO ESTABLISH FACTORS THAT HINDER DEVELOPMENT OF EDUCATIONAL PROGRAMMES FOR THE MENTALLY HANDICAPPED IN KAYOLE ZONE – NAIROBI

A SPECIAL STUDY PAPER

PRESENTED BY

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TITLE OF THE STUDY

To Establish Factors Hindering Development of Educational Programmes for Learners who are Mentally Handicapped in Kayole Zone, Embakasi Division Nairobi.

DECLARATION

I, **Florence Atieno Abuto**, Admission Number **BED/SNE/14916/62/DF** hereby declare that this Special Education Research Paper is my own original work and not a duplication of similarly published work of any scholar for academic purpose as partial requirement of any college or otherwise. It has therefore never been submitted to any other institution of higher learning for the award of a degree in Special Needs Education.

I further declare that, all materials cited in this paper which are not my own have been duly acknowledged.

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DEDICATION

I dedicate this to my children Larvin, Travor, Kelvin and Bevan who showed a lot of patience as I struggled with books for two years in order to attain the Degree.

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Abstract

This study took cognizance of the fact that the development of educational programmes for the mentally handicapped have been hindered by several factors. Awareness creation among the various stakeholders on these problems would lead to the solutions with the aim of finally improving on these programmes. The survey research method was used with three different questionnaires as the tools for quantitative data collection. The number of participants (respondents) were thirty out of which fifteen were special education teachers, fourteen parents of the mentally handicapped children in Mwangaza and Unity primary schools with special units and one Education Assessment Resource Center (EARC) co-ordinator. The major research findings were that there were only two units for the mentally handicapped in Kayole Zone. The level of awareness about mentally handicapped by the community was found to be still very low and facilities were not adequate. The research also revealed that the need for training more special education teachers was necessary. The core recommendations included the need to establish more special education programmes and more awareness campaigns.

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CHAPTER ONE

1.0 INTRODUCTION

The introduction of Educational Programmes for Mentally Handicapped whether special unit, special schools, inclusive or pre-vocational institutes are part of the areas where mentally handicapped individuals acquire basic education as well as training to assist them live an independent life, socially in their daily living activities as well as handling of family issues, and also in their minimum occupational adequacy. The awareness of this has been taking root in the Kenyan society and has assisted in "rubbing off" the mentality that these individuals are either insane, epileptic, fools or idiots. It has made the society to realize that these individuals can also support themselves, work for wages and salaries if given opportunity to train in vocational centers. However, there are a number of people who are yet to be informed about accepting these individuals and it is for this reason that the establishment of more educational programmes in our republic is essential. Special/inclusive educators therefore have a big challenge towards the general society in creating general awareness as well as applying intervention procedures to the Mentally Handicapped individuals in improving their lifestyle in their day to day life.

There is need to get in touch with all the stakeholders in the community to device ways and means to improve the Educational programmes for them to get a chance to improve their social as well as vocational adjustment i.e. effective social living as well as vocational competency not forgetting the acquisition of self – help skill applied in day to day living.

1.1. Background information

The Kayole zone has 15 public schools. The zone so far has made very little progress as far as special education is

concerned. The awareness of special education reached the zone a few years ago and so far there are only two no special units schools within the zone i.e. Mwangaza and Unity Primary school.

There is no assessment center in the zone so Educational Assessment Resource Center (EARC,) which is found in the neighboring division is the only one which conducts assessment of children sent to them from Kayole zone.

Many factors have led to the zone lagging behind on issues pertaining to special education. The core one include lack of awareness on the need for children with special needs like mentally handicapped to be educated. This has led to negative attitude towards such children. Parents of such children don't come out openly so that they could be assisted. Financial constraints have also made parents not to give education priority to the special education needs children. The per capita income of the residents of Kayole is very low further compounding financial difficulties.

1.2 Statement of the problem

There are different factors that hinder the development of education programmes for the mentally handicapped at global and national levels. Such studies like broader levels may not offer more accurate solutions at the divisional or zonal levels. There is therefore need to focus a the zonal level where the problems and solution would be more locally oriented and own by the stakeholders, since such studied at zonal level have not been reported in Kayole zone the researchers intension is to do in-depth study on these problems and come up with solutions which could be used by various stakeholders with the aim of improving on the programmes which would enhance education

of the mentally handicapped. The research through systematic study would establish this problems and suggest way forward based on the result or outcome

1.3 The purpose of the study

The purpose of the study is to establish the factors that hinder development of effective educational programmes for learners who are mentally handicapped in Kayole zone, Embakasi Division.

1.4 Objectives of the study

- Establish the Educational programmes for Mentally handicapped existing in Kayole zone.
- Establish problems that hinder expansion and introduction of more Educational programmes for mentally handicapped in the zone.
- Establish possible solution that can lead to development of Educational programmes for Mentally handicapped in the zone.
- Identify problems that hinder expansion of more education programmes for the mentally handicapped in the zone.
- Find out the skilled personnel (staff) within the zone who can inclusively accommodate the mentally handicapped children.

1.5 Research Questions

- How many educational programmes exist for Mentally Handicapped children in Kayole zone?
- What are the factors that hinder introduction of more educational programmes for mentally handicapped children?
- What are the problems that hinder expansion of more education programmes for mentally handicapped children?

- Which are some possible solutions that can lead to development of Educational programmes for Mentally Handicapped children?
- How adequate are the skilled personnel who can inclusively accommodate the mentally handicapped children?

1.6 Significance of the Study

Since the creation of Kayole zone, there has been very little progress as far as special education is concerned. Only two schools have special units and there is no any other type of special educational programme.

The result of this study will lead to awareness creation among the parents, teachers and policy makers on the plight of the mentally handicapped children in Kayole. A more sensitized community will enhance positive behaviour change and create more openness and acceptance of such handicaps.

Since this study highlighted the problems that hinder expansion and introduction of more educational programmes for the mentally handicapped in the zone, the result would be used by the Ministry of Education and other stakeholders and special education to mobilize both financial and material resources to expand the few existing ones and establish more. Such a move would cater for more mentally handicapped children and also reduce the distance of traveling to the schools.

1.7 Limitations and delimitations

1.7.1 Limitations

Weather - Weather condition was very dusty and hot that led to absenteeism of some of pupils and felling that they can't settle well in their units.

Time - This was a limiting factor given that the schools were on. It was very difficult to be granted permission and leave the lessons unattended to. So the time given was not enough to visit all the schools.

Reference - Most of the references books are at KISE and reaching there inorder to go through all the books within a day was very difficult. It needed many days.

Financial Factors - There were financial constraints in producing the questionnaires, for transport and final production of the document.

Security - Some schools are situated in unsafe areas. When going there you need to get somebody to accompany you.

1.7.2 Delimitation

Research topic - The study was only restricted to the subject of research regardless of other cases in the zone. In this case the subject was problems affecting the establishment factors that hinder development of educational programme for the mentally handicapped.

Language – The language used in the area is English and Kiswahili. This made it easier for the researcher to communicate with the respondent as they understood the two languages.

Area of study – Their was no barrier to get to the area of the study due to the fact that the researcher was familiar with the environment and readily got people who assisted.

1.8 Operational definition of terms

Hydrocephalus

A condition in which cerebrospinal fluid accumulates in the head creating pressure on the brain and skull. This is usually drained form the central nervous system.

Microcephalus:

Means small skull/brain i.e. a circumference of more than two standard deviation below average for age and sex.

Phenylketonuria (PKU)

This is inherited inability to properly metabolize an essential amino acids, building block for protein called phenylalanine. The accumulation of phenylalanine result in mental retardation and is frequently associated with aggressive hyperactivity, destructiveness and other distractive behaviours.

Genetic

Is the study of heredity and variation. The study of heredity begins with study of genes. Genes are the basic biological unit carrying inherited physical, mental or personality traits.

Chromosomal Abnormalities

This is a situation where there is a presence of an extra chromosome above the normal 46. This results to Downs Syndrome (cases of lower intelligence)

Galactomia

This is an example of defective carbohydrates metabolism. It is an inherited recessive trait. The child shows early growth failure, feeding problems sometimes early cataracts.

Intoxications

Intoxications better known as poison cause mental retardation e.g. drugs, lead e.t.c

Malnutrition

Malnutrition is another cause of mental retardation. It refers to lack of a balanced diet.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

The literature review involved primary and secondary sources. The primary sources cited included journals, newspapers and bulletins. However, the major review was from the secondary sources which included a variety of textbooks, modules and encyclopedias among many other. In this study, the literature review captured the following key areas: meaning of mental retardation, causes of mental handicaps, classification and characteristics of mentally handicapped person, historical background of special education in Kenya, educational programs and factors hindering the development of education programmes for the mentally handicapped in Kenya.

2.2 Definition of mental retardation

With the confusion and misinterpretation that is associated with the term intelligence in the study of mental retardation, the result has been that the label 'mentally retarded' is frequently misunderstood not only by professionals.

Similarly, many people think of mentally handicapped persons as not able to learn anything at all. This assumption is based on the feeling that intelligence is the only global measure of ability with this, there should be labeled mentally handicapped and who should not be. This is an important issue in legal terms because whenever special programmes for Mentally handicapped are established, kinds of people who are specified entitled to do the service are well identified. Attempts to define mental retardation can be placed roughly into three categories;

i) Definition based on failure in social adjustments.
ii) Definition based on the essential cause of mental retardation
iii) Definition on the intelligence test score.

2.2.1 Definition based on failure in social adjustment

Many people prefer to define retardation in terms of how well the individual adjust to the environment and culture.

(Iredgold, 1937) defines mental deficiency as a state of incomplete mental development to the extend of the individual not being capable of adapting himself to the normal environment of his fellows in such a way to maintain existence independently of supervision, control or external support. However it is difficult to define retardation as failure to adapt to the environment reliability. Different ideas concerning constitutes successful adaptation and particularly where legal matter are concerned.

2.2.2 Definition on essential cause of Mental Retardation

Here defining retardation involves definitions on theoretical considerations about the cause or essential nature of retardation as "Mentally retarded children are those that have suffered from severer brain disease while in the uterus or in early childhood, and this has disturbed the normal development of the brain and produced serious anomalies in mental development. The mental retarded child is sharply distinguished from normal by range of ideas he can comprehend and by character of his perception of reality (Laura, 1963) . However such a definitions of retardation is not satisfactory in that there are many individuals who are functioning at an obviously retarded level, but there is no evidence of any defect in their nervous system.

2.2.3 Definition on the intelligence Test Score

Intelligence test are specifically designated to detect children who would not be able to benefit from normal school curriculum, that is the mentally retarded and their use has always been for this purpose.

Some people have defined Mental Retardation solely in terms of performance on such standardized tests that is anyone with an 1Q below certain level, usually set at 70, is considered mentally retarded –

examples are the Wechsler Scale and Standford Binet test. The primary advantage of this test is that it is reliable and objective.

2.2.4 The Current Consensus; The AAMD definition

The most widely accepted definition of mental retardation to day is that adopted by American Association on mental deficiency (AAMD). "Mental retardation refers significant sub – average general intellectual functioning existing concurrently with deficit in adaptive behaviour and manifested during the developmental period. The individual adjustment to the demand of his or her natural and social environment must be impaired relative to his or her age mates.

Since there are different social expectation at different ages, deficits in adaptive behaviour will manifest themselves differently in younger children then they will be in older children or adults. (Grossman, 1973)

2.3 Causes of mentally handicapped

2.3.1 Postnatal Gross Brain Damage

This included a number of disorders that do not begin to manifest themselves until birth. Examples of these syndromes are Tuberous Sclerosis and Von Reckling Hausens disease (Neurofibromatosis). These two syndromes refers to heredity condition that result in development disorders of the skin and nervous system.

2.3.2. Tuberous Sclerosis

This problem is characterized by the formation of numerous hardened Sclerotic nodules on the surface of the cerebral cortex. These sclerotic areas result in mental retardation and Epileptic seizures, but gradually form during development and as a result the retardation is often progressive: that is the person become more impaired as he/ she gets older.

Many adults are profoundly retarded. In addition to retardation and Epilepsy, a skin rash on the face that resembles Acne is another

characteristics symptom except its confined to a region around nose. Tuberous sclerosis is some what unusual in that dominant gene show only mild symptoms and no retardation.

2.3.3 Biochemical disorders

Chemical substances reads: Carbohydrates, Lipids and Amino acids have been identified as a number of abnormal genetic condition that can be traced.

2.3.4 Phenylketonuria

This is a well known inherited disease causing mental retardation. It is caused by inherited abnormality in amino acid metabolism. Children can be diagnosed for this early by means of urine analysis. If both parents are carriers of this gene, there is a chance that one out of four children may be PKU positive. If phenyketonuria (PKU) is detected at an early age and a child is given a diet low in phenylanine, the harmful effects on the brain are prevented and the child may not become mentally retarded (Waisman and Garritsen, 1964)

2.3.5 Galactomia

According to Ingalls (1978) this is an example of defective carbohydrate metabolism. It is an inherited recessive trait. The child shows early growth failure, feeding problems and sometimes-early cataracts. The treatment consists of a special diet, which excludes Galactose by with holding milk and by using a soya milk substitute.

2.3.6 Infections and Intoxications (Pre – natal)

An infection is a condition or disorder caused by micro-organisms such as viruses or bacteria. Such micro – organisms can attack the nervous system resulting in mental retardation. The time when this is likely to cause prenatal when the nervous system is just beginning to develop. An example of pre-natal infection that can lead to mental retardation is RUBELLA, also known as German Measles. Another disease that can

produce serious congenital defects is syphilis. Fortunately it can readily be detected and easily cured with penicillin if treated promptly and as result, the incident of infants born with congenital syphilis has declined dramatically from earlier times.

2.3.7 Infections after birth

Although most organic retardation originates prior to or during the birth process, it's possible for a child to be born with an intact nervous system but become mentally retarded sometimes after birth as a result of an injury or infection of the brain. The most common source of post natal neurological damage is infection. Examples of these infections are Meningitis which refers to an inflammation of meninges:- the membrane that protects the brain and spinal code effects. Another infection responsible for postnatal mental handicapping is Encephalitis. This is infection of brain itself.

2.3.8 Intoxications

Intoxications better known as poison cause mental retardation. This refers to disorders in which a foreign substance of some sort enters the system of the child either prenatal or after birth causing permanent damage of some sort.

2.3.9 Drugs

Different drugs that the mother takes during pregnancy can have adverse effects on the development. These drugs may have adverse effects on the brain of the foetus and some cases leading to mental retardation and other deformities. The most dramatic examples of the adverse effects of the seductive thalidomide, which if taken by pregnant women, result in gross deformities of the child such as absence of limbs. Other non prescribed, non – medical drugs, that can cause mental retardation if taken by pregnant mothers are alcohol, nicotine, and heroine. Chow et al, (1971) observed that there is a

syndrome of congenital disorders that is common among man children of alcoholic mothers and one of the characteristic of this syndrome is microcephulus and lowered mental abilities.

2.3.10 Lead Poisoning

While most organic mental retardation can be traced to conditions prior to or during the birth process, one important toxic condition that usually develops sometimes after birth is lead poisoning. The main source of the lead poisoning is paint that has lead elements. Children can eat chips containing lead which can eventually cause brain damage. The symptoms of a cute lead poisoning are convulsions, optic atrophy, perceptual difficulties and sometimes lowered intelligence (Ingalls, 1978)

2.3.11 Malnutrition

Severer malnutrition result to diseases such as kwashiorkor and can cause brain damage and mental retardation.

2.3.12 Perinatal effects

The perinatal period refers to the time when a mother is in labour up to the actual birth of the baby. The birth process involve the mother and the child. Sometimes complications may arise and a mother fails to follow the normal delivery pattern. Factors that may cause harm to the child being born during the labour process are premature birth :-

Babies who are born before, the full 38 week pregnancy period are likely to be of low birth weight, consequently they are likely to experience problems with breathing, sucking and maintaining body temperature. Prolonged labour:- This is when a baby takes a long time to be born after the onset of labour. Long labour may result in lack of oxygen to the baby and fatigue to the mother due to the babies head being big or baby lying in wrong position (breech). Lack of oxygen is likely to lead to brain damage of the foetus. Hygienic conditions:- If equipments use during delivery are dirty, for example the razor for

cutting the umbilical cord, the baby may contract tetanus which is likely to cause damage to the central nervous system. Forceps/ vacuum delivery:- In an unusual delivery, a doctor may use certain equipment like the foreceps. These equipment risk causing damage to the child's brain as a result of extra force.

2.3.13 Prenatal nutrition

The nutrition state of the mother during pregnancy is an important determination of physical and mental development of the child. Malnutrition during pregnancy leads to a marked growth retardation accompanied by decreased learning capacity and hyper –emotional to offspring (Chow et al, 1971)

2.3.14 Maternal antibodies

There is unusual set off circumstance in which a mother actually produces antibodies that attack the blood cells of the developing foetus causing brain damage, mental retardation and frequent death. A great number of population contain a substance in their blood called the Rhesus (Rh) factor. These people are called Rh Positive and those without are Rh negative. When the mother is Rh negative and the feotus is Rh positive this causes the mother to produce an antibody which can cross through the placenta then to the circulatory system of the feotus causing blood clot. Oxygen may not be distributed normally. This can result to mental retardation (Ingalls, 1978)

2.3.15 Unknown prenatal influences

This includes a number of congenital malformations of the brain on the skull that are frequently associated with mental retardation.

2.3.16 Hydrocephelus

This result from inability of the cerebrospinal fluid to drain properly thus resulting in tremendous pressure on the skull and brain. This fluid is

normally drained from the central nervous system and absorbed in various ducts. But in hydrocephalus a blockage occurs somewhere in drainage system or else the drainage ducts are not properly formed resulting to pressure that cause the skull to enlarge. Hydrocephaly is often accompanied by spinal bifida.

2.3.17 Microcephaly

This term means small brain/skull. This frequently accompanies other syndrome of retardation such as Downs syndrome and retardation caused by pre-natal infection or radiation.

2.3.18 Chromosomal Abnormalities

This is a situation where there is presence of an extra chromosome above the normal 46. This usually result in Downs syndrome cases commonly referred to as Mongolism, characterized by lower intelligence. The other chromosomal aberrations that are extremely lower and rare are those involving sex chromosomes.

2.3.19 Sex Chromosomes Aberrations includes

i) Turners syndrome which is caused by non-disjunction. If during the formation of an ovum non- disjunction occurs in a normal female, one daughter cell would have two Y- Chromosomes and the other a non-disjunction. The ovum with no sex chromosomes may be fertilized either by X - bearing or Y-bearing sperm. If the fertilizing sperm has an Y – Chromosome the result is visible individual with only 45 chromosomes and the sex genotype is YO. This condition is referred to as Turners syndrome.

ii) Another type of chromosomal disorder is Klinefelters syndrome. This involves the zygote having 47 chromosomes having genotype XXY. Ingalls (1978) observed that both condition cause mental retardation.

2.4 Classification of the mentally handicapped

The four levels of mentally handicapped according to AAMD classification are:- the mildly handicapped, moderately handicapped, severely handicapped and profoundly handicapped. The classification can be based on communication skills, social skills, independent functioning occupational ability and academic performance.

2.4.1 The Mildly mentally handicapped child (1Q 67 –52)

They are referred to as educable mentally handicapped individuals by the school system. Mildly handicapped children have no serious physical problems and their poor school performance can rarely be attributed to as specific organic skills and are considered mentally handicapped solely on the basis of the results of an 1 Q test and poor school performance. The goals of education for the educable mentally handicapped student differ only slightly from the education goals of non handicapped children. They must be taught the basic tool subjects as their potential level allows and be taught enough basic adjustment skills so that they can lead independent productive lives
(Ingalls, 1978)

2.4.2 Moderately Mentally Handicapped (1Q 51 – 36)

They are referred to by educators as trainable mentally handicapped. They do not benefit from school curriculum featuring academic but they require specialized training programs that concentrate on self-care, communication, and social skills. The moderately mentally handicapped children show significant delays in development during their pre- schools. As they grow older discrepancies between the moderately retarded and their age mates who are non – retarded grows wider. Approximately 30% are children with Down syndrome an approximately 50% exhibit some form of brain damage. Moderately mentally handicapped are identified easily by even untrained individuals through their physical appearance and also their behaviour.

Those skill emphasized in their learning are self – help skills e.g. feeding, grooming, toileting, washing and other aspects of daily living activities. With proper training many can achieve some independence and lead satisfying life. They also learn basic vocational skills (Neisworth,1978)

2.4.3 Severely mentally handicapped (1 Q 20 – 39)

They are identified at birth or shortly afterwards. Most of these children have significant central nervous system damaged and many have other handicapped condition. Training for severe handicapped typically consists of self – help skill i.e. Toileting, dressing, eating, drinking and language development. They require supervision throughout their life. They are also referred to as dependent group (William, 1980).

2.4.4 Profoundly mentally handicapped (1Q 10 and Below)

This is the lowest group and is also referred to as life support. Some of the individuals will be able to communicate through gestures or simple signs Some are able to recognize familiar faces, some can respond to simple command and achieve some self-help –skills others however, may be very unaware and unresponsive to the environment. Their life span is shorter than the normal. They are easily identified at birth and require intensive training and therapy.

2. 5 Characteristics of mentally Handicapped Persons

2.5. 1 Mildly Mentally Handicapped

This is the group where majority of the mentally handicapped fall. This handicapping condition can be by any one of a number of factors, such as cultural or environment impoverishment, chromosomal damage or even brain trauma. However, for most of the midly mentally handicapped, no known biological factor has been identified.

Mild retarded generally lack pronounced physical abnormalities and look normal. Mildly mentally handicapped appear completely normal and often not detected until the child is school aged. Many cases of

mild mental retardation appear to be related to environmental disadvantages. They exhibit a subnormal and in school performance nutritional deficits, lack of academic orientation in the home, suppressed verbal communication, curiosity and inadequate educational facilities all contribute to diminished intellectual functioning. Language delays and speech defects are often present in mild retarded so as sensory motor delays and impairment. Attention spans are shorter and memories poorer than those of their normal peers. They portray development delays as follows:- At 28 weeks an infant who is mildly retarded is functioning at about 16 week level. The child is only able to sit when supported while who is normal sits momentarily, leaning on hands for support while the head is erect. At 36 months, the mildly handicapped infant functions between 18 and 21 month level, (Gesell et al, 1974)

Academic achievement is usually limited to the fourth or fifth grade levels. The typical educational placement is in an educable class although a trainable class is also necessary. While some individuals can learn vocational skill to perform semi-skilled and non-skilled occupations, others can handle employment only on a sheltered workshop situation. Whether a mild retardate can be mainstreamed vocationally will ultimately depend on such traits as inter-personal skills of punctuality and ability to follow directions. Some hold jobs and raise families. It is possible for mildly retarded to be assimilated into the community without requiring special services for mental retardation (Lederman, 1984)

2.5.2 Moderately Mentally Handicapped

Individual in the moderate group do not necessarily show pronounced physical abnormalities. Some children and adults in this group look quite normal. Other exhibit the physical stigma associated with various syndromes.

Speech and language deficits are common so is a general motor inco-ordination. Sensory motor problems may be evident. Moderate retardates typically have a short attention span, poor problem – solving skills and limited initiative and creativity.

At 28 weeks, the moderately retarded infants is functioning at a 12 week level, presenting a reduced development rate of about 42% and unable to sit erect momentarily or lift the head in supine. Language skills are limited to coos and chuckles that don't begin to approximate the controlled syllables vowel sounds of their normal 28 week infant.
At three years the moderately retarded child may function at bout the one year level. Most of them achieve rudimentary pre-school levels. In most cases trainable classroom is more appropriate.

Vocational skills are limited, carefully supervised shelter workshops are appropriate. Most moderately mentally handicapped individuals can attain complete independence. Some individuals are able to be successfully integrated into small community group homes. Others remain in their parents home or in institutions (Lederman, 1984).

2.5.3 Characteristics of severely Retarded individuals

This is a group with IQs range of 20 to 34. Some of these individuals have multiple handicaps and medical disorders such as circulatory, visual, auditory and neurological problems. Seizures are not uncommon.

Self – care skills may include adequate handling of a drinking cup, pulling on a simple garment and indicating toilet needs. The severely retarded adult is able to gain some independence basic self – care skills. Some also manifest motor speech problems and consequently communicate through gestures.

2.5.4 Characteristic of profoundly Retarded individuals

These individuals range in the IQs of 19 and below. A variety of pre-natal, natal and postnatal factors can cause profound retardation. Most profoundly retarded are multiply handicapped. Sensory defects, skeleto – muscular problems, neurological abnormalities and health problems involving the cardiopulmonary Genetouring and Gastrointestinal systems are prevalent. Life expectancy is significantly reduced.

Most of them manifest distinctive physical appearance with stigma related to various syndromes. Unique behaviour patterns may be present with self- stimulation very common.

At 28 weeks, the profoundly retarded infant is typically functioning on a neonatal level. Virtually no head control is present. Fine motor development is limited to holding on objects reflexively without regard. Vocalization consists of small throaty noises. Self – care is limited to co-operation in feeding by opening his/ her mouth dressing and toileting are totally dependent. Only rudimentary socialization skills are present, to the degree of some recognition of familiar individuals.

In his studies, Lederman (1984) found that the profound retardate may achieve the functional level of a normal three year old upon maturity and independence in spoon feeding may be obtained. At this level basic needs may be communicated through one or two words expression or gestures. Basic gross motor skill may include walking, but usually with deficits in motor skills and co-ordination.

Severer deficiencies may exist in locomotion pre-hension and oral motor skills

2.6 Prevention

According to (Ingalls, 1978) It is felt that by age four or five, its too late for any intervention to be truly effective and the best way to deal with the problem of functional retardation, is to prevent it rather than provide

a massive dose of special education once it has been diagnosed. In order for this strategy to be effective, it is necessary to make a determination of which children are at high risk for becoming mentally retarded at sometimes in the future and to provide them with the necessary stimulation, training and medical attention that they require but that their environment is not supplying.

Some of the preventive measures to be taken especially to expectant mothers are:- care measures to areas which can led to falling like slippery floors to prevents accidents. Expectant mothers should at all means try and make sure that they give birth at hospitals where experts area available to assist and also in case of an emergency. The expectant mothers should avoid exposure to radiations i.e. x – rays or any radio active materials. Midwives should be advised to be extra careful to prevent head injuries to babies during birth. Spouse should attend genetic counselling clinics to be given advise prior to marriage. They should be faithful to their partners to avoid instance of getting sexually transmitted diseases, which can cause mental retardation in the growing embryo. Another preventive measure is providing expectant mothers with proper nutrition and medical care to prevent birth complications such as pre-maturity. According to (Ingalls, 1978) screening programmes provide both primary and secondary prevention. Primary prevention refers to the prevention of the developmental disability in the fist place, while secondary prevention refers to minimizing the symptoms of an already developed disorder and the prevention of the development of behaviour problems or other complications arising from primary condition.

2.7 Historical background of special education in Kenya

Special Education programmes in Kenya started as early as 1940's by voluntary organizations and missionaries. A class examinations of the history of special education in Kenya (according to pamphlet bearing a report on case studies in special education ENESCO press 1974)

shows that although the problem of the mentally handicapped children have existed for a long time in Kenya, It has only received attention a few years ago. St. Nicholas (Present Jacaranda) special school for the mentally handicapped that existed as long as 1946, was meant only for Europeans who were in the country. Asians had their first unity at Agakhan school. However the two were joined together, becoming the present Jacaranda special school.

Since 1964, voluntary organizations like Kenya Society for the Mentally Handicapped, Lions Clubs, Rotary Foundation, Round Tables, Church Organization and individuals involved themselves in establishing units and schools for mentally handicapped. The African children also started benefiting from the services.
Through the Governments Sessional Paper No. 5 of 1968 on the Care and Rehabilitation for Disabled, the Government realized early the need for provision and improvement of the facilities and general welfare of the disabled and made initial steps towards that direction.

According to special Education Bulleting for Eastern and Southern Africa on Education Assessment Page 2 March 1989, about 110 units had been established most of these being for mentally handicapped only. The majority had been established by schools and the community according to the bulletin.

The first specialist teachers' course was started at Jacaranda Special school in 1966. The course was in 1969 moved to Highridge Teachers Training College and the units remained there until May 1969 when it move to K.I.S.E. The turn out was very slow though the training was being offered to teacher especially between 1966 to 1975 since and each year less than ten teachers graduated.

In 1980's there was a positive change and the environment for the mentally handicapped course rose from less than 10 presently to

between 80 – 90 graduates after every two years and about 60 teachers after three month in service course. This can be attribute to the effort of the independent Kenya Government through education Commission such as Ominde Commission (1964), Mwenda Committed (1968) ,Gachathi report (1976) and Kamunge Report (1988) as well as the personal efforts of former H. E. President Daniel Arap Moi since 1980. Other factors which have contributed to the expansion of special Education, is the establishment of Educational Assessment and Resource Services in 1984 in Kenya.

The declaration of 1980 by the former President as the Year of Disabled and the raising of 21 million shillings and also raising of 76 million shillings for the same purpose in 1989 helped a great deal.

2.8 Educational programmes for the mentally handicapped

2.8.1 Pre- school programmes

Pre-school or kindergarten programmes include self – contained, special classrooms. The reason is that these children are not usually identified as mentally handicapped at an early age. They are admitted to kindergarten with normal children when such exist in the community. After identification the child is placed in a special pre-school programmes for special instructions in language, perceptions and in adaption to school materials and activities (Ingalls, 1978).

2.8.2 Special classrooms

These are rooms where mildly and severely mentally handicapped children are placed. They receive their education from special education methods. Teaching in special classrooms for the mentally handicapped children is more structured with less emphasis on incidental learning and that the materials need to be simplified. These children are ignored or teased by their normal peers as a result there's little social

damage done by placing them in special class- instead of regular class.

These children also suffer damage of their already low – esteemed if they are to compete with children of normal intelligence. The mentally handicapped children have greater chance to experience wining and success if placed in a class of their own (Ingalls 1978)

2.8.3 Peripatetic services

It involves providing regular class teachers with consultative services and instructional services for their retarded pupils. A peripatetic teacher usually operates from a central office and visit the school periodically. The teacher always spends much of his/her time in individualized or small group instruction with students who have special need. These services are very limited in scope and can only be provided weekly. The basic responsibility for the education of the retarded children remains with regular class teachers.

2.8.4 Special residential school

In many instance children attend a residential school if appropriate education services are not available in the local school system. Most residential school are designed to provide educational programmes for children whose educational and social needs cannot be met in regular schools settings. In many of the private residential schools, staff-pupil ratios are very low and the children receive intensive instructions. Residential schools vary in function and can either serve to remove the retarded person from the society or prepare him or her to the community.

2.8.5 Educational integration

Education integration operates on a number of fundamental premises e.g first in spite of his/her disability, a handicapped child is still capable of maintaining a great deal of efficiency to such extent that under adequate conditions he/she can attain in personal and social life close to normal level of functioning. Secondly, while past educational provisions for handicapped children were based on a classification system which categorized children by type and degree of impairment, the common features that links impaired children with their non-impaired counter parts constitutes the basis for implementation of an integrative system (inclusive).

Educational integration is considered to be a most viable approach for preparing disabled persons for normal individual and social environment existing such as:-

i) Handicapped children attending regular classes; with the help of a consultant specialized teacher or a team of specialists and mentally handicapped children attending exclusively special class in a regular school thus integration may be achieved at different levels. The highest degree of integration occurs in regular classes and the lowest in special classes. It is important to point out that, even integrated institutions, degree of integration may be achieved through various means for example, the practice of locating special schools in vicinity of regular ones, allows for co-operation between the types in organizing common learning and recreational activities.

2.8.6 Non – School based programmes

This kind of programmes are mostly temporary for children with server and profound retardation. The programmes are divided into two groups:

2.8.6.1 Hospital instructions

The hospital instruction is usually offered to person who is recovering from an illness or accidents but it can be also be long term. Plan for children confined to hospital or convalescent home, the peripatetic or regular teachers usually provide the instruction.

2.8.6.2 Home bound instructions

According to Kauffman and Payne (1975) this kind of service is designed for students who are either temporarily confined to their home environment. Peripatetic (itinerant) teachers usually furnish the institutions (Kauffamn and Payne 1975)

2.9 Factors hindering the development of education programmes for the mentally handicapped

There are several factors with the core ones as discussed below. The issue of access and participation is a major problem hindering the special education in general but more specifically for the mentally handicapped. Poverty is the man hindrance to access as the residents of Kayole are in the lower class. With their low income, it becomes very difficult for them to provide financial support for their children with special needs.

The stigma associated with the handicaps in general has been a bottleneck as this has forced some parents to keep such children in their house. This finally affects their being exposed to special needs education and finally hindering their access and participation. The spatial distribution of special schools in Embakasi Division and more so in Kayole Zone hinders the access because the schools are not only too few but are also far in between. The whole of Embakasi Division has got only two schools (Mwangaza and Unity) See table 4.2.1 which are all in Kayole Zone. The distance makes transport costs to be high and also consumes a lot of time. This makes the already poor parents

not to give a priority to their children with the mental disabilities as they are not yet convinced of any academic returns. A poor working relationship between the parents and the teachers of special education has not been good. Browne and Haylock (2005) states that "teachers understand that positive relationships with parents can have a crucial bearing on all children's progress at school. Constructive relationships are even more important with parents of children with special education needs (SEN)"

Parents know their children well and if the information they have is shared, teachers will have a much more complete picture of the child's strengths and difficulties. Teachers should also share their views of the child with the parents. This will help teachers to plan more effectively to meet the child's individual needs in ways that are appropriate (Browne and Haylock, 2005)

Inadequate funding by the Government has also affected the programmes especially in the areas of curriculum materials and equipment. A lot of funding has been left to different donors like Aga Khan foundation, Danish International Development Association and Swedish Organization for the Handicapped.
The area of monitoring and evaluation has also been left behind. Assessment, centers are inadequate and understaffed implying that many children have not had access to these centers to diagnose the problems.

The agent need for staffing should be addressed. Special education requires a high teacher pupil ratio: The current situation is that those units are not adequately staffed hence impacting negatively on the success of these programmes.

CHAPTER THREE

3.0 Methodology

3.1 Introduction

This chapter has included the research procedures including all the essential components, which were relevant to such a study. The data collection techniques, the instruments used, methods of analysis and presentation have all been highlighted. The description of the study site and justification of the methods used have been given.

3.2 Research Approach

The quantitative research method has been adopted in this study. According to the researcher, this was because of the method being in line with the research objectives which required aspects of measurement and statistical principals (quantification of concepts under investigation). The data was collected from teachers in two schools in Kayole zone, parents found and EARC co-ordinator. The data collected was then analyzed to give the actual representation on the ground.

3.3 Research Design

The principal design used by the researcher was survey method. The study was preceded by a detailed literature review on the development of special educational programmes for the mentally handicapped in Kenya, the problems faced and the characteristics of the various handicaps. The purpose of the review was to provide the researcher with relevant baseline information on the current understanding of special education programs in Kenya and in particular Kayole Zone.

Before the survey visit, the researcher embarked on a pilot visit to provide her with basic information, such as the effectiveness of the questions on the interview schedule Zanden (1993) cited in Nyakiti (2004) states that a good deal of presenting is required to ensure that questions are understandable, unbiased and specific enough to elicit

the desired information. The researcher finally embarked on a four days survey to collect the primary data which formed the bulk of information. The researcher spent time interviewing the respondents and completing the interview schedules appropriately.

3.4 Target population

The target population involved the special educators in the two schools (Mwangaza and Unity) in Kayole Zone, the parents of the mentally handicapped children in the two schools and the EARC co-ordinator.

3.5 Sample

During the study the researcher interviewed 15 special education teachers in two schools, 14 parents and 1 special education co-ordinator in the division totaling to 30 respondents for the whole survey.

3.6 Sampling procedure

Whereas there was only one special education co-ordinator who was interviewed, the researcher used random sampling to select the parents and special education teachers to be interviewed (Nachmias and David, 1996,; Cohen and Lawrence 1998). The researcher prepared a list of all parents and special education teachers in the two schools. The parents were assigned random numbers from 1 to 40. The researcher then picked the first number and every third until the end except where the picked parent was missing, then the next number was picked. On the side of special education teachers listed, all the names were interviewed except those who were not present on the specific days.

3.7 Instruments/Tools used

The researcher used questionnaire as the instrument in the study. Three different questionnaires were used targeting the three different groups of the respondents; that is special unit teachers, parents of the

mentally handicapped and special education co-ordinator (Appendices 1, 2, 3). A total of 30 questionnaires were used. The questionnaires had structured questions majority of which had fixed alternative items and very few with open-ended items.

The two schools (Mwangaza and Unity) were selected on the basis that they were the only public primary schools having special education units for the mentally handicapped in Kayole zone.

CHAPTER FOUR

4.0 DATA ANALYSIS AND PRESENTATION

4.1 Introduction

The data from this study were edited then analyzed using quantitative techniques. Descriptive statistics were used, where frequencies and percentages of the various responses were calculated. The information was presented mainly in the form of tables. The responses analysed were from the teachers in the schools handling mentally handicapped learners, parent and EARC co-ordinator.

4.2 Analysis of response from the teachers

Table 4.2.1- Number of mentally handicapped children in the schools

School	No. of boys	No. of girls	Total
1. Mwangaza	20	11	31
2. Unity	9	7	16
Total	29 (62%)	18 (28%)	47

There were only two units and no special education school. The table shows that more mentally handicapped boys (62%) are in units in Kayole Zone than the girls (28%). The issue of gender should be addressed

Table 4.2.2 - How mentally handicapped children relate to non-handicapped peers socially

RESPONSE	FREQUENCY	PERCENTAGE %
POORLY	14	93.3 %
WELL	1	6.6 %

According to the interpretation from the above data a big percentage (93.3%) of the Mentally handicapped individuals do not have relationship with non-handicapped socially.

Table 4.2.3 - Feeding children at school or carrying packed lunch

Do you feed your children at school or do they carry packed lunch?

RESPONSE	FREQUENCY	PERCENTAGE %
PACKED LUNCH	15	100 %
FEEDING PROGRAMME	0	0

The percentage above (100%) shows that all children carry packed lunch and feeding programmes do not exist in any unit. This might disadvantage children from homes that can't afford lunch always.

Table 4.2.4 Frequency of awareness meeting on special education in the zone

RESPONSE	FREQUENCY	PERCENTAGE
OFTEN	1	6.6 %
RARELY	12	70%
NEVER	2	13.3 %

The bigger percentage above (70%) indicated that there are very few awareness meetings held in Kayole Zone towards special education despite that the government gives funds for this exercise.

Table 4.2.5 Adequacy of facilities to enable teachers instruct sufficiently?

RESPONSE	FREQUENCY	PERCENTAGE %
YES	O	O %
NO	15	100 %

From the responses above this shows that there's no one unit that has adequate facilities instruction of the mentally handicapped learners.

Table 4.2.6 The number of children who travel long distance from school

RESPONSE	FREQUENCY	PERCENTAGE %
YES	12	80 %
NO	3	20 %

The table above shows that most of the mentally handicapped children travel long distances to their school even though some comes from nearby.

Table 4.2.7 The general attitude of the catchment area towards special education?

RESPONSE	FREQUENCY	PERCENTAGE %
POSITIVE	2	13.3 %
NEGATIVE	13	86.6 %

The above information shows that most of the people 87% within the catchment where the units are do not value special education. Little percentage only (13.%) have positive attitude towards it.

Table 4.2.8 Do you receive external assistance i.e. instructional materials or other wise from well wishers or Government?

RESPONSE	FREQUENCY	PERCENTAGE %
YES	3	20 %
NO	12	80 %

The information above shows that very little is received as materials and funds for instruction from well wishers and the Government to help teacher in their teaching.

Table 4.2.9 Problem faced when teaching mentally handicapped

RESPONSE	FREQUENCY	PERCENTAGE %
YES	14	93.3 %
NO	1	6.6 %

From the above information most of the teachers interviewed have problems in handling mentally handicapped learners due to various reasons.

Table 4.2.10 Level of training in Special Education

RESPONSE	FREQUENCY	PERCENTAGE %
YES	4	26.6 %
NO	11	73.3%

Positive responses (Yes) quoted the 3 months in-service, diploma (inclusive) and Degree. The above information shoes that few teachers have received a course in special Education (26.6%) and majority have not received any training.

Table 4.2.11 Rate of attendance in special education units

RESPONSE	FREQUENCY	PERCENTAGE %
YES	2	13.3 %
NO	13	86.6 %

The above table shows that the attendance in almost all units is not constant as the greater percentage i.e. (86.6 %) do not have constant attendance by the learners.

Table 4.2.11 Assistance from the area Administration in creating awareness towards special education programmes?

RESPONSE	FREQUENCY	PERCENTAGE %
YES	0	0
NO	15	100%

The above table shows that there is no assistance given out by the area administration towards creating awareness on special education the area.

4.3 Analysis of Responses from the parents

Table 4.3.1 - How does your child relate to his/her brothers and sisters?

RESPONSE	FREQUENCY	PERCENTAGE %
POSITIVE (WELL)	7	50 %
NEGATIVE (NOT WELL)	7	50 %

The information above shows that some of the siblings accommodate the mentally handicapped child as others ignore the handicapped individuals. Some of the positive response were:

- He is happy when they are together because they accommodate him in their play.

- The siblings are okay as they play together, they take care of him. They like sharing with the child.

Some of the negative responses were:

- He is a bother to siblings especially when they're playing.
- He is dependent and troublesome and thus ignored most of the time.
- They refer him/her to the mother not to disturb them as they play.

Table 4.3.2 Attendance of awareness workshops on education of the mentally Handicapped

RESPONSE	FREQUENCY	PERCENTAGE %
YES	0	0
NO	14	100%

The table shows the parents have never been given an overview on education of the handicapped. There has never been a meeting either for parents.

Table 4.3.3 The number of times parents of the handicapped are visited by personnel concerned with special education.

RESPONSE	FREQUENCY	PERCENTAGE %
YES	7	50 %
NO	7	50 %

Some of the parents have received special educators in their homes. All of them said that it's only their children's teacher who have visited them and no other personnel. Half of them said they have never seen any personnel in their homes.

Table 4.3.4 The number of times the parents visit their children who are handicapped.

RESPONSE	FREQUENCY	PERCENTAGE %
OFTEN	3	21.4 %
RARELY	11	78.6 %

The table shows that a great percentage (78.6%) of the parents rarely visit the units to see how their children operate. Some said that is only when the teacher requires them to go for certain reasons.

A few of them (21. 4%) visit their children oftenly. Whether the teacher needs them or not.

4.4. Analysis of responses from the special education co-ordinator.

Q.1 How many special units are there in the zone (No of special units in the zone)

RESPONSES - "2 units"

The number of special units in the zone shows that special Education has not yet developed much.

Q.2 About how many children with mental retardation do you asses in a term?

RESPONSE:

"They are not many as this is usually done mostly at the start of the year. It depends with the number of pupils joining the unit at what time and that is when I do assessment when they are brought at EARC"

The response above shows that assessment has not taken root well in the zone because the assessors just does assessment only to those sent to her.

Q.3 How often do you offer in service courses? Often/Rare.

RESPONSE

" Rare but I advice teachers as I visit the unit."

The response above shows that the teachers who have never had a chance to attend special education in service courses or others have no basis on handling although they gain a bit of experience in the work.

Q.4 Do you organize meetings with parents of the mentally handicapped children? Y/N

RESPONSE:

" No due to lack of time"

The above response show that most of the parents have never had a chance to be educated towards the importance of special education to their children as well as to other children.

Q.5 About how far a part are the programmes in the zone?

RESPONSE:

" The distance from one unit to another is about 5 km." The programmes show that the units are close to each other. They should rather start another on the other far end of the zone in schools like Garrison, Embakasi, Utawala e.t.c. Children from these areas suffer a lot due to transport problems or trained teachers inclusive should be well spread in all the schools to handle those cases.

Q.6 Do the educational programmes for the mentally handicapped in the District (Zone) receive Funds from well wishers or Government.

RESPONSE:

" No, it is very rare to receive funds from well-wishers but only receive little funds from the Government. The responses shows that there should be enough funds from the Government to enable them to work in all schools well and sensitization in order for well wishers to come in.

Q.7 Have you ever had a meeting with Head Teachers who host the units and in service them on how much they should support these units? Y/N

RESPONSES:

"No, we haven't had a meeting with heads solely on special education

but have talked to them during the District Education Officers meetings with the headteachers as well as when I visited the school units. " The answer above shows that the head teachers at least have the knowledge of special education taking place in their schools.

Q 8. What is the general attitude of other education officers towards special education in the zone?

RESPONSES:

"They respect the department as well as others." The response shows that special education is likely to receive support from the whole office.

Q.9 Have you been to a Baraza where the organizers gave a chance to sensitize the public need to have special education programmes in the zone? Y/N if yes specify.

RESPONSES: " No"

The response shows that the general public is yet to receive more information on importance of special education within their localities.

Q. 10 Does the department of special education in the zone have enough teachers? What is the ratio relation to learners?

RESPONSE:

The ratio is about 2:10. The ratio above shows that the teachers are less than the learners taken care of: but many are now graduating following the introduction of distance learning on inclusive education.

Q.11 is there any unit that offers vocational courses? If yes, how many units? If No, what are the possible limiting factors.

RESPONSE:

No, the special education units in schools have not started such courses due to limiting funds of expansion" The response indicates vocational courses are yet to be started although they have a good baseline putting into consideration many grandaunts within the zone.

CHAPTER FIVE

5.0 SUMMARY, DISCUSSION, CONCLUSION & RECOMMENDATION

5.1 Summary

This research was carried to investigate the factors that hinder the development of special education programmes for the mentally handicapped and suggest solutions or remedial measures which would be applied to solve the problems. There are many factors on the ground which have led to slow progress on such educational programs some of which are lack of awareness, negative attitude towards the mentally handicapped as well as poverty.

A comprehensive literature review was carried out from both primary and secondary sources where the key areas captured included:- meaning of metal retardation, causes, classification and characteristics of such person are explained. A review of the historical background of the development of special education gave a good background information and put the problem under investigation into focus. The various causes of mentally handicapped included:- post-natal brain damage, tuberous sclerosis, biochemical disorders, pheny ketonunia galctomia, pre-natal infections, peri-natal effects, drugs and lead poisoning among many others. The review also captured the characteristics of the mentally handicapped depending on whether such would be mild, moderate, severe or profoundly retarded individuals.

A historical back ground dated back to before independence in 1940's. When special education was started by voluntary organisations and missionaries. A case in point was St. Nicholas (Present Jaracanda) special education school which date back to 1946, which was meant for the Europeans and later AgaKhan School for the Asians. By 1989 about 110 units had been established in the country and majority for the mentally handicapped. The personal efforts of the former President, Daniel Arap Moi, led to the more focus on Special Education in the 80's and 90's.

The various education programs for the mentally handicapped included per-school programs, special classroom, peripatetic service, special residential schools educational integration and non-school based. On programmes methodology the researcher used quantitative research method with survey and the principal research design. Three different questionnaire were used to gather the information from the respondent who were special educators, parents of the mentally handicapped children and EARC co-ordinator. Radom sampling procedure was used.

Finally the collected data was edited analyzed and interpreted. The presentation of data was mainly through frequency distribution. Tables which gave different percentages for each category of the questions which the researcher seek to answer.

5.2 Discussion

The study found out that there were only two units for the mental handicapped in Kayole zone with a population of about 47 pupils out of which 29 (62%) were boys and 18 (28%) were girls (see table 4.2.1). There were no special education schools in Kayole. This was in line with the fact that since independence especially in the 80's and 90's, more special schools and units have been established in various parts of the country. The Nairobi City Council Education report on special education identified thirty different such units and schools in the city with Kayole having only two.

Given that there were only two such units in Kayole Zone, this supports the argument that they are still very few and poor spatial distribution showing that the parents and the mentally handicapped children still walk long distances. It's the view of the researcher that such discourages parents from taking such children to schools and the cost of transport because of the long distance is high. According to the

researcher, the gender issue must be addressed since more girls who are mentally handicapped appear to be at home compared to the number of boys.

In table 4.2.4 the researcher found out that awareness meetings in the schools were only at about 7% and in table 4.3.2 attendance of awareness meetings by the parents was 0% implying that many residents of Kayole have not been sensitized well about the mentally handicapped children. Lack of awareness was cited as one of the major problems on the ground by Songole, Chief advisor to schools. In view of the above, the researcher further feels that more of awareness campaigns will make the residents develop a positive attitude towards such handicaps. It also shows that there is no good positive relationship between parents, the mentally handicapped and the teachers and yet constructive relationships are even more important with parents of children with special needs (Brown and Haylock, 2005). When there is high level of awareness and interaction teachers can plan more effectively to meet the child's individual needs in ways that are appropriate.

On adequacy of materials / facilities to enable teachers instruct sufficiently the researcher found out that 100% of the respondent teachers interviewed stated that they were not adequate (Table 4.2.5). It was a clear evidence to the researcher, that facilities were lacking due to inadequate funding by the government, special education units or schools rely heavily on donor funding and well wishers / (UNESCO, 1989).

On the level of training the researcher found out that only about 27% of the respondents had received a training in special education (Table 4.2.10). There is therefore poor staffing confirming that the current situation is that these units are not adequately staffed hence impacting infectively on the success of these programmes.

5.3 Conclusion

After careful analysis and presentation of the results, the researcher came up with some major findings. There are still very few special units for the mentally handicapped children in Kayole zone. The two units only cater for about 47 cases which is a very low figure implying that many more children are still at home and have got no access to education especially the girls.

With fewer schools and poor spatial distribution, it means that it was expensive for the parents to take their mentally handicapped children to school because of long distance.

The level of awareness about the mentally handicapped children is still very low amongst the parents / residents and even in the schools. There have been few awareness meetings and even visits by the parents to the schools to know how their children were processing in the schools. The general altitude therefore still negative.

The inadequacy of facilities for efficient institutions was working as this was evidenced in the two schools which were the units of study. Coupled with the low level of training in special education by the teachers, the likelihood of compromised quality of education delivered to the mentally handicapped is not in doubt.

5.4 Recommendations

In view of the research findings and conclusion, the researcher strongly recommends the following:-

- There is need to establish more special units for the mentally handicapped children in the more schools in Kayole zone. This can be implemented by the Nairobi City Council (Education Department) religion sponsors of some of the schools, stakeholders of special education like Aga Khan Education

Services and the Government. The above can be implemented by the Government training more teachers on special education for mentally handicapped and strengthening policies to ensure that all the mentally handicapped children are also catered for by the Children's Act. The Government can put up additional classrooms to accommodate or cater for more children with special needs more so the mentally handicapped.

- There is need for more awareness creation to sensitize the residents of Kayole on the rights of all children to have access to education whether they are in the mentally handicapped category. Such campaign through Chiefs' Barazas, Organized Seminars and Workshops and sensitization Campaigns during parents day would be useful.

- The Headteachers, EARC Coordinators, Local Churches would be at a better position to Champaign such programmes.

- There is need to equip the special education units with relevant instructional materials which can further enhance children's participation in the teaching/ learning process.

- This can be done by the Ministry of Education, Science and Technology, the donors like Aga Khan Foundation, Swedish Development Agency, Mobil Kenya.

REFERENCES

Browne, A. and Derek H. (Eds.) (2005) Professional issues for Primary Teachers, London, Sage.

Colien, Louis and Lawrence M. (1998). Research methods in Education, London, Routledge.

Grossman, H.J. (1973). Manual on technology and classification in Mental Retardator, Washington DC.

Herward L. William & Orlansky. D. MichaelColombus, onio.

Ingalls P. Robert (1978) Mental Retardation, the changing outlook,Macmillan Publishing Company, New York.

Kauffman Mj. & Pyne S J (1975), Mental Retardation, Introduction and Personnel perspective, Charles E Mevill Publishers, Colombus, Onio.

Kirk A. R, (1963) Psychological studies of Mental deficiency, MC Graw – Hill, New York.

Luna, A.R, (1978) exceptional children and Youth, USA.

Nachmias, DC. F and David. N (1996). Research methods in the social sciences. New York, Madison Publishers.

Neisworth, J.T Smith, RM (1978) Retardation issues, assessment and intervention MC Graw, New York.

Nyakiti C.A. (2004) Indigenous knowledge documentation and seeds studies in Suba District. IPGRI, Nairobi

Tradgold AF (1937) A text book of mentally deficiency 6th edition Baltimore; Wood

Special Education for Eastern and Southern Africa Educational Assessment (1989)

APPENDICES

Appendix 1 - Questionnaire for teachers

1. How many mentally handicapped children do you have in your school

   .....

2. How does the mentally handicapped child relate to non handicapped peers socially? Poorly /Well

   .....

3. Do you feed your children at school or do they carry packed lunch?

   .....

4. How often do you hold awareness meeting on Special Education in Kayole Zone?

   .....

5. Do you have adequate facilities to enable you instruct sufficiently ? No/ Yes

.....

6. Do your children travel generally long distance to school?

   .....

7. What is the general attitude of the catchment area towards Special Education? Positive/ Negative

   .....

8. Do you receive external assistance i.e. instructional materials or otherwise form well-wishers?

   .....

9. Do you have any problem in teaching Mentally/ Handicapped? Yes/ No if Yes then list them

   .....

   .....

   .....

10. Do you have any training in Special Education? Yes/No if yes to which level?

    .....

11. Is the attendance in your class some how constant ? Yes/No.

    .....

12. Do the area administration assist you in creating awareness towards Special Education Programmes? Yes/No.

    .....

Appendix 2 - Response from parents.

1. Has your child been assessed? Yes/ No. If yes where?
   Assessment center ;.....
   Hospital .....
   Other (Specify) .....

2. How does your child relate to his father/ her brothers and sisters?

   .....

   .....

3. Have you attended any awareness workshop on education of the handicapped?

   .....

   .....

4. Do you receive any visits by personal concerned about special education? Yes/No

   .....

   .....

5. How often do you visit your child in school? Often/Rarely

   .....

Appendix 3 - Questionnaire For Special Education Co-ordinator

1. How many special Units of Special Schools are there in Kayole Zone?.....
2. About how many children with mental retardation do you asses in a term?.....
3. How often do you offer in service Courses in the zone to special educators? Often/ Rare.....
4. Do you organize meeting with parents of the mentally handicapped children? Yes/No.....
5. About how far apart are the programmes in the zone?.....
6. What are the plans in your office for more establishment of new programmes?.....
7. Do the Education Programme for the mentally handicapped in the zone receive funds from well wishers for the development projects ? Yes/No.....
8. Have you ever had a meeting with head teachers who hosts the Units and In-service them on how much they should support these Units? Yes/ No .....
9. What is the general view of other Education Officers towards special Education in the Zone? Sensitive department/ Minor department .....
10. Have you been to a Baraza where the organizers gave you a chance to sensitize the public the need to have special education programmes in the zone? Yes/ Yes.....
11. Does the department of special Education in the zone have enough teachers? Yes/ No What is the ratio in relation to learners? .....
12. Is there any Unit that offers vocational Courses? If yes then how many Units? If no then what are the ratio possible limiting factors? .....

Appendix 4 - Research Time Schedule

ACTIVITY	MONTH
Proposal Writing	October – Nov. 2008
Presentation	December 2008
Preparation for points and main research work	Jan. – Feb. 2009
Data Collection	April – June , 2009
Data Analysis and Report writing	July - August 2009
Submission of the report	August 2009

Appendix 5 - Research Budget

Activity /item

1. Proposal writing	
a) Stationery	350.00
b) Transport	650.00
Sub – Total	**1000.00**
2. Piloting instruments	
a) Typing and printing of questionnaires	150.00
b) Photocopying	30.00
c) Transport	600.00
d) Lunch	400.00
Sub – total	**1,180.00**
3. Data collection	
a) Printing of Questionnaires	150.00
b) Photocopying 2 x 35	70.00
c) Transport @ Kshs. 200 x 3 days	600.00
d) Lunch @ Kshs. 250 x 3 days	750.00
Sub – Total	**1,570.00**
4. Data analysis and final Report	
a) Typing, Type setting and Printing @ Kshs. 40 x 50 copies	3,000.00
b) Photocopying @ Kshs 2 x 300 copies	800.00
c) Binding @ Kshs 80 x 2 copies	200.00
Sub – Total	**4,000.00**
Grand Total Budget =	**7,750.00**