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Early Intervention for Children with Disability: A Comparison of Nigeria and Czech Republic

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Certification

I, Igoni, Joy Sade with student ID number D120564 certify that this thesis titled “Early Intervention for Children with Disability: A Comparison of Nigeria and Czech Republic” and submitted as partial requirement for Master post graduate study programme of Special Education was carried out by me and all sources in any form cited and used have been acknowledged in the text and in list of reference.

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Signature Date

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Abstract

Early intervention do not only reduces the effect of disabilities or prevents the occurrence of learning and developmental problems later in life, but also helps to provide support and needed assistance to family's as well as maximizing the child's intervention and the family benefit to the society at large. Making sure that a well-coordinated, highly effective early intervention services and programmes are available in every society, policy maker, government, professionals, parents, and the society at large need to be involved.

This study adopted mixed research methods that include literature review, questionnaire, and unstructured interview. This study described how Nigeria and Czech Republic carry's out their early intervention for children with disabilities, focusing on the practice of early intervention, government policies/legislations/Act for early intervention, and parents' attitude and involvement in early intervention of children with disabilities. The participants were mainly professionals involved in the practice of early intervention for children with disabilities and parents of children with disabilities. A total of 57 female and 36 male participated in Nigeria while 40 female and 23 male participated in Czech Republic. The simple descriptive statistic was used to analyze the data.

The findings from the descriptive data revealed that in Nigeria, the practice and provision of early intervention is not obtainable for many. The resources for the practice are not adequate and there is no structure for identification, referral, and practice of early intervention. There is no law/legislation/Act that legalized the practice of early intervention. There is no financial support and other needed support from government to enhance early intervention practice. And lastly, parents' attitude shows rejection to intervention of their children as early as possible.

Also, the findings from the descriptive data shows that in Czech Republic, there are adequate resources available for early intervention and there is a structure put in place for identification and practice of early intervention. There is well established law/legislation/Act that promotes the practice of early intervention for all children with disabilities from birth to seven years of life. There is financial support and other needed support for smooth running of early intervention of children and their respective family's. Finally, parents' attitude seems positive, acceptable and encouraging to their children intervention.

Based on the findings, some recommendations were proffered and suggestions were made for further studies in the area.

Keywords: Early intervention, Practice of early intervention, Children with disability, Government policy/legislation/Act and support, Parents attitude, Nigeria, Czech

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THEORETICAL PART

Chapter 1 Introduction

1.1 Background of Research

Early childhood special needs education became globalised as a result of the Salamanca Declaration of 1994. It called on people and governments to invest in early intervention and identification strategies for children with disability. Thus, early intervention practice has been studied by many scholars. There is an adage that says "an ounce of prevention is worth a pound of cure". This adage is worthwhile when the cost of incurred is consider if a child requires purposeful special education services during the later years of the child's life. Early intervention is better than later cure (Ackah and Appiah 2009).

According to Ackah and Appiah (2009), and Unegbu (2012), early childhood intervention is an essential contributor and catalyst for the development of a culture of positive attitudes towards children with disability in a country like Nigeria and Ghana. As Nigeria struggles towards attaining the quest for Education for All (EFA) and the Millennium Development Goals (MDGs), an integrated, inclusive and effective early intervention programme becomes inevitable for children with disabilities. This would provide mutual benefits for children with disabilities, parents and families, educators and professionals and the society at large (Unegbu 2012).

Ackah, (2011), Ackah and Appiah, (2009) states that failing to start interventions as early as possible is seen as missing an important opportunity for learning and favorably influencing early brain development. Early intervention promotes development of the child and well being of families. Professionals of any discipline who are concerned with children's growth and development know that the early identification of infants who either have disabilities or are at risk of developing them is essential, as is the provision of appropriate services in order to promote these children's developmental progress (Chen, 2014). Chen (2014) noted that "the primary purpose of early intervention is to promote the development and learning of very young children by helping their families identify and put into practice ways to support their healthy growth. Because the infant is a member of a family system that has a significant role in the infant's early care, experience, and future, early intervention services need to be family centered rather than child centered. Working in collaboration, early interventionist and families identify, develop and provide early and appropriate learning experience to facilitate the child's learning and development" (p.3).

Also, Omumu, Oriaifo and Odirin Omiegbe (2012) stated that there are three primary reasons for intervening early in a child's with disability: i) to enhance the child's development; ii) to provide support and assistance to the family, and iii) to maximize the child's intervention and family's benefit to society. Kames and Lee (1978) in Omumu et al., (2012) have noted that "only through early identification and appropriate programming can children develop their potential" (p.1).

Omumu, Oriaifo and Odirin Omiegbe (2012) further stated that early intervention programmes have a significant impact on the parents and siblings of infant or young child with disability. The family of a young child with disability often experience disappointment, social isolation, added stress, frustration and helplessness. The compounded stress of the presence of the child with disability may affect the family's well-being and interfere with the child's development. Families of children with disability/disabilities are found to experience increased instances of divorce and suicides in Nigeria and the children's with disability are more likely to be abused than children without disability. Early intervention can result in parents having improved and positive attitudes, positive information and skills, and more leisure time for themselves and their children with disability.

According to Heward (1996), early intervention reduces the effects of disabilities or prevents the occurrence of learning and developmental problems later in life for children presumed to be at risk for such problems. It provides support for the child and family that will help prevent the child from developing additional problems or disabilities.

In recent time, there have been too few attempts to determine critical features of effective early intervention programmes and there are few factors which are present in most studies that report the greatest effectiveness. These programme features include: the age of the child at the time of intervention; parents' involvement; and the intensity and/or the amount of structure of the programme model. However, many studies and literature reviews report that the earlier the intervention, the more effective it is. With interventions at birth or soon after the diagnosis of a disability or high risk factors, the developmental gains are greater and the likelihood of developing problems is reduced (Cooper, 1981; Garland, Stone, Swanson and Woodruff, 1981; Maisto and German, 1979; Strain, young, and Horowitz, 1981 in Omumu et al 2012). More so, the involvement of parents in their child's treatment is also important. Several evidences in Literature show that parents of children with disability need support and skills necessary to cope with their child's disability. Outcomes of family intervention include: the parent's ability to implement the child's programme at home and reduced stress that facilitates the health of the family. Both of these factors appear to play an important role in the success of the programme with the child (Beckman-Bell, 1981; Cooper, 1981; Garland et al 1981; Karnes, 1983, Lovaas and Koegel, 1973; Shonkoff and Hauser-Cram, 1987 in Omumu et al, 2012). Moreover, certain structural features are related to the effectiveness of early intervention, regardless of the curriculum model employed. Successful programmes are reported to be more highly structured than less successful ones (Shonkoff and Hauser-Cram, 1987; Strain and Odom in Omumu et al. 2012). This mean that maximum benefits are recorded in programmes that are clearly specify and frequently monitor child and family behavior objectives; precisely identify interventionist behaviors and activities that are to be used in each lesson; utilize task analysis procedures; and regularly use child assessment and progress data to modify instruction.

Guralnick (2005) alludes that making sure that the availability of well-coordinated, highly effective early intervention programmes in every community, each representing contemporary principles and practices, is held to be a reasonable goal by the policy makers, parents, and professionals. Early childhood intervention is important and beneficial to children with disabilities, as well as their families. Siblings, educators and professionals, and society as a whole derive maximum benefits. Morally, a fundamental responsibility of parents and caregivers in every society is to nurture their young ones for full membership in that society. From a practical viewpoint, promoting the health and development of children with disabilities increases their preparedness to participate as adults in the economic life of their communities (Ackah and Appiah, 2009).

Most findings based on the available literatures on early intervention have reported effective early intervention programme. In many countries in Europe and America, intervention programmes for children and persons with disabilities are effective. Their early intervention programmes are indigenous to their people and are integrated in their existing special education delivery models. Current trends in the early intervention programme for children and persons with disability are adapted to suit individual country needs. In Czech Republic, literature reveals that the country prepared an early intervention programme model called "Guidance" based on three methodological approaches: child development support, family support and society support. In Nigeria, early intervention programmes are prepared by special educationist in the child's later life. For Nigeria to establish indigenous early intervention programmes for children or infants and persons with disability, existing structures of special education models must be reviewed with early intervention programmes properly integrated into it.

Additionally, there have been very few studies conducted to compare the different early intervention practices within countries in Europe and Africa. Early intervention is becoming a national and cultural issue because of the different indigenous early intervention programme, government policies and legislation coupled with parents and professionals' involvement. It is meaningful to know and consider if there are differences in how countries in Africa and countries in Europe carry out their early intervention practices and programmes for children with disabilities. Having this in mind, the researcher of this work who is of African descent, from Nigeria, currently on post graduate studies in Czech Republic chose to research on early intervention for children with disability: a comparison of Nigeria and Czech Republic. This seeks to describe early intervention practice for children with disabilities in Nigeria with what obtains in Czech Republic.

1.2 Aims of the Research

The general aim of the research is to examine and describe early intervention practices obtained in Nigeria and Czech Republic, focusing on the differences in the way both countries carry out their early interventions pertaining to infants and children with disability. To achieve this aim, the research is conducted to: (i) describe the early intervention practices available for children with disability. (ii) the government policies and legislation for the practices of early intervention for children/infants and persons with disabilities as well as government supports for parents and families having children with disability. (iii) accessibility of resources/aids for early intervention for children with disability. (iv) parents' attitude and involvement in early intervention practice for their children with disability.

Specifically, the research focuses on the following questions:

i. Does the early intervention practice available for children with disability in Nigeria differ from that of Czech Republic?
ii. Are there government policies and legislations for early intervention practice?
iii. Are there some differences in the Czech Republic government support for parents and families with children with disability to that of Nigeria?

iv. Does Czech parents' attitude differ from that of Nigerian parents in early intervention for their children with disabilities?

If there are positive and effective practice of early intervention in one country than the other why? And what exactly contributes to the effectiveness of early intervention in that country?

1.3. Outlines of the Thesis

In this thesis, there are five chapters. Chapter 1 introduces the background of the research and its aim. Chapter 2 describes the literature review that focuses on early intervention practices, government policies and support, parents' attitude and involvement in the practice of early intervention and the theoretical frameworks for early intervention. Chapter 3 describes and presents the methodology. Chapter 4 presents the descriptive data results of the findings as well as discussion of the findings while Chapter 5 presents conclusion, proffers recommendations as well as the limitation in carrying out this research.

1.4. Operational Definition of Terms

For the avoidance of ambiguity, variation in terms meaning and understanding, the following terms are defined according to usage and meaning in this study.

Early Intervention: This is a comprises set of support, services and experiences to prevent or minimize long-term problems as early as possible (Dunst and Trivette, 1997; Guralnick, 1997 in Feldman 2004).

Disability: This is a condition of being restricted or unable to perform a task or function because of impairment.

Children with Disability: These are infants or toddlers living with one or more disabilities e.g. mental disability, hearing impairment, visual impairment, physical disability etc.

Parents: In this study, it is specifically refers to the individuals who gave birth to or nurtures and raises a child with disability.

Attitude: This is a tendency of reacting positively or negatively towards a particular thing or person.

Government policies/legislation: Laid down rules and regulations of a country guiding the practice of early intervention and right of children with disability.

Chapter 2 Literature Review

2.1 Early Intervention Practice

The provision for children with disabilities and those who are at risk for reasons of socio-economic disadvantages in terms of early intervention has being an international issue. The concept of early intervention was borne out of the need to provide specific programmes of support to children with disabilities and vulnerable children, including their families at critical stages of children's development, usually earlier than traditional forms of early education would be available to them (Telzrow, 1992; Barnett, Bell and Carey, 1999; Wolery and Bailey, 2002 in McGough and Ware 2007). According to Dunst (2007), early intervention is the experiences and opportunities affords infants and toddlers with disabilities by the children's parents and other primary caregivers that are intended to promote the children's acquisition and use of behavioral competencies to shape and influence their pro-social interactions with people and objects. Also, early intervention refers to a comprehensive set of individualized service designed to meet the development needs of infants and young children and families (Ramey, Ramey and Lanzi in Lanzi, Ramey and Ramey 2007). Early intervention offers an opportunity to improve the developmental trajectories of infants and young children who are identified as having developmental disabilities or at risk for having developmental delay (Lanzi, Ramey and Ramey 2007). Typically early intervention is provided for children who already have a known disability or are judged to be at risk for non-optimal development, based on biological, psychosocial, or other life factors (Ramey and Ramey 2000). According to Lanzi, Ramey and Ramey (2007), new research on brain development has show the tremendous benefits of providing intensive, comprehensive, continual services, beginning early in life. A fundamental principle of early intervention is that it should begin as early in life as possible, and that it should be tailored to the specific needs of the individual infants and young children (Lanzi, Ramey and Ramey 2007). Thus, an intervention that began at age 3 with children who were already developmentally delayed, would have different expected outcomes one year later than an intervention that began at birth for children with disability or for high-risk infants who were being assessed at age 1 year (Ramey, Ramey, and Lanzi 2001).

Early intervention programmes involve a broad array of service. These can include: educational and medical services for diagnosis, evaluation and support; health and nursing services; nutritional counseling; psychological services; and assistive technology devices and services. Additionally, services can support the family in terms of family training, counseling, home visits, service coordination, special instruction, transportation and related costs (Lanzi, Ramey and Ramey 2007). More so, early intervention programmes should be developed in partnership with families and should work with them in a dynamic relationship which is characterized by active development of existing family strengths and sensitivity to the family culture and to the nature and extent of family needs (Guralnick, 1997, 1998, 2001, 2002; Sameroff and Fiese, 2000; Farran, 2000; Wolery, 2000; Wolery and Bailey, 2002 in McGough and Ware, 2007). However, the development of individualized services coordination varies depending on the specific needs of the infants and young children with disability and their family situations. Furthermore, McGough and Ware (2007) reports Trivette, Dunst and Deal, 1997; Sameroff and Fiese, 2000; Guralnick, 2001 model for effective early intervention. They alludes that early intervention must be evidence based, must support the child's development in the context of the child's family and community and must integrate the contributions of multiple disciplines and agencies within a web of supports constituting a programmes which is at once comprehensive and uniquely so to meet the needs of individual children and families.

Research has found that in most countries in Europe and in the United States, infants and young children with disability commence early intervention programme or services from birth through the age of 5 years, while other programme begin theirs with pregnant women even before the child is born. Additionally, Lanzi, Ramey and Ramey (2007) reported that the intervention strategy in most industrialized Western countries includes three key elements: adequate family income, sufficient time for parenting, and supportive care and services. Although, Bruder, 2000a, 2001; Dunst, 2000 in Bruder (2010) also opined that infants and young children are developing and learning in the context of their families, and this need requires that services and supports target families as well as children. Effective interventions should evolve from a family's priorities for a child's everyday routines and activities (Bruder, 2001; in Bruder 2010, Dunst, 2007).

2.1.1 Guiding Principles of Early Intervention

Dunst (2007) alluded that the following principles guide the ways in which early intervention is operationalized and practiced. The principles include:

(1) The experiences and opportunities afforded infants and toddlers with disabilities should strengthen children's self-directed learning, development to promote acquisition of functional behavioral competencies, and children's recognition of their abilities to produce desired and expected effects and consequences. Dunst explained that a fundamental distinction is made between experiences and opportunities that are contexts for a child's acquisition and use of behavior that is intended to have desired consequences (e.g., a child who learns to use a pointing gesture to get an adult to retrieve a desired object) and those intended to elicit a child's behavior (e.g., having a child name objects shown to him or her or by an adult) (Dunst, 2007).

(2) Parent-mediated child learning is effective to the extent that it strengthens parent's confidence and competence in providing their children with development-instigating and development-enhancing learning experiences and opportunities. In this principle, Dunst contended that the principle makes explicit that the benefits of early intervention should be realized by both children and their parents or other primary caregivers. The likelihood that parents and other primary caregivers will provide children with the kinds of experiences and opportunities that influence their development is maximized when

adults recognize and understand the important role they play in influencing their children’s growth and development (Dunst, 2007).

(3) The role of early intervention practitioners in parent-mediated child learning is to support and strengthen parent capacity to provide their children with experiences and opportunities of known qualities and characteristics (i.e., evidence based) that are most likely to support and strengthen both parent and child capacity. In this principle, Dunst emphasized that knowledgeable practitioners are aware of what research “tells us” about the characteristics of practices that are associated with optimal positive benefits. Practitioners intervene directly with children only to the extent that it serves to model for parents the use of evidence-based practices with their children (Dunst, 2007).

2.1.2 Concepts of Early Intervention

Keilty (2010) noted that there are six concepts of early intervention that are at the heart and process of early intervention. These include the followings:

Children learn and develop using their curiosity, active discovery, and genuine excitement in the everyday experiences that occur in their family and community. Keilty (2010) explained that infant and toddlers learn throughout their everyday lives. They do not have to go to school to learn, and do not need special videos or toys. They learn by interacting with the people in their lives, looking at, hearing, and touching the objects in their daily activities. Also, she further said that infant and toddlers learn through excitement of exploring what each day brings, and learn competencies and skills needed to participate in the world, and important values and traditions of their family’s individual culture, or way of life. However, children with disabilities are no different, but for infant and toddlers with disabilities, families may have a harder time finding out how best to provide these experiences due to their child’s unique learning needs (Keilty, 2010). Early intervention is there to develop children’s interest and participation in these everyday experiences so that they can learn and develop based on what is important to their family (Keilty, 2010). It is notable that the overwhelming majority of early intervention supports occur within the family’s home and community, during the routine activities in which the child with disability participates everyday (Keilty, 2010).

Children are part of a family. The goals, values, and needs of the family are the goals, values, and needs of the child. Here, families provide their children with learning experiences that promote development. These experiences occur with the family, through their everyday life together (Keilty, 2010). In other words, when a family is concerned about other aspects of life (stressors), the child development is affected and in the opposite, when families feel comfortable with family life, they are more able to focus on their child's development. More so, not only do family stressors impact the family's ability to provide learning opportunities, but they impact the child in general as a member of the family. Hence, early intervention can not only be about the child and his or her developmental needs, but it has to be about the needs of each individual family member and the family as a whole (Keilty, 2010). She further noted that if the family wishes, early intervention professionals are available to give the necessary assist to the families in meeting goals for the entire family or individual family members.

Children learn through the kinds of interactions they have with others and the objects they have to explore. According to Keilty (2010), what children learn depends a lot on the kinds of interaction they have with adults and other children. Generally, positive interactions are ones that are enjoyable for everyone because there is a lot of back and forth among those interacting and thus, everyone understand what each other are trying to say. Also, learning is affected by the materials i.e. toys, utensils, and other objects; and setting i.e. the layout of the area, furniture and equipment, of the child's everyday routine activities. The child needs safe opportunities to explore in ways that are developmentally appropriate for the child's age and ability, and slightly challenging for the child to figure out (Keilty, 2010). She further stressed that every child is different and by so doing, families have to find out which interactions, materials, and settings are best for their child based on his or her personality and learning style. For children with disabilities or developmental delays, what they need in order to learn may be similar or quite different from what a typically developing child needs to learn. Thus, early intervention professionals partner with family to determine whether the environment is the best set up for the child learning, or adjustment will be needed for the particular child, and can identify ways to better promote development according to the child's unique learning characteristics (Keilty, 2010).

Families and communities provide many learning opportunities for young children. Early intervention is a support to families and communities, not a substitute. Keilty (2010) affirms that families have friends, extended family, and others who support them. Thereby, provides them with parenting advice, give a shoulder to lean on, an ear to listen and day to day needs throughout their lifetimes. Family's lives in a community where their children will grow up, make friends, and participate in community activities. However, she explained that this does not have to change because a child has a disability or developmental delay. Early intervention professionals collaborate with the adults who are part of the child's everyday life so that they can feel confident in doing what is best for the child (Keilty, 2010). Professionals do not have to take over the natural role families and others in community play to promote the child development, thus, they are not a substitute for what is already happening but they are to collaborate with the family and the community to understand the best way to help the child learn, and then support the family and community as they uses those strategies throughout the child's day (Keilty, 2010).

There are multiple resources available for families, but accessing and keeping them straight will require coordination. Certain developmental supports are available to families through early intervention programmes. These are: (i) special education (also known as special instruction in early intervention); (ii) speech-language pathology; (iii) physical therapy; and (iv) occupational therapy (Keilty, 2010). She contended that a coordinated efforts among these supports is needed so that everyone can understands what everyone else is doing and learns from each other. Also, families do receive supports outside of early intervention. These supports can include various medical and other health providers as well as social and financial resources. Thus, service coordinator is responsible for assisting the family as they move through early intervention process and bringing together all the pertinent resources (Keilty, 2010).

Early intervention is just the beginning. As supports are provided in the present, future is also considered. At most, families participate in early intervention for 3 years. Hence, this is just the beginning for families, as they will parent their child for a lifetime. Keilty opined that after early intervention, on or before the child's third birthday, children may receive preschool special education services, or they may have no specialized supports at all. However, as the child grow and have different experiences, different competencies become important. As family thinks of goals and competencies for their child's while in early intervention, professionals and family think about the competencies the child needs immediately after early intervention and later in life as well as how the new programmes need to be ready for the child and his or her unique learning characteristic. As such, the family and professional partnership thinks about the present and the future simultaneously (Keilty, 2010)

2.1.3 *Benefit of Early Intervention*

Lanzi, Ramey, and Ramey (2007) alluded that numerous comprehensive reports of early intervention makes a difference in children's development in reviews by Carnegies Task

Force on Meeting the Needs of Young Children report, 1999; Guralnick, 1997; Haskins, 1989; Odom, Hanson, Blackman and Kaul, 2003; Ramey and Ramey 1998, 1999; Ramey, Ramey and Lanzi in press b. They further posited that "the first 5 years of life is a critical time in the developmental disabilities. It is during this time that the brains of infants and young children have the greatest capacity to change and the earlier the intervention begins, the more opportunity the brain has to makes changes and produced desired outcomes" (p.295). However, Carnegie Task Force Report, 1994; Shore, 1997; Ramey and Ramey, 1998, 1999; in Lanzi, Ramey and Ramey (2007) further explained that if children do not experience necessary stimulation during the early years, their brains may not be able to compensate for the critical loss. For an adequate outcome of early intervention, the earlier an intervention and the longer it is maintained, the more likely it is to produce greater benefits for infants and young children involved. Nevertheless, Ramey et al., (1992) in Laniz, et al., (2007) noted that the amount of services received from intervention programmes have a strong positive relationship to the child's social and intellectual development. Early intervention programme did not only help children with disabilities, they can also be beneficial to families who often feel socially isolated due to their child's disability. The sooner a child is reached through an intervention programme, the sooner parents receive the tools they need to cope with their child's disability, and assist in therapies designed to improve their child's quality of life, both socially and academically (Wistrom 2012). In agreement with this, Dunst (2007) opined that families benefit from the support given to them through the intervention process.

2.1.4 Research Foundations for Early Intervention Practices

According to Dunst (2007) there are four different kinds of intervention practices used to illustrate what is known about the characteristics of practices that positively affect the learning and development of infants and toddlers with disabilities: (1) response-contingent child learning; (2) parent responsiveness to child behavior; (3) everyday natural learning opportunities; (4) capacity-building help-giving practices. However, these are by no means the only practices that constitute the content and scope of early intervention (e.g., Guralnick, 2005; Odem and Wolery, 2003 in Dunst 2007). Moreover, they do make up a conceptually and operationally coherent set of practices that taken together provide one way of thinking about parent-mediated, evidence-based early childhood intervention (Dunst, 2000, 2004 in Dunst 2007).

Response-Contingent Child Learning

Response-contingent child learning refers to environmental arrangements by which a child's production of a behavior produces of elicits a reinforcing or interesting consequence that increase the rate, frequency, or strength of behavior responding (Hulsebus, 1973 in Dunst 2007). For instance, the movement and sound of a mobile that occurs as a result of an infant swiping the apparatus is an example of this type of learning. Infants without disabilities or delay typically learn and remember this kind of relationship by two to three months of age (Lipsitt and Werner, 1981 in Dunst, 2007). According to Watson, (1966) in Dunst (2007) infants' recognition of the relationship between what they do and what happens in response to their behavior is called "contingency awareness" or it could be called "contingency detection" (Rochat, 2001 in Dunst, 2007, p165). Dunst (2007) opined that this awareness or detection is often manifested by concomitant social-emotional behavior. An infant's ability to understand that he or she is the agent of an environmental consequence produces social-emotional responding because cognitive achievement is pleasurable (Haith, 1972 in Dunst 2007).

Furthermore, the extent to which infants and young children with disabilities are able to learn the relationship between their behavior and its consequences has been the focus of investigation in more than 50 studies spanning some 40 years (Dunst, 2003; Hutto, 2003 in Dunst 2007). However, the characteristics of response-contingent learning opportunities associated with variations in rates and patterns of learning in children with disabilities has been examined in three research syntheses of this practice (Dunst, 2003; Dunst, Storck, Hutto, and Snyder, 2006; Hutto, 2003 in Dunst, 2007). Dunst (2007) stressed that these syntheses included analyses of how long it takes children with disabilities to learn a response-contingent relationship, the correlates of rapidity of learning, the relative effectiveness of different types of environmental arrangements and reinforcers, and whether children with disabilities manifest social-emotional responding as a result of contingency awareness or detection in a manner similar to their typically developing peers. In line with this, the result of the findings taken together in available studies, show that children with disabilities are capable of response-contingent learning and that these kinds of learning opportunities constitute a useful early intervention practice for these children (Lancioni, 1980 in Dunst, 2007). It is also important to note that there are differences in the patterns of learning among children with disabilities compared with their typically developing peers (Dunst, 2007). Infants without disabilities typically demonstrate response-contingent learning in as few as two to four minutes. In contrast, it more often than not takes children with disabilities considerably longer to demonstrate the same kind of learning (Hutto, 2003 in Dunst 2007) in which rapidity of learning is differentially affected by a number of factors. As it might be expected, the more profoundly delayed a child's is when he or she is first provided with response-contingent learning opportunities, the longer it takes the child to learn the relationship between his or her behavior and its consequences (Dunst, 2007).

Essentially, Dunst (2007) asserted that response-contingent learning opportunities "either arise naturally as part of children's everyday interactions with people or objects or can be intentionally arranged so that children have opportunities to learn the relationship between their behavior and its consequences. These kinds of learning opportunities are especially important for infants and toddlers with disabilities because they promote children's acquisition of behavior that can be used to initiate and produce desired effects" (p.166).

Parent Responsiveness

According to Shonkoff and Phillips (2000) in Dunst (2007) parents' sensitivity and responsiveness to their infant or toddler's behavior during parent-child interactions is a potent determinant of child development. Also, Affleck, McGrade, McQueeney and Allen, 1982; Marfo, 1988 in Dunst (2007) noted that encouraging and supporting parents' use of a responsive interactional style with children with disabilities has been recognized as an important early intervention practice for more than 25 years. However, it is generally recognized that parent responsiveness is a complex process that includes different elements and features that both individually and in combination influence child learning and development (De Wolff & Van IJzendoorn, 1997 in Dunst 2007). This process includes but is not limited to, parental response quality, timing, appropriateness, affect, and comforting (Dunst 2007). Parents' contingent responsiveness to their children's behavior is associated with improved child functioning (Dunst 2007). The effectiveness of the parents' behavior is maximized when the parent is attuned to the child's signals and intent to communicate, when the parent promptly and appropriately responds to the child's behavior, and when parent-child interactions are synchronous and mutually reinforcing (Kassow & Dunst, 2004, 2005 in Dunst 2007).

In contrast, the extent to which parents' responsiveness to the behavior of children with disabilities influences the children's behavioral and developmental outcomes and this has been assessed in three practice-based research syntheses (Trivette, 2003; Trivette, 2004; Trivette & O'Herin, 2006 in Dunst 2007). However, Dunst (2007) explained that in studies of children with disabilities, parents' responsiveness to the children's behavior shows much the same kind of relationship with the outcomes that constitute the focus of investigation as is found in studies of children without disabilities. The author further expressed that almost every case, measures of parents' responsiveness during interactions with their children were positively associated with subsequent performance by the children on the outcomes measured in the studies. Notwithstanding differences in the absolute levels of functioning of the children with and without disabilities, the amount of covariation, or effect size, between parent responsiveness and child functioning were more alike than different for the two groups of children.

Conclusively, Dunst (2007) stated that the reason parent responsiveness is "associated with positive child benefit is perhaps best understood by considering what it "teaches" a child. A parent who is responsive to a child's efforts and success, who is helpful and supportive when necessary, and who is encouraging and facilitative, helps a child learn that the parent is nurturing and dependable, which are exactly the kind of environmental conditions that are necessary catalysts for optimal learning and development" (p.168). This seems necessary especially for infants and toddlers with disabilities, who more often than not need an extra boost to learn about their own capabilities as well as the behavioral propensities of others (Dunst 2007).

Natural Learning Opportunities

Children's lives throughout the world are an admixture of everyday activities that are the contexts for learning culturally meaning behavior (Goncu, 1999 in Dunst 2007). The experiences and opportunities afforded children, as part of everyday life are the "ordinary setting in which children's social interaction and behavior occurs. They are the, who, what, where, when, and why of daily life" (p. 201) (Farver, 1999 in Dunst, 2007). According to Dunst, Hamby, Trivette, Raab and Bruder, 2000 in Dunst (2007) everyday activities can be defined as natural learning environments in which contextually meaning and functional behavior is learned, further increasing children's participation in family and community life. The extent to which infants and toddlers with disabilities participate in everyday activities and benefit from these natural learning opportunities has been examined in a number of practice-based research syntheses (Dunst, 2006; Masiello and Gorman, 2006; Raab and Dunst, 2006b; Trivette and Click, 2006 in Dunst, 2007). Findings from research on naturally occurring learning opportunities indicate that everyday life is made up of some 22 different categories of natural learning opportunities (Dunst et al., 2000 in Dunst 2007) and that preschool children with and without disabilities, on average, participate in about 40 to 50 different kinds of activities on a fairly regular basis (Dunst and Bruder, 1999 in Dunst 2007). More so, Dunst, Hamby, et al., (2002) in Dunst (2007) contended that during the first three years of a child's life, participation in everyday family and community activities increases in a relatively linear fashion, albeit at different rates depending on the everyday activity. However, Dunst (2007) enumerated that more specifically, infants with disabilities from birth to six months of age are typically involved in about 19% family activities and about 11% community activities, and toddlers with disabilities from 30-36 months of age are involved in about 34% of family activities and about 21% of community activities. In line with this, infants and toddlers with disabilities on average tend to participate in somewhat fewer everyday activities compared with their typically developing counterparts (Dunst 2007). Trivette, Dunst and Hamby (2004) in Dunst (2007) stated that the differences in the experiences and opportunities afforded children with disabilities are due less to their disabilities and more to their parents' beliefs about the value of everyday learning opportunities.

However, in many studies, results have revealed that learning opportunities that either provided a context for interest expression or had interest-evoking features were associated with positive and decreased negative child functioning (Dunst, 2007). He further posited that the benefits were greatest in situations in which interest-based learning occurred in the context of everyday activities, in which the pattern of relationships between the characteristics of the activities and benefits to the child were very much same for children with and without disabilities. The everyday activities that make up that fabric of a child's life include but are not limited to, the kinds of responses-contingent and parent-child interaction learning opportunities described. Everyday activities are powerful contexts for child learning, and when used as sources of learning opportunities for children with disabilities, they can and generally do have positive child benefits as well as parent benefits i.e., improved sense of parent competence (Dunst, 2007).

Capacity-Building Help-Giving Practices

As a result of the efforts of practitioners, early intervention effectiveness is considered when parents' and children's competence and confidence are strengthened. Thus, parents' sense of their own parenting abilities is considered a mediating factor influencing the kinds and characteristics of learning opportunities afforded their children (Dunst, Trivette, and Hamby, 2006b in Dunst, 2007). These authors stressed that the extent to which practitioner help-giving practices influences (1) parents' competence in performing their roles and tasks; (2) parents' confidence in carrying out parenting responsibilities and (3) parents' enjoyment in interacting and playing with their children was assessed as part of three research syntheses of family-centered help-giving practices.

Dunst, (2007) reported that more than half of the studies in the different syntheses were conducted with parents of children with disabilities who were involved in early childhood intervention programmes and three different kinds of family-centered help-giving practices were examined as potential determinants of parenting abilities: relational help giving, participatory help giving, and parent-practitioner collaboration. He further explained that relational help giving involves practices typically associated with good clinical practice (active and reflective listening, empathy and compassion, reassurance, etc.). Participatory help giving involves practices that promote parent decision making and action based on choice necessary to obtain desired resources or attaining desired goals. Parent-practitioner collaboration involves practices in which partners work together to plan courses of action and to decide what will be the foci of intervention (Dunst, 2007). From those studies examined, collaboration had no discernable direct or meditational effects on parenting competence, confidence, or enjoyment (Dunst and Dempsey, in press in Dunst, 2007). However, Dunst (2007) noted that relational help giving had small direct effects and somewhat larger meditational effects on the three parenting measures. Participatory help giving had both large direct effects and large meditational effects on parenting competence, confidence and enjoyment. The nature of the relationships between help giving and parenting was much alike for parents of children with or without disabilities.

Summarily, Dunst (2007) attested that the fact that participatory help giving proved to be more important determinant of parenting competence, confidence, and enjoyment was not unexpected. Practitioners who use participatory help-giving practices with families encourage and support parents' involvement in experiences that provide contexts for them to successfully provide their children with learning opportunities that benefit parents as well as children. In agreement to this, when practitioners support parents and parents in turn support their children, both parents and children realize a heightened sense of competence and confidence.

2.1.5 The Practices of Early Intervention/Special Education in Nigeria

Agunloye, Pollingue, Davou, and Osagie (2011), and Ikpaya (2001) reported that the practice of special education in Nigeria began from an inclusion education premise. The 2008 National Policy on Education (Federal Ministry of Education, 2008) makes inclusive education the norm rather than the exemption. However, there is no structure in place for early detection and identification of children with disabilities and early intervention at the governmental level. The responsibility of bringing children with disabilities to schools rests completely on the shoulders of their parents. More so, when the children's are brought to school, they are immediately assigned to special education teachers' classes in self-contained resource settings for intensive teaching and learning of the necessary socialization and other transition skills needed to move them from the self-contained resource setting to completely inclusive classrooms in a short period of time. Agunloye, Pollingue, Davou, and Osagie (2011) further asserted that there are limited numbers of evaluation specialists. Evaluative services, in terms of the nature of disability, learning needs of children and eligibility for special education services/intervention are done by special education teachers at the school level or through few referrals to special centers. They also affirmed that at the special center, there is no extensive battery of tests in place to determine eligibility for the category of learning disabilities. By so doing, majority of children classified as qualified for special education services are those with very obvious disabilities that includes children with visual impairment, children with hearing impairment, children with speech impairment , children with mental retardation, children with learning disabilities, and children with orthopedic impairment. Attention to behavior disorder, autism, traumatic brain injury, and emotional disability is not yet a priority. Moreover, if parents bring children with these types of disabilities to school, they are accepted and integrated into inclusive settings as soon as possible. There is no law yet that separates early intervention, special education services from vocational and rehabilitation services. It is observable that children who qualify for special education services automatically qualify for vocational and rehabilitation services (Agunloye et al., 2011). Also, "Free and appropriate special education services are only available to children up to the age of 16 when transition services are provided to move them to senior secondary schools or vocational/technical institutions" (p.94). From this point on, the funding of their education becomes the solely responsibility of their parents or guardian.

The inclusive education requirement allows both special education and the general education teachers to cooperatively expose children with special needs to a general education curriculum. States are now requiring that special education teachers have advanced degrees in special education beyond a diploma. There is no legally binding requirement for the development of individualized educational plan. However, school-level special education coordinators are appointed to ensure that systematic planning, organization, and monitoring are in place to meet the needs of children with disabilities in their respective schools (Agunloye, et al., 2011).

Nigeria has 36 states and a Federal Capital Territory (FCT). At the state level, a state director is assigned to coordinate special education programmes across the state. Agunloye, et al., also reported that funding for special education in Primaries 1-6, Junior Secondary School (JSS) 1-3 (equivalent to Grades 1-9) comes directly from the Federal Government to special UBE Boards at the state level. The state departments of education are separate from the UBE Boards and have limited control over the funds for primary and JSS education. They further explained that there is no accurate data on the categorical proportions of children with disabilities in public schools in Nigeria. However, the Federal Department of Education (1999) in Agunloye et al., (2011) estimates indicated that the largest categories of children served in special education are the children with visually impairment, children with hearing impairment, the orthopedically challenged, and children with mental retardation. Conclusively, for early intervention practice to be in place and functional in Nigeria, Abang (2005) opined that what Nigeria needs today is the enactment of a federal law aimed at young children with disabilities and their families. This law should provide direct services to infants and young children with disabilities and their families, assessment devices, curriculum materials and parents teaching materials. Abang further stressed that under this law, incentives should be given to states or NGOs for establishing programmes for infants or toddlers with disabilities.

2.1.6 The Practices of Early Intervention/Special Education in Czech Republic

The care for children and persons with disability in Czech Republic is on the state level, ensured especially by three departments, namely; health care system, social care system and school system. The care is directed and funded by the Ministry of Labour and Social Affairs of CR (MoLSA), Ministry of Health of CR (MH) and Ministry of Education, Youth and Sports of CR (MEYS) (Jeřábková, 2013). The author further explained that the legislation defines the basic activities of each service, costs of its provision, qualification of workers in social services, ways of setting and maintaining the quality of social services etc. In early intervention, the practice is carried out through social services with an Act no. 108/2006 Coll., passed for effective practice. The Social Service Act No. 108/2006 stated that early intervention services is a field or possibly ambulatory service provided to a child and parents of a child of 0 up to 7 years of age who is disabled or whose development is threatened due to an adverse social situation. The service is focused on support provided to the family and development of a child in view of his specific needs. Service according to subsection (1) shall include the following basic activities: a) upbringing, educational and activation activities, b) mediating contacts with the social environment, c) social therapeutic activities, d) assistance with asserting rights, justified interests and looking after personal matters (54, Act No. 108/2006 Coll., about Social Services). This Act completely changed the existing practice of providing cares for persons with disability. The flow of finances changed, the number and character of social services which can be provided increased significantly, the rights and obligations of social services providers and user changed, etc. (Jeřábková, 2013). According to Jeřábková, (2013), the act is continually amended and revised according to how effective or not its implementation in practice proves to be.

Early childhood education in the Czech Republic is regarded as a part of the system of education and its objectives are defined by the Education Act (Act No. 561/2004 Coll., on Preschool, Primary, Secondary, Higher Vocational and Other Education, as amended Zákon, 2004 in Rabušicová, 2007). However, EASNIE (2009) reported that since 1989 there has been a progressive process of change in the Czech educational system. All these change have opened gaps for a wider differentiation and individualization of educational possibilities. The most important changes deal with the group of children with disabilities. EASNIE (2009) further explained that new educational philosophy which responded to the tendency and trends of the society's democratic development and orientation was formulated in the National Programme of Education Development in the Czech Republic (White Book) by the Ministry of Education in 2001. More so, EASNIE (2009), in their report enumerated the main changes concerning the access condition for pupils with disabilities to education as follows:

(1) Mainstream schools were opened for pupils with disability
(2) Education was made available for pupils with even the most serious complex needs
(3) Diverse forms of individualization of education were established to meet the needs of pupils with disabilities
(4) A counseling system for pupils with behavior difficulties has been set up
(5) A broad range of support provisions have been implemented to increase participation of pupils with disabilities into mainstream education
(6) The role of parents was stressed
(7) Special schools have been developing into resource centers.

Pupils with disabilities are educated preferably in mainstream classes, but there is another choice of placement available i.e. special classes within mainstream schools or they can attend schools (special schools) founded for those pupils with special needs whose parents prefer this kind of school (EASNIE, 2009). Special educational centers also provides early intervention services by supporting children, parents, and family as well as providing necessary support to teachers. These centers provide their services under the “Decree 72/2005 Coll., on Providing Advisory Services in Schools and School Advisory Centers. In sum, it is worth to knowing that in Czech Republic there is a structure for early intervention and special education appropriate identification, early detection, assessment, and placement. There is a network of counseling institutions in the Czech educational system providing psychological and special pedagogical support and other services as well as diagnostic institution (EASNIE, 2009).

2.2 Government Policy/Legislation and Supports

Legislatively, early intervention is used to describe the years from birth to age 3, although the term early childhood special education or preschool special education has been used to describe the period of preschool years (ages 3-5) as described by the Individuals with Disabilities Education Improvement Act (IDEA), Part C, which addresses services for children from birth to age 3 and their families and section 619 of Part B, which covers services for children ages 3 through 5 (Bruder, 2010). The Education for All Handicapped Children Act of 1975 initially mandated services for children with disabilities (Lanzi, Ramey and Ramey 2007). Bruder (2010) further explained that in 1986, Public Law 99-457 was passed as amendments to IDEA (20 U.S.C. Secs. 1471 et seq.). This law mandated preschool services for children with disabilities and extended to them all rights and protection under IDEA Part B, (Section 619). In United States and other countries early intervention services and practices are mandated through federal legislation. Education for All Handicapped Act Amendments of 1986 provided additional funding for children aged 3-5 and funded the creation of a system of early intervention for children from birth through their third birthday. Early intervention services are currently funded by Part C (birth to 3 years) of the Individuals with Disabilities Education Act (IDEA) Amendments of 1997 (Lanzi, Ramey and Ramey 2007; Keilty, 2010). Most European countries have established social policies that exemplify early intervention, including progressive family policies concerning parental leave, childcare, home-health visiting and family support policies and programmes. The European social policy infrastructure includes income transfers, health care, housing assistance that provides a solid basis for supporting child and family services (Kamerman, 2000 in Lanzi, Ramey & Ramey 2007). Turnbull et al., 2007 in Bruder 2010, added that both Part C and Part B under the law recognize the importance of families through the provision of services.

2.2.1 Government Policy, Legislation and Supports of Early Intervention in Nigeria

Nigeria is a signatory to United Nations Edict on Human Rights and Child Right. The child has a right to be free, enjoy leisure and play, and be protected from harmful practices, violence, injury, and abuse. In agreement with this, Nigeria promulgated a decree in 1993 for the provision of clear and comprehensive legal protection and security for Nigerians with disabilities (Eskay, Onu and Igbo 2012). However, children and youth with disabilities are yet to be provided with necessary intervention services and programmes as well as free education as provided by the decree. Policy help in the formulation and implementation of special education programmes for children with disability in various countries (Eskay, Onu and Igbo 2012). In any democratic society, no programmes can be successful without a legal enforcement. As regards special education or early intervention for children or adults with disability in Nigeria, the only mandate comes from the Section 8 of the National Policy of Education. In other words, there is no legal mandate from the government to carry out the objectives enumerated in Section 8 of the National Policy on Education with regards to people with disabilities. This absence of legal mandate leads to civil rights violation and the lack of adequate programming (Eskay, Onu, Igbo, Obiyo and Ugwuanyi, 2012). Also, Ajuwon, (2008) in Eskay et al., (2012) pointed out that the absence of legal mandates to enforce special education programmes including early intervention perpetuate, negative societal perceptions of children and adult with disabilities. Ajuwon (2008) further contended that it is human knowledge that the lack of legal mechanism affects "(1) the knowledge of who should be served, why someone should be served, how a person should be served and where a person should be served; (2) procedural safeguards and due process rights; (3) non-discriminatory identification and assessment; (4) confidentiality of information; (5) individualized educational programming and intervention; (6) parental rights and responsibilities; (7) appropriate categorization, placement and instruction" (p.480). However, the practices of polices in the National Policy on Education are yet to be implemented and the objectives are not yet functional (Eskay, Onu, and Igbo 2012). As said earlier, Nigeria made a decree in 1993 for the provision of clear and comprehensive legal protection and security for Nigerians with disabilities. The backing of this, however is being resubmitted as a bill yet to be signed by the Senate even in the year 2011 (Eskay, Onu and Igbo 2012) and up to date.

More so, the policy document neither do not classified any criteria for personnel training nor co-ordination of its special education unit (Eskay, Onu and Igbo 2012), and has failed in the effective implementation and legal backup for children clinics for early identification, curative measures and medical care for children with disability as stated in the policy. This situation has led to the stagnation of special education/early intervention in Nigeria.

It is important to note that the lack of legal enforcement on 'National Policy on Education' and 'Nigeria and The Rights of the child' has impeded:

(i) special education progress;

(ii) early intervention services and programmes for children and adult with disabilities;

(iii) parental rights to due process are denied;

(iv) parents and professionals involvement in intervention services and programmes. Thus, making children and adults with disability to suffer as well as being treated as third class citizens.

However, due to the lack of enabling legislations, government is lacking in their support in early intervention/early childhood special education and towards parents and families of children with disabilities. The only evidence of budgetary allocation of 2% to UBEC but this fund hardly gets to appropriate agencies that should use it effectively for special needs provision (Ubani, 2012). Moreover, Ubani (2012) further opined that since nothing is happening in terms of providing/supporting early intervention services for children with disability in their early years, there is need to revisit existing policies in early childhood to accommodate and supports the interests and needs of children with disability.

2.2.2 *Government Policy/Legislation and Supports of Early Intervention in Czech Republic*

According to the EASNIE (2009) website, under country information, reported that in Czech Republic, the Parliament enacts laws on education and decides on the general principles of education policy. The Government and the Ministry of Education, Youth and Sports implement these principles into the national policy at the central government level. The Ministry of Education, Youth and Sports is in charge of the administration of education, youth issues and sports. However, the right for all children to be educated is enshrined in the Constitution of the Czech Republic (Ústava České republiky No 1/1993). The Constitution states that everybody is equal in accessing the law and according to the law. Everyone has the equal opportunity to receive education. Everyone also has the right to basic and secondary education free of charge. Also, one of the most important documents of a comprehensive character related to persons with a disability is the National Plan of Integration and Support of Persons with Disabilities for the period 2006 – 2008. This important document contains the main aims, tasks and principles for implementing the inclusion policy into practice concerning health, culture, social and educational policy. More so, a central document on education is the Long-term National Strategy of Development in Education which is discussed and approved by the government and then approved by the Parliament. The approved document is revised every two years. It is worth to note that from the European Agency report, education of children, pupils and pupils with special needs (disability) is a standard part of the mentioned strategic document.

Based on the Long Term National Strategy on Development in Education, each of the 14 regions in the Czech Republic are obliged to formulate their own Long-term Regional Strategy of development in Education for the particular region. Due to the Act on Sign Language that was approved in 1998 and with the amendments approved in 2008, the importance of sign language for the education of pupils with a hearing impairment as well as the use of other alternative communication systems including specific systems of communication for deaf-and-blind persons, was legally recognized and stressed. The Act guarantees the right to education for deaf children by means of sign language, guarantees the access to sign language interpretation for upper secondary level pupils, as well as the access to courses in sign language for parents of deaf children. Needless to say, using sign language in the education of pupils with hearing impairment was already a practice enshrined by the previous Act on Education No 29/1984 and its amendments.

The new Act on Education regulating the whole system of education in the Czech Republic was approved in September 2004 (which came in force in January 2005). This Act presents the definition of pupils with special educational needs and individual target groups - pupils with mental, sensory or physical disabilities, pupils with speech and language impairments, pupils with multiple disabilities, autism, pupils with specific learning and behavioral difficulties, chronically ill and socially disadvantaged pupils. There is also focus on the education of gifted and talented pupils.

The Act on Education guarantees that the support provisions and services required in supporting the access to education of pupils with special needs are to be available to children, pupils and/or pupils at all levels of education. Pupils with special needs have the right to be provided with adapted text books, with specific teaching materials, compensatory and rehabilitation equipment and tools as well as with support and counseling services, free of charge. The Act on Education guarantees that alternative communication and/or sign language will be available for those pupils who cannot profit from using oral language. Braille print is available for pupils who cannot read regular print. Additional staffs are available, as well as individual educational plans which describe the conditions necessary for successful learning when dealing with a pupil with special needs. The process of the education of pupils with special needs has the features of differentiation, individualization and adaptation tailored to meet the needs of pupils and their diversity. It is worthy of note in the report that the role of parents in the decision-making concerning the education of their child is crucial (EASNIE, 2009).

On government support, EASNIE, (2009) reported that Basic and secondary education is free of charge at schools registered by the conditions described in the Act on Education. The expenditure in connection with education is covered by the national budget. Also additional special needs of pupils are covered by the national budget. The financial resources are disseminated by the Ministry of Education, Youth and Sports to the regions according to the actual number of pupils – 'financial units'. Regions are obliged to re-distribute the resources including additional budget resources to support education of pupils with special needs to individual schools. Also, according to European Commission reports (2013), stating the supports of European countries given to their parents of children with disability, Czech Republic was listed to have supported parents through early intervention services and speech therapy, and systems whereby families can receive economic support and family counseling.

It is worth to note that Czech Republic through her Ministry of Labour and Social Affairs and according the law has financial support for families and parental allowance. For effectiveness on the part of Czech Republic government supports to children with disability and their parents, there is legislation enforcing early intervention service under Social Service Act No. 108/2006 Coll. (54) (Act retrieved from www.mpsv.cz).

2.3 Parents' Attitude and Involvement in Early Interventions in Children with Disabilities

Early parental reactions following the diagnosis of a child's with disability include ambivalence, anger, confusion, denial, self pity, blame, feeling of helplessness, depression, disappointment, grief, guilt, mourning, rejection, shock, impulses to kill the child and suicidal impulses (Mary, 1990; McConachie, 1986; Ntombela, 1991; in Govender, 2002). In agreement with this, Gupta and Singhal (2004) affirm that existing studies reveal that very often the parents have a negative attitude towards a child with disabilities. The parents are plagued with feelings of pessimism, hostility, and shame. Denial, projection of blame, guilt, grief, withdrawal, rejection, and acceptance are the usual parental reactions (Drew et al., 1984; Gupta and Singhal, 2004). Some parents also experience helplessness, feelings of inadequacy, anger, shock and guilt whereas others go through periods of disbelief, depression, and self-blame. The siblings also experience feelings of guilt, shame, and embarrassment (Frude, 1992; Gupta and Singhal, 2004). Thereafter, parents gradually enter an adaptation stage, when they begin to ask questions about what can be done, and finally, a reorganization stage, when they seek help and begin to plan ahead (McConachie, 1986; Drotar, Baskiewicz, Irvin, Kennell, and Klaus, 1975; Cunningham and Davis, 1985 in Govender, 2002).

According to Innocenti (2014), all children benefit from positive parenting behaviors that support early child development. As such, parent attitude and involvement is an important aspect of early intervention programmes for children with disabilities. Much interest has been on parents' attitude and their involvement during the early childhood period of their children (Gordon, 1977; Langenbrunner and Thornburg, 1980; Radin, 1972; Wardle, 1982; Zigler and Muenchow, 1992; in Gavidia-Payne and Stoneman, 1997). Also, Bennett (2012) explained that research has shown the importance and effectiveness of parental attitude and their involvement in early intervention programmes, but there is lack of research showing the effectiveness of programmes when there is lack of parental involvement, negative attitude and the impact it can have on the child development. However, the emphasis on parents' attitude and involvement has been continuous in programmes serving children and young children with disabilities or developmental delays, where family participation is considered to be an indispensable element of sound early intervention practices (Dunst, Trivette and Deal, 1988; Fewell, 1986; Slentz, Walker and Bricker 1989; in Gavidia-Payne and Stoneman, 1997). Parent positive attitude and involvement is one invariable factor and an integral part of the success of early intervention programmes for children with disabilities (Bennett, 2012). More so, parents' involvement has been conceptualized as either an outcome of early intervention programmes or as an independent (Gavidia-Payne and Stoneman, 1997, European Commission, 2013).

Bruder (1993) noted that intervention services for young children should be based upon the premise that the family is the enduring central force in the life of the child, and as such, any services should be provided according to the lifestyles, values, and priorities of the family. That is, each family brings unique resources to the task of parenting a child with disabilities, and these may vary according to cultural heritage, family structure and economic condition (Lynch and Hanson, 1992; Vincent and C Salisbury, 1988; Vincent, Salisbury, Strainn, McCormick and Tessier 1990 in Bruder, 1993). Cultural beliefs about disability play an important role in determining the way in which the parents and family perceives, behave and are involved in disability and the kind of measures it takes for early intervention, prevention, treatment and rehabilitation (Gupta and Singhal, 2004). Parents that have a positive attitude towards disability, commence intervention programmes early for their young children and toddlers with disability.

Thus, early intervention became an effective way of helping parents themselves to deal with their children disabilities. By so doing, parents get actively involved in the intervention process, so that they can discover their own possibilities and capacities. Parents' involvement can be aimed at the needs of parents to become competent as quickly as possible in caring routines, in skills for positioning, handling and treatment, and in child rearing (De Moor et al., 1993). Positive attitude of parents and their involvement in early intervention saves parents from the heavy burden of coping with the emotional problems on their own and it makes a valuable contribution to the acceptance process (De Moor et al., 1993). Moreover, right and positive attitudes like warmness, sensitivity, encouragement, affection, and caring from parents to children's with disability are often emphasized in early intervention because early parenting is more important in relation to later outcomes for children with a disability than for children without a disability (Innocenti, 2014). However, unless parents learn how to work effectively with their children, the gains accomplished in an early intervention programmes may not be maintained (Turnbull and Turnbull, 1996; in Lee, 2003). In order for early intervention programmes to be effective and the child to make improvements, the parents need to have positive attitudes and be involved, but this responsibility ultimately lies on the parents themselves (Bennett, 2012). One major step forward for current early intervention programmes is the effort to facilitate the parent's care giving behavior because of its importance for the development of the child (Sameroff and Fiese, 2000).

2.3.1 Parents' Attitude and Involvement in Early Interventions in Children with Disabilities in Nigeria

Today, it is a common practice to recognize how crucial it is to consider parents as partners in progress of intervention, treatment and education of children with disability. Professionals' view of the role of parents has changed dramatically from being negative to positive (Uyanwa and Tuoyo, 2009). The authors opined that professional also have recognized that parents have positive influence on the development of their children with disability, as such they demonstrate positive attitude and involve in early intervention, treatment, and education of their children. At first, the birth of a child with disability or at developmental risk has a profound effect on a family (Gatty and Janice, 2007 cited in Koleoso, 2012). Hence, making parents as well as family's develop negative attitude toward the child because such a child may require a large portion of the family time, attention, money and psychological support. However, some children with disability even as infants, sometimes process difficult temperaments which influence how parents respond to them (Brooks-Gunn and Lewels; Mohoney and Robehalt; in Uyanwa and Tuoyo, 2009). According to Gearheart and Wershan (2001) in Koleoso (2012), parents influence the early developmental relationship, language, interest, skills, and other behaviors of their children. Likewise, parents' attitude can also bring a total damage to early developmental process of their children's when unpleasant attitude is display to such a child (Koleoso, 2012). The degree of involvement of parents in their children's early intervention provides more progress than less involvement. Thus, parents influence almost every aspect of the child's total experience and usually develop consist pattern of behavior with their children, i.e. the child usually know what to expect from parent in different situations. More so, parents and families contribute as much as other professionals involved in early intervention services of their children or even contribute more when positive attitude is involved. For early intervention practice to be effective or successful, parents positive attitude and involvement is important for the child, therefore making them feel safe, meeting their basic needs of love, food, shelter, clothing, as well as preparing the children's with disability to become future participants in the society (Koleoso, 2012).

According to Mukuria & Obiakor, (2004), in Eskay, Eskay, & Uma (2010), stated that a closer examination of parental involvement and due process reveals the urgency for a fundamental policy shift to facilitate successful collaboration between policy makers, professionals, parents of children with disability. Many Nigerian parents' voices continue to be silenced and excluded from their children's life, intervention and education. In accordance with this, Ozoji (2005) stated that in Nigeria, parents' involvement is limited because parents hardly influence the education of their children, and parents of children with disability are more worsen in attitude and their involvement in intervention programmes for their children is minimal. He further stressed that the major problem is that many parents are insufficiently aware of the role of early intervention in equalizing opportunity for children with disability.

Also, society is yet to view programmes for children with disability with positive attitude and the training of enough experts who will implement such programmes for their children are lacking as such, parental involvement equally just ends with information passed on as some parents are ignorant of what to do or intent to do (Onu, 2008 in Eskay, et al 2012; Eskay, Onu, & Igbo 2012). The Nigerian scenario is pathetic as most parents do not know their rights and hence might not be able to insist on due process (Eskay, Onu, & Igbo 2012). Thus, parents may not know when inappropriate placements and intervention services are given to their children as well as not knowing how, where and when to litigate to enforce their rights. Ozoji (2005) noted that the absence of clearly defined intervention and guidance programmes for parents are lacking as such, negative attitudes are perceptibly wide spread. Lack of parents' awareness and the uncertainty of parents of the influence of early intervention of their children lead many parents to place early intervention programmes far from the top of priority list and by so doing looking for fast healing solution for their children with disability. However, most parents are interested to assist or involve in their children with disability if they are told what is involved and having necessary support available for early intervention of their children (Ozoji, 2005).

2.3.2 Parents' Attitude and Involvement in Early Interventions in Children with Disabilities in Czech Republic

According to Jeřábková, (2013), until 1990 in the area of care for children and persons with a disability, segregation tendencies prevailed in the Czech Republic. Michalík (2006) in Jeřábková, (2013), said that there was a society wide pressure on families to which a child with disability was born into. However, after 1990 the situation began to change little by little whereby families of children with severe disabilities begins to take care of their children and parents later pushed toward introducing an integrative education of their children (Jeřábková, 2013). The reaction of parents to the birth of a child with disability remains the same as experienced by other parents in many part of the world. Vágnerová (2004) in Jeřábková, (2013) affirms this by categorizing parents' reactions into shock, denial, gradual acceptance and coping with the problem, to bargaining. More so, numerous studies have documented the strain on parents raising a child with a disability. Parents of children with disability often report feelings of isolation and high levels of stress, with several studies pointing to an increase in depression. The stress of having a child with disability can challenge family functioning through exerting pressure on parental well-being, the well-being of siblings and other relatives, spousal relationships, extra-spousal support, and negative effects on parenting behavior (European Commission, 2013). Parental responsiveness and sensitivity are necessary for children with disability to develop secure attachments, yet these are liable to be compromised by the stress exerted on some parents. The time-intensive nature of the care required by many children with disability also presents an inherent risk of parental burn-out. Providing support to parents with children with disability is therefore vital to both the flourishing of the child and of the family as a whole (European Commission, 2013). Nowadays, parents attitude has gradually changed to a positive and encouraging one that give birth to many seeking for the right services that will help their child's with disability as earlier as possible. But it is notable that the beginnings of early intervention in the form of work of volunteers were not the response to the pressure from parents, nor the response to the needs that they expressed. The parents were told by the government that the care of their children with disability will be completely in the hands of experts, but only from the age of entering a kindergarten (Hradilková and Vachulová, 2000). Hence, they develop the right attitude and they are involved in the early intervention of their children.

State Role in Family Functioning in Czech Republic

According to Sed'ová (2007), a number of original functions of the family have gradually shifted to the state. The family policy of the Czech Republic continues to be characterized by a high degree of redistribution of resources. The basis of this policy is the family allowance, varying in the amount of money according to family income and drawn by an overwhelming majority of families with dependent children. Sed'ová (2007) reported that each woman is entitled to a maternity leave of twenty-eight weeks after the birth of a child, drawing 68 percent of her previous wages during this period. Maternity leave is followed by parental leave, which can be drawn by the mother or the father up to 3 years of age of the child. More so, Sed'ová (2007) further explained that the parent draws a fixed allowance of approximately 20 percent of the average wage during this period. If the parent does not insist that he/she will be able to return to her/his initial work position, he/she may draw the allowance until the child is 4 years old. Maternity and parental leave in combination are very long when compared with other European countries or Africa. However, most parents are taking advantage of this long parental leave offered by the state to provide their child's full-time care up to 3 years of age (Sed'ová 2007).

Family Involvement in Early Childhood in Czech Republic

In the Czech Republic, family is regarded the basic, natural, and the most crucial environment for a child at an early age. Majority of children remain at home, cared for by the mother or another member of the family (Rabušicová, 2007). She further stressed that the family policy of the state make this possible through a long maternity/parental leave lasting until the child is 4 years old. Also, various religious and private initiatives and activities on nongovernmental organisations offer parents, mainly mothers' different opportunities for spending time with their children within a group, with the support of expert (Rabušicová, 2007). Beyond the different debates about the appropriateness of this "family" arrangement are discussions surrounding the issue of equal opportunities for women and men, support to family as such, and the development of the demographic situation characterized by a low birth rate (Rabušicová, 2007). However, the prevailing opinion today in the Czech Republic is that a close bond between the child and the mother is the most crucial element for the development of a very young child (Rabušicová, 2007)

2.4 Theoretical Framework/Perspectives

In describing the practices of a successful early intervention for children with disability, many frameworks has been developed to guides this practice. These frameworks have emerged from developmental ecology, developmental-psychoanalytic perspective, behavioral and educational perspectives, and neurobiological bases. However, for the purpose of this research, the transactional model of intervention under transactional regulation (developmental ecology), Guralnick's early development and risk factors model and Dunst and Trivette's resource-based approach both under behavioral and educational approaches will be employed as the theoretical frameworks that guide this research.

2.4.1 Transactional Model of Intervention

The transactional model assumes that the nonlinear premise that continuity in individual behavior is a systems property rather than a characteristic of individuals provides a rationale for an expanded focus of intervention efforts (Sameroff & Fiese, 2000). In accordance with this model, changes in behavior are the result of a series of interchanges among individuals within a shared system following specifiable regulatory principles (Sameroff & Fiese, 2000). The authors further explained that targets can be indentified that minimized the necessary scope of the intervention while maximizing the cost efficiency. In some cases, little alterations in child behavior may be all that is necessary to re-establish a well regulated developmental system. While in another cases, changes in the parents' perception of the child may be the most strategic intervention. However, in cases that requires improvements in the parents' ability to take care of the child (Sameroff and Fiese, 2000), the three Rs of intervention, remediation, redefinition and reeducation respectively (Sameroff, 1987 in Sameroff and Fiese, 2000) are used to improve the parents ability in early intervention.

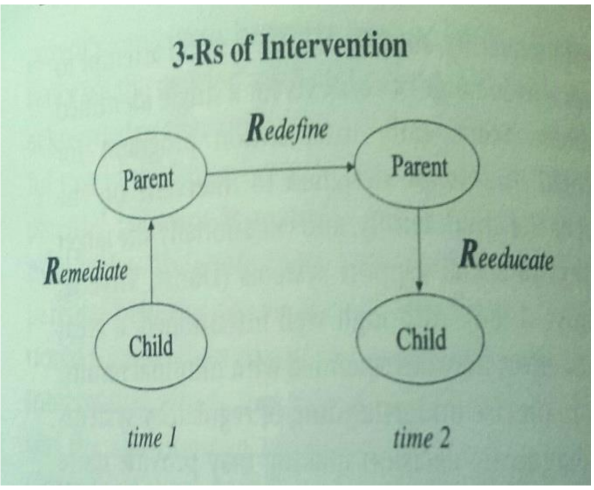

Figure 1: The 3-Rs of early intervention within a transaction model. Adapted from Sameroff, A.J. and Fiese, B.H. (2000, p.150) in Shonkoff, J.P. and Meisels, S.J. (Eds) Handbook of Early Childhood Intervention. 2nd ed. Cambridge University Press USA.

As shown in figure 1 above (upward arrow), remediation changes the way the child behaves toward the parent. The intervention aim is to fit the child to preexisting care giving competence that could operate adequately, given appropriate infant triggering responses (Sameroff and Fiese, 2000). In remediation, the implementation is outside the family system by a professional whose aim is to change an identifiable condition of the child. However, once the child's condition has been altered, the intervention is complete (Sameroff and Fiese, 2000). Also, the authors explained second R-redefinition as changes in the way parents interprets the child's behavior (Figure 1 horizontal arrow between parent's time1 and time2). Hence, redefinition strategies are directed primarily toward the facilitation of more optimal parenting interactions through an alteration in parental beliefs and expectations (Sameroff and Fiese, 2000). They also opined that redefinition is warranted when the parents have defined the child as abnormal and are unable or unwilling to provide normal care-giving. It is worth to note that the difficulties in care-giving could arise from a variety of sources which include a failure of parents to adapt to a disabling condition in the child, failure of parents to distinguish between their emotional reactions to the child and the child's actual behavior and maladaptive patterns of care that extend across generation (Sameroff and Fiese, 2000). According to the authors, reeducation as the third R as shown in figure 1 (downward arrow), changes the way parents behaves toward the child. Also, reeducation teaches the parents how to raise their children. Typically, reeducation interventions are aimed at the practicing aspect of the family ways. Therefore, these interventions focus on the immediate and momentary exchanges between parent and child that are associated with optimal development (Sameroff and Fiese, 2000).

In this framework, it is assumed by the authors that once parents have the requisite knowledge about their child's behavior, care-giving will proceed to facilitate development.

2.4.2 Guralnick's Early Development and Risk Factors Model

Wolery, (2000) reported that Guralnick (1997, 1998) presented a model that links factors influencing early childhood development to the components of early intervention programmes. This model proposes to connect programme features, child and family characteristics and outcomes (Guralnick, 1997 in Wolery, 2000).

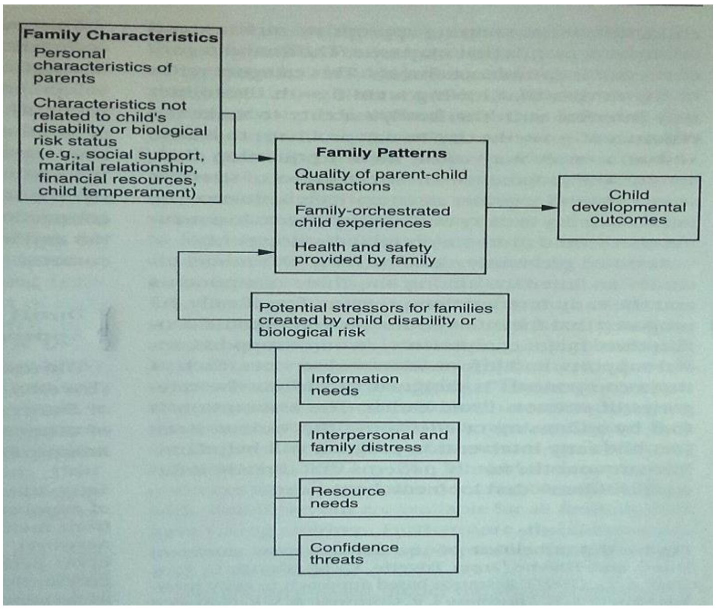

Figure 2: Guralnick's model of factors influencing children's developmental outcomes. Adapted from Guralnick, M.J. (1998, p324) Effectiveness of Early Intervention for Vulnerable Children: A Developmental Perspective. In AJMR, Vol. 102, No. 4. Also, Wolery, M. (2000, p193) Behavioral and Educational Approaches to Early Intervention. In Shonkeff, J.P. and Meisels, S.J. (Eds). Handbook of Early Childhood Intervention. 2nd ed. Cambridge University Press.

In this model, Guralnick (1998) ascertained that the experiential factors govering the course of child developmental outcomes can be divided into three sets of family patterns of interaction: the quality of parent-child transactions, family orchestrated child experiences, and health and safety provided by the family (as shown in figure 2 above). Guralnick further explained that for parent-child transactions, the dimensions and characteristics of family interaction patterns that appear to support optimal development include responding contingently, establishing reciprocity, providing affectively warm and nonintrusive interactions, appropriately structuring and scaffolding the environment, being discourse-based, and ensuring developmentally sensitive patterns of caregiver-child interactions (Baumrind, 1993; Clarke-Stewart, 1988;

Dumas & LaFreniere, 1993; Hart & Risley, 1995; Lewis & Goldberg, 1969; Pratt, Kerig, Cowan, & Cowan, 1988; Wachs, 1992; Wachs & Gruen, 1982; in Guralnick, 1998).

Also, the second family pattern of interaction governing child developmental outcomes consist of children's experiences with the social and physical environment that are orchestrated by family members, primarily parents and these includes the variety and developmental appropriateness of toys and materials provided, general stimulation value of the environment, and the frequency and nature of contacts with other adults and children that occur through parent-based friendship and family networks or alternative care arrangement (Guralnick, 1998). Lastly, Guralnick opined in the last stage of family pattern of interaction that parents are directly responsible for ensuring the general health of and establishing a safe environment for their child as such, obtaining immunizations, providing adequate nutrition, and protecting child from violence.

However, Wolery (2000) said that the family patterns, do not occur in a vacuum but they are influenced by two other components of the model that is the family characteristics and the potential stressors. The family characteristics component includes two broad contextual factors: the personal characteristics of the parents and the characteristics of the child that are not related to his/her disability. Hence, family characteristics occurs within the context of historical and current events and conditions (Wolery, 2000), such as degree of depression, level of education, intergenerational parenting experiences including cultural expectation, while characteristics not related to the child's disability or risk status includes quality of the marital relationship, child temperament, available supports that include family resources and social support networks (Guralnick, 1997, in Wolery, 2000).

According to Wolery's report, potential stressors due to the child's disability may interfere with family carrying out the family patterns. Therefore, Guralnick (1997) cited in Wolery (2000) classified these potential stressors into four. These includes: information needs that arise as a result of the child's disability (i.e. parents may have needs some areas that include basic information about their child's diagnosis and prognosis, information about how to interact with and care for the child, etc.), interpersonal reactions and family distress that may occur as a result of the child's disability (i.e. potential for marital problems, negative reactions of individuals outside of the family, and difficulties related to caring for the child), resource needs (i.e. demand on parents' energy and time to care for the child difficulties securing appropriate services and financial demands), and confidence threats implies the notion that having a child with disabilities may interfere with the family day-to-day problems that arise and as a result may cause them to question their actions and judgments (Wolery, 2000).

This model suggested that intervention programme should contain three major components which are resource supports, social supports, and information and services (Guralnick, 1997; Cited in Wolery, 2000). Wolery added that these components are designed to address the stressors. By addressing the stressors, early intervention programmes will help families carry out the family patterns that directly influence children's developmental outcomes.

2.4.3 Dunst and Trivette's Resource-Based Approach

According to Wolery (2000), resource-based approach to early intervention (Trivette, Dunst & Deal, 1997) grew from the work of Dunst and his colleagues as well as the research of others investigators. He wrote that Dunst drew on a number of literatures and defined early intervention as follows: Early intervention is the provision of support to families of infants and young children from members of informal and formal social support networks that impact both directly and indirectly upon parental, family and child functioning. However, Dunst and his colleagues conducted a substantial research based on this definition and thus, led to the resource-based model as shown in figure 1.3 below.

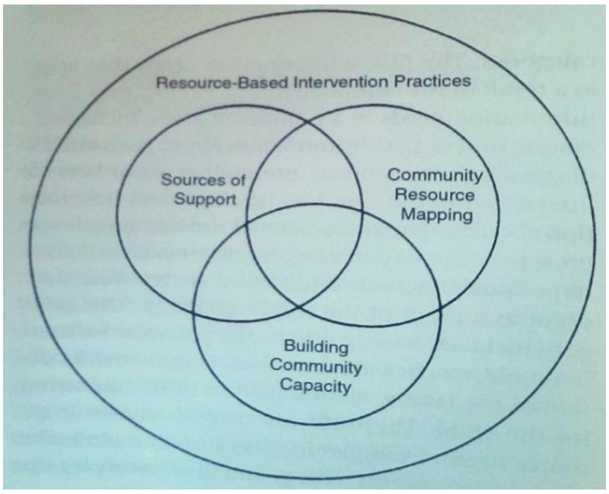

Figure 3: Resource-Based Model of Dunst and Trivette. Adapted from Wolery, M. (2000, p.194). Behavioral and Educational Approaches to Early Intervention. In Shonkoff, J.P. and Meisels, S.J. (eds). Handbook of Early Childhood Intervention. 2nd ed. Cambridege University Press, USA.

The resource-based model of early intervention along side with the definition of early intervention assumes that families and children are embedded within a number of influential ecological systems, and families as well as communities have assets and strengths (Wolery, 2000). Dunst, (1985) as reported by the author, stated that the model seeks to promote the use of those strengths hence placing emphasis on developing partnerships with families as contrasted to promoting paternalism and on empowering families to make decisions and be independent of early interventionists as compared to professionals making decisions and usurping the family's role in determining their own paths of actions. More so, this model recognizes how support and assistance provided is highly related to perceptions of how effective it is and specially how the helping relationship is established will predict how useful that help was (Dunst et al., 1994 in Wolery, 2000).

The resource-based model has three components as indicated in figure 3 above. These are sources of support, community resource mapping and building community capacity. Source of support, Trivette et al., (1997) in Wolery, (2000) enumerated four categories which are social network members (e.g. persons from whom the family seeks assistance, guidance, and nurturing), associational groups (e.g. range of potential community organizations such as church groups, civic events, service clubs etc.), community programme and professionals (e.g. child care programmes, hospitals, employment agencies, medical services, etc.), and specialized services (e.g. services designed specifically for families, children, or both such as mental health agencies, specialists, referral services, etc.). These four categories sources of support are commonly associated with early intervention programmes (Wolery, 2000). Community resource mapping involves identifying the various kinds of resources that exist in a given neighborhood, village, and county and also, identifying the location of each resource, hence serves as a source from which families of children with disabilities can find and access resources they deem important (Trivette et al., in Wolery, 2000). Building community capacity recognizes the strengths and assets of a community (Trivette et al., in Wolery).

Wolery noted that Trivette et al. recommended a three-step process used in building community capacity: "1) identifying the strengths of community people and groups, 2) demonstrating how these strengths addresses child and family desires, and 3) eliminating barriers through use of other resource" (p.196). Thus, this model relies more on assisting families in addressing their priorities in the context of their existing and potential relationships with available and accessible community resources and sources of support.

2.5 Summary

Summarily, early intervention as opined by Chen, (2014), is to promote the development and learning of very young children by helping their families identify and put into practice ways to support their healthy growth. Also, early intervention helps to provide support and assistance to family as well as maximizing the child's intervention and family's benefit to the society at large. As such, failing to commence interventions as early as possible is seen as missing an important opportunity for learning and influencing early brain development. As well said by many authors in the literatures reviewed, early intervention help to reduces the effects of disabilities or prevents the occurrence of learning and developmental problems later in life as well as nurtured, promote health and development. By so doing, it prepared the children with disability to participate as adults in the economic life of their communities.

In Nigeria, there is no structure in place for early detection and identification of children with disabilities as well as early intervention at the governmental level. There is yet to be a law that separates early intervention, special education services from vocational and rehabilitation services. Also, there is no appropriate funding of early intervention programmes for children with disability, making all responsibilities to be on their parents and families. Due to lack of enabling laws/legislations, government is lacking in their support in early intervention for children, parents and families of children with disabilities. Majority of the parent show negative attitude, which in turn influences the early developmental process of their children. But parents with positive attitude help to influence their children early developmental relationship, language, interest, as well as other behaviors. Parents' involvement is limited because of lack of awareness and the uncertainty of the influence early intervention services/programmes can be on their children.

In Czech Republic, care for children and persons with disabilities is on state level ensured by three different ministries, ministry of health, ministry of labour and social affairs, and ministry of education, youth and sports. Early intervention practice and support is guided with a Social Service Act no. 108/2006, thus making the practice legalized. The government has supported parents through early intervention services and systems whereby families can receive economic support and family counseling. Formally, the Czech parents had negative attitude due to the challenges of having a child's with disability posed on family functioning. Recent times, parents' attitude has gradually changed to positive and encouraging one that gave birth to seeking for the right services as early as possible for their children. These changes came as a result of the government taking over the care of their children with disabilities coupled with the family policy that gives more privilege to parents to provide their child’s full time care up to 3 years of age with a steady family allowance.

However, as a matter of urgency, Nigeria government need to develop enactment Federal laws/legislation aimed at young children with disabilities and their families, and providing necessary support needed for early intervention to parents, families and all concerned bodies as regard to early intervention of children with disabilities. Parents as well need to accept their children’s disabilities and seek for intervention appropriate to the child needs and disability. Also, the society needs to be oriented on the important of early intervention for all children with disabilities at birth to seven years of life. This will help to change their views and perceptions on children and persons with disabilities in the society.

It is worth to note that this research seeks to bring to limelight the usefulness of enabling government policy, legislation, supports and positive attitude for the practice of early intervention of children with disabilities in Nigeria. And to emulate what is obtained in the practice of early intervention in Czech Republic. Having noticed what makes the practice of early intervention effective in Czech than Nigeria, it is necessary for the researcher to examine and further describe the parameters needed for an effective implementation of early intervention in Nigeria in her doctoral study.

PRACTICAL PART

Chapter 3 Research Design/Methodology

3.1 Research Purpose

This study considers it worthwhile to examine and describe the early intervention of children with disability in Nigeria to what is obtainable in Czech Republic. The purpose is to increase awareness on the usefulness of the government enabling policy, positive attitudes and effective practice of early intervention as a means of prevention for children with disability. This study specifically seeks to:

(1) Describe the differences and the effective practice of early intervention for children living with disability.
(2) Describe the discrepancy and similarity of government policies and supports to parents and family of children with disability in both countries.
(3) Propose some useful strategies on how to effectively develop and implement early intervention practice for children with disability in Nigeria.
(4) Identify the effect of parents' attitude towards early intervention for children with disability in Nigeria and Czech Republic.

3.2 Research Questions

To be more precise in this study, the following are used as research questions.

(1) Are there any differences in the practice of early intervention for children living with disability in Nigeria with that of Czech Republic?
(2) Are there any significant differences in government policies and support for early intervention practice for children with disability between Nigeria and Czech Republic?
(3) Is there any difference between the attitudes of parents in Nigeria to that of Czech Republic in early intervention of their children with disability?

3.3 Research Methods

In this study, three methods are combined for successful completion. These include: literature review, questionnaire and unstructured interview. This study firstly began with informal and unstructured interviews before the questionnaire was constructed to collect the main information about early intervention practice, government policy and support, and parents' attitude in early intervention of children with disability. The questionnaire items was developed and constructed based on the information gotten from the recorded and oral conversations of the interview. Thereafter, a pilot study was conducted in Nigeria to examine the clarity and validity of the questionnaire. Following this, formal questionnaire survey was implemented in several locations (Local Government Areas and States) in Nigeria and Czech Republic.

3.4 Research Instruments

The major instruments used to source for data in this study were questionnaire and unstructured interview. Two questionnaires were designed to investigate and describe early intervention practices as well as government policy, support, and parents' attitude towards children with disabilities. The first questionnaire was designed for professionals in the practice of early intervention for children with disability in order to provide information about parents' attitude and government, while the second questionnaire was designed for parents of children with disabilities. However, the informal and unstructured interview was directed at directors (these are key persons for the responsibilities of special education in each states) of special education in the states, Principals of special education centers and teachers in primary special education centers (centers that provides educational needs for children with disability).

3.5 Data Collection and Analysis

3.5.1 Interviews

In order to get accurate information about the topic under research, an unstructured interview was used. This was done by asking a general question on early intervention practices in Nigeria. The participants provided elicit views and opinions that form the bases for the formulation of questions used as questionnaire in this study. The recorded interview and written conversation were transcribed after listening to the audio recording. It is worthy to note that all draft transcripts were discussed and corrected by the researcher's supervisor and other professionals. However, due to limited time and language barriers, the interview was conducted fully only in Nigeria but with the help of the researcher's supervisor (face to face discussion), necessary information about the practice of early intervention was acquired to form the bases for Czech Republic interview.

3.5.2 Questionnaires Survey

The questionnaires in this study comprised of two parts. The first part contained the bio-data of respondents while the second part focused on items that relate to early intervention practices, government policy and support, and parents' attitude. For both questionnaires i.e. professionals and parents questionnaires, a five-point Likert five-point scale was utilized. The questionnaire was written in English and transcribed to Czech language. The English questionnaire was administered in Nigeria while the Czech version was administered in Czech Republic, both to professionals in early intervention for children with disabilities and parents of children with disabilities. The questionnaire was scored and data collated from the Likert scale was used in describing the questions. The simple descriptive statistical analysis was used in data analysis.

3.6 Participants

The participants in this study were mainly professionals involved in the practice of early intervention for children with disability and parents of children with disability in Nigeria and Czech Republic. In Nigeria professionals, 63% (34) of the participants were female while 37% (20) were male. For parents, 41% (16) were male while 59% (23) were female. In Czech Republic professionals, 62% (25) of the respondents were female while 38% (15) were male. For parents, 35% (8) were male while 65% (15) were female.

3.7 Validity and Reliability of the Instrument

3.7.1 Validity of Instrument

The draft of the research instrument was subjected to face and content validation by the researcher's supervisor. Face validation prove that the questions showed appropriateness of measures in terms of its general appearance. Content validation refers to how much a measure covers the range of the meaning included within a concept (Babbie 2010). The necessary corrections, discussion and modification were made before final approval and the pilot study conducted for this study. Validation of the instrument was necessary so that items will ensure that it measured what it supposes to measure.

3.7.2 Reliability of Instrument

To measure the reliability of the instrument for this study, the split half method of estimating reliability was used. Here, each questionnaire items were randomly assigned into two sets, and were scored separately and correlated to obtain an index of its reliability using the Spearman-Brown formula. The correlation co-efficient obtained was 0.85, thus, indicating a high correlation. This means that the instrument for this study was reliable as a result obtained from the correlation.

Chapter 4 Interpretation of Data and Results

The collated data was analyzed using the descriptive statistics for both Nigeria (hereafter NGA) and Czech Republic (hereafter CZ) professionals and parents and thus shown in graphs.

4.1 Graphs and tables showing the items and responses on the practices of early intervention for children with disability in NGA.

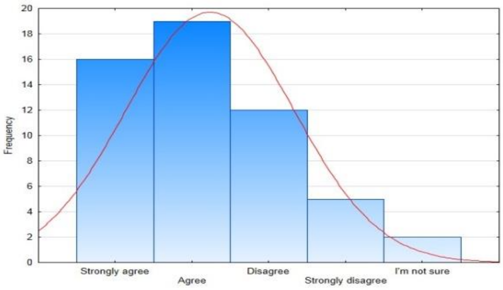

Figure 4 Early interventions (hereafter E.I) obtainable in NGA

	Mean responses	Standard deviation
Item 1	3.00	1.37

Table 1

From figure 4 above, it is not difficult to find out that the practices of E.I were not obtained by both respondents. Because overwhelming majority of the respondents, responses agree and strongly agree as analyzed in the simple descriptive data. Also, the average mean score of item 1 is 3.00 with a standard deviation of 1.37 as shown in table 1.

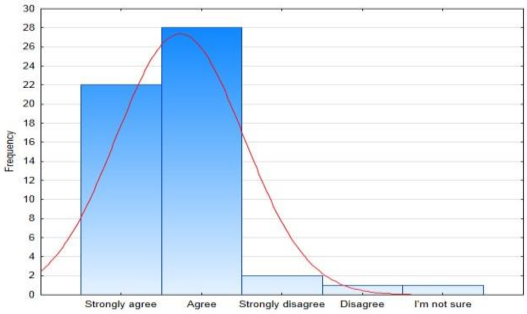

Figure 5 Minimal existent of E.I practice in NGA

	Mean responses	Standard deviation
Item 2	3.00	0.89

Table 2

In this analysis as shown above in the descriptive data (figure 5), the practice of E.I is at minimal existent in the country, due to the responses agree and strongly agree of the respondents. And the average mean score for item 2 is 3.00 with a standard deviation of 0.89 as shown in table 2.

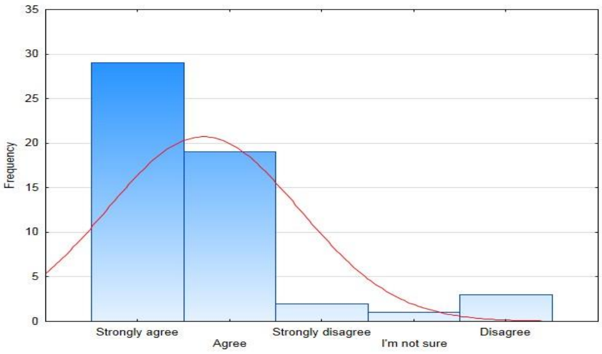

Figure 6 Government involvements in the practice of E.I NGA

	Mean responses	Standard deviation
Item 8	4.00	1.02

Table 3

According to the descriptive data above, majority of the respondents responses strongly agreed and agreed. This is in accordance to the fact that government involvment in the practice of E.I is minimal. Having a mean score of 4.00 with standard deviation of 1.02 as shown in table 3.

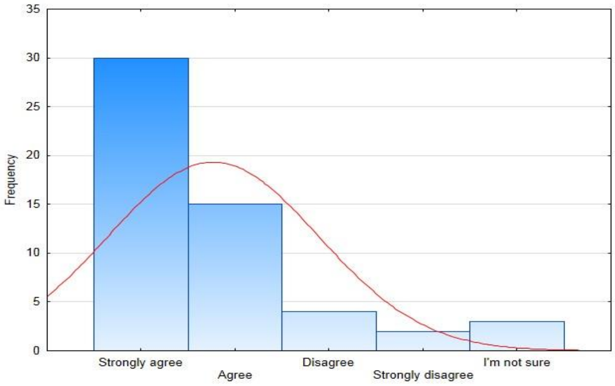

Figure 7 Practice of E.I as family matters in NGA

	Mean responses	Standard deviation
Item 13	4.00	1.10

Table 4

Considering item 13 represented by figure 7, that seeks to know if the practice of E.I is limited to the family. Majority of the respondents' responses strongly agreed and agreed. This shows that the practice of E.I for their children with disability is a family matter. Thus, with an average mean score of 4.00 and standard deviation of 1.10 as shown above in table 4.

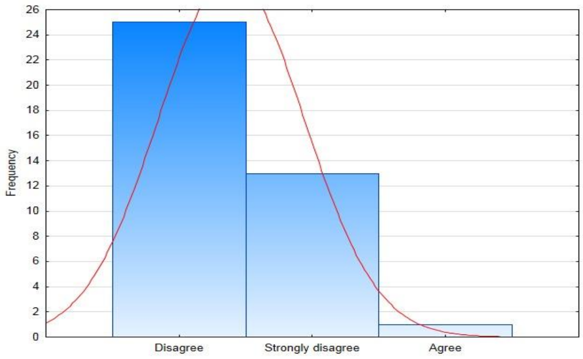

Figure 8 Adequate resources for E.I practice in NGA

	Mean responses	Standard deviation
Item 14	1.00	0.60

Table 5

From the descriptive data as shown in figure 8, it is apparent that majority of the respondents disagreed and strongly disagreed, indicating that the resources for the practice of E.I is not adequate. Having a mean score of 1.00 with a standard deviation of 0.60 (see table 5).

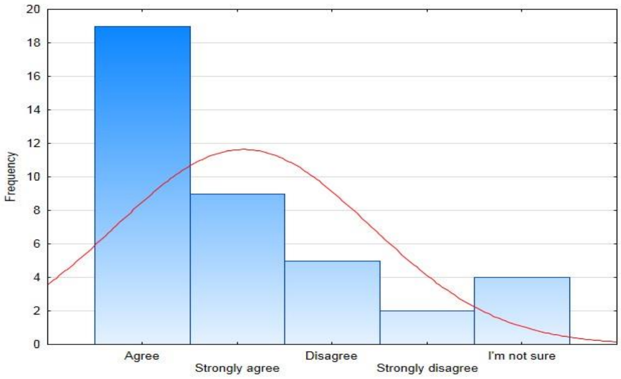

Figure 9 Accessibility of resources for E.I practice in NGA

	Mean responses	Standard deviation
Item 15	3.00	1.12

Table 6

Majority of the respondents agreed and strongly agreed that the accessibillity of the resources for E.I practice is restricted as shown in figure 9 and with a mean score of 3.00 and standard deviation of 1.12 in table 6 above.

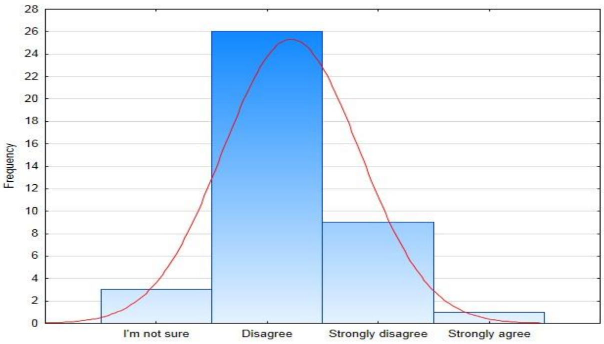

Figure 10 Availability of children clinic for E.I practice in NGA

	Mean responses	Standard deviation
Item 17	1.00	0.74

Table 7

Figure 10 above is representing item 17 on parent questionnaire which seeks to know if children clinic for identification/E.I practice is available. The majority of the respondents responses centered on disagree and strongly disagree indicating that such children clinic are not available as shown in figure 10. The average mean is 1.00 with a standard deviation of 0.74 (see table 7).

4.2 Graphs and tables showing the items and responses provided on government policy, legislation, and support for early intervention of children with disability in NGA.

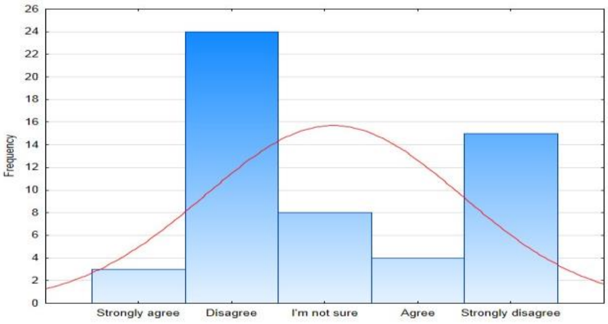

Figure 11 Legal supports for E.I in NGA

	Mean responses	Standard deviation
Item 3	1.00	1.10

Table 8

From figure 11, the data shows that majority of the respondents centered on disagree and strongly disagree, indicating that the country do not have a legal support for early intervention. Hence, having a mean score of 1.00 with a standard deviation of 1.10 as indicated in table 8.

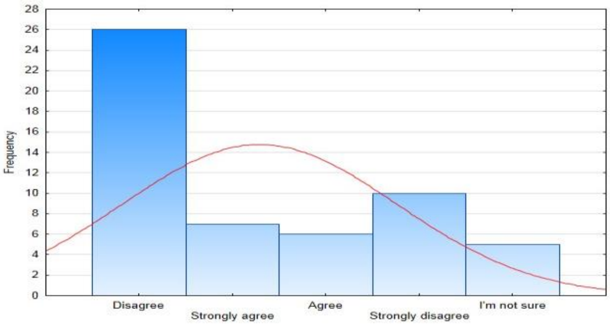

Figure 12 Genuine policies for E.I in NGA

	Mean responses	Standard deviation
Item 4	1.00	1.28

Table 9

It’s apparent that majority of the respondents disagreed. This shows that the legislature/policy available is not genuine. The average mean of the data is 1.00 along side with a standard deviation of 1.28

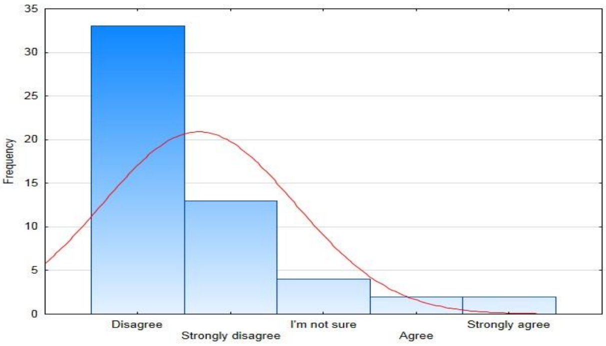

Figure 13 Satisfaction of legal support for E.I in NGA

	Mean responses	Standard deviation
Item 5	1.00	0.90

Table 10

The average mean for item 5 is 1.00 with a standard deviation of 0.90 (see table 10), indicating that responses have been centered on disagreed to strongly disagreed (see figure 13), which mean that respondents were not satisfied with the legal support in caring for children with disability.

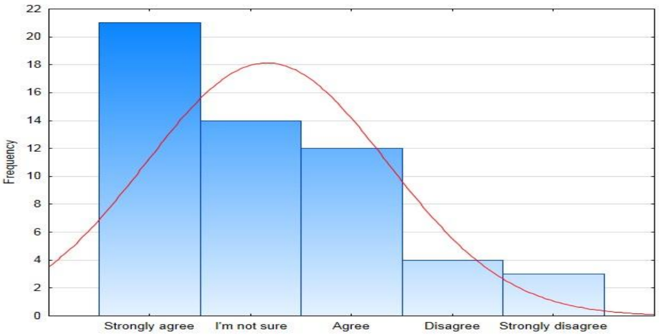

Figure 14 Government priorities in policy/legislature for E.I in NGA

	Mean responses	Standard deviation
Item 6	3.00	1.20

Table 11

Figure 14 represents item 6 used to seek information whether the priority of government is minimal or not in the implementation of policy/legislature for early intervention. The majority of the respondents responses centered on strongly agree to agree (figure 14). Indicating that the government priority is at minimal to such support with a mean score of 3.00 and 1.20 of standard deviation (see table 11).

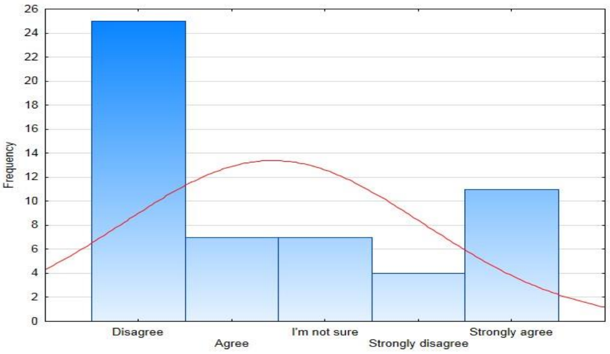

Figure 15 Enhance policies of government for E.I in NGA

	Mean responses	Standard deviation
Item 7	1.00	1.32

Table 12

In accordance with the descriptive data in figure 15, majority of the respondents responses centered on disagree with a mean score of 1.00 and 1.32 of standard deviation (see table 12). Thus shows that the policy does not enhance early intervention for children with disability.

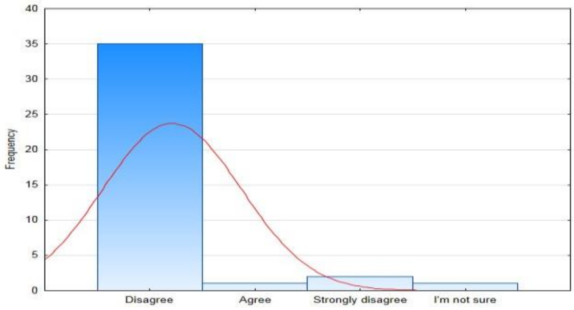

Figure 16 Health care supports for E.I in NGA

	Mean responses	Standard deviation
Item 8	1.00	0.43

Table 13

In figure 16 above, almost all the respondents responses centered on disagree. The average mean score is 1.00, with a standard deviation of 0.43 as shown in table 13. Indicating that there is no health care support provided by the government for early intervention of children with disability.

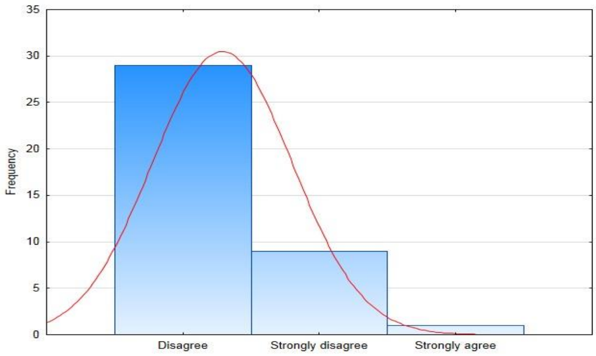

Figure 17 Government financial supports for E.I in NGA

	Mean responses	Standard deviation
Item 9	1.00	0.67

Table 14

Almost all the respondents reported that they do not receive any financial support from the government as responses centered on disagree and strongly disagree as shown in figure 17. Having a mean score of 1.00 and a standard deviation of 0.67 (see table 14).

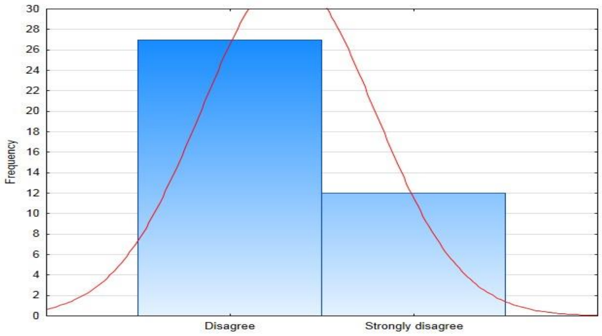

Figure 18 General supports from government for E.I in NGA

	Mean responses	Standard deviation
Item 10	1.00	0.47

Table 15

Obviously, it is notable that all respondents responses centered on disagree and strongly disagree as shown in figure 18 above. Thus, having an average mean score of 1.00, with a standard deviation 0f 0.47. This means that from birth (0 year to 3years) no necessary care/support was given to parents and their families of children with disability.

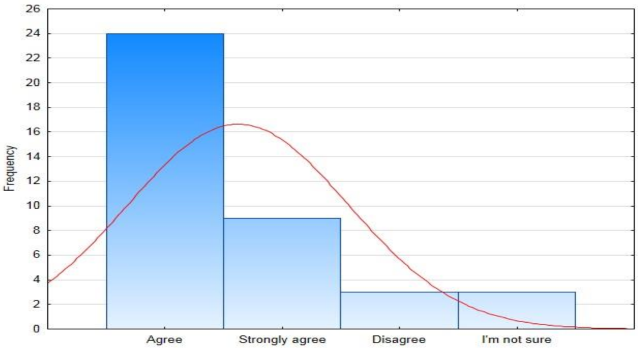

Figure 19 Substitution of resources for E.I in NGA

	Mean responses	Standard deviation
Item 16	3.00	0.79

Table 16

For detailed information on government support, item 16 seeks to find out if there was substitution of resources needed for early intervention with edible items. Majority of the respondents responses centered on agree and strongly agree (see figure 19), showing a mean score of 3.00 and standard deviation of 0.79 (see table 16). This indicates that most resources were substitute and thus presented as gift to them from the government.

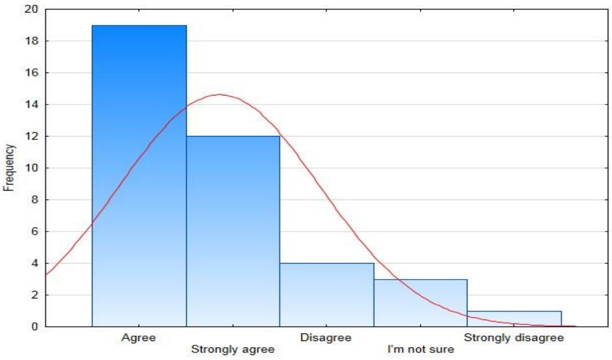

Figure 20 Attitude of government in support of E.I in NGA

	Mean responses	Standard deviation
Item 19	3.00	1.02

Table 17

From figure 20, the descriptive data shows that majority of the respondents responses centered on agree and strongly agree, with a mean score of 3.00 and 1.02 of standard deviation (see table 17). Indicating that nonchalant attitude of government toward support of early intervention is increasing.

4.3 Graphs and tables showing the items and responses on parents' attitude in early intervention of children with disability in NGA.

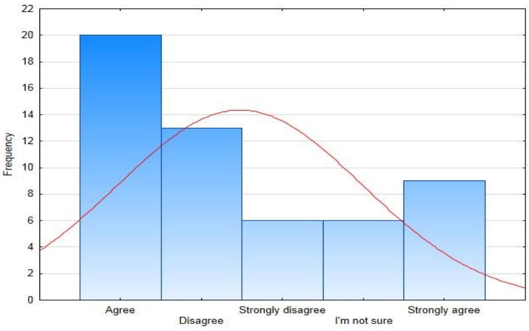

Figure 21 Attitude of parents in E.I in NGA

	Mean responses	Standard deviation
Item 10	3.00	1.30

Table 18

Majority of the respondents reported that most parents completely abandon their children with disability to their grandparents as responses centered on agree (see figure 21) and having a mean score of 3.00, with a standard deviation of 1.30 as shown in table 18.

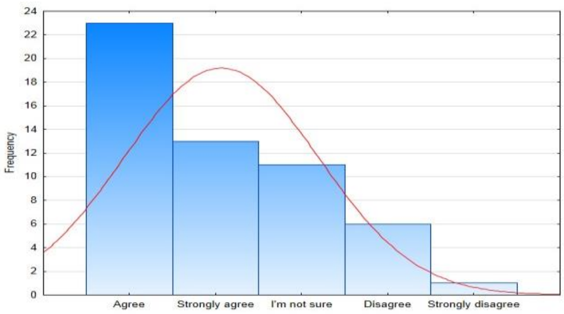

Figure 22 Faith healers instead of E.I in NGA

	Mean responses	Standard deviation
Item 11	3.00	1.01

Table 19

The descriptive data shows that majority of the respondents responses centered on agree and strongly agree as seen in figure 22 above, with a mean score of 3.00 and 1.01 of standard deviation as shown in table 19. This shows that parents of children with disability prefer to look for fast healing for their children than intervention programmes.

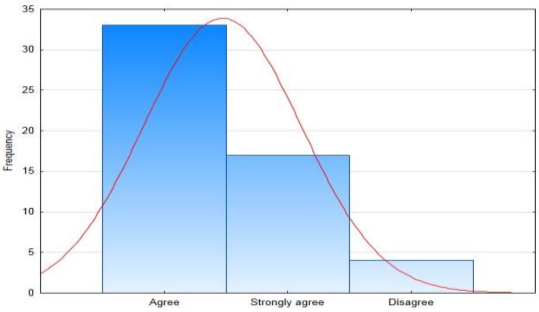

Figure 23 Parents attitude toward children with disability in E.I in NGA

	Mean responses	Standard deviation
Item 12	3.00	0.77

Table 20

More so, the majority of the respondents responses centered on agree and strongly agree (see figure 23), having a mean score of 3.00, with 0.77 standard deviation (see table 20). Indicating that most parent tends to hid their children with disability due to the embarrasment of seeing them with a child's with disability.

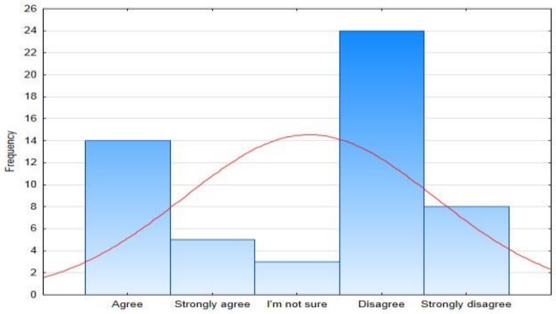

Figure 24 Acceptable attitudes of parents in E.I in NGA

	Mean responses	Standard deviation
Item 14	1.00	1.27

Table 21

It is not difficult to admit that the attitude of parents to early intervention of their child's is not acceptable due to the majority respondents responses that centered on disagree as shown in figure 24 above. The average mean score is 1. 00, with standard deviation of 1.27 (see table 21).

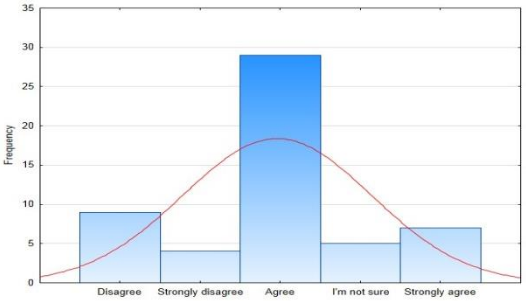

Figure 25 Rejection as part of parents' attitude in E.I in NGA

	Mean responses	Standard deviation
Item 15	3.00	1.14

Table 22

Also, it is apparent that the majority of the respondents responses centered on agree from figure 25 above, showing mean score of 3.00 and 1.14 for standard deviation in table 22 above. Thus, indicating that parent's attitude show rejection to early intervention services for their children with disability.

4.4 Graphs and tables showing the items and responses on the practices of early intervention for children with disability in CZ.

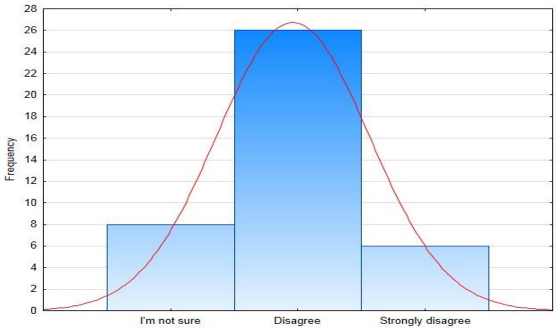

Figure 26 Early intervention (hereafter E.I) obtainable in CZ

	Mean responses	Standard deviation
Item 1	1.00	0.47

Table 23

From the descriptive data in figure 26, almost all the respondents responses centered on disagree and strongly disagree, with a mean score of 1.00 and 0.47 of standard deviation (see table 23). This indicates that early intervention practice is obtainable for them.

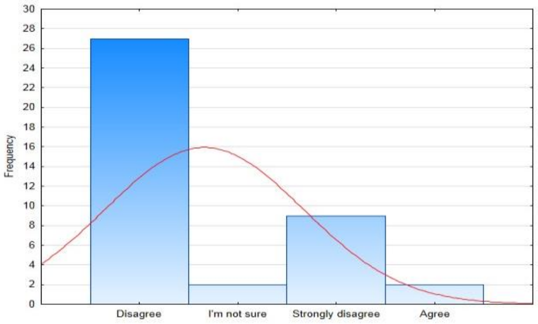

Figure 27 Minimal existent of E.I practice in CZ

	Mean responses	Standard deviation
Item 2	1.00	0.69

Table 24

In figure 27 above, almost all the respondents responses disagreed and stronly disagreed. Showing that early intervention practice is not at minimal existent. The mean score for the item is 1.00, with a standard deviation of 0.69 as shown in table 24 above.

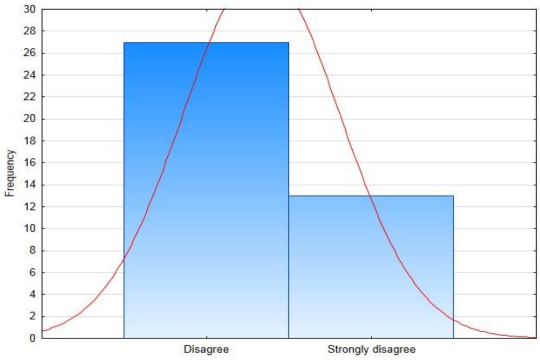

Figure 28 Governemnt involvment in the practice of E.I in CZ

	Mean responses	Standard deviation
Item 8	1.00	0.60

Table 25

In sum, all respondents responses centered on disagree and strongly disagree (figure 28), showing a mean score of 1.00 and standard deviation of 0.60 (table 25). Thus, indicating that government involvment in the practice of early intervention is not minimal.

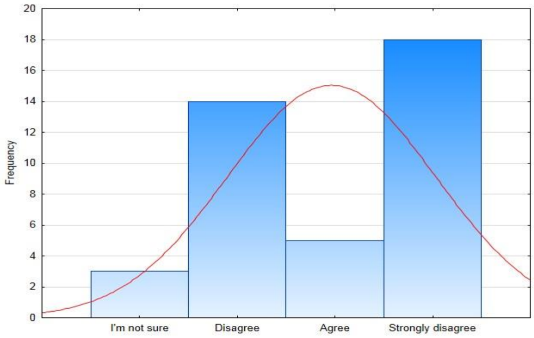

Figure 29 Practice of E.I as family matters in CZ

	Mean responses	Standard deviation
Item 13	1.00	1.02

Table 26

Item 13 was designed to explore if early intervention practice is just within the family. Majority of the respondents responses centered on disagree and strongly disagree as seen in figure 29 and having a mean score of 1.00, with standard deviation of 1.02, indicating that early intervention practice is not a family matter alone.

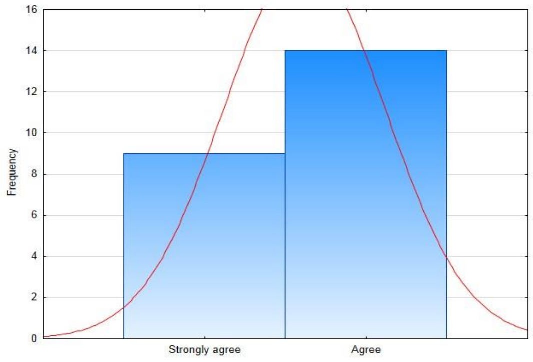

Figure 30 Adequate resources for E.I practice in CZ

	Mean responses	Standard deviation
Item 14	3.00	0.50

Table 27

It is apparent that all respondents responses centered on agree and strongly agree (see figure 30). This indicates that resources for the practice of early intervention are adequate. Showing a mean score of 3.00 and 0.50 for standard deviation (see table 27).

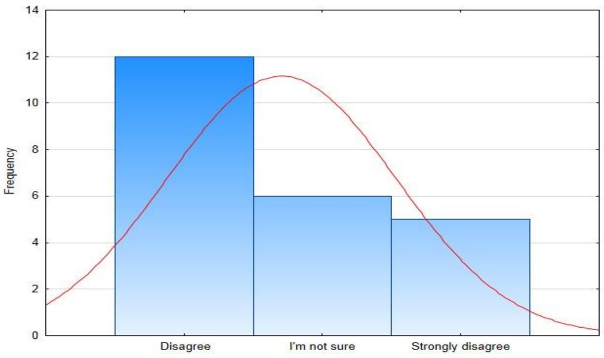

Figure 31 Accessibility of resources for E.I practice in CZ

	Mean responses	Standard deviation
Item 15	1.00	0.71

Table 28

Data in figure 31 shows that majority of the responses disagreed and strongly disagreed, this indicating that the resources for the practice of early intervention are not restricted but accessible, at 1.00 mean score and 0.71 standard deviation as shown in table 28.

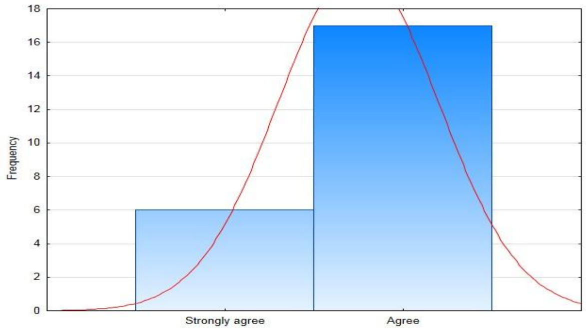

Figure 32 Availability of children clinic for E.I practice in CZ

	Mean responses	Standard deviation
Item 17	3.00	0.45

Table 29

It is an evident that children clinic are available for the practice of early intervention as displayed in figure 32. Having all respondents responses centered agree and strongly agree, with a mean score 3.00 and a standard deviation of 0.45 as shown in table 29 above.

4.5 Graphs and tables showing the items and responses on government policy, legislation, and support for early intervention of children with disability in Czech Republic.

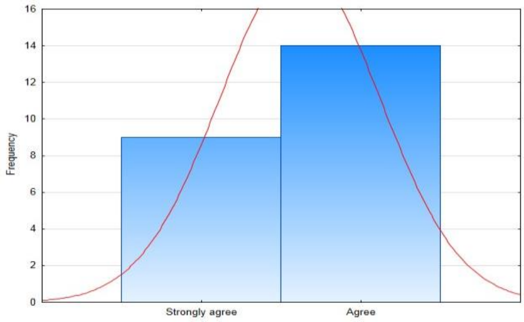

Figure 33 Legal supports for E.I in CZ

	Mean responses	Standard deviation
Item 3	3.00	0.71

Table 30

According to all respondents responses as shown in figure 33, it is obvious that there is a policy/legislature (Act) for the practice oof early intervention because all responses centered on strongly agree and agree, with 3.00 as mean score and 0.71 as standard deviation (see table 30).

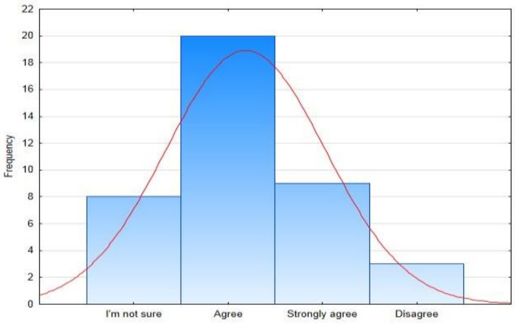

Figure 34 Genuine policies for E.I in CZ

	Mean responses	Standard deviation
Item 4	3.00	0.86

Table 31

Based on the descriptive data shown in figure 34, the overwhelming majority of the respondents responses centered on agree and strongly agreed, showing that the available policies are genuine, and having 3.00 as mean score and 0.86 as standard deviation (see table 31).

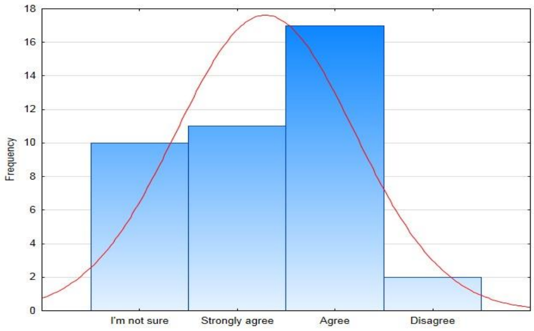

Figure 35 Satisfaction of legal support for E.I in CZ

	Mean responses	Standard deviation
Item 5	3.00	0.85

Table 32

With the respondents responses that emphasized agreed and strongly agreed as demonstrated in figure 35, at 3.00 mean score and 0.85 standard deviation as shown in table 32 above, indicating that they are satisfied with the policy/legislature/act for early intervention.

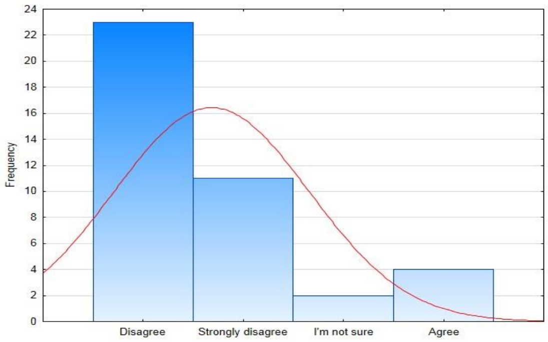

Figure 36 Government priorities in policy/legislature for E.I in CZ

	Mean responses	Standard deviation
Item 6	1.00	0.86

Table 33

According to the descriptive data in figure 36, it is found that majority of the respondents responses centered on disagree and strongly disagree. Indicating that government priority is not minimal in the implementation of the policy for early intervention practice. The mean score is 1.00, with a standard deviation of 0.86 (see table 33).

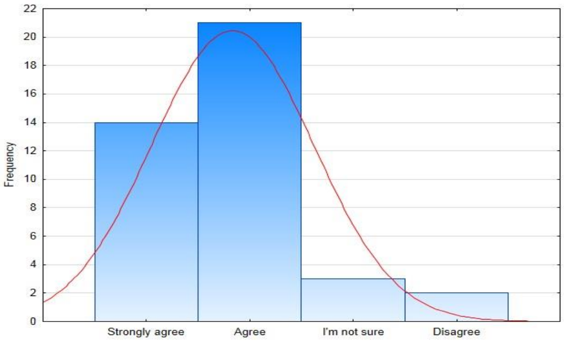

Figure 37 Enhance policies of government for E.I in CZ

	Mean responses	Standard deviation
Item 7	3.00	0.78

Table 34

Almost all the respondents responses centered on agree and strongly agree (figure 37), indicating that the governement policies enhances early intervention practice. Thus, having a mean score of 3.00 and 0.78 standard deviation respectively.

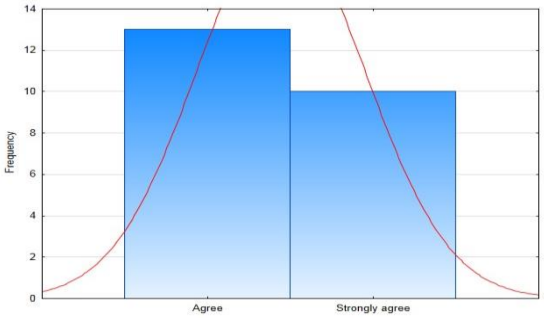

Figure 38 Health care supports for E.I in CZ

	Mean responses	Standard deviation
Item 8	3.00	0.51

Table 35

It is much apparent that all respondents responses centered on agree and strongly agree as shown in figure 38 above. The means score is 3.00, with 0.51 standard deviation (table 35), indicating that they all received necessary health care for their children.

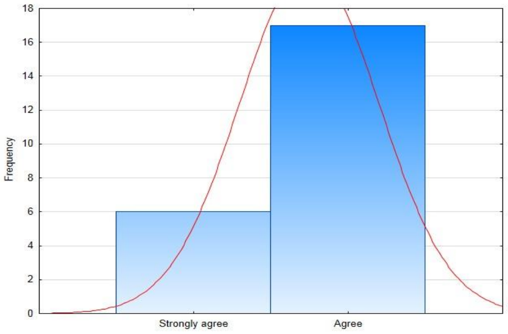

Figure 39 Government financial supports for E.I in CZ

	Mean responses	Standard deviation
Item 9	3.00	0.47

Table 36

From figure 39 above, all respondents responses centered on agree and strongly agree. Having a mean score of 3.00 and a standard deviation of 0.47 as seen in table 36. This mean that parents and their respective families also receive financial support from the government.

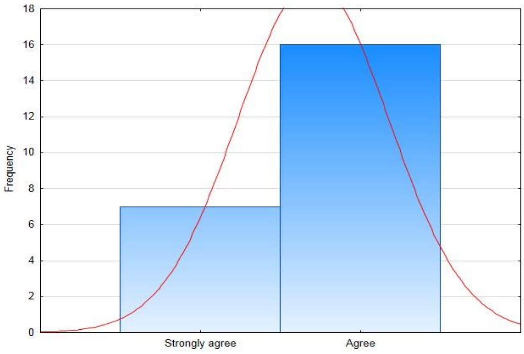

Figure 40 General supports from government for E.I in CZ

	Mean responses	Standard deviation
Item 10	3.00	0.45

Table 37

More so, all respondents responses centered on agree and strongly agree (see table 40). Showing that they all received necessary cares from government and professionals related to intervention. The item has a means score of 3.00, with a standard deviation of 0.45 as indicated in table 37.

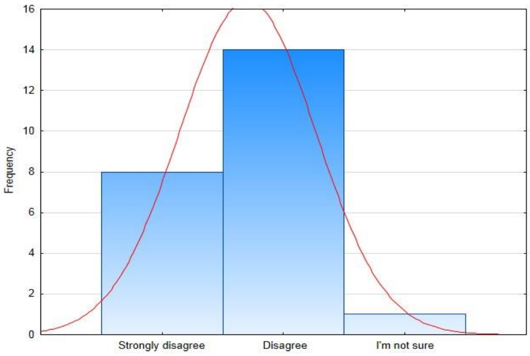

Figure 41 Substitution of resources for E.I in CZ

	Mean responses	Standard deviation
Item 16	1.00	0.56

Table 38

Item 16 was designed to show how the government provides or substitute resources for the practice of early intervention for parents and families. Almost all the respondents reponses centered on disagree and strongly disagree (see figure 41), indicating that intervention resources needed are not substituted for edible items. The mean scores is 1.00, with 0.56 standard deviation.

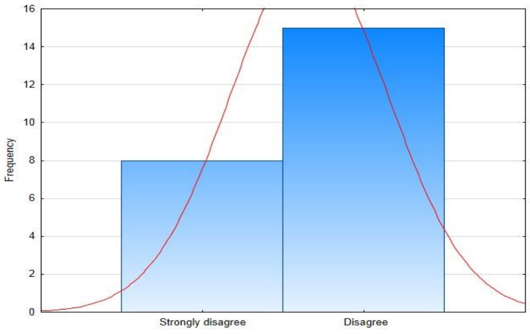

Figure 42 Attitude of government in support of E.I in CZ

	Mean responses	Standard deviation
Item 19	1.00	0.49

Table 39

Trying to seek for information about government attitude in support of early intervention practice, it is very obvious that all respondents reported that government do not have a nonchalant attitude on support of early intervention practice/programmes. This is seen in figure 42 above as all responses centered on disagree and strongly disagree, with a mean score of 1.00 and standard deviation of 0.49 in table 39 above.

4.6 Graphs and tables showing the items and responses on parents' attitude in early intervention of children with disability in Czech Republic.

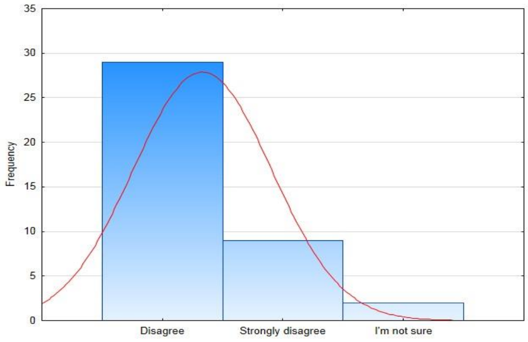

Figure 43 Attitude of parents in E.I in CZ

	Mean responses	Standard deviation
Item 10	1.00	0.50

Table 40

As shown in the descriptive date above, almost all respondents disagreed and strongly disagreed, indicating that parents do not abandon their children with disability for their grandparents. As the mean score is 1.00 and 0.50 standard deviation.

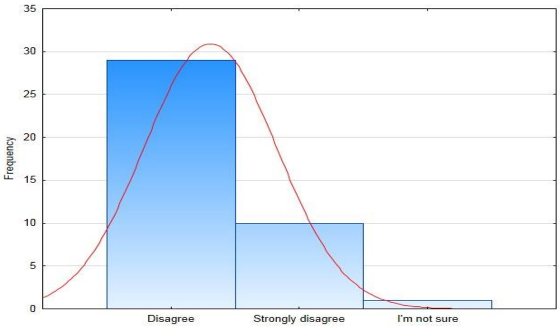

Figure 44 Faith healers instead of E.I in CZ

	Mean responses	Standard deviation
Item 11	1.00	0.48

Table 41

In figure 44 above, it is apparent that almost all the respondents responses centered on disagree and strongly disagree, indicating that the parents of children with disability do not substitute intervention programmes for faith healers. Showing a mean score of 1.00 and a standard deviation of 0.48 (see table 41).

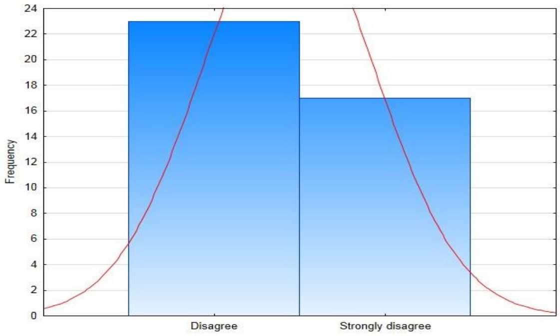

Figure 45 Parents attitude in children with disability in E.I in CZ

	Mean responses	Standard deviation
Item 12	1.00	0.50

Table 42

In accordance with the data above (figure 45), all respondents responses centered on disagree and strongly disagree, with a mean score of 1.00 and 0.50 standard deviation (table 42). Indicating that parents do not hid their children with disability as a result of the embarrassment of having such a child.

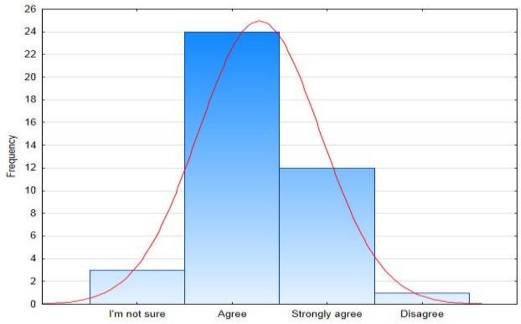

Figure 46 Acceptable attitude of parents in E.I CZ

	Mean responses	Standard deviation
Item 14	3.00	0.68

Table 43

As shown in the descriptive data (figure 46), most of the respondents responses agreed and strongly agreed, with a mean score of 3.00, and standard deviation of 0.68 (see table 43). The result means that parents attitude shows acceptance of intervention for their children.

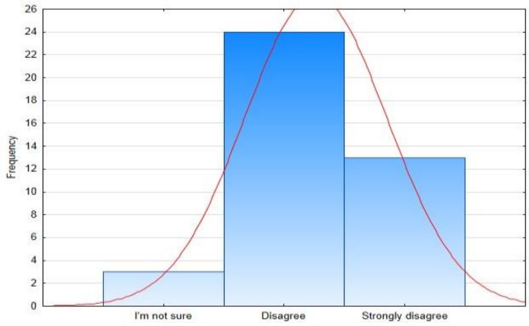

Figure 47 Rejection as part of parents's attitude in E.I in CZ

	Mean responses	Standard deviation
Item 15	1.00	0.59

Table 44

It is very clear from the descriptive data that parents attitude do not show rejection toward intervention programme of their children as almost all the respondents responses centered on disagree and strongly disagree as shown in figure 47, having a mean score of 1.00 as well as standard deviation of 0.59 as indicated in table 44.

4.7 Discussion of Results

4.7.1 The practices of early intervention for children with disability in NGA.

According to the descriptive data above, from figure 4-figure 10, showing result of items 1,2,8,13, on professionals questionnaires and items 14, 15, 17, on parents questionnaires used to seeks information on the practice of early intervention for children with disability in Nigeria. The result show that majority of the respondents responses agree and strongly agree that the practices of early intervention for children with disability are not obtainable, while minority of the respondents responses disagree that the practices of early intervention is obtainable for them. Meanwhile, few of the respondent responses I'm not sure that this practice is obtainable or not is due to the fact that they haven't heard of the term "early intervention".

However, figure 8 above which is item 14 on parents questionnaire, try to find out if the provision of resource for the practice of early intervention is adequate, but the majority of the respondent responses disagree and strongly disagree. This indicates that the provision of resources for the practice is not adequate. Also, figure 10 above which is item 17 on parents questionnaire seeks to know if children clinic for identification/early intervention practice are available for parents, but majority of the respondents responses disagree and strongly disagree. Which means that there are no specific children clinic that is meant for identification or that allow early intervention practice. Few respondent responses are I'm not sure because they have never seen such children clinic expect the general clinic where they do take their children to whenever they have health issues.

4.7.2 Government policy, legislation, and support for early intervention of children with disability in NGA.

In sum, according to the descriptive data from figure 11-figure 20 above, showing results for items 3,4,5,6,7, in the professionals questionnaire and items 8,9,10,16,19 in the parents questionnaire administered to acquire information on government policy, legislature, and support for early intervention practice for children with disability and their respective parents and families in Nigeria. The results show that majority of the respondent disagree and strongly disagree. This indicates that the country do not have a policy/legislature for early intervention practice. Thus, minimize or non-existent of support given to parents and families of children with disability. Some (minority) of the respondent responses agree and strongly agree that there is government policy due to the fact that there is a National policy on Education, however there is no implementation of the policy. Few respondent responses I'm not sure because they haven't heard or see any policy/legislature or receive any given support from the government.

Specifically, in figure 14 above, result of item 6 on professionals questionnaire that seeks to know the priority of government toward the implementation of a legal for early intervention and special education as stated in the National policy on Education Section 8, most (majority) respondents responses strongly agree and agree that the priority of the government to implement such legal support is minimal. While the minority respondent responses I'm not sure. This indicates that they do not know if the government priority to implement a legal support or pass a bill in line with the policy is minimal or of non-existent. But few respondent responses disagree and strongly disagree, indicating that the government priority to implement the legal support is not minimal.

Also, in figure 19 above that show result for item 16 on parents' questionnaire that seeks to know government support for early intervention. Most respondent responses agree and strongly agree that facilities/resources needed for early intervention are substituted for edible item and thus lead to moral boosting on the part of the government. Meanwhile, very few respondent responses disagree and I'm not sure because most edible items received as support from government may not be a mean of replacing the resources/facilities needed but a concern on the part on the government.

Lastly, figure 20 above shows the result of item 19/9 in parents and professional respectively questionnaires. The item seeks to find out the attitude of government to early intervention, policy and support. Majority of the respondents responses strongly agree and agree. This shows that government has a nonchalant attitude toward early intervention policy and support to parents and children with disability. While very few respondents strongly disagree and disagree that is not a nonchalant attitude on the part of the government but it might be unforeseen circumstances. Meanwhile very few respondents responses I'm not sure. Indicating it is not nonchalant attitude or unforeseen circumstance on the part of the government (neutral).

4.7.3 Parents' attitude in early intervention of children with disability in NGA.

In accordance with the descriptive data above, specifically from figure 21 to figure 25 which is representing items 10, 11,12,14,15 on professional questionnaire that is used to collate data on parents' attitude in early intervention of children with disability in Nigeria. The result shows that majority of the respondents responses agree and strongly agree because most parents abandon their children with disability to their grandparents, prefer to take their children to a faith healer rather than early intervention programmes for such a child. And when there is no improvement, they hid the child due to embarrassment of seeing them with such a child.

Minority of the respondents responses disagree and strongly disagree because not all of the parents abandon their children to grandparents and few do not hid their children despite the embarrassment. While few respondents indicated I'm not sure.

However, figure 24 above, shows item 14 result on professionals' questionnaire used to get information about parents' attitude in early intervention if acceptable by them. The result from the figure 24 shows that majority of the respondents responses disagree and strongly disagree indicating that parent's attitude show not accepting intervention for their children at an early stage. While minority of the respondents responses agree and strongly agree that parents attitude towards early intervention is acceptable for their children when necessary support and awareness are in place. Meanwhile, in figure 25, also show item 15 result on professional questionnaire, seeks to find out if parents attitude was totally rejection of early intervention for their children but the majority of the respondents responses agree and strongly agree due to how parents choose faith healers to intervention programmes. Very few respondent responses disagree and strongly disagree. This indicates that not all parents reject the available services for early intervention.

4.7.4 The practices of early intervention for children with disability in CZ.

From the descriptive date, figure 26-figure 32 above, representing the results for items 1, 2,8,13 on professionals' questionnaire and items 14, 15, 17 on parents' questionnaire both used to acquire respondents points of view for the practice of early intervention for children with disability in Czech Republic. It is notable that majority of the respondents responses disagree and strongly disagree, indicating that early intervention practice is obtainable for them, not at minimal existent, government involvement in early intervention practice is not minimal, and early intervention practice is not just a family matters. While few respondents responses I'm not sure because they do not understand the questions. In figure 30 and figure 32 above, which are items 14 and 17 on parents questionnaire, seeks to find out if resource for the practice of early intervention is adequate as well as children clinic for identification/early intervention practice is available, all respondents responses agree and strongly agree. This indicates that resource for the practice of early intervention is adequate and also children clinic for identification/early intervention practice available.

4.7.5 Government policy, legislation, and support for early intervention of children with disability in CZ.

As shown in figure 33-figure 42 above, showing results for items 3,4,5,6,7, in professionals questionnaire and items 8,9,10,16,19, in praents questionnaire which was administered to collate data on government policy, legsilature, and support for early intervention practice of children with disability and their respective parents and families in Czech Republic. It is very notable that majority if the respondents responses agree and strongly agree, indicating that the country have a policy/legislature/Act for the practice of early intervention.

In figure 36, item 6 on professionals questionnaire that seeks to know the government priority on the implementation of legal support for early intervention if minimal, the majority respondents responses disagree and strongly disagree. Also, indicating that government priority is not minimal as such, available Act/policy for early intervention are usually reviewed every two years interval or as it pleases those concern. While few respondents responses I'm not sure and agree due to lack of understanding of the question.

More so, figure 38 to figure 40, items 8,9,10 om parents questionnaire on support received by parents of children with disability and their respective families, all respondents responses agree and strongly agree, indicating that they received and get the necessary health care for their children and their respective families do receive financial assistance from the government.

Moreover, figure 41 above showing item 16 result on parents questionnaire, majority of the respondents responses strongly disagree and disagree. This shows that facilities/resources needed for early intervention are not substituted for edible item. Very few respondents responses I'm not sure due to lack of understanding of the question.

Lastly, in figure 42 above, item 19 on parents questionnaire, seeking to know government attitude in early intervention practice, all respondents responses disagree and strongly disagree, indicating that government do not have a nonchalant attitude on policy and support for early intervention.

4.7.6 Parents' attitude in early intervention of children with disability in CZ.

As shown in the descriptive data above, figure 43 to figure 47 representing items 10,11,12,14,15 in professionals questionnaire employed to acquire information on parents attitude in early intervention of children with disability in Czech Republic. From the descriptive data, results show that majority of respondents responses disagree and strongly disagree, thus, indicating that parents do not abandon their children with disability to their grandparents and likewise do not prefer faith healer to intervention programmes. Very few respondents responses I'm not sure, showing that they do not understand what the question actually meant.

In figure 45, item 12, all respondents responses disagree and strongly disagree, indicating that parents do not hid their children with disability. Also, figure 46, item 14, majority of the respondents responses agree and strongly agree, thus, parents attitude shows acceptance of intervention programmes for their children with disability. Meanwhile, very few respondents responses I'm not sure and disagree. This shows how they understood the question.

Finally, figure 47, item 15, on professionals questionnaire, shows that majority of the respondents responses disagree and strongly disagree. As such, indicates that parents attitude do not reject early intervention services/programmes for their children with disability. Very few respondents responses I'm not sure because do complain of not understanding what the question meant.

Chapter 5 Conclusion of the Study

5.1 Conclusion

5.1.1 Early intervention for children with disability in Nigeria

In conclusion, it is obvious from the obtained descriptive data that the early intervention of children with disabilities is not effective and well implemented in Nigeria because parents and professionals alluded that the provision of early intervention for children with disabilities are not obtainable by many, the resources for the practice are not adequate, no structures for identification, referral and commencement of intervention for children with disabilities. There is no laws/legislation/Act that legalized the practice thus making it difficult to influence the intervention for children. There is no financial support or other necessary support as regards to the practice of early intervention making all intervention responsibilities to be on parents. Government priority to implement the existing policy is minimal coupled with the nonchalant attitude of government. The professionals further opined that parents attitude to the little available intervention programmes is rejection thus limited their involvement in early developmental process of children's with disabilities. Parents also have negative attitudes due to the embarrassment and perceptions associated with having a child's with disability. However, as regards to the described situation about early intervention for children with disabilities in Nigeria, it could be linked to what Eskay, Onu, and Igbo (2012) called associated problems of early intervention programme in Nigeria. This includes:

i. Lack of enforced legislature.
ii. Non-existence of facilities or screening, identification, assessment, and evaluation.

iii. Stagnation of programmes due to inadequate funds.
iv. Poor attitudes of the public/society towards the children and persons with disabilities.
v. Many parents would rather avoid screening their children's with disability and others may not seek intervention as early as possible due to ignorance.
vi. Lack of accurate data and documentation to show accurate figures of children needing intervention. Thus, no reliable data on prevalence of disabilities among Nigerian children.

For Nigeria as a developing country to succeed in caring for her children and persons with disabilities, focus should be on how to eliminate all obstacles that had severely blocked the implementation of the existing policy for children and persons with disabilities. As nothing is been done in terms of providing support in early intervention services for children with disability in their early years of life, it is advisable that the government need to revisit the existing policies in early childhood to accommodate and support the interests and needs of children with disabilities and their immediately families.

As rightly said by Abang (2005), what Nigeria needs today is the enactment of a Federal and State law/Act aimed at young children with disabilities and their families. This law should provide direct services, protect their rights, as well as providing all necessary supports to infants and young children with disabilities and their families. Also, under the law, incentives should be given to States or NGOs for establishing programmes for infants or toddlers with disabilities. More so, a specific law/legislation/Act on early intervention that mandate a clear and very flexible Federal and State government financial support, resources support and in-service training for old professionals should be developed. These will enable the professionals/concerned bodies for the intervention of children will disabilities to update their knowledge with numerous practices about services/programmes for early intervention of children with disabilities.

In sum, when this law/legislation/Act is put in place and functional, all negative and nonchalant attitudes by parents, families, professionals, government and the society at large will diminish and eventually eradicate, hence bringing appropriate steps to effective and functional early intervention practice to children with disabilities and their respective families in Nigeria.

5.1.2 Early intervention for children with disability in Czech Republic

Conclusively, as earlier said, the care for children and persons with disabilities in Czech Republic is on state level ensured by three different ministries; ministry of health, ministry of labour and social affairs, and ministry of education, youth and sports. Czech has established relevant early intervention laws/legislation/Act to promote the practice of early intervention for children with disability from birth to seven years of life. Czech parents' attitude seem positive, acceptable, and encouraging to their children early developmental process. Parents' involvement in their children's early intervention is great as obtained in the descriptive data. It is also, notable that parents attested that early intervention services/programmes are obtainable, the practice is functional, early intervention responsibilities are not left for them alone, there are adequate resources available for early intervention, and government has a positive attitude in regard to early intervention of all children with disabilities.

It could be said that early intervention for children with disabilities in Czech Republic is effective and well implemented due to the fact Czech government legalized the practice for early intervention and took over the care and intervention of children with disabilities and has supported parents through early intervention services and systems whereby families can receive economic support and family counseling. To end this up, Czech government has a family policy that aids parents to provide full time care for their children up to 3 years of age with a steady family allowance during the duration.

5.2 Recommendations of the study

Based on the findings of this study, the following are recommendation proffered.

There are no clear policies and laws on early intervention and education of children and persons with disability in Nigeria. The only written policy that has special education mandates is the National Policy on Education Section 8. Therefore, a comprehensive policy, legislation or law on public provision of early intervention programmes and services for children with disability aged birth to seven should be developed as a matter of urgency. Also, Nigeria should have a special education Act of Parliament. This Act will give children with disability a legal right to intervention and education, with the government having certain obligations to fulfill. More so, the policy should state the financial aspect of the intervention as regards to each child and their families. All areas that require financial support by the government should be covered by a clear policies/law including health care, support equipment and devices, food and shelter, security and education.

Government should have a positive attitude in the implementation of such policies/laws on early intervention of children with disability. Thus, a penalty/fine should be included in the policies/laws on any negative/nonchalant attitude towards infants, toddlers and children with disability. This will encourage parents, families, and the society at large to take appropriate steps toward intervention of a child’s with disability.

Furthermore, Federal and State government should endeavor to provide or attach children clinic for identification, referral and practice of early intervention in all existing Local, State and Federal hospitals/clinics. This will encourage a full practice of early intervention as soon as a child is identified as having disability or at risk of developmental disability.

Moreover, Federal and State government should provide appropriate supports to parents and families of children with disability and not leaving them to carry their cross alone. In agreement with this, adequate information or awareness about how, where, and when to access services/programmes and supports for early intervention should be made available for parents and families. This can be achieved through publicity and education (e.g., television, radio, and other kinds of public activities). Thus, it will help parents, families and the society at large to put away their old tradition of negative perceptions on having children with disability. This will also help parents not to hide their children’s but seek for intervention as early as possible.

Most importantly, all parents should endeavor to take their children for necessary medical screening, as this will help to detect a child’s who is having disability or at risk of developmental disabilities.

More so, both Nigeria and Czech Republic should endeavor to educate their parents on the right terminology used on their children as regards their disabilities, and informative level of the child’s should be disclosed to them as well.

Finally, Czech Republic should endeavor to make available all literatures related to how they carry out their early intervention (documentation) in English for easy accessibility, so that others can emulate same.

5.3 Limitations of the study

In carrying out this research, there have been constraints and deficiencies such as:

The uncooperative attitude of professionals involved in early intervention of children in Nigeria coupled with the unwillingness on the parts of the respondents to respond to the questionnaire for the study both in Nigeria and Czech Republic.

Also, majority of the literature about early intervention in Czech Republic were not published in English while in Nigeria, many articles/literatures written in English are published within the local journals. Thus making it very difficult to access by the researcher, hence limited the researcher to only available articles, books and using the respondents' responses for description.

Most questionnaires were not valid due to the level of the parents understanding of terminology used. Thus, makes the study to have low number of respondents.

Finally, language barrier between the researcher and the respondents in Czech Republic constituted a limitation for this study, making it difficult to communicate directly with the respondents.

5.4 Suggestions for further research

The followings are suggested as further research topics:

1. Policies as foundational tools for effective practice of early intervention of children and persons with disabilities.
2. Early intervention for children with disability: the parameters for effective implementation.
3. Relevance of professionals' competence and service delivery for early intervention practice.
4. Attitudes as prerequisite for early intervention and transition for children with disabilities within homes and communities.

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Appendix

EARLY INTERVENTION QUESTIONNAIRE

Dear Professional,
The survey is anonymous and will take about 10 - 15 minutes to complete.

Thank you in advance for your assistance.

Igoni Joy Sade

Gender

☐ Male ☐ Female

Age

☐ under 29 ☐ 30 - 39 ☐ 40 - 49 ☐ 51 - 59 ☐ 60+

1. The provision of early intervention for children with special needs is not obtainable for you?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

2. The practice of early intervention for children with special needs is at minimal existent?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

3. Does the country have a legal support for early intervention for children living with special needs?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

4. The legal support for early intervention for children living with disability is genuine?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

5. Are you satisfied with the legal support in caring for children with disability?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

6. What is the priority of the government toward the implementation of the legal support for early intervention? Minimal?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

7. There are government policies that enhance early intervention of children with disability?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

8. Government involvement towards early intervention of children living with disability is minimal?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

9. Nonchalant attitude of government in early intervention of children living with disability is increasing?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

10. Biological parents of children with disability completely abandon them to their grand-parents?
☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

11. Parents of children living with disability substitute taking their children with disability to faith healer instead of hospital/children clinic for better intervention?
☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

12. Parents do hid their children living with disability from partaking in early intervention program due to the embarrassment of seeing them with disabled child (ren)?
☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

13. Early intervention program for children (0-3years) living with disability is a family matters?
☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

14. Parents attitude towards early intervention of children with disability is acceptable?
☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

15. Parents attitude towards early intervention of children with disability is rejection?
☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree ☐ Strongly Disagree

EARLY INTERVENTION QUESTIONNAIRE

Dear Parent
The survey is anonymous and will take about 10 - 15 minutes to complete.

Thank you in advance for your assistance.

Igoni Joy Sade

Gender
☐ Male ☐ Female

Age
☐ under 29 ☐ 30 - 39 ☐ 40 - 49 ☐ 51 - 59 ☐ 60+

1. The provision of early intervention for children with special needs is not obtainable for you?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
   ☐ Strongly Disagree

2. The practice of early intervention for children with special needs is at minimal existent?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
   ☐ Strongly Disagree

3. Does the country have a legal support for early intervention for children living with special needs?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
   ☐ Strongly Disagree

4. The legal support for early intervention for children living with disability is genuine?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
   ☐ Strongly Disagree

5. Are you satisfied with the legal support in caring for children with disability?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
   ☐ Strongly Disagree

6. What is the priority of the government toward the implementation of the legal support for early intervention? Minimal?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
   ☐ Strongly Disagree

7. There are government policies that enhance early intervention of children with disability?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
   ☐ Strongly Disagree

8. Did your child with special needs receive the necessary health care?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
   ☐ Strongly Disagree

9. Did your family receive any financial assistance for your children with special needs?
   ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
   ☐ Strongly Disagree

10. From birth, government and professionals render necessary care to family, siblings, and other relatives of children with special needs?
    ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
    ☐ Strongly Disagree

11. People run away at the sight of a child (ren) with disability?
    ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
    ☐ Strongly Disagree

12. The reaction of people towards children with disability is hostile?
    ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
    ☐ Strongly Disagree

13. People think that having children with special needs is as a result of punishment from gods?
    ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
    ☐ Strongly Disagree

14. The provision of resources for early intervention for children living with disability is adequate?
    ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
    ☐ Strongly Disagree

15. The accessibility of resources available for early intervention for children with special needs is restricted?
    ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
    ☐ Strongly Disagree

16. Facilities needed for early intervention are substituted for edible item for moral boosting?
    ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
    ☐ Strongly Disagree

17. Children clinic for early intervention/identification for children with special needs are available?
    ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
    ☐ Strongly Disagree

18. Government involvement towards early intervention of children living with disability is minimal?
    ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
    ☐ Strongly Disagree

19. Nonchalant attitude of government in early intervention of children living with disability is increasing?
    ☐ Strongly Agree ☐ Agree ☐ Not Sure ☐ Disagree
    ☐ Strongly Disagree

DOTAZNÍK RANÉ INTERVENCE

Váženíodborníci,

šetření je anonymní a jeho vyplnění vám zabere okolo 10 - 15 minut času.

Děkuji ji vám předem za vaši spolupráci

Igoni Joy Sade

Pohlaví
☐Muž ☐Žena

Věk
☐ do 29 ☐ 30 - 39 ☐ 40 - 49 ☐ 51 - 59 ☐ 60+

1. Poskytování rané intervence pro děti se specifickými potřebami je pro vás nedostupné?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

2. Provádění rané intervence pro děti se specifickými potřebami je na minimální úrovni?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

3. Poskytuje vaše země právní podporu rané intervence pro děti se specifickými potřebami?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

4. Právní podpora rané intervence pro děti žijících se specifickými potřebami je skutečná?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

5. Jste spokojený/spokojená s právní podporou týkající se péče a vaše dítě/děti se specifickými potřebami?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

6. Jakou prioritu vláda dává implementaci právní podpory pro ranou péči?Minimální?

   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

7. Existují opatření vlády podporující ranou intervenci dětí se specifickými potřebami?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím☐ Silně nesouhlasím

8. Podíl vlády na rané intervenci dětí žijících se specifickými potřebamije minimální?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím☐ Silně nesouhlasím

9. Nedbalý přístup vlády k rané intervenci dětí žijících se specifickými potřebami narůstá?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím☐ Silně nesouhlasím

10. Biologičtí rodiče dětí se specifickými potřebami je zcela ponechávají jejich prarodičům?
    ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím☐ Silně nesouhlasím

11. Rodiče dětí žijících s postižením (disabilitou) upřednostňují léčitele před nemocnicí/dětskou klinikupro poskytnutí lepší intervence?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

12. Rodiče odmítají dávat své děti s postižením do programů rané intervenci z důvodu toho, že se stydí vidět své děti s dítětem/dětmi se specifickými potřebami?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

13. Programy rané intervence pro děti (0-3 roky) žijících se specifickými potřebami jsou rodinnou záležitostí?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

14. Přístup rodičů vůči rané intervenci dětí s postižením se specifickými potřebamije přijatelný?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

15. Přístup rodičů vůči rané intervenci dětí se specifickými potřebami je odmítavý?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

DOTAZNÍK RANÉ INTERVENCE

Vážení rodiče,

šetření je anonymní a jeho vyplnění vám zabere okolo 10 - 15 minut času.

Děkuji ji vám předem za vaši spolupráci

Igoni Joy Sade

Pohlaví

☐Muž ☐Žena

Věk

☐ do 29 ☐ 30 - 39 ☐ 40 - 49 ☐ 51 - 59 ☐ 60+

1. Poskytování rané intervence pro děti se specifickými potřebami je pro Vás nedostupné?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím
   ☐ Silně nesouhlasím

2. Provádění rané intervence pro děti se specifickými potřebamije na minimální úrovni?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím
   ☐ Silně nesouhlasím

3. Poskytuje Vaše země právní podporu rané intervence pro děti se specifickými potřebami?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím
   ☐ Silně nesouhlasím

4. Právní podpora rané intervence pro děti žijících se specifickými potřebami jeskutečná?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím
   ☐ Silně nesouhlasím

5. Jste spokojený/spokojená s právní podporou týkající se péče a vaše dítě/děti se specifickými potřebami ?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím
   ☐ Silně nesouhlasím

6. Jakou prioritu vláda dává implementaci právní podpory pro ranou péči?Minimální?

   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím
   ☐ Silně nesouhlasím

7. Existují opatření vlády podporující ranou intervenci dětí se specifickými potřebami.
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím☐ Silně nesouhlasím

8. Byla vašemu dítěti se specifickými potřebami poskytnuta nezbytná zdravotní péče?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím
   ☐ Silně nesouhlasím

9. Obdržela vaše rodina nějakou finanční podporu pro děti se specifickými potřebami?
   ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím
   ☐ Silně nesouhlasím

10. Od narození se vláda a odborníci nezbytně starají o rodinu, sourozence a jiné příbuzné dětí se specifickými potřebami?
    ☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím☐ Silně nesouhlasím

11. Odvracejí lidé zrak (nebo odcházejí pryč), pokud se ocitnou v blízkosti dítěte/dětí se specifickými potřebami?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

12. Reagují lidé vůči dětem se specifickými potřebaminepřátelsky?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

13. Lidé se myslí, že mít děti se specifickými potřebami je důsledkem potrestání Boha?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

14. Poskytování zdrojů pro ranou intervenci dětí žijících se specifickými potřebami je adekvátní?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

15. Je přístup ke zdrojům dostupným pro ranou intervenci dětí se specifickými potřebami omezen?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

16. Zařízení nezbytná pro ranou intervenci jsou nahrazována ve značné míře jinou formou spíše hmotné pomoci(příspěvků na jídlo apod.) z důvodu morálního posílení/uspokojení?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

17. Dětské kliniky/zařízení pro ranou intervenci/diagnostiku dětí se specifickými potřebami jsou dostupné?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

18. Podíl vlády na rané intervenci dětí žijících se specifickými potřebamije minimální?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím

19. Nedbalý přístup vlády k rané intervenci dětí žijících se specifickými potřebami narůstá?
☐ Silně souhlasím ☐ Souhlasím ☐ Nejsem si jistý/jistá ☐ Nesouhlasím ☐ Silně nesouhlasím