



ASSESSMENT OF EDUCATIONAL NEEDS OF DISABLED CHILDREN IN BANGLADESH



Assessment of Educational Needs of Disabled Children in Bangladesh

Prepared by:

Dr. Paul Ackerman
Dr. Mary S. Thormann
Dr. Sharmin Huq

Coordinated by Md. Arifur Rahman

With research assistance from
Enayet Baten, Soma Dutta, Md. Akhter Hossain, Md. Mominul Islam,
Sharmin Jahan Khan, S.M. Khaled Mahfuz, Fahmida Afroz Nipa,
Md. Abu Sayem, Nargis Sultana
and
Unnayan Shamannay,
Dhaka, Bangladesh

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Acronyms

| | |
|--------|------------------------------------------------------------------------|
| ADB | Asian Development Bank |
| ADD | Action on Disability and Development |
| APCD | Asian-Pacific Development Center on Disability |
| BBS | Bangladesh Bureau of Statistics |
| BCCW | Bangladesh Council for Child Welfare |
| BISE | Bangladesh Institute of Special Education |
| BNFD | Bangladesh National Federation of the Deaf |
| BPF | Bangladesh Protibondhi Foundation |
| BPKS | Bangladesh Protibondhi Kallyan Samity |
| BRAC | (formerly) Bangladesh Rural Advancement Committee |
| BSSBG | Baptist Sangha School for Blind Girls |
| CAHD | Community Approaches to Handicap and Disability |
| CAMPE | Campaign for Popular Education |
| CBM | Christopher Blinden Mission |
| CBR | Community Based Rehabilitation |
| CDD | Center for Disability in Development |
| CIDA | Canadian International Development Agency |
| CRC | Convention on the Rights of the Child |
| CRP | Center for the Rehabilitation of the Paralyzed |
| CSID | Center for Services and Information on Disability |
| DeCWAB | Deaf Children's Welfare Association of Bangladesh |
| ECCD | Early Childhood Care and Development |
| ECD | Early Childhood Development |
| EFA | Education for All |
| ESCAP | United Nations Economic and Social Commission for Asia and the Pacific |
| ESTEEM | Effective Schools through Enhanced Education Management |
| FGD | Focus Group Discussion |
| GDP | Gross Domestic Product |
| GOB | Government of Bangladesh |
| GPS | Government Primary School |
| ICF | International Classification of Functioning, Disability, and Health |
| IFB | Impact Foundation Bangladesh |
| IMR | Infant Mortality Rate |
| INGO | International Nongovernmental Organization |
| JICA | Japan International Cooperation Agency |
| KDPOD | Kurigram Disabled Peoples Organization to Development |
| MOPME | Ministry of Primary and Mass Education |
| MOSW | Ministry of Social Welfare |
| NAP | National Action Plan |
| NCC | National Coordination Council |
| NCSE | National Center for Special Education |
| NFB | National Federation of the Blind |
| NFDD | National Foundation for the Development of the Disabled |

| | |
|---------|-------------------------------------------------------------------|
| NFOWD | National Forum of Organizations Working with the Disabled |
| NFPE | Nonformal Primary Education |
| NGO | Non-Governmental Organization |
| NORAD | Norwegian Agency for International Development |
| ODA | Overseas Development Assistance |
| PEDP-II | Second Primary Education Development Program |
| PNA | Participatory Needs Assessment |
| PRA | Participatory Rural Appraisal |
| PRSP | Poverty Reduction Strategy Paper |
| PWD | Persons with Disability |
| SAARC | South Asian Association for Regional Cooperation |
| SAHIC | Society for Assistance to Hearing Impaired Children |
| SC | Save the Children Federation, Inc. |
| SIDA | Swedish International Development Agency |
| SMC | School Management Committee |
| SWID-B | Society for the Welfare of the Intellectually Disabled Bangladesh |
| UNESCO | United Nations Educational, Scientific, and Cultural Organization |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| VSO | Voluntary Service Organization |
| WHO | World Health Organization |

Executive Summary

This study provides the results of a desk study analysis, informational site visits, and a research study to assess preschool and primary education in Bangladesh for children with disabilities. The study was commissioned by USAID in order to understand the needs of disabled children in Bangladesh, to inventory existing services, and to identify points of entry for basic educational assistance to disabled children

Status. Analysis of existing statistics on disparate sample studies offer only an approximation of the configuration of types of disabilities. Most indicate physical disabilities have the greatest reported incidence (41.5 percent). In descending order of incidence are visual disabilities (19.7 percent), speech and hearing (19.6 percent), intellectual disabilities (7.4 percent), cerebral palsy (7.0 percent), multiple disabilities (3.4 percent) and mental illness (1.4 percent). The overall prevalence rate for preschool and primary-aged children (ages 3-10) with disabilities, according to, is approximately 2.6 (2,559,222), or almost 10 percent of the childhood population figures estimated from the million Bangladesh Bureau of the Census and the World Health Organization in Bangladesh. Parasitic infections, malnutrition, and diseases are major contributors.

Policy Context. The Salamanca Statement was a significant milestone in the education for children with disabilities worldwide. It is a powerful instrument that proclaims inclusive education as the leading principle in serving children with disabilities through special needs education. It states that those with special educational needs must have access to regular schools that should accommodate them within a child-centered pedagogy capable of meeting these needs. Inclusive education is regarded as the most effective means of combating discriminatory attitudes. The guiding principle is that schools should accommodate all children, regardless of their physical, intellectual, social, emotional, linguistic or and other conditions.

Although Bangladesh is a signatory to the Salamanca Statement and Framework for Action on Special Needs Education (1994) and the Dakar Framework for Action (2000),¹ and endorsed the Education for All (EFA) framework (1990) and other international conventions such as the Convention on the Rights of the Child (CRC), the vast majority of children with disabilities and special learning needs in Bangladesh do not have access to an education. In the context of the overall current situation of primary education in Bangladesh, especially with respect to the quality of education, the challenges are enormous.

Approximately 40 percent of regular students enrolled at the primary level drop out before completing grade 2, and 40 percent of those who do continue, repeat the grade. It's been shown that only two percent of second graders demonstrate competencies expected at that grade level. A lack of school readiness is often cited as a causative factor for high dropout and grade repetition rates in early primary education. In this general context, the lack of resources for children with disabilities such as qualified and trained teachers, appropriate infrastructure,

teaching materials, and assistive technology, as well as the stigma associated with disability, are additional daunting barriers to their education.

Service Delivery, Preprimary and Primary. Of the estimated 2.6 million children with disabilities in Bangladesh, less than 1,500 have access to an education in special schools sponsored by the Government of Bangladesh (Ministry of Social Welfare). Of those who do have access to day or residential programs in the special schools, only children with selected disabilities (hearing, vision, and intellectual disabilities) are served. It is reported that children with intellectual disabilities and those with physical handicaps have been the most marginalized and neglected.

To the extent that children with these and other disabilities such as cerebral palsy, autism, physical disabilities, and multiple disabilities have access to an education, it is provided by NGOs, many started and sustained with international donor support. NGOs are major players in Bangladesh. Of the more than 40,000 NGOs in Bangladesh, approximately 400 NGOs claim to be working in the area of disability.

The major NGOs in the area of education for children with disabilities in Bangladesh are the Center for the Rehabilitation of the Paralyzed (CRP), including children with cerebral palsy, in Savar; the Bangladesh Protibondhi Foundation (BPF) for the intellectually disabled and the multiply disabled; the Society for the Welfare of the Intellectually Disabled Bangladesh (SWID-B); HI-CARE and the Society for Assistance to Hearing Impaired Children (SAHIC) for the hearing impaired; Baptist Sangha School for Blind Girls (BSSBG); and for children with autism spectrum disorders, the Autism Welfare Foundation (AWF).

Save the Children, through its SUCCEED project, and BRAC are the NGOs that provide educational programs for preschool or preprimary age children with disabilities.

The SUCCEED project, signed into effect in August 2004 with funding from USAID, will identify children with disabilities in the communities using house-to-house surveys. The SUCCEED project will have linked activities in five regions of the country: Sylhet, Rajshahi, Khulna, Barisal, and Dhaka divisions. In each region, Save the Children will select an area known as a "Learning Hub" where "Beacons of Success" will demonstrate best practice examples for early childhood development and primary education initiatives and advocacy. SUCCEED's targeted interventions aim to improve children's learning in early childhood, grades one and two, especially for children with physical disabilities in the initial stages.

Beginning in 1999, BRAC, in collaboration with Helen Keller International, successfully included children with mild to moderate disabilities, in five of its eleven schools, followed by including children with all types of disabilities. To develop human resources and a cadre of trained teachers, BRAC established collaboration with the Center for Disability in Development (CDD). At the present time, only three children per class (about 10 percent of the class size) with mild and moderate disabilities can be enrolled.

The Study and the Findings. Field visits were organized to a demographically varied but representative sample of locations in Bangladesh: Kurigram, Jessore, Savar and Tangail. The research team was comprised of nine research assistants, trained in interview and focus group discussion techniques, and the senior consultants. The measurement parameters included educational needs of disabled children, the obstacles to obtaining these needs, and recommendations for improving the current educational system to provide suitable education. The results of this data gathering show that stigma against disabled children by society is the biggest obstacle to education. This obstacle, and the universal lack of government educational facilities for disabled children, present formidable challenges for improving educational opportunity for children with disabilities. The solutions identified by those interviewed include recommendations for public education and awareness, demonstration projects that can be replicated, a configuration of special education that includes mainstreaming into public schools, medical and educational counseling, food aid and poverty reduction, and curriculum that includes sports and fine arts.

Parents. From the data and from qualitative reports, a profile of disability in Bangladesh from the parents' point of view was compiled. It is obvious that most families having disabled children are at risk in economic, social and educational dimensions. Not only did they have to worry about how to feed and care for their child, but they also had to protect the child from hostile attitudes of the society, from rejection by almost all educational systems, by lack of knowledge about their child's disability, and by even less information about how to parent that child. The thinking of the parents was dominated by the attitude that there was no future for their child. The research methods, however, also showed that parents, if given the chance for knowledge or education, become energized and active. They represent a receptive population for educational and educational/medical interventions.

Opportunities. Opportunities exist to impact on any dimensions of needs found for children with disabilities in Bangladesh. USAID already funds projects that could have great impact on the biases and prejudices against children with disability and the adoption of new, integrated models of education. SISIMPUR, the local adaptation of the children's educational television series, *Sesame Street*, will be a great influence on preschool and primary children throughout Bangladesh—and a potential model for inclusion (perhaps the only model known to Bangladeshi families). SUCCEED offers a new educational approach through a careful study of potential users, including children with disabilities. Much groundwork is still needed and the opportunities are great. An accurate count of children with disabilities is greatly needed by planning agencies. Programs to build the self-esteem of children and families through sports and arts curricula await development. Parent education and knowledge would energize a new force for reform. In addition, coordination of medical, food and educational programs, even if only on a demonstration project level, would show solutions to education and prevention that do not exist today.

I.

The Status of Disabled Children

A. Definitions

This is the study of preschool and primary-aged children with disabilities in Bangladesh, from three to ten years of age. Long ignored, shunned, and isolated, these children are the victims of inequity and stigma. Experience in other parts of the world has shown that with a proper education, children with disabilities not only become literate, but they also train for jobs, become valuable family members and citizens, and can achieve a level of satisfaction and independence enjoyed by their non-disabled peers. Equity of education is not just a civil responsibility; it is an investment in human resources that will reward the State as well as its individual citizens.

The inclusion of the early childhood-aged youngster in educational systems is a new idea for many educators in countries with complex and overcrowded schools. A recent study of Early Childhood Education (ECD) in Bangladesh¹ noted that when educational experts of Bangladesh were interviewed about their interest in ECD they usually stated:

“...ECD is new for Bangladesh”, usually in those exact words. Interest in ECD itself is a trend—only very recently has programming begun in this area for most currently active NGOs. The lack of capacity at universities, colleges, PTIs and in most NGOs—and at all levels of the education department system—reflects this novelty.”

The concept of ECD for children with disabilities is complicated by the fact that most persons think of disabilities as labels. That is, if a child has a certain medical condition, then that child has defined needs that can be “treated” educationally and medically by prescribed methods. With primary and pre-primary-aged children, this labeling does not work. The child’s needs have to be viewed as part of developmental stages; symptoms are the results of multiple causations; and the environment of the child plays a larger role in his or her manifestations of disability than in older ages. For the educator of pre-primary and primary-aged children, an educational/development diagnostic model best works when grouping disabled children. Such a model works on the data from assessments of a disabled child’s capacities and learning strengths. Unfortunately, these types of data are not available in Bangladesh.

What is used as nomenclature for children with disabilities in Bangladesh are traditional medical labels. They currently serve as the basis for legislative action and for the naming of groups to be researched or served. The Bangladesh Persons with Disability Welfare Act² lists the following categories of disabilities: physically crippled, visual impairment, physically handicapped, hearing impairment, speech impairment, mental disability, multiple disabilities, or any other type of impairment that the government chooses. When quoting incidence figures, this nomenclature will be used; it serves as the structure of most incidence studies.

¹ M. Diane Lusk, Rubina C. Hashemi, and M. Nazmul Haq, *Early Childhood Education: Context and Resources in Bangladesh*, (Washington, DC: CAIL, 2002), 8.

² *Bangladesh Persons with Disability Welfare Act – 2001*, http://www.disabilityworld.org/05-06_01/gov/bangladesh.

In a World Bank situational analysis of disability in Bangladesh³ the authors cite the terms “impairment”, “disability” and “handicap” as words traditionally used to name disability types. A more recent trend is to assess functions that can respond to education (and vice versa). This type of system is referenced in a citation of the International Classification of Functioning, Disability and Health (ICF).⁴ An adapted version of the ICF for use in contexts involving children and youth, known as the ICF-CY is currently being field-tested in a number of countries. The versions of the questionnaires (<3 years to >13 years) being used as part of the field trials have been designed to evaluate the utility of the ICF-CY, not as assessment measures. Further information on the ICF and the ICF-CY is listed in the reference section of this report.

In an attempt to gather information about the education needs of pre-primary and primary-aged children with disabilities in Bangladesh, research was conducted by the staff of this assessment effort. In this research (described in Chapter V) a compromise nomenclature, encompassing functions, medical labels, and educational grouping was used with parents, teachers, and administrators. This nomenclature was understood and useful for all respondents and helped them determine educational needs as well as medical needs. This terminology used the following groupings to address those who need educational services: mental disability (encompassing mental retardation, neurological and developmental delays and other disabilities of cognition and mental illness); hearing disability (including mild to severe problems, language acquisition problems and resultant speech formation difficulties); visual disability (from Vitamin A deficiency problems to complete blindness); physical disability (problems with mobility, coordination and muscular control; and all others/multiple disability, usually overlapping disabilities and other rare types.

B. Scope of Disabled Populations 0 – 10 and 3 - 10

The World Health Organization⁵ offers guidance in determining the health environment of Bangladeshi children from birth to ten who have disabilities needing interface with education. Table I gives a snapshot of the overall statistics of Bangladesh.

³ Jens Byskov, Khandaker Jahurul Alam, Nazmul Bari and Birgitte Bruun, *Disability in Bangladesh: A Situation Analysis, Final Report*, (Dhaka: Danish Bilharziasis Laboratory for the World Bank, People’s Republic of Bangladesh, May 2004), 9-10.

⁴ WHO, International Classification of Functioning, Disability and Health. Website: <http://www.who.int/classifications/icf/en>

⁵ World Health Organization, *The World Health Report 2004: Changing History*. <http://www.who.int/countries/bgd/en/>

Table 1: Country Summary, Bangladesh, 2004

Total population: 143,809,000
GDP per capita: \$1,668
Life expectancy at birth m/f (years): 62.6/62.6
Healthy Life expectancy at birth m/f (years): 55.3/53.3
Child Mortality: m/f (per 1000): 71/73
Total Health Expenditures per capita: \$58.

The number of children in Bangladesh between the ages of birth through ten are taken from the Bangladesh Census of 2000⁶ and extrapolated, through their percentage, to the UN projected figures. Table 2 shows the population totals for children in different age groups.

Table 2: Age Grouping of Bangladesh Population

| Age Range | Actual Population |
|------------------|--------------------------|
| <1 | 387,490 |
| 1-4 | 14,995,620 |
| 5-9 | 17,896,110 |
| | <u>4,239,973</u> |
| Total: | 37,519,193 |

No national census has taken actual counts of the number of disabled children. Rather, in 1991, the Bureau of Statistics sampled a group of citizens and determined the estimates of children in the aforementioned groupings based on that sample of 1991⁷. The incidence of this census for citizens of all ages was 0.47%, a far smaller number than is known to actually exist, and indicated serious under-estimation or reporting. However, the sample of children with disabilities led them to infer that the percentage of children known to have disabilities in the general population is closer to global norms and is as follows:

⁶ Bangladesh Bureau of Statistics (BBS), *Bangladesh Census, 2000*. (Dhaka, Ministry of Finance 2000). Please note that the figure 4,239,973 in Table 2 is an extrapolation from the 2000 census figures and does not represent a precise age range.

⁷ Sample of 10 districts by Bangladesh Bureau of Statistics (BBS) in 1991. Information obtained from unpublished report obtained from NFOWD.

Table 3: Disability Percentages by Age, Based on Samples

| Age Group | Percentages |
|------------------|--------------------|
| 0 – 4 | 5.2 |
| 5 – 9 | 9.8 |
| 10+ | 9.9 |

If those percentages are applied to the 2004 UN/WHO statistics, the total number of disabled Bangladesh children, ages birth to ten is 3,153,886, or 7.7% of the population of that age. This total is at least double the number projected for preschool/primary disability by any reporting disability agency or study.

Two baseline studies conducted by ActionAid Bangladesh offer different incidence figures, but probably more accurate groupings than do the Bureau of Statistics studies⁸. These studies, which were conducted in nine different locations in all parts of Bangladesh, derived overall incidence figures between 7 percent and 15 percent. These figures indicate that the GOB's incidence figures are conservative and, perhaps, under-representative. However, since the GOB's report represents the largest study of subjects, they were used for estimation of incidence.

This report focuses on the population of pre-primary and primary aged children, ages three to ten; thus, it is necessary to calculate that population for estimations of disabilities within this age group. The formula used to determine the numbers of children ages 0 – 10 is used to calculate the number of children in Bangladesh who are ages 3 – 10. Using the WHO figures for 2004, and the 1991 BBS sample study, the total number of disabled children falling between ages 3 and 10 is 2,559,222. This reflects an incidence of 9.9% of all children between 3 and 10.

The distribution of disabilities in the population aged three to ten, is made possible by studies done at the Japan International Cooperation Agency (JICA)⁹. Through small sample size studies in Bangladesh as well as desk review, they concluded percentages of disabilities within populations of young children. The estimated number of Bangladeshi children, ages three to ten, calculated by disability categories can be found in Table 4.

⁸ Kabir Nazama, Nefeesur Rahman *Four baseline surveys on prevalence of disabilities*. (Dhaka: ActionAid Bangladesh 1996).

⁹ *Country Profile on Disability People's Republic of Bangladesh*, (Japan International Cooperation Agency (JICA) March, 2002). http://www.jica.go.jp/english/global/dis/pdf/ban_eng.pdf

Table 4: Types of Disability in Preprimary and Primary Ages (3- 10) in Bangladesh Based on 2,559,222 Disabled Children

| Type of Disability | Percentage Of Population | Total No. Of Children |
|--------------------|--------------------------|-----------------------|
| Mental Illness | 1.4 | 35,829 |
| Cerebral Palsy | 7.0 | 179,145 |
| Multiple | 3.4 | 87,014 |
| Intellectual | 7.4 | 189,382 |
| Visual | 19.7 | 504,166 |
| Speech and Hearing | 19.6 | 501,607 |
| Physical | 41.5 | 1,062,078 |

C. Reliability and Availability of Incidence Figures

The figures quoted in this report are the product of interpretations of available studies that sample various Bangladesh populations. Clearly a national census is needed to obtain accurate data. Such a study of a sample population was attempted by the GOB in 1992, but results have not been released.¹⁰ Census methodology for a 1998 sample study--a sample study with the largest sample population to date--was used to calculate the incidence figure for the Bangladeshi populations. Because the end results are close to that recommended by the WHO, it is probably the most accurate statistic that can be used.

Because of the difficulty in clarity of terms used in incidence research, accurate data are difficult to find. There are a few key studies are country reports compiled by NGOs to describe Bangladeshi disability situations. There are almost no finished studies dealing with children from three to ten. Promising starts are being made by Save the Children Federation, Inc. and Sesame Street¹¹, which will collect data from a service-based activity. Each of these projects will focus on children with educational special needs rather than emphasize types of disabilities. This convention is considered by most child researchers to be completely appropriate for this age group. Perhaps these agencies will be able to assist in pioneering the sampling procedures and tests that are necessary to find standardized and comparable educational needs for pre-school primary children in Bangladesh. Because poverty, malnutrition, disease and stigma are so prevalent in Bangladesh, it is obvious that the disability population will be bigger and different than in most other countries, especially developed countries. This report raises the questions of efficacy of disability estimates.

¹⁰ Based on information obtained in a meeting in Dhaka with Mr. Nafeesur Rahman, Executive Secretary, CSID, January, 2005.

¹¹ Project activities funded by USAID/Bangladesh.

D. The Disability Population and Pathological Environments

The incidence figures for persons with disabilities within the population of Bangladesh are close to the estimate of the World Health Organization's projected global number of ten percent. However, examination of the reality of child health, poverty, malnutrition and disease in Bangladesh would presume much higher incidence figures for disability because these conditions in themselves cause or are highly correlated with disability. Haque and Shahnaz¹² express the justified mistrust of the above figures:

"The prevalence of disability is believed to be high for reasons relating to overpopulation, extreme poverty, illiteracy, lack of awareness, and above all, lack of medical care and services. Although disability is a major social and economic phenomenon in Bangladesh, there is very little reliable data available on this issue, especially in the absence of a comprehensive national survey on persons with disabilities...ACTIONAID Bangladesh put the disabled population at 8.8 percent of the total population. Bangladesh Protiband Kalayan Samiti records 7.8 percent. Dr. Julian Francis, in a report prepared for the Aid Management Office (AMOD) of the Overseas Development Administration (ODA) of the British Government in 1995, estimated the Persons with Disabilities population to be 9 million, of which no less than 7 million live in rural areas. Most of the estimates generally appear to be underrated, sometimes excessively."

Special educational needs of children are not necessarily related to a traditional disability label. Children living in poverty have a particular vulnerability to disability (or have impairments of learning similar to disabilities). Yeo states that "It is already known that: living in poverty increases the likelihood of getting an impairment; disabled people generally experience higher rates of poverty as a result of being disabled; and that when people living in poverty become disabled they are often more severely marginalized than are wealthier people."¹³ The Impact Foundation Bangladesh illustrated this principal with a study¹⁴ of 256 disabled persons selected from over 4,000 households. The study found a direct inverse correlation between disability and land-holding: the more land a family held, the less chance of finding a family member with an identifiable disability.

Much of the correlation between poverty and disability is because of poor health care and conditions in poverty populations. Yeo¹⁵ states it succinctly:

"Not only do disabled people experience disproportionately high rates of poverty, but being poor dramatically increases the likelihood of getting an impairment. Those living in chronic poverty often have limited access to land, healthcare, healthy food, shelter, education and employment. Furthermore, people in chronic poverty often have to put

¹² Shahidul Haque and Begum Shahnaz, *Feelings on Disability Issues in Bangladesh*, (Dhaka: SARPV, 1997).

¹³ Rebecca Yeo, *Chronic Poverty and Disability*, (Dhaka, Action on Disability and Development, August 2001), 6.

¹⁴ *Preventing disability today...alleviating poverty tomorrow A study report on relationship between poverty and disability*, (Dhaka: Impact Foundation of Bangladesh, August, 1998). www.impactfoundationbd.org/publication.html

¹⁵ (Short form) Yeo, *Chronic Poverty and Disability*, 15.

up with hazardous working conditions. All these factors can cause illness, injury and impairments.”

The Bangladesh Bureau of Statistics¹⁶ estimates that in 2000 the number of persons in poverty amounted to 64.3 percent of the total population.¹⁷ The implication of this significant figure is that because incidences of disability are greater in populations embedded in chronic poverty, it is likely that the 9.9 percent of the population being delineated in this report is an under-estimation of the number of children needing special needs education opportunities. A realistic figure may indeed be closer to results of studies^{18 19} that suggest incidence as high as 13 and 14 percent.

Table 5, extrapolated from a study archived by WHO,²⁰ shows the differences in some diseases and medical care between the poorest and the richest Bangladeshis in 1996-97. It is easy to see why poverty is a pathological environment for children and their families.

E. The Environment of the Young Child in Bangladesh

The environment of a child born in Bangladesh, particularly a child born in poverty, can only be called dangerous. UNICEF's report on the State of the World's Children²¹ paints a very bleak picture for a child born in Bangladesh. This picture paints a health environment fraught with potentials for disabling conditions. It is a very fortunate child in Bangladesh who has:

- not died at birth (Bangladesh babies have an infant mortality rate of 71(males) and 73(females) per thousand²²).
- a normal birth weight (30 percent of all children are below a healthy birth weight).
- a normally breastfeeding schedule, but with complementary food (46 percent of children are breastfed by mothers milk only, 78 percent are offered complementary food, and 87 percent are breastfed until around 23 months).
- a normal, healthy weight (13% are severely underweight and 48 percent are below normal limits. 45 percent of children are stunted in growth and 10 percent are severely “wasted”--emaciated--all conditions with correlated emotional and intellectual coordinates).
- received vitamin A supplements to prevent blindness (90 percent of households in Bangladesh lack vitamin A to reduce visual disabilities, including both night and day blindness.)
- a household that used iodized salt (70 percent of Bangladeshi households do not, thus increasing the possibility of cognitive and skeletal disabilities.)

¹⁶ (Short title) *Bangladesh Census 2000*.

¹⁷ Poverty in Bangladesh is described in calories per day: 44.3 percent Bangladeshis exist on less than 2,122 calories per day; 20 percent exist on less than 1,905 calories per day.

¹⁸ (Short form) Kabir, *Four Baseline Surveys on Prevalence of Disability*.

¹⁹ *Five Baseline Surveys of Disability: A Micro-Study of Disability in Jamalpur District*, (Dhaka: ActionAid, Bangladesh, 1996).

²⁰ *Status Report on Macroeconomics and Health, Bangladesh*, (Geneva: World Health Organization, Research Archives, 2000).

²¹ *The State of the World's Children, 2004*, (UNICEF, 2004). 106.

²² *The Bangladesh Country Report*, World Health Organization (WHO). <http://www.who.int/countries/bgd/en/>

**Table 5: Differences in Disease and Medical Care
Between Poorest and Richest Persons in Bangladesh**

| HNP Status Indicators | Quintiles Population Poor/Rich | | |
|-----------------------------------------------------|--------------------------------|---------|-------|
| | Poorest | Richest | Ratio |
| IMR (Infant Mortality Rate) | 96.3 | 56.6 | 1.701 |
| USMR (Under 5 Mortality Rate) | 141.1 | 76 | 1.857 |
| Low Mother's BMI (%) (Body Mass Index) | 64.4 | 32.6 | 1.975 |
| HNP Service Indicators | | | |
| Immunization coverage (%) | | | |
| --DPT3 (Diphtheria, Pertussis, Tetanus) | 60.4 | 83.2 | 0.726 |
| --All | 47.2 | 66.7 | 0.708 |
| --None | 18.3 | 4.9 | 3.735 |
| Treatment of Diarrhea (%) | | | |
| -% Seen in a Public Facility | 9.3 | 13.9 | 0.669 |
| Treatment of ARI (%) (Acute Respiratory Inf) | | | |
| Prevalence | 12.6 | 10.77 | 1.178 |
| Seen Medically | 22.9 | 50.6 | 0.453 |
| -% Seen in a Public Facility | 6.6 | 14.2 | 0.465 |
| Antenatal Care Visits (%) | | | |
| --to a Doctor | 9 | 51 | 0.176 |
| --to a Nurse or Trained Midwife | 5.4 | 7.5 | 0.72 |
| --2+ visits | 9.4 | 50.5 | 0.186 |
| Delivery Attendance (%) | | | |
| --by a Medically Trained Person | 1.8 | 29.7 | 0.061 |
| --by a Doctor | 1.3 | 20.1 | 0.065 |
| --by a Nurse or Trained Midwife | 0.5 | 9.6 | 0.052 |
| -% in a Public Facility | 0.8 | 8.6 | 0.093 |
| -% in a Private Facility | 0.1 | 8.7 | 0.011 |
| -% at Home | 98.3 | 80.6 | 1.22 |

Source: Extrapolated from the "Status Report on Microeconomics and Health, Bangladesh," World Health Organization (WHO), Research Archives, Geneva, 2000

In the course of growing from birth to preprimary and primary age, there are other factors in the poverty environment that many experts propose in many journals and speeches to cause disabilities in a child:

- A child may receive lead poisoning from heavily lead-polluted air in densely populated Bangladesh cities.
- Children may be cognitively affected by arsenic in the water.
- Accidents are possible in highly trafficked urban areas, or in construction or other dangerous environments in the rural areas.
- Domestic violence and abuse may be directed at a child.
- Disease may occur from impure water, foods, and general unhygienic conditions.
- Children may not have received necessary immunizations against disease.
- Children do not receive proper health care.

Growing up with a disability in Bangladesh means that a child experiences exclusion; exclusion from institutions, from the environment, and by people's attitudes. Yeo²⁵ states it succinctly:

“Institutional discrimination builds and reinforces attitudinal discrimination and condones environmental discrimination. In many cases, people know that the law requires them to send their primary aged children to school, except their disabled children; bus drivers can throw disabled passengers off the bus with impunity or charge extra for carrying wheelchairs; and bank managers can refuse disabled people an account, simply because they are disabled. This leads to the general perceptions that these actions are valid. Together they have a logic and people use their fears, suspicions and prejudices to build a supporting rationale. Negative attitudes prevent spending on the necessary measures to overcome an inaccessible environment.”

²⁵ (Short form) Yeo, *Chronic Poverty*, 4.

II Social and Political Context

The purpose of this chapter is to provide a brief history of efforts to address the educational needs of disabled children in Bangladesh. The political and social context is discussed in terms of international policy on reforms and initiatives, especially the Salamanca Statement, that, when agreed to, serves to ensure a basic education for all children, including children with disabilities. Country-level policy and laws as they relate to children with disabilities are briefly described, as well as discussion of the cultural milieu or social context that frames some of the main issues under consideration. Mechanisms for service delivery, governmental and non-governmental (NGOs and INGOs), are identified. Public and private efforts to disseminate information and increase awareness about the educational needs of children with disability, as well as a discussion of funding levels (government/donor/private) on children with disability are addressed.

A. Political Context: International and National

International Context

As noted in a publication on serving children with disabilities in developing countries in Asia,²⁶ some progress has been made, but not drastically, since the World Conference on Education for All held in Jomtien, Thailand in 1990. The Salamanca Framework for Action (1994) was a significant milestone in the education for children with disabilities: The Statement defines and recommends the mode of service delivery (inclusion) and the timing of intervention, linked to inclusive practices.

Bangladesh endorsed the Education for All (EFA) framework and is a signatory to the Salamanca Statement and Framework for Action on Special Needs Education (1994) and the Dakar Framework for Action (2000).²⁷

The *Salamanca Statement*²⁸ proclaimed inclusive education as the leading principle in serving children with special educational needs. The Salamanca Statement and the Framework for Action emerged from the World Conference on Special Needs Education, organized by the Government of Spain in cooperation with UNESCO in June 1994. It states that those with special educational needs must have access to regular schools that should accommodate them within a child-centered pedagogy capable of meeting those needs. A total of 92 governments and 25 international organizations reaffirmed commitment to the goals of Education for All (EFA), recognizing the necessity and urgency of providing an education for children and youth with special needs within the regular education system.

²⁶ Sudesh Mukhopadhyay, *Early Childhood Care and Education (ECCE) For Children with Visual Impairment in Asia*. (New Delhi: National Institute of Educational Planning and Administration, 2002).

²⁷ (Short form) Jens Bryskov et al., *Disability in Bangladesh*, 21.

²⁸ UNESCO, *The Salamanca Statement on Principles, Policy, and Practice in Special Needs Education and A Framework for Action*, (World Conference on Education, Salamanca, Spain, June 7-10, 1994).

Inclusive education is regarded as the most effective means of combating discriminatory attitudes; it is believed to provide an effective education to a majority of children and improve the efficiency and ultimately the cost effectiveness of the entire educational system. The guiding principle outlined in the *Framework for Action* is that schools should accommodate all children, regardless of their physical, intellectual, social, emotional, linguistic and/or other conditions.

Article 53 of the 1994 Salamanca Framework for Action addresses the need for early childhood education for children with disabilities:

The success of the inclusive school depends considerably on early intervention, assessment, and stimulation of the very young child with special educational needs. Early childhood care and education programs for children aged up to six years ought to be developed and/or reoriented to promote physical, intellectual and social development and school readiness. Programs at this level should recognize the principle of inclusion and be developed in a comprehensive way by combining preschool activities and early childhood health care.

A comprehensive approach that links education and healthcare in Bangladesh is critically important given the serious nutrition issues related to poverty that impact directly on a child's cognitive development. Failure to respond to the nutritional or health needs of the young child may cause irreparable neurological damage and cognitive damage. Parents and family members need to be empowered with knowledge and skills to understand and serve the development needs of children.

The decade 1993-2002 was proclaimed by the United Nations Economic and Social Commission for Asia and the Pacific (ESCAP) as the Asian and Pacific Decade of Disabled Persons. In May 2003 the ESCAP adopted a resolution on promoting an inclusive, barrier-free and rights-based society for persons with disabilities in Asia and the Pacific. It supplements the UN Millennium Development Goals and proclaims an extension of the Asian and Pacific Decade of Disabled Persons for another decade, 2003-2012. Guidelines for government actions to be undertaken during the decade, known as the Biwako Millennium Framework, were developed to conclude the first decade and set priorities. The framework identifies seven priority areas for action, including areas of particular relevance to children, "early detection, early intervention and education" and "access to information and communications, including the information, communication and assistive technologies."²⁹

The United Nations Standard Rules on the Equalizing of Opportunities for Persons with Disabilities (referred to as the "Standard Rules") was adopted by the United Nations in 1993. It is one of the international conventions that supports the rights of persons with disabilities and provides guidance to governments on making social, political, and legal changes to ensure that persons with disabilities become "full and equal citizens of their countries." The Government of Bangladesh adopted the Standard Rules in the same year.

²⁹ (Short form) Bryskov et al., *Disability in Bangladesh*, 19-20.

The Convention on the Rights of the Child (CRC), to which Bangladesh is a signatory, establishes minimum standards for every aspect of children's lives, including education. The core minimum targets for education include free, compulsory primary education for all (Article 28) and the right of disabled children to special care and training designed to help achieve self-reliance and a full and decent life in society (Article 23).

National Context

In Bangladesh, the national framework for disabilities is the Bangladesh Constitution which states "no citizen shall, on grounds only of religion, race, caste, sex, or place of birth be subjected to any disability, liability, restriction or condition with regard to access to any place of public entertainment, or resort, or admission to any educational institution." In 1995 the first National Policy for the Disabled was approved by the Government, which "mainstreamed disability into the country's development agenda."³⁰ An Action Plan to operationalize this policy was approved in 1996.

The Bangladesh Parliament adopted its first comprehensive disability legislation, the Bangladesh Persons with Disability Welfare Act 2001, in April of that year. The legislation includes definitions of persons with disability that identifies those with physical disabilities, visual impairment, hearing impairment, speech impairment, mental disability (cognitive disability or mental retardation), and mental illness, characterized as "...loss or damage, partially or wholly, of mental balance."

Persons with multiple disabilities (more than one type of impairment) are also covered under the Act, whether the cause of the disability is congenital or a result of accident or disease, maltreatment, or other reasons. If a person is incapacitated and unable to lead a normal life, either partially or fully, as a result of the disability or mental impairment, the Act identifies that person as one with a disability.

On May 7, 2002, The National Action Plan for People with Disability (PWD) was promulgated as a directive from the office of the Prime Minister. The Action Plan stipulates what needs to be done to realize the goals of the Disability Welfare Act in five areas: education, health, employment, accessibility, and transportation.³¹ As examples, the plan recommends creating mass awareness about disability as a method of prevention; conducting surveys and registration at birth for the identification of disabilities; providing special schooling and logistical support, including disability in the curriculum; teaching children "alongside general students;" setting up programs of inclusion of severe and multiply handicapped students for education; and developing public accessibility so that disabled persons will have communication and mobility. A major constraint to implementation of the Action Plan is funding, discussed elsewhere in this report. This action plan has not yet been implemented.

³⁰ Ibid., 21.

³¹ Meenu Bhambani and Maj-Lis Voss, *The World Bank and Disability in South Asia A Portfolio Review*, (Washington, DC: World Bank, October 2003).

The two government organizations that work to promote better dialogue between the government and the NGOs targeting disability include the National Coordination Committee (NCC) and the National Foundation for the Development of the Disabled (NFDD).

The National Coordination Committee (NCC) on Disability was set up to provide a forum for open dialogue between the government and NGOs in order to promote mutual understanding and cooperation and to identify and discuss issues that impede cooperation on disability issues between the government and NGOs. The NCC, which was started in 1993 under the chairmanship of the Minister of Social Welfare, is comprised of 52 members, including women, persons with disabilities, and relevant government organizations, NGOs, and self-help organizations. The NCC works in close cooperation with the National Forum of Organizations Working with the Disabled (NFOWD), which is the umbrella organization of the NGOs in Bangladesh.

The National Foundation for the Development of the Disabled is an organization established to provide necessary guidance and support to the government and NGOs regarding disability issues.

B. Social Context: Vision versus Reality³²

Bangladesh's economic situation, especially its high incidence of poverty, is the context for discussing the overall social context. Poverty makes a parent unable to provide an environment that supports a child's growth and development. Parents in poverty are not in a position to buy assistive devices and to proactively seek out and find appropriate education for their child who is disabled. Parental literacy, which is lacking in poverty, is strongly associated with education achievement. Education and literacy are critical to a family breaking out of the poverty cycle.

The cultural and social milieu provides the framework for understanding constraints to full inclusion of children with disabilities in schools in Bangladesh. The tendency to ridicule someone who is atypical, for example, illustrates how children with disabilities are often considered as strange (different) and become subject to bullying and harassment. This negative environment influences parents who are not comfortable having their disabled children seen in public places. The child with a disability is considered a curse to the family and a punishment from God; parents, thus, are, metaphorically "sinners".

Disability also has a correlation with literacy. According to a study on prevention of disability, 70 percent of persons with disabilities are illiterate.³³ A study by the Impact Foundation Bangladesh³⁴ in the Chuadanga district found that disability is directly correlated with literacy status. The majority of persons identified as disabled (77 percent) were concentrated in those

³² Many of the points discussed in this section are based on feedback from Bangladeshi researchers, parents, and others interviewed for this study.

³³ Christiana Rozario, "Prevention of Disability: Impact of Bangladesh Experience," *Abstracts Regional Symposium on Disability*, (Dhaka: NFOWD, December 9-11, 2003. <http://www.nfowd.org/symposium2/Abstract.doc>.

³⁴ Impact Foundation Bangladesh (IBF) is a charitable trust and a non-governmental organization working in the country as part of a global movement. The mandate of this organization is to achieve sustainable and affordable change to prevent disabilities and alleviate poverty. Website: <http://www.impactfoundationbd.org>.

households where most illiterate persons lived. Conversely, when the rate of literacy increases there is a concomitant decrease in incidence of disability. Only two percent of persons with disability were found in households where all family members were literate. A UNICEF study in 2000 found that literacy rates in Bangladesh for females were 29 percent, 52 percent for males.

Parents in poverty, most of whom are illiterate, are not aware of their fundamental and constitutional right as parents to demand an education for their child. This is especially applicable to parents of children with a disability. Children with disabilities tend to be neglected and ignored, tend not to be taken outside the home because of embarrassment and potential teasing and ridicule from others. They are often abused by family members and others in the community who are caught up in this negative stigma. The children lead isolated lives, excluded from their peer groups. This aloneness has a very negative effect on the self-concept and self-esteem of disabled children, a contributing factor to poor school performance.

The media has neither included children with disabilities in their programming nor do children with disabilities have access to print and non-print materials. With respect to the media, children with disabilities are “invisible;” they don’t exist.

Access to school and retention in school are negatively influenced by the fact that school management committees (SMCs), community leaders, and village leaders (Imams) do not accept children with disabilities, with few exceptions. School managers (principals and head masters or mistresses) do not welcome them either, reflecting community attitudes that children with disabilities will harm other children or they are “hopeless” to teach. Likewise, typically developing children absorb negative community and societal attitudes and will not or do not know how to interact with children with disabilities.

School environments are not supportive of special needs education. They do not include adequate hygiene (toilets) for children with disabilities, appropriate furniture, assistive devices (e.g., Braille and hearing aids), and appropriate educational materials. Special teaching equipment is not available in the country’s schools. The government, although it has stipulated a policy of inclusive education, has not provided the resources or the will to ensure that children with disabilities do, in fact, attend mainstream schools.

Trained and motivated teachers are critical to provision of a quality education for all students, and especially for those with disabilities. In Bangladesh, there is a scarcity of such skilled teachers. Curriculum adaptations are often necessary, but they do not exist.

Awareness programs are needed to create greater awareness of parents and family, teachers, community members, SMCs, and the disabled children’s peers. These programs can be offered through NGOs, self-help organizations, Government efforts, and other means.

Expectations influence educational achievement. Parent expectations, as well as teachers’ expectations, are limited by their feeling that these children can’t learn. Inability to learn is often confused with stubbornness when in fact the child could learn and perform if appropriate training, support, and materials were available.

To promote access and retention in school, a quota system should be in place. This has worked in other countries. It does not exist currently in Bangladesh.

Political will is necessary if an inclusive society is to become an actuality. Apparently that will does not exist in Bangladesh, at least by a significant number of influential people. None of the four or five key political parties in Bangladesh, for example, has spoken out or advocated for the rights of children with disabilities to receive an education. Because of this silence, millions of Bangladeshi children are disenfranchised and without a voice.

Institutional discrimination serves to limit access to education. In Bangladesh, the education of children with disabilities is mostly dependent on NGOs because there are very few government programs. Also, only children with visual impairment, hearing impairment, and mental illness have any access to government-supported special schools.

Because children with disabilities do not have access to an education, they are excluded from the learning of skills necessary to generate income. They are, consequently, in a dependent position on others throughout their life, and, just as importantly, they are not in a position to contribute to Bangladesh's development. They cannot break out of the cycle of poverty nor can they avail themselves of aids and appliances that would contribute to a better quality of life for them and for their family. Their poverty thus contributes to additional discrimination—the self-fulfilling prophesy of “hopelessness” bestowed upon them by society in general.

Those in poverty also are excluded from basic health care services. This has direct implications for disability, since prenatal care and early intervention are critical factors in preventing and ameliorating disability. Bangladesh has few health care services for those in poverty.

One advocate sums up the situation thusly: “An unequal educational system, a rigid and unfriendly education curriculum, the ignorance and a lack of awareness of teachers, and the unfriendly environment existing in most of the institutions, have done very little to promote education of children with disabilities in Bangladesh.”³⁵

C. Key Players in Systemic Reform for Children with Disabilities

Some agencies are accepting the mandate of the constitution and moral responsibility to try to change the educational and societal systems that exclude and marginalize children with disabilities in Bangladesh. A few of the major players in systemic reform are:

- *National Coordination Committee (NCC)*. The National Coordination Committee on disability was set up to provide a forum for open dialogue between the government and NGOs in order to promote mutual understanding and cooperation and to identify and discuss issues that impede such cooperation. The NCC, which was started in 1993 under the chairmanship of the Minister of Social Welfare, is comprised of 52 members, including women, persons with disabilities, and relevant government organizations, NGOs and self-

³⁵ Nafeesur Rahman, “Country Profile on Disability,” *The Daily Star*, December 3, 2004.

help organizations. The NCC works in close cooperation with the National Forum of Organizations Working with the Disabled (NFOWD), which is the umbrella organization of NGOs in Bangladesh.

- *National Foundation for the Development of the Disabled (NFDD)*. The NFDD is an organization that was established to provide necessary guidance and support to the GOB and NGOs regarding disability issues.
- *The National Forum of Organizations Working with the Disabled (NFOWD)*. The NFOWD was formally established in 1991 in order to create linkages between strategic agencies and interventions. It is the leading national level coordinating body of NGO agencies working on disability issues in Bangladesh. It currently has 176 member organizations and an additional 126 organizations waiting for NFOWD approval for membership. The NFOWD provides support to the NGOs in a number of ways, such as training, research, and “hands-on” activities to help mainstream disability into the NGO’s organization. The NFOWD also plays a coordinating role and proactively uses national media and cultural events to promote inclusion and equity, and plays a policy and advocacy role vis-à-vis the central government, and its regional and district levels. For example, the NFOWD helped the government develop its national policy on disability in 1995 and has spearheaded the development of the National Action Plan (Draft),³⁶ using participatory processes to obtain feedback from 17 ministries.
- *NGOs and INGOs*. According to the NFOWD, approximately 400 NGOs “claim to be working” in the area of disability out of a total of more than 40,000 NGOs in Bangladesh.³⁷ According to key stakeholders interviewed for this study, NGOs have taken on responsibilities that should be the responsibility of the government. The Campaign for Popular Education (CAMPE) and ActionAid Bangladesh are two prominent NGOs working in education. NGOs that work with specific disability areas include the National Federation of the Blind (NFB); the Bangladesh National Federation of the Deaf (BNFD) and the Society for Assistance of Hearing Impaired Children (SAHIC); Society for the Welfare of the Intellectually Disabled Bangladesh (SWID-B); and the Center for the Rehabilitation of the Paralyzed (CRP), for those with physical and neurological impairments including cerebral palsy.
- *Donor Agencies*. Various donor agencies have assessed barriers and possibilities for inclusive education, but sustained follow-up has sometimes been limited. A new initiative by the European Commission (EC) includes a set of specific indicators measuring the inclusion of disabled children into public schools. These indicators will be included as part of the research plan for the massive educational reform and systemic change effort embodied in the Second Primary Education Development Plan (PEDP-II), which will be described in greater detail in a later section of this report. The performance indicators developed by

³⁶ The National Action Plan (NAP) is awaiting approval by the Cabinet, according to the NFOWD; based on stakeholder comments at meeting at the NFOWD, January 2005: “...Unless the NAP is approved by the Parliament, it won’t work.”

³⁷ The actual number of NGOs in Bangladesh is closer to 50,000, according to the NFOWD, but not all NGOs are fully functioning and some are NGOs in name only.

the EC include: the number of children enrolled in state primary schools, number of children with disabilities enrolled in state primary schools, and the number of children with disabilities who complete primary school.

D. Level of Government/Donor/Private Funding for Children with Disabilities

No documentation lists accurately the amount of taka appropriated, budgeted or spent by the GOB, NGOs, and INGOs, or private funding for the education of pre-primary and primary-aged children with disabilities. What can be safely estimated, however, is that the amount spent is only a fraction of what is needed. Government schools serve less than 1,500 students in residential and separate schools for the visually impaired, the hearing impaired and the intellectually disabled³⁸. Estimates of the numbers of disabled children served by NGOs range from 10,000 to 15,000. Thus the total number of disabled children known to be served is but a small fraction of the over 2.25 million disabled, primary-aged Bangladeshi children. Each NGO has a different style of education or advocacy, a different age range and disability type, disparate educational objectives, and a variety of trained personnel. Comparison of services and the delineation of service costs do not exist and must await a cost-effectiveness study of extensive scope; a study that no agency has yet designed.

The National Action Plan for People with Disability (Draft), based on the Bangladesh Disability Welfare Act 2001, promised action towards systemic reform in the education of disabled children. However, no costs were attached to the plan. Most often the activities were listed as being funded “within existing resources.”³⁹ A recent newspaper article⁴⁰ indicates that the National Action Plan, along with other educational plans, has been significantly delayed in receiving approval from the Cabinet and may not be activated in the foreseeable future.

The largest resource of developmental and system change financing lies in two national plans funded primarily by INGOs and international financial institutions. The Poverty Reduction Strategy Paper (PRSP), while not addressing disability education directly, would target disability reduction and treatment through poverty reduction as its goals. The World Bank, in June 2003, approved \$300 million to support initial actions that will enable the successful implementation of the PRSP. This money will focus on three lines of action against poverty: further advances in health and education; an integrated approach to rural development; and promotion of private sector-led growth.⁴¹

The Second Primary Education Development Program (PEDP-II) is a jointly funded development project between the Ministry of Primary and Mass Education (MOMPE), ten INGOs and two financial institutions (Asian Development Bank and The World Bank).⁴² Component Four of the PEDP-II plans calls for improving and supporting equitable access to quality schooling,

³⁸ Shirin Z. Munir and Sultana S. Zaman, “Services and Programs for the Disabled in Bangladesh,” *International Journal of Disability, Development and Education*, 1992, Vol. 39 (No.1), University of Queensland Press, 1-23.

³⁹ *National Action Plan for People with Disability: Task Force Report* (Directive from Prime Minister’s Office, March 7, 2002).

⁴⁰ *New Age*, Feb. 2, 2005, 1-2.

⁴¹ *Country Brief*, (Dhaka: World Bank in Bangladesh, December 2004).

⁴² *Second Education Development Program PEDP-II*, (Dhaka: Directorate of Primary Education, n.d.).

utilizing special needs education, continuing a stipend program for families in poverty, providing grants for children living with disabilities, development of a “better health for better education” program and developing pedagogical support for children with special learning needs at the school level. The total funding of the PEDP-II is \$1.815 billion, of which the GOB contributes one third. The PEDP-II is supposed to run for six years.

A few INGOs and NGOs are attacking the task of initiating system change by demonstrating exemplary programs that may be adopted by local NGOs and the GOB. Save the Children USA, with funding from USAID, is addressing pre-primary disability as an equity issue, and will be starting inclusive classes, initially including children with mild physical disabilities under its project, SUCCEED (described elsewhere in this report).

The Bangladesh Rural Advancement Committee (BRAC) serves approximately 14,000 children with mild disabilities each year,⁴³ in inclusive settings, making it the largest service provider for children with disabilities in the country.

Save the Children’s SUCCEED project, the BRAC schools, and the USAID-funded SISIMPUR, the Bangladeshi version of Sesame Street©, are projects funded to improve the system through the demonstration of effective methods.

E. Public Forums, National Workshops, Media Campaigns on the Needs of Children with Disabilities and the Outcome

The initiative for public awareness through the celebration of disability events and triumphs seems to be centered in the NFOWD, the Government of Bangladesh (GOB) through the Department of Social Services (DSS) of the Ministry of Social Welfare (MOSW), many local NGOs and INGOs. Through collaboration, arranged events have been tied to international disability events such as a “white cane safety day” and the anniversary of Helen Keller, which build support for persons with disabilities. Most of these celebrations are of recent origin, stimulated in no small part through NGOs’ (especially NFOWD) writing of reports and stories and publicizing local and national events. The *Daily Star*, for instance, has published disability reports at the rate of two per month for the last three months of 2004. Many NGOs initiate local events such as cultural and sports activities to dramatize the success of their clients, emphasizing positive attitudes.

Following is a list of cultural and media events illustrative of the celebrations that have, as their objectives, the awareness and the cultivation of positive feelings towards the person with a disability. Most of these celebrations focus on children, youth, and adults with disabilities, all at the same time. None targets exclusively early childhood years.

⁴³ BRAC Education Program (2003-2004): Progress Report. NEPE Phase III. (Dhaka: BRAC Center).

International Cooperation

- DSS and MOSW have taken up several actions to fulfill the international commitments of Bangladesh, such as the ESCAP Decade Agenda for Action,⁴⁴ for the development of people with disabilities.
- In 1997, Bangladesh organized and hosted the Second South Asian Conference on Community-based Rehabilitation in collaboration with NGOs and the government.
- The Government in cooperation with other South Asian Association for Regional Cooperation (SAARC) countries set up a SAARC Voluntary Disability Fund for the promotion of persons with disabilities in the region.
- The Government hosted the 11th Asia-Pacific Regional Leadership Training Seminar in 1993.⁴⁵
- The Asia-Pacific Development Center on Disability (APCD) sent a mission team to Dhaka, Bangladesh from 1-5 July 2003 to meet with ministry officials and NGO representatives.
- The GOB organized the Second South Asian Conference on Community-based Rehabilitation for the Disabled in Dhaka in 1997. The Dhaka Declaration was adopted at the conference, highlighting the actions for Government agencies and NGOs of the region to promote the causes of persons with disabilities.

Public Awareness

There is greater awareness about disability since 2001 because media campaigns were launched to celebrate the Disability Welfare Act of 2001. Mass media were used to create greater awareness on what causes disability and ways to prevent it. Examples include:

- Publication of newsletters/bulletins.
- Flexible access to performance of television and radio programs.
- Observation of disability-related days.
- Socio-cultural programs focusing on topics of disability.
- Sports programs. As examples, the Ministry of Social Welfare, in association with NGOs, organized regular cultural and sporting events for the disabled in order to further promote public awareness of persons with disabilities. Many NGOs also independently organized cultural and sports events for persons with disabilities. Disabled athletes also participated in international disability sports events such as the World Special Olympics in June 2003. A National Sports Federation was formed to facilitate sporting activities for persons with disabilities. Steps also have been taken by the Government and NGOs to include persons with disabilities in the country's mainstream sports. These events/activities are generally organized only in urban areas.
- Seminars and symposiums. In October 2004 the NFOWD sponsored a workshop for all its members to come to a common definition of community-based rehabilitation (CBR). Publication of results is expected in 2005.

⁴⁴ A Study on Documentation of Good Practices on Inclusive Education in Bangladesh, Report Prepared for UNICEF, (Dhaka: CSID), 14.

⁴⁵ Asian Pacific Center on Disability (APCD), (Bangkok: JICA, 2002). www.apcdproject.org

Research and Books for Public Technical Education Training

In an attempt to promote new and innovative disability programs in Bangladesh, several organizations commissioned studies and either have or will release the results to the public, hoping to stimulate further activities. Some of these projects are as follows:

- ESTEEM II research at CSID started in 2003; the report, which included some questions about disabled children, was released in 2004. ESTEEM II was a government initiative of the Ministry of Primary and Mass Education (MOPME). It was a study of 12 districts and only covered 8 to 10 percent of the country. The final report is not yet available.
- The Ten Questions (TQ) study was successful in setting up a door-to-door screening process to identify children with significant disabilities. A follow-up was conducted by ActionAid on Disability (ADD): the "15 Questions Probe."
- According to the NFOWD, studies have been conducted on disaster and disability. Flooding and extensive exposure to the ocean have been identified as a cause of hearing impairments and cyclones as a cause of physical impairments.
- The various training "vendors" (CDD, BPF, CRP, and the University of Dhaka Department of Special Education, Institute of Education and Research) have played a key role in creating greater awareness about disability intervention through teacher training and research reports.

Illustrative Examples of Awareness Activities by NGOs

The Center for Rehabilitation of the Paralyzed, in Savar, Bangladesh, is a large NGO that serves children and adults with disabilities, especially physical and neurological impairments. The CRP has been innovative in its approach to public awareness. The CRP:

- Produced skits and drama productions of the highest quality that are performed regularly.
- Produced a full-length film, the documentary, "Bihongo," in 2002. The film has been shown successfully in commercial cinemas and has been successful in raising awareness. It's the story of a young girl working as a maid who, because of an accident (falling from the balcony), is paralyzed. "Bihongo" is her success story.
- Sponsors and conducts wheelchair rallies on roads and highways.
- Designed posters and banners for many public places in Bangladesh.
- Through its staff (officials and students), hold meetings with schools and colleges near to the CBR centers to create awareness and acceptance of persons with disabilities into the higher education sector.
- Effectively utilize print-based and electronic media to tell stories and create slogans to promote greater awareness about disability.
- Held seven local and two national seminars on disability issues.
- Adopted sister agencies and developed friendly relations with international committees, "Friends of CRP." To date, there are "Friends" committees in countries such as England, Germany, USA, Denmark, Australia, and the Netherlands.

The *Bangladesh Protibondhi Foundation (BPF)* has sponsored two significant regional seminars:

- With the theme, “Ensuring Health, Education and Rights of the Disabled: From Awareness to Action” the BPF, with joint sponsorship of ODA, UNICEF, ACTIONAID, the British Council and Beximco Pharmacy, and the Shishu Bikash Network of CDC, Dhaka, Shishu Hospital conducted a large seminar 3-5 December, 1994. This was followed by five workshops on specific disabilities and sign language.
- A second conference used the theme, “Creating Barrier-Free Inclusive Communities and a Rights-Based Society for Children with Disability.” It was held 2-7 December, 2004. It was followed by a workshop on Visual Impairment (VI), Hearing Impairment (HI), Learning Disabilities (LD), Occupational Therapy (OT), Physical Therapy (PT), and Inclusive Education. This conference was sponsored by DFID, UNICEF, and UNESCO, but organized by BPF. All South Asian countries participated.
- The latest conference was “Beyond Access (Better Health for Better Education).” It was held in Dhaka during a hartal (nationwide general strike) in late January 2005, and was sponsored by DFID, Oxfam, and the Institute of Education in London. This was the last of five workshops on equity and other gender-related issues, including inclusion.

Finally, a subtle celebration of childhood disability is in the UNICEF-sponsored TV and print cartoon: “Meena.” This child is known to millions of Bangladeshi children through television. When Meena plays with her friend who is disabled, the children of Bangladesh have an instant identification of the positive aspects of a child with a disability.

III

Preschools in Bangladesh: Their Role in Educating Children with Disabilities

In Bangladesh, the family is the main provider of care and education of children from birth to age 8. Children of poor families, especially in the rural areas where approximately 75 percent of the population live, do not experience environments that support their early development. Impoverished early environments, emotional, social, and intellectual, are known to be associated with decreased performance in primary school.

A. Nutrition and Education

Nutritional status must be considered as a contributing factor to disability and poor educational outcomes. Slightly more than half of all children are chronically malnourished and approximately 45 percent are stunted. Chronic conditions of stunting, wasting, and parasitic infestation impair functioning and contribute to childhood disability.⁴⁶ Malnourishment and other conditions such as iron-deficiency anemia, even in mild to moderate cases, are strongly associated with reduced cognitive function and mental capacity and adverse school performance.

School readiness and the opportunity for early childhood education are particularly relevant in this context. A total of 40 percent of students who enroll at the primary level drop out before completing grade 2, and 40 percent of those that stay, repeat the grade. Educational outcomes, as measured by meeting expected competencies, are abysmal: only two percent of second graders do so.⁴⁷ A lack of school readiness is often cited as a causative factor for high dropout and grade repetition rates in early primary education. Parasitic infections, malnutrition, and diseases may not only predispose children to developmental complications and disability, at any level, they may be factors limiting the child's ability to learn and achieve in school.⁴⁸

A detailed study of nutritional status and its effect on learning is outside the scope of this report. Nevertheless, there is ample evidence from a number of studies, for example the work of Matthew Jukes,⁴⁹ that health and nutrition are helpful, if not critical, to improve educational outcomes for children, as measured by rates of attendance, school achievement, and prevention of drop outs and grade repetition.

Providing a meal for very poor children during the school day has been attributed as one reason for school retention and achievement in one primary school that targets girls, visited in the Kurigram district.⁵⁰ The availability of snacks or a meal is a powerful incentive for enrollment and participation in school, especially for a child with a disability. This was often mentioned during the site visits in meetings with parents and school staff.

⁴⁶ Rune J. Simeonsson, *Early Childhood Development and Children with Disabilities in Developing Countries*, (University of North Carolina at Chapel Hill and the FPG Child Development Institute, n.d.).

⁴⁷ Save the Children Federation, Inc., SUCCEED Project Summary September 2004-June 2009, (Dhaka: SC).

⁴⁸ Ibid.

⁴⁹ Matthew Jukes, Judith McGuire, Frank Method, and Robert Sternberg, "Nutrition and Education," *Nutrition: A Foundation for Development*, Geneva: ACC/SCN, 2002.

⁵⁰ The Town Center School, supported by an INGO, Terre des Hommes.

B. Access to Preschool for Children with Disabilities

Access to preschool education for children with disabilities is a function, in part, of the opportunity available to any Bangladeshi child for an education in the early years; an opportunity (through formal, nonformal, and informal ways) that is available to very few children. Of those who do have access to early childhood education, of whatever quality or setting, 40 percent come from advantaged families⁵¹ who can afford to pay the fees and related costs. There is virtually no access to preschool education in Bangladesh for children with disabilities, except for programs designed and implemented through non-governmental organizations.

According to the World Bank Sector Review⁵² in 2000, 35 non-governmental institutions have set up 2,100 early childhood education centers during the last three years (since 1997), benefiting 63,000 children. Except for two programs, BRAC and Save the Children's SUCCEED project, there are no known preschools or early childhood programs in Bangladesh that serve children with disabilities. These programs serve children at the "preprimary" level, which includes children ages 5 to 6 or 7 years of age. These NGO programs are described briefly in the following section.

BRAC

BRAC, previously known as the Bangladesh Rural Advancement Committee, is the major player in Bangladesh's nonformal education network. BRAC has 32,549 NFE centers throughout the country and employs 32,549 teachers, program officers, team leaders, and quality assurance specialist regional managers. The programs include preprimary children (starting at age 5) to age 15.

Beginning in 1999, BRAC successfully included children with mild to moderate disabilities, in collaboration with Helen Keller International, in five of its eleven schools, followed by including children with all types of disabilities. To develop human resources and a cadre of trained teachers, BRAC established collaboration with the Center for Disability in Development (CDD). At the present time, only three children per class (about 10 percent of the class size) with mild and moderate disabilities can be enrolled.

A review by CSID⁵³ indicated that the screening policy was not comprehensive (a few children were incorrectly diagnosed) and lack of adequate skill in assessing the level of disability. Of equal concern, and an area for targeting technical assistance, is the lack of teachers trained in adapting the curriculum to include the special needs of the students. Teacher expertise in developing individual education programs (IEPs) was identified as one area of particular need. Children with severe and profound disabilities could be included in the regular education program if teachers were trained and if appropriate learning materials were available.

⁵¹ The World Bank Group, *Bangladesh Education Sector Review* (Washington, DC: World Bank, 2000), 22-38.

⁵² *Ibid.*, 26.

⁵³ *Together in Education: Promoting Education of Children with Disabilities through BRAC Non-formal Education Approach*, (Dhaka: CSID, May 30, 2004).

More recently, BRAC initiated services for children at the preprimary level. These programs target children with mild to moderate disabilities ages 5 to 6 (with the option to age 7, if indicated). These programs have served a total of 683 students in these areas: physical impairments (307); intellectual (88); visual (73); hearing (40); and speech (175). Children with physical impairments and speech difficulties represent 71 percent (n = 482) of the total number served in BRAC's preprimary program.⁵⁴

SUCCEED

SUCCEED is a four and a half year project in early childhood education developed by Save the Children Federation, Inc. (SC) to support achievement of USAID/Bangladesh's Strategic Objective 10: Improved Performance at Early Childhood and Primary Education Levels through Innovative Learning Models. Its funding is \$12 million. The project was signed into effect in August 2004 and was to be officially launched January 30, 2005. However, due to political unrest and a hartal (general strike), formal launching of the project has been delayed.

The SUCCEED project will have linked activities in five regions of the country: Sylhet, Rajshahi, Khulna, Barisal, and Dhaka divisions. In each region, Save the Children will select an area known as a "Learning Hub" where "Beacons of Success" will demonstrate best practice examples for early childhood development and primary education initiatives and advocacy. SUCCEED's targeted interventions aim to improve children's learning in early childhood, grades one and two.

The SUCCEED project will collect data through house to house surveys on children with disabilities, and implement program planning to serve children, ages 5 to 8, with disabilities, primarily with physical handicaps, in the beginning stage. Children who can be educated in the mainstream (regular classes) with accommodations will be served. The project will promote the concept of inclusive education in the formal schools, making adaptations as necessary for those with mild disabilities; outreach to ethnic communities is also planned.

The capacity of selected institutions will be strengthened through curriculum and material development in order to better serve children with special needs. Through national awareness campaigns, national and regional workshops, and other activities, the SUCCEED project will promote education equity for all.

Beneficiaries at the preschool level are expected to be 72,000 children, 72,000 parents, 600 teachers, and 600 institutions and groups. A door-to-door survey will be conducted to identify children in the community with disabilities. Only children with disabilities allowing them to be mainstreamed (mild to moderate) will be targeted. Children with physical disabilities will be targeted initially for services.

⁵⁴ BRAC Education Program (2003-2004): Progress Report. NFPE Phase III, (Dhaka, BRAC Center), 8.

Lessons Learned

Identifying children with disabilities, and appropriate and valid assessment and diagnosis, are critical to the delivery of services to children with disability. Other key areas of service delivery, based on empirical research, are parent and family involvement and teacher training. The examples in this section are for illustrative purposes only. An attempt was made to utilize examples specific to Bangladesh.

C. Training Needed to Identify Children with Disabilities in the Community

In Bangladesh, disabilities and impairments in children are associated with stigma. Family members or others may not account for the child with a disability due to stigma. Research has shown that reliance on informal community identification of children with disabilities is likely to yield substantial underestimates of prevalence in light of the fact that stigma attached to disability which may keep families from letting others know of their child's condition, missing children with less severe or hidden levels of disability. The best method for yielding estimates of childhood disability in developing countries is the household survey, if conducted by persons trained to interview a family member, typically the mother, using simple questions related to functional characteristics of the child.⁵⁵

SUCCEED's plan is to conduct door-to-door household surveys to identify children with disabilities. Its success will depend to no small degree on the adequacy of the training the field workers receive. A lesson learned from the BRAC experience relates to the necessity of specialized training to accurately identify children with disabilities.

D. Screening for Disabilities

In Bangladesh, as in other developing countries, what is needed is a screening tool that is simple and efficient to obtain information useful to further diagnosis and planning interventions, especially in the local communities. A few examples:

- Screening for hearing loss of infants in China from 6 to 8 months of age was carried out in an innovative study using questionnaires in a two-stage protocol. Parents of 1,020 infants attending two child health clinics in urban areas were asked to respond to a questionnaire with five straightforward questions. These questions were based on behaviors that a mother could observe, such as responding to a loud noise, noticing a car horn or bell, and eye contact when being spoken to. The mother also was asked to make an overall judgment about the child's hearing. A negative response to any item resulted in a referral for a follow-up questionnaire and examination.⁵⁶
- The Ten Question Screen has been shown to be a simple and efficient screening tool for children between the ages of 2 and 9 years of age. The Ten Questions Screen (used in

⁵⁵ (Short form) Simeonsson, 9.

⁵⁶ Ibid., 14.

Bangladesh, Jamaica, and Pakistan) appears to be the only tool available that has been used with any consistency across a number of different countries following a two-phase design approach.⁵⁷ The Ten Questions Screen was designed to identify children with seizures as well as cognitive, motor, vision, and hearing disabilities and was administered to parents by well-trained community workers. All of the children who screened positive and a random sample of children who screened negative were evaluated in the second phase of the study. Overall, it was concluded that the Ten Questions Screen could be an efficient tool in identifying children with nonsensory disabilities in developing countries.

- The ABILITIES Index is an instrument designed to be non-categorical and appropriate for use across all disabilities. It has been successfully used in a number of developing countries. The ABILITIES Index yields a score using a scale of 0 to 5, with a range from “normal” ability to extreme or profound disability.⁵⁸ An advantage of the ABILITIES Index is that a child’s strength as well as his or her weaknesses (or disability) are identified. A total of nine areas are assessed:
 - Audition (hearing);
 - Behavior and Social Skills;
 - Intellectual Function (Thinking and Reasoning);
 - Limbs (Use of Hands, Arms, and Legs);
 - Intentional Communication (Understanding and Communicating with Others);
 - Tonicity (Muscle Tone);
 - Integrity of Physical Health (Overall Health);
 - Eyes (Vision); and
 - Structural Status (Shape, Body, Form, and Structure).

E. Parent and Family Involvement

Parent involvement has been recognized as an essential component of early childhood programs in developed countries. Strategic approaches such as community-based rehabilitation (CBR), discussed elsewhere in this report, are relevant in this context. A basic principle for the development of programs and services in developing countries is that interventions for children and adults with disabilities need to build on the community-based rehabilitation approach. Although community-based programs vary in terms of their focus and mode of service delivery, they share a common characteristic of involvement by parents and community members in the provision of services for children with disabilities.⁵⁹

⁵⁷ Sultana S. Zaman, *Rapid Epidemiological Assessment of Childhood Disabilities in Bangladesh*, (Dhaka: University of Dhaka/BPF, May 1992).

⁵⁸ Rune J. Simeonsson, D. B. Bailey, T. Smith, and V. Buysse, “Young Children with Disabilities: Functional Assessment by Teachers,” *Journal of Developmental and Physical Disabilities*, 7, (1995): 267-284.

⁵⁹ (Short form) Simeonsson, 27.

F. Hospital-based Service Delivery

The Shishu Bikash Kendra (child development center) at the Dhaka Shishu Hospital (children's hospital) was established in 1992. Its main objective is to provide services to children with developmental disabilities and neurological impairments as well as to normal children. The center provides support to both at the outpatient clinics and in-patient departments. A multidisciplinary team provides key services to the children and their families. It is a place where a child, normal or disabled, is assessed and treated through a holistic approach. The long-term goal of the center is to improve functional skills and adaptive behavior of children.⁶⁰

G. Training for Serving Children with Disabilities in Communities

At the level of training and personnel development, the International Society on Early Intervention--a society devoted to the international exchange of ideas, clinical approaches, and research findings--maintains an Internet site accessed by persons working with young children with disabilities around the world, <https://depts.washington.edu/isei/>.⁶¹ According to Simeonsson,⁶² one promising model involves a project coordinator who works with a number of field workers. In this approach, project coordinators with experience in disability provide training and supervision of field workers who relate directly to the family or caregiver. The field workers, on the other hand, may have little if any formal education, but are given highly practical skills to work with the families.

⁶⁰Bangladesh Education Sector Review, (World Bank, 2000), 27.

⁶¹ (Short form) Simeonsson.

⁶² Ibid.

IV

Primary Education for Children with Disabilities: Grades 1-5

Access to primary education (grades 1-5) for children with disabilities is discussed in the following parameters: numbers served, type of school (government, NGO, private), location,⁶³ disability area, and service delivery mechanisms. The status of teacher training in special education and rehabilitation is discussed by provider and disability area for long-term (degree and diploma) and short-term training.

A. Access to School: Children with Disabilities and Gender Issues

It is well known that children with disabilities in developing countries have negligible access to basic education. According to UNESCO, studies indicate that only one to two percent of children with disabilities in developing countries have access to basic education and girls have even less access than boys.⁶⁴ Bangladesh is no exception.

Girls with disabilities are at particular disadvantage; often they are the unwilling and bewildered objects of emotional, physical, and sexual abuse. Parents of the girls often perpetuate sexual abuse of girls with disabilities, especially girls with intellectual disabilities.⁶⁵ A CSID study conducted for UNICEF on inclusive practices points out a commonly accepted phenomenon: fear of abuse (emotional, physical, sexual) often prevents parents of children with disabilities, especially girls, from sending them to school. A child-rights organization in Bangladesh⁶⁶ reports that female disabled children, especially from rural areas, where 76 percent of Bangladesh's population reside, are often victims of physical torture.

Access is also constrained by location--rural or urban. According to CSID, the NGOs, the main service providers for children with disabilities, cover only seven percent of all the rural areas, which would mean that the 96 percent of children with disabilities, who reside in the rural areas of Bangladesh, have very limited opportunity to attend school.⁶⁷

B. Primary Level Education for Children with Disabilities: Current Situation

The Ministry of Social Welfare, Department of Social Services, is the responsible agency for the education of children with disabilities, and has been since the 1960s. Children without disabilities have access to different types of schooling under the Ministry of Primary and Mass Education (MOPME). Registered non-government primary schools (RNGPS) and community schools (COM), for which the Government is partly responsible, make up a sizable proportion of the 11 different types of primary schools in Bangladesh, enrolling almost 18 million children.⁶⁸

⁶³ Location of schools provided, based on available information.

⁶⁴ C. Lewis and S. Sygall, eds., *Loud, Proud and Passionate: Including Women with Disabilities in International Development Programs*, (Rome: UNESCO, 1997).

⁶² (Short title) "A Study Report on Documentation of Good Practices" for UNICEF.

⁶⁶ Bangladeshi Protibondhi Sishu Odhikar (Disabled Child-rights in Bangladesh).

⁶⁷ (Short title) "A Study Report on Documentation of Good Practices" for UNICEF, 12.

⁶⁸ *Primary Education Statistics in Bangladesh – 2001*, (Dhaka: Directorate of Primary Education, PMED, Government of the People's Republic of Bangladesh, May 2002), 3.

Of the 78,126 primary schools, the RNGPS, or non-government primary schools, constitute 24.9 percent of the total number of primary-level institutions.

Following the formula used previously in this report,⁶⁹ it is estimated that 1,735,121 children in Bangladesh, out of a total population of 18 million children in the 6 to 11 age range, are disabled. This number represents approximately 9.8 percent of the 6 to 10 year olds (grades 1-4) and 9.9 percent of the 10 to 11 year olds (grade 5). In other words, a conservative estimate is that almost 10 percent of all children within those age ranges have a disability that requires special schooling. This is shown by type of disability in Table 6, without designation of degree of involvement (i.e., mild, moderate, severe, or significant disabilities). It should be noted that the types listed are not inclusive; for example, autism spectrum disorders are not included.

Table 6: Types of Disability for Children Ages 6-11, by Number and Percent

| Type of Disability | Number | Percent |
|---------------------------------|-----------|---------|
| Physical Handicaps (PH) | 720,076 | 41.5 |
| Visual Impairments (VI) | 341,819 | 19.7 |
| Speech/Hearing Impairments (HI) | 340,084 | 19.6 |
| Intellectual Disabilities (ID) | 128,398 | 7.4 |
| Cerebral Palsy (CP) | 121,458 | 7.0 |
| Multiple Disabilities (MD) | 58,994 | 3.4 |
| Mental Illness (MI) | 24,292 | 1.4 |
| Total | 1,735,121 | 100 |

Source: Based on APCD report/JICA

According to the study on disability in Bangladesh for the World Bank,⁷⁰ over the past several years there have been initiatives to begin the process of integrating children with disabilities into the government schools. The Government's major systemic change and reform program, the Second Primary Education Development Program (PEDP-II), has major support from 11 donors including the GOB,⁷¹ and is in the final planning stages for implementation.⁷² Its primary aim is to ensure the quality of primary education for all children in Bangladesh, with specific objectives to increase school access, participation, and completion, and to improve the quality of student learning and standards-based achievement outcomes. NGOs will not be involved in PEDP-II.

⁶⁹ Based on terminology used in Bangladesh. Figures follow the formula used in Chapter I of this report to estimate the number of Bangladeshi children with disabilities.

⁷⁰ (Short form) Byskov et al., *Disability in Bangladesh*.

⁷¹ International donors include the ADB; IDA (the World Bank); DFID; EU; Netherlands; NORAD; SIDA; CIDA; JICA; and UNICEF

⁷² Based on meeting at the Second Primary Education Development Program (PEDP-II), Directorate of Primary Education, February 2, 2005.

The PEDP-II consists of four components,⁷³ including Component 4 (Improving and Supporting Equitable Access to Quality Schooling) that addresses special needs education within the context of equity. Specific interventions to meet the objectives include “pedagogical support for special needs children at the primary school level.”⁷⁴

While the details of PEDP-II are being worked out, indications are that this government program will target children with mild learning needs. Children with moderate or severe needs will not be served.

C. Special Government Schools for Children with Disabilities: Current Situation

It should be noted that information in this section is presented by category of disability based on current terminology in Bangladesh. The categories of the special government schools are: blind, deaf, and intellectual disabilities.

Designations of disability for children with mild to moderate disabilities are: visually impaired (VI); hearing impaired (HI); and intellectual disabilities (ID). The continuum of educational service delivery for the physically disabled (PH) includes children with moderate to severe disabilities including children with physical disabilities or handicaps, cerebral palsy (CP), or autism spectrum disorders (no acronym at present).

Opportunity for an education through government-sponsored schools for children with disabilities is extremely limited. Only 13 government special schools exist to accommodate three areas: blindness; deafness; and intellectual impairments.⁷⁵ The five schools for the blind and seven schools for the deaf serve a total population of approximately 1200 children.

- *Schools for the Blind and Visually Impaired.* Four schools for the blind, with a capacity to serve 500 children, are located in Divisions in Bangladesh: Dhaka, Chittagong, Rajshahi, Khulna. Of the total children served, residential facilities are provided for only 180 blind children.

It is often mentioned that there are 64 government-sponsored integrated schools for the visually impaired. However, these are at the secondary level, not primary. A resource teacher and a resource room in the respective schools provide integration.

- *Schools for the Deaf and Hearing Impaired.* The seven schools for the deaf are located in Dhaka, Chittagong, Rajshahi, Khulna, Chandpur, Faridpur, and Sylhet. The total capacity for deaf children is 700. Of the total, residential facilities are provided for 180 deaf children. Stipends are not provided for the day students, but residential students receive free room and board at government expense.

⁷³ Component 1: Quality Improvement through Organizational Development and Capacity Building; Component 2: Quality Improvement in Schools and Classrooms; Component 3: Quality Improvement through Infrastructure Development; and Component 4: Improving and Supporting Equitable Access to Quality Schooling.

⁷⁴ Second Primary Education Development Program (PEDP-II), Directorate of Primary Education.

⁷⁵ Shirin Z. Munir and Sultana S. Zaman, “Services and Programs for the Disabled in Bangladesh,” *International Journal of Disability, Development and Education*, 39, no. 1 (1992): 1-23.

“We met, today, a devoted father and an apparently bright deaf son. The two were obviously fond of each other, and the father was a natural teacher, the son communicating in the natural gesture sign language he had developed with his father. The father reported that his son, who was present during the interview, was one of 114 students on the waiting list for one of the government schools, with space available for only four students.”⁷⁶

- *Schools for the Intellectually Disabled.* As late as 1992, there were no government-sponsored programs for children with intellectual disabilities. It has been reported that children with intellectual disabilities have been the most neglected and uncared for group in the Bangladesh.⁷⁷

It is reported there are now two special schools, run by the Ministry of Social Welfare,⁷⁸ that have a total enrollment of 100 children with intellectual disabilities. The Society for the Welfare of the Intellectually Disabled, Bangladesh (SWID-B), an NGO, is the pioneer organization for the education and advocacy of the intellectually disabled in Bangladesh.

The Ministry of Social Welfare subsidizes 80 percent of SWID-B teacher salaries; the additional 20 percent is locally generated. Information about SWID-B is included here in the section on NGOs.

- *Children with Physical Disabilities and Neurological Impairments.* There are no government educational services for preprimary or primary age children with physical disabilities. According to key stakeholders, children with physical disabilities are at the greatest disadvantage of any category of disability. There are a number of reasons for this, including inaccessible buildings, lack of ramps and aids such as crutches and wheelchairs, and inappropriate toilets and classrooms.

The government does not provide specialized schooling for the neurologically impaired such as cerebral palsy (CP) or autism spectrum disorders. These children, to the extent served at all in government-supported programs, are integrated with children with intellectual disabilities, primarily through SWID-B programs.

D. National Center for Special Education (NCSE) for VI, HI, and ID.

The National Center for Special Education (NCSE) was established by the Department of Social Services, Ministry of Social Welfare, in 1991 in Mirpur (Dhaka) with donor assistance from NORAD. NORAD no longer provides financial assistance. The NCSE is fully funded by the government through the National Foundation of the MOSW.

The NCSE has a school that enrolls 190 children, 130 of whom are residential. The program goes to the 8th grade for children with visual impairments and hearing impairments, and up to

⁷⁶ From notes taken by team leaders at field visit at Kurigram, Bangladesh.

⁷⁷ Ibid., 15.

⁷⁸ Mamum Jowaherl, “Coalition for Inclusive Education in Bangladesh,” paper presented at the ISEC 2000.

the 7th grade for children with intellectual disabilities; some vocational training opportunities (e.g., making mats, carpentry) are provided. There are 50 students in the VI and HI programs, respectively, and 30 children in the ID program. Children with physical or multiple disabilities⁷⁹ are not admitted.

As is evident from information in this section, only a miniscule number of children with disabilities have access to an education in the schools sponsored by the government, specifically those of the Ministry of Social Welfare, the Ministry that has had responsibility for the education of children with disabilities since the 1960s.

E. Non-Governmental Organizations (NGOs)⁸⁰

As discussed elsewhere in this report, to the extent that children with disabilities have access to an education in Bangladesh, the NGOs are the main providers. The network of NGOs is extensive. Educational opportunity for preprimary and primary level children with disabilities, to the extent it exists, is mainly through the work of the NGOs. Of the approximately 40,000 NGOs that work in development areas in Bangladesh, only about 400 work in the disability area, and of these, relatively few work with children with disabilities.⁸¹

Visually Impaired Children (VI)

The Baptist Sangha Blind School for Girls (BSSBG), located in Dhaka, was established in 1977, and works in the 64 districts of Bangladesh. Its priority areas are general education for the blind (especially girls), vocational training, integrated education, and computerized Braille book production. Residential facilities are available for blind girls. THE BSSBG is a source of technical assistance for orientation and mobility, Braille translators, special teaching techniques, and vocational training. It has served approximately 138 girls and 22 boys since its establishment. The school is used as a student teaching placement for special education students at the Institute of Education and Research, Dhaka University.

Hearing Impaired Children (HI)

HI-CARE. This NGO, serving hearing impaired children, was started in 1982 and has a school for 100 students from age 2 to 18. The school has a preschool section for language development. There are four centers in each of four Divisions: Dhaka, Khulna, Chittagong, and Rajshahi. There are 10 schools within the four Divisions.

Hearing aids are provided for a fee; those who cannot afford the cost of the hearing aids are sponsored. HI-CARE is the “wholesale dealer” for hearing aids in Bangladesh, imported from England, and, more recently, from Singapore. A normal curriculum is followed for primary and secondary. Students who go on to higher secondary (grade 9 and 10) They sit for their exams under the Open University, which allows some flexibility in accommodating to their needs.

⁷⁹ National consultant, personal communication, January 31, 2005.

⁸⁰ Information is based on a number of sources, including the *Directory of Organizations Working in the Field of Disability in Bangladesh* (Dhaka: NFOWD, 2002), and interviews with key stakeholders.

⁸¹ NFOWD, personal communication, January 27, 2005.

Taking the examination in two parts is allowed for these special students. HI-CARE also is used as a student teaching placement for the Special Education Department, Institute of Education and Research, Dhaka University.

In the Dhaka center, fees are generated from the audiology center. Since the NGO receives no funding from the government, it is dependent on fund raising and donations for program sustainability. Services include awareness building (“deaf campaign”), hearing assessment, counseling, and support to other NGOs as a referral base. Students may be referred to the normal government school or to a special school depending on need. The auditory-oral method is used; this means that sign language is not taught. HI-CARE staff provides technical assistance to teachers in the regular schools and serve also as advocates to obtain a placement for the child if appropriate. A constraint is their severely limited capacity to serve more children with hearing impairments.

Society of Assistance to Hearing Impaired Children (SAHIC). SAHIC, founded in 1989, provides education and rehabilitation, using oral auditory methods, special education, and awareness raising on prevention and treatment for deafness, including assistive devices. A top priority of this NGO is prevention, early identification and detection of hearing problems. Resources include highly trained audiologists and technicians, trained teachers, and qualified medical personnel (doctors). SAHIC works in two districts in Bangladesh and has provided services to 127 children, as well as adults.

Deaf Children’s Welfare Association of Bangladesh (DeCWAB) is an education center, located in Dhaka, for the area of deafness and hearing impairments. It was started initially as a center for hearing impaired children by the parent of a deaf child, but has expanded its service to children with multiple disabilities. The Center accommodates 34 children (seven girls and 27 boys), ages two to 18 years. Among the 34 students, there are seven or eight with Downs Syndrome and one or two with autistic spectrum disorder. There are 12 students on the waiting list.⁸² The formal primary level curriculum is used for the hearing impaired students and an individual education program for the non-HI students. The Center is privately funded.

Intellectual Disabilities (ID)

Society for the Welfare of the Intellectually Disabled, Bangladesh (SWID-B) is an NGO, a voluntary social service organization started over 25 years ago by a few parents and some professionals. For 18 years (until 2000) it received funding from the Norwegian Association for the Mentally Retarded (NFU). Its many activities include parent training, research, counseling, clinical services (each year more than 350 children receive services), training for teachers in inclusive education, and, through its organizational development program, awareness building and advocacy. SWID-B works with other NGOs, especially BRAC, to promote inclusive education. There are 40 schools (units/branches) that provide special education and vocational training and other programs for children with intellectual disabilities, in addition to the National Institute for the Intellectually Disabled (NIID) and the BRAC schools.⁸³

⁸² Based on telephone interview conducted by the study’s national consultant, January 2005.

⁸³ 25 years of SWID Bangladesh, (Dhaka: Society for the Welfare of the Intellectually Disabled Bangladesh, December 24, 2002).

The Bangladesh Protibondhi Foundation (BPF) has spearheaded initiatives in many areas that have served to improve the quality of life and increase educational opportunity for children with disabilities. The BPF has been serving the intellectually disabled and children with neurological damage (e.g., cerebral palsy) since it was founded in May 1984. It serves the urban poor and children with disabilities in five districts, eight “thana,” and 29 villages throughout the country. The work is accomplished through its medical centers, sheltered workshops, and community-based rehabilitation (CBR) programs. As of December 2004, the beneficiaries of its various programs were a total of 11,370 children, of whom 5,085 were girls.⁸⁴ There are many on the waiting list for services.

The BPF runs a special school for the intellectually (cognitively) disabled; the Kalyani-Special School. In Dhaka there are two special schools at which these children, after screening and diagnosis, are placed in different classes for education and training according to their age levels. The special classes are named after Bangla flowers:

Komolkoli (4 to 8 years)
Champakoli (9 to 12 years)
Korobi (13 to 17 years); and
Madhobi (18 years and older).

In addition to the school, BPF has two clinics; the Shishu Bikash Clinics for screening, identification, medical and therapeutic intervention, counseling, and training. One clinic is located in Dhaka, and the other in Dhamrai. A mother-child stimulation program, Dishari-Special Unit, has been developed for children with cerebral palsy. This program provides educational and therapeutic services for school age children with cerebral palsy, as well as the mother-child stimulation program for preschool age children with cerebral palsy. Services are also provided to these mothers and their children in the rural areas through the Rural Multipurpose Project.

BPF also has a distance-training program that includes booklets for the parents on motor development, communication, speech development, and cognitive development. Mothers from all over the country are served through these training manuals known as “Distance Training Manuals.” This center also is used for student teaching by the special education department, Institute of Education and Research, Dhaka University.

Physical Impairments

The Center for Rehabilitation of the Paralyzed (CRP). CRP, founded in 1979, is widely recognized for its outstanding programs serving children and adults with severe physical impairments and paralysis. Located in Savar, currently with three functioning sub centers,⁸⁵ it also operates a 100-bed hospital and outpatient services.

⁸⁴ (Short title) *Directory of Organizations Working in the Field of Disability in Bangladesh*, 38.

⁸⁵ Gonokbari (Savar), Dhaka City Center (Mohammadpur) and Gobindapur (Mouvlibazar District) and, in addition, the CRP is constructing a new rehabilitation center at Mirpur in Dhaka.

The CRP offers large-scale rehabilitation programs, vocational training, and health education. It has community-based rehabilitation (CBR) programs in 49 thanas or counties.

CRP has a special vocational training and employment-generation project for disabled girls and women. Their philosophy is that successful rehabilitation is not only a physical process. Social, economic, and psychological aspects must be given equal importance.

Special Education Needs Unit (CRP). The CRP runs a special school, established in 1993 primarily for children with cerebral palsy. The school serves a total of 27 children between 5 and 15 years of age. The classes are divided into four units based on the student's degree of disability: mild, moderate, or severe. The class time consists of 4 hours in the morning for academic study, followed by 3 hours in the afternoon for therapy. In addition, a total of 34 students are placed in mainstream classes that follow the regular national curriculum. The school also provides vocational training (e.g., carpentry, mat making, block printing). Fees are charged.⁸⁶ in the amount of 4500 taka (\$75) per month. Residential students pay an additional 1600 taka (\$27).

A certificate in special education (a two-semester program) is awarded to students to upgrade their skills as teachers. An impact assessment of the program in August 2003 indicated that the training could provide support, guidance, and motivation for the teachers. Further, it was found that the training should be conducted on a long-term, and short-term, basis to develop trained personnel at different levels.

Center for Rehabilitation of the Paralyzed (CRP) offers training for physiotherapists, occupational therapists, rehabilitation nurses, special education teachers, and community-based rehabilitation workers and others.

Both long- and short-term training are provided through the CRP's academic institute; the Bangladesh Health Professions Institute (BHPI). Courses related to special education include the Certificate in Education for Special Education (a 12-month course); orientation one-week workshops for teachers, two-day workshops for head teachers, and a one-day workshop for policy makers on inclusive education.

Autism Welfare Foundation (AWF). The AWF, a recent NGO founded by a mother⁸⁷ of an autistic child, provides a number of services including a thorough medical checkup and psychological assessment in conjunction with the Child Development Center (CDC) located in the Children's Hospital. CDC is well known and considered by many to be the best hospital in Bangladesh. An all-day educational program is provided for 53 children ages 3 to 15 based on parental interview, developmental history, and results of other assessments such as CHAT; a Childhood Assessment Checklist.

The AWF also sponsors a home-based program where 60 children, including children on a

⁸⁶ The fees for residential students are Tk4300 (\$72) on admission plus a monthly charge of Tk600 (\$10). Non-residential students pay an admission fee of Tk1500 (\$25) plus a monthly fee of Tk300 (\$5).

⁸⁷ Chairperson, Autism Welfare Foundation, Dhaka, Bangladesh.

waiting list, some of whom live outside Dhaka, are given educational interventions. These children range from 2.5 to 15 of years of age. Some are high-functioning autistic children with Asperger's syndrome, who are in mainstream schools but need additional support, such as a resource teacher. Home-based programs are necessary because almost none of the regular classroom teachers have received training appropriate for working with children with autism and related disorders of the spectrum. Funding for the center is tuition-based; the Center's committee members raise local funds.

F. Teacher Training in Special Education and Disability

The *Department of Special Education, Institute of Education and Research, Dhaka University*, offers two degree programs that prepare teachers in special education. One is at the bachelor's level (honors), the other at the master's level. Admission is limited to an annual enrollment of 20 students, 16 of whom, on average, complete their studies. A few students go on for a specialist degree (post-graduate) and the Ph.D. in special education. Choice of emphasis includes three disability areas: visually impaired (VI), hearing impaired (HI), and intellectual disabilities (ID).

The program includes a course (a "100 marks course") on inclusive education and on assessment, compulsory for each of the three emphasis streams. Assessment is integrated into each of the content and strategy courses as well. Through microteaching and a six-month student teaching placement,⁸⁸ the students gain experience in teaching children with VI, HI, and ID. There is no special course to prepare teachers in the other areas of disability such as the neurologically disabled, autism, or mental illness. Job placements for graduates typically are in the NGOs and government sector such as the Department of Primary Education.⁸⁹

Bangladesh Health Professionals Institute, the academic unit of CRP, Savar, under Dhaka University offers the following degree training:

- Bachelor of Science (Honors) in occupational therapy
- Bachelor of Science (Honors) in physiotherapy
- Bachelor of Science (Honors) in speech therapy, under Jahangirnagar University.

The National Center for Special Education, under The National University of Bangladesh provides teacher training in special education. A post-graduate degree, a Diploma in Special Education, is awarded under the National University of Bangladesh.

The Bangladesh Institute of Special Education (BISE), a program of the *Bangladesh Protibonhi Foundation (BPF)*, is a teachers training college affiliated with the National University of Bangladesh. A bachelor degree in special education and a master's degree are offered through the BISE, with a specialization on teaching children with mental retardation, visual impairments, and hearing impairments.

⁸⁸ Based on personal communication with the national consultant, student teaching placement are primary in the NGOs: BDF for the intellectually disabled; HICARE for the hearing impaired; the Baptist Sangha Blind School for Girls for visual impairments. Institute faculty monitor student progress through a minimum of 10 observations.

⁸⁹ In 2004, students have been successful in obtaining positions in Bangladesh civil service (BCS) in different sectors, according to the national consultant.

The BPF conducts research, published in local and international journals, seminars, workshops, and provides training on all aspects of disability, collaborating with national and international expertise. Short and long-term training programs are held regularly to train all levels of professionals and paraprofessionals: special teachers, therapists, staff and community workers from the urban and rural areas.

The BPF links with other organizations, nationally and internationally, For example, the Institute of Child Health in London provides technical assistance in occupational therapy (OT) and physical therapy (PT). The Voluntary Service Organizations (VSOs) has provided a volunteer in the area of physical therapy.

G. Strategic Approaches to Serving Children with Disabilities at the Community Level: CBR and CAHD

Community-based rehabilitation (CBR) is a strategic approach to community development that has special significance in Bangladesh for the prevention of disability and to identify, serve, and integrate those children with disabilities in the rural areas. It is a strategy that is implemented through the combined efforts of disabled people themselves, their families and communities, and appropriate health, education, vocational and social services, according to the WHO.

Community approaches to handicap and disability (CAHD), developed in Bangladesh by an NGO, the Center for Disability and Development (CDD),⁹⁰ with a focus on mainstream education, is a strategic approach that assists communities in implementing CBR. Its many activities seek to effect change by focusing on the community as a whole.

Many of the disability organizations utilize the CAHD approach. A few of the NGOs working in the area of childhood disability, using CBR or CAHD, are described in the next section. The selection of the NGOs is illustrative of the range of services provided to address childhood disability, with a special focus on education. It is not exhaustive.

Blind and Visually Impaired Children.

Bangladesh was selected as a site for data collection (qualitative and quantitative) in May 2001, for research on childhood blindness by a Bangladeshi doctor from the Center for Eye Health at the London School of Hygiene and Tropical Medicine. The purpose of the study was to identify the major causes of blindness in children, birth to age 16, living in the country's 64 districts. Of the 2,000 children that represented the research sample, it was found that in 30 percent of the cases, blindness was caused by Vitamin A deficiency (cornea problem). Thirty percent of the

⁹⁰ CAHD was developed in Bangladesh in 1997 by CDD, with support of Handicap International (HI) France, and Christoffel Blinden Mission (CBM) Germany. This process has been supported by other international organizations like ActionAid Bangladesh, Save the Children Fund Sweden and Foundation for Children's Welfare Stamps Netherlands, Nippon Foundation Japan, and the CBR Development and Training Center Indonesia. The vision of CAHD is to establish activities that will minimize the negative impacts disabilities to create changes in attitudes while countering the existence of or eliminating handicaps.

children had cataracts in addition to other conditions associated with loss of sight, such as retinal detachment and glaucoma.

In addition to the study per se, which included the finding that approximately 40,000 children have bilateral problems, the research team performed eye operations on 830 children (1,275 operations including both eyes). A one-year follow-up study indicated that full recovery of sight is possible; the younger the child the better the outcome. This finding underscores the importance of early medical intervention. Dependent on receiving funding, future plans include integrating blind children--those whose sight cannot be restored--in regular primary schools.

Intellectual, Multiple Disabilities

The BPF runs community-based rehabilitation (CBR) programs in the rural areas of Dhamrai, Savar, Kishoregonj, Narshingdi, Faridpur, Nabinagar, and Comilla, and one in the slum areas of Mirpur. Door-to-door surveys are conducted to identify children with disabilities. They are diagnosed if appropriate and then provided with an educational or training program. All BPF's CBR centers have started "inclusive schools" that include children with disabilities, the disadvantaged, and normal children.

Physical Handicaps, Multiple Disabilities.

The Bangladesh Council for Child Welfare (BCCW) uses CBR and CAHD approaches to rehabilitate children who have physical disabilities, cerebral palsy, and hearing and speech impairments. Over its long history (it was established in 1957), BCCW has provided physiotherapy and rehabilitation therapy, and other services, for a total of over 80 percent of its 8,514 children.⁹¹

Hearing Impaired Children.

ADESH is an NGO that uses CBR approach to help children with hearing impairments and other disabilities. ADESH does informal community surveys and, if any hearing-impaired child is found, ADESH sends the child to HI-CARE in Dhaka for audiological and hearing aid assessment. ADESH buys the hearing aid for the child and then facilitates the child's inclusion in a regular school; the World Concern school (an NGO-run school in Savar). If they find an HI child who wants to go to school in the locality and child is rejected, then ADESH serves as advocate for enrollment. VI children are referred to World Concern Savar. Foreigners train teachers and monitor the teaching; there is no government involvement. ADESH provides home service physical therapy, free of cost. ADESH also provides assistive devices free of charge.

Training for CBR.

The Center for Disability in Development (CDD) has effective community-based worker training programs for existing community-based development workers in the areas of women,

⁹¹ (Short title) *Directory of Organizations Working in the Field of Disability in Bangladesh*, 30.

children, aging, poverty, and economic development in order to empower persons with disabilities at the community level. CDD has developed teaching and awareness campaign materials, including picture and cartoon communication, which are effective for guiding disability workers who have not had opportunities for formal education.

“A researcher just returned from an eight hour rickshaw, boat and trekking trip to a very remote union (cluster of villages) to our research site. He was enthusiastic and talkative about what he had just seen; it represented the best of CBR: Kurigram Disabled People’s Organization for Development (KDPOD) is a self-help NGO, a member of the Bangladesh Protibandhi Kallyam Somity (BPKS), located in the Kurigram district. KDPOD envisions that all persons with disabilities live independently, with dignity in a barrier-free family and community, and that they are in a position to contribute to their own and society’s development. The goal of the organization is to ensure equality in occupations for persons with disabilities through equal rights, opportunity, and full participation in society. This NGO works to develop other grass roots organizations, to empower people, to eliminate discrimination, and to actualize development for all. The director of KDPOD⁹² reported that a local survey of persons with disabilities had been completed, and it identified 681 persons with disabilities from birth in Fulbari, Borovita and Vangamor village clusters (“unions” in Bangladesh). Activities of the NGO include leadership development, advocacy and lobbying, and surveys. The KDPOD assists children with disabilities by bearing some of the costs, such as for books, fees, clothing, and assistive devices, as well as providing some training for the teacher on awareness building and positive attitude formation. They help train the visually impaired on ways to ensure personal safety such as how to walk safely on roads and highways and for the physically disabled how to use a wheel chair. Some of the causes of disability identified by this NGO include malnutrition, heavy work done by pregnant women, and their use of antibiotics, and a lack of awareness on the part of families about disability and its prevention.”⁹³

Assistive Technology

Educational opportunity for children with disabilities is severely constrained in Bangladesh due to a lack of appropriate teaching aids, facilities, and assistive devices and technology.

Some NGOs have been successful in addressing this situation, which benefits adults with disabilities, and children, to the extent linkages are established with the NGOs that run the special schools. For example, the Bangladesh Protibandhi Kallyan Somity (BPKS) established an Assistive Devices Production Center in 1988 and has been producing different types of assistive devices. Maintenance support also is provided to users. The Center produces various types of wheelchairs, crutches, white canes and calipers, and long leg braces. The BPKS has developed innovative varieties of wheelchairs as well.

⁹² Md. Ayub Ali, Director of Kurigram Disabled People’s Organization for Development (KDPOD), personal communication, January 2005.

⁹³ Case study prepared from notes provided by project research assistant Md. Akhter Hossain.

The Assistive Device Network (ADNet) was started in August 1998 to assist and support organizations serving adults and children with disabilities. By November 1998, eight government and NGOs were members of ADNet. These member organizations, government agencies, and NGOs (there were eight as of November 1998) produce and distribute orthotics and prosthetics, standing and walking devices, special seats, wheelchairs, tricycles, hearing aids, toys, assistive devices for activities of daily living, protective footwear, tools and equipment for work, simple devices for communication, and Braille books. They also assist in adaptations of homes and other premises to increase accessibility.⁹⁴

Hearing Aids.

Mild to moderately disabled children with hearing, visual, and physical impairments could be integrated in regular schools if appropriate assistive devices were available at low-cost or no cost for poor families. The government, however, does not provide any assistance for assistive devices, unlike neighboring India, where assistive devices are not only available but also free if parents cannot afford to pay for them. In Bangladesh, it is only those children who have parents with means who have access to hearing aids.

One of the NGOs, (HI-CARE), assists, to the extent feasible, children in obtaining hearing aids, but the process is not systematic. A constraint is the necessity for adjusting the size of the hearing aid as the child gets older, a recurring cost. The cost of replacing batteries is also a consideration. Bangladesh imports hearing aids due to lack of domestic production capability.

Braille-Writing Machine

The Government of Bangladesh operates a national Braille press, through the Social Services Department. It has not been functional, however. Some NGOs have also initiated computerized Braille printing services, but these are limited in scope. With private funding from the Baptist SANGHO, a school for blind girls, a Braille computer system has been set up with capacity to print books, but not on a large scale. A Braille printing press would help increase access to the general curriculum. It is not known how many blind persons in Bangladesh could utilize the output of a Braille press.

Low Vision Aids

With support of Sight Savers International, a low vision laboratory has been established in the Department of Special Education to help prepare teachers serve children with low vision. The facility allows students to gain experience in low vision aids and conduct research using large print formats (television and computer based), assessment materials ("assessment kits" for low vision), and other teaching aids such as Braille writing machines. Capacity to produce books in Braille requires a special printing press.

⁹⁴ JICA: Asian-Pacific Development Center on Disability (APCD) Bangkok, Thailand.

Sign Language and Augmentative Devices

Children with disabilities such as deafness, cerebral palsy, or autism typically have great difficulty in communicating. Sign language and augmentative communication devices provide vehicles for receiving and expressing language. Bangladesh has made some strides in promoting sign language and augmentative communication systems.

Sign Language. The Department of Special Education, Institute of Education and Research, Dhaka University was energized by the late Dr. N. Anam, who worked with her students in the hearing impairment department. With her leadership, the students developed a vocabulary for common functions and translated those into signs. A video was made of the gestures and an artist was enlisted to draw pictures of each sign. The CDD provided logistical support for the project. Using a participatory approach, approximately 30 hearing impaired “stakeholders” validated the product, item by item. A dictionary of signs was printed in early 2003. Two volumes have been published.⁹⁵

Augmentative Communication. The BPF has taken the lead in promoting the use of augmentative communication systems for children with intellectual disabilities and for those with cerebral palsy, working on its initial development with a British expert.⁹⁶ A number of Bangladeshi girls have been trained in the use of augmentative communication systems through BPF-funded training for them in India, in collaboration with the Spastic Society of Eastern India, which has special expertise in that area.

⁹⁵ Available from the CDD, based on personal communication with the national consultant, February 1, 2005.

⁹⁶ Margaret Walker, Bangladesh Protibondhi Foundation (BPF).

V

What Stakeholders Say About the Educational Needs of Disabled Children

No study of the educational needs of disabled children is valid without input from the stakeholders themselves. In this case, stakeholders include children with disabilities and/or their spokespersons, families of children with disabilities, teachers who work with both disabled and non-disabled primary-aged children, and the administrators of schools facing a responsibility to educate children with disabilities.

This study focused on three questions:

1. What are the educational needs of preprimary and primary-aged children with disabilities?
2. What are the current obstacles to obtaining these needs?
3. What recommendations might be made for the improvement of the Bangladesh society and educational system to educate young disabled children?

Methodology

In this study, the majority of the stakeholder population was rural, representing therefore, the majority of the Bangladesh population (76.61 percent in 2001⁹⁷). Ten researchers at the senior and research assistant level, trained and monitored by the Senior Consultants, conducted interviews, focused group discussions (FGD), and descriptive literature searches. Although research sites were originally targeted for five locations, unforeseen extended holidays and six days of general strikes (hartals) limited the flexibility of the researchers to travel. Kurigram thus produced data from the most people because it combined visits to both agencies in Kurigram and a visit to a neighboring village with a large group of stakeholders—Ulipur. Data from both Ulipur and Kurigram were consolidated because demographics were similar. This report presents all data that were gathered from four districts. The districts were picked for their demographic and statistical heterogeneity and their generalizability to the Bangladeshi population.⁹⁸

- *Jessore*, to the west and south of Dhaka by about six hours, has an area of 1,158 sq. km. Over 128,000 students are between 6-10 years of age.
- *Savar* is a suburb of Dhaka, the capital city. This site was chosen because it contained an exemplary program of Project SUCCEED, of Save the Children, USA, and the Center for the Rehabilitation of the Paralyzed (CRP), a service organization of Bangladesh.
- *Kurigram*, 9 hours north of Dhaka, has an area of 2,296 sq. km and over 306,000 6 to 10 year olds. It has as many non-government schools as government schools serving children.

⁹⁷ (Short form) *Bangladesh Census, 2000*.

⁹⁸ *Primary Education Statistics in Bangladesh*, (Dhaka: Directorate of Primary Education, Primary and Mass Education Division, Government of the People's Republic of Bangladesh, May, 2002).

- *Tangail* is a district about 4 hours north of Dhaka. It has an area of 3, 414 sq. km and a school population of over 454,000 children between 6 and 10 years old. It's teacher/student ratios are some of the highest in the country.

These sites were selected for in-depth investigation based on specific selection criteria, which included:

- Nearness to SUCCEED programs, the observation of which was requested by USAID;
- Regional variation;
- Varied socio-economic conditions (rural and urban, poverty and middle-class, food insecurity and malnutrition effects). Kurigram is a community of poverty and has low educational levels, Savar is urban, Jessore is rural, and Tangail has a model private school;
- Variation in disability type and in gender.

Both primary and secondary sources were used in the data reporting and analysis. Respondents were assembled by hosting agencies, and were served snacks or a meal as a reward for participating.

Triangulation methods were used to increase the validity and reliability of data using different methods on the same issues with different stakeholders. Qualitative methods such as Participatory Needs Assessment (PNA), Focused Group Discussion (FGD, formal and informal discussions, and interviews were used. When interviewing children, parents were almost always present to clarify answers or to respond for the child.

Each researcher reported his or her data to the Team Leader, who entered into tables:

- the nature of the respondent group e.g. parent/child, family only, teacher, administrator, or other;
- the source of the data; from interviews or FGD;
- data on the age level of the children; one to six year olds or over six years old;
- if the respondent(s) were enrolled in an education program;
- comments of the responders in each of the three target areas of interest;
- a clarified English translation of the data to make sure the meaning was understood and confirmed by the researcher.

Raw data were preserved and may be obtained from the libraries of Unnayan Shammanay in Dhaka.

From the raw data, grids were formed for each of the four sites. Each site was described briefly. The comments from each of the three topics were then transcribed according to the topic. The source of the data--i.e., child/parent, family, teachers, or administrators/other--was ascribed to the data element. This material is contained in Appendix 4.

From this material, using the technique of contextual grouping (a qualitative exercise using information from the Senior Team personal interviews and the comments of the researchers),

statements of needs, obstacles, and recommendations were compiled/consolidated from the entire grid of statements. These data, and the frequency to which each respondent group mentioned them, are contained in Appendix 5.

For purposes of clarity, the consolidated conclusions of the groups are summarized in this chapter. They are ranked by the frequency of response. A final summarization of these points, with connecting narrative and derived strategies for activation, complete this chapter.

Findings

Needs

Following are summaries of what the respondent groups felt were the greatest needs of disabled primary-aged children and their families.

- The top-ranked need for pre-school and primary disabled children, as articulated by all the respondent groups, is for what is globally known as “traditional special education”. That is, most of the respondent groups felt that there should be free classes for children with disabilities, constituted by disability types, within every government school. These classes should have lower teacher-pupil ratios than other classes, adequate space, adequate materials, trained staff, motivation, and administrative and fiscal support.
- The therapeutic community for a child with a disability is a community that is socially aware of the child and acts to support that child within its boundaries. Social awareness is generally seen as a function of facts and knowledge about personal strengths in persons with disabilities and is the result of media presentations, community educational efforts, and concerted efforts by community leaders to establish community attitudes that support those who have disabilities. This statement derives from the recommendations of Children/Parents, Teachers and Administrators, not the families (who have never experienced “social awareness”).
- The teachers and administrators, as well as parents/children groups, recognized the vital role of teacher training in the needed special education program. Many of these groups felt that no progress could be made in services unless and until teachers were trained in modern intervention methodology, disability characteristics, integration practices, and general orientations to disability education.
- What children need at this point in history, all respondents said, was for separate schools or classes for children with moderate to severe disability. They did not see “inclusion” as a viable option for children with moderate to severe disabilities. There was recognition that separate classes could work best with children with these disabilities because the teachers would be trained in that disability. The necessary type of training for teachers struggling with “inclusion” is still a long way off. Segregated teaching is better than no teaching at all.

- No educational program could be effective for children with disabilities and their families if there are not parallel medical services available. Parent/child dyads and administrators recognized that parents and schools can be much more effective in working with disabled children if the children have been appropriately assessed and given medical treatment when necessary, and if families have been counseled about short- and long-term care and maintenance of the child.
- A child cannot be expected to reach his/her full potential when assistive technology is missing. Many children with disabilities can function significantly better when they have proper eyeglasses, hearing aids, mobility prosthetics, orthotics, wheelchairs, augmentative equipment, or other such devices. All realized that assistive technology would have to be free or affordable--another complication in the provision of these needed aids.
- Teachers and administrators recognized that children with disabilities need more than academic work. To be rounded, rewarded, and accepted, children with disabilities also needed "non-academic" courses such as music, arts, sports, and other forms of planned recreation. These offerings will tend to "normalize" the school offerings to the child with a disability, and help that child fit into his peer culture. Probably the strongest case for these subjects, however, is their intrinsic motivation for studying them. Everyone likes arts, sports, and recreation. They are also great "mixers" of disabled and non-disabled children on a social level.
- Teachers and administrators reminded the researchers that no educational program would work if children could not get to it. Therefore, they recommended that a revised educational intervention also include provision for adequate and free transportation from home to school.
- Disability is treated and education will be effective if the disability condition has been adequately assessed. An assessment program that gives data to both teachers and family is needed, say the administrators.
- Along with assistive technology, adjunctive therapies such as speech therapy and physical therapy are needed to help a person with a disability become fully functioning in the school and at home. These therapies are recognized as needed by the child/parent dyads.
- Food has to be supplied at school, say the administrators. Its need is self-evident. Education does not take place when hunger pains and malnutrition prevent proper attention and focus.
- Schools in Bangladesh usually use uniforms—for all the reasons that any school has uniforms. Because children with disabilities are more often poor, uniforms become prohibitive. Thus an educational need is for free or low-cost uniforms for all children with disabilities. Administrators recognize this importance.

- Of course, say the administrators, there needs to be a continual local contribution of finances. Current educational financing does not encourage this. Administrators want either better laws or enforcement of the current ones.
- Transportation, a problem already described, would be enhanced by special vans. This is a specific request of administrators.

Obstacles

When the data on reported obstacles were consolidated, there were some surprises. The most obvious response would have been the reluctance of the traditional school to make infrastructure needs and trained personnel available to accommodate children with disabilities. That was not the case.

- The major obstacle to pre-primary and primary education for Bangladeshi children with disabilities is what American sociologists call stigma. Stigma is a negative and hostile attitude on the part of society toward anyone perceived as different. Stigma, it is postulated, is bred in superstition, fear, traditions of inequality, misconceptions and ignorance of facts. Stigma is stronger than attitude because it causes actions that restrain or inhibit the stigmatized person, who is usually of a lower class or in poverty. Stigma is behind the statistic of 90 percent abuse of children with disabilities. It generates the shame that a parent feels when he or she generates a “defective” child. It is responsible for the often-heard statement by parents of children with disabilities that “my child is hopeless. He/she will never have any happiness in life; and therefore neither will we.” If accepted without question, there can be no education for the child by the parents; the school accepts the negativism because it has no way of offering special education. The child keeps the family in poverty—and the cycle of poverty to deprivation to dependence and non-marriage to everlasting poverty rolls on. Almost twice as many respondents named this negativism as an obstacle than responses to any other obstacle.
- The second obstacle is the failure of the State to prevent or alleviate poverty. Only when awareness is overcome through societal education, coupled with financial independence from poverty, can the obstacles to a free public education be addressed. The questions of poverty alleviation are seen by most economists and developmentalists as a function of the State: only the State has the resources and the obligation to do the most good for the most citizens. The responders agreed to this statement across the board.
- The current state of education in Bangladesh is unfriendly to children with disabilities unless radical changes are made. Classrooms often contain 70 children to one teacher. Teachers are not trained in inclusion or special provisions for persons with disabilities. There are no supplementary professionals to offer special tutoring, Braille instruction, speech therapy, mobility, and activities of daily living. The government schools do not currently have the money to change the system, and if they did, there would be a severe shortage of trained teachers and specialists. Thus

overcoming school resistance to educating children with disabilities is a major governmental problem. This was an observation given primarily by children/parents and by teachers.

- Stigma is not just for persons outside the family of a person with disabilities. The parents often “buy in” to the stigma premises because they know nothing different. They feel their children are “hopeless” because they have never seen a successful or coping adult with disabilities. They do not understand their child’s condition—they don’t even know a name for it—and they therefore envision it as a curse, “bad luck”, or a punishment for bad deeds. Education to prevent family negativism should prioritize families before the general public, but both are strongly needed in order to make societal pathways to education. Teachers and administrators recognized this obstacle more than did parents.
- There are few if any governmental schools, either segregated or inclusive, that can handle more than a fraction of the children with special educational needs, say the teachers. This lack of services cannot be blamed on stigma; schools cannot be built fast or large enough to keep up with the rate of population growth.

**“I want to go at the school with my classmates.
But I did not get admission anywhere.”**
Student comments at Solidarity, Khalilgonj, Kurigram.

- Most of the schools serving children with disabilities are funded by the central government, NGOs, or INGOs. There is no local flow of educational funds, thus preventing local groups, such as parent groups, from exerting pressure for the education of known local children with disabilities. Even if the State were to provide disability education through Government Schools, it would be split between two Ministries, Social Welfare and Education, so that many children, and their families, would lose services in jurisdictional squabbles. This was a comment mostly made by school administrators.
- Most children have to be transported to government schools. The current system in rural areas offers little to no specialized transportation from home to school. Children with disabilities are also not eligible for assistance with rickshaw transportation as are children without disabilities. This is a poignant complaint by parents of children with disabilities.
- At the current time, families noted, there are no books or other educational materials available to educational programs or to families that have children with disabilities. There are no books containing the issues of successful living with a

disability, no books portraying heroes who are disabled, nor books written in large print, Braille, or recorded in order to meet special needs of children with disabilities.

- Parents noted that almost no child with a disability, particularly if they are poor, has assistance with aids and appliances, orthotics and prostheses. Therefore children with mobility problems and sensory problems are even more severely constrained in school systems than they need to be. Their efforts have to be greater than those of the non-disabled child.
- Some educational administrators noted that the laws assisting young children with disabilities in Bangladesh are few and, when they exist, inadequately monitored. Although there is a special education law, the State feels more bound to conventions of the UN to which Bangladesh is a signatory. In any case, there is little or no enforcement of these legislative initiatives.
- In the rural areas of Bangladesh, there is almost no medical assistance to assess, counsel, or treat disabilities and their consequences. Families in particular suffer from this lack of knowledge.

Recommendations

Most of the recommendations were derived from themes of the “needs” data. However, many of the recommendations often showed knowledge of successful practices in other districts, other NGOs, or other countries and were incorporated into the recommendations.

- The major recommendation was the building of a “traditional” special education program in all government schools. This meant that all the respondents wanted a program that would offer special education classes mainstreamed in each school. All classes containing children with disabilities should have a reasonable teacher/student ratio, about half the current one. Teachers should be especially trained in disability methodology and content, especially those teachers who taught children with visual impairments, hearing impairments and intellectual disabilities. There needs to be useable space for the varied needs of instruction in the schools, the age of entry and leaving from the special classes should be flexible, and the schools should be equipped with appropriate teaching materials. In addition to education, each school should have an aggressive program that seeks disabled students, provides safety measures for children with disabilities (to protect them from stigma-related abuse), provides at least one meal per day, and builds home-school cooperation through family meetings. Although parent/child dyads wanted these schools, it was the teachers and administrators that articulated the concepts most cogently.
- Child/parent dyads and teachers strongly advocated for the concept of free education for children with disabilities. Because so many children with disabilities were in poverty, they explained that “free” meant that there should be no costs for expenses like clothing and books. There should be scholarships and/or stipends for children with disabilities (as there are for children without disabilities). Families who

have children with disabilities should be helped so that the child does not become an economic liability to that family.

- Besides government schools and the inclusion of children with mild disabilities, there is great need for special and segregated educational programs for children with multiple disabilities, reported teachers and administrators. Many of the schools needed should be residential schools so that children with severe disabilities can be unimpeded in their educational pursuits by negative family and social conditions and given effective special education. This was a recommendation of both families and educators.
- Awareness campaigns, i.e., campaigns of public education through all media including printed and broadcast material, theater and dance, should be aggressive and started immediately. The purpose of these awareness efforts would be to minimize (if not eliminate) stigma and the deprivation of rights of persons with disabilities. Included in the awareness campaigns should be stories of successful coping and success by persons with disabilities, and an open forum of disability issues. All respondents mentioned this recommendation as an absolute necessity.
- No educational programs should be started without a corresponding medical service program, responded the parents. They needed to know what the medical basis for the disability was, whether it could be prevented in the future, and if and how it could be treated. They needed to know if what they were doing to nurture a disabled child were in actuality hurting that child's chances for future adjustment or if they were providing an environment that would stimulate growth and development. These medical services would, of course, have to be free to all families.
- Teachers discussed the curriculum for children with disabilities and articulated that such a curriculum should be well-rounded and as close to the non-disability curriculum as possible. They recommended that the curriculum should contain sports, fine arts, recreation, and vocational preparation as well as academic content. The academic curriculum should also contain specialized methods in teaching Braille and sign language.
- All the respondents agreed that transportation should be provided to children with disabilities attending school. It should be free to those who cannot afford it.
- Children, parents and teachers insisted that assistive devices should be provided all disabled children who could use them. Because Bangladesh citizens cannot afford such assistive technology, the State should consider funding such technology development and providing it, free, to children with disabilities and their families.
- Children and parents as well as teachers remarked that they are more functional and effective in raising and educating their children if they have information about their children, such as the nature of the disability and the strengths and weaknesses of the

disabled child. Medical and educational assessment and counseling are needed greatly. It was suggested that “camps” (rural gatherings of persons with disabilities by medical and educational personnel for the purpose of quick assessment and counseling) would be an excellent idea to initiate in Bangladesh. Such services would, of course, have to be free to families.

- Administrators and teachers reminded the data gatherers that Bangladesh had a constitutional guarantee of free and appropriate education for children with disabilities, and those constitutional provisions should be strongly enforced. In addition, further laws are needed to enforce inter-ministerial cooperation on disability education and the aforementioned “education for all” convention to which Bangladesh is a signatory. The State needs to provide protection to children with disabilities from the effects of misguided and cruel stigma in the community.
- School administrators felt strongly that all educational buildings should be physically accessible to children with disabilities, including toilets and ramps. Most schools were built from old, standardized building plans, created without awareness of the needs of children and adults with disabilities.

One administrator recommended that disability advocacy groups should be encouraged at the highest levels of Bangladeshi government. Only when this happens will there be changes in law and policy.

Limitations

Although a great deal of data were collected and analyzed, there are some limits to the study itself. It was planned for execution in a very short period; a period cut even shorter by longer-than-expected holidays, and hartals of six days, effectively changing interior travel and processing plans and cutting off contact between Senior and Junior researchers. Communication was maintained by email and telephone. The sites of Jessore, Tangail, and Savar were researched without the team leaders because of the travel restrictions. The data, however, appears to have face validity.

Comments

The educational needs statements show that families of children with disabilities as well as educators want what other countries take for granted: special teachers and classes within regular schools, adequately trained teachers and specialists, a reasonable space, and teacher/student ratios in which to do special needs education. Unlike other countries, however, they recognize that obtaining that goal means overcoming difficult social barriers caused by stigma and prejudice; thus the stated educational needs includes a vision of motivation and acceptance by society. They know that teachers will have to have in-depth and specialized training, and that is hard to find in the current educational system. In fact, a large percentage of the respondents felt that a comprehensive educational program for special needs children would have to embrace many separate residential facilities to take care of the most severely disable children. Interspersed with the special education vision, is a vision of effective

medical assessment, treatment and counseling; families need to have realistic information about their disabled children: they need to know how to physically and mentally nurture the child, they need to know if they can or should send their child to school, and they require information on prevention. In the ideal concept they are describing, all services are central and free. Because disabled children and their families are most often from poverty environments, the costs for these services must be minimal and include transportation from home to school, specialized services such as speech therapy, appropriate clothing, food, and other living and maintenance stipends and scholarships. The stakeholders want enforcement and stronger laws that provide the constitutional rights of education for all.

In the listing of obstacles, stigma has the highest frequency, by twice, of any other obstacle. Stigma, or negative biases, cause the educational system to refuse disabled children, brings shame to the child and his family, invites teasing and abuse, and otherwise destroys self-esteem. The second obstacle is poverty. The causative and cyclical relationship between poverty is described in the first section of this report and is recognized by the respondents. Even if the schools were welcoming to disabled students, however, the respondents felt that it was unlikely that they could educate disabled children adequately because they lacked training and because they had too large teacher/student ratios in the classrooms. Poor to no financing presents a formidable barrier to marginalized disabled children in the poverty environment. There are also no assistive devices, nor special books nor educational material, nor accessible transportation that could even basically assist the child with a disability to leave her or his home for school.

**“My son is mad! None call him good.
School also does not take him,
So he is walking around.”**

Father’s comments at Esho Desh Gori,
Kurigram

When asked to make recommendations, the respondents described special education programs in all schools, a responsibility of the Bangladesh Government, including the Ministry of Education in public schools and the Ministry of Social Welfare for the special schools, coordinated by inter-ministerial cooperation. The majority of special education should be located in regular, government or NGO schools. Each school should have at least one special needs classroom with a teacher/student ratio of no more than 1:30, and there should be resource teachers in each school for hearing impaired, visually impaired and intellectually disabled children. The education for special needs would be aggressive, not caretaking, and the children would have adequate free food, clothing, and transportation. Those children who could not be served adequately in a good special education program could gain admission to a residential school for those with multiple or severe disabilities—again at government expense. The vision of special education now is comprehensive. It not only includes academic content, but it offers what non-disabled children receive in school: sports, entertainment, fine arts,

recreation, and vocational preparation. The school and the local medical facility act as a center for family counseling and advice regarding children with disabilities, and either the school or the clinic will refer the child to the best educational program. Assistive devices would be provided by the government or the NGOs at no cost, and changed as the child grows. The laws guaranteeing the right of education to all of Bangladesh's children would be enforced. These recommendations are given with a mandate: they must be enforced immediately.

From the conversations of the Senior Team with the interviewed families and the school personnel, immediate response to the many and varied educational, financial, and medical needs would not happen. The Bangladesh government, NGOs, and INGOs simply did not work that way.

A natural progression of events for system change, however, presented itself. The medical and educational counseling of the parents is the first step in the process of change, followed by systemic change of both the government and non-government schools in accepting children with disabilities and improving teaching conditions. The qualitative information indicated that many administrators know how to improve teaching conditions; they are hampered by lack of funds and governmental indifference. Stipends, scholarships and other financial and material support for the laborious efforts of families and disabled children to attend educational institutions must be put into place. The final phase of systemic change is a mass effort at public education about positive role models and achievements of persons with disabilities.

VI Parenting and Parent Education

Being a parent of a child with a disability in Bangladesh is often a full time occupation—and a severe test to a family’s economic and psychological stability. The data about parenting and potentials for parent education contained in this report are qualitative and represents the personal testimony and opinions of parents interviewed both singly and in groups during the field visit part of the investigation. As has been noted in previous chapters, the largest majority of children with disabilities are in poverty conditions—conditions that not only cause disability through malnutrition, disease, and lack of medical attention, but also inhibit education through stigma, negative beliefs, and lack of transportation, attentive care, and inadequate home schooling among many factors. With a poverty rate of 64.3 percent⁹⁹ and three fourths of the population rural, it is likely that the overall figures heretofore quoted are conservative; the number of disabled children in Bangladesh will be greater than these estimates, and their population lies mainly below the poverty line and in rural areas. It is from these populations that these observations are drawn.

Parenting a disabled child has many dimensions.

- **Care.** A disabled child of any variety requires more intensive care than any non-disabled child. Often, the first task of caring for a disabled child is geared towards survival. The child must learn to eat, eliminate, communicate and thrive—all of which may require, in severe cases such as acute malnutrition or diseases, round-the-clock vigilance and nurturing by the family. Trained medical help is often not available, so neighbors and semi-medical personnel are needed. Medicines are often too costly to afford, and specialized treatments such as physiotherapy or speech pathology or assistive technology such as braces, crutches or hearing aids are non-existent. The child will receive only what the parents and family have to give—a little food, perhaps some breast milk, holding and comforting, and little more. The mother will, by tradition and unspoken law, be the main caretaker of the child, and, although the grandmother may help (many rural families live three generations to a house), the secondary caregivers will be the siblings of the child. The father, the extended family, and the neighbors may help the mother with the care of the child, particularly if the mother is working, but it is the mother who must make the caregiving decisions about the child.
- **Beliefs.** One of the first thoughts of a parent when he or she knows that the baby is disabled is, “What have I done to deserve this?” Is my disabled child a message from Allah? Often there is guilt: “I am receiving punishment for past transgressions.” A life is sacred, however, and most parents usually realize eventually that they must accept this “burden” and try to help the child as much as possible. Behind their thinking, however, is a fatalistic attitude: “A disabled child has no future.” They know of no persons with disabilities who have been educated or are successful. They know that the Government schools will not

⁹⁹ (Short form) *Bangladesh Census 2000* .

accept their child for education and, if they did, the child would soon drop out because there are so many other children in the class that the teacher cannot teach their child. They know that other children and adults will make fun of the child, and possibly even abuse her or him. They know that there will be no financial help or extra food for this child, as there are for non-disabled children who go to school, because none of these institutions believes that a disabled child has promise. Parents may grow to love their child, as was seen in almost all of the interviewees of this study, but such love must be unconditional: their child has no future. Now.

**“When my child goes to school, we get inspired.
We hope one day he will get rid of this situation.”**
Mother’s comments at SWID Bangladesh
Kurigram

- **Economies.** In poverty conditions, all members of the family must work for the common good. In many families, poverty or non-poverty, the wife also works to add to the standard of living. Because the woman of the house must raise the children in it, she must also be responsible for the care of the disabled child. This usually prevents her from working. In the poverty situation, this eliminates the chance to be released from the poverty cycle; therefore a disability in a family has grave economic consequences. If a child receives proper medical care, including prostheses, orthoses, medical treatment, medicine, assistive technology, or any of the numerous supports given disabled children in developed countries, the cost is overwhelming to the Bangladeshi family; there is no relief from these expenses except from a handful of NGOs—and then in a very limited way. Most families bear the task of caring for their disabled children without ever knowing the name of the disabling condition, actions to be taken to help the child become more self-sufficient, or the medical or educational resources are needed and/or available to the family. For most families, this little knowledge is a blessing; they cannot afford more than they have to offer from their meager incomes.
- **Practices.** The interviewees seemed to have no generalized set of parenting practices for disabled children. What shaped the parenting practices was the nature of the disability, the obvious needs of the child, and the behaviors of the parents according to their degree of acceptance and their concepts of stigma. Most mothers, feeling that the child had no future, were content to concern themselves with food, cleanliness, and survival, developing routines of care, and training siblings and extended family members to watch the child when the mother had a need to be absent. In many cases, however, there were antagonisms towards the child in the village—or even in the home. Several parents told of disabled children abused by the father, the siblings, healers, or neighbors. Girl children were especially vulnerable. Often the shame of having a disabled child (stigma) manifested itself in the home by isolating the child from the community, sometimes even locking the child in the house. Wife and husband often disagreed on the care of a child, and the resulting

friction eroded the family stability. In only one interview, that of a father and his bright, deaf, but attractive son, was seen pride in a disabled child and a concurrent shard of hope for the future. (The child had applied to the Government School for Hearing Impaired children, but only 4 children could be selected from a waiting list of 114.) This view of a disability, obviously involving both the mother and father, was the only positive interview in over 100 such conversations.

- **Gender.** In the studies of gender and disabilities, more females than males are identified as disabled.¹⁰⁰ In the field visits, this ratio seemed skewed toward more parents with girl children than males. This is attributed to the fact that girls with disabilities are seen as bigger liabilities than male children with disabilities because stigma drastically reduces their chance for marriage (and consequent dowry income for the family plus more freedom from her care). Male children are trained more often to do menial tasks to help the family, thus becoming economic producers. Interviewed parents and girls revealed the high rate of abuse, both physical and sexual reported in studies.¹⁰¹ In the values of the Bangladesh family, male children with disabilities are more likely to receive the advantages of lessened stigma. That child can possibly go to school (if they will take him). Although one would expect an equal ratio of male to female children with disabilities, the discrepancy between males and females reported with disabilities may reflect a more liberal and or positive attitude towards males than females in the culture. This, however, is speculation.
- **Parent Education.** In the search for projects of parent education about disabilities, very little effort is apparent. Project SUCCEED, in its equity program thrust, mentions providing knowledge to people and organizations about disability and disability rights, but does not describe parent education. Community Approaches to Handicap and Disability (CAHD) is a movement fueled by an organization, The Center for Development and Disability (CDD) and mentions, as an activity, the provision of knowledge to people and organizations about the roles of family members in creating handicaps (vs. disabilities). The researchers found no examples, however, of focused efforts to teach parents how to help or provide home education to their children with disabilities. Yet, this need was articulated at all the field visits. Parents want to know about their child's disability. They want to know its name. They want to know how best to help that child. They want to know how to reduce stigma in the community. And they want to be able to talk to someone about their child. So far, that knowledge and the ways of teaching it or providing it to parents with simplified written or broadcast resources, is not on any known organization's priority list. Project SUCCEED may initiate it in the future. Sesame Street has a chance to work in this area but has not programmed it yet. The BRAC schools promise to refer students with disabilities, thus providing parents with some information—but no agency could be found that undertakes the task of educating all parents about disabilities. When such programs are started, they

¹⁰⁰ (Short form) Kabir, *Four Baseline Surveys on Prevalence of Disabilities*. A study of 12,578 disabled persons from a population of 94,260 concluded that 41 percent were males and 59 percent were females, a statistic very close to that of the 1999 Census sample study conducted by the Bangladesh Bureau of the Census, 2000.

¹⁰¹ (Short title) *A documentation of good practices on inclusive education for UNICEF, CSID*.

will provide valuable information about new methods of educating disabled children—as they have done in developed countries.¹⁰²

In the field, working to gather information for this report, groups of parents, holding their disabled children, met with the researchers to discuss their opinions on educational needs, articulate the obstacles to education for disabled children, and make wishful recommendations. The energy among the parents, as described by the researchers, was palpable. Parents finally had a professional to talk to, and they were grateful—and demanding—and tearful—and angry—and verbal—and articulate. Their stories were sometimes terrifying, sometimes heroic, and always unique. They wanted medical help, educational advice, and general knowledge. They wanted enough knowledge to allow hope. They were willing to come long distances, with great hardships, to talk about their children. If they could work together, they might achieve systemic change, but they had no idea how to do that. All the researchers saw them as a potential force for helping not only their disabled children, but improving the stigma and removing some of the barriers of disability in their cities and villages. Parents are still an untapped force in the education of disabled children in Bangladesh.

¹⁰² The US has been particularly aggressive in parent education, funded by governmental funds. The results have shown remarkable improvements in the education of children with disabilities. An overview of the US parent training system may be found at <http://www.pacer.org>.

VII

Opportunities in the Education of Children with Disabilities in Bangladesh

Young children with disabilities in Bangladesh have so many needs in the process of getting an education that assistance can start in almost any sector. It is known that poverty is a major cause, limitation, and barrier to education but even more so is stigma, superstition and ignorance. The government schools, which by law and the Bangladesh Constitution should be educating children with disabilities, have not taken into consideration necessary inputs such as trained teachers. The few programs of excellence that would serve as cost-efficient models are not known in most of Bangladesh; and even if these models and centers were famous, they could not be replicated without help. The families of children with disabilities feel burdened by their offspring and hopeless about their futures because they don't even know the name of their child's disability, let alone know what to expect from it or how to help it. Planners are stymied by lack of accurate information about the "who?" "what?" and "where?" of young disabled children in Bangladesh; there are mostly only guesses at numbers. No one knows what adequate education for disabled children will cost the government and the taxpayers and if there will be financial as well as moral gain to do so.

These are all questions and dimensions that need to be considered in any effort to assist in the education of children with disabilities in Bangladesh. They should not be viewed as questions that define the limitations of assistance, however. They are all areas that can be examined to show USAID the varied parameters that can be considered in investing in the education of disabled children. In the USA, earlier cost-effectiveness studies showed that monies invested by government in the special education and/or rehabilitation of a person with disabilities was returned fourfold in the lifetime of that person by reduced dependency costs, increased tax payments, and more positive contributions to the work force. That type of cost-effectiveness study can also be conceived as being helpful in Bangladesh, where the difference between self-sufficiency and dependency in the home is the difference between survival and starvation for a family. There are economic reasons for early childhood education as well as the psychological and moral reasons. The USA has long believed in and invested in the productivity of its own citizens with disabilities. Sharing knowledge and experience--in the spirit of the Individuals with Disabilities Education Act and the Americans with Disabilities Act (ADA)-- with disabled Bangladeshis and the Government could do much to improve the education of pre-primary and primary disabled children in Bangladesh.

USAID will find many opportunities to consider investments in the educational health of preschool and primary disabled Bangladeshi children—the target for education that offers the best outcomes for an educational investment. The opportunities for this investment are grouped as follows:

- **Models of Excellence.** There are programs in place that fit the needs for education of disabled children and their families as articulated both by the parents and knowledgeable early childhood disability educators. The SUCCEED project will probably be one of those models when it is fully developed and evaluated. It carefully selects students and

teachers, and integrates disabled and non-disabled children, it offers trained teachers and new curriculum, and integrates nutrition, health, and activities of daily living. In the short term, SUCCEED is an intervention that addresses the need for technical assistance for comprehensive training on the subtle manifestations of disabilities. It also can address issues of training in the use of valid screening tools or instruments, critical to correctly identifying children with disabilities. Another exemplary program for preprimary to primary schools for mild children with disabilities is the BRAC school program that integrates up to three mildly disabled children in its pre-primary classes. Both of these programs are well thought out and are models of excellence.

Perhaps this is a chance to invest in an effort of diffusion; the aggressive establishment of models in new school systems by providing consultant help, training, curriculum, seed monies, and other replication/diffusion needs. Those in Government Schools and NGOs who stated that they want a model program now have both the models and the materials. The question for USAID is how can the models be installed in general education? How can they be disseminated and diffused?

- **The Planning Infrastructure.** In an account in the Asian Development Bank sits (metaphorically) a sum amounting to \$1.815 billion contributed by ten INGOs and banks plus a one third contribution from the GOB. This amount of money is to be used to effect system change in the Government schools. Local committees assisted by full-time foreign consultants reporting to the ADB leadership office are now planning this concerted and comprehensive change. It is called the PEDP-II. Among its components is Component 4--an equity project that will seek to establish inclusion programs in future Government schools to include girls, other minorities, and young disabled children. There is money in the account to fulfill some of the dreams of parents, such as stipends and scholarships, guaranteed rights to education, and, perhaps, food. Despite the best efforts of the donors, the implementation of PEDP-II is delayed. It is not comprehensively planned yet, because of a lack of foreign consultant participation, at least for component 4. Perhaps this is an opportunity for USAID participation.
- **Training of Personnel.** With the small numbers of teacher trainers available for traditional special education and fewer than four universities offering any type of training for working with disabled children, it remains a fact that the growth of disability education will be arrested until teacher training can be improved and increased. BRAC and SUCCEED will be training their own teachers, but mostly for their own schools. Who will train for the vast majority of opportunities in the Government schools when the system is reformed? The research team of this assessment talked to many disability education academics. They want assistance. They want to expand teacher training--greatly. They want research, information, and knowledge about new methods, new content, new educational configurations, and the education of new types of disabled children like those with autism or learning disabilities. The current small corps of teacher trainers spends many hours outside its classrooms teaching in-service groups, learning about modern education, or conducting research. They desperately seek to improve both their skills and their numbers so that increasingly larger numbers of teachers and teaching aides for children with disabilities can be made available.

- **Involving Parents.** Parents of children with disabilities have energy in search of an outlet. Time after time, they asked the research team “what can I do?” not “what can a doctor or a teacher do for me?” They would function in an active mode if they had some knowledge, some leadership, and some incentives to work for their families and their disabled children within them. They need information. They need examples of what can be done for disabled children and the raw materials with which to replicate useful practices. They need to enlist the help of their elders and their neighbors. They need friends who are sympathetic and helpful to them and not condemning or exploitative. They want to make informed decisions. They want knowledge. Perhaps USAID can develop such an informational system. Perhaps SISSIMPUR can assist with this.
- **Building Self-Esteem.** Families are frequently stifled by the hostility of their community, but undoubtedly they also are constrained more frequently by their own lack of self-esteem. If the community finds their children hopeless, disfigured, or non-responsive, they may turn on them. They do not, however, turn against members of the community who show their creativity, their athletic prowess, or their determination to be “just like all the others”. All the players in education and most of the parents remarked on the need for programming in sports, entertainment, and also the arts. Many children can participate in the arts or sports, particularly through the excellent programs offered by the Special Olympics or Very Special Arts, and many children have been literally “saved” from frustration and abuse by their performances and their integration into society through these extra-curricular activities. A comprehensive arts and sports program can be started in Bangladesh and taken into the rural areas. The voices, the drums, and the arts are there. The project team has seen and heard them. USAID could work with existing international organizations to start or increase programs like that in Bangladesh.
- **Medicine and Food.** Finally, there are models of rural medical services and food distribution that bring very needed information, treatment, and referral as well as nutrition to disabled children and their families. In the phases of systemic change in the rural areas, free medical help and food play crucial roles. They attack poverty cycles and the stigma of ignorance, and they offer a glimmer of hope after treatment. They offer nutrition that facilitates learning and reduces the burden of household feeding. These are actions that will start a powerful movement of parents of children with disabilities (who might be as many as 30 percent of the population). Demonstrations and diffusion of model medical/educational assessment and referral centers could be made possible through the education and health sectors of USAID.
- **The Facts.** It is obvious that precise planning, particularly when the stakes are high and the investment is heavy, is much better when the statistics on status and trends are stable and well founded. There have been attempts to get accurate counts of children with disabilities, but they have not used the most efficient methods and are often internally and externally non-comparable. A question in the last National census now appears to have been worthless; it has never been reported. Good sampling, accurate

instruments (such as the Ten Plus Questions), or the functional measures of the CY-ICF would give the most useful data for positioning oneself as a multiplier of change in the education of children with disabilities in the future. Because of the inadequacy of previous attempts at finding disability and disability economic figures for both the urban and rural, poverty and non-poverty sectors of Bangladesh, fact-finding is still a high priority in the paradigm of change. There are examples from the past on which to learn the lessons that will make future counts more accurate. USAID could provide some of that needed research.

Bangladesh has many donors contributing many studies and coordinating with few others. The scramble for data and studies and explanations of disability education in Bangladesh was very difficult, particularly because there was no central repository for it. The area of preschool education for children with disabilities was particularly difficult. It is hoped that with USAID's good library facilities, that it may develop into a valuable archive of important data in this area.



Investment in early childhood interventions, pioneered and championed by the USA, is now seen worldwide as a logical first step in systemic educational reform for children with disabilities and their families. Early intervention prevents what is now an increased dependency and economic liability of persons with disabilities as they grow older. Early intervention also shows the citizenry that all people can be valued, not diminished, by stigma or vulnerability. Only with increased independence and the acquisition of skills by all family members can poverty cycles be broken. Early medical, nutritional, educational, and awareness efforts are crucial components of an early intervention model for Bangladesh.

USAID has a unique opportunity to stimulate early childhood intervention systems in a country that literally has almost no offerings in this area. Already USAID is funding two projects that directly address stigma reduction and the setting up of models for early educational inclusion. There is more that can be done through these projects, and also through careful planning and execution of other projects.

What this study has found, however, is the deadly apathy of exemplary projects without replication or diffusion targets or resources. INGOs and NGOs are the major providers of educational interventions for young children with special needs. Where are the efforts and resources that should be provided from public education and health systems?

USAID has the chance to use its investments to leverage both public and more private interventions. It can plan these interventions wisely and with multiple resources. Sustainability is possible when educational reform occurs and successful models are in place to show value and to train needed personnel. USAID has an opportunity, through its actions in Bangladesh, to model strategies and programs for young disabled children in other developing nations. This study shows that change is possible in Bangladesh—slowly. The Study Team views USAID as a potential accelerator.

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IX APPENDICES

**APPENDIX I
THE STUDY TEAM**

| Name | Area of Specialization | Designation | Address, phone & e-mail |
|-------------------------|-------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Paul R. Ackerman, Ph.D. | Child Psychology Special Education | Team Leader Consultant, disability and development | Tel.: (540)7782451 ackerman_paul@hotmail.com |
| Mary S. Thormann, Ed.D. | Special Education (Early Childhood) Educational Psychology | Consultant, Disability and Special Education | msthormann@earthlink.net |
| Sharmin Huq, Ph.D. | Special Education Disability | National Consultant Associate Professor Dept. Of special education(IER) University Of Dhaka | Off :9661920, X6200 hksh@accesstel.net |
| Md. Arifur Rahman | Socio-Economic Development Research | Study Coordinator Fellow, Unnayan Shamannay | Unnayan Shamannay 2/E/1-B, Mymensingh Road, Shahbagh Dhaka Tel:8610332,0176-620093 (cell) Fax:880-2 -8622320, arif@sdnbd.org, arifbids@yahoo.com |
| Enayet Baten | MBA | Research Assistant | 281 South Ibrahimpur Cantonment, Dhaka 0187088821 enayet@yahoo.com |
| Fahmida Afroz Nipa | Economics | Research Assistant | 1-F/3-25, Mirpur Dhaka, 8023436, nipamoni@hotmail.com |

| Name | Area of Specialization | Designation | Address, phone & e-mail |
|-----------------------|--------------------------|--------------------|-------------------------------------------------------------------------------------------------------------------------|
| Md. Akhter Hossain | Economics | Research Assistant | 3013,ZahurulHaque Hall, University Of Dhaka 0171154484(cell) asikder@epals.com apurbo_sik@hotmail.com |
| Md.Abu Sayem | Psychology | Research Assistant | 241Zahurul Haque Hall,University Of Dhaka 0189451182,0172044588(ce ll) lyceum_agro@yahoo.co.uk |
| Md.Mominul Islam, LLM | Law | Research Assistant | Rokey Shanti Niketon 281Ibrahimpur,Dhaka 0171007938, mominprodhan@yahoo.co m |
| Nargis Sultana | Anthropology | Research Assistant | 1-E,5-37/38 Mirpur, Dhaka 8023818 nayar124@yahoo.com |
| S.M. Khalid Mahfuz | Environmental Management | Research Assistant | 15/10 Modhubag, Magbazar, Dhaka 9358239 , bandhu01@msn.com |
| Sharmin Jahan Khan | Anthropology | Research Assistant | H # 509, R # 9, 5 th Floor, New DOHS, Baridhara, Dhaka 8814716, 0172131157(cell) |
| Soma Dutta | Psychology | Research Assistant | Property Heights, Flat # 7/E-2, !2 R. K. Mission Road, Dhaka 9556932, 0172710757(cell) soma_91981@yahoo.com |
| Mohammad Ahmed khan | Computer Science | Interpreter | 367 Elehant Road Apt. # 8B Basera Apartment Dhaka8611593 , 011823434(cell) eusuf.khan@gmail.com |

APPENDIX 2

Statement of Work

The USAID contracted with Creative Associates International, Inc. to conduct a study for the Bangladesh mission entitled “The Assessment of Educational Needs of Disabled Children in Bangladesh”. The objectives of USAID in funding this project are:

- To strengthen overall USAID understanding of the educational needs of disabled children in Bangladesh;
- To inventory and assess existing institutions and systems that currently exist in Bangladesh to meet the educational needs of disabled children and the preprimary and primary levels of education.
- To identify obstacles that act to discourage disabled children from fully participating in the mainstream educational system;
- To identify cost-efficient opportunities to help overcome these obstacles, and
- To identify potential entry points for basic education assistance to disabled children, framed within the context of USAID’s existing programs, particularly Sesame Street Bangladesh and SUCCEED.

Through Creative Associates International, Inc., USAID chose the research team. It was composed of Dr. Paul Ackerman, Team Leader, Dr. Mary Thormann, both of the USA, Dr. Sharmin Huq of the University of Dhaka, and Mr. Arifur Rahman of Unnayan Shammanay. An additional ten research assistants/graduate students assisted in the collection of data, the acquisition of facts and information, and the processing of the report.

The following Statement of Work guides the work of the project, the analysis of data, and the report of findings.

The Status of Disabled Children:

What is the size of the disabled population 0-10 years old and current birth trends? What do available statistics and indicators reveal about lives of disabled children in Bangladesh? What is the availability and reliability of data?

Social and political context:

Provide a brief history of efforts to address the educational needs of disabled children in Bangladesh. Discuss the social and political context of efforts to help these children. What laws exist to protect/treat these children and to provide them with an education? Similarly, what institution exist to protect/ treat these children and to provide them with an education? What are EFA recommendations regarding the education of disabled children? What level of government/ donor/ private funding is available to meet the education needs of these disabled children? Have there been public forums, national workshop, and media campaign focusing on the needs of these children? What was the outcome?

Parenting and Parent Education

Who cares for disabled children – fathers, mothers, grandparents, older siblings, or other relatives? How does this care differ from children without disabilities? How do working parents

care for disabled children? What impact do disabled children have on the ability of the parents towards? What social/ economic impact do disabled children have on their nuclear and extended families? What are parenting beliefs and practices the upbringing of disabled children and their access to education? Do gender differences exist in care of disabled children and their access to education? Have any programs been developed to help improve the parenting skills of the parents of disabled children? If so, what have been the results?

Preschools – formal, non-formal and private sector

To what extent do disabled children attend preschool? What types of pre-schools? Where are they located? Are these preschools successful in helping/educating-disabled children? What lessons have been learned?

Early Primary Schools – formal, non-formal and private sector

To what extent do disabled children attend early primary school? What types of early primary schools? Where are they located? Are these schools successful in helping/ educating disabled children? What lessons have been learned?

Opportunities

Discuss cost-efficient opportunities to help educate disabled children in Bangladesh. What trends, issues and obstacles impact on these opportunities?

Recommendations

What are suggested programmatic interventions by USAID, if any, to assist in the education of disabled children given USAID's expected resources, comparative advantages? Please frame these suggestions in the context of USAID's existing programs, particularly Sesame Street Bangladesh and SUCCEED. Also consider the possible contributions that might be made by other USAID/ Bangladesh programs in other sectors, such as health and energy.

APPENDIX 3

Survey Tools

I. Interviewing Children in the Field

Educational Needs of Disabled Children

A. Basic information about the child with disability(s)

- Age
- Sex
- Type of disability: “What kind of problem do you have?”

B. Educational Information

- Do you have any education?
- If yes: how old were you when you started? –or- if you left school (dropped out), why?
- What is the name of your locality? What school is nearest? With whom do you come to school?
- How did the school teach you? (What methods did they use?)
- Are there any difficulties/discouragements/obstacles at present time in your school?
- What do you find easy about your school?
- What difficulties/problems did you find in getting into school the first time.

C. Recommendations/Needs

- What one thing would help you the most?
- What can be helpful/useful to help people like you in school?

II. Focused Group Discussion (FPG) Guidelines for procuring information data from parents, teachers, administrators, and groups of same.

A. Big Issues

- How do you define disability (of different types)?
- Describe the situation particularly of the children by types and severity (local/national level)
- NGO/Institutions/Schools/Government working in the field
- Methods/Approach used: e.g., CBR, Inclusive, Special, etc.
- Educational/Learning Needs of disabled children (particularly at early childhood and pre-primary school level) in Bangladesh/the area
- Obstacles/discouragements of disabled children in being included in the mainstream educational institutions including the special and integrated approach from the perspectives of parents, community, school, social/religious institutions, government, schools, Management Committee, teachers and from themselves.
- Way out/recommendations to address the obstacles for each stakeholder.

B. FGD with parents of Children with Disabilities

- Educational/learning needs of disabled children (particularly at early childhood and pre-primary school level) in Bangladesh/the area
- Obstacles/discouragement of disabled children in being included in the mainstream educational institutions including the special and integrated approach from the perspectives of parents, community, school, social/religious institutions, government schools, Management Committee, teachers and from themselves
- Way out/recommendations to address the obstacles for each stakeholder

C. Participatory Learning Need Assessment for Children with Disabilities

- Listing of all the problems/obstacles in plenary of about 10-15 parents
- Prioritizing/ranking of the needs/problems in order
- Divide the group into three smaller groups
- take the most serious three problems/obstacles and distribute one for each group
- Discuss the issue elaborately in the small group with focus on: (one facilitator, one writer from the participants)
 - Details of the problems/obstacle in the given situation: what, why, how
 - Nature and severity
 - Parents' views on Special, integrated, inclusive and CBR approach from the perspectives of community, school, social/religious institutions, government, schools, Management Committee, teachers, and their children
 - Three practical key recommendations to address the obstacle

APPENDIX 4 Summary of Field Information/Data

Field Data

Division: Dhaka

District: Sub District: Savar

Profile (2001): Suburb of Dhaka District; 1,464 sq. km.; Govt schools=756; Regd NGPS and Non-Regd NGPS=155; kindergartens=402; teacher/student ratio= 1:84 in Govt schools and 1:81 in Regd Non-Govt Schools.

Respondent Characteristics:¹⁰³

| School or Agency | Child/Parent Interviews | Family FGD | Teachers in FGD | Admin/Other in FGD |
|------------------|-------------------------|------------|---------------------------------------------|----------------------|
| CRP | 4 | | 2 teachers, 2therap, 2 social workers, 1SMC | Comm Dis. Leaders 20 |
| Total: | 4 | | 7 | 20 |

Results:

Educational Needs

| Need | Ch/Par | Families | Frequency | |
|----------------------------------------------------------------------------|--------|----------|-----------|-----------|
| | | | Teach | Admin/Oth |
| Small class size with individual attention | | | | |
| Appropriate assistive technology that assists with special needs education | | | | |
| Residential facilities for multiple problems | | | | |
| Adequate physical space for education | | | | |
| Full-time teachers/therapists, adequately trained | | | | |
| Sports and recreation facilities for dis.ch. | | | | |
| Adapted fine arts programs | | | | |
| Food | | | | |
| Appropriate Clothing | | | | |
| Transport | | | | |
| Free Education | | | | |
| Assistive Devices | | | | |
| Medical Treatment | | | | |

¹⁰³ Data in the columns marked "Child/Parents..", "Teachers" and "Administrators/Other.." represent numbers of persons interviewed singly or in Focused Group Discussion (FGD). Data in the column titled "Families.." represents numbers of families which range from 2 to 4 persons per family.

Obstacles

| Obstacles | Ch/Par | Families | Frequency | |
|------------------------------------------------------------------------|--------|----------|-----------|-----------|
| | | | Teach | Admin/Oth |
| Very little laws of protection and treatment | | | | |
| Public awareness | | | | |
| Parent awareness | | | | |
| Local financial support | | | | |
| Govt. support through infrastructure, buildings, space, teachers, etc. | | | | |
| Social Discouragement | | | | |
| Lack of parental awareness | | | | |
| Negative attitude of NGOs at village level | | | | |

Recommendations

| Recommendation | ChPar | Families | Frequency | |
|------------------------------------------------------------|-------|----------|-----------|-----------|
| | | | Teach | Admin/Oth |
| Protective laws for babies abandoned because of disability | | | | |
| Better and more training of teachers | | | | |
| Full time staff of teachers and therapists | | | | |
| Better student/teacher ratio (suggest 1:2) | | | | |
| Better classroom space | | | | |
| Vocational/technical programs for older youth | | | | |
| Residential facilities | | | | |
| Special chairs for sitting or wheelchairs | | | | |
| Recreation for disabled children | | | | |
| Community awareness and acceptance | | | | |
| Goal of at least 1 disabled teacher in each primary school | | | | |
| Meeting of disability advocacy groups with PM | | | | |
| Ramping and accessibility | | | | |
| Financial initiatives from NGOs and Govt. | | | | |
| Nationwide media campaign. | | | | |

Field Data

Division: Dhaka

District: Tangail

Profile (2001): North of Dhaka (about 50+km); 3,414 sq.km.; Govt. Prim. Sch.=937; Regd. NGPS and Non-Regd. NGPS= 455; Kindergarten=26; Total 6-10 year olds=454,317; Teacher/student ratio=1:89 in Govt. Schools, 1:60 in Non-Govt. Schools

Respondent Characteristics¹⁰⁴:

| School or Agency | Child/Parent Interviews | Family FGD | Teachers in FGD | Admin/Other in FGD |
|------------------|-------------------------|------------|-----------------|------------------------------------------|
| Ghatail | | | 7 | 25 Community— 10 comm. and 15 parents |
| | | | | |
| | | | | |
| | | | | |
| Total: | | | 7 | 50 |

Results:

Educational Needs

| Need | Ch/Par | Families | Frequency | |
|-------------------------------------------------------------|--------|----------|-----------|-----------|
| | | | Teach | Admin/Oth |
| Sufficient land and buildings | | | | |
| Special classrooms/training rooms for ch. with disabilities | | | | |
| Adequate transport | | | | |
| Sports, games, fine arts for ch. with dis. | | | | |
| Teachers get equal salary to govt. teachers | | | | |
| Local financial support | | | | |

¹⁰⁴ Data in the columns marked "Child/Parents..", "Teachers" and "Administrators/Other.." represent numbers of persons interviewed singly or in Focused Group Discussion (FGD). Data in the column titled "Families.." represents numbers of families which range from 2 to 4 persons per family.

Obstacles

| Need | Ch/Par | Families | Frequency | |
|----------------------------------------------|--------|----------|-----------|-----------|
| | | | Teach | Admin/Oth |
| Parents not aware or accepting of disability | | | | |
| No public awareness and no acceptance | | | | |
| No local support for programs for dis. ch. | | | | |
| Poor financing | | | | |
| Only Govt support through Govt schools. | | | | |

Recommendations

| Need | Ch/Par | Families | Frequency | |
|----------------------------------------------------------------------|--------|----------|-----------|-----------|
| | | | Teach | Admin/Oth |
| Better teacher training | | | | |
| More classrooms like Ghatal | | | | |
| Ramps and accessibility | | | | |
| Healthcare programs | | | | |
| Vocational and technical education at later ages (computer training) | | | | |
| Public awareness through disability training | | | | |

Field Data

Division: Rajshahi
District: Kurigram

Profile (2001): Northern Bangladesh (over 300 km from Dhaka); 2,296 sq. km.; Govt. Primary Schools=563; Regd NGPS and Non-Regd NGPS=564; Kindergartens=10; Total 6-10 year olds = 306,113

Teacher/student ratio = 1:67 in Govt Schools, 1:63 in Regd Non-Govt Schools.

Respondent Characteristics¹⁰⁵:

| NGO | Child/Parent Interviews | Family FGD | Teachers in FGD | Admin/Other in FGD |
|----------------------------------|-------------------------|------------|-----------------|--------------------|
| SWID-B | 3 | | 5 | 2 |
| Community Meeting ¹⁰⁶ | 4 | 22+10=32 | 12 | |
| Ulipur (Jummahat) | 7 | 40 | | |
| Phulbari | 2 | | | 1 |
| BRAC School | 2 | | | |
| Total: | 18 | 72 | 17 | 3 |

Results:

Educational Needs

| Need | Ch/Par | Families | Frequency | |
|------------------------------------------------------------|--------|----------|-----------|-----------|
| | | | Teach | Admin/Oth |
| Medical knowledge, especially physical therapy, assessment | 4 | | | |
| Medical facilities/centers | 1 | | | |
| Medical treatment | 2 | | | |
| Teachers supportive/caring | 4 | | 2 | |
| Special education | 7 | 1 | | |
| Motivated teachers | 2 | | | |
| Trained teachers | 5 | | | |
| Open admittance policies/free | 1 | | 1 | |
| Special recreation | | 1 | | |
| Speech and communication | 2 | | | |
| Assistive devices/technology | | 1 | 1 | |

¹⁰⁵ Data in the columns marked "Child/Parents..", "Teachers" and "Administrators/Other.." represent numbers of persons interviewed singly or in Focused Group Discussion (FGD). Data in the column titled "Families.." represents numbers of families which range from 2 to 4 persons per family.

¹⁰⁶ This meeting was facilitated by a non-educational NGO, Solidarity, to assist in this research.

| | | | | |
|----------------------------------------|---|---|---|---|
| Separate/specialized schools | | 1 | 3 | |
| Assessment tools | 1 | | | |
| Proper staffing | 1 | | | |
| Residential special schools | | | 1 | |
| Specialized training in disability | | | 1 | |
| Transportation to schools | | | 2 | |
| Teacher training in methodology | | | | 1 |
| Disability assessment tools in schools | | | | 1 |

Obstacles

| Need | Ch/Par | Families | Frequency | |
|---------------------------------------------------------------------------------|--------|----------|-----------|-----------|
| | | | Teach | Admin/Oth |
| No medical facilities or personnel | 2 | | | |
| School is distant from home | 1 | | | |
| Community stigma | 1 | 1 | | |
| Lack of transportation | 1 | 1 | | 1 |
| Teachers negative: not helpful, not caring, ignore child | 2 | | 3 | 1 |
| Schools will not accept | 2 | | 3 | |
| SMC supports teachers negativity | 2 | 1 | | |
| Peers negative, teasing and/or abusing | 2 | 1 | 2 | |
| No food/nutrition | 2 | 2 | | |
| Child strange acting/not communicate=visibly disabled | 5 | | | |
| Lack of adequate educational program | 1 | | | |
| Family believes no future for child | 2 | | 1 | 4 |
| Lack of child or family motivation | 1 | | | |
| Parents unaware of rights | 1 | | | |
| No assistive devices or technology | 2 | | 1 | 1 |
| Inadequate health services | | 1 | | |
| Poverty | | 1 | 2 | |
| No books, educational tools | | 1 | | |
| Educational costs | | 1 | 1 | |
| Lack of trained teachers | | 1 | | |
| No help with disabled child at home | 1 | | | |
| Teachers' salaries withheld because of govt. bureaucracy. | | | 1 | |
| Father wants child to work | | | 1 | |
| No govt initiative | | | 1 | |
| Parents not educated about disability | | | 1 | |
| No govt schools or facilities | | | 1 | |
| No scholarship | | | | 1 |
| No special seating in schools for disabled children (to better see, hear, etc.) | | | | 1 |

| | | | | |
|-------------------------------------------------------------------------------|--|--|--|---|
| No attack on causes of disability, i.e., poverty, malnutrition, superstitions | | | | 2 |
| Bad prenatal care and habits | | | | 1 |
| Antibiotics and other toxins | | | | 1 |

Recommendations

| Need | Ch/Par | Families | Frequency | |
|--------------------------------------------------------------------------------------|--------|----------|-----------|-----------|
| | | | Teach | Admin/Oth |
| Specialized medical personal in centers | 1 | 1 | | |
| Special schools for certain types of disability (e.g., Cerebral Palsy) | 6 | 1 | 2 | |
| Free education for all children | 1 | | | |
| Schools with positive attitudes—friendly behavior of teachers | 3 | | 2 | |
| Adequate transportation | 1 | 2 | 3 | 2 |
| Medical treatment as needed | 3 | 2 | | |
| Assistive technology—free and as needed | 3 | 2 | | |
| Train cadre of teachers | 1 | 1 | 2 | 2 |
| Free medical treatment | 1 | | | |
| Economic improvement of family | 3 | | | |
| Community awareness | 1 | | | |
| Safety measures | 1 | | | |
| Parental assistance/education in raising children with disabilities | 1 | | | |
| Referral of children with disabilities to helping organization or medical facilities | 1 | | | |
| Work training as part of disability curriculum | 1 | | 1 | |
| Stipend to families for children with disabilities—or scholarships | 2 | 1 | 4 | 1 |
| Food | 1 | 1 | 3 | 1 |
| Home-school cooperation | 1 | | | |
| Aggressive disability programs that educate, not babysit. | 1 | | | |
| Recreation facilities | | 1 | | |
| Education to shift attitudes of peers. | | 1 | 1 | |
| Govt. financial support | 1 | | 1 | 1 |
| Free school uniforms | | | 1 | |
| More educational tools in the hands of teachers | | 1 | | |
| Music and sports facilities | | | 1 | |
| Parental encouragement/motivation | | | 1 | |
| Teaching materials | | | | 1 |
| Separate Schools | | | 1 | |
| Building accessibility | | | | 2 |

| | | | | |
|--------------------------------|--|--|--|---|
| Sign language-Braille | | | | 1 |
| Disability assistants | | | | 1 |
| Improved teacher/student ratio | | | | 1 |

Field Data

Division: Khulna

District: Jessore

Profile (2001): Western Bangladesh (200+km from Dhaka); 2,578 sq. km.; Govt. Prim Sch.=662; Regd. NGPS and Non-Regd. NGPS=513; Total 6-10=319,867; Teacher/student ratio=1:58 in Govt. schools, 1: 46 in Non-Govt. Schools

Respondent Characteristics¹⁰⁷:

| School or Agency | Child/Parent Interviews | Family FGD | Teachers in FGD | Admin/Other in FGD |
|-------------------------|-------------------------|------------|-----------------|--------------------|
| Shishu Niloy | | | | 11 from all NGOs |
| Jagorani Chakra Fdn. | | | | |
| Andha Kallyan | | | 1 | |
| Banehte Shekha | | | | |
| Bandhu Kallyan Sangstha | | | | |
| The Salvation Army, Int | | | 1 | |
| Total: | | | | |

Results:

Educational Needs

| Need | Ch/Par | Families | Frequency | |
|------------------------------------------------------------|--------|----------|-----------|-----------|
| | | | Teach | Admin/Oth |
| Specially trained teachers | | | 2 | 1 |
| Accepting social awareness | | | 1 | 1 |
| Specially-constructed school for disabled children | | | 1 | 2 |
| Sports and recreation in the curriculum | | | 1 | |
| Positive attitudes of parents/family towards dis. Children | | | 1 | 1 |

¹⁰⁷ Data in the columns marked "Child/Parents..", "Teachers" and "Administrators/Other.." represent numbers of persons interviewed singly or in Focused Group Discussion (FGD). Data in the column titled "Families.." represents numbers of families which range from 2 to 4 persons per family.

| | | | | |
|-------------------------------------------------------|--|--|--|--|
| Free assessment of child for assistive devices. | | | | |
| Special school van for child. with disab. | | | | |
| Free educational tools (books), instruments | | | | |
| Friendly attitudes from other students | | | | |
| Peer awareness | | | | |
| Enforceable State Law providing for disabled children | | | | |
| Specially-trained therapists | | | | |

Obstacles

| Obstacles | Ch/Par | Families | Frequency | |
|------------------------------------------------------------------------------------------------|--------|----------|-----------|-----------|
| | | | Teach | Admin/Oth |
| Untrained teachers | | | | |
| Negative attitudes by peers/schools | | | | |
| Parents of non-disabled children negative to acceptance (competition) of disabled children | | | | |
| No special facilities for disabled children | | | | |
| Parents feel hopeless about dis. Child. | | | | |
| Parents are poor and slum dwellers, the shift living places often, and dis. children drop out. | | | | |
| Teachers are negligent, lack awareness | | | | |
| In a family with both disabled and abled, family gives priority to non-disabled | | | | |
| Shame/embarrassment in using aids | | | | |
| Dis. Ch. burden to the family | | | | |
| Malnutrition | | | | |
| Lack of general knowledge about sign language/use of non-standard sign lang. | | | | 2 |
| Inadequate laws and enforcement | | | | |
| No suitable transport system | | | | |
| Poverty | | | | |
| Heavy weight and use of antibiotics during pregnancy | | | | |

Recommendations

| Recommendations | Ch/Par | Families | Frequency | |
|----------------------------------------------------------------------------------------|--------|----------|-----------|-----------|
| | | | Teach | Admin/Oth |
| Teacher training should be included in PTI courses | | | | |
| Adequate and enough special schools for children with severe disabilities | | | | 2 |
| Inter-ministerial coordination | | | | |
| Family counseling about educational opportunities for disabled children | | | | |
| Teaching of disabled and non-disabled should occur in same building in primary schools | | | | |
| Extra classroom for disabilities in every primary school | | | | |
| Games and entertainments should be provided to children with disabilities. | | | | |
| Every teacher should have positive attitudes | | | | |
| All dis. children should be included in mainstream education | | | | |
| All GO and NGO workers with dis. child should have specialized training | | | | |
| Every school should have 2 special-trained teachers: 1=VI/HI/Sp and 1=ID | | | | |
| Student/teacher ratio 1:15 in dis. classes | | | | |
| Relax age restrictions for dis. children in primary schools | | | | |
| Include stories about dis. children in primary textbooks=awareness | | | | |
| Family awareness activities | | | | |
| Media campaign—all types of media | | | | |

APPENDIX 5

Consolidated Data: Kurigram, Jessore, Savar, Tangail

Educational Needs (rank order of frequency)

| Need | Frequency | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|----------|-------|-----------|
| | Ch/Par | Families | Teach | Admin/Oth |
| Traditional Special Education—class within regular school, low t/s ratio, free, with adequate space, materials, staffing, salary, motivated, accepting teachers | 12 | 1 | 8 | 6 |
| Social awareness that helps family, teachers, community, peers and child accept disability without bias and leads to motivation and assistance. | 4 | | 4 | 4 |
| Special training available to teachers and therapists in methodology, disability and integration, and general orientation | 5 | | 4 | 3 |
| Separate schools, usually residential, teaching special children with specific disabilities | 1 | 1 | 5 | 2 |
| Medical service which includes free assessment, treatment, continued care, family counseling on disability. | 7 | | | 1 |
| Appropriate and free assistive devices such as crutches, wheelchairs, hearing aids, eyeglasses, etc. and assessment for them. | 1 | 1 | 1 | 2 |
| “Normalizing” the curricula for disabled children to make available activities also available to non-disabled such as sports, recreation and fine arts | | 1 | 3 | 1 |
| Adequate and free transportation from home to educational setting | | | 2 | 2 |
| An active disability assessment program for both families and teachers | 1 | | | 1 |
| Adjunct, specialized services such as speech therapy | 2 | | | |
| Food supplied at school | | | | 1 |
| Appropriate clothing, such as uniforms supplied free | | | | 1 |
| Local financial, continuing support | | | | 1 |
| Special van at school to provide transportation | | | | 1 |

Appendix 5 (Continued)

| Obstacles | Frequency | | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------|-----------------|--------------|------------------|
| | Ch/P | Families | Teach | Admin/Oth |
| Negative attitudes and stigma against disability that discourage the provision of education, promote harassment, and cause shame of person w disability and family for being different | 13 | 5 | 8 | 7 |
| The conditions of poverty and the failure of the State to prevent and/or treat it, such as food, medical care, etc. | 2 | 3 | 2 | 8 |
| Govt and non-govt. schools do not want to educate disabled children because teachers are untrained, with high t/s ratios. Biases against | 4 | 2 | 5 | 2 |
| Parent's superstitions, beliefs and traditional family practices are negative to education for their disabled children, not aware of rights or educated about dis child | 2 | 1 | 3 | 5 |
| Lack of Govt. or other schools and/or teachers to educate children with disabilities | 1 | 2 | 4 | 1 |
| Poor to no financing of educational opportunities at local level by local or National govt or NGOs. | | 1 | 1 | 2 |
| No transportation or the educational facility is too far away to be useful | 2 | 1 | | 1 |
| No books or other educational materials available to dis. child and no financial help to purchase or help with educational costs | | 2 | 1 | 1 |
| Lack of assistive technology and devices | 2 | | 1 | 1 |
| Inadequate laws and enforcement of the few that exist | 1 | | | 1 |
| No medical assistance to assess, counsel, treat disabilities and their consequences | 2 | 1 | | |

Appendix 5 (Continued)

| Recommendations | Frequency | | | |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------|----------|-------|-----------|
| | Ch/Par | Families | Teach | Admin/Oth |
| A special education program should be offered in all schools. It should be mainstreamed in each regular school and should include small t/s ratios, trained teachers especially in VI, HI and ID, useable space, relaxed age restrictions, appropriate teaching materials, an aggressive educational program, safety measures, food for children and home-school cooperation | 5 | 1 | 8 | 9 |
| All education for disabled children should be free, including no-costs for expenses like clothing, books, etc. There should be sholarchips and/or stipends for children with disabilities. Families should be helped who are financially burdend by children with disabilities | 7 | 1 | 6 | 3 |
| More schools are needed for severely or multiply disabled children, including residential schools. | 6 | 1 | 6 | 3 |
| Negative attitudes of school personnel and the community should be changed through aggressive awareness and acceptance campaigns. | 4 | 1 | 5 | 6 |
| Every disabled child and his family should have free medical services including assessment, treatment and counseling | 5 | 3 | | 1 |
| The curriculum for children with disabilities ought to be well rounded, that is, it should contain sports, fine arts, recreation and vocational preparation as well as academic content and specialized courses such as sign language and Braille. | 1 | 1 | 5 | 2 |
| As part of educational costs and facilitation, transpotation should be provided between home and school, free to those who cannot afford it. | 1 | 2 | 3 | 2 |
| Assistive devices and technology should be provided to all disabled children, free when they are below poverty line. | 3 | 2 | 1 | |

| | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---|--|---|---|
| Parents and the families of disabled are more functional if they have information and counseling about their children. Such services should be free and a part of the national disability program. | 2 | | 2 | |
| Bangladesh should enforce its constitutional guarantee of free and appropriate education for disabled children and should have additional laws and policy that enforce inter-ministerial cooperation and “education for all” as well as protect children with disabilities. | 1 | | 2 | 1 |
| All educational buildings should be physically accessible to children with disabilities, including ramps and toilets. | | | | 4 |
| Disability advocacy groups should be encouraged at the highest levels of government. | | | | 1 |