DISABILITY IN BANGLADESH

PREVALENCE, KNOWLEDGE, ATTITUDES AND PRACTICES

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CONTENTS

LIST OF FIGURES AND TABLES

List of Figures

List of Tables

List of Annex Tables

List of Appendixes

EXECUTIVE SUMMARY

1. Understanding disability, throughout the history, has rested on make-belief ideas. The direct result of these stereo-typed imaging and consequential action by the society and polity on the persons with disabilities (PWDs) has been their neglect. This neglect bars persons with disabilities from normal economic, social and political activities in their families, communities, essential services and education, etc. The overall objective of the study is to promote the rights of PWDs in Bangladesh by conducting research on the prevalence of disability, causes of disability, and situation of the PWDs in Bangladesh. As part of the study, a nation-wide survey carried out to find out the rate of prevalence of disability, causes of disability, and the social status of persons with disabilities and their families. A survey on the knowledge, attitude and practices (KAP) of the people towards the PWDs was also carried out to uncover the types of thinking, attitudes, and behaviour that characterise a given population, in order to be able to evaluate a particular social phenomenon as a process.

Understanding disability

2. Usually disability is defined as the physical or mental impairment through out the literature surveyed. But disability is not only a physical or mental impairment rather it is defined by the culture also. Somewhere what is normal sickness in other context it is a disability recognized in the socio- cultural settings. In this study disability is defined as a complex form of deprivation. And the PWDs are found with less capability and less self-confidence within the existing physiological, social and cultural settings.

Methodology

3. The general methodology followed for conducting study are *Focus group discussions, Observation, Written document analysis and Questionnaire survey.* For these purposes two different studies are conducted namely: a) prevalence survey- to find out the incidence of disability in the society and their composition according to different aspects like age, sex, location, disability type etc.; b) Knowledge, attitude and practice (KAP) study- to attain the general notion of the people towards PWDs.

   For prevalence study a total of 12000 samples are surveyed throughout the country which comprises 25% of urban people and 75% of rural populations. From every division 1 ward from urban area and 3 villages from rural areas have been selected as the general principle of the followed statistical analysis. For KAP study a total of 2400 samples are surveyed throughout the country, which comprises 25% of urban people and 75% of rural populations. Same composition of survey areas from the divisions is used as in the prevalence survey.

Prevalence of disability

4. *5.6% people in Bangladesh have a disability of one kind or another*. Among the PWDs the distribution also varied with different aspects i.e. physiological, location, gender, age, education etc.

5. The overall disability situation of the country according to the geographical taxonomy is found that the *people living in Char or Haor areas in Bangladesh have grater incidence in disability terms. Almost 7 percent have at least one kind of impairment,* closely followed by plain (6.0 percent). The prevalence of impairment is slightly lower in Hill tracts areas and coastal areas (2.8 percent in Hill tracts and 3.7 percent in coastal areas).

6. Among the PWDs a significant variation in the physiological aspect is found in the *prevalence survey.* The visual impairment has the larger prevalence than any other kind. Among the persons with disabilities percentage share of different types of impairments are *hearing 18.6 percent, visual 32.2 percent, speech 3.9 percent, physical 27.8 percent, intellectual 6.7 percent and multiple 10.7 percent.*

7. If the location aspect of disability prevalence is cross-examined with the physiological aspect, it is found that *physical impairment are observed at higher rate at khulna division (38%), closely followed by Chittagong division (30%).* The *visual impairment is lowest in Khulna division compared to all other division while intellectual impairment is higher at Sylhet division.* Rate of prevalence of speech and hearing impairments are similar in all administrative divisions.

8. The composition of PWDs by different types and geographical variation gives a picture that in *hill-tract areas people are highly affected by disability of more than one kind (multiple 31.3 percent).* The *visual impairment and physical impairment are most common (38.1 percent and 28.6 percent respectively) in Char or Haor areas.* For c*oastal areas, most prevalent form of impairment is of physical (45.2 percent),* though high percentage of prevalence of speech and hearing (both at 11.3 percent), and visual impairment (24.2 percent) is evident.

9. A larger portion of disable people experiences deficit of food over the year. Their housing condition is also very poor, mainly of *katcha* roof, wall and floor. People living with decent housing and hygienic toilets facilities have lower prevalence of impairment of one kind or another. More than three-fifths (68.9 percent) disabled person met with doctor for their respective problem. Those who did not receive any treatment nor visit doctors mainly due to their economic hardship.

10. A marked difference is found in terms of availability of services in the areas of residence of the persons with disability. It is found that the rate of disability prevalence is lower in areas where some sort of services for disability exists (4.3 percent) compared to that of the areas where no such services exist (5.8 percent).

Knowledge, Attitude and Practice Towards PWDs

11. A good number of respondents (78%) although claim that they have knowledge about disability issues, it is found that they have very cursory knowledge about the issues relating to disability. While responding to the cause of disability, majority blamed to the *Congenital and birth problem is the principal cause of disability.*

12. It is observed that *96.8 percent people did not know whether there were initiatives taken by the policymakers or local government bodies for prevention of disability.* 78.8 percent individuals opined that they did not have any idea whether PWDs were getting help from any organisation.

13. The people have little knowledge about the obstacle to employment opportunities for the PWDs and recommended special training program, micro credit, and specialised programmes for the women with disability, rehabilitation services, and establishment of quota for the PWDs in government employment. They also know about inclusion of disabled children and adults in education programs, and establishing special education schools for children with special needs. In health sector, there are some degree of awareness on preventing disability through pre-natal and delivery related health care, polio, leprosy, and epilepsy treatment, removal of vitamin deficiency and iodine deficiency. Some participants also cited programmes related to pollution control, noise control, accident prevention and government provided free and accessible health care as the requirements of PWDs.

14. While responding to the attitude of people towards the PWDs, it is observed that about *55% respondents accept PWDs well and about 20% give extra privilege to them. Very few are found behave roughly with the disables.* When asked, is *social relation with the disable people permissible, most of the participant would permit to make friendship with the disable but never permits to marry.*

15. *The majority of respondents (63 percent) think that PWDs are not burden to the family.* Most of the people argued that PWDs should get extra security on road, reserve seat in the public transport like bus, train etc., separate hospital, health centre, and in schools, these are the attitude that should prevail in the society.

16. When asked, whether the PWDs be given extra preference, they were of the view that they should get extra preferences, *in that case government and rich persons should come first,* speaks the FGD participants that they should be given monthly allowance. A number of people proposed to give interest free loan, extra preference in education system, donation from the poor fund and establish aid organisation in every thana, district, and division. *Government should enlist the disable person and also manage their better treatment.*

Development and the PWDs: Policy Issues

17. Development means the social change, which weakens forces disabling people, households and classes. The disability raises fundamental questions about human welfare – for example, rights and citizenship, the material and social conditions from freedom, the exercise of agency and enjoyment, the question of the class-space assumed in the notions of participation and integration.

18. PWDs are handicapped in society due to physical, social and cultural barriers that prevent them from fully and equally participating in social, economic, political and cultural activities. Measures targeted to disabled persons are necessary only when there are special needs to be addressed. Preventing the incidence of disability can be done in the framework of general programs to improve health and living environments.

19. PWDs must be brought into the mainstream of the development process. As PWDs are predominantly poor and marginalized in society, it is, at times, necessary to first support the organizing of people with disabilities in order to make them "visible" and to empower them to make their voices heard. Some PWDs may require specialized support services, assistive devices or job modifications, but more importantly, right of PWDs to decent work need to be recognized. This sort of approach can ensure the meaningful participation of disabled people in the development process.

20. If development is self-realisation through social agency as well as material improvement, then the condition of PWDs provides sets of sensitive indicators and effective constellation forces of institutional engineering is needed for disability. Public policies need to be packaged in such a manner as to establish a logical path to escape from poverty and vulnerability. Gender disparity and the rights and potential of children with disabilities require special attention. Disability concerns should not be left to the social welfare sector alone. Rather, every sector has a primary responsibility for the disability issues arising in the sector concerned.

DISABILITY PREVALENCE AND KNOWLEDGE, ATTITUDES AND PRACTICES ON DISABILITY IN BANGLADESH

CHAPTER I
INTRODUCTION

Nothing imperfect or maimed shall be brought up.
Aristotle

A blind man, or a lame, or he that hath a flat nose, or anything superfluous, or a man that is broken handed, or crookbacked, or a dwarf, or hath a blemish in his eye or be scurvy, or scabbed or hath his bones broken.
Old Testament

At the time of consultation, let him (the king) cause to be removed idiots, the dumb, the blind and the deaf, animals, very aged men, women, barbarians, the sick and those deficient in limbs. Such despicable persons, particularly women, betray secret council.
Manu

The king shall provide the orphans, the aged, the infirm, the afflicted and the helpless with maintenance.
Kautilya

Change agents should be like waves on a sea; made of the same water, but which rise up above the water according to the needs of the situation and merge into the water again when the need is over.
Anon

Disability is a universal element in the human condition to which no one is immune. Unrecognised as a problem for development, the condition of being disabled is at the bottom of the development agenda. This low priority can be explained in public choice theoretic terms by the political weakness of disabled persons and by the high perceived economic costs and low perceived political benefits (or the high political opportunity costs and low economic benefits) of a state response to problems which are administratively anomalous and transactions-costly. Such a calculus operates more powerfully on the comprehension of the issues and welfare agendas of the least developed countries like Bangladesh than that of developed ones.

The comprehension on disability, throughout the history, has rested on make-belief ideas. The direct result of these stereo-typed imaging and consequential action by the society and polity on the persons with disabilities (PWDs) has been their neglect. This neglect bars persons with disabilities from normal economic, social and political activities in their families, communities, essential services and education, etc.

Many people in the Bangladesh view disability as a curse and a cause of embarrassment to the family. In Bangladesh, there have been only a few systemic interventions to raise awareness of persons with disabilities at the community level[1]. Women with disabilities are particularly vulnerable to social discrimination and neglect. The PWDs are usually excluded from existing governmental and non-governmental development programmes. The number of employed persons with disabilities is assumed to be less than 1%.

Such neglect is atop as national data on disability is very scarce and is far from reflecting the reality[2]. There have been *no attempts* to conduct regular national disability prevalence survey[3] by

[1] One of the such systematic approach is Community Based Rehabilitation (CBR), a distinct model emerged at 80s with an aim to reach the disable people deprived from any provision of basic rehabilitation programme. Primarily it was limited to only medical intervention, but for time being the concept changed and developed and now it includes not only medical or economic intervention, but also issues related to ensuring the social right, participation, and status of the persons with disabilities.

[2] The estimates on the prevalence of disability vary from country to country and also within countries. Typical estimates are between 5 percent and 15 percent of the population at large. Reliable, valid, and comparable estimates are difficult

the national statistical agency, Bangladesh Bureau of Statistics (BBS). Action Aid-Bangladesh and Social Assistance and Rehabilitation for the Physically Vulnerable (SARPV) put the percent of PWDs at 8.8% of the total population. Bangladesh Protibandi Kalayan Samiti records 7.8%, while in another survey ActionAid Bangladesh (1996) records 14.04% people suffered from a form of impairment. On the other hand, the Government of Bangladesh (GOB) surveys in 1982, 1986 and 1998 estimated a national prevalence rate of disability at 0.64%, 0.5% and 1.60% respectively. The WHO's global estimate predicts approximately 10% of all people have a disability of one kind or another. This is also considered to be true in Bangladesh with some sources quoting a higher disability rate in rural Bangladesh.[4] The prevalence of disability in Bangladesh is believed to be high because of overpopulation, extreme poverty, illiteracy, lack of awareness, and above all, lack of medical care and services.

The present survey emanates from the *current knowledge gap* which exists on the prevalence of disability. The prevalence survey on disability, including on the causes of disability, and the social status of persons with disabilities and their families will provide the knowledge required to address the disability as a developmental issue.

Most of the people in Bangladesh, being guided by the social taboo, seemingly suffer from scarcity of knowledge about disability. In addition, perspectives that guide general people to perceive disability is influenced by *stigma, ignorance, impairment-based definitions.* Moreover, information relating to disability is scare in public domain. Indicative evidence on poverty and disability is though available to some extent but comprehensive studies on the linkages are not available. The lack of comprehensive information on the poverty of PWDs is another indicator of their marginalized and invisible status in their societies. A great majority of the populace is unaware of the main reasons that cause disability. This is due to the attitude of general people towards PWDs which at its great length is based on prejudices.

This lack of understanding calls for knowledge, attitude and practices (KAP) survey. A KAP study usually seeks to uncover the types of thinking, attitudes, and behaviour that characterise a given population, in order to be able to evaluate a particular social phenomenon as a process. A KAP study also enable comparison of differences in investigated factors and trace their changes over time. The findings of the KAP study on disability issues will enable informed design and implementation of awareness raising initiatives, policies, programmes and strategies that address the complete reversal of *existing structural negligence* from all levels of duty bearers *towards the specially challenged people.* KAP findings can be used as a measure of disability status and provide information for shaping policies. In specific terms, KAP findings may guide Handicap International and NFOWD to design specific interventions for creating awareness based on rights based approach.

In this context, the overall objective of the study is to promote the rights of persons with disabilities in Bangladesh by conducting research on the prevalence, causes of disability, and situation of the PWDs in Bangladesh. The specific objectives of the Prevalence Survey are to: (a) assess the prevalence of the PWDs in Bangladesh through a nationwide representative sample survey; (b) find out the causes of disability through a stratified random sampling survey, ensuring cross section and also balance across groups; (c) investigate the social status of the PWDs and their families in the selected areas through a survey conducted from household to household; and (d) recommend relevant information for advocacy purposes with the Government, with an overall aim to improve the situation of people with disabilities.

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to come by as there are differences in definitions. Also, disabled people are invisible in their communities and subject to underreporting. The problem is further complicated by the influence of age structures on overall figures.

[3] Sight Savers International, based on a nation wide sample of 12,782 adults, carried out national eye health survey in Bangladesh. However, national prevalence survey on of other types of impairment is rather scarce.

[4] JICA (2000), Country profile on Disability- Bangladesh.

The objectives of the KAP study are to: (a) investigate the knowledge base of general people regarding disability issues; (b) identify the beliefs, perceptions and practices of persons close to the specially challenged people; (c) identify constraints faced by PWDs in their bid to seek dignified and secured lives; (d) examine attitudes towards different programmes and policy; especially focusing on programmes/services provided by the Government (particularly observing the distributions of investment in health or education factors); (e) suggest possible strategies through which the quality of any awareness raising program, training program, social interrogation campaign or service delivery could be improved; and (f) Obtain relevant information to inform the policy makers and planners of the government.

The following chapter presents study approach and methodology. The third chapter presents general characteristics of study population for both the disability prevalence survey and Knowledge, Attitude and Practices (KAP) survey. The fourth and fifth chapters respectively present the findings of the disability prevalence survey and survey on knowledge, attitudes and practices on disability in Bangladesh. The final section draws conclusion by way of summing up the findings of the study.

CHAPTER II
CONCEPTUALISING DISABILITY AND THE RESEARCH FRAMEWORK

UNDERSTANDING DISABILITY

Prior to the development of research methods, it is important to have a clear understanding of the issues regarding disability. The Ministry of Social Welfare, in association with the National Forum of Organisations Working with the Disabled (NFOWD) initiated draft legislation on disability related issues in 1996. This legislation was formally enacted in April 2001 and is known as The Disability Welfare Act of 2001. Under the legislation, definitions for persons with disabilities were outlined as follows:[5]

1. Persons with Disabilities are those who: are physically disabled either congenitally or as a result of disease or being a victim of accident, or due to improper or maltreatment or for any other reasons became physically incapacitated or mentally imbalanced as a result of such disabled-ness or mental impaired-ness has become incapacitated, either partially or fully and is unable to lead a normal life
2. Persons with visual impairment are classified as: no vision in any single eye, no vision in both eyes, visual acuity not exceeding 6/60 or 20/200 (Snellen) in the better eye even with correcting lenses or limitation of the field of vision subtending an angle of 20 (degrees) or worse
3. Persons with physical disabilities are classified as: Lost either one or both the hands, lost sensation, partly or wholly, of either hand, lost either one or both the feet, lost sensation, partly or wholly, of either or both the feet, physical deformity and abnormality, permanently lost physical equilibrium owing to neuro-disequilibrium
4. Persons with a hearing impairment are classified as: Loss of hearing capacity in the better ear in the conversation range of frequencies at 40 decibels (hearing unit) or more, or damaged or ineffective hearing abilities
5. Persons with a speech impairment are classified as: Loss of one's capacity to utter/pronounce meaningful vocabulary sounds, or damaged, partly or wholly or dysfunctional
6. Persons with a mental disability are classified as: One's mental development is not at par with his chronological age or whose IQ (Intelligent Quotient) is below the normal range, or has lost mental balance or is damaged, partly or wholly
7. Persons with multiple disabilities are classified as: People who suffer from more than one type of impairment stated above

The definition of Bangladesh Government is largely based on impairment. While disability can be a consequence of illness it is not a health issue, as such. A person with a disability can be in good health or he/she can be ill as anyone else. It is necessary to distinguish between the physiological, personal, and social dimension of disability. Nowadays more large definitions have been used like focusing on the act of social discrimination rather than the health status of the person.

The currently used WHO standard terminology makes a distinction between impairment (physiological), disability (personal) and handicap (social).

- an **impairment** is any loss or abnormality of psychological, physiological or anatomical structure or function;
- a **disability** is any restriction or lack of ability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being;
- a **handicap** is a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfillment of a role that is normal depending upon age, sex, social and cultural factors, for that individual.

[5] Disability World, Retrieved February 6, 2002, from http://www.disabilityworld.org/

While, disability remain to be social rather than natural fact, it may be identified by appearance – 'ugliness', albinism, the absence of (even a functionally unimportant) digit – while impairments recognised as disabling in some cultures (mild to moderate mental retardation, club foot) are often not treated as disabling elsewhere (Helender, 1993; 12). In South Asia, many local people classify disability as social deviancy. Some see economically oppressive, socially tyrannical and politically disenfranchising forms of work, such as child labour and bonded labour, as disabling. Yet others find (female) infertility or the delayed onset of menarche a serious social impairment. Conditions such as asthma and tuberculosis, - which are classified as 'sickness' are experienced as disabling in agrarian economies (White and Subramanian 1999).

Disability is, thus, a relative term because cultures define differently their norms of being and doing. Disability signifies what a person suffering impairment cannot be and cannot do. Sen's concept of capability-what people can be or do – for the incapabilities that follow from impairment (Sen, 1990). His notion of development as capability expansion involves the exercise of positive freedom and residualises negative freedom. But for certain disable people, certain types of capability expansion are simply not possible. For most PWDs to experience, let alone expand, positive freedom, both the capability to function and the negative freedom of non-disabled people have to be constrained. A reduction in the negative freedom of non- disabled people has to be constrained. A reduction in the negative freedom of others is a logical precondition to the achievement by poor PWDs of equality in the list of otherwise 'basic capabilities' which are denied to the entire set of poor by their condition of poverty.

Disability is intractably complex form of deprivation. The concept of 'disability has been termed as a crude political label, a probabilistic type of development problem- different from those, which are location, income or gender specific. Yet, can be perverse since there is disability transition. The increases in life expectancy and increased survival rates from disabling accidents and diseases are causative factors. Impairment forms a continuum from 'ability' to a range of kinds, combinations and intensities of incapacity' (White 1996).

Disability and poverty are interlinked. While disability causes poverty, in a country with mass poverty it is also possible that poverty causes disability (Rao 1990). The mechanisms are malnutrition, exposure to disabling disease, inadequate access to inadequate preventative and curative health care, and an enhanced risk of occupation-related accident among the poor. The relationships between poverty (economic disability), 'weakness' (social disability) and medicalized disability result in a condition of simultaneous deprivation. This is a syndrome composed of ideological reinforcement, punitive experience, psychological extinction (the lack of consequence in behavioural development); stimulus deprivation and a cognitive and verbal development, which probabilistically affects the participation of low-income groups. This syndrome sets up barriers to the participation of all PWDs - but especially the mentally disabled and especially girls.

Most often, the PWDs are either neglected or over protected. Both have a negative effect and do not empower the person. As the PWDs generally have less self-confidence, they tend to express or assert themselves though they may have strong feelings about this. Often people tend to adopt a patronising tone while talking to the PWDs, just as they do while talking to children.

The provisions made by governments world-wide are welfare-oriented, reflecting the same perception of providing for or looking after. Neither the medical profession nor the government focuses on the abilities of PWDs. Instead they promote an attitude of dependence. The policies and schemes reflect an attitude of paternalism towards persons with disability.

There are two current practices in relation to disabilities. Parental or relief oriented approach: where welfare schemes are formulated and the people are passive receivers of charity. Managerial approach: where programmes and activities are administered, skills imparted, as in

institutionalised care. Transformational or people-oriented approach: where people discuss and decide what they need, learn the skills they want to learn as well as learn managerial skills. In the first two approaches, people who are to benefit from the programmes and activities are not involved in making decisions – they are made to feel dependent. In the transformational or people-oriented approach, people are transformed and become independent and take all the decisions concerning themselves. Putting disability on the development agenda implies focusing on the root causes. This shift of focus leads to empowerment of PWDs.

Figure 2.1: Old model of disability work

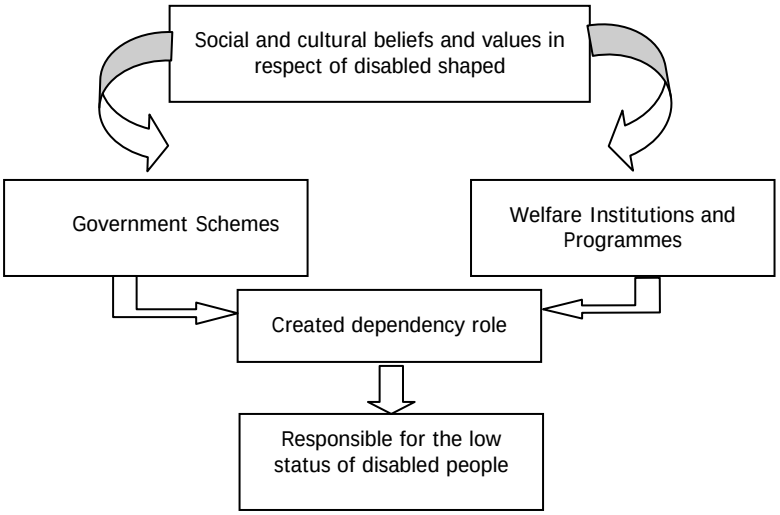
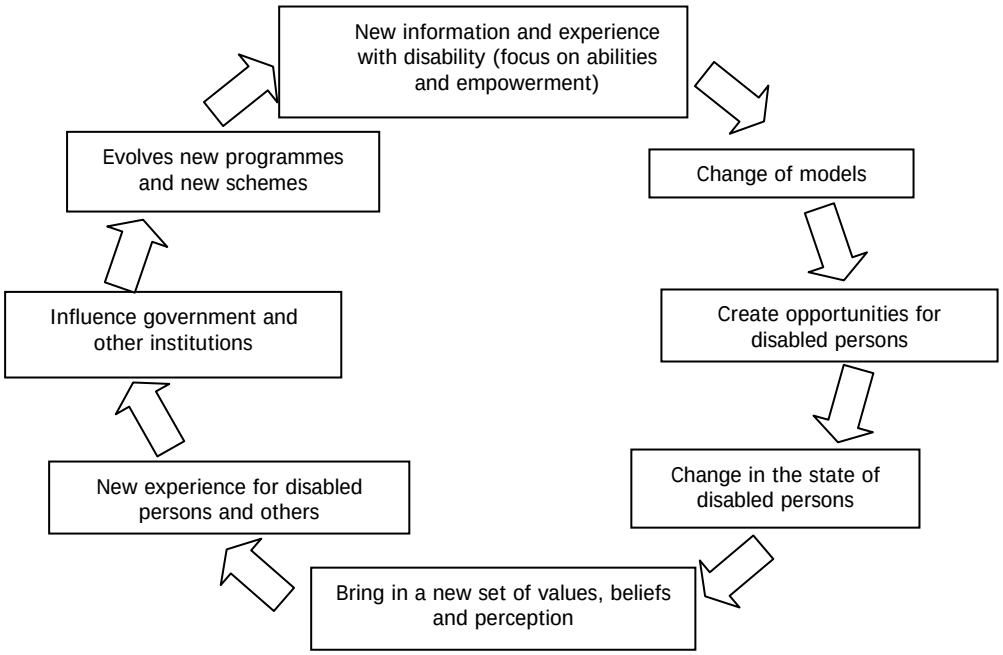


Figure 2.2 : Model of disability as a development issue



This approach encourages PWDs to grow towards self-reliance. It focuses on bringing awareness both among the disabled and the community through a gradual process of animation. The process of empowerment focuses on building a sense of self worth in PWDs. They are helped to understand that the cause of their situation is the attitude of non-disabled people towards them and that it is not their physical impairment. PWDs have the same needs as the non-disabled and can participate in their own development.

Empowerment can mean a great variety of things depending on the persons and contexts. It is a term difficult to define and gives rise to many explanations. Some see empowering as the development of skills and abilities; or enabling people to manage their life better. Others see it more fundamentally political, enabling people to decide upon and to take actions essential to their own development. While 'empowering' has slipped easily into everybody's vocabulary, its link with taking action is *not* always understood.

Empowerment is a movement from a feeling of 'I/we can't' to I/we can'. It is a sense of being oneself, as opposed to a sense of helplessness, powerlessness, apathy and inertia. Critical awareness sets off a process of empowerment. It is an approach in which people are encouraged to value their own experiences and to share with them; to recognise common issues, to analyse their own situation and its underlying causes; to articulate their knowledge and develop confidence in their own individual and collective capacities to change their situation. The key element in this strategy is to build on the self-image of the members and enhance it so that they *discover* their strength, as individuals and as a community. This is more so, since disability is not an individual destiny, rather the outcome of situations and decisions of a community. The disable person carries the consequences of collective situations and decisions, thus, society has a collective responsibility to eliminate the unjust system that turn an impairment into a disability.

RESEARCH DESIGN

General Methodology of the study

The disability prevalence and knowledge, attitude and practices on disability in Bangladesh has used both quantitative as well as qualitative techniques for data collection and analysis. The following data gathering methods and techniques has been used:

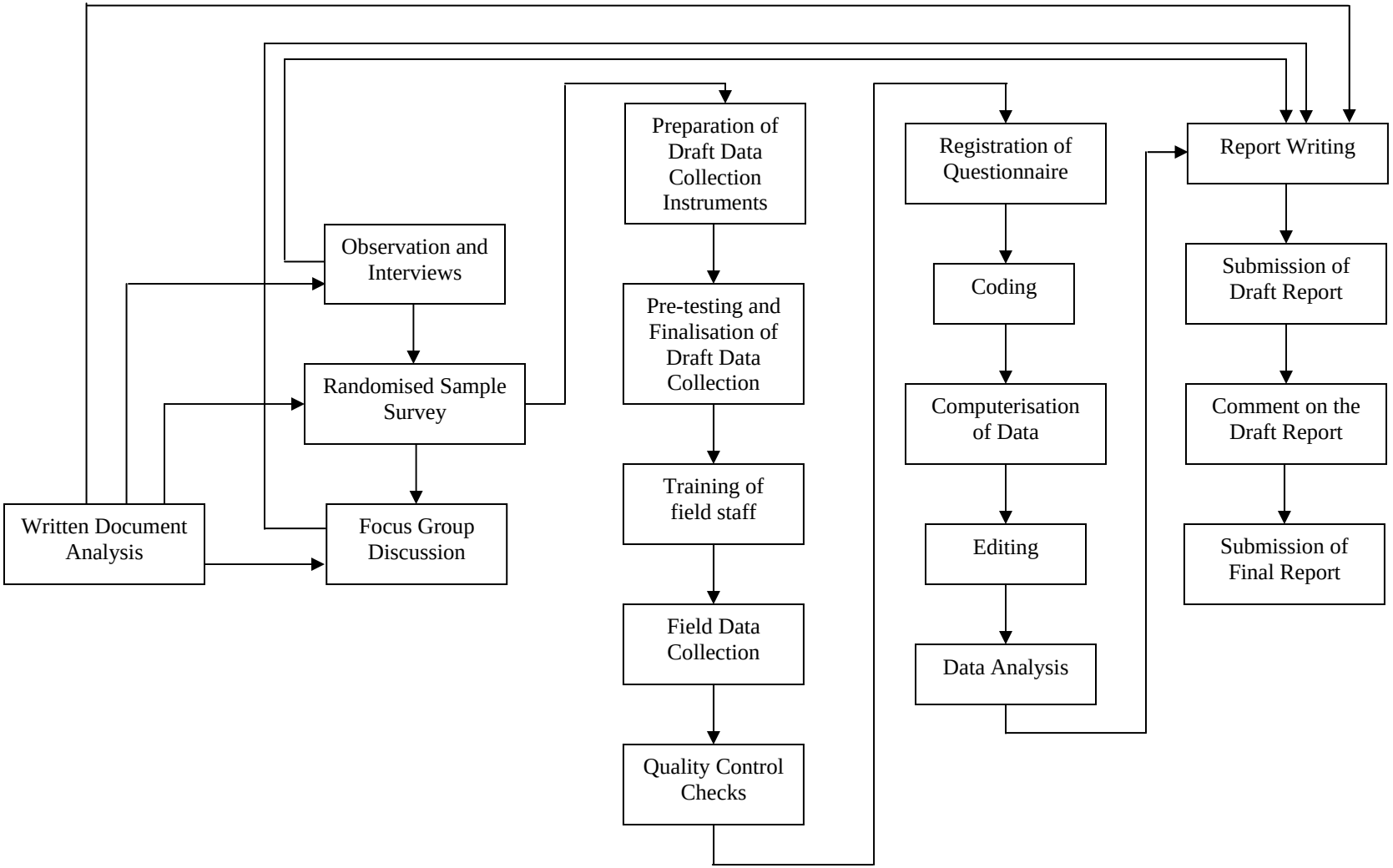
- ***Written document analysis:*** This has involved review documents such as disability act, academic papers, official reports and training materials on disability, in addition to optimal use of relevant knowledge culled from global stock.

- ***Questionnaires:*** In accordance with the objectives of the studies, a set of survey questionnaires has been developed. The draft questionnaires have been piloted to assess suitability of the questionnaires in collecting the data. The set of questionnaire has served as an interview protocol for face-to-face interviews. A host of interviews has been conducted. These verbal interactions have listened to various stakeholders including women and men, boys and girls, and persons with disabilities from different backgrounds. The interviews have been administered face to face in both formal and informal setting, and the interview protocol comprised close-ended technique wherein a series of possible answers have been suggested to specific questions, and open-ended wherein broad questions have been followed up with more specific questions.

- ***Observation:*** A mix of direct and participatory observation techniques have been followed. The observation involved observing and recording in a log what goes on, who is involved; what happens, when and where; and how events occur in relation to the objectives of the studies. Several interviews have been conducted to collect information through in-depth examination of issues. The output of interviews, descriptive and explanatory, has served to answer the questions 'how' and 'why'.

- ***Focus group discussions:*** A series of focused discussion with stakeholders involved with or working for the pertinent issues have been organised. This has been done with the purpose to compare the reality about which the participants will be responding questions with the abstract concepts inherent in the study objectives.

Study Implementation Process



Methodology for Prevalence Survey

Past Disability Prevalence Estimates

Until recently, most commonly cited disability prevalence rate has been the WHO, which estimates that approximately 10% of the world's population suffers from disabilities. In the context of Bangladesh that would translate into approximately 12 million people with disabilities based on the 2001 census. However, recent WHO estimate for disability prevalence is around 4 to 5 percent of any given population. In Bangladesh, based on a sample survey conducted in 1991, the number of PWDs was placed at just over 500,000. The Government of Bangladesh (GOB) surveys in 1982, 1986 and 1998 estimated a national prevalence rate of disability at 0.64%, 0.05% and 1.60% respectively. Estimates by ActionAid Bangladesh based on 5 locations of 4 districts cite that approximately 12 million people (14% of the total population) require some form of immediate service due to disability related issues.

Sampling

A two-stage stratified sampling was followed in selecting final sampling units (fsu). In selecting fsu, the whole of Bangladesh was treated as universe that contains six divisions and each division was considered as a stratum which has two strata namely urban and rural. In the first stage, 4 enumeration areas (1 in urban and 3 in rural) obtained from Census Report 1991, were selected at random from each division. Thus 24 locations were selected from 6 divisions.

Determination of sample size

The formula used for estimating the sample size is

$$n = Z^2_{1-\alpha/2}(1-p)\,p/d^2 \quad \text{..(1.1)}$$

Where, n = the desired sample size in a situation where population is greater than 10,000.

α = level of significance=5%

$1-\alpha$ =confidence interval =95%

Z=the standard normal deviate, usually set at 1.96, which corresponds to the 95% confidence level

p= proportion in the target population estimated to have a particular characteristics (Here it is 0.14)

d=Degree of desired accuracy =0.02

Putting these values in formula (1.1) we get n =1156. Considering the design effect 1.75 the sample size for each division comes at n =1156 $\times$ 1.75 = 2023 for each division and for 6 divisions the total sample size becomes 2023 $\times$ 6 = 12141 $\cong$ 12000 individuals.

Distribution of Sample

Considering 5 members per household (BDHS 1999-2000 shows that there are 5.6 members in a household), the sample size of the study is estimated to be 12000 (for national level), and the required number of households are 2400.

According to the approximate proportion of urban and rural population respectively 25% and 75% (urban 23.39% and rural 76.61% according to BBS Statistical Pocketbook 2002) the required sample size for rural area is 8911 and for urban area the size is 2970. For the current study, 24 locations have been selected, of which 6 from urban areas and 18 from rural areas. Rural sample includes ethnic communities, geographical variations e.g. coastal/ haor areas, char land, hill tracts. Out of 18 rural locations 3 locations cover coastal, haor and hill tracts. The sample area distribution is presented in the following Table 2.1.

Table 2.1 Distribution of Sample Area

Area	Proportion of total population	Sample size	Number of Location
Urban	25 %	3000	6
Rural	75%	9000	18
Total	**100%**	**12000**	**24**

Distribution of Location and Households

Considering 5 members per household, it is calculated that 2400 households could cover the estimated sample. Based on this information study was conducted in six divisions (Dhaka, Khulna, Rajshahi, Barisal, Sylhet and Chittagong) of Bangladesh. From each division 1 urban and 3 rural areas are selected randomly where 100 households have been taken from each urban area and 300 households have been taken from each rural area. (Table-2.2)

Table 2.2 Distribution of Location and Households by Administrative Divisions

Divisions	**Location**		**No. of HHs**	
	Urban (Ward)	**Rural (village)**	**Urban**	**Rural**
Barishal	1	3	100	300
Chittagong	1	3	100	300
Dhaka	1	3	100	300
Khulna	1	3	100	300
Rajshahi	1	3	100	300
Sylhet	1	3	100	300
Total	6	18	600	1800

Sampling Methodology for KAP Survey

The sampling design of KAP survey has the following characteristics: (a) aim at a truly representative sample; (b) result only on small sampling error; (c) viable for the study; (d) systematic bias can be controlled in an effective manner; and (e) the result can be applied with a reasonable level of confidence.

The formula used for estimating the sample size is $n= Z^2_{1-\alpha} (1\text{-}P)P/d^2$

Where, n=the desired sample size

α = level of significance=5%

1-α =confidence interval =95%

Z=the standard normal deviate, usually set at 1.96, which corresponds to the 95% confidence interval

P= proportion in the target population estimated to have a particular characteristics (Here it is .30)

d=Absolute precision =.06

Sample size

Considering P=30%, the proportion of awareness on disability issues and Absolute precision, d= 6% the estimated sample size is n= 224 × 1.75 = 392 for each division and for 6 divisions the total sample size becomes 392 × 6 = 2352 ≅ 2400 individuals**.**

Distribution of Sample Area, Location and Sample Population

According to the approximate proportion of urban and rural population 25% and 75% (urban 23.39% and rural 76.61%, Statistical Pocketbook 2002) respectively the required sample size for rural area was 1800 and urban area was 600 (Table 2.3). Distribution of location and households by administrative divisions is presented in Table 2.4.

Table 2.3 Distribution of Sample by area

Area	Proportion of total population	Sample size	Number of Location
Urban	25 %	600	6
Rural	75%	1800	18
Total	**100%**	**2400**	**24**

Table 2.4 Distribution of Location and Sample Population by Administrative Divisions

Divisions	Location		Sample Size	
	Urban (Ward)	Rural (village)	Urban	Rural
Barishal	1	3	100	300
Chittagong	1	3	100	300
Dhaka	1	3	100	300
Khulna	1	3	100	300
Rajshahi	1	3	100	300
Sylhet	1	3	100	300
Total	6	18	600	1800

Sampling Frames

The list of enumeration area (EA) for rural and urban areas for six administration divisions available from Zilla Community Series 1991-95 was used as sampling frame for selecting PSUs (Primary Sampling Unit). Total number of households in each PSU was available in the same series. Then every 3rd/4th/5th household, as the interval for a particular location was determined dividing the total households by 100, were searched systematically to fill the requirement of having 100 households in each location in the prevalence survey. For KAP study 100 individuals from the same location of prevalence survey were interviewed from different groups of respondents in each EA.

Selection Criteria of Study Locations

Sample units have been interviewed from 24 locations (village/wards from each division) of 12 union/municipality of 6 administrative divisions of Bangladesh. Each union/ municipality comprises 2 villages/wards. One location has been selected from urban and other three from rural areas following randomization for both prevalence and KAP studies from each division. As few selected locations were changed over time due to river erosion and forming new chars enumeration areas were updated after preliminary search of the PSUs. The revised list of enumerated areas are given in Table-2.5.

Table 2.5 Geographical coverage of study areas

Division	District	Thana	Union/Municipality	Selected Village/ Ward
Barisal	Barisal	Barisal Sadar	Barisal Municipality	Ward no. 19 (Jhautola, Kalibari, Nutun Bazar, Nazir Mahulla, Purba B.M. College, Professor Para)
	Pirojpur	Kawkhali	Kawkhali	Basuri
	Pirojpur	Kawkhali	Sayna Raghunathpur	Hogla
	Patuakhali (Costal area)	Dashmina	Bahrampur	Bahrampur
Chittagong	Chittagong	Chittagong Port	Chittagong Municipality	Ward No. 39 (Dakshin Halishahar)
	Rangamati (Hill Tracks)	Rangamati Sadar Thana	Kalindipur	ward no -8
	Brahmanbaria	Banchharampur	Dariadaulat	Kalainagar
	Lakshmipur	Ramgati	Char Alexander	Asol Para
Sylhet	Sylhet	Sylhet Sadar	Sylhet Municipality	Ward No. 4
	Moulavibazar (Haor)	Kamalgonj	Shamsher Nagar	Badardeul
	Hobiganj	Hobiganj Sadar	Nizampur	Sayedpur
	Hobiganj	Hobiganj Sadar	Nurpur	Bisura
Dhaka	Dhaka	Mirpur	Dhaka Municipality	Ward No. 8 (Ahmed Nagar, Co-operative Market, Dakshin Bishil, Dakshin Paikpara, Hazrat Shah Alibagh, Madhya Paikpara, Paikpara, Purba Kandar)
	Faridpur	Alfadanga	Gopalpur	Bazra
	Sherpur	sreebardhi	Gosaipur	Rahamatpur
	Tangail	Ghatail	Deulabari	Porabari
Khulna	Khulna	Daulatpur	Khulna Municipality	Ward No. 26 (Dakshin Pabla, Sk. Ayub Ali Rd., Daulatpur B.L. College)
	Khulna	Dumuria	Bandarpara	Banda
	Kustia	Mirpur	Amla	Kachubaria
	Bagerhat	Bagerhat Sadar	Khanpur	North Khanpur
Rajshahi	Rajshahi	Boalia	Rajshahi Municipality	Ward No. 13 (Futkipara, Kumarpara, Saheb Bazar, Sahebganj)
	Rangpur	Rangpur Sadar	Tapodhan	Ramgobindo
	Sirajgonj	Kamarkhanda	Bhadradhat	Nandina
	Nawabgonj	Gomastapur	Radhanagar	Rokanpur

Household Selection

The country's population is almost evenly distributed throughout its 64 districts except for the three Hill Tracts districts which are rather sparsely inhabited. Regionally, the eastern districts have a slightly higher density than the western ones. On average, a district has a population of about 1.8 million, a thana 230,000, a union 25,000 and a village 2,000. There are 490 thanas, 4,451 unions and 59,990 villages. The number of households is about 20 million. On average, a household consists of 5.6 persons. There are 4 metropolitan cities and 119 municipalities in the country.

Judging the above criteria it was decided to select every third/four/five household (as varies location to location), in a specific location to cover about 100 household in each

location for prevalence study**.** But the first household has been specified randomly and subsequent households have been selected taking the given interval for a particular area, see appendix Table 1).

Questionnaire & Instruction Manual

Following the objectives of the survey the draft questionnaires for both prevalence and KAP study were designed. A series of pretest was carried out in Dhaka city to finalize the draft questionnaire and develop instruction and training manuals, control forms and survey procedures. The survey questionnaires and instruction manuals were finalized incorporating findings of the pretests and suggestions by the members of research team.

The pre-tested questionnaire was thoroughly reviewed and analyzed and placed in the meetings of the research team. The questionnaires were several times updated from the inputs of two brainstorming sessions participated by the members of research team. The questionnaires were presented at a sharing meeting at the Handicap International. The meeting was participated by key members of HI, CDD, NFOWD and the Innovators' research team. Following the meeting, the team incorporated ideas and inputs provided by the HI, CDD and NFOWD. The questionnaires were also finalised through the Disability Orientation workshop conducted by the CDD. During the training sessions, all the trainers of CDD were consulted. The draft forms of questionnaires were also circulated to three organisations, HI, CDD and NFOWD, of which the team received written comment on the draft from the NFOWD. The comments were subsequently incorporated in the final questionnaires. The two questionnaires were subsequently translated in Bengali. The translated questionnaires are attached as appendix Table 2.

Selection of Field Investigators and Supervisors

This stage consisted of recruitment and orientation of Field Interviewers, Supervisors. Through two days intensive interviews 48 field investigators and 6 supervisors were selected from young, energetic, qualified university graduates. All those selected preliminarily had been recruited as trainees. Depending on his/her performance in the training, a trainee investigator has been finally appointed to the specific post.

Orientation on Disability and Research Methodology

To conduct the survey appropriately an intensive training was arranged for all field investigators and field supervisors. The training was imparted in two phases.

Orientation on Disability

A two day orientation training on disability issues in Bangladesh was organised on September 10 to September 11, 2004 for the first group and on September 13 and September 14, 2004 for the second group comprising of core members of research team, field investigators and field supervisors. The Centre for Disability in Development (CDD) provided the training to all 48 field investigators and 6 field supervisors. Other members of research team and participants from the Handicap International were also present during the training sessions. The training dwelt on number of issues relating to disability including (a) understanding, definition and causes; (b) type and kinds of disabilities; (c) situation analysis on disability; and (d) perception and prevailing attitude.

Training on Research Methodology

A one day training on Research methodology was organised for field supervisors and field investigators. The training took place on September 15, 2004 for first group and September 16, 2004 second group. The training was conducted by the members of core research team. The sessions focused on issues relating to questionnaire survey, particularly ways of collecting quantitative and qualitative data, ways of rapport building, sample selection strategies, mock test of filling questionnaires and ways to conduct focus group discussion.

Data Collection Instruments
In line with the objectives of the study, draft data collection instruments were developed. In developing the data collection instruments care has been taken to use local vocabulary as much as possible to subsequently ease communication with the sample respondents. The instruments included Interview schedules, observation checklist, structured and semi-structured questionnaires, inventory guidelines etc.

The instruments developed, have been pre-tested to assess suitability in collecting the relevant information and to find out problems relating to actual administration of the same. Pre-testing of the instruments took place in a site in Dhaka other than the selected areas. On the basis of the pre-test results, the draft instruments have been modified. The pre-testing teams included, among others, the members of the core research team and three field investigators. This ensured understanding of the field situation, comprehension level of the field staff as well as respondents and thereby quality of the final data collection instruments.

Data Collection
All 48 field investigators have undertaken field survey in respective 24 locations during October 19, 2004 to November 2, 2004. The field investigators personally contacted the respondents and obtained the desired information fairly and accurately by explaining the objectives of the study to the respondents and following the methodology of research set at training sessions. For qualitative information related to the study, 24 Focus Group Discussion (FGD) were accomplished in 24 locations by field supervisors in association with the field investigators. For the prevalence study enumerators searched the households following the systematic sampling approach and for each household they have taken one respondent to get the desired information of the whole household members. The KAP study respondents were taken from different groups e.g. children with or without disability, adult with or without disability, influential persons, government officials and service providers. EA map, household size and the interval of searching household in each location following a systematic manner were supplied to all enumerators before enumeration.

The 6 Field supervisors for six divisions visited six locations each in their respective areas, facilitating field survey. They also checked the survey done by the field investigators. Field Supervisors have also conducted focus group discussions in all these locations. The members of research team, survey coordinator and field supervisors were in constant touch with the field investigators so that investigator could obtain clarifications and instructions on the concepts, definitions and difficulties encountered in carrying out the field work under the actual operation conditions. The filled in questionnaires, validated by the field supervisors have been submitted to the research team on November 3, 2004. The research team had also extensive discussions on the issues that could not be captured in the set questionnaires. The issues raised in the discussion have been incorporated in the report.

Quality Control Checks

A sound quality control system has been developed to adequately monitor the quality of data collection. The field supervisors and members of research team constantly moved around the sample spots; and ensured quality data through: (i) field checking, and (ii) data monitoring.

Field checking has been undertaken in both `presence' and `absence' of the interviewing teams. `Checking in presence' meant verification of the work of an interviewing team in a sample area during the time of the interview. `Checking in absence' meant verification of the work of an interviewing team in a sample area after the team had left the site, having completed its assigned work in the area.

During field checking, the field supervisors performed re-interview, and checked the data accuracy. Some of the reported non-response items have been checked to ensure that they were all due to valid reasons. `Field checking in presence' has been conducted for all field investigators, while `field checking in absence' has been done over randomly selected sites.

Data monitoring has been done by comparing results of some key variables in completed format/questionnaire, tabulating the variables by interviewing teams, sample sites and investigators.

Data Management

Data management has comprised: (a) registration of questionnaires received from the field; (b) data processing; and (c) computerisation of data. As soon as the questionnaires were received from the field, those were entered into registration books to ensure that all schedules received from the field have been received at Dhaka. The data processing activities have involved: editing and coding of the questionnaire, and computerization of data. Editing has been done by a team consisting of the members of the Core Team, the Computer Programmer, editors and edit verifiers. Since, many of the questions answered in the questionnaire had been coded from the field, the major objectives of editing had been to verify that the survey questionnaires have been correctly filled-in, correct samples have been interviewed; that items of information recorded or responses to questions obtained are consistent with one another; and that all questions in the questionnaire have been asked.

The members of the core team have randomly checked edited schedules after verification, and the Programmer has checked another 5 percent. In any qualitative study, open-ended questions provide broader insights. Responses to such open-ended questions have been recorded `Verbatim'. In order to meaningfully present and analyze such questions, categorisation of those responses has been necessary. After the categorization has been completed and the coding scheme finally accepted responses to the open-ended questions in every schedule have been categorised and coded, using the coding scheme. The Categorisation and coding of responses to the open-ended question has been conducted by the core research team.

Some of the questions answered in the data collection instruments have been coded from the field. There were several questions for which field coding had been difficult. Answers to such questions have been coded in-house.

Computerisation of data has involved the following major tasks: (a) entering data onto the computer; (b) conducting validation checks to ensure that data have been correctly entered onto the computer; (c) preparation of output tables; and (d) ensuring that the output tables are correct.

Data set was entered; using SPSS version 11.5 which is a fully integrated data entry, cleaning and editing tool with user-defined skip logic, rules, and input screens. The program has the built-in mechanism to guard against erroneous entry of data on to the computer file. Before giving output tables, proper range checks and checks of internal consistencies have been done.

Limitation of the study

Although the study methodology is based on scientific rigour, one of the limitations of the study relates to narrowing down the error margin posed in the statistical analysis. Results of the survey could reduce error margin more if the study could able to enlarge the number of locations from where data were collected.

Much of the information on severity, age of onset of disability and causes of disability may bear some inaccuracies, since the information collected are from the statements from memory / perceptions of the respondents. The study did not use any specific tools for measuring severity of the disability. The data collectors were to some extent trained to distinguish different forms of disability and symptoms of severity, however, due to the short period of disability orientation training it would be rather misleading to claim that the data collectors were able to distinguish the level of severity of particular type of impairment. However, efforts were taken to understand the issues not only from the respondents but also from other members of the household. To tackle all these limitations by way of observation from inside and outside, data collectors were trained how to build rapport with respondents and community to elicit information based on respondents perceptions.

Further limitation of the study could be the data collection period. Survey information was collected during the time of Ramadan, which though posed some challenges in making the respondents agreeable to talk openly during the fasting period; however, in most cases respondents were able to free their time for answering all the questions of the survey. The data collection time, rather posed difficulty in the focus group discussions, where the participation was not very spontaneous from its start. However, with the participation of field supervisors and field investigators, focus group participants in all study areas provided inputs to the understanding on peoples' perception, attitude and practices on disability issues in Bangladesh.

CHAPTER III
SOCIO-DEMOGRAPHIC CHARACTERISTICS OF STUDY POPULATION

For an approximation of the representativeness of the survey, this chapter presents the information on socio-demographic characteristics of household population, such as age, sex, residence and educational level, housing facilities and household characteristics.

HOUSEHOLD POPULATION

The prevalence survey questionnaire contained the several questions regarding household characteristics and household roster to collect information on demographic and social characteristics of all residents of the sampled household[6].

Age-Sex Composition

The prevalence survey households constitute a population of 13025 people. Table 3.1 exhibits the distribution of household population covered in the prevalence survey by different age groups, according to sex and urban rural residence. As information regarding age or residence of 17 peoples is unavailable, the Table shows that figure at 13008. The overall study population is almost equally divided into males (52 percent) and females (48 percent). Total urban respondents are 3204, while rural respondents are 9804. For Both areas on an average households belongs to largest percentage (32%) of population for age group 16-30, (where female represents 34.2% and male represents 30.4%), following by 23.4% for age group 31-50, 23.1% for age group 6-15 and 10.5% for age group 0-5.

Table 3.1 Household Population distribution by age, sex and residence

Age Group	Urban			Rural			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-5	6.6	7.1	6.8	11.8	11.7	11.7	10.5	10.5	10.5
6-15	16.6	18.7	17.6	25.2	24.4	24.9	23.1	23.0	23.1
16-30	39.1	38.7	39.0	27.6	32.7	30.0	30.4	34.2	32.2
31-50	25.1	27.7	26.3	22.6	22.2	22.4	23.2	23.5	23.4
51-64	8.2	4.6	6.5	7.0	5.4	6.2	7.3	5.2	6.3
64+	4.4	3.2	3.8	5.8	3.7	4.8	5.4	3.6	4.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number	1676	1528	3204	5117	4687	9804	6793	6215	13008

Household Composition

Household composition of a society indicates social characteristics of the society. Table 3.2 demonstrates that a small proportion of households of the study are headed by females (10 percent), while almost 90 percent headed by males. The number of respondents from female-headed households in rural area is slightly higher than that of urban area. The average household size in the studied areas is found to be 5.3 people, with a small variation between rural (5.3) and urban areas (5.2). The majority of households, around 60 percent, have 4 to 6 members in the family.

[6] A household is defined as a person or group of people who live together and share food

Table 3.2 Percentage distribution of households by sex of head of household and household size, according to urban-rural residence

Characteristic	Area of residence		
	Urban	Rural	Total
Household headship			
Male	85.2	90.3	89.1
Female	14.8	9.7	10.9
Total	100.0	100.0	100.0
Number of usual members			
1	.3	.5	.5
2	3.7	4.3	4.1
3	12.3	10.6	11.0
4	24.0	20.4	21.3
5	23.3	21.2	21.7
6	12.5	18.6	17.1
7	11.0	10.1	10.3
8	5.0	5.8	5.6
9+	8.0	8.7	8.5
Total	100.0	100.0	100.0
Number	600	1800	2400
Mean HH size	5.20	5.34	5.31

Education

Education is one of the key determinants of lifestyle and status an individual enjoys in a society. It has a significant affect on all aspects of human life including demographic and health behaviour. Table 3.4 provides the data on year of schooling of household population by demographic and geographical variation. A steady decreasing percentage of no education is observed in each younger age group of the study population. The proportion of no education decreases from 52 percent in the oldest age group (64 years or more) to 13 percent among those aged 6-15. Though 'no education' rate is still higher in case of female (33%) compared to male (28%) respondents of the study population.

Table 3.4 Percentage distribution of study population by year of schooling

Background characteristics	Year of Schooling						
	No Education	1-4	5-9	10-12	12+	Total	Number
Age							
0-5	90.4	9.6				100.0	1366
6-15	13.3	44.6	38.0	4.1	.0	100.0	2998
16-30	14.8	6.2	33.7	33.3	12.1	100.0	4189
31-50	32.5	7.8	27.7	21.7	10.3	100.0	3035
51-64	41.8	9.1	22.9	16.6	9.7	100.0	814
64+	52.0	12.0	20.8	10.5	4.6	100.0	590
Sex							
Male	27.5	16.3	26.6	19.8	9.8	100.0	6790
Female	32.6	16.2	30.6	16.5	4.2	100.0	6216
Residence							
Urban	14.9	10.8	25.9	30.1	18.3	100.0	3209
Rural	34.8	18.0	29.3	14.4	3.5	100.0	9797

Division							
Barisal	23.4	21.0	30.5	17.1	8.0	100.0	2086
Chittagong	31.6	14.8	31.6	19.8	6.2	100.0	2190
Dhaka	31.0	17.2	27.8	17.0	7.0	100.0	2142
Khulna	25.9	11.5	32.4	21.2	9.1	100.0	1919
Rajshahi	29.7	14.9	27.7	20.2	7.6	100.0	2326
Sylhet	36.5	17.6	36.5	14.7	5.4	100.0	2343
Total	29.9	16.2	29.9	18.3	7.1	100.0	13006

Substantial urban-rural gaps in year of schooling of the respondents persist. About thirty five percent of rural people have no education (not a single year of schooling), compared to 15 percent of urban people. The proportion of year of schooling is also higher in urban area compared to rural part. As for difference by division, the proportion of population with no education is higher in Sylhet (37%) and lower in Barisal (23%).

Housing Characteristics

Housing characteristics and consumption structure of household represents economic condition of family. According to the housing characteristics and their food consumption structure in the study areas (shown in Annex Table-3.1), it is found that about 73% households use tin in constructing roof for their houses in total compared to 18% use cement/concrete/tiles and about 9% use bamboo/thatch, though in urban areas about 58% households live in a house with cement made roof. Housing characteristics of study population also reveals that about 37% of these households' house structure is made by wood/tin wall, 33% households use jute/bamboo or mud, and 29% households use cement or concrete for their wall. More than eighty percent of urban households live in structure with brick or cement walls while about 90 percent of rural households live in structure with walls made of natural materials or tin/wood. The most commonly used floor material is cement in urban area (90%) and mud in rural areas (85%).

More than half of the household respondents consumption pattern is in neither surplus nor deficit condition. The rate is about 57% in urban areas and 31% in rural areas. Though only 5% of households have food deficit in whole year, it is about 19% households that remain in deficit sometimes in a year, while this rate is about 35% in rural areas. Households having their surplus consumption are about 20% of households, but in case of rural areas there are about 13% households enjoy surplus condition.

Almost 90 % of both rural and urban households have some toilet facilities. However, 80% of them have access to sanitary latrines. The rate of septic tank or modern toilet uses is higher in urban areas (85.3%), while in rural areas most households' do not have access to sanitary latrines. And it is observed that about 9% households of the study population in rural areas have no toilet facilities.

The main material of the houses of the respondents is CI Sheet. About 73 percent of both urban and rural households posses houses of tin roof. However, urban and rural households vary widely in the use of other types of roofs. In the urban areas, 58 percent of the households live in dwellings with cement or concrete roofs, while in rural areas, bamboo or thatch are the most common materials after tin.

Almost 33 percent of households live in structure with walls made of natural materials such as jute sticks, bamboo or mud while 37 percent's houses are made of wood/tin and 29 percent of cement or concrete. More than eighty percent of urban households live in structure with brick or cement walls while about 90 percent of rural households live in structure with walls made of natural materials or tin/wood. The most commonly used floor material is cement in urban area and mud in rural areas.

More than 50 percent of urban households' respondents indicated that they have neither deficit nor surplus of food in terms of food consumption, compared to 31 percent in rural areas. Eighteen percent of urban households mentioned that they have sometime food deficit while the share is 35 percent in rural households. Nineteen percent of rural households have food deficit in whole year, compared to 5 percent in urban households.

Almost ninety percent of both urban and rural households have some toilet facilities; however eighty percent of them have hygienic toilets. No such facilities exist in 0.7 percent and 8.8 percent of household respectively in urban and rural areas.

Household Possessions

Possession of household durable goods is a reflection of the socio-economic status of the study population. It is observed from the Annex Table 3.2 that almost 97 percent households own cot and this is almost close in urban (99%) and rural (96%) areas. 87 percent of households own table, chair or bench and 60 percent own wardrobe. The owner of watch or clock is about 91% in urban areas, while it is about 60% in rural areas. In the case of ownership of radio, television, refrigerator, motorcycle, bicycle, sewing machine, DVD player, VCR is much higher in urban areas than that of in rural areas. And it is observable for ownership of refrigerator is higher (about 43%) than that of in rural areas (7%). The higher proportionate uses of electronic instrument in urban areas reflects only the respondents level of economic condition but also the access to electricity, which is much lower in rural areas.

About 75 percent of households own a homestead and 46 percent own land other than homestead. 50 percent of rural households own land other than homestead, compared to 35 percent in urban households.

In the prevalence survey, respondents were asked about their monthly household income. 75 percent of the respondents willingly say their household income and 25 percent were unwilling to say. Mean incomes for urban households were found to be 7687 and for rural household it is 3259. Though only 2% household earn less than 1000 Tk per month, it is about 44% of household's earnings between 1000-3000 Tk/month in the rural areas. While in urban areas, 19% households earn above 10,000 Tk/month, in rural areas the rate is only 3%. So this shows the income inequality between urban and rural areas.

Socio-demographic condition of the respondents in KAP study

As regards socio-demographic condition of study population of the Knowledge, attitude and practices survey, it is observed that among the respondents majority were adults (74.1%) who cover the age limit starting from 19 to 63 and 19.2 % were children (below 18). To have a broad based views on issues relating to disability, respondent groups were formed from child with and without disabilities, adult with and without disabilities, local political

leaders/ influential persons, government officials etc. While majority of the respondents of the study are adult persons without any disability, around 13 percent respondents are from persons with disabilities. About 21.8 % respondents were from families having at least one person with disability.

In the KAP survey urban respondents were one third of the rural counterparts. KAP study respondents also vary in terms of geographical taxonomy, for instance, coastal, char-haor, hilly and plain lands. The study population from coastal, char -haor, hilly, and plain lands respectively represented 12, 3, 6 and 78 percent of total study population.

Such socio-demographic condition of respondents and also a broad classification of respondents in terms of gender, religion and occupation are presented in Annex Table 3.3.

CHAPTER IV
PREVALENCE OF DISABILITY IN BANGLADESH

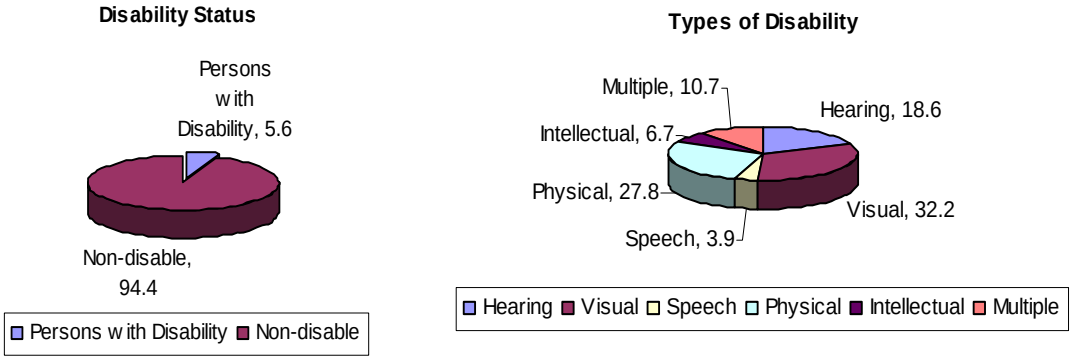
DISABILITY PREVALENCE

The statistics on prevalence of disability has been a matter of serious debate: *a number of sources providing conflicting numbers*. The WHO's global estimate predicts approximately 10% of all people have a disability of one kind or another. This is while considered to be true in Bangladesh with some sources quoting a higher disability rate in rural Bangladesh in view of the overpopulation, extreme poverty, illiteracy, lack of awareness, and above all, lack of medical care and services. Action Aid-Bangladesh and Social Assistance and Rehabilitation for the Physically Vulnerable (SARPV) put the disabled population at 8.8% of the total population. Bangladesh Protibandi Kalayan Samiti records 7.8%, while in another survey ActionAid Bangladesh (1996) records 14.04% people suffered from a form of impairment. The study is however based on survey in four areas namely Lalbagh slums of Dhaka City, Ewazpur village under Charfesson thana of Bhola Island, villages in the outskirts of Netrokona districts and villages in the outskirts of Companiganj in Noakhali. On the other hand, the Government of Bangladesh (GOB) surveys in 1982, 1986 and 1998 estimated a national prevalence rate of disability at 0.64%, 0.5% and 1.60% respectively.

The present survey emanates from the current knowledge gap and debate on the rate of prevalence of disability in Bangladesh, put a statistically valid figure from the largest so far survey in Bangladesh in terms of volume and coverage. According to the current survey, *5.6% people in Bangladesh have a disability of one kind or another.*

Among the persons with disabilities percentage share of different types of impairments are *hearing 18.6 percent, visual 32.2 percent, speech 3.9 percent, physical 27.8 percent, intellectual 6.7 percent and multiple (more than one type) 10.7 percent* (Figure 4.1). The rate of prevalence of particular type of impairment is difficult to compare with the existing knowledge on prevalence due to lack of such specific national level survey. The available national survey carried out by the Sight Savers International on age specific visual disability is also a large number. It found out that in total 25.86% of survey people suffered from any sort of visual impairment.

Figure 4.1: Percentage distribution of population by disability status and Types



Geographical Taxonomy of Disability Prevalence

In terms of geographical taxonomy of the disability prevalence rate, disability status by area of residence and divisional variation are presented in Graph 4.2 and Annex Table 4.1 and Annex Table 4.2. The study found that amongst the study population *about 6 percent of PWDs live in rural areas while 4.2 percent live in urban areas*. An analysis of the prevalence rate of different categories of disability by rural-urban dichotomy suggests that *urban people are highly affected with physical and intellectual impairment compared to rural people*. The prevalence of *hearing and visual impairments are however higher in rural people than persons with disabilities living in urban areas*.

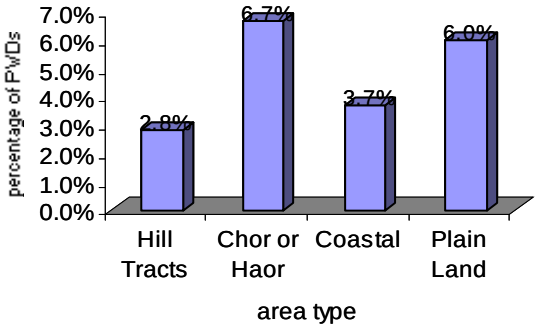
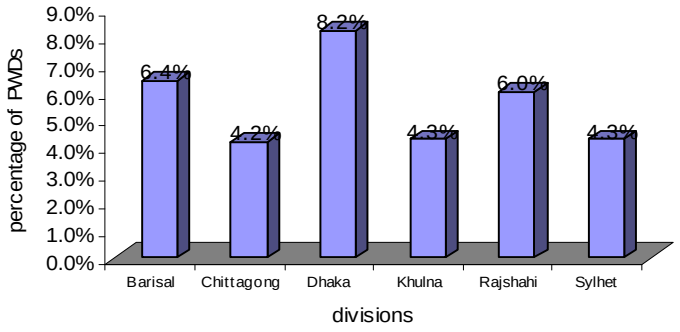
The overall *prevalence of disability is higher in Dhaka division (8.2 percent), compared to 4.2 percent in Chittagong division, closely followed by Khulna and Sylhet division (4.3 percent each)* and it is observed at 6.4 percent and 6.0 percent in Barisal and Rajshahi division respectively. However, a diagnosis of the prevalence of different types of disability reveals that problems with *physical impairment are observed at higher rate at khulna division (38%), closely followed by Chittagong division (30%)*. The *visual impairment is lowest in Khulna division compared to all other division while intellectual impairment is higher at Sylhet division*. Rate of prevalence of speech and hearing impairments are similar in all administrative divisions.

The prevalence of impairment by geographical taxonomy shows that *7 percent of people living in Char or Haor areas in Bangladesh have at least one kind of impairment,* closely followed by plain land (6.0 percent). The prevalence of impairment is slightly lower in Hill tracts areas and coastal areas (2.8 percent in Hill tracts and 3.7 percent in coastal areas). As regards different types of disability it is found that in *hill-tract areas people are highly affected by disability of more than one kind (multiple 31.3 percent)*. The *visual impairment and physical impairment are most common (38.1 percent and 28.6 percent respectively) in Char or Haor areas.* For c*oastal areas, most prevalent form of impairment is of physical (45.2 percent),* though high percentage of prevalence of speech and hearing (both at 11.3 percent), and visual impairment (24.2 percent) is evident.

In terms of disability prevalence in different administrative divisions in Bangladesh, the study shows that *Dhaka, Barishal and Rajshahi divisions have higher proportion of persons with disabilities compared to others three divisions.* In Dhaka division the rate is 8.2% and in Barisal 6.4%, closely followed by Rajshahi division (6%). In Khulna, Sylhet and Chittagong this rate is observed as respectively 4.3%, 4.3% and 4.2%.

The study also reveals *marked difference in terms of availability of services in the areas of residence of the persons with disability*. It is found that the rate of *disability prevalence is lower in areas where some sort of services for disability exists* (4.3 percent) compared to that of the areas where no such services exist (5.8 percent).

Figure 4.2: Geographical Taxonomy of Disability Prevalence

Disability Prevalence by area of residence	
Disability Prevalence by Area pattern	
Divisional Variation in Disability Prevalence	

Disability Prevalence by Socio-demographic characteristics

Prevalence by General Socio-demographic Characteristics

The disability prevalence by socio-demographic characteristics of the persons with disability is presented in Annex Table 4.3.

The study found that *disability prevalence rate is shared between people with different religions and ethnicity.* The disability prevalence reveals that almost 6 percent of Muslim people have at least one kind of impairment. The rate is 4.4 percent for Hindu and 3.5 percent for Buddhist people. In case of distribution by ethnicity, it is found that the rate of prevalence of impairment is lower in Ethnic minority (3.8%) compared to 5.6% in Bengali people.

It is also found from the study that males are more affected than females and the percentage for males and females are 6 and 5.1 percent respectively.

Disability Prevalence by Age

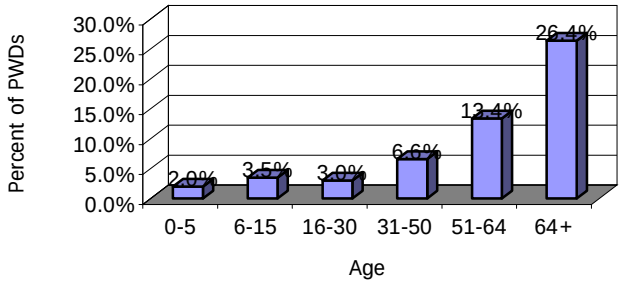
The study observed that *disability rate is higher at the higher age level*. For age group sixty-four and above the rate is 26.4% and this rate tends to lower as lower the age group except 3.5% of age group 6-15. For age group 0-5 it is found that there are 2 percent of people having disability of one kind or another (Figure 4.3). Again it was found that among various types of disability, visual impairment is highest (32.2%), and the people in highest age group i.e. 64+ suffer mostly (47.4%) from visual disability, which supports the finding that disability is larger at the higher age level.

The survey revealed that the highest concentration of persons with impairments (26.4 percent) are within the age group 64+ years and followed by 51-64 year' (13.4 percent), compared to younger age group.

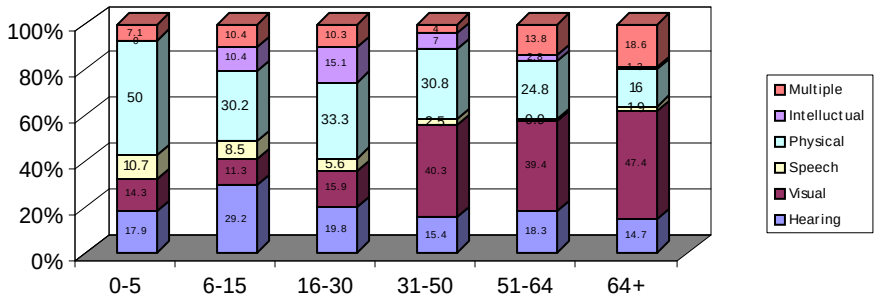
The study reveals that *types of disability also vary according to different age group.* It can be seen from the figure 4.3 that *visual disability is highest for people in age group 64+* (47.4%). It is lowest (11.3%) for the age group 6-15. For other age group, it does not vary significantly. *Percentage of people having more than one kind of impairment is highest for age group 64+(18.6%)*. For age groups below 30, this sort of disability is not so acute, but for age groups higher than 30, the percentage rises. Intellectual disability is found to be higher (15.1%) for 16-30 age group. The prevalence of speech disability is not acute. It is highest for age group 0-5(10.7%), and is almost absent (.9%) in age group 16-51. Hearing impairment is highest (29.2%) for 6-15 age group, while the lowest (14.7%) percentage has been found for age group 64+. For other groups, the percentage does not vary much.

Figure 4.3: Disability Prevalence by Age

Disability Prevalence by Age



Types of Disability by Age

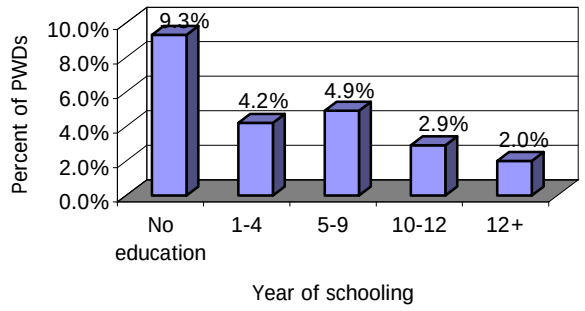
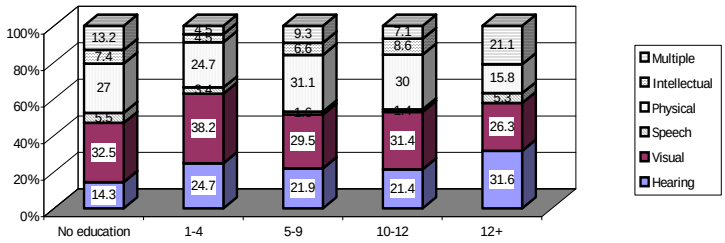


Disability Prevalence by Education Status

The prevalence of impairment decreases with an increase of year of schooling of the study population. *Almost 10 percent of people with no education have an impairment of one kind or another compared to 2 percent the peoples with higher education.* Disability rate significantly decreased with the increase in year of schooling of the respondents. *About 10 percent PWDs have no education. Only 2 percent of respondents with disabilities had 12 or above schooling experience. This rate is 4.2% for 1-4 years school, 4.9% for 5-9 years of schooling and 2.9% for 10-12 years of schooling.*

Almost all PWDs with different year of schooling are equally suffered from visual and physical impairment.

Figure 4.4: Disability Prevalence by Education Status

Disability Prevalence by Year of schooling	
Types of Disability by education status	

Disability by Income level

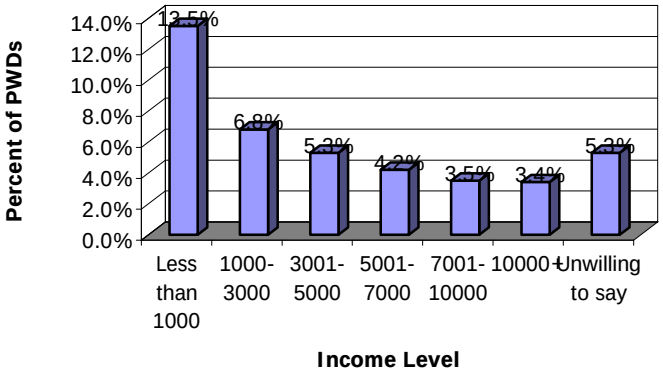
Though about 5.3% PWDs were unwilling to say their income, among the rest of the respondents about *14 percent PWDs are found with their income level less than 1000. This rate significantly decreased with the increase of income level. Only 3.4% of disable people are found their income level above 10,000.*

It was observed from the survey that prevalence of impairment is decreasing by an increase of income. Almost 13 percent of peoples with income less than 1000 have one kind of impairment, compared to 3.4 of the peoples with income 10000 or higher.

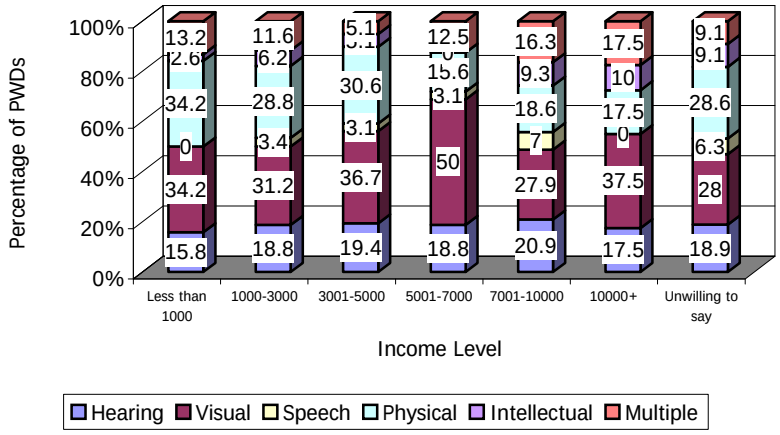
It can be seen from the graph that *types of disability also differs along with different income level*. People in income group 7001-10000 suffer mostly (20.9%) for hearing disability, while the lowest (5.81%) percentage is found for the income group below 1000. Visual disability is highest for income group 5001-7000, which is 50%. For other groups, the percentage doesn't vary so much, lies between 28% to 38%. Speech disability is absent for income group below 1000 but highest (7%) for income group 7001-10000. Physical disability is highest (34.2%) for income group below 1000 and it is lowest (5.6%) for income group 5001-7000. Percentage of people having intellectual disability is highest for group 7001-10000, which is lowest for income group below 1000. Multiple disability is highest (17.5%) for income group 10000+, and it is lowest (5.1) for income group 3001-5000.

Figure 4.5 Disability Prevalence by Income Level

Disability Prevalence by Income Level



Disability Prevalence by Type and Income Level



PREVALENCE OF IMPAIRMENT BY TYPE

Hearing Impairment

Among different types of hearing impairment *more than 60 percent persons have the problem in both ears and about 25 percent persons have the problem in one ear*. As regards severity of the impairment defined in terms of the respondents perceptions, it is revealed that about *half (48.1 percent) of the impaired persons' problems are moderate and quarter (25.9 percent) are severe.*

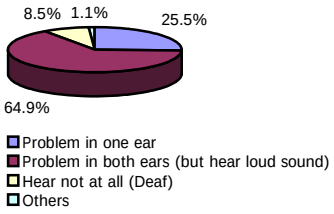
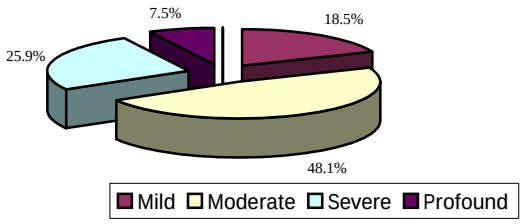
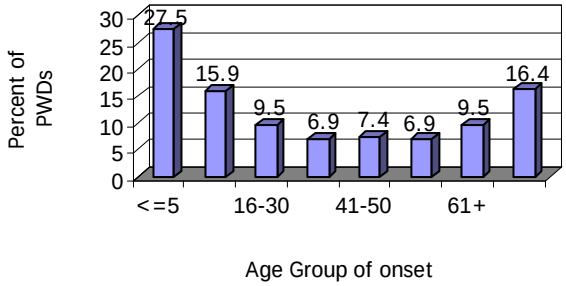
As regards the onset of the problem, about 16 percent persons with hearing impairment do not know the age of onset of the problem. Among the rest of the persons with hearing impairment about *28 percent PWDs are facing the difficulty from their early ages (from less than or equal to five years), followed by 16 percent between the age 6-15, about 10 percent between the age 16-30 years and 10 percent in the age of 61 years and above.*

The reasons of hearing impairment are due to number of causes. *About 27 percent cited disease as the reason for such impairment. Other important causes of hearing impairment are accident (13.2 percent), congenital or birth problem (11.1 percent) and natural ageing (14.8 percent).*

More than *85 percent persons having hearing impairment do not use any assistive devices (AD)* to overcome the problems associated with impairment. The reasons for not using assistive devices include economic reasons and non availability of such service providers within reach of the respondents. Only 3.64 percent and 3.14 percent persons use hearing aid and sign language respectively to enable them to overcome problems associated with hearing impairment.

The types, severity, age of onset, causes and tools used to overcome of hearing impairment are presented in Graph 4.6 and Annex Table 4.6.

Figure 4. 6: Type, Severity and Age of Onset of Hearing Impairment

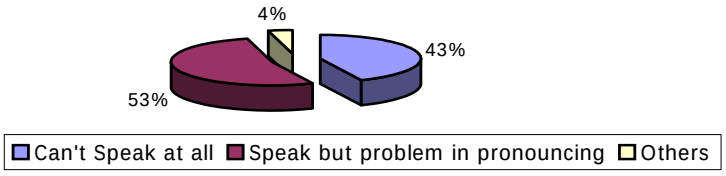
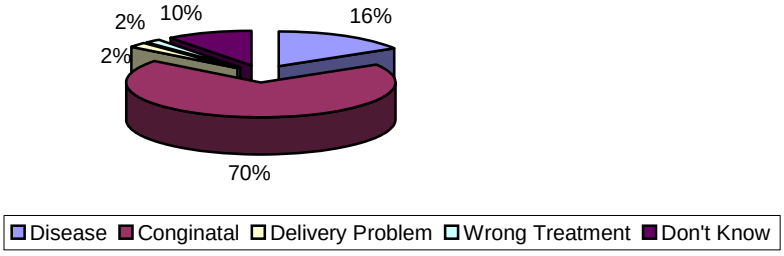
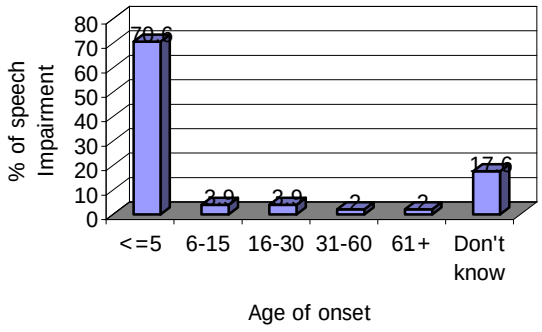
Types of hearing Impairment	
Severity of hearing Impairment	
Age of onset	

Speech Impairment

Half (52.9 percent) of the speech impaired persons have the problem in pronunciation and vocabulary but they can speak. A large number of persons having speech impairment (43.2 percent) can't speak at all. According to severity condition perceived by the respondents, 39.2 percent hold this in severe condition and 27.5 percent in moderate condition. *About two-thirds (70.6 percent) contain the difficulty from their early (less than or equal to five years) age. More than three-fifths (66.7 percent) of this caused by congenital or birth problem and 15.7 percent caused by diseases.*

The types, severity, causes and age of onset of the problems associated with speech impairment is shown in Figure 4.7 and Annex Table 4.7.

Figure 4.7: Type, Severity and Age of Onset of Speech Impairment

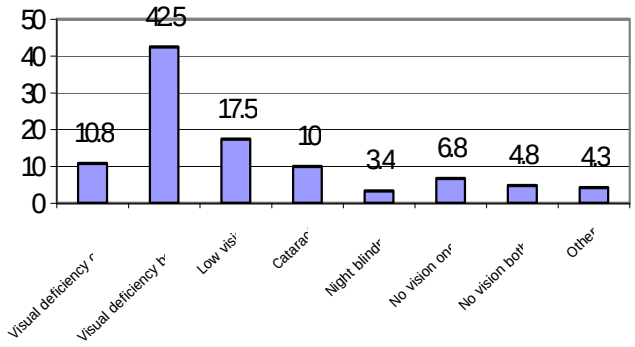
<table>
<tr><td>Types of speech impairment</td><td> 
</td></tr>
<tr><td>Causes of Speech Impairment</td><td> 
</td></tr>
<tr><td>Age of Onset</td><td> 
</td></tr>
</table>

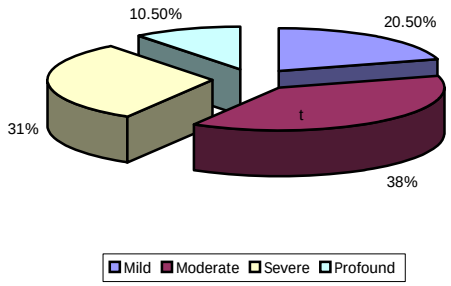
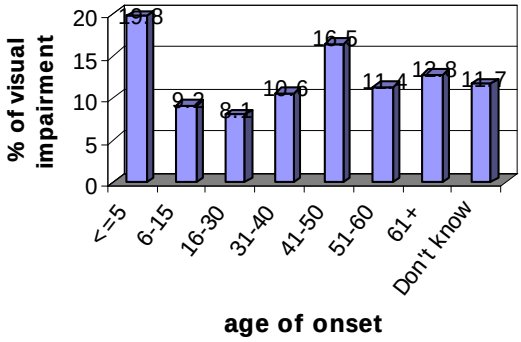
Visual Impairment

Visual impairment corresponds to a greater portion of disable people among the overall disability rate. Information on types, severity and age of onset, causes and tools used to overcome of visual impairment are presented in following figure 4.8 and Annex table 4.8. It shows that *most (42.5 percent) of the visual impaired persons have the deficiencies in both eyes to see.* Visual deficiency in one eye (10.8 percent), low vision (17.4 percent) and cataracts (10 percent) are important types that the visual impaired persons have. *37.4 percent are in moderate condition and 30.4 percent are in severe condition according to severity perception of the respondents.* 19.8 percent contain the difficulty from their early (less than or equal to five years) age.

Natural ageing are found most responsible (about 42%) for causing visual impairment among various reasons for the impairment. Though about 13% do not know the actual reason for this problem, disease is an important cause for visual impairment and 14.7 percent turn out to be impaired by this cause.. However accident, birth problem, malnutrition, wrong treatment are also responsible significantly for suffering this problem. For this impairment more than half (56 percent) do not use any tool to overcome problems associated with visual impairment. Among those who use some form of tools to overcome problems associated with visual impairment most people use (37.7 percent) spectacles and magnifying glass. In contrast with this, Cataract was found as the major cause behind blindness in Sight Savers Survey, where 79.6% of bilateral blindness, 61% if unilateral blindness and 74.2% of low vision caused by cataract. It also found that visual impairment prevalence were common in women than men. They also found that cataract accounts for 80% of total blindness in Bangladesh, and 32.5% of child blindness where in each year 130,000 people get affected by cataract blindness.

Figure 4.8 Type, Severity and Age of Onset of Visual Impairment

Types of visual impairment	

Severity of visual impairment	
Age of Onset	

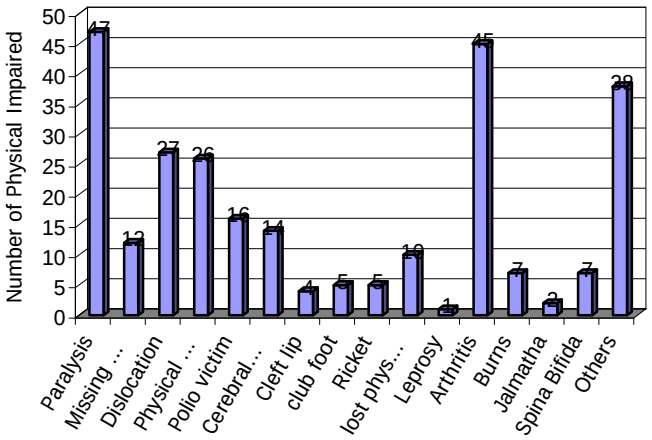
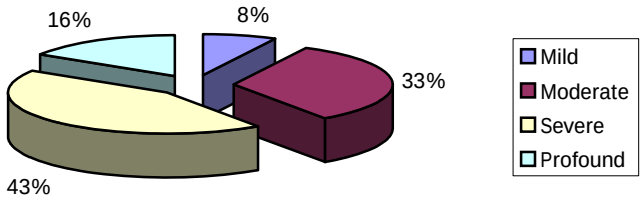
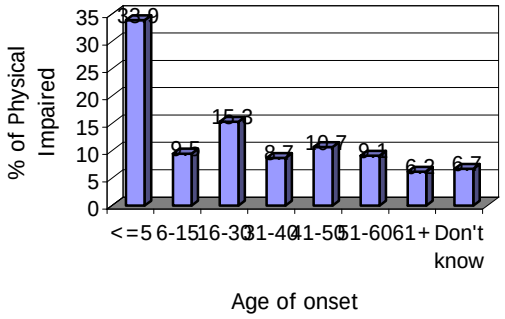
Physical Impairment

Physically impaired people have the largest share (about 31%) among the PWDs. The following Figure and Annex Table 4.9 provides information on types, severity, and age of onset, causes and tools used to overcome of physical impairment. Among the 266 physically impaired persons, 47 are suffering from paralysis. 45 are suffering from arthritis. However, physical deformity, polio victim, cerebral palsy, cleft lip, clubfoot, reckets leprocy, spina bifida are observed in the studied areas.

Among the PWDs, *about 17.7 percent are physically impaired due to paralysis and 16.9 percent bear arthritis. Dislocation (10.2 percent) and physical deformity (9.8 percent) are important types for physical impairment.* In case of physical impairment, study finds that *large portions (about 44%) of this type of impairment are suffering severely.*

About 33% are facing this problem moderately and very small portions (8%) have with mild problems. From early age 33.9 percent impaired persons developed this impairment. *Physical impairment are found mostly for the reason of accident (about 20%), followed by 19% by diseases, 13% as a congenital problem, 13% for natural ageing.* However, malnutrition, burn injury, wrong treatment, fatal accident are also the reason of this impairment, while about 15% do not know about specific reason of their impairment. To overcome this impairment 69.8 percent persons do not use any tool.

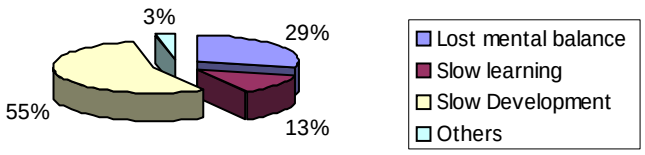
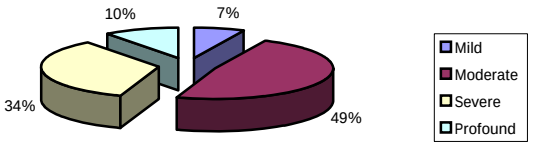
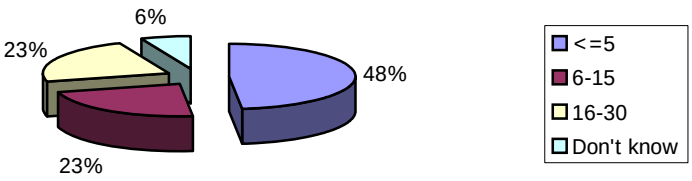
Figure 4.9: Type, Severity and Age of Onset of Physical Impairment

Type of Physical Impairment	
Severity	
Age of Onset	

Intellectual Impairment

Different characteristics on intellectually impaired persons are presented in the following figure 4.9 and Annex Table 4.10. Both reveals that *54.8 percent persons have the problem of slow development and 29 percent have lost their mental balance partially or wholly*. 45.2 percent have in moderate condition and 32.3 percent have in severe condition. The severity condition has been determined by the respondents themselves. About half (48.4 percent) of the impaired persons fall in the problem from their early age. *Congenital or birth problem is the main reason to have this impairment and 38.7 percent persons are in this category*. Disease (9.7 percent), accident (9.7 percent) and due to fatal accident (9.7 percent) are the other causes to become intellectual impairment.

Figure 4.9: Type, Severity and Age of Onset of Intellectual Impairment

Types of intellectual impairment	
Severity of Intellectual Impairment	
Age of Onset	

PERSONS SUFFERING FROM MENTAL DISEASES

The study population also had 20 persons suffering from mental disease. The data collectors were trained to distinguish between mental disease and intellectual impairment. Information on mental disease was collected in order to exclude the numbers in counting the prevalence of disability in Bangladesh. Among those identified as having some sort of mental disease, 35 percent are in severe condition of mental disease according to respondents perception and this is revealed in Annex Table 4.11. 16-30 is the age range on which most of the persons fall in the problem. Disease, congenital or birth problem and accident are the main causes for having this disease.

GENERAL INFORMATION ON DISABILITY

More than *three-fifths (67.8 percent) of disable people can function without help of others.* 25.3 percent of disable can not function properly without support. 6.3 percent disabled persons categorised as other in the table however shows that these persons only require support or other people's help only when they perform heavy work. Annex Table 4.12 presents general information on PWDs and disability.

More than *three-fifths (68.9 percent) disabled person met with doctor for their respective problem. When asked what kind of treatment received, half (49.4 percent) of them informed that they took medicine for treatment and a good number of people (8.1 percent) took the service of traditional healers.* Other kind of treatment received included injection, surgery, physiotherapy and homeopathy. However, only 42 percent attained some improvement through such treatment received. A large portion (38.7 percent) observed no change even after receiving treatment of some sort.

When the respondents were asked by whom the treatment cost was provided, it is found that *family burdened the most of the cost associated with treatment.* About 60 percent disabled families compensated the cost for treatment. While *only for 3.2 percent of respondents' treatment cost was shared by government organisations, development organisations and community at large.*

Those who did not receive any treatment nor did visit any doctors held poverty as the main reason for doing so. *More than three-fifths (62.5 percent) didn't met with doctor for economic hardship. Oth*er reasons for not consulting doctors include ignorance, negligence and owing to wrong belief and superstition. Religious belief was also the cause for not visiting doctors for one of the respondents of the study.

As regards the availability and accessibility of help from any organisation, it is evident that only a small number of people got some sort of help for problems associated with disability from any organisation. *Almost everyone (96.7 percent) from those who responded and 84.3 percent from the total sample population did not get any help from any organization.* About half of the small number of people who got some sort of help from any organisation in their areas received economic support from these organisations. Other support received by PWDs includes food, treatment, instrument and information on availability of support services.

Key Findings

- According to the current survey, *5.6% people in Bangladesh have a disability of one kind or another.* Among the persons with disabilities percentage share of different types of impairments are *hearing 18.6 percent, visual 32.2 percent, speech 3.9 percent, physical 27.8 percent, intellectual 6.7 percent and multiple 10.7 percent* (Figure 4.1).

- Rural area contains larger portion of PWDs compare to that of urban areas. But the study also found that *urban people are highly affected with physical and intellectual impairment compared to rural people*. The prevalence of *hearing and visual impairments are however higher in rural people than persons with disabilities living in urban areas*.

- The prevalence of impairment is slightly lower in Hill tracts areas and coastal areas compare to the char and plain areas. It is also found that in *hill-tract areas people are highly affected by disability of more than one kind (multiple 31.3 percent)*. The *visual impairment and physical impairment are most common (38.1 percent and 28.6 percent respectively) in Char or Haor areas.* For c*oastal areas, most prevalent form of impairment is of physical (45.2 percent),* though high percentage of prevalence of speech and hearing (both at 11.3 percent), and visual impairment (24.2 percent) is evident.

- The religious and ethnic distribution of PWDs also found varying. The PWDs among muslims, hindu and buddists are found 6%, 4.3% and 3.3% respectively. In case of distribution by ethnicity, it is found that the rate of prevalence of impairment is lower in Ethnic minority (3.8%) compared to 5.6% in Bengali people

- Higher the age level, higher the incidence of PWDs. The highest incidence is found in the highest age group (For age group sixty-four and above the rate is 26.4%), and gradually it becomes less with the lower age groups. A minimum 2% incident of PWDs found for age group 0-5.

- Year of schooling among the PWDs has significant implications. A large proportion of PWDs has little or no education. About half of the disable people have no education and a very high rate is found in them who are either visually or physically disable.

- Though about 5.3% PWDs were unwilling to say their income, among the rest of the respondents about *14 percent PWDs are found with their income level less than 1000tk/month. This rate significantly decreased with the increase of income level. Only 3.4% of disable people are found their income level above 10,000.*

- The sex structure of the PWDs shows that the male have more shares in the disability than that of female. But there is another dimension that both male and female have similar pattern and frequency of disability types. Highest incidence is found in the visual and physical type of disability for both sexes.

- *The age wise* disability scenario gives us very unique picture about the distribution of different types of disability among different age groups. For maximum types, the frequency of disability is gradually decreased with the increase of age. The highest incidence is found for physical disability, hearing disability, speech disability and

intellectual disability in the lower age groups and the frequency is gradually decreased with the increase of age. Exceptional are the visual and multiple disabilities.

- A larger portion of disable people experiences deficit of food over the year. Their housing condition is also very poor, mainly of katcha roof, wall and floor. Lower percentage people living with hygiene toilets facilities have impairment of one kind or another.

- More than three-fifths (68.9 percent) disabled person met with doctor for their respective problem. Only 42 percent attained some improvements through receiving treatments and the rest observed no change even after receiving treatment of some sort. Only 3.2 percent responded that their treatment cost is bared by the government organisations. Those who did not receive any treatment nor visit doctors mainly due to their economic hardship.

- A marked difference is found in terms of availability of services in the areas of residence of the persons with disability. It is found that the rate of disability prevalence is lower in areas where some sort of services for disability exist (4.3 percent) compared to that of the areas where no such services exist (5.8 percent)

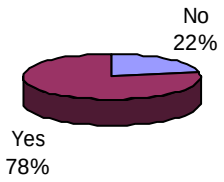
CHAPTER V
KNOWLEDGE, ATTITUDE AND PRACTICES ON DISABILITY IN BANGLADESH

KNOWLEDGE ON DISABILITY ISSUES

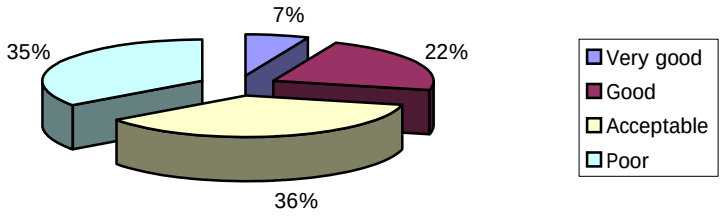
The study respondents' knowledge on disability issues shows that a good number of respondents *claimed to have some idea about the issues of concern to the persons with disabilities.* Graph 5.1 shows the knowledge of respondents on disability issues. It is found that around *78 percent people have claimed to have some knowledge on the issues or are aware of the issues relating to disability.* However, when they were asked to rate the degree of knowledge on such issues, only *28.7 % bear either very good or good ideas on the issues, 36.3 % have general ideas and about 35 percent have poor ideas on disability.*

Figure 5.1: Perceived Knowledge on Disability Issues

Idea about disability Issues



Degree of knowledge about disability Issues



While the respondents' claim has been that the majority have some degree of knowledge on disability issues, *the degree of knowledge on the issues articulated through different focus group discussions highlights how little they are aware on the issues related to PWDs. They also have conflicting ideas on the role of people with disability in the society.* To most of them, *'disability' as an abnormal condition of a person due to physical inability or incompetence of any part of body, lack of mental strengths of a person.* According to the respondents and focus group participants 'blind', 'deaf', 'dumb', 'mentally disordered person', 'aged people-who are unable to work normally', are identified as person with disability. During the focus group discussion, in a number of instances, participants had at length argued whether the aged and mentally retarded persons would be included in the group of people who might be a person with disability. However, *to most of them mental illness is a form of disability.* The aged population to

them is not PWD unless they are incapable of living their lives. The real state of knowledge on disability issues is further evident in their understanding on causes of disability.

Causes of Disability

According to the perception of the respondents various reasons are found responsible for disability. *Among them about 18% respondents believe that congenital and birth problem is the principal cause of disability. About 17% expresses that the reason is a result of diseases and 16% claims the disability as a result of accident. About 15% have their opinion on God's will.* In their opinion other leading causes of disabilities are malnutrition (11%), wrong treatment (7%). (Annex Table 5.1). However, As regards possible causes of disability, FGD participants from different districts of Bangladesh thought that various causes and effects are responsible for disability. The causes they mentioned can be summarised under following groups:

1. Improper Caring Practices and Ignorance
    - Wrong treatment
    - Wrong treatment of mother during pregnancy period
    - Lack of awareness of the mother in pregnancy period
    - Services of untrained caregivers
    - Lack of vaccination
    - Short gap between giving birth of two children

2. Malnutrition
    - Lack of nutrition
    - Malnutrition, lack of vitamin or iodine

3. Diseases and Accident and natural disasters
    - Accident or other fatal reasons
    - Various diseases
    - Polio, typhoid, diabetes, high blood pressure, paralysis etc.
    - Participation in the labour force as a child labour
    - Addiction
    - Acid violence, burn injury
    - Ageing, nervous debility
    - Lack of proper knowledge managing post-accident period (burn case)
    - Natural disaster

4. Heredity
    - Heredity causes
    - Congenital problem, curse,

5. Superstitious belief:
    - Disobedience to parents
    - Bad character of parents
    - Abnormal intercourse and miscarriage
    - Some practices in lustre of the sun or moon (e.g., cutting fish, jack fruit, betel-nut, taking rice)
    - If husband or wife do intercourse on the first day of the moon
    - Polygamy of parents
    - Superstitious beliefs (e.g., bad air), genetic problem etc.

Although the primary causes are by all means comprises the above, the main exogenous factor for these causes is the poverty of the people and this prime cause introduces most of the causes responsible for incidence of disability.

Knowledge about Rehabilitation programs for PWDs

Above eighty five percent of the survey respondents did not know whether there were any rehabilitation programmes available in their respective areas for PWDs. In contrast, however, the FGD participants were well informed about the programs that are taken for the PWDs. They knew about the existence of some rehabilitation programs and the programs like inclusion of disabled children and adults in education and special education schools for children with special needs.

As regards health issue, they were able to mention areas of action required for preventing disability and argued that delivery related health care, vaccination (for polio, leprosy, epilepsy) vitamin supplements, balance diet, improved nutrition status, prevention of accidents and natural disaster and pollution control can avoid incidence of disability significantly. They strongly opined the need to provide free and accessible health care for the disabled by government for the prevention of disability.

It is observed that *96.8 % people did not know whether there were initiatives taken by the policymakers or local government bodies- MPs, Ministers chairman, member etc for prevention of disability*. 78.8 % individuals opined that they did not have any idea whether disable people were getting help from any organisation. Most of the respondents replied that the PWDs get help from their own family. About 73 percent of them knew that disabled did not get any health care facility.

Perceptions on disability

FGD participants have had different perceptions on the condition of PWDs in society. Some of the FGD participants' *think that disable are burden of a society.* The FGD participants thought that *if PWDs have no job then they remain burden for the society*. So the PWDs need skill generating programmes or training, micro credit coverage, specialised programmes for the women with disability, rehabilitation services, quota system for the PWDs in government employment with punitive action for non-compliance, they suggested.

Participants agreed in general that *there should be some special arrangements to ensure better access for the PWDs in the different public services. For this purpose they argued for disabled-friendly public places, places of social amenities and municipal buildings and public transport and transport terminals and easy access for visually impaired in public places and roads*. A good number of participants also *emphasised the need to introduce disable-friendly education materials and transport facilities* for the students with disabilities. The general understanding of the FGD participants was that the services and facilities provided by t*he government and other non-government organisations were insufficient to enable disable people to live and continue their livelihood as complete human beings.* So, *government could contribute much in this regard by not only providing services to the PWDs but also through awareness programme on electronic, print and folk media, a good number of participants opined..*

ATTITUDE OF PEOPLE TOWARDS PWDS

Desired Behaviour of the respondents

Most of the FGD participants feel that *they should behave properly and kind to the disable. We should never hurt them and careful to them*, they opined. They should be encouraged with their ability to do certain things. The feelings of FGD participants found very positive towards the PWDs and they have the realisation that people should help the PWDs for better access to services, solve their problems and create opportunities for them, help them in proper education, listen to them patiently and should help them in their work; these were. *Every one thought that disabled should not call in bad name; in practice by they confessed that they themselves sometime call them boba, kana, lengra, pagol and many other names.* There are number of local names for different types of disability. The respondents also provided some of those local names by which the PWDs are known in their local areas (Annex Table 5.2).

It is observed that about *55% respondents accept PWDs well and about 20% give extra privilege to the disables. Very few are found behave badly towards the persons with disabilities.*

Role of PWDs in Society

More than *77 percent respondents claimed that they do not treat disability as a curse. Respondents who thought that disability is not a curse mentioned that this was due to reason of willingness of God*. To their understanding God has created all men equal and it is the will of the God who will borne disability. The respondents who treat disability as curse mention the reason why such perception prevailed. To them, *PWDs are considered as curse because they can't work and cannot engage themselves in development of themselves.*

A few number of participants of expressed the general notion (in their words) of the society towards PWDs that *every person of a society want disable persons should be removed from society because they have no ability to work. To them, everyone hates them and never wants to make relationship with them. They also never count them as a member of the society. However, a number of participants disagreed with the statement and told that such mentality prevails in only in few.*

Permissibility of Social Relationship

When asked, is *social relation with the disable people permissible, most of the participant would permit to make friendship with the disable but never permits to marry.* Few people think that if such environment is created, only then they agree but did not mention what's the environment. Many people think that disables are outcast, so the social relation with them is untenable and nobody wanted to talk details about this. Only a few people said that if their children agree to marry a disable person then they wouldn't mind because they will maintain their family.

A participant in Ashal para of Laxmipur thought that the parents brought up their children within so many obstacles, so they have some right upon them. For that reason, *if their child makes a relationship with any PWD, then there is a strong possibility that they would mind upon the child. But it may be okay if it is happened only among their relatives or it is done in exchange of a handsome amount of dowry.*

Some people want social and national recognition of PWDs, only then marital relationship will be possible. To most of them, *there are some social obstacles, so it is impossible to accept such relationship. It is the society that keeps the PWDs in the margin, benevolence of one or two people will not change the situation,* participants agreed in general. People of Barisal Sadar expressed

that, they never accept a relationship if a family having PWDs. A participant of Rajshahi said that no one accept such kind of relationship but another participant said that if his/her economic condition was good only than it might be possible. An elderly notify that, if a relationship exists then everyone should accept it. But seldom, it is found due to social obstacles. One of the participants thought that, relationship between two disabled persons is rather much desirable.

Stated desired attitudes and reality of treating PWDs

The majority of respondents (63 percent) think that PWDs are not burden to the family. They should get extra security on roads, reserved seats in the public transports like bus, train etc., separate hospitals and schools, these are the attitude that should prevail in the society, FGD participants opined.

Most of the people (about 80 percent) think that extra facilities and care should be given to the disabled. More than half of the respondents (53%) expressed their willingness to help the disables and at the same time 59.6 percent persons stated their willingness to employ the disabled. 57 percent agree to make relationship with the disabled.

The FGD participants mentioned that sometime they feel embarrassed for the PWDs. Usually people are not interested to take them in various social programs like marriage, religious festivals, birthday parties or others. Because of their disability, no one is interested to engage them in various jobs, but if they could prove their worth, then only they could have been employed, opined a good number of participants.

There has been a good number of contradiction in what people ideally would like to do for PWDs in general and what in their own life they would do. A good number of participants told that disabled should get equal right, because they are also human beings. In this context, some participant's opinions are noteworthy. According to a participant, PWDs never get food properly and most of them keep themselves isolated from the society due to the attitudes of the society towards them. Even some educated persons also badly treat PWDs.

Opportunity in the form of Charity

When asked, whether disable people be given extra preference, they affirmed the need for such preferences. *In that case government and rich persons should come first,* spoke the FGD participants. A participant from Bagherhat district says that in God's world every body should be given equal preference. For PWDs, at first their family should come forward and then the others. Participants in Dashmina of Patuakhali say that, they should be given monthly allowance (300-500Tk.) for disability. Many people propose to give interest free loan, extra preference in education system, donation from the poor fund and establish aid organisation in every thana, district, and division. They should also be given the opportunity in service (quota), sacrifice seats in transport, loan, housing, education, vocational training and many other facilities according to their need.

Another participant from Kalainagar thinks that PWDs should be given the opportunity according to their position both in economic and social context. *Government should enlist the disable person and also manage their better treatment.* Every person should do the work for PWDs and then do their own job. Government should make employment opportunity and give extra facility in social and other organisational field.

While talking on the opportunity provision for the PWDs a paradoxical view is found in the FGD discussion. A number of the FGD participants' think that *PWDs should not get any work since they have less quality and merit. Some people thought that they should get equal opportunity only according to their respective abilities.* The government should provide quota in service for the PWDs, few expressed. They should get opportunity through free of cost schooling, priority in medical treatment. A FGD participant opined that disable person should not get equal opportunity because they have not equal quality. One person in Mirpur expressed that, disabled persons should get registered and then considering their problem and counting their ability they should get extra preference. Disable shouldn't get equal opportunity because they have not equal quality like an able person.

According to a participant of Chittagong, *they should give double opportunities because in spite of their disability they have some quality*. Another person says that *disabled person shouldn't expect equal opportunity, but if they are poor only then they should get some charity*. Many people realise that as a part of a society and human being they should get extra opportunity. In Hobigonj Sadar a good number of participants feel same but many of them think, they should get equal opportunity in education and medical treatment but not in employment opportunities. A few express that in service, the government should introduce different arrangement according to their physical and mental abilities. However, from several discussions, it was revealed that many of the above opportunities proposed by the participants for PWDs were in general they would like to see ideally. There has been debate on the contradiction in what people ideally would like to do for PWDs in general and what in their own life and capacity they would do for and with PWDs.

PRACTICE BY PEOPLE REGARDING DISABILITY

Practice by people regarding disability is shown in Annex Table 5.4. About half of persons (47 percent) opined that they would buy food from disabled sales person with epilepsy though a large percent (40.7) avoid buying food from them. 39.7 percent persons agree to give equal opportunity to the disabled. *42.5 percent express that they will accept marriage with visual impaired persons*[7]*. 65.8 percent guardians agree to accept the disabled children as a classmate of own children.*

Programs to Prevent disability

People are sometimes aware of the various programs to prevent disability such as prenatal care, safe delivery, post natal care, vitamin supplements, capsule, vaccine, balanced diet, and nutrition status, public awareness programmes on electronic, print, radio, television, and folk media preventing road accident. *28.4 percent know about ANC, PNC programs are taken to prevent disability, 27% know about vitamin supplement programs, 16% about balance diet providing program and 15% know about public awareness programs to prevent disability.*

Rehabilitation programs

People are not much aware of the disability programmes; only those families who have disabled person know or deal such programs. In education sector they know about inclusion of disabled children and adults in education programs, and establishing special education schools for children with special needs. *About 38% know about the efforts of inclusion of children with*

[7] The questionnaire for prevalence survey made specific enquiry whether people will accept marriage with visually impaired persons since in Bangladesh, the visually impaired persons are more visible due to the impairment and more acceptable for marriage due to peoples perception on the linkage of impairment to reproductive health than other forms of impairment.

disabilities in education program. Some participants also cited programmes related to pollution control, noise control, accident prevention and government provided free and accessible health care. About 35% knew about vaccination program. In employment arena they know little about the programmes providing skill generating programs or training (26%), quota in government jobs (about 29%), and micro-credit with special focus on disabled women.

POSSIBLE MEASURES FOR PWDS

Participants believe that disable should be treated as a part of the society. They should be given special and extra preferences such as security on road, reserve seat in the public transport like bus, train etc., separate hospital, health centre, and education facilities. A participant said that, we should behave well because they are dependent and should give equal opportunities in education, health and other facilities. He thought that we should treat them as friend because they are destitute. Another participant thinks that if the disable have the quality to do with a job then they should get the job. Disable person should be given nutritious and delicious food and no one should do injustice to them. Many people propose to give interest free loan, Donation from the poor fund and establish aid organisation in every thana, district, and division.

Required Programs for PWDs

Though The FGD participants are sometimes aware of the various programs to prevent disability as we have mentioned earlier, many of them have not proper conceptions about disability and disability programs. Thus, there remains a need to more awareness program to improve the situation, opined a number of participants. FGD participants thought the following programmes would provide support to persons with disabilities. The sectoral policy recommendations from the FGD discussion can be summarized as--

1. In education and awareness raising
    - Inclusion of disabled children and adults in education programs
    - Home based education
    - Develop education for all to remove the superstitious believes
    - Increase peoples' awareness on disability issues through meeting, seminar and symposium.

2. In health sector
    - Increase health consciousness among the people.
    - Awareness on nutritional food practices
    - Prenatal care, safe delivery, post natal care program
    - Vitamin supplements, capsule, vaccine, balanced diet, nutrition status program
    - Ensure proper growth of child and proper treatment.
    - Stop child-marriage

3. In case of employment
    - Establish separate training centre for persons with different disabilities
    - Micro-credit targeted towards women with disability
    - Rehabilitation services
    - Quota system for the disabled in government service and private services

4. Accessibility to services

- Ensure disability-friendly public places, social amenities, municipal buildings, public transport and transport terminals
- Ensure proper livelihood for the disabled

KEY FINDINGS

The content of this chapter is derived from FGDs carried out throughout the country attempted to find out a real picture of the people's knowledge, attitude and practice towards the PWDs. The key finding of the chapter is given below.

Knowledge about disability

- A good number of respondents (78%) claimed that they have knowledge about disability but again a major portion among them responded in the FGD that they have very cursory knowledge about the issues relating to disability. A gulf of difference is found between the knowledge and attitudes of the respondents towards PWDs.

- While responding to the cause of disability, majority blamed to the *Congenital and birth problem is the principal cause of disability. About 17% expresses that the reason is a result of diseases and 16% claims the disability as a result of accident. About 15% have their opinion on God's will.*

- It is observed that *96.8 % people did not know whether there were initiatives taken by the policymakers or local government bodies, chairman, member etc, MP, Ministers for prevention of disability.* 78.8 % individuals opined that they did not have any idea whether disable people were getting help from any organisation. Most of the respondents replied that the PWDs get help from their own family. About 73 percent of them knew that PWDs did not get any health care facility.

- The FGD participants thought that *if PWDs have no job then they remain burden for the society*. So the disabled need skill generating programmes or training, micro credit, specialised programmes for the women with disability, rehabilitation services, and establishment of quota for the PWDs in government employment with punitive action for non-compliance, they suggested.

- In education sector they know about inclusion of disabled children and adults in education programs, and establishing special education schools for children with special needs. *About 38% know inclusion of disabled in education program.* In health sector, there are some degree of awareness on preventing disability through pre-natal and delivery related health care, polio, leprosy, and epilepsy treatment, removal of vitamin deficiency and iodine deficiency. Some participants also cited programmes related to pollution control, noise control, accident prevention and government provided free and accessible health care. About 35% knew about vaccination program. In employment arena they know little about the programmes providing skill generating programs or training (26%), quota in government jobs (about 29%), and micro-credit with special focus on disabled women.

Attitudes and practice towards PWDs

- While responding to the attitude of people towards the PWDs It is observed that about *55% respondents accept disables well and about 20% give extra privilege to the disables. Very few are found behave roughly with the disables.* When asked, is *social relation with the disable people permissible, most of the participant would permit to make friendship with the disable but never permits to marry.* Few people think that if such environment is created, only then they agree but did not mention what's the environment. Many people think that disables are outcast, so the social relation with them is untenable and nobody wanted to talk details about this. Only a few people say that if their children agree to marry a disable person then they don't mind because they will maintain their family.

- *The majority of respondents (63 percent) think that PWDs are not burden to the family.* They should get extra security on road, reserve seat in the public transport like bus, train etc., separate hospital, health centre, and in schools, these are the attitude that should prevail in the society, FGD participants opined. According to a participant, even an educated person also badly treats disable persons. No one wants to make relationship with any disable person.

- When asked, whether disable people be given extra preference, they were of the view that they should give extra preference, *in that case government and rich persons should come first,* speaks the FGD participants they should be given monthly allowance (300-500Tk.) for disability Many people propose to give interest free loan, extra preference in education system, Donation from the poor fund and establish aid organisation in every thana, district, and division. *Government should enlist the disable person and also manage their better treatment.* One person in Mirpur expresses that, disabled persons should get registered and then considering their problem and counting their ability they should get extra preference. Government should make employment opportunity and give extra facility in social and other organisational field. They should get opportunity through free of cost schooling and priority in medical treatment. Disable shouldn't get equal opportunity because they have not equal quality like an able person.

CHAPTER VII
EXTRAPOLATION FROM SURVEYS AND CONCLUSION

FINDINGS FROM THE PREVALENCE AND KAP SURVEYS: A SUMMING UP

Distorted and fractured understanding

The understanding on disability issues, its measurement, causes and its implication, as a relative term of restriction of the ability to perform a normal human activity, is beset with problems, including the lack of reliability and validity of the instruments, most of which are poorly standardized and produce non-comparable estimates. Accordingly, the knowledge about disability *per se* in Bangladesh has been limited: existing figures are sketchy – and limited, by and large, to very divergent rough estimates based on targeted surveys. The distorted and fractured understanding on disability prevalence and knowledge, attitude and practices on disability has been significant factors leading to the neglect of disability issues. Development agenda of the country in effect left untouched the issue of civil, cultural, economic, political and social rights of persons with disabilities. Felt with the current knowledge gap, which exists on the prevalence of disability and need to address and protect rights of the parsons with disabilities, the current study has for the first time put a national disability prevalence rate of 5.6 percent based on nation wide survey.

Lower education and lower income level

PWDs have lower education and income levels than the rest of the population. They have incomes below poverty level, and less likely to have savings and other assets than the non-disabled population. Analysis of the study result shows that higher disability rates are associated with higher illiteracy, poor nutritional status, higher unemployment and underemployment rates, and lower occupational mobility.

Higher prevalence on rural areas

It has been argued in a number of studies done elsewhere that the prevalence of disability is likely to be higher in urban than in rural areas because of greater risk of injury from accidents, the pull factor of services, institutions and medical care, the existence of sedentary jobs and the possibility of begging. The study findings in contrast indicate that Bangladesh has a higher proportion of PWDs in rural areas. Urban/rural differences tend to remain when age and sex are taken into account.

Disability positively correlates with age

The age-structure of disabled persons is predominantly elderly, although it is seen that disability affects all ages to a greater degree. Age specific disability rates increase with age, and the severity of disablement also increases with age.

The study found that disability rates for women lower than men. Lower female rates indicate that severe impairments may be male-dominated, and/or females with disabilities may be under-reported or may receive less care and die sooner. For the childbearing age groups, female rates tend to be slightly higher, possibly because of ill health resulting from too many pregnancies, inadequate health and medical care, and poor nutrition.

Disability stems from Preventable impairment

There is relatively little information about the prevalence, incidence or epidemiology of disabling diseases. The proportion of disability caused by communicable, maternal and pre-natal diseases and injuries and the proportion of childhood disability are higher. Much of the disability identified in the prevalence survey stems from preventable impairments, and a large part of the disability could be eliminated through treatment or alleviated through rehabilitation. Poor households do not have adequate food, basic sanitation, and access to preventive health care. They live in lower quality housing, and work in more hazardous occupations. Malnutrition can cause disability as well as increase susceptibility to other disabling diseases. Lack of adequate and timely health care can exacerbate disease outcomes, and a remedial impairment can become a permanent disability.

Stigmatised Social Attitude restricts Basic services

PWDs are not recognized in society as full members to be taken into account on equal terms with others. Public awareness is still weak. Awareness of the abilities of PWDs is particularly weak and overshadowed by prejudice and ignorance. Further to this, awareness on disability issues rarely translates into practices promoting rights of persons with disability.

Disability seen as a family 'burden'

Disability affects the non-poor as well as the poor and the social and economic costs of a disability differ according to social or ethnic group, gender, age and economic status. Poverty renders people in a precarious and unhealthy living and working environments. It causes disabling illnesses that would be preventable at a relatively low cost. Long lasting or permanently disabling illness of any member exposes the whole family to a high risk of falling into poverty. Any social, economic, or environmental shock hits harder those people who are already vulnerable and have fewer resources to cushion themselves against the consequences or to cope with the consequences. The presence of poverty and disability in combination destroys the lives of people with impairments and impose burdens on their families that are too crushing to bear. Disability increases dependence, not only among children and the elderly, but also among adults of working age. It also forces those on whom the disabled person depends to be more socially dependent in turn.

Poverty and disability reproduces each other

Poverty and disability seem to be inextricably linked. Poverty is both a cause and consequence of disability, reinforcing each other and contributing to increased vulnerability and exclusion. It is noted that PWDs are poorer, as a group, than the general population, and that people living in poverty are more likely than others to be disabled. Well-being is associated with the ability to work and fulfill various roles in society. While their employment levels and incomes tend to be only a fraction of that of non-disabled people, they also are deprived from participation and opportunities available to others. Many physical, social and attitudinal barriers restrict their access to basic services. PWDs are very likely to be disempowered and excluded in their societies. Since, PWDs are by any indicator poorer than the non-disabled sections of the population, for many, lifetime exclusion is the only option available from childhood onwards.

Inaccessibility marginalises the disabled
Poor accessibility of the built environment restricts normal daily activities and renders PWDs "invisible". New infrastructure development continues to be done without sufficient consideration to accessibility. Inaccessibility is prominent in public transportation, public buildings and communication.

There is a general scarcity of education opportunities for the people with special needs Disabled girls are even worse off than boys. Lack of access to education leads to lack of access to work or poor quality jobs and poor livelihoods and subsequently to lifelong poverty. PWDs – whatever their capabilities – lack access to vocational training and are often trained into trades for which there is no demand or that do not provide decent livelihoods. Access to self-employment is also limited by lack of access to credit and other support services. Employers' awareness of PWDs' abilities is also poor and tends to enforce marginalization.

ehabilitation services neither accessible nor affordable
Most of the rehabilitation services are not accessible or affordable to the majority of PWDs, particularly for those living in rural areas. Also, the quality of existing services is sometimes poor. Access to low-cost and appropriate assistive devices is very limited and the cost renders PWDs dependent on their families. Persons with disabilities have unique differences and abilities. The right to work and right in work is based on disabilities not on their abilities.

Organisation of the disabled in its infancy
The organizations of PWDs themselves have yet to prove to be effective in improving the visibility status and opportunities of PWDs. There has been no substantial mark difference in policies geared to needs of the persons with disabilities. Legislation is still underdeveloped. In several cases, policies and legislation discriminate against people with disabilities or restrict their participation. Women with disabilities are particularly affected and subjected to discrimination, violence and abuse. Policy implementation is deficient, as the governmental mechanisms do not function effectively and do not respond adequately to the needs of PWDs. Thus, issues of concern for persons with disability still remains in the domain of potential and possible and mainly viewed as a charity not as rights as citizen.

Scanty public sector involvement
Without income promotion and protection and other public sector programmes the disabled in poor families are usually the responsibility of their families; without family support, a disabled person's condition can be very precarious. Till now, families play a major role in preventing poverty among the elderly through shared living arrangements. Certain groups within the disabled population are more vulnerable to the risk of poverty, including the elderly, those with mental handicaps, and women. Disabled girls receive less care and food, and have less access to health care and rehabilitation services and fewer education and employment opportunities. They also tend to have lower marriage prospects than disabled men, and can be at risk of being abused physically and mentally.

CONCLUSION

Society is disabling

It is society, which is disabling rather than people who are disabled. Development means the social change, which weakens forces disabling people, households and classes. The disability raises fundamental questions about human welfare – for example, rights and citizenship, the material and social conditions from freedom, the exercise of agency and enjoyment, the question of the class-space assumed in the notions of participation and integration.

Disability is a cross-class phenomenon, even if relations of disability manifest themselves differently by class. The relations of disability are reinforced by social divisions of labour and by ideologies, which appear natural but are in fact historically constructed. Disability is stigmatising regardless of economic status.

Preventing Disabling Conditions

Poverty increases the risk factors such as communicable diseases, poor nutrition, hazardous living and working conditions, etc. PWDs, in turn, are handicapped in society due to physical, social and cultural barriers that prevent them from fully and equally participating in social, economic, political and cultural activities The resulting dependency and marginalization of a disabled member in a family in the end affect the quality of life and opportunities of whole family. Furthermore, people who live in poverty have few opportunities to protect themselves from the consequences of eventual disability.

Measures targeted to disabled persons are necessary only when there are special needs to be addressed. While there is a need to increase specific measures to cater to the needs of PWDs, such as special schools for the severely disabled. Preventing the incidence of disability can be done in the framework of general programs to improve health and living environments.

Prevention of disabling conditions should be adopted as a central social and health consideration in all sectors. Accessibility should be taken as a central and natural quality criterion in infrastructure development. The consideration of the disability dimension in policies towards "basic societal services for all" should be a standard practice.

Ensuring meaningful participation of PWDs

Participation of persons with disabilities in public policy making and implementation is seen as essential to poverty reduction, and ensuring their rights. As PWDs are predominantly poor and marginalized in society, it is, at times, necessary to first support the organizing of people with disabilities in order to make them "visible" and to empower them to make their voices heard. Exclusionary policies not only put pressure on the country in socio-economic terms but also results in psychological barriers for persons with disabilities in exploring full potentials. Thus, investments for lifetime productivity and contribution to the society are required. Some PWDs may require specialised support services, assistive devices or job modifications, but more importantly, right of PWDs to decent work need to be recognised. They should be able to choose what they want to do based on their abilities, not on their disabilities. The condition in work and at work must be geared towards conditions of freedom, equity, security and human dignity.

Need for institutional engineering

The constraints on PWDs as activists are far greater and more debilitating than other groups. If development is self-realisation through social agency as well as material improvement, then the condition of PWDs provides sets of sensitive indicators. Responses to the issues of concern of PWDs requires changes in public policies. Public policies need to be packaged in such a manner as to establish a logical path to escape from poverty and vulnerability. Gender disparity and the rights and potential of children with disabilities require special attention. While, approaches towards social capital investment in development efforts by encouraging the widening of social responsibility and networks need to be developed, support services for PWDs need to be provided across a range of government departments.

The challenge of integrating and including persons with disabilities in the development agenda calls for policies guided by standard rules on the equalization of opportunities for disabled persons. Disability concerns should not be left to the social welfare sector alone. Rather, every sector has a primary responsibility for the disability issues arising in the sector concerned. The awareness of planners and government agencies of the existence and needs of PWDs in their target groups should be improved. The orientation of development support should be systematically geared towards an enabling and empowering approach rather than a passive safety net approach that does not involve support for efforts to escape from poverty, disability and vulnerability nexus exist in the country.

ANNEX Chapter 3

Annex Table 3.1 Housing characteristics, level of food consumption

	Area of Residence		
Roof of the House	Urban	Rural	Total
Katcha (Bamboo/Thatch)	5.9	9.6	8.6
Tin	36.3	85.7	73.3
Cement/Concrete/tiled	57.9	4.5	17.9
Others	.0	.2	.1
Total	100.0	100.0	100.0
Number	598	1784	2382
Wall of the House			
Katcha (Jute/Bamboo/Mud)	5.5	42.2	33.0
Wood/Tin	12.1	45.9	37.4
Cement/Concrete/tiled	82.4	11.6	29.4
Others (specify)	.0	.3	.3
Total	100.0	100.0	100.0
Number	601	1784	2385
Floor of the House			
Katcha (Earth/Bamboo/Mud)	8.0	85.0	8.0
Rudimentary Floor	2.3	1.2	2.3
Cement/Concrete/tiled	89.3	13.0	89.3
Others (specify)	.3	.7	.3
Total	100.0	100.0	100.0
Number	600	1784	600
Household according to food Consumption			
Deficit in whole year	4.8	19.8	4.8
Sometimes deficit	18.5	35.4	18.5
Neither deficit nor surplus	56.8	31.1	56.8
Surplus	19.9	13.7	19.9
Total	100.0	100.0	100.0
Number	599	1792	599
Toilet Facility			
Septic tank/Modern toilet	85.3	19.0	35.6
Pit toilet/latrine	1.8	15.3	11.9
Water sealed /slab-latrine	11.2	47.1	38.1
Open latrine	.7	7.6	5.9
Hanging latrine	.3	2.3	1.8
No facility/Bush/field	.7	8.8	6.8
Total	100.0	100.0	100.0
Number	599	1793	239

Annex Table 3.2: Household durable goods and land ownership

Ownership	Area of residence		Total
	Urban	Rural	
Almirah (Wardrobe)	84.2	52.7	60.7
Cot/Wooden Bed	98.8	96.3	96.9
Table, chair or bench	94.0	85.5	87.6
Watch or clock	91.3	59.8	67.8
Radio that is working	55.9	36.5	41.5
Television	75.2	21.5	35.0
Refrigerator	42.6	7.3	16.3
Bicycle	27.5	20.6	22.3
Motorcycle	16.1	6.8	9.2
Sewing machine	29.8	10.0	15.1
Tube well	48.1	40.5	42.4
DVD player	20.0	6.3	9.8
VCR/VCP	18.3	4.7	8.1
Land Ownership			
Own any homestead	74.4	79.9	75.9
Own any other land	35.3	50.5	46.6
Number of HHs	601	1763	2364
Income			
Less than 1000	.2	3.7	2.8
1000-3000	10.9	44.3	35.9
3001-5000	16.9	13.4	14.2
5001-7000	9.5	4.5	5.8
7001-10000	17.3	5.0	8.1
10000+	19.3	3.7	7.6
Unwilling to say	26.0	25.5	25.6
Mean income	7687.10	3259.62	
Number	100.0	100.0	100.0
Total	597	1775	2372

Annex Table 3.3 Information on socio-demographic condition of the respondents

Age of the Respondents	No. of Respondents	Percent
0-5	15	0.6
6-15	265	11.0
16-30	922	38.4
31-50	823	34.3
51-64	215	9.0
64+	156	6.5
System Missing	4	0.2
Total	2400	100.0
Category of the Respondents		
Under 18	461	19.2
Adult	1778	74.1
Old	157	6.5
System Missing	4	.2
Total	2400	100.0
Sex of the Respondents		
Male	1595	66.5
Female	805	33.5
Total	2400	100.0
Occupation of the Respondents		
Government employee	88	3.7
Non-government employee	101	4.2
Business	306	12.8
Lawyer	12	0.5
Farmer	338	14.1
Fishing	23	1.0
Labour	41	1.7
Student	477	19.9
Unemployed	127	5.3
Self-employed	24	1.0
Housewives	555	23.1
Retired	23	1.0
Agricultural Labour	8	0.3
Teacher	102	4.3
Doctor	26	1.1
Politician	17	0.7
Others	125	5.2
System Missing	7	0.3
Total	2400	100.0
Urban-rural classification of the Respondent		
Urban	604	25.2
Rural	1786	74.4
System Missing	10	0.4
Total	2400	100.0
Geographical Taxonomy of the Respondent		
Hill Tracts	143	6.0
Char or Haor	72	3.0
Coastal	293	12.2
Plain land	1884	78.5
System Missing	8	0.3
Total	2400	100.0

Religion of the Respondents		
Muslim	2054	85.6
Hindu	255	10.6
Buddhist	72	3.0
Christian	2	0.1
System Missing	17	0.7
Total	2400	100.0
Ethnicity of the Respondents		
Bengali	2315	96.5
Tribal	73	3.0
Others	3	0.1
System Missing	9	0.4
Total	2400	100.0
Respondents' locality		
Served Area	400	16.7
Non-served Area	1987	82.8
System Missing	13	0.5
Total	2400	100.0
Distance of non-served area from served area		
Less than 5 km	308	15.5
5-10	56	2.8
10+	608	30.6
Observation Unavailable	1015	51.1
Total	2400	100.0
Respondents' family with disability perspective		
Family with Disable	522	21.8
Family without Disable	1861	77.5
System Missing	17	0.7
Total	2400	100.0
Respondent Group		
Child with disability	70	2.9
Child without disability	296	12.3
Adult with disability	236	9.8
Adult without disability	1408	58.7
Local political leaders/Influential person	101	4.2
Different Service providers (either public or private)	40	1.7
Government officials	219	9.1
System Missing	30	1.3
Total	2400	100.0

ANNEX Chapter IV

Annex Table 4.1 Disability Prevalence by geographical taxonomy and socio-ethnic divide

Geographical Variation	Disability Status		Total	Number
	Non-disable	Disable		
Area of Residence				
Urban	95.8	4.2 (135)	100.0	3210
Rural	94.0	6.0 (591)	100.0	9809
Divisions				
Barishal	93.6	6.4 (133)	100.0	2086
Chittagong	95.8	4.2 (93)	100.0	2194
Dhaka	91.8	8.2 (176)	100.0	2143
Khulna	95.7	4.3 (83)	100.0	1921
Rajshahi	94.0	6.0 (141)	100.0	2332
Sylhet	95.7	4.3 (100)	100.0	2343
Geographical Area Pattern				
Hill Tracts	97.2	2.8 (16)	100.0	572
Char or Haor	93.3	6.7 (42)	100.0	630
Coastal	96.3	3.7 (62)	100.0	1672
Plain land	94.0	6.0 (606)	100.0	10137
Religion				
Muslim	94.3	5.7 (661)	100.0	11933
Hindu	95.6	4.4 (35)	100.0	796
Buddhist	96.5	3.5 (10)	100.0	286
Christian	100.0	.0	100.0	4
Ethnicity				
Bengali	94.4	5.6 (716)	100.0	12721
Tribal	96.2	3.8 (10)	100.0	262
Others	100.0	.0	100.0	29
Area of Disability Service				
Served Area	95.7	4.3 (89)	100.0	2049
Non-served Area	94.2	5.8 (637)	100.0	10970
Total Number	12293	726		13019
Percentage Total	94.4	5.6	100.0	

Annex Table 4.2 Percentage distributions of disables by disability type according to geographical variation

Geographical Variation	Disability type						
Area of Residence	Hearing	Visual	Speech	Physical	Intellectual	Multiple	**Total**
Urban	14.1%	26.7%	5.9%	31.9%	12.6%	15.6%	100.0%
	(19)	(36)	(8)	(43)	(8)	(21)	135
Rural	19.6%	33.5%	3.4%	26.9%	5.4%	13.4%	100.0%
	(116)	(198)	(20)	(159)	(19)	(79)	591
Divisions							
Barishal	13.5%	39.1%	3.8%	26.3%	3.8%	14.3%	100.0%
	(18)	(52)	(5)	(35)	(4)	(19)	133
Chittagong	19.3%	31.2%	7.5%	30.1%	2.2%	9.7%	100.0%
	(18)	(29)	(7)	(28)	(2)	(9)	93
Dhaka	18.2%	36.4%	4.5%	22.7%	8.5%	15.4%	100.0%
	(32)	(64)	(8)	(40)	(5)	(27)	176
Khulna	22.9%	19.3%	1.2%	38.6%	8.4%	12%	100.0%
	(19)	(16)	(1)	(32)	(5)	(10)	83
Rajshahi	19.1%	31.2%	3.5%	27.0%	5.7%	15.6%	100.0%
	(27)	(44)	(5)	(38)	(5)	(22)	141
Sylhet	21.0%	29.0%	2.0%	29.0%	6.0%	13.0%	100.0%
	(21)	(29)	(2)	(29)	(6)	(13)	100
Geographical Taxonomy							
Hill Tracts	18.8%	18.8%	6.3%	18.8%	6.3%	31.3%	100.0%
	(3)	(3)	(1)	(3)	(1)	(5)	16
Char or Haor	16.7%	38.1%		28.6%	7.1%	14.3%	100.0%
	(7)	(16)		(12)	(1)	(6)	42
Coastal	11.3%	24.2%	11.3%	45.2%	1.6%	6.5%	100.0%
	(7)	(15)	(7)	(28)	(1)	(4)	62
Plain land	19.5%	33.0%	3.3%	26.2%	7.3%	14.0%	100.0%
	(118)	(200)	(20)	(159)	(24)	(85)	606
Religion							
Muslim	18.4%	32.3%	3.8%	27.9%	7.0%	13.8%	100.0%
	(125)	(220)	(26)	(190)	(26)	94	681
Hindu	20.0%	34.3%	5.7%	31.4%		8.6%	100.0%
	(7)	(12)	(2)	(11)		(3)	35
Buddhist	30.0%	20.0%		10.0%	10.0%	30.0%	100.0%
	(3)	(2)		(1)	(1)	(3)	10
Christian							0
Ethnicity							
Bengali	18.4%	32.4%	3.9%	28.1%	6.7%	13.6%	100.0%
	(132)	(232)	(28)	(201)	(26)	(97)	716
Tribal	30.0%	20.0%		10.0%	10.0%	30.0%	100.0%
	(3)	(2)		(1)	(1)	(3)	10
Area under Disability Service							
Served Area	11.2%	29.2%	7.9%	30.3%	12.4%	18.0%	100.0%
	(10)	(26)	(7)	(27)	(3)	(16)	89
Non-served Area	19.6%	32.7%	3.3%	27.5%	6.0%	13.2%	100.0%
	(125)	(208)	(21)	(175)	(24)	(84)	637
Total Number	135	234	28	202	49	78	726
Percentage Total	18.6%	32.2%	3.9%	27.8%	6.7%	10.7	100.00

Annex Table 4.3: Disability Prevalence by Socio-demographic characteristics

Characteristics	Disability Status			Total	Number
	Non-disable (%)	Disable (%)	No. of disable		
Age					
0-5	98.0	2.0	28	100.0	1367
6-15	96.5	3.5	106	100.0	2998
16-30	97.0	3.0	126	100.0	4193
31-50	93.4	6.6	201	100.0	3040
51-64	86.6	13.4	109	100.0	815
64+	73.6	26.4	156	100.0	590
Total			726		
Education (Year of schooling)					
No Education	90.7	9.3	363	100.0	3888
1-4	95.8	4.2	89	100.0	2110
5-9	95.1	4.9	183	100.0	3707
10-12	97.1	2.9	70	100.0	2374
12+	98.0	2.0	19	100.0	927
System missing			2		
Total			726		
Sex					
Male	94.0	6.0	406	100.0	6797
Female	94.9	5.1	320	100.0	6222
Total			726		
Marital Status					
Unmarried	96.7	3.3	208	100.0	6364
Married	93.0	7.0	438	100.0	6249
Others	80.2	19.8	77	100.0	388
System missing			3		
Total			726		
Income					
Less than 1000	86.5	13.5	38	100.0	282
1000-3000	93.2	6.8	292	100.0	4296
3001-5000	94.7	5.3	98	100.0	1849
5001-7000	95.8	4.2	32	100.0	771
7001-10000	96.5	3.5	43	100.0	1219
10000+	96.6	3.4	40	100.0	1174
Unwilling to say	94.7	5.3	175	100.0	3302
Missing			8		126
Total Number	12293	726	726		13019
Percentage Total	94.4	5.6		100.0	

Annex Table 4.4 Disability Prevalence by Type and Socio-demographic characteristics

	Type of Disability							
	Hearing	Visual	Speech	Physical	Intellectual	Multiple	Total	Number
Age								
0-5	17.9	14.3	10.7	50.0		7.1	100.0	28
	(5)	(4)	(3)	(14)		(2)		
6-15	29.2	11.3	8.5	30.2	10.4	13.2	100.0	106
	(31)	(12)	(9)	(32)	(8)	(14)		
16-30	19.8	15.9	5.6	33.3	15.1	14.3	100.0	126
	(25)	(20)	(7)	(42)	(14)	(18)		
31-50	15.4	40.3	2.5	30.8	7.0	10.0	100.0	201
	(31)	(81)	(5)	(62)	(2)	(20)		
51-64	18.3	39.4	.9	24.8	2.8	14.7	100.0	109
	(20)	(43)	(1)	(27)	(2)	(16)		
64+	14.7	47.4	1.9	16.0	1.3	19.2	100.0	156
	(23)	(74)	(3)	(25)	(1)	(30)		
Education								
No Education	14.3	32.5	5.5	27.0	7.4	16.5	100.0	363
	(52)	(118)	(20)	(98)	(15)	(60)		
1-4	24.7	38.2	3.4	24.7	4.5	6.7	100.0	89
	(22)	(34)	(3)	(22)	(2)	(6)		
5-9	21.9	29.5	1.6	31.1	6.6	11.5	100.0	183
	(40)	(54)	(3)	(57)	(8)	(21)		
10-12	21.4	31.4	1.4	30.0	8.6	12.8	100.0	70
	(15)	(22)	(1)	(21)	(2)	(9)		
12+	31.6	26.3	5.3	15.8		21.1	100.0	19
	(6)	(5)	(1)	(3)		(4)		
Missing								2
Sex								
Male	18.7	28.3	4.2	28.3	8.9	14.3	100.0	406
	(76)	(115)	(17)	(115)	(25)	(58)		
Female	18.4	37.2	3.4	27.2	4.1	13.1	100.0	320
	(59)	(119)	(11)	(87)	(2)	(42)		
Marital status								
Unmarried	23.1	13.0	7.2	33.7	13.5	13.1	100.0	208
	(48)	(27)	(15)	(70)	(21)	(27)		
Married	17.6	40.0	2.7	25.6	4.3	13.0	100.0	438
	(77)	(175)	(12)	(112)	(5)	(57)		
Others	13.0	41.6	1.3	22.1	1.3	20.8	100.0	77
	(10)	(32)	(1)	(17)	(1)	(16)		
Missing							100.0	3
Income								
Less than 1000	15.8	34.2	0	34.2	2.6	13.2	100.0	38
	(6)	(13)		(13)	(1)	(5)		
1000-3000	18.8	31.2	3.4	28.8	6.2	14.7	100.0	292
	(55)	(91)	(10)	(84)	(9)	(43)		
3001-5000	19.4	36.7	3.1	30.6	5.1	6.1	100.0	98
	(19)	(36)	(3)	(30)	(4)	(6)		
5001-7000	18.8	50.0	3.1	15.6	0	12.5	100.0	32
	(6)	(16)	(1)	(5)		(4)		
7001-10000	20.9	27.9	7.0	18.6	9.3	18.6	100.0	43
	(9)	(12)	(3)	(8)	(3)	(8)		
10000+	17.5	37.5		17.5	10.0	20.0	100.0	40
	(7)	(15)		(7)	(3)	(8)		
Unwilling to say	18.9	28.0	6.3	28.6	9.1	14.8	100.0	175
	(33)	(49)	(11)	(50)	(6)	(26)		
Missing								8
Number	135	234	28	202	49	78		726
Total	18.6	32.2	3.9	27.8	6.7	10.7	100.0	

Annex Table 4.5 Percentage distribution of study population whether disable or not by Household (HH) characteristics

HH characteristics	Disability Status			Total	Number
	Non-disable (%)	Disable (%)	No. of disables		
HH Food consumptions					
Deficit in whole year	90.8	9.2	180	100.0	1949
Sometimes deficit	93.8	6.2	251	100.0	4029
Neither deficit nor surplus	96.3	3.7	180	100.0	4869
Surplus	94.8	5.2	111	100.0	2140
System missing			4		
HH items					
0-3	92.2	7.8	287	100.0	3683
4-6	94.6	5.4	275	100.0	5094
7+	96.2	3.8	161	100.0	4248
System missing			3		
HH own homestead Land					
No	94.6	5.4	263	100.0	4863
Yes	94.4	5.6	453	100.0	8096
System missing			10		
HH own land other than homestead					
No	93.9	6.1	385	100.0	6309
Yes	95.3	4.7	298	100.0	6344
System missing			43		
Housing Characteristics					
Roof					
Katcha (Bamboo/Thatch/Mud)	93.1	6.9	72	100.0	1040
Tin	94.2	5.8	553	100.0	9592
Cement/Concrete/tiled	95.7	4.3	99	100.0	2291
Others	100.0			100.0	11
System missing			2		
Wall					
Katcha (Jute/Bamboo/Mud)	93.5	6.5	274	100.0	4218
Wood/Tin	94.1	5.9	291	100.0	4893
Cement/Concrete/tiled	95.9	4.1	159	100.0	3854
System missing			2		
Floor					
Katcha (Earth/Bamboo)	93.6	6.4	546	100.0	8577
Rudimentary Floor	96.7	3.3	7	100.0	214
Cement/Concrete/tiled	95.9	4.1	171	100.0	4171
System missing			2		
Toilet Facilities					
Septic tank/Modern toilet	95.9	4.1	192	100.0	4736
Pit toilet/latrine	92.3	7.7	119	100.0	1553
Water sealed /slab latrine	94.3	5.7	278	100.0	4913
Open latrine	93.3	6.7	48	100.0	712
Hanging latrine	93.8	6.2	15	100.0	242
No facility/Bush/field	91.6	8.4	70	100.0	835
System missing			6		
Count	12293		726		13019
Total	94.4	5.6		100.0	

Annex Table 4.6 Information on types, severity, age of onset, causes and tools used to overcome of hearing impairment

	No. of Disabled	Percent	Valid Percent
Types of Hearing Impairment			
Problem in one ear	48	25.4	25.5
Problem in both ears (but hear loud sounds)	122	64.6	64.9
Not hear at all (deaf)	16	8.5	8.5
Others	2	1.0	1.1
System Missing	1	0.5	100.0
Total	189	100.0	
Severity of Hearing Impairment			
Mild	35	18.5	18.5
Moderate	91	48.1	48.1
Severe	49	25.9	25.9
Profound	14	7.5	7.5
Total	189	100.0	100.0
Age of onset of Hearing Impairment			
<=5	52	27.5	27.5
6-15	30	15.9	15.9
16-30	18	9.5	9.5
31-40	13	6.9	6.9
41-50	14	7.4	7.4
51-60	13	6.9	6.9
61+	18	9.5	9.5
Don't Know	31	16.4	16.4
Total	189	100.0	100.0
Causes of Hearing Impairment			
Disease	51	27.0	27.1
Accident	25	13.2	13.3
Congenital or birth problem	21	11.1	11.1
Complexity during delivery period	2	1.1	1.1
Natural aging	28	14.8	14.9
Malnutrition	2	1.1	1.1
Wrong treatment	3	1.6	1.6
Physical Abuse	2	1.1	1.1
Ignorance	3	1.6	1.6
Don't know	29	15.3	15.4
Heredity	1	0.5	0.5
Others	21	11.1	11.2
System Missing	1	0.5	100.0
Total	189	100.0	
Tools Used to Overcome the Hearing Impairment			
Hearing aid	7	3.64	3.93
Sign language	6	3.14	3.37
Nothing	165	85.93	92.70
System Missing	14	7.29	100.0
Total	192	100.00	

Table 4.7 The types, severity, age of onset and causes of speech impairment

Types of Speech Impairment	No. of Disabled	Percent	Valid percent
Cannot speak at all	22	43.2	43.2
Speak but problem in pronunciation and vocabulary	27	52.9	52.9
Others	2	3.9	3.9
Total	51	100.0	100.0
Severity of Speech Impairment			
Mild	8	15.7	15.7
Moderate	14	27.5	27.5
Severe	20	39.2	39.2
Profound	9	17.6	17.6
Total	51	100.0	100.0
Age of onset of Speech Impairment			
<=5	36	70.6	70.6
6-15	2	3.9	3.9
16-30	2	3.9	3.9
31-60	1	2.0	2.0
61+	1	2.0	2.0
Don't Know	9	17.6	17.6
Total	51	100.0	100.0
Causes of Speech Impairment			
Disease	8	15.7	16.3
Congenital or birth problem	34	66.7	69.7
Complexity during delivery period	1	2.0	2.0
Wrong treatment	1	2.0	2.0
Don't know	5	9.8	10.0
System Missing	2	3.9	100.0
Total	51	100.0	

Table 4.8 Types, severity, age of onset, causes and tools used to overcome of visual Impairment

Types of Visual Impairment	No. of Disabled	Percent	Valid percent
Visual deficiency one eye	38	10.8	10.8
Visual deficiency both eyes	149	42.5	42.5
Low vision	61	17.4	17.4
Cataracts	35	10.0	10.0
Night blindness	12	3.4	3.4
No vision one eye	24	6.8	6.8
No vision both eyes	17	4.8	4.8
Others	15	4.3	4.3
Total	351	100.0	100.0
Severity of Visual Impairment			
Mild	55	20.1	20.5
Moderate	102	37.4	38.0
Severe	83	30.4	31.0
Profound	28	10.3	10.5
System Missing	5	1.8	
Total	273	100.0	
Age of onset of Visual Impairment			
<=5	54	19.8	19.8
6-15	25	9.2	9.2
16-30	22	8.1	8.1
31-40	29	10.6	10.6
41-50	45	16.5	16.5
51-60	31	11.4	11.4
61+	35	12.8	12.8
Don't Know	31	11.7	11.7
Total	273	100.0	100.0
Causes of Visual Impairment			
Disease	40	14.7	14.8
Accident	20	7.3	7.5
Congenital or birth problem	15	5.5	5.5
Natural aging	114	41.8	41.9
Malnutrition	17	6.2	6.2
Complexity during delivery period	2	0.7	0.7
Wrong treatment	10	3.7	3.7
Physical Abuse	2	0.7	0.7
Ignorance	4	1.5	1.5
Heredity	1	0.4	0.4
Don't know	36	13.2	13.4
Others	10	3.7	3.7
System Missing	2	0.7	100.0
Total	273	100.0	
Tools Used to Overcome the Visual Impairment			
Optical device (Spectacles, magnifying glass, contact lens)	103	37.7	39.2
Non-optical device (colorful object, block etc.)	3	1.1	1.1
Nothing	153	56.0	58.2
Others	4	1.5	1.5
System Missing	10	3.7	100.0
Total	273	100.0	

Annex Table 4.9 Types, severity, age of onset, causes and tools of physical impairment

Types of Physical Impairment	No. of Disabled	Percent	Valid percent
Paralysis	47	17.7	17.7
Missing Limb or amputation	12	4.5	4.5
Dislocation	27	10.2	10.2
Physical Deformity (Congenital)	26	9.8	9.8
Polio victim/affected	16	6.0	6.0
Cerebral Palsy	14	5.3	5.3
Cleft lip/Palate	4	1.5	1.5
Club foot	5	1.9	1.9
Rickets (abnormalities in shape and structure)	5	1.9	1.9
Have permanently lost physical equilibrium	10	3.8	3.8
Leprosy	1	0.4	0.4
Arthritis	45	16.9	16.9
Burns	7	2.6	2.6
Jalmatha	2	0.8	0.8
Spina Bifida	7	2.6	2.6
Others	38	14.3	14.3
Total	266	100.0	100.0
Severity of Physical Impairment			
Mild	18	7.4	7.6
Moderate	77	31.8	32.6
Severe	103	42.6	43.6
Profound	38	15.7	16.2
System Missing	6	2.5	100.0
Total	242	100.0	
Age of onset of Physical Impairment			
<=5	82	33.9	33.9
6-15	23	9.5	9.5
16-30	37	15.3	15.3
31-40	21	8.7	8.7
41-50	26	10.7	10.7
51-60	22	9.1	9.1
61+	15	6.2	6.2
Don't Know	16	6.7	6.7
Total	242	100.0	100.0
Causes of Physical Impairment			
Disease	45	18.6	19.0
Accident	47	19.4	19.8
Congenital or birth problem	32	13.2	13.4
Natural aging	31	12.8	12.8
Malnutrition	6	2.5	2.5
Burn injury	4	1.7	1.7
Complexity during delivery period	4	1.7	1.7
Wrong treatment	9	3.7	3.7
Due to fatal accident	14	5.8	5.8
Don't know	35	14.5	14.7
Others	12	5.0	5.0
System Missing	3	1.2	100.0
Total	242	100.0	
Assistive Devices Used			
Wheel Chair	4	1.7	1.8
Crutches	7	2.9	3.2
Artificial Limbs	1	0.4	0.4
Nothing	169	69.8	77.9
Others	36	14.9	16.7
System Missing	25	10.3	100.0
Total	242	100.0	

Annex Table 4.10: Types, severity, age of onset and causes of intellectual impairment

Types of Intellectual Impairment	No. of Disabled	Percent	Valid percent
Lost mental balance (partially or wholly)	9	29.0	29.0
Slow learning	4	12.9	12.9
Slow Development	17	54.8	54.8
Others	1	3.2	3.2
Total	31	100.0	100.0
Severity of Intellectual Impairment			
Mild	2	6.5	6.9
Moderate	14	45.2	48.3
Severe	10	32.3	34.5
Profound	3	9.7	10.3
System Missing	2	6.5	100.0
Total	31	100.0	
Age of onset of Intellectual Impairment			
<=5	15	48.4	48.4
6-15	7	22.6	22.6
16-30	7	22.6	22.6
Don't know	2	6.5	6.5
Total	31	100.0	100.0
Causes of Intellectual Impairment			
Disease	3	9.7	12.0
Accident	3	9.7	12.0
Congenital or birth problem	12	38.7	48.0
Complexity during delivery period	2	6.5	8.0
Due to fatal accident	3	9.7	12.0
Don't know	1	3.2	4.0
Others	1	3.2	4.0
System Missing	6	19.4	100.0
Total	31	100.0	

Annex Table 4.11 Severity, age of onset and causes of mental disease

Severity of Mental Disease	No. of people suffering mental disease	Percent
Mild	2	10.0
Moderate	6	30.0
Severe	7	35.0
Profound	5	25.0
Total	20	100.0
Age of onset of Mental Disease		
<=5	4	20.0
6-15	3	15.0
16-30	6	30.0
31-40	2	10.0
51-60	2	10.0
Don't Know	3	15.0
Total	20	100.0
Causes of Mental Disease		
Disease	3	15.0
Accident	1	5.0
Congenital or birth problem	3	15.0
Wrong treatment	2	10.0
Due to fatal accident	3	15.0
Don't know	5	25.0
Others	3	15.0
Total	20	100.0

Annex Table 4.12: Availability, Accessibility and Affordability of Support Services

Meet with doctor for Impairment	No. of Disabled	Percent	Valid percent
No	210	28.9	31.1
Yes	466	64.2	68.9
Information unavailable	50	6.9	100.0
Total	726	100.0	
Result of Treatment			
Great improvement	39	5.4	8.6
Some Improvement	191	26.3	42.0
No change	176	24.2	38.7
Got Worse	45	6.2	9.9
Don't know	4	0.5	0.9
Information unavailable	271	37.3	100.0
Total	726	100.0	
Mode of treatment			
Oral medicine/medicine	355	49.4	49.4
Injection	96	13.4	13.4
Surgery	68	9.5	9.5
Physiotherapy	25	3.5	3.5
Homeopathy	45	6.3	6.3
Traditional healing	58	8.1	8.1
Herbal	02	0.3	0.3
Not mentioned	70	9.7	9.7
Total	719	100.0	100.0
Payment of treatment			
Self	149	29.9	29.9
Family	299	59.9	59.9
Doctor	18	3.6	3.6
Development organization	02	0.4	0.4
Relatives	12	2.4	2.4
Government	04	0.8	0.8
Community	10	2.0	2.0
Not mentioned	05	1.0	1.0
Total	499	100.0	100.0
Reason not to meet with doctor			
Due to economic hardship	155	28.3	62.5
Ignorance	18	2.5	7.3
Negligibility	38	5.2	15.3
Owing to wrong belief, Superstition	2	0.3	.8
Couldn't trace a specialist doctor	20	2.8	8.1
No availability of health service	6	0.8	2.4
Others	9	1.2	3.6
Sub-total	248	-	100.0
Information unavailable	478	65.8	
Total	726	100.0	
Get help from any Organization			
No	612	84.3	96.7
Yes	21	2.9	3.3
Sub-total	633	-	100.0
System Missing	93	12.8	
Total	726	100.0	

Types of help received			
Economic	10	50.0	50.0
Treatment	1	5.0	5.0
Food	5	25.0	25.0
Different equipment	2	10.0	10.0
Rehabilitation	1	5.0	5.0
Other	1	5.0	5.0
Total	20	100.0	100.0
Function in daily life			
Can function without help	444	61.1	67.8
Can't function without help	166	22.9	25.3
Other	45	6.2	6.9
Sub-total	655	-	100.0
System Missing	71	9.8	
Total	726	100.0	

ANNEX Chapter V

Annex Table 5.1 Knowledge of the respondents on disability issues

Idea about disability issues	No. of Respondents	Percent	Valid percent
No	521	21.7	21.7
Yes	1879	78.3	78.3
Total	2400	100.0	100.0
Knowledge about disability			
Very good	152	6.3	6.5
Good	521	21.7	22.2
Acceptable	850	35.4	36.3
Poor	822	34.3	35.0
System Missing	55	2.3	100.0
Total	2400	100.0	
Knowledge about disable existence in the community			
No	663	27.6	28.3
Yes	1679	70.0	71.7
System Missing	58	2.4	100.0
Total	2400	100.0	
Number of disables in the community according to respondent			
Don't know	624	26.0	33.7
Less than 5	714	29.8	38.5
5-10	304	12.7	16.4
11-15	91	3.8	4.9
15+	121	5.0	6.5
Information Unavailable	546	22.8	100.0
Total	2400	100.0	
Knowledge about causes of disability			
God's will	989	15.0	15.0
Curse on family	191	2.9	2.9
Due to disease	1113	16.9	16.9
Heredity	190	2.9	2.9
Due to accident	1047	15.9	15.9
Congenital or birth problem	1179	17.9	17.9
Natural Aging	192	2.9	2.9
Malnutrition	717	10.9	10.9
Wrong treatment	472	7.2	7.2
Ignorance	134	2.0	2.0
Negligence	166	2.5	2.5
Insolvency	136	2.1	2.1
Others	50	0.8	0.8
Total	6691	100.0	100.0
knowledge about the rehabilitation programs taken for the disabled			
No	1972	82.2	86.2
Yes	316	13.2	13.8
System Missing	112	4.7	100.0
Total	2400	100.0	

(a) Knowledge of rehabilitation programs in education			
Inclusion of disabled in education program	173	48.6	48.6
Home based education	33	9.3	9.3
Inclusion of disability into curriculum	24	6.7	6.7
Special education schools for disable	126	35.4	35.4
Total	356	100.0	100.0
(b) Knowledge of rehabilitation programs in health			
Prevention through: ANC,PNC etc.	148	27.4	27.4
Provide vaccination for polio, leprosy	195	36.1	36.1
Remove vitamin deficiency, iodine deficiency	88	16.3	16.3
Environmental/external pollution control	15	2.8	2.8
Free and accessible health care	94	17.4	17.4
Total	540	100.0	100.0
(c) Knowledge of rehabilitation programs in service			
Skill generating programs/training	74	25.0	25.0
Providing micro-credit on disabled women	92	31.1	31.1
Rehabilitation programs	58	19.6	19.6
Quota in Govt. jobs	72	24.3	24.3
Total	296	100.0	100.0
(d) Knowledge of rehabilitation programs in accessibility			
Ensured disabled in friendly public place	78	49.4	49.4
Ensured visually impaired in public place	80	50.6	50.6
Total	158	100.0	100.0
(e) Knowledge of rehabilitation programs-transportation			
Transport facilities for disabled student	63	65.6	65.6
Follow Prime Minister's Directives	33	34.4	34.4
Total	96	100.0	100.0
Prevention of disability			
No	789	32.9	40.4
Yes	1166	48.6	59.6
Observation Unavailable	445	18.5	100.0
Total	2400	100.0	
(a) Knowledge about method of disability prevention			
Prevent through ANC, PNC etc	842	28.3	28.3
Provide vitamin supplements/capsules/vaccine	779	26.2	26.2
Provide balance diet/improve nutrition s	533	17.9	17.9
Public awareness programs on electronic	363	12.2	12.2
Proper steps against natural disasters	73	2.5	2.5
Proper steps against accidents	381	12.8	12.8
Total	2971	100.0	100.0
Taken training to help disabled			
No	1910	79.6	97.3
Yes	53	2.2	2.7
Observation Unavailable	437	18.2	100.0
Total	2400	100.0	
Initiative taken by the policymakers or local government bodies, chairman, member etc, MP, Minister for prevention of disability			
No	1736	72.3	96.8
Yes	57	2.4	3.2
Information Unavailable	607	25.3	100.0
Total	2400	100.0	

Knowledge of getting help from Organization			
No	1483	61.8	78.5
Yes	405	16.9	21.5
Information Unavailable	512	21.3	100.0
Total	2400	100.0	
Sources from where disabled get help			
Family	180	44.4	44.4
Development organization	95	23.5	23.5
Relatives	9	2.2	2.2
Government	79	19.5	19.5
Community	12	3.0	3.0
Others	30	7.4	7.4
Total	405	100.0	100.0
Restrictions to get opportunity for disabled persons in any field			
No	746	31.1	41.0
Yes	552	23.0	30.4
Don't know'	520	21.7	28.6
Information Unavailable	582	24.3	100.0
Total	2400	100.0	
Sufficiency to get rehabilitation health care facilities			
No	1315	54.8	72.6
Yes	68	2.8	3.7
Don't know'	431	18.0	23.7
Information Unavailable	586	24.4	100.0
Total	2400	100.0	
Getting educational facilities			
No	1172	48.8	64.6
Yes	219	9.1	12.0
Don't know'	422	17.6	23.4
Information Unavailable	587	24.5	100.0
Total	2400	100.0	
Status of disables in the family			
Extra privileged	520	21.7	22.3
Well accepted (in indifferent way)	1433	59.7	61.4
Tolerated	355	14.8	15.2
Excluded	14	0.6	0.6
Rejected and stigmatized	12	0.5	0.5
Information Unavailable	66	2.8	100.0
Total	2400	100.0	
Status of disables in the society			
Extra privileged	473	19.7	22.9
Well accepted (in indifferent way)	1365	56.9	60.2
Tolerated	420	17.5	18.6
Excluded	17	0.7	0.8
Rejected and stigmatized	12	0.5	0.5
Information Unavailable	133	4.7	100.0
Total	2400		

Annex Table 5.2: Local names of persons with disabilities

	Hearing Impairment	Speech Impairment	Visual Impairment	Physical Impairment	Intellectual Impairment
Barisal	Kana, Bodhir, Boyra	Boba	Andha, Kana	Khora, Pongu, Langra, Lula	Boka, Haba
Chittagong	Boyra, Kala, Thanda.	Baha, Boba	Andha, Kana	Langra, Luja, Lula	Bakub, Haba, Habla, Moga, Soja
Dhaka	Boba	Kana	Andha	Langra, Lula	Haba, Habla
Khulna	Boyra, Kala	Boba	Andha, Kana	Khora, Langra, Lula	Pagol, Boka, Haba, Tar Chara
Rajshahi	Boyra, Tasa	Boba, Gonga, Kala	Andha, Kana	Khora, Langra, Lula, Nula	Boka, Haba, Pagla, Pagol
Sylhet	Kala, Atkal	Boba, Abor	Kana	Lula	Haba

Note: This is not a complete list rather indicative of uses of local names used to describe PWDs

Annex Table 5.3 Attitude of people towards disables

Behaviour to disabled person	No. of Respondents	Percent	Valid percent
Extra privileged	469	19.5	22.5
Well accepted	1319	55.0	63.2
Tolerated	267	11.1	12.8
Excluded	29	1.2	1.3
Roughly	4	0.2	0.2
Information Unavailable	312	13.0	100.0
Total	2400	100.0	
Treating disability as a curse			
No	1855	77.3	85.3
Yes	320	13.3	14.7
Information Unavailable	225	9.4	100.0
Total	2400	100.0	
Thinking disable people embarrassment /burden to the family			
No	1511	63.0	78.1
Yes	423	17.6	21.9
Information Unavailable	466	19.4	100.0
Total	2400	100.0	
Taking disabled in social programs			
No	467	19.5	25.0
Yes	1403	58.5	75.0
Information Unavailable	530	22.1	100.0
Total	2400	100.0	
Willingness to help the disabled			
No	745	31.0	37.0
Yes	1271	53.0	63.0
Information Unavailable	384	16.0	100.0
Total	2400	100.0	
Willingness to employ the disabled			
No	357	14.9	20.0
Yes	1430	59.6	80.0
Information Unavailable	613	25.5	100.0

Total	2400	100.0	
Willingness to make relationship with the disabled			
No	490	20.4	26.3
Yes	1370	57.1	73.7
Information Unavailable	540	22.5	100.0
Total	2400	100.0	
Thinking to give extra facilities to the disabled			
No	102	4.3	5.0
Yes	1911	79.6	95.0
Information Unavailable	387	16.1	100.0
Total	2400	100.0	
Thinking the basic needs for the disabled			
No	230	11.5	11.5
Yes	1765	73.5	88.5
Information Unavailable	405	16.9	100.0
Total	2400	100.0	

Annex Table 5.4 Practices by people regarding disability

Practice to buy food from disabled sales person with epilepsy	**No. of Respondents**	**Percent**	**Valid percent**
No	976	40.7	46.4
Yes	1127	47.0	53.6
Information Unavailable	297	12.4	100.0
Total	2400	100.0	
Practice to give equal opportunity to the disabled in the employment			
No	832	34.7	46.6
Yes	953	39.7	53.4
Information Unavailable	615	25.6	100.0
Total	2400	100.0	
Practice to accept marriage with visual impaired person			
No	808	33.7	44.2
Yes	1019	42.5	55.8
Information Unavailable	573	23.9	100.0
Total	2400	100.0	
Practice to support a special law about disabled person			
No	190	7.9	10.4
Yes	1643	68.5	89.6
Information Unavailable	567	23.6	100.0
Total	2400	100.0	
Practice to accept the disabled children as a classmate of own children			
No	223	9.3	12.4
Yes	1580	65.8	87.6
Information Unavailable	597	24.9	100.0

Total	2400	100.0	
Programs taken to prevent disability			
ANC,PNC etc	893	28.4	28.4
providing vitamin supplements/capsules	849	27.0	27.0
providing balanced diet/improvement of n	493	15.7	15.7
Public awareness programs on electronic	479	15.2	15.2
proper steps against natural disaster	106	3.4	3.4
proper steps against road accidents	326	10.4	10.4
Total	3146	100.0	100.0
Rehabilitation programs taken			
(a) Education			
Inclusion of disabled in education programs	271	37.7	37.7
Home based education	78	10.9	10.9
Inclusion of disability into curriculum	114	15.9	15.9
Special education schools for disable	255	35.5	35.5
Total	718	100.0	100.0
(b) Health			
Prevention through: ANC,PNC etc.	310	26.7	26.7
Provide vaccination for polio, leprosy; epilepsy	400	34.5	34.5
Remove vitamin deficiency, iodine deficiency	226	19.5	19.5
Environmental/external pollution control	81	7.0	7.0
Free and accessible health care	142	12.3	12.3
Total	1159	100.0	100.0
(c) Employment			
Skill generating programs/training	167	26.3	26.3
Providing micro-credit on disabled women	170	26.7	26.7
Rehabilitation programs	115	18.1	18.1
Quota in Govt. jobs	184	28.9	28.9
Total	636	100.0	100.0
(d) Accessibility			
Ensured disabled in friendly public places	224	50.7	50.7
Ensured visually impaired in public places	218	49.3	49.3
Total	442	100.0	100.0
Inclusion of the disabled in different policy design and process			
No	832	34.7	54.6
Yes	693	28.9	45.4
Information Unavailable	875	36.5	100.0
Total	2400	100.0	

APPENDIX

Appendix Table 1.1 Study Area and Sample Households

Sl. No	Division	District	Thana	Union/Municipality	Selected Village/ Ward	No. of existing HHs	No. of Sample HHs
1.	Barisal	Barisal	Barisal Sadar	Barisal Municipality	Ward no. 19 (Jhautola, Kalibari, Nutun Bazar, Nazir Mahulla, Purba B.M. College, Professor Para)	2488	100
2.		Pirojpur	Kawkhali	Kawkhali	Basuri	272	100
3.		Pirojpur	Kawkhali	Sayna Raghunathpur	Hogla	366	100
4.		Patuakhali (Costal area)	Dashmina	Bahrampur	Bahrampur	521	100
5.	Chittagong	Chittagong	Chittagong Port	Chittagong Municipality	Ward No. 39 (Dakshin Halishahar)	9118	100
6		Rangamati (Hill Tracks)	Rangamati Sadar Thana	Kalindipur	ward no -8	298	100
7.		Brahmanbaria	Banchharampur	Dariadaulat	Kalainagar	290	100
8.		Lakshmipur	Ramgati	Char Alexander	Asol Para	716	100
9.	Sylhet	Sylhet	Sylhet Sadar	Sylhet Municipality	Ward No. 4	5961	100
10.		Moulavibazar (Haor)	Kamalgonj	Shamsher Nagar	Badardeul	433	100
11.		Hobiganj	Hobiganj Sadar	Nizampur	Sayedpur	211	100
12.		Hobiganj	Hobiganj Sadar	Nurpur	Bisura	269	100
13.	Dhaka	Dhaka	Mirpur	Dhaka Municipality	Ward No. 8 (Ahmed Nagar, Co-operative Market, Dakshin Bishil, Dakshin Paikpara, Hazrat Shah Alibagh, Madhya Paikpara, Paikpara, Purba Kandar)	14137	100
14.		Faridpur	Alfadanga	Gopalpur	Bazra	256	100
15.		Sherpur	sreebardhi	Gosaipur	Rahamatpur	659	100
16.		Tangail	Ghatail	Deulabari	Porabari	354	100
17.	Khulna	Khulna	Daulatpur	Khulna Municipality	Ward No. 26 (Dakshin Pabla, Sk. Ayub Ali Rd., Daulatpur B.L. College)	3270	100
18.		Khulna	Dumuria	Bandarpara	Banda	375	100
19.		Kustia	Mirpur	Amla	Kachubaria	366	100
20.		Bagerhat	Bagerhat Sadar	Khanpur	North Khanpur	318	100
21.	Rajshahi	Rajshahi	Boalia	Rajshahi Municipality	Ward No. 13 (Futkipara, Kumarpara, Saheb Bazar, Sahebganj)	887	100
22.		Rangpur	Rangpur Sadar	Tapodhan	Ramgobindo	359	100
23.		Sirajgonj	Kamarkhanda	Bhadradhat	Nandina	313	100
24.		Nawabgonj	Gomastapur	Radhanagar	Rokanpur	354	100

Appendix Annex: 1.2 QUESTIONNAIRE FOR PREVALENCE SURVEY

Section 1: Basic Information

1. Household ID	
2. Name of the Respondent:……	A3 ☐
3. Division: 1=Barisal 2=Chittagong 3=Dhaka 4=Khulna 5=Rajshahi 6=Sylhet	A4 ☐
4. District:…… …… ….	A5 ☐
5. Thana……	A6 ☐
6. Union/Municipality……	A7 ☐
	A8 ☐
7. Village/Ward……	A9 ☐
8. Region…… 1=Urban 2=Rural……	A10 ☐
9. Area of residence……1=Hill Tracts 2=Char/Haor 3=Coastal 4=others……	A11 ☐
	A12 ☐
10. Religion: …… 1=Muslim 2=Hindu 3=Buddhist 4=Christian 5=others……	
11. Ethnicity ……1= Bengali, 2=Tribal, 3=Others……	
12. Disability served/non-served area: 1= Served area, 2= Non-served area……	

Date of Interview: ……

I declare hereby the information collected is true and accurate and these are collected in line with the training manual.

Name of Interviewer:…… Code: ☐

Signature of Interviewer:

Name of Supervisor :…… Code: ☐

Signature of Supervisor:

Section 2: Individual Information

Q1. Household Roster

First row is available for the Household head only
*****Columns 7 and 8 will be completed after completion of Section4***

1	2	3	4	5	6	**7	**8
SL. No.	Name	Sex Male=1 Female=2	Age in year	Marital Status Unmarried=1 Married=2 Others =3	Education (Year of schooling)	Status of disability Yes=1 No=0	*Type of disability
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							

No. of members in the HH: .....

*Type of disability:

1. Hearing impairment
2. Speech Impairment
3. Visual Impairment
4. Physical impairment
5. Intellectual Disability
6. Multiple Disability (if one have more than one Impairment)
7. Others (specify)
9. Not applicable

Section 3: Household Information

Q2 Does your household own any……..? *(Fill in the rectangle Yes=1 and No=0)*	
Q2a. Almirah ……..	**Q2a** ☐
Q2b. Cot/Bed……..	**Q2b** ☐
Q2c. Table, chair or bench…….	**Q2c** ☐
Q2d. Watch or clock ……	**Q2d** ☐
Q2e. Radio that is working…	**Q2e** ☐
Q2f. Television that is working……	**Q2f** ☐
Q2g. Refrigerator……..	**Q2g** ☐
Q2h. Bicycle……..	**Q2h** ☐
Q2i. Motorcycle ……..	**Q2i** ☐
Q2j. Sewing machine……	**Q2j** ☐
Q2k. Tube well ……..	**Q2k** ☐
Q2l. DVD player	**Q2l** ☐
Q2m. VCR/VCP……..	**Q2m** ☐

Q3. What are the main materials of your house?		
a) Roof *Record Observation*	Natural Roof Katcha (Bamboo/Tatch)--------11 Rudimentary Roof Tin ----------21 Finished Roof (Pakka) Cement/Concrete/tiled ----------31 Others (specify)----------96	**Q3a** ☐
b) Walls ***Record Observation***	Natural Walls Katcha (Jute/Bamboo/Mud)--------11 Rudimentary Walls Wood/Tin----------21 Finished Walls (Pakka) Cement/Concrete/tiled ----------31 Others (specify)----------96	**Q3b** ☐
c) Floor *Record Observation*	Natural Floor Katcha (Earth/Bamboo)--------11 Rudimentary Floor----------21 Finished Floor (Pakka) Cement/Concrete/tiled ----------31 Others (specify)----------96	**Q3c** ☐

Q4. Does your household own any homestead? Yes=1 No=0	**Q4** ☐
Q5. Does your household own any other land? **<u>if No go to Q7</u>** Yes=1 No=0	**Q5** ☐

Q6. If yes how much land does your household own (other than homestead)? Amount:. ……Acre. ……Decimal	Acre | Decimal
Q7. Would you please tell me your gross household income per month? Amount: …… (taka)	**Q7**
Q8. In terms of household food consumption, how do you classify your household; deficit in whole year; neither deficit nor surplus, surplus? (Circle the number) 1. Deficit in whole year 2. Sometimes deficit 3. Neither deficit nor surplus 4. Surplus	**Q8**
Q9. What kind of toilet facility does your household have? 1. Septic tank/Modern toilet 2. Pit toilet/latrin 3. Water sealed /slablatrin 4. Open latrin 5. Hanging latrin 6. No facility/Bush/field	**Q9**

Instructions

For answering every question, there are 3 (three) boxes in the right column. Fill in the first box for first disabled, second box for second one and so on if there are more than one disabled are found in the same household..

Section 4: Information on Disability Issues

4A: Hearing Impairment **Q10.** Does anybody in your household who has a problem in hearing? Yes……1 No……0 **if no go to section Q11** *If yes, probe: How many? Who are they? Then mark the disable persons in the section2*	**Q10**
Q10a. If yes, what kind of following problem of impairment is that? 1. Problem in one ear 2. Problem in both ears (but hear loud sounds) 3. Not hear at all (deaf) 4. Others	**Q10a**
Q10b.How can you rate the severity of his/her problem? 1. Mild 2. Moderate 3. Severe 4. Profound	**Q10b**
Q10c. At what age did you have this difficulty? Age in years …… [*If age was less than one year enter 00]* Don't know…… 888	**Q10c**
Q10d. Which one of the following is the **BEST** description of the cause of this: was it a 1. Disease 8. Wrong treatment 2. Accident 9. Physical Abuse 3. Congenital or birth problem 10. Ignorance 4. Complexity in delivery 11. Don't know 5. Natural aging 12. Heredity 6. Malnutrition 13. Others (Specify)…… 7. Burn injury	**Q10d**
Q10e. What type of instrument do you use in your daily life to overcome the difficulty? 1. Hearing aid. 2. Sign language 3. Communication board	**Q10e1** **Q10e2**

4. Nothing
5. Others (specify)…… …

4B. Speech Impairment

Q11. Does anybody in your household who cannot speak easily?
Yes……1
No……0 **if no go to Q12** **Q11** ☐☐☐

If yes, probe: How many? Who are they? Then mark the disable persons in the section2

Q11a. If yes, what kind of following problem of impairment is that? **Q11a** ☐☐☐
1. Cannot speak at all
2. Speak but problem in pronunciation and vocabulary
3. Others (specify)…… **Q11b** ☐☐☐

Q11b.How can you rate the severity of his/her problem?
1. Mild
2. Moderate
3. Severe
4. Profound **Q11c** ☐☐☐

Q11c. At what age did you have this difficulty?
Age in years……. [*If age was less than one year enter 00]*
Don't know…… 888

Q11d. Which one of the following is the best description of the cause of this: was it a
1. Disease
2. Accident
3. Congenital or birth problem
4. Natural aging
5. Malnutrition
6. Burn injury
7. Complexity in delivery
8. Wrong treatment
9. Physical Abuse
10. Shocking in fatal event
11. Mental abuse
12. Don't know
13. Others (Specify)…… **Q11d** ☐☐☐

Q12 ☐☐☐

4C: Visual Impairment

Q12. Does anybody in your household who has a problem in seeing?
Yes……1
No……0 **if No go to Q13** **Q12a1** ☐☐☐
If yes, probe: How many? Who are they? Then mark the disable persons in the section2

Q12a. If yes, what kind of following problem of impairment is that
1. visual deficiency one eye
2. visual deficiency both eyes
3. low vision?
4. Cataracts
5. Night blindness
6. No vision one eye
7. No vision both eyes
8. Others (specify)…… **Q12a2** ☐☐☐ **Q12b** ☐☐☐

Q12b.How can you rate the severity of his/her problem?
1. Mild
2. Moderate
3. Severe
4. Profound **Q12c** ☐☐☐

Q12c. At what age did you have this difficulty?
Age in years --------- [*If age was less than one year enter 00]*
Don't know------ 888

Q12d. Which one of the following is the best description of the cause of this: was it a **Q12d** ☐☐☐
1. Disease
2. Accident
3. Congenital or birth problem
5. Natural aging
5. Malnutrition
6. Burn injury
7. Complexity in delivery
8. Wrong treatment
9. Physical Abuse
10. Ignorance
11. Heredity
12. Don't know
13. Others (Specify)……

Q12e. Which type of visual aid/instrument do you use to overcome the problem in your daily life? **Q12e** ☐☐☐

1. Optical device (Spectacles, magnifying glass, contact lens)
2. Non-optical device
3. Nothing
4. Others (specify)……..

4D:Physical Disability

Q13. Does anybody in your household who has a physical problem? **Q13** ☐☐☐

Yes……..1
No……..0 **if no go to Q14**

If yes, probe: How many? Who are they? Then mark the disable persons in the section2

Q13a. If yes, what kind of following problem of disability is that? **Q13a1** ☐☐☐

1. Paralysis (Lost sensation partly or totally in either one or both hands, Lost sensation partly or totally in either one or both legs)
2. Missing Limb (Lost either one or both hand, Lost either one or both legs) **Q13a2** ☐☐☐
3. Dislocation (Displacement of any part, esp. the temporary displacement of a bone from its normal position in a joint.)
4. Physical Deformity (Congenital)
5. Polio victim/affected
6. Cerebral Palsy
7. Cleft lip/Palate **Q13a3** ☐☐☐
8. Club foot
9. Rickets (abnormalities in shape and structure of bones)
10. Have permanently lost physical equilibrium
11. Leprosy
12. Arthritis
13. Burns
14. Hydrocephalus
15. Spina bifida **Q13b** ☐☐☐
16. Others (specify)

Q13b.How can you rate the severity of his/her problem?

1. Mild
2. Moderate
3. Severe **Q13c** ☐☐☐
4. Profound

Q13c. At what age did you have this difficulty?

Age in years --------- [*If age was less than one year enter 00]*
Don't know------ 888 **Q13d** ☐☐☐

Q13d. Which one of the following is the best description of the cause of this: was it a

1. Disease
2. Accident
3. Congenital or birth problem
4. Natural aging
5. Malnutrition
6. Burn injury
7. Complexity in delivery
8. Wrong treatment
9. Physical Abuse
10. Ignorance
11. Mental abuse
12. Don't know
13. Others (Specify)…….. **Q13e** ☐☐☐

Q13e. Which type of aid/instrument do you use to overcome the problem in your daily life?

1. Wheel Chair
2. Crutches
3. Artificial limbs
4. Nothing

5. Others (specify)

Q13f. If you are using all these devices, are these imported, locally produced, home made?

1. Home made
2. Locally produced
3. others (specify)……..

Q13f

4E: Intellectual Disability

Q14

Q14. Does anybody in your household who has delay development, slow learning?
Yes……..1
No……..0 **if no go to Q15**

If yes, probe: How many? Who are they? Then mark the disable persons in the section2

Q14a

Q14a. If yes, what kind of problem of disability is it?
1. Lost mental balance (partially or wholly)
2. Slow learning
3. Slow Development
4. Others (specify)……..

Q14b

Q14b.How can you rate the severity of his/her problem?
1. Mild
2. Moderate
3. Severe
4. Profound

Q14c

Q14c. At what age did you have this difficulty?
Age in years --------- [*If age was less than one year enter 00]*
Don't know------ 888

Q14d. Which one of the following is the best description of the cause of this: was it a

Q14d

1. Disease
2. Accident
6. Congenital or birth problem
7. Natural aging
5. Malnutrition
6. Burn injury
7. Complexity in delivery
8. Wrong treatment
9. Physical Abuse
10. Ignorance
11. Mental abuse
12. Don't know
13. Others (Specify)……..

Q15

4F: Mental Illness

Q15. Does anybody in your household who has a mental problem (development delay, mental imbalance)?
Yes……..1
No……..0 **if no go to Q16**

If yes, probe: How many? Who are they? Then mark the disable persons in the section2

Q15a

Q15a.How can you rate the severity of his/her problem?
1. Mild
2. Moderate
3. Severe
4. Profound

Q15b

Q15b. How many years his/her problem starts?
Age: ----------(Year) [*If age was less than one year enter '00'*]
Don't know--------- 888

Q15c

Q15c. Which one of the following is the best description of the cause of this: was it a
1. Disease
2. Accident
3. Congenital or birth problem
4. Natural aging
5. Malnutrition
6. Burn injury
7. Complexity in delivery
8. Wrong treatment
9. Physical Abuse
10. Shocking n a fatal event
11. Mental abuse
12. Don't know
13. Others (Specify)……..

Q16. Does anybody in your household who has any other problem not yet mentioned? Yes=1 No=0 **Q16** ☐☐☐

If yes specify ----------.

Note: Now fill up the column 7 and 8 in section2

Section 5: General Information on disability **Q17** ☐☐☐

Q17. Did he/she meet with doctor for this problem?

Yes.....1

No.....0 **(if no, go to Q21)** **Q18** ☐☐☐

Q18. If yes what kind of treatment received?

1 Medicine
2. Injection
3. Surgery
4. Physiotherapy
5. Homeopathy
6. Traditional healing (Tabiz, Jharfooq, Kobiraj)
7. Herbal
8. Others (specify)

Q19 ☐☐☐

Q19. What is the result of treatment?

1. Great improvement
2. Some Improvement
3. No change
4. Got Worse
5. Don't know

Q20. Treatment cost paid by whom?

1. Self
2. Family **Q20** ☐☐☐
3. Doctor
4. Development organization
5. Relatives
6. Government
7. Community
8. Others (specify).....

Q21. Why didn't you go to a doctor for treatment?

1. Had economic hardship **Q21** ☐☐☐
2. Ignorance
3. Negligibility
4. Had wrong belief, Superstition
5. Couldn't trace a specialist doctor
6. No availability of health service
7. Others (specify)

Q22. Did you get any help for disability from any organization?

Yes.....1 **Q22** ☐☐☐

No.....0

Q23. If yes, what kind of help you got?

1. Economic
2. Treatment
3. Food **Q23** ☐☐☐
4. Instrument (wheel chair, sketch....)
5. Rehabilitation
6. Others

Q24. Can you function in daily life easily with / without any others help?

1. Can function without help
2. Can't function without help
3. Others (specify) **Q24** ☐☐☐

Appendix: 1.3 QUESTIONNAIRE FOR KNOWLEDGE, ATTITUDE AND PRACTICE (KAP) SURVEY

Section 1: Basic Information

1.Household ID	
2. Name of the Respondent (optional):.....	
3. Sex: ..... 1= Male, 2 = Female	A3
4. Age of the respondent: ..... (in years)	A4
5. Occupation of the Respondent:.....	A5
6. Division:...1=Barisal, 2=Chittagong, 3=Dhaka, 4=Khulna, 5=Rajshahi, 6=Sylhet.	A6
7. District:.....	A7
8. Thana:.....	A8
9. Union/Municipality.....	A9
10. Village/Ward.....	A10
11. Region:.....1= Urban, 2 = Rural.....	A11
12. Area of residence:...1= Hill tracts, 2 = Char/haor 3 = Coastal, 4 = Plain land...	A12
13. Religion: ..... 1=Muslim, 2=Hindu, 3=Buddhist, 4=others.....	A13
14. Ethnicity.....1= Bengali, 2=Tribal, 3=others.....	A14
15. Disability served/non-served area: 1= Served area, 2= Non-served area.....	A15
15.a. If it is 2, how is it far away from served area?.....	A15a
16. HH Type: .....1= Family with disability, 2 = Family without disability.....	A16

Date of Interview : .....

I declare hereby the information collected is true and accurate and these are collected in line with the training manual.

Name of Interviewer:..... Code:

Signature of Interviewer: .....

Name of Supervisor :..... Code:

Signature of Supervisor:.....

17. Respondent Group

1. Child with disability (Q: 1,2,7,9)
2. Child without disability (Q: 1,2,7,8,9,16a)
3. Adult with disability (Q: 1-7,11,14,15)
4. Adult without disability
5. Local political leader/Influential person
6. Government official
7. Different Service providers (school teacher, religious leader, government/private)

☐

Section 2: Knowledge

	Code
Q1a. Do you have any idea about disability issues? Yes.....1 No.....0	**Q1a** ☐
Q1b. How do you rate your degree of knowledge on disability issues? 1=Very good 2=Good 3=Acceptable 4=Poor	**Q1b** ☐
Q1c. Does anyone exist in your community who is disabled (e.g, physical, intellectual, visual, hearing, speech impairment)? Yes .....1 No.....0 Don't know.....4	**Q1c** ☐
Q1d. If yes, how many? Specify-------- Don't know----0	**Q1d** ☐
Q2. According to you what are the reasons of disability? Fill the boxes with best three answers. 1. God's will 2. Curse on a family 3. Due to disease 4. Heredity 5. Due to accident 6. Congenital or birth problem 7. Natural Aging 8. Malnutrition 9. Wrong treatment 10. Ignorance 11. Negligibility 12. Insolvency 13. Others (specify).....	**Q2** ☐ **Q2** ☐ **Q2** ☐
Q3. Do you know about the rehabilitation programs taken for the disabled? Yes.....1 If no go to Q4 No.....0 **Q3a.** If yes, what types of following programs have taken for them? **1. Education** 1=Inclusion of disabled children and adults in education programs 2= Inclusion of home based education 3= Inclusion of disability into curriculum 4= Establishment of special education schools for children with special needs **2. Health** 5=Prevention of disability through: Pre-natal, delivery related, post-natal care 6= Prevention of disability through providing polio, leprosy; and epilepsy vaccination 7= removal of vitamin deficiency, iodine deficiency pollution control 8 = environmental/external - noise, accidents and natural disasters pollution control 9= Provided free and accessible health care to the disabled by govt. (public health care)	**Q3** ☐ **Q3a1** ☐☐☐ **Q3a2** ☐☐☐

3. Employment 10= providing skill generating programmes/trainings 11=Providing micro-credit with special focus on disabled women 12= Maintaining rehabilitation services 13=Establishment of quota for the disabled in government employment with punitive action for non-compliance. **4. Accessibility** 15=Ensure disabled-friendly public places, places of social amenities and municipal buildings, and public transport and transport terminals 16=Ensure easy access for visually impaired in public places and roads **5. Transportation** 17=Introduce transport facilities for disabled students to educational institutions 18=Follow Prime Minister's Directives for providing easy physical access at all public places to all persons with physical and sensory impairments	**Q3a3** ☐☐☐ **Q3a4** ☐☐ **Q3a5** ☐☐
Q4. Do you know how to prevent disability? **If no go to Q5.** Yes.....1 No.....0 **Q4a.** If yes, tell me what types of following methods/treatment are available to prevent disability? 1= prevent through prenatal care, safe delivery, post-natal care 2= provide vitamin supplements/capsules/vaccine 3=provide balance diet/improve nutrition status 4=Public awareness programmes on electronic, print and folk media (radio and television, folkmedia etc.) 5= proper steps against natural disaster (preparedness and management) 6=proper steps against road accidents (safety - transport, workplace and others)	**Q4** ☐ **Q4a1** ☐ **Q4a2** ☐ **Q4a3** ☐
Q5. Does anyone who has taken training to help disabled in your community/area? Yes .....1 No.....0 Don't know.....8 **Q5a.** If yes, how many? Do not know.....0 Specify..... with Name:..... Occupation..... **Q5b**. Are the policymakers / local govt. bodies, chairman, member etc, MP, Minister taking initiative for prevention of disability and rehabilitation of the disable? Yes .....1 No.....0 **Q5c. I**f yes, what type?..... , By whom?.....	**Q5** ☐ **Q5a** ☐ **Q5b** ☐ **Q5c** ☐

Q6a. Is the disabled person receiving any assistance from any corner? (e.g., see 6b) Yes .....1 No.....0 **<u>If no go to Q6c</u>** **Q6b**. If yes, who assists? 1. Family 2. Development organizations 3. Relatives 4. Government 5. Community 6. Others (specify)..... **Q6c.** Are there any restrictions to get opportunity for disabled persons in any field (e.g education, job, social activities)? Yes .....1 if yes, explain..... No.....0 Don't know.....8 **Q6d**. Are the PWDs getting enough health care? Yes .....1 if yes, explain..... No.....0 Don't know.....8 **Q6e**. Are the PWDs getting educational facilities? Yes .....1 if yes, explain..... No.....0 Don't know.....8	**Q6a** ☐ **Q6b** ☐ **Q6c** ☐ **Q6d** ☐ **Q6e** ☐
Q7a. What is the status of the person with disability in the family? 1. Extra privileged 2. Well accepted (in indifferent way) 3. Tolerated 4. Avoided 5. Rejected and stigmatized **Q7b.** What is the status of the person with disability in the society? 1. Extra privileged 2. Well accepted (in indifferent way) 3. Tolerated 4. Avoided 5. Rejected and stigmatized	**Q7a** ☐ **Q7b** ☐

Q8. How do you treat/behave disabled? 1. Give extra privilege 2. Accept well (in indifferent way) 3. Tolerate 4. Usually avoid 5. Seem rejected and stigmatized **Q8a**. Which name do you use to call disabled (local name)? 1. Hearing impairment (local name)..... 2. Speech impairment (local name)..... 3. Visual impairment (local name)..... 4. Physical impairment (local name)..... 5. Intellectual disability (local name).....	**Q8** ☐
Q9. Do you treat disability as a curse? Yes .....1 if yes, why..... No.....0	**Q9** ☐
Q10. Do you think that disable people cause embarrassment /burden to the family? Yes .....1 if yes, why..... No.....0 **Q10a**. Do you take disabled in social programs like marriage, religious festivals, and birthday? Yes .....1 No.....0 if no, why.....	**Q10** ☐ **Q10a** ☐

Q11. Are the people willing to help the disabled? Yes -----1 if yes, how..... No-------0	**Q11** ☐
Q12. Are you willing to employ the disabled? Yes -----1 No-------0 if no, why.....	**Q12** ☐
Q13. Do you think that it should make all relationships like marriage to the family with disability? Yes -----1 if yes, why..... No-------0 if no, why.....	**Q13** ☐
Q14. Do you think that disabled person needs extra facilities in everywhere? Yes -----1 if yes, why..... No-------0 if no, why.....	**Q14** ☐
Q15. Do you think, "Every disabled person/children has equal right for basic needs"? Yes -----1 if yes, why..... No-------0 if no, why.....	**Q15** ☐

Section 4: Practice

Q16a. Do you buy food from disabled sales person (e.g. people with epilepsy? Yes -----1 if yes, why..... No-------0 if no, why..... **Q16b**.do you emphasize the disables getting equal opportunity in the employment? Yes -----1 if yes, why..... No-------0 if no, why..... **Q16c**. if your child agrees will you accept a marriage of your son/daughter to the person visual impairment? Yes -----1 if yes, why..... No-------0 if no, why..... **Q16d**. will you support the special law about the person with disability? Yes -----1 if yes, why..... No-------0 if no, why..... **Q16e**. Do you accept the disable children as a classmate of your own child with a pleasant heart? Yes -----1 if yes, why..... No-------0 if no, why.....	**Q16** ☐ **Q16B** ☐ **Q16C** ☐ **Q16D** ☐ **Q16E** ☐
Q17 Which of the following programs are taking to prevent disability? 1= prenatal care, safe delivery, post-natal care 2= providing vitamin supplements/capsules/vaccine 3=providing balanced diet/improvement of nutrition status 4=Public awareness programmes on electronic, print and folk media (radio and television, folk media etc.) 5= proper steps against natural disaster (preparedness and management) 6=proper steps against road accidents (safety - transport, workplace and others)	**Q17** ☐ **Q17** ☐ **Q17** ☐

Q18. Which of the following programs are taking for the persons with disability? **a) Education** 1=Inclusion of disabled children and adults in education programs 2= Inclusion of home based education 3= Inclusion of disability into curriculum 4= Establishment of special education schools for children with special needs **b) Health** 5=Prevention of disability through: Pre-natal, delivery related, post-natal 6= Prevention of disability through providing polio, leprosy; and epilepsy vaccination 7=Removal of vitamin deficiency, iodine deficiency pollution control 8 = Environmental/external - noise, accidents and natural disasters pollution control 9= Providing free and accessible health care to the disabled by govt. (public health care) **c) Employment** 10= providing skill generating programmes/training 11=Providing micro-credit with special focus on disabled women 12= If yes, then who? 13= Maintaining rehabilitation services 14=Establishment of quota system for the disabled in government service with punitive action for non-compliance. **d) Accessibility** 15=Ensure disabled-friendly public places, places of social amenities and municipal buildings, and public transport and transport terminals 16=Ensure easy access for visually impaired in public places and roads	**Q18a** ☐☐☐ **Q18b** ☐☐☐ **Q18c** ☐☐☐ **Q18d** ☐☐☐
Q19. Are the PWDs included in the different policy design and process? Yes -----1 No-------0, if no why.....	**Q19** ☐

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