

COURSE 10: CREATING AN INCLUSIVE SCHOOL

UNIT – I UNDERSTANDING THE DISABILITY

OBJECTIVES

After the completion of the unit, the learners will be able to:

1. understand the disability
2. explain the characteristics of disability
3. classify the different types of disability

INTRODUCTION

Education is the fundamental right of every child. Sufficient opportunities should be provided to the child in education. Based on this, Educational opportunities for special children are also stressed in our country. Swami Vivekananda emphasizes “If special children are unable to move towards education, the education should go towards them”.

MEANING AND DEFINITION OF DISABILITY

Disability is defined as “any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being”.

Disability is a condition or function judged to be significantly impaired relative to the usual standard of an individual or group.

IMPAIRMENT

Impairment is the loss of an organ or the defect in structure and function of the organs of a person. This defect may be temporary or permanent.

DIFFERENCES BETWEEN DISABILITY AND IMPAIRMENT

S.No	DISABILITY	IMPAIRMENT
1.	Any restriction or lack (resulting from an impairment) of ability to perform an activity considered normal for a human being.	Any loss or abnormality of psychological, physiological or anatomical structure or function.
2.	Disability results from impairment, limiting the range and efficiency of one's functioning.	May be genetic; may occur in developmental stages or may be due to accidents, diseases etc.
3.	The degree of disability could be reduced with the use of equipments and appliances.	Once impairment occurs, it cannot be completely rectified.

CHARACTERISTICS OF DISABILITIES

1. Due to loss or abnormality of physical organs. (e.g.) mal-formation of limbs, cleft lip, disfigured fingers.
2. Disorders due to dysfunctioning of organs of the body even though they may have normal anatomical structure.
3. Impairment of organs of the body.
4. Due to genetic disorders, developmental defects, accidents or diseases.
5. Due to the limitation of one's functioning arising from impairments.
6. Due to the inability to undertake activities of daily life like others. i.e. one's functional efficiency getting affected.
7. The degree of disability could be reduced with the use of appropriate equipments and appliances.
8. The handicap arising out of disability could be greatly reduced by providing appropriate opportunities and facilities in the society.
9. Rehabilitation could be provided to the disabled by offering proper educational climate and exercise.
10. Without motivation and exercise, the degree of disability is likely to increase.

CAUSES OF DISABILITIES

- Genetic Disorders
- Severe Malnutrition
- Diseases (Polio, Paralysis, Brain fever, cerebral palsy etc.)
- Adverse effects of drugs consumed during pregnancy
- Artificial fertilization
- Problems during delivery
- Severe accidents

HEARING IMPAIRMENT

INTRODUCTION

Among the five sense organs, Ear is not only responsible for tactile sensation but also paves way for awareness in the environment. Also it helps to learn a language and the skill of speaking it. When one loses his hearing capacity he is unable to adjust & face problems in the society. Hearing is defined as the reception of the environmental sound, knowing the properties of the sound & by whom it has been made. Defect in listening and understanding the conversations is called listening disability. It affects the natural growth of the children and behavior. Especially it affects hearing, speaking and understanding abilities. Hearing impaired children face more difficulty in hearing, speaking and communicating with others. These children have less speaking skills.

TYPES OF HEARING IMPAIRMENT

- Hearing impairment has three types. They are,
- Conductive loss happens in the External ears.
- Sensory neural hearing loss, it happens due to the defects in the nerves, Ear drums and bones in the internal ear.
- Mixed hearing loss is a combination of conductive and sensory neural hearing loss.

The defects occur in Internal and external ears. Audiometer is used to identify these types of defects. This type of measuring is called Audiogram. The unit of sound is mentioned as Decibel (db).

SYMPTOMS OF HEARING IMPAIRMENT

1. Non- response (shock) of the child for loud clapping within 3 feet.
2. Unable to turn towards the direction of the sound.
3. Delay in understanding.
4. Insist the teacher to repeat the taught units.
5. Keen observation of the facial expressions of teacher, while talking.
6. Very low level skills in Listening and Understanding.
7. More stammering while speaking and very poor in reading.
8. Bend head to listen to the side of speakers.
9. Differences in voice, sound and pronunciation.
10. Non-responding while calling.
11. Disinterested in listening to stories.
12. Leakage of puss from ears.
13. Seek others help when teacher dictates in the class.

REASONS FOR HEARING IMPAIRMENT

1. Genetical factors (Related to Genes).
2. Non Genetical factors (unrelated to Genes).

GENETICAL FACTORS

- *Warden perk Syndrome*: One who has this syndrome should marry another person with this syndrome to deliver a normal child without this hearing impairment. Otherwise there are more chances for the birth of hearing impaired babies.
- Close relationship marriage.
- Genetic defects.
- Genes Aberrations.

NON –GENETICAL FACTORS

- Chicken Pox.
- High fever e.g. Flu fever, Dengue fever.
- Inflammation in inner ear during accident.
- Defects in the ear-brain nerves.
- Brain injury disturbing the growth of language skill.
- Exposure to loud noise.

- Nerves problem in old age.
- Jaundice during pregnancy.
- Mal- Nutrition during pregnancy.

HEARING DEVICES FOR HEARING IMPAIRED CHILDREN

- Horn, calling bell, Flute, Drum.
- World map and Globe.
- Cartoons.
- Colour Pictures.
- Hearing Aids, Materials.
- Mirror.
- Speech Box.
- Music dolls.
- Audiometer.
- Text to speech.
- Audio Books.
- Individual hearing devices & group hearing devices.

WAYS OF ATTAINING SUCCESS FOR HEARING IMPAIRED PERSONS

Identify the hearing impaired in the early childhood and provide suitable hearing aids. Practice them to observe the various sounds in their surroundings. Hearing impaired people can lead a normal life in the society. This idea is to be developed among the teachers & parents. Engage the parents in activities that increase the speaking skill of the hearing impaired students.

Creating awareness among the parents and people & enable them to think, that they can also lead a normal life like the other children of their age.

ROLE OF TEACHERS IN TEACHING THE HEARING IMPAIRMENT

1. The Hearing impaired children must have a good view of the teacher in the classroom. A good rapport between the teacher and the students is to be maintained.
2. The teachers must look at the faces of these students while teaching, so that they follow the lip movement and the gestures of the teachers.
3. The teachers should use more teaching learning materials; especially more visual pictures are to be used.

4. More training for speaking skills should be given.
5. While teaching new lessons, real objects must be used.
6. More reading practice is given to the learners.
7. While teaching new lessons, the teacher writes it on the blackboard and explains the contents.
8. Develop speech skill through conversation.
9. Provide opportunities for visual experiences.
10. Make use of mirrors for speech practice.
11. Poems are taught with rhythm and music.
12. Integrate writing activities with reading skills.
13. Avoid signs among the less hearing impaired children.
14. Train the students to read simple sentences.
15. Provide opportunities for the children to learn drama & conversation lessons in a simple way.
16. Ascertain whether the students use the hearing aids properly in the class room.
17. More colourful pictures, charts and flash cards are to be used.
18. Teacher creates opportunities to bring out individual talents and creativity.

SPEECH IMPAIRMENT

Of all the species on Earth, mankind is superior in Nature because of his skill of speech. It is rather a gift to mankind. A baby begins the language by uttering some sounds in an unclear manner. Then it starts to utter of small syllables, words, phrases, sentences and finally attain the skill of conversation. The sound, word and the sentence structure makes the speech skill effective. In order to develop this skill, the skill of listening becomes extremely essential. The speech skill is affected among the hearing impaired children.

The controlled movement of the speech organs like mouth, tongue, throat, jaw, trachea, vocal cards, hard & soft palate, produce different types of sounds. If there is a defect in any of the speech organs, the speaker fails to utter the words appropriately. This deficiency is known as speech impairment.

We may come across these types of children in the classroom. Mostly they go unnoticed in the eyes of the teacher. While speaking, these children fail to spell some alphabets, words and

phrases. They stammer in speaking sentences. Their speech is incoherent & sometimes inordinate delay occurs in their speech. The teachers and the parents must identify this impairment among the children at the earlier stage and take necessary measures.

CAUSES FOR SPEECH IMPAIRMENT

- Insufficient brain growth.
- Incomplete growth of inner ear organs.
- Uncontrollable movements in the speech organs.
- Multi language speaking environment.
- Shyness and fear.
- Inability to understand language sounds.
- Cleft in lips.
- Thick tongue.
- Stammering.
- Knowledge of a few Vocabularies.
- Delay in the growth of Speech activity.

SYMPTOMS OF SPEECH IMPAIRMENT

1. Difficulty in speaking continuously.
2. Inordinate delay in speaking a word.
3. People with speech impairment give unnecessary stress in the syllable while speaking.
4. They are always in the grip of fear and tension.

TYPES OF SPEECH IMPAIRMENT

The defects noticed among the hearing impaired and the speech impaired children can be classified as follows:

1. DEFECTS IN ARTICULATION

- a. Addition.
- b. Distraction.
- c. Substitution.
- d. Skipping of sounds.

2. DEFECTS IN VOICE

- a. Lowering/Raising of voice.
- b. Tone.

c. Stress.

3. DEFECTS IN FLUENCY

a. Stammering / stuttering.

b. Cluttering.

c. Fear.

DEFECTS IN ARTICULATION

Children with cleft lips struggle to speak properly. These defects are curable and can be treated medically. The brain has many speech integrating centres. Any damage in any of these centres may cause impairment. This is known as **Disarthria**.

Normally, the defects among the Hearing impaired can be divided into following categories.

a. Addition.

b. Distraction.

c. Substitution.

d. Skipping of sounds.

DEFECTS IN VOICE

In case of any defect in the speech organ like vocal cord or if the speech organ remains unused, defects in voice occur.

A) Voice prosody - High/Low pitch

The tone's density, power, nature, are the three important factors for a good voice. The high/low pitch of the voice is decided by the movement of air passing through the speech organs.

B) Prosody

Some hearing impaired persons always speak in high pitch. This problem can be rectified through tactile sense and by ball technique.

C) Stress (prosody)

In normal speech, some sounds are unnecessarily overstressed.

DEFECTS IN SPEECH FLUENCY

Stammering

In speech, Fluency, style and prosody are important in speech. Stammering is due to a break in the fluency. Repetition of a same word and prolonged uttering of a word takes place in stammering.

Nature of stammering

Struggling to start the speech, unnecessary repetition of same sounds and prolongation of few sounds.

Causes for stammering

Psychological barriers, unsteadiness and mal functioning of nerve system cause stammering among children.

Cluttering

Absence of pause while speaking and very fast speaking are the causes for cluttering.

Fear

Excess fear is one of the reasons which disturb fluency in speech.

HINDRANCES IN LEARNING

- Difficulty in expressing the teachers' concepts.
- Hindrances in reading lessons.
- Unable to read lessons in a stipulated time.
- Wrong use of syllables (Stressed/unstressed) in speaking.
- Listeners are unable to comprehend these children's speech due to their prolonged spell of words and inordinate delay in speaking.
- The voice/ tone of the child are spoiled by constant stammering.

THE ROLE OF PARENTS

- Parents should motivate the children to converse with them in simple sentences without grammatical errors.
- Information and communication technology (ICT) is to be used as a model to develop their speech.
- Parents should follow the recommendations of the speech specialists for their children.
- Children must undergo medical treatment regularly.
- Provide speech therapy as per the advice of the speech specialists.
- Help the children to be courageous.

TRAINING IN PRONUNCIATION

1. Simple sounds of the alphabets and words are introduced. Adequate training is given to spell the sounds correctly.

2. From easy to difficult sounds of words, phrases are taught. Train the children to use apt words, phrases and sentences in their speech.

3. The alphabetic sounds are recorded in a tape recorder. Visual aids like computer, T.V. can be used for correct pronunciation. The speech organs are also trained under the supervision of the teacher.

4. Child oriented topics are presented to the children in the form of dialogue, conversation and seminars. With the help of educational tools, these children are trained to speak the same with correct pronunciation.

VISUAL IMPAIRMENT

INTRODUCTION

The physical condition of a child which completely prevents his/her participation in childhood activities either socially or professionally or in entertainment aspects, is known as Inability Deficiency. The child is emotionally affected. Further, the child is unable to cope with the society and their peer groups. No man is without defects in this world. Mostly the defects can be rectified or compensated. Therefore, our primary duty is to identify the impairment in children (body/mind). According to the impairment in children, we will be able to educate them. Senses are the only way to achieve intelligence. In our five senses, the vision (seeing) skill is very special because we are able to see the activities in our surroundings using our eyes. The knowledge we gain by seeing (vision) is hundred times greater than the description (of person, place or things) in words. There is no equivalent for visual experiences. But the blind children are unable to witness the activities in their surroundings. For the benefit of the blind children, efforts are taken to fulfill their needs, to provide treatment and upgrade their education.

TYPES OF VISUAL IMPAIRMENT

1. Low vision

2. Total Blindness

1. Low Vision

The children with low vision learn with their residual vision using audio and visual equipments.

2. Total Blindness

Totally blind people learn with the help of Braille Letters, Audio Equipments and tactile method.

VISUAL IMPAIRMENT

Eye diseases, accident and defect by birth are the causes for visual impairment. They have less visual ability. Some visual defects can be cured by treatment.

REASONS FOR VISUAL IMPAIRMENT

- Cataract
- Vitamin A deficiency
- Trachoma
- Small
- Accident
- Hereditary disease
- Malnutrition
- Brain Tumor
- Diabetes in childhood

PROBLEMS FACED BY THE CHILDREN WITH VISUAL IMPAIRMENT IN THE CLASSROOM

Learning environment plays a vital role in effective learning. Learning environment includes teachers, students and methods of learning. Learning Environment includes not only classroom but also laboratory, playground, library and educational tour. The above mentioned visually impaired children will face hindrances in these learning environments. The classroom hindrances faced by these children are listed below.

1. Letters on the blackboard are either partly visible or fully invisible.
2. The students with visual impairment will have problems in reading the words on the blackboard and in books, due to light failure in the rainy season or some other reasons.
3. The students find it difficult in doing science experiments in the lab and in identification of different colors.

4. The students with visual impairment are unable to perform on par with the other students in Drawing and S.U.P.W.
5. Problems in collecting data from photos and maps.
6. Visual based subjects like geometry possess a great problem in answering the questions in the examination.
7. The children with total blindness have to read the normal lessons along with the Braille system. This causes depression.
8. Due to variation in the individual's visual impairment these children cannot work together in one activity.
9. The students with visual impairment should be seated only in first bench or else they cannot be able to see the blackboard or the teachers clearly.
10. These students will find difficult in reading and writing in dim light and in bright light.
11. While reading continuously, they drop few lines.
12. Continuous and rapid writing is not possible.
13. Spelling mistakes are done in reading and writing.
14. Difficulty in color identification.
15. Hindrance in reading manuscripts.
16. When the background color and printed words are the same, these students will find it difficult to read.
17. Difficulty in completing or delay in submitting the teacher's homework or assignments.
18. Inability to walk in dim light.
19. Difficulty in differentiating the shapes of objects.
20. Difficulty in identifying rumbles in the school route.
21. Facing difficulties in reading and writing the lessons fast.
22. Tiredness in the eyes while reading.
23. Difficulties in reading small letters.

TEACHER'S APPROACHES TO ELIMINATE THE VISUAL DEFECTS

1. The children should be made to sit in first row
2. Light should not be directly focused on them.
3. They should be given felt pen or sketch pen or marker pen while writing.
4. Contrasting colours and bold letters are essential in the teaching learning material.

5. While writing on the board, the teacher reads it.
6. Constant listening to the recorded words and phrases.
7. Clay models are used in teaching.
8. Abacus and Taylor Frame instruments are used to teach Mathematics.
9. Distribution of enlarged Xerox copies of scripts to the students with low vision.
10. Usage of safe teaching learning materials.
11. Tactile based pictures are used to teach science and social science
12. Teaching through tactile sense, hearing sense, skill of taste and smell are mostly used.

INSTRUMENTS FOR VISUALLY IMPAIRED

- Braille slates and styles
- Braille machine
- Abacus
- Taylor Frame
- Cassette Recorder
- Magnifier
- Embossed Diagram
- Reading Book stand
- Relieve sheet
- Long cane
- Braille text book
- Rattle ball
- Magnetic Chess

PHYSICALLY CHALLENGED

Human beings possess many talents physically and mentally to live happily in this world. We live happily by using those talents. But, among us so many people are affected for many reasons in their life. This causes handicap both mentally and physically. In English it is called mentally impaired and physically disabled. If any part of our body becomes inactivated, it is called physically challenged. For example, a school going child is unable to participate in any activity either at home or in the society. Physically challenged are classified on the basis of their

impairment. For example, if there is a leg or hand becomes inactive, then it is called physically challenged.

COMMON SYMPTOMS OF PHYSICALLY CHALLENGED

- Non cooperation of body organs with its movements
- Pain in joints while moving
- Struggle in sitting, getting up and walking
- Incapable of using legs& hands normally.
- Uncontrollable body movements.
- Getting tired easily.
- Delay in activities.
- Cheeks and fingers become blue in colour.
- Inferiority complex.
- Hands, legs and feet in folded condition.

TEACHERS' APPROACHES

- To strengthen the muscles, exercises are given.
- To make the students participate in games of their choice.
- Practice is given to write the correct shapes of letters.
- Designing of school environment for their free movement.
- Provide ramp instead of steps.
- Provide facilities for inactive to reach the examination hall.
- Provide scribe facilities during examination.
- Give practice to write with the other hand if one hand is affected.
- Priority is given to these children in all educational activities to motivate them.
- Identifying individual talents, tapping their skills and motivating them to participate in co- curricular activities.
- Train the parents to continue the muscles exercises given to the children in the school & in resource centre.
- The teachers based on their training identify the disabled children by observation with the aid of Resource teacher; the teacher helps these children for doctor consultation.
- These children must be involved in games depending upon their ability.

- Instructions are given to the parents for the proper use of equipments issued to these children during Medical camps conducted by S.S.A.

PSYCHOLOGICAL DISORDERS

A psychological disorder, also known as a mental disorder, is a pattern of behavioral or psychological symptoms that impact multiple life areas and create distress for the person experiencing these symptoms.

"...a syndrome characterized by clinically significant disturbance in an individual's cognitive, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental process underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities."

NEURODEVELOPMENTAL DISORDERS

- ❖ Neuro developmental disorders are those that are typically diagnosed during infancy, childhood, or adolescence. These psychological disorders include:
- ❖ **Intellectual disability** (or Intellectual Developmental Disorder) was formerly referred to as mental retardation. This type of developmental disorder originates prior to the age of 18 and is characterized by limitations in both intellectual functioning and adaptive behaviors.
- ❖ **Global developmental delay** is a diagnosis for developmental disabilities in children who are under the age of five. Such delays relate to cognition, social functioning, speech, language, and motor skills. It is generally seen as a temporary diagnosis applying to kids who are still too young to take standardized IQ tests. Once children reach the age where they are able to take a standardized intelligence test, they may be diagnosed with intellectual disability.
- ❖ **Communication disorders** are those that impact the ability to use, understand, or detect language and speech. There are four different subtypes of communication disorders: language disorder, speech sound disorder, childhood onset fluency disorder (stuttering), and social (pragmatic) communication disorder.

- ❖ **Autism spectrum disorder** is characterized by persistent deficits in social interaction and communication in multiple life areas as well as restricted and repetitive patterns of behaviors. The symptoms of Autism spectrum disorder must be present during the early developmental period and that these symptoms must cause significant impairment in important areas of life including social and occupational functioning.
- ❖ **Attention-deficit hyperactivity disorder** is characterized by a persistent pattern of hyperactivity-impulsivity and/or inattention that interferes with functioning and presents itself in two or more settings such as at home, work, school, and social situations.

BIPOLAR AND RELATED DISORDERS

- ❖ Bipolar disorder is characterized by shifts in mood as well as changes in activity and energy levels. The disorder often involves experiencing shifts between elevated moods and periods of depression. Such elevated moods can be pronounced and are referred to either as mania or hypomania.
- ❖ Mania is characterized by feeling overly excited and even hyper. Periods of mania are sometimes marked by feelings of distraction, irritability, and excessive confidence. People experiencing mania are also more prone to engage in activities that might have negative long-term consequences such as gambling and shopping sprees.
- ❖ Depressive episodes are characterized by feelings of intense sadness, guilt, fatigue, and irritability. During a depressive period, people with bipolar disorder may lose interest in activities that they previously enjoyed, experience sleeping difficulties, and even have thoughts of suicide.

ANXIETY DISORDERS

- ❖ Anxiety disorders are those that are characterized by excessive and persistent fear, worry, anxiety and related behavioral disturbances. Fear involves an emotional response to a threat, whether that threat is real or perceived. Anxiety involves the anticipation that a future threat may arise.
- ❖ Types of anxiety disorders include:

- ❖ **Generalized anxiety disorder** which is marked by excessive worry about everyday events. While some stress and worry are a normal and even common part of life, GAD involves worry that is so excessive that it interferes with a person's well-being and functioning.
- ❖ **Agoraphobia** is characterized by a pronounced fear a wide range of public places. People who experience this disorder often fear that they will suffer a panic attack in a setting where escape might be difficult. Because of this fear, those with agoraphobia often avoid situations that might trigger an anxiety attack. In some cases, this avoidance behavior can reach a point where the individual is unable to even leave their own home.
- ❖ **Social anxiety disorder** is a fairly common psychological disorder that involves an irrational fear of being watched or judged. The anxiety caused by this disorder can have a major impact on an individual's life and make it difficult to function at school, work, and other social settings.
- ❖ **Specific phobias** involve an extreme fear of a specific object or situation in the environment. Some examples of common specific phobias include the fear of spiders, fear of heights, or fear of snakes. The four main types of specific phobias involve natural events (thunder, lightning, tornadoes), medical (medical procedures, dental procedures, medical equipment), animals (dogs, snakes, bugs), and situational (small spaces, leaving home, driving). When confronted by a phobic object or situation, people may experience nausea, trembling, rapid heart rate, and even a fear of dying.
- ❖ **Panic disorder** is a psychiatric disorder characterized by panic attacks that often seem to strike out of the blue and for no reason at all. Because of this, people with panic disorder often experience anxiety and preoccupation over the possibility of having another panic attack. People may begin to avoid situations and settings where attacks have occurred in the past or where they might occur in the future. This can create significant impairments in many areas of everyday life and make it difficult to carry out normal routines.
- ❖ **Separation anxiety disorder** is a type of anxiety disorder involving an excessive amount of fear or anxiety related to being separated from attachment figures. People are often familiar with the idea of separation anxiety as it relates to young children's fear of being apart from their parents, but older children and adults can experience it as well.

MENTALLY RETARDED

CAUSES FOR MENTALLY RETARDED

- Brain Fever.
- Genetically impaired
- Defect in nervous system and spinal cord.
- Low supply of oxygen to brain during birth.
- Deep head wound during birth.

SYMPTOMS OF MENTAL RETARDNESS

- Delay in all growth and development.
- Not able to sit even after 12-15 months.
- Not able to walk even after two years.
- Not able to speak even after two years.
- Not able to eat and dress independently
- Dependence in answering nature calls.
- Difficulty in playing with their peer.
- Become ferocious frequently.
- Incapable of carrying out oral orders.
- Inability to communicate personal needs.
- Difficulty in understanding two or more orders at the same time.
- Ignorance of environment takes more time in learning skill activities.
- No progress in studies,
- Inattentive and excess loss of memory.
- Not able to participate in all classroom activities.
- Inability to sit in a same place for long time.

PROBLEMS FACED BY MENTALLY RETARDED CHILDREN

- Due to delay in brain growth, the learning skill is relegated to the background.
- Difficulty in understanding concepts in a same method. For example, to know the parts of body and day today habits.
- Loss of memory power. Difficulties in retention. For example: forgetting the learning skills within a short time.
- Difficulties in problem solving. Example: Unable to decide after missing a regular bus.

- Drawback in decision making.
- Distraction in concentration. For example: Leaving classroom at the time of teaching.
- Failure to implement the understood habits like wishing teachers in the classroom and welcoming the guests at home.
- Difficulties in understanding the consequences.
- Touching the hot vessel without realizing its effect.

TEACHERS ROLE FOR MENTALLY RETARDED CHILDREN

- Exempted from the school curriculum for promotion by giving concession.
- It is important to develop life skill in the teaching learning activities for these children.
- With the guidance of an expert teacher, the teacher imparts the skill to do their personal duties.
- Depending upon the child's mental ability, the teacher not only imparts the content part of the syllabus orally, but also through activities.
- According to the mental growth of the child, the teacher develops the learning skills by using life oriented objects.
- Training is started after identifying success oriented opportunities.
- After learning the numbers, the addition and subtraction should be taught.
- Display of related objects for introduction of "Sunday" may not be possible. So, 'Sunday' related activities can be incorporated.
- The parts of the body can be introduced by showing the different parts of organs.
- Retention of learned skill is possible by the repetition of teaching skills.
- Imperative statements are either limited to one or two.
- Training is given to develop memory power. Ex: List out the objects after five minutes of observing five objects on the table. Daily activities are recollected and arranged orally by the retarded students.
- Teach the methods of routine activities or duties. Ex: To wash hands before and after taking food. To wear clean clothes after bathing. To use toilets properly.
- Talent based follow up work is provided. Individual attention by the teacher is essential to involve the mentally retarded children in the entertainment oriented play-way methods to bring out the individual talents of the children.

CEREBRAL PALSY

Cerebral palsy (CP) refers to a group of disorders that affect muscle movement and coordination. In many cases, vision, hearing, and sensation are also affected. The word “cerebral” means having to do with the brain. The word “palsy” means weakness or problems with body movement.

SYMPTOMS OF CEREBRAL PALSY

- delays in reaching motor skill milestones, such as rolling over, sitting up alone, or crawling
- delays in speech development and difficulty speaking
- stiff muscles
- abnormal muscle tone
- a lack of muscle coordination
- tremors or involuntary movements
- excessive drooling and problems with swallowing
- difficulty walking
- favoring one side of the body, such as reaching with one hand
- neurological problems, such as seizures, intellectual disabilities, and blindness.

CAUSES FOR CEREBRAL PALSY

- a lack of oxygen to the brain during labor and delivery
- severe jaundice in the infant
- maternal infections, such as German measles and herpes simplex
- brain infections
- bleeding into the brain
- head injuries as a result of a car accident, a fall, or child abuse.

MULTIPLE DISABILITIES

A person who has a combination of two or more disabilities is considered to have multiple disabilities. The effect of multiple disability can be more than the combination of two individual disabilities.

CHARACTERISTICS OF MULTIPLE DISABILITIES

- Two or more disabilities
- Additional disabilities
- Due to combined loss of two or more disabilities, the rate and speed of learning is very low.
- Communication is most significantly affected in children with multiple disabilities.
- Some children with multiple disabilities have difficulty in body movements.
- Most children with multiple disabilities show strange behaviours that are called self stimulating behaviours.
- Deaf, blind children show disturbed sleep patterns.
- Most multi disabled children also suffer from other medical conditions, such as frequent eye and ear infections, respiratory disorders, muscular degeneration, and so on.

CONCLUSION

In this unit, we came to know vividly that education should not hurt the handicapped children either physically or mentally and the educational environment must provide a happy & joyful learning for the disabled. The role of the teachers and the parents for the hearing impaired, physically handicapped and mentally retarded and their challenges & solutions, the causes for the deficiencies & disabilities and the methods and approaches of the teachers in teaching these children are discussed in this unit in detail.

QUESTIONS FOR DISCUSSION AND REFLECTION

1. Explain the characteristics of disability
2. Analyse the causes of disability
3. Describe the different types of disability

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UNIT-II: UNDERSTANDING THE LEARNING DISABILITIES

Objectives:

After the completion of the unit, the learners will be able to:

1. explain the concept of learning disability.
2. list down the signs and symptoms of learning disabilities.
3. describe the different types of learning disabilities.

4. identify children with learning disabilities.
5. discuss the importance of integrated and inclusive education.

Introduction

Learning disabilities are neurologically-based processing problems. These processing problems can interfere with learning basic skills such as reading, writing and calculating. They can also interfere with higher level skills such as organization, time planning, abstract reasoning, long or short term memory and attention. It is important to realize that learning disabilities can affect an individual's life beyond academics and can impact relationships with family, friends and in the workplace. Since difficulties with reading, writing and calculating are recognizable problems during the school years, the signs and symptoms of learning disabilities are most often diagnosed during that time.

Generally speaking, people with learning disabilities are of average or above average intelligence. There often appears to be a gap between the individual's potential and actual achievement. This is why learning disabilities are referred to as "hidden disabilities", the person looks perfectly "normal" and seems to be a very bright and intelligent person, yet may be unable to demonstrate the skill level expected from someone of a similar age.

Meaning

Learning disabilities are lifelong. Learning disabilities are due to genetic and/or neurobiological factors or injury that alters brain functioning in a manner which affects one or more processes related to learning. It refers to a number of disorders which may affect the acquisition, organization, retention, understanding or use of verbal or nonverbal information. These disorders affect learning in individuals who otherwise demonstrate at least average abilities essential for thinking and/or reasoning.

Kinds of Learning Disabilities

1. Dyslexia
2. Dysgraphia

3. Dyscalculia
4. Dyspraxia

Dyslexia

A specific learning disability that affects reading and related language-based processing skills. The severity can differ in each individual but can affect reading fluency, decoding, reading comprehension, recall, writing, spelling, and sometimes speech and can exist along with other related disorders. Dyslexia is sometimes referred to as a Language-Based Learning Disability. It affects reading and related language-based processing skills.

Dyslexia is a chronic problem with reading. It is a common learning difficulty, affecting a large percentage of those identified as "learning disabled." People with a learning difference like dyslexia may have trouble with reading, writing, spelling, math, and sometimes music.

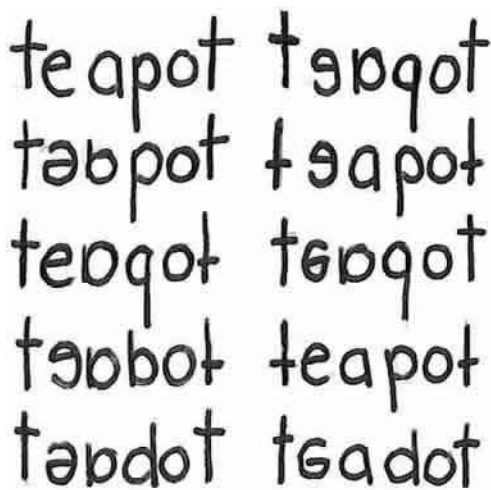


Figure:1

The severity of this specific learning disability can differ in each individual but can affect reading fluency, decoding, reading comprehension, recall, writing, spelling, and sometimes speech and can exist along with other related disorders. Dyslexia is sometimes referred to as a Language-Based Learning Disability. Dyslexia can occur at any level of intellectual ability. Dyslexia may be accompanied by lack of motivation, emotional problems, and sensory impairment.

A more positive view of dyslexia describes people with dyslexia as visual, multidimensional thinkers who are intuitive, highly creative, and excel at hands-on learning. Many people with dyslexia shine in the arts, creativity, design, computing, and lateral thinking.

Signs and Symptoms

1. Reads slowly.
2. Experiences decoding errors, especially with the order of letters.
3. Shows wide disparity between listening comprehension and reading comprehension of some text.
4. Has trouble with spelling.
5. May have difficulty with handwriting.
6. Exhibits difficulty recalling known words.
7. Has difficulty with written language.

Intervention Strategies

There are numerous programmes, teaching aids, software packages etc that you can use with students. Whichever you choose, if you are positive about it then the pupil's confidence is improved there is a far greater chance of success. Training should be multi-sensory involving looking, listening, speaking, touching etc with as much variation as possible but we are all unique and it is good to observe whether the child/adult is predominantly Visual Learner(learns best by seeing), Auditory Learning(learns best by listening) and Kinesthetic Learner(learns by doing/feeling).

Visual Learner

1. Use pictures and multi-media material
2. Stick spelling words anywhere in view
3. Look at pictures in a book before reading
4. Play games and solve puzzles to improve memory

5. Draw mind maps
6. Use different colours
7. Use good visual software programmes

Auditory Learners

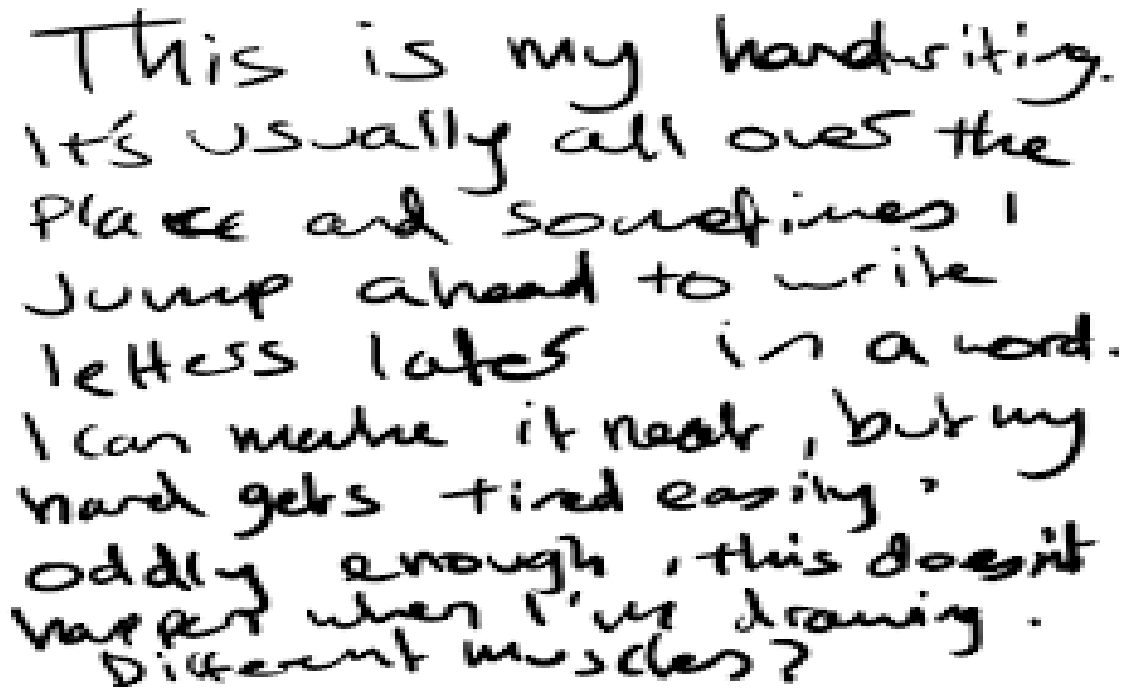
1. Talk about the book to be read or the information to be learned
2. Make sure instructions are orally clear
3. Get the student to record the information so it can be listened to again
4. Use software which has good auditory input.

Kinesthetic Learners

1. Trace letters in sand or in the air.
2. Use concrete objects which can be handled eg wooden letters, numbers etc
3. Memorise facts while moving about.

Dysgraphia

The term dysgraphia is taken from the Greek word, (dys) meaning "bad" or "difficult" and (graphia) meaning "writing." Thus, "dysgraphia" literally means "bad writing". It is also defined as a learning disability with impairment in written expression that is the inability to write.



This is my handwriting.
It's usually all over the
place and sometimes I
jump ahead to write
letters later in a word.
I can make it neat, but my
hand gets tired easily.
Oddly enough, this doesn't
happen when I'm drawing.
Different muscles?

Figure:2

It affects a person's handwriting ability and fine motor skills. A person with this specific learning disability may have problems including illegible handwriting, inconsistent spacing, poor spatial planning on paper, poor spelling, and difficulty composing writing as well as thinking and writing at the same time.

Signs and Symptoms

1. May have illegible printing and cursive writing.
2. Shows inconsistencies: mixtures of print and cursive, upper and lower case, or irregular sizes, shapes or slant of letters
3. Inconsistent spacing between words and letters
4. Exhibits strange wrist, body or paper position
5. Has difficulty pre-visualizing letter formation
6. Copying or writing is slow or labored
7. Shows poor spatial planning on paper
8. Has cramped or unusual grip/may complain of sore hand
9. Has great difficulty thinking and writing at the same time (taking notes, creative writing.)

Intervention Strategies

1. Children with dysgraphia need to strengthen hand muscles and improve motor control by playing with clay, keeping within lines on mazes, connecting dots or dashes to create complete letters, and tracing letters with an index finger or a pencil eraser.
2. To improve motor memory, have students practice forming letters and numbers in the air with big arm movements. Then, have them form letters and numbers with smaller hand or finger motions. Students should also experiment with pencil grips, shorter pencils, and other pencils and pens to find what feels best for them.
3. While remediation should be ongoing since good handwriting takes time and practice, strategies for dealing with dysgraphia include modifications, or changes in assignments to avoid writing.
4. Reduce copying of assignments and tests. Choose the questions that the student should answer in complete sentences, then allow the others to be answered in phrases or words. When students are copying definitions, let the student shorten them or give him the definitions and have him highlight or underline important words or phrases.
5. Give shorter written assignments.
6. Assignments can be modified in the following ways without changing the academic task: Grade assignments on individual elements of the writing process. On one assignment, make spelling count, then make grammar count on the next. On long-term assignments, help the student plan by providing intermittent due dates and working with him as a deadline approaches.
7. Give the student an alternative to a written assignment. Assign an oral report or visual project and specify what the student should include.
8. Providing additional time for note-taking, copying, and tests.
9. Starting projects or assignments early.
10. Providing the student with an outline so he can fill in details under major headings instead of taking notes.
11. Dictating some assignments or tests using a scribe.
12. Allowing abbreviations in some writing.
13. Not counting spelling on rough drafts.

14. Using a spell checker or having another student proofread his work.
15. Allowing the student to print or write in cursive, whichever is most legible.
16. Encouraging younger students to use paper with raised lines.
17. Allowing older students to use a different line width.
18. Allow students to use different color paper, pens, or pencils.
19. Allowing the student to use graph paper for math to help with lining up columns of numbers.
20. Allowing the student to use a word processor and speech recognition software, if necessary and appropriate.

Students should continue to work on improving their handwriting as it is an important skill and necessary in daily life. Meanwhile, strategies for dealing with dysgraphia, such as these modifications and accommodations, help facilitate learning and ease difficulties inside and outside the classroom.

Discalculia A specific learning disability that affects a person's ability to understand numbers and learn math facts. Individuals with this type of LD may also have poor comprehension of math symbols, may struggle with memorizing and organizing numbers, have difficulty telling time, or have trouble with counting. It affects a person's ability to understand numbers and learn math facts.

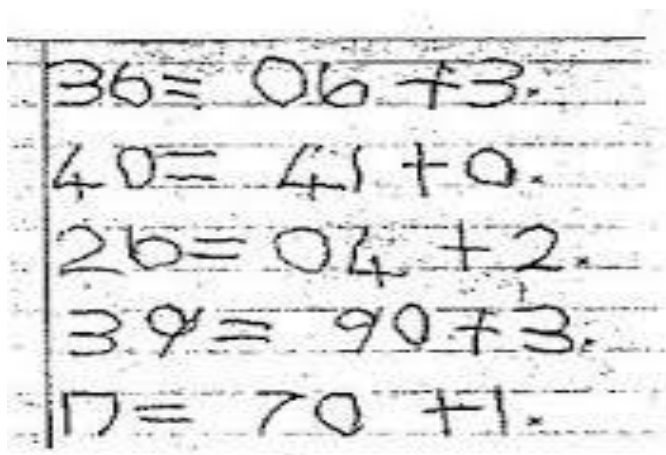


Figure:3

Signs and Symptoms

1. Shows difficulty understanding concepts of place value, and quantity, number lines, positive and negative value, carrying and borrowing
2. Has difficulty understanding and doing word problems
3. Has difficulty sequencing information or events
4. Exhibits difficulty using steps involved in math operations
5. Shows difficulty understanding fractions
6. Is challenged making change and handling money
7. Displays difficulty recognizing patterns when adding, subtracting, multiplying, or dividing
8. Has difficulty putting language to math processes
9. Has difficulty understanding concepts related to time such as days, weeks, months, seasons, quarters, etc.
10. Exhibits difficulty organizing problems on the page, keeping numbers lined up, following through on long division problems

Intervention Strategies

1. Use concrete materials and start from practical activities.
2. Avoid creating anxiety for the student.
3. Establish the student's preferred learning style.
4. Teach more than one way to solve mathematical operations.
5. Build on student's existing knowledge.
6. Try to understand the student's errors, do not just settle for wrong.
7. Concentrate on one concept at a time.
8. Language should be kept to a minimum and specific cues given for various mathematical operations in word problems.
9. Encourage students to visualise mathematical problems. Allow students to draw a picture to help them understand the problem and ensure they take time to look at any visual information such as charts and graphs.

10. If the student does not have co-existing reading difficulties, encourage him/her to read problems aloud.
11. In the early stages of teaching new mathematical skills ensure that the mathematical problems are free of large numbers and unnecessary calculations.
12. Provide examples and try to relate problems to real-life situations.
13. Provide students with graph paper/squared paper and encourage them to use this to keep the numbers in line.
14. Ask to explain verbally how he/she arrived at particular solutions.
15. Explain new concepts in a logical manner.
16. Encourage students to teach a concept back in order to check understanding.
17. Ensure worksheets are uncluttered and clearly laid out and provide ample room for uncluttered computation. Ensure that the page does not look intimidating.
18. Limit copying from the board.
19. Allow students to use computers and calculators, especially to self-correct.
20. Provide students with extra time to complete tasks and encourage the use of rough work for calculations.
21. Directly teach the language of Mathematics.
22. Always bear in mind the language of Mathematics differs significantly from spoken English.
23. Use consistent mathematical language both in your classroom and throughout the school.
24. Make use of mnemonics and visual prompting cards to assist students in memorising rules, formulae and tables. Repetition is also very important.
25. Always match the strategy to the student's identified needs and abilities.

Dyspraxia

Dyspraxia is a condition which can be acquired or developmental. Children with dyspraxia often have difficulty organizing their bodies to perform the tasks they want their bodies to do. They find motor planning challenging, and struggle to perform fluid, smooth movements with finesse and control. They may find their motor skills fall behind those of their peers, and can often appear clumsy and awkward. A disorder that is characterized by difficulty in muscle control, which causes problems with movement and coordination, language and speech,

and can affect learning. Although not a learning disability, dyspraxia often exists along with dyslexia and dyscalculia. They face problems in movement, coordination, language and speech.



Figure: 4

Different Kinds of Dyspraxia

Dyspraxia can affect different kinds of movement. Professionals you speak to might break it down into these categories:

1. **Ideomotor dyspraxia:** Makes it hard to complete single-step motor tasks such as combing hair and waving goodbye.
2. **Ideational dyspraxia:** Makes it more difficult to perform a sequence of movements, like brushing teeth or making a bed.
3. **Oromotor dyspraxia**, also called verbal apraxia or apraxia of speech: Makes it difficult to coordinate muscle movements needed to pronounce words. Kids with dyspraxia may have speech that is slurred and difficult to understand because they're unable to enunciate.
4. **Constructional dyspraxia:** Makes it harder to understand spatial relationships. Kids with this type of dyspraxia may have difficulty copying geometric drawings or using building blocks.

Signs and Symptoms

1. Exhibits poor balance; may appear clumsy; may frequently stumble
2. Shows difficulty with motor planning

3. Demonstrates inability to coordinate both sides of the body
4. Has poor hand-eye coordination
5. Exhibits weakness in the ability to organize self and belongings
6. Shows possible sensitivity to touch
7. May be distressed by loud noises or constant noises like the ticking of a clock or someone tapping a pencil
8. May break things or choose toys that do not require skilled manipulation
9. Has difficulty with fine motor tasks such as coloring between the lines, putting puzzles together, cutting accurately or pasting neatly
10. Irritated by scratchy, rough, tight or heavy clothing

Intervention Strategies

There are some specific strategies you can employ in and outside the classroom to assist the student with dyspraxia. These include:

1. reducing the information load by providing instructions one at a time or as visual and / or auditory instructions.
2. avoiding situations where the student has to perform in front of an audience if they don't want to perform.
3. keeping objects in the classroom in the same place so it remains a predictable physical environment.
4. providing alternatives for handwriting tasks (such as keyboarding).
5. involving therapy support services and seeking advice when needed.
6. ensuring the play area is safe for a child with dyspraxia.

Approaches in identifying children with Disabilities

The Rehabilitation Council of India (1995) reports that not even five per cent of the disabled population are currently enjoying educational facilities. To provide education to this uncovered population, appropriate strategies need to be adopted for locating them for early intervention services. Early intervention would solve many of the problems of the child later in life. The common approaches in identifying persons with disabilities are as follows.

(1) Cognitive approach: This identification is purely based on the cognitive abilities of the child. By adopting the cognitive approach, identification of children may be made as those who are mentally retarded, slow learners, normal learners, academically advanced learners and gifted learners. For example

- The child who has an IQ between 50 and 75 will come under the category of educable mentally retarded child.
- The trainable mentally retarded children have an IQ of 25 to 50 and they may find it difficult even to perform manual kind of work.
- Those who have an IQ of less than 25 are called totally dependent category.

(2) Sensory approach: The sensory approach is based on the ability of the senses. By adopting it we can identify visually impaired, hearing impaired and deaf & dumb children. Out of them, visually impaired children are neither cognitive impaired nor communication impaired. They lack abilities in the orientation of environment. On the other hand, the deaf child's main problem is in the area of communication skills. The deaf blind children will have a serious disadvantage in both orientation and communication skills. As blind and deaf children are not impaired cognitively, they can follow the same curriculum meant for the sighted and hearing children. However, certain curricular adaptations have to be made to suit their learning styles.

(3) Ability-based approach: There are many children who experience difficulty in processing information. Though their intelligence is normal and senses too are normal, sometimes they perform poorly due to lack of ability in processing information. Information processing theorists feel that these children lack adequate skills in attention, perception, memory, encoding etc. These children are called as learning disabled children. Dysgraphia, Dyslexia and Dyscalculia are some of the defects associated with the learning problems in general.

(4) Society-based approach: Among disabled children, some of them are facing emotional problems too. The behaviour disorders in these children may also be a result of social problems such as the state of experience of neglect, over-protection, etc. There are many children who experience emotional problems. These children have to be provided the most appropriate environment for overcoming difficulties.

Role of Teacher in Managing Students with Disabilities

1. Break learning tasks into small steps.
2. Probe regularly to check understanding.
3. Provide regular quality feedback.
4. Present information visually and verbally.
5. Use diagrams, graphics and pictures to support instruction.
6. Provide independent practice.
7. Provide prompts of strategies to use and when to use them.
8. Use graphic organizers to support understanding of relationships between ideas.
9. Use adaptive equipment if appropriate (books on tape, laptop computers, etc.).
10. Provide clear photocopies of notes and overhead transparencies.
11. Provide a detailed course outline before class begins.
12. Keep oral instructions logical and concise and reinforce them with brief cue words.
13. Repeat or re-word complicated directions.
14. Give assignments both in written and oral form.
15. Have practice exercises available for lessons, in case the student has problems.
16. Have student underline key words or directions on activity sheets (then review the sheets with them).
17. Provide and teach memory strategies, such as mnemonic strategies and elaborative rehearsal.
18. Clearly label equipment, tools, and materials, and use color-coding.
19. Provide a peer tutor or assign the student to a study group.
20. Use mnemonic devices to teach steps of a math concept.

Conclusion:

A learning disability is a neurological disorder. In simple terms, a learning disability results from a difference in the way a person's brain is "wired." Children with learning disabilities are as smart or smarter than their peers. But they may have difficulty reading, writing, spelling, reasoning, recalling and organizing information if left to figure things out by themselves or if taught in conventional ways. A learning disability can't be cured or fixed; it is a

lifelong issue. With the right support and intervention, however, children with learning disabilities can succeed in school and go on to successful, often distinguished careers later in life.

Parents can help children with learning disabilities achieve such success by encouraging their strengths, knowing their weaknesses, understanding the educational system, working with professionals and learning about strategies for dealing with specific difficulties.

Questions for discussion and reflection

1. Explain the different kinds of learning disabilities.
2. Describe the importance and means of identifying the learning disabilities of students.
3. Suggest the strategies to overcome the learning disabilities of students.
4. Explain the various approaches in identifying children with disabilities.
5. Discuss the role of teacher in managing students with disabilities.

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UNIT-III: MODELS OF DISABILITY

Objectives

After the completion of the unit, the learners will be able to:

1. explain the concepts of models of disability.
2. describe the different models of disability.
3. discuss the importance of models of disability.
4. analyse the features of various models of diversity.

Introduction

Models of Disability are tools for defining impairment and, ultimately, for providing a basis upon which government and society can devise strategies for meeting the needs of disabled people. Some thought they do not reflect a real world, often incomplete and encourage narrow thinking, and seldom offer detailed guidance for action. However, they are a useful framework in which to gain an understanding of disability issues, and also of the perspective held by those creating and applying the models. Models of disability are essentially devised by people about other people. They provide an insight into the attitudes, conceptions and prejudices. From this, Models reveal the ways in which our society provides or limits access to work, goods, services and economic influence for people with disabilities.

Models are influenced by two fundamental philosophies. The first sees disabled people as dependent upon society. This can result in paternalism, segregation and discrimination. The second perceives disabled people as customers of what society has to offer. This leads to choice, empowerment, equality of human rights, and integration.

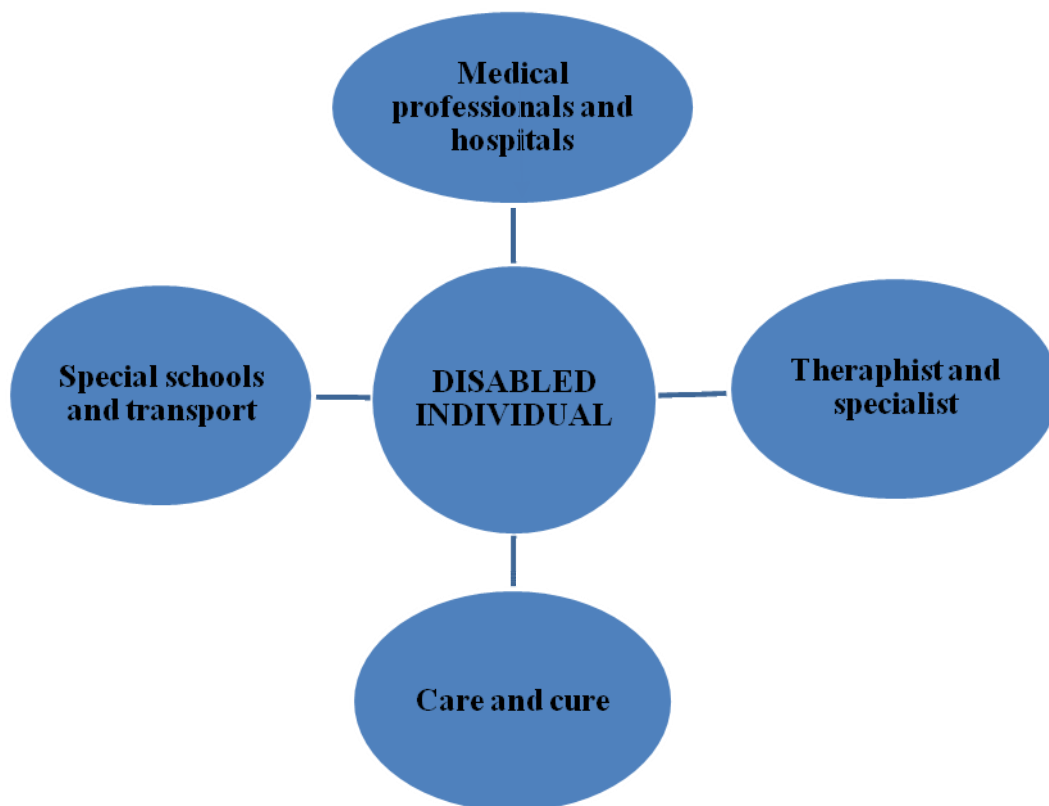
The Medical Model or Individual Model

The medical model of disability is a medical model by which illness or disability, being the result of a physical condition intrinsic to the individual may reduce the individual's quality of life, and cause clear disadvantages to the individual.

The medical model is presented as viewing disability as a problem of the person, directly caused by disease, trauma, or other health condition which therefore requires sustained medical

care provided in the form of individual treatment by professionals. In the medical model, management of the disability is aimed at a "cure," or the individual's adjustment and behavioral change that would lead to an "almost-cure" or effective cure. In the medical model, medical care is viewed as the main issue, and at the political level, the principal response is that of modifying or reforming healthcare policy.

Here disabled people are defined by their illness or medical condition. They are disempowered on the basis of medical diagnosis used to regulate and control their access to social benefits, housing, education, leisure and employment. This model promotes the view of a disabled person being a dependent and needing to be cured or cared for, and it justifies the way in which disabled people have been systematically excluded from society. This model is also known as the 'individual model' because it promotes the notion that it is the individual disabled person who must adapt to the way in which society is constructed and organised. It is sometimes referred to as the Biological-Inferiority or Functional-Limitation Model.



It is illustrated by the World Health Organisation's definitions, which significantly were devised by doctors:

Impairment: Any loss or abnormality of psychological or anatomical structure or function.

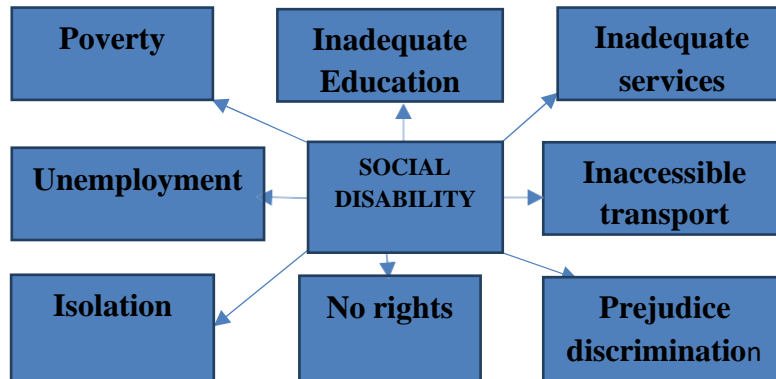
Disability: Lack of ability to perform an activity in the manner or within the range considered normal for a human being.

Handicap: Any disadvantage for a given individual, resulting from impairment or a disability that limits or prevents the fulfilment of a role that is normal for that individual."

And hence the medical approach is to make people with disabilities "normal" which of course implies that people with disabilities are in some way abnormal. Persons with disabilities need special services, such as special transport systems and welfare social services. For this purpose, special institutions exist, for example hospitals, special schools or sheltered employment places where professionals such as social workers, medical professionals, therapists, special education teachers decide about and provide special treatment, education and occupations.

The Social Model of Disability

In 1983, a disabled academician Mike Oliver coined "social model of disability." It focussed on an independent model and a social model, derived from the distinction originally made between impairment and disability. A fundamental aspect of the social model concerns equality and strongly believes in the phrase "Nothing about us without us". The social model of disability is based on a distinction between the terms "impairment" and "disability." Impairment is used to refer to the actual attribute, the abnormality, of a person, whether in terms of limbs, organs or mechanisms, including psychological. It addresses issues such as under-estimation of potential of disabled people to contribute to the society by enhancing economic values if given equal rights, suitable facilities and opportunities.



The Social Model regards *disability* to be a result of the way society is organised. Shortcomings in the way society is organised mean that people with disabilities face the following types of *discrimination* and barriers to *participation*.

- Attitudinal: This is expressed in fear, ignorance and low expectations (influenced by culture and religion);
- Environmental: This results in physical inaccessibility affecting all aspects of life (market and shops, public buildings, places of worship, transport, etc.); and
- Institutional: This means legal *discrimination*. Persons with disabilities are excluded from certain rights (e.g. by not being allowed to marry or to have children), or from school, etc.

According to the Social Model, a *disability* not only depends on the individual but also on the environment, which can be disabling or enabling in various ways. The social model describes that these variations from the "normal state" are in fact, normal and that any disability is the result of societal perceptions rather than barriers to participation in life.

The social model approaches disability problems, and therefore solutions, in a very different fashion than the biomedical model. For example, an individual with limited hand and arm strength may have problems opening public doors. The biomedical model would propose a solution that would address physical strength issues in the upper limb, perhaps through the

provision of physical therapy. The social model, conversely, would suggest a solution that would address the environmental limitation that imposed this disability and may advocate for automatic doors to replace the manual ones.

The social model advocates equality among individuals, and proposes that everyone can fully and completely participate in life if society's attitudes, information, and physical structures are appropriate for both "normal" and "differently abled" individuals.

The social model seeks to change society in order to accommodate people living with impairment; it does not seek to change persons with impairment to accommodate society. It supports the view that people with disability have a right to be fully participating citizens on an equal basis with others.

HUMAN RIGHTS MODEL

This is the definition of **DRPI (Disability Rights Promotion International)**. According to this group and many other rights groups, “As full citizens with equal rights, people with disabilities are entitled to: access to education, equal rights to parenthood, rights to property ownership, access to courts-of-law, political rights such as the right to vote, equal access to employment”

A human rights approach to disability acknowledges that people with disabilities are rights holders and that social structures and policies restricting or ignoring the rights of people with disabilities often lead to discrimination and exclusion. A human rights perspective requires society, particularly governments, to actively promote the necessary conditions for all individuals to fully realize their rights.

However, the rights approach does not address fundamental flaws within the system that disabled people are seeking inclusion in. For example, the rights model recognizes the right of disabled people to own private property but does not question fundamental injustices attached to property ownership. Further, it does not necessarily address colonialism which has resulted in

much of the property ownership in many parts of the world to be a direct result of racism and theft.

It is important to acknowledge that much of the access and privileges that disabled people have today is a direct result of the people who struggled and continue to struggle for disability rights. Many people have fought very hard for disabled people's inclusion in society and these struggles need to be recognized and celebrated. However, we need to do more than fight for rights within society as it is structured now, we need to fight for social justice for everyone and that means restructuring society.

A human rights-based approach to disability implies that all people are active subjects with legal claims and that persons with disabilities need to participate in all spheres of society on an equal basis with their non-disabled peers. According to the human rights-based approach to development as defined by the UN, development cooperation contributes to capacity development of "duty bearers", i.e. States and their institutions acting with delegated authority, to meet their obligations, and on the other hand of "rights-holders", e.g. persons with disabilities, to claim their rights.

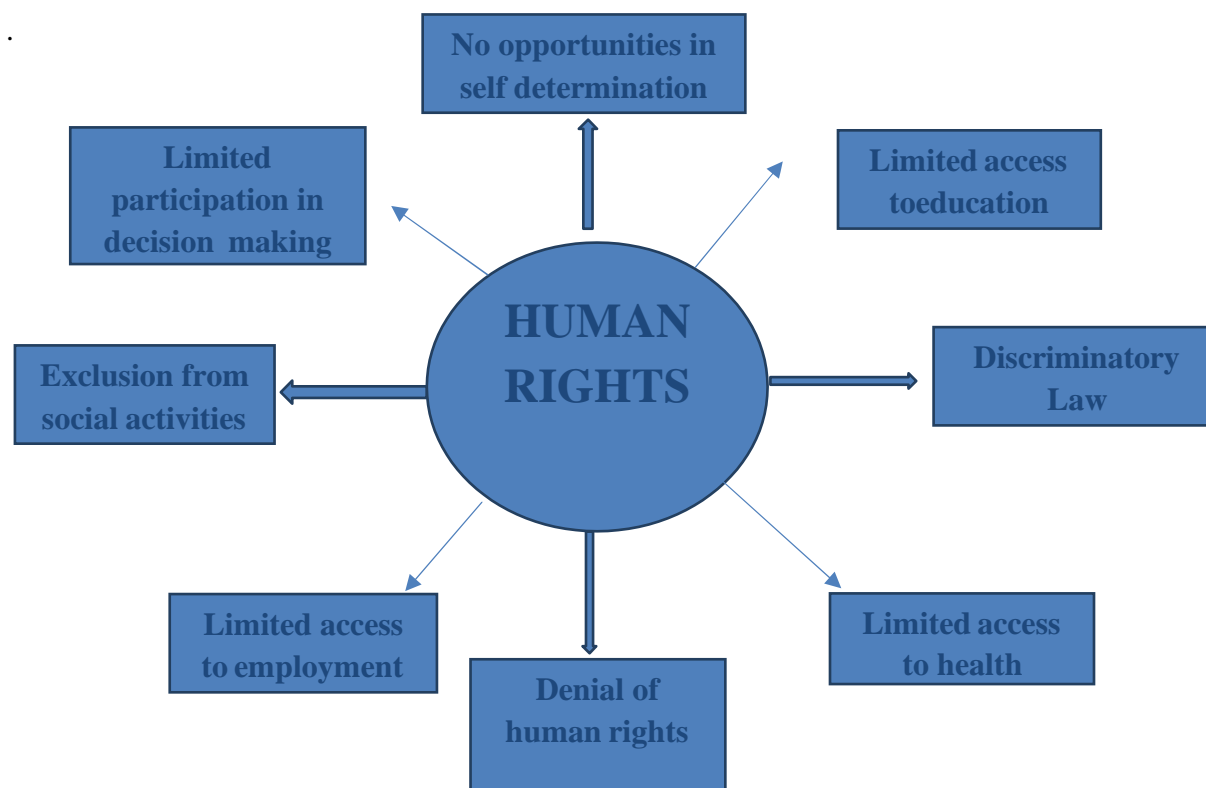
Throughout this process, the following core human rights principles should be applied:

- Equality and non-discrimination
- Participation and empowerment
- Transparency and accountability

Development cooperation needs to address the multiple barriers to the inclusion of persons with disabilities - physical, attitudinal and communication barriers. As these barriers can be found in all sectors and at all levels, a human rights-based approach to disability is relevant for programmes in a variety of sectors, including infrastructure, water and sanitation, health, education, social protection, employment, economic development or governance. Applying an HRBA (human rights-based approach) demands more than simply adding persons with disabilities to the target groups of development programmes.

It means adhering to and promoting the core human rights principles that underpin international human rights law. The Physical accessibility, Information and communication accessibility are the dimensions of accessibility. Physical accessibility is a key dimension for all

development programmes that include an infrastructure component. Information and Communication accessibility can be improved by providing information material in accessible formats or by using alternative communication



This model is closely related to the Social Model. It focuses on the fulfilment of human rights, for example the right to equal opportunities and *participation* in society. Consequently, society has to change to ensure that all people including people with disabilities have equal possibilities for *participation*. It is a fact that persons with disabilities often face a denial of their basic human rights, for example the right to health or the right to education and employment. Laws and policies therefore need to ensure that these barriers created by society are removed.

The Rights-based Model states that support in these areas is not a question of humanity or charity, but instead a basic human right that any person can claim.

The two main elements of the rights-based approach are *empowerment* and accountability. Empowerment refers to the *participation* of people with disabilities as active stakeholders, while accountability relates to the duty of public institutions and structures to implement these rights and to justify the quality and quantity of their implementation.

The human rights model positions disability as an important dimension of human culture, and it affirms that all human beings irrespective of their disabilities have certain rights which are absolute. This model builds upon the spirit of the Universal Declaration of Human Rights, 1948, according to which, 'all human beings are born free and equal in rights and dignity.'

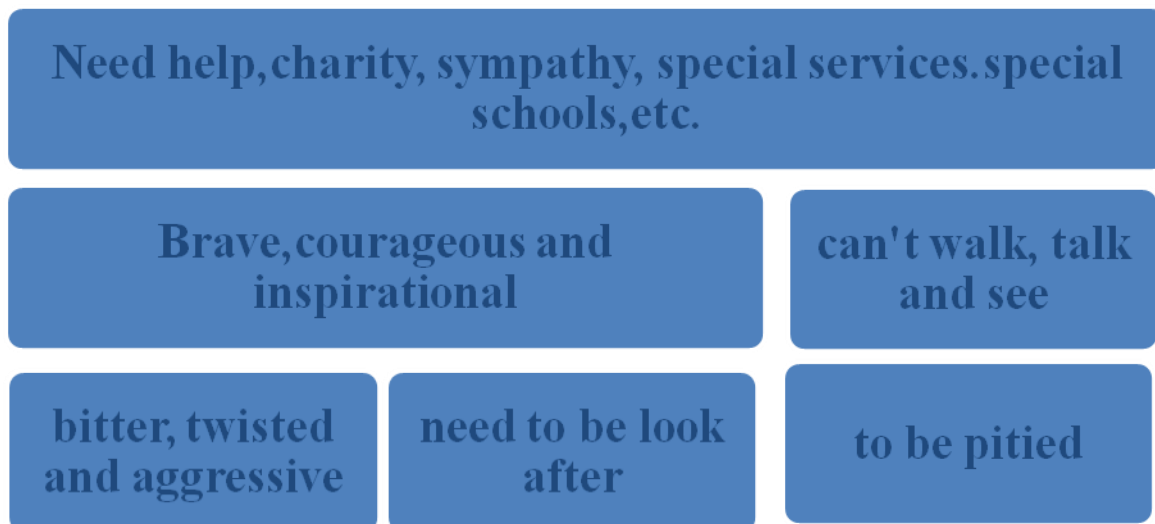
THE CHARITY MODEL

This model treats persons with disability as helpless victims needing 'care' and 'protection'. This model relies largely on the goodwill of benevolent humanitarians for 'custodial care' of the person with disabilities rather than justice and equality and creates an army of powerless individuals dependent on either arrangements maintained by these so called benevolent individuals who are outside of the mainstream development and State sponsored charities or mechanisms of social support like special schools and protection homes for person with disabilities. In the core of this model, disability was perceived as a disqualification for claiming the right of social resources which ensured the exclusion of persons with disabilities from social arrangements, public services and justified their exclusion from mainstream education and employment.

The Charity Model sees people with disabilities as victims of their *impairment*. Depending on the *disability*, the disabled persons cannot walk, talk, see, learn, or work. Disability is seen as a deficit. Persons with disabilities are not able to help themselves and to lead an independent life. Their situation is tragic, and they are suffering. Consequently, they need special services, special institutions, such as special schools or homes because they are different. People with disabilities are to be pitied and need our help, sympathy, charity, welfare in order to

be looked after. Sometimes people with disabilities themselves adopt this concept, in which case they usually feel “unable” and have a low sense of self-esteem.

The idea of being recipients of charity lowers the self-esteem of people with disabilities. In the eyes of "pitying" donors, charitable giving carries with it an expectation of gratitude and a set of terms imposed upon the beneficiary. The first is patronising; the second limiting upon the choices open to disabled people. Also, employers will view disabled people as charitable cases. Rather than address the real issues of creating a workplace conducive to the employment of people with disabilities, employers may conclude that making charitable donations meets social and economic obligations.

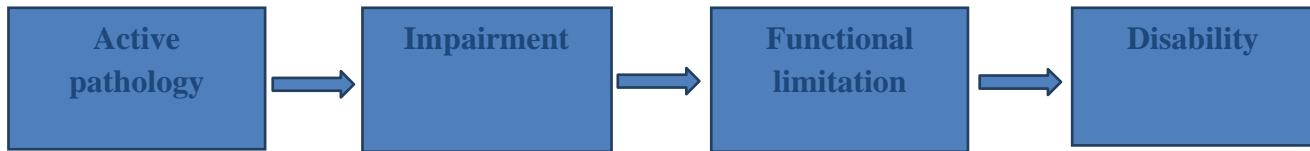


This is not to advocate dismantling charities and outlaw caring, charitable acts, which enrich our society and bring badly needed funds. But we do need to educate charity managers and professionals to review the way they operate and ensure that funds are channeled to promote the empowerment of disabled people and their full integration into our society as equal citizens requiring our respect and not our pity.

THE DISABLEMENT MODEL

The Disablement Model was created in the early 1960's by sociologist SaadNagi as part of efforts to study disability for the United States Social Security Administration (SSA). This

model describes four basic phenomena that Nagi considered fundamental to rehabilitation, active pathology, impairment, functional limitations, and disability.



The four elements of Nagi's Disablement Model:

- **Active pathology** describes an interruption in normal body processes that leads to a deviation from the normal state. These include infection, trauma, disease processes, or other degenerative conditions.
- **Impairment** is the complete loss, damage to, or interruption in normal body structures or systems. Interestingly, this model describes how active pathologies commonly result in impairments, but the reverse is not always true. For example, impairment, such as a congenital limb absence, is not the result of active pathology.
- **Functional Limitations** are described as individual performance restrictions. Here, a muscular contraction could cause a functional limitation such as limited range-of-motion in the upper limb.
- **Disability** is described as an express physical and/or mental limitation in the context of a society.

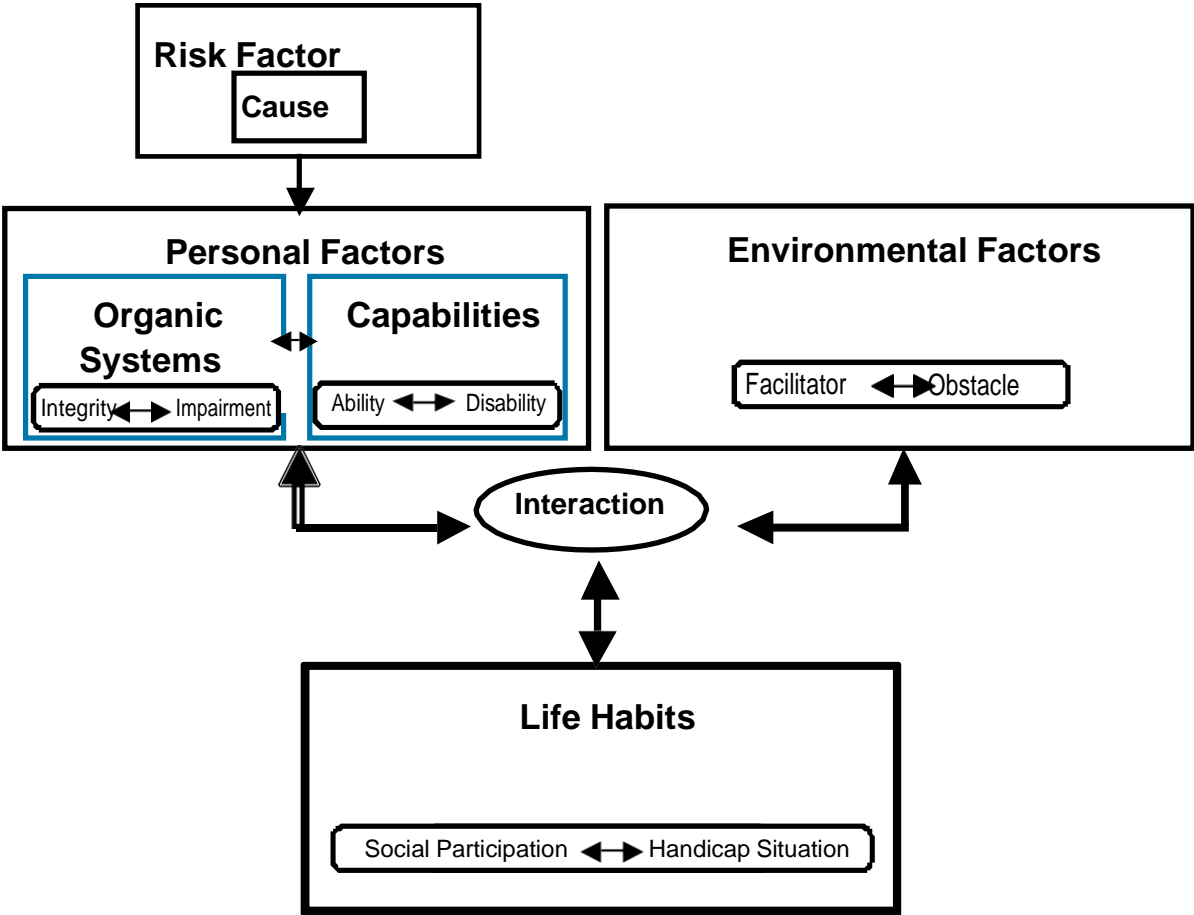
The Disablement Model views disability as an interaction between the individual and society. Furthermore, Nagi's model suggests that individual and social accommodations to an underlying pathology may diminish disability for one individual, while emphasizing it in another individual

THE DISABILITY CREATION PROCESS

The disability creation process is close to the International Classification of Functioning, Disability and Health developed by the World Health Organization (WHO). It is also in line with

the definition of disability provided in the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD). At present these three converging references provide a shared, common vision and understanding of disability and add clarity to the notions of impairment, disability and disabling situations. Disability is not considered a characteristic of the person but as the result of interaction between the person and his/her environment. Reducing situations of disability therefore implies action on both personal and environmental factors.

Disability is therefore not only the concern of medical services: it needs to be inscribed more broadly within multi-sector dynamics and needs to be addressed by all development sectors such as education, employment, health, social protection with a cross-cutting approach. Disability is relevant to all development stakeholders acting at international, national and/or local levels.



The Disability Creation Process is an adaptation of the human development model in the area of disability. It uses the central notion of social participation as resulting from an interaction between personal factors and environmental factors.

Personal factors, which are internal, are the result of the combination of **organic systems** (for example, the muscular system) and **aptitudes** (for example, motor activity capabilities). Organic systems can vary in degrees, from integrity to organic impairment (or deficiency). An individual's aptitudes can also vary from capacity to inability (or functional impairment).

Environmental factors constitute either facilitators or obstacles regarding an individual's life habits. Environmental factors enable social participation or, on the contrary, worsen a disabling situation.

organic system is a group of bodily components all sharing a common function. An **impairment** refers to the degree of anatomical, histological (structural) or physiological anomaly or alteration of an organic system.

aptitude is the extent to which a person is capable of accomplishing a physical or intellectual activity.

The notions of impairment and capabilities are measured in terms of "degrees".

A **risk factor** is an element of an individual or within his/her environment that is *likely to* provoke a disease, trauma or any other disruption to his/her integrity or development.

A **cause** is a risk factor that has *effectively* led to a disease, trauma or any other disruption to a person's integrity or development, for example, a car accident, or failure to treat diabetes causing diabetic foot.

An **environmental factor** is a physical or social dimension that determines a society's organization and context.

Facilitator refers to an environmental factor that contributes to the accomplishment of life habits (when interacting with personal factors).

An **obstacle** is an environmental factor or situation that hinders the accomplishment of life habits (when interacting with personal factors).

Life habits

The interaction between personal factors including the degree of impairment of organic systems, degree of inability to realize some aptitudes, but also the age, sex, identity and environmental factors, which can be facilitators or obstacles, either does or does not enable the full realization of a person's life habits. Life habit is a daily activity or a social role valued by the person the socio-cultural context according to the characteristics, which ensures the survival and well-being in the society.

social participation corresponds to the full realization of life habits, for example: Cook and eat, Work, Tinkering ,Go to school, Go to the cinema, Play chess etc.

A **disabling situation** corresponds to lack of, or reduced, realization of life habits. For example, where an individual: cannot play music, does not have a job, does not go to school, cannot go out, cannot live where they wants etc.

CONCLUSION

Models of Disability are tools for defining impairment and, ultimately, for providing a basis upon which government and society can devise strategies for meeting the needs of disabled people. They are often treated with skepticism as it is thought they do not reflect a real world, are often incomplete and encourage narrow thinking, and seldom offer detailed guidance for action. However, they are a useful framework in which to gain an understanding of disability issues, and also of the perspective held by those creating and applying the models.

Questions for Discussions and Reflections

1. **Explain briefly the medical model of disability.**
2. Explain any two models of disability with its salient features.
3. Explain charity model of disability.
4. What are models of disability? Explain different types of disabilities with examples.
5. Write down the salient features of Nagi's Disablement Model.

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UNIT IV: INCLUSIVE EDUCATION

Objectives:

After the completion of the unit, the learner will be able to,

1. obtain the knowledge of inclusive education
2. trace out the barriers in inclusive education
3. Explore the ways and means for education for all and mixed ability grouping and teaching.

Introduction

Inclusion in education is an approach to educating students with special educational needs. Under the inclusion model, students with special needs spend most of their time with non-disabled students. Inclusion rejects the use of special schools or classrooms to separate students with disabilities from students without disabilities.

Meaning of Inclusive Education

Schools most frequently use the inclusion model for selected students with mild to moderate special needs. Inclusive Education does not separate "general education" and "special education" programs; instead, the school is restructured so that all students learn together. Inclusive education is a process of strengthening the capacity of the education system to reach out to all learners and can thus be understood as a key strategy to achieve education for all.

UNESCO's Definition of Inclusive Education

UNESCO, along with other UN agencies, a number of international and national non-governmental organizations, been working towards achieving this goal- adding to the efforts made at the country level for Inclusive Education.

Despite encouraging developments, UNESCO recognized that current strategies and programmes have largely been insufficient or inappropriate with regard to needs of children and youth who are vulnerable to marginalization and exclusion. Where programmes targeting various marginalized and excluded groups do exist, they have functioned outside the mainstream – special programmes, specialized institutions, and

specialist educators. The educational opportunities that do not guarantee the possibility to continue studies, or differentiation becoming a form of discrimination, leaving children with various needs outside the mainstream of school life and later, as adults, outside community social and cultural life in general (UNESCO, 1999).

UNESCO works to assist in providing a sound understanding and support for the principle of inclusion and its implications which could be applied in the school system by the national and local governments, schools and teachers. Assistance is also provided in exploring and identifying what countries could do to more proactively seek and reach out to any learner who is left behind. These endeavors aim to better promote improvement and implementation of education policies and practices on inclusive quality education.

Education For All (EFA)

Significant progresses in achieving EFA have been made by countries through policies, programmes and projects implemented in the past and currently implemented. Specific strategies, approaches and targeted programmes have aggressively been pursued by countries to reach particular groups. Although significant improvements have shown in national aggregates, however many issues still exist and must still be addressed urgently if EFA is to be met by 2020. Poverty and marginalization are major causes of exclusion from education, which need to be effectively responded to avoid setbacks in progresses the countries have achieved towards attaining the EFA goals.

Barriers to Inclusive Education

The greatest barriers to inclusion are caused by society, not by particular medical impairments. Negative attitudes towards differences result in discrimination and can lead to a serious barrier to learning. Negative attitudes can take the form of social discrimination, lack of awareness and traditional prejudices. Regarding disabled children some regions still maintain established beliefs that educating the disabled is pointless. Often the problem is identified as being caused by the child's differences rather than the education systems shortcomings.

Physical Barriers

The vast majority of centers of learning are physically inaccessible to many learners, especially to those who have physical disabilities. In poorer, particularly rural areas, the centres of learning are often inaccessible largely because buildings are rundown or poorly maintained. They are unhealthy and unsafe for all learners. Many schools are not equipped to respond to special needs, and the community does not provide local backing. A major problem identified by many students is physically getting into school.

Curriculum

In any education system, the curriculum is one of the major obstacles or tools to facilitate the development of more inclusive system. Curriculum is often unable to meet the needs of a wide range of different learners. In many contexts, the curriculum is centrally designed and rigid, leaving little flexibility for local adaptations or for teachers to experiment and try out new approaches.

Teachers

Teachers' abilities and attitudes can be major limitations for inclusive education. The training of staff at all levels is often not adequate. Where there is training it often tends to be fragmented, uncoordinated and inadequate. If teachers do not have positive attitudes towards learners with special needs, it is unlikely that these children will receive satisfactory education.

Language and Communication

Teaching and learning often takes place through a language which is not the first language of some learners. This places these learners, at a disadvantage and it often leads to significant linguistic difficulties which contribute to learning breakdown. Second language learners are particularly subject to low expectations and discrimination.

Overcoming the Barriers in Inclusive Education

Creating a more inclusive system requires a new approach in attitude. Simply placing children with special needs within the school system will not lead to meaningful inclusion. The focus needs to shift from seeing the problem as the child's differences to problem identification with the unwelcoming school system. In order to change the school system, there first must be change in the attitudes of the stakeholders. One way of improving stakeholders' attitudes towards inclusive education is to raise awareness of the potential benefits of inclusive education for all students.

Teacher Training And Support to overcome the barriers in inclusive education

In addition to being re-trained in curriculum and evaluation, teachers need to be trained to change their attitude of special needs children. Teachers can be trained to view those who do not fit into existing arrangements as offering 'surprises'; that is, opportunities that invite further inventiveness. This implies a more positive view of differences.

Teachers must also be supported with appropriate materials. Lack of teaching/learning materials may hamper the quality of education. Teachers need support for their work in terms of information and background materials so that they can prepare their lessons and update their own knowledge. Also locally made learning/teaching materials can enhance considerably the quality of the learning/teaching process.

Promoting Inclusive Education

Countries have made many strong progresses in developing and implementing inclusive education, namely in its inclusion in national policies and strategies; in development and dissemination of supportive guidelines; and in the increasing number of regular private and public schools that practice inclusive education.

An inclusive system benefits all learners without any discrimination towards any individual or group. Inclusiveness should be reflected in the policies, curriculum, teacher training, and capacity development support provided. Policies for inclusive education that aim to address the learning needs of all children, especially those who are vulnerable to marginalization and exclusion (whether left out from school, or excluded within the school)

need to be strengthened. More flexible rules and teacher training are needed so schools and teachers would be able to develop child-focused teaching methods and individual learning plans and assessments/evaluations for all children who may not be able to follow the centrally designed curriculum and examination. Adequate and coordinated training needs to be given to teachers, in order for them to be able to provide satisfactory education for all of their students, namely on how to make classroom practices more child-friendly, flexible, and without any discrimination towards any individual. External support needs to be mobilized to strengthen capacities of schools and teachers in implementing inclusive education practices.

Mixed Ability Grouping Teaching

In general, mixed age grouping contributes a lot to social development of student members. Research reveals that children are aware with the differences and the expected behavior associated with their age. Thus, students in mixed groups have different expectations and play different roles in the group. Older students, more mature and experienced students realize that they have a more tutoring and protecting role for their younger group mates. Usually, these students are more willing to play this role, to act as mentors for their younger colleagues, than in the case when they have to cooperate in groups with mates of the same age. When children have to cope with mates of their age in groups, there are more possibilities of exhibiting aggressive and competitive behavior than cooperating. On the other hand cooperation and productive interaction is much more likely to exist among groups of children of different ages.

Younger mates are inspired and try to comprehend models of behavior of their older mates not simply imitate behaviors. At the same time cognitive development occurs in older students as well since their role as tutors in the group require deep comprehension of the knowledge they are about to transfer.

S.NO	INTEGRATION EDUCATION	INCLUSIVE EDUCATION	SPECIAL EDUCATION
1.	Needs of “special students”	Rights of ALL students	Special needs of individual differences
2.	Changing/remedying the subject	Changing the school	Challenges with learning in schools
3.	Benefits to the student with “special needs”	Benefits ALL students	Benefit from additional educational services
4.	Professionals, specialist expertise, and formal support	Informal support and the expertise of mainstream teachers	Different approaches to teaching

Teacher Development Initiatives for Inclusive Schooling

The idea of inclusive education brings new demands and challenges to all teachers. Schools are expected to accommodate all students with and without special educational needs and accordingly, teachers should have the competence to support every student’s learning.

Experience is also considered to be important factor in promoting positive attitudes and helping teachers to feel more confident and competent. Besides ‘knowledge’ and ‘experience’ there is one major factor that is important in fostering teachers’ positive attitudes towards students with special needs. Namely, the ideological commitment to the principle of inclusion forms the grounds of facilitating the learning of students with special needs.

Teachers’ competence development towards more inclusive education includes in general an ability to facilitate learning of diverse students and to develop school

as well as educational environment so that the individual needs are taken into account. Changes in teachers' own practices and in the system (school) are concrete results of competence development in Inclusive Education.

Questions for discussions and reflections:

1. Examine the impact of Inclusive Education.
2. Analyze the barriers of Inclusive Education and how to overcome the barriers.
3. Discuss – Mixed Ability Grouping Teaching.
4. Differentiate Integration Education, Inclusive Education and Special Education.

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UNIT-V: POLICIES AND PROGRAMMES OF INCLUSIVE EDUCATION

Objectives

1. discuss the contributions of Global Policies and programmes on inclusive education
2. discuss the various inclusive education policies and programmes in india

Introduction

There are an estimated 25 million children out of school in India (MHRD 2003 statistics, cited in World Bank, 2004), many of whom are marginalized by factors such as poverty, gender, disability, caste, religion etc. Therefore undoubtedly the idea of inclusive education is certainly highly relevant to our current condition, where differences in religion, faith, gender, ethnicity and ability are often seen as a threat rather than a source of richness and diversity. Inclusive education stands for improvement of schools in all dimensions to address the educational needs of all children. The major support for inclusive education came from the 1994 World conference on Special Needs Education in Salamanca, Spain which emphasized that: Schools should accommodate all children regardless of their physical, intellectual, social, emotional, linguistic or other conditions. The urgency to address the needs of learners who are vulnerable to exclusion through responsive educational opportunities was also highlighted at the Dakar (Senegal) World Education forum in April 2000 where in it was emphasized –“The key challenge is to ensure that the broad vision of education for all as an inclusive concept reflected in national government and funding agency policies. Education for All.... must take account of the needs of the poor and the most disadvantaged, including working children, remote rural dwellers and nomads, and ethnic and linguistic minorities, children, young people and adults affected by conflict, HIV/AIDS, hunger and poor health; and those with special learning needs....”.

Inclusive Education Policy

Recommendations to send children with disabilities to mainstream schools were first made in the Sargent Report in 1944, and again in 1964 by the Kothari Commission (Julka, 2005). Despite this, the change has been slow, with segregation in special schools dominating the scene until recently.

The 1995 Persons with Disability Act (PDA) states that disabled children should be educated in integrated settings where possible, although it seems that the lack of implementation may be due to there being no enforcement agency for this legislation.

Despite the promotion of inclusive education, govt. documents focus on inclusive education as being about including children with disabilities in the education system, but not specifically the mainstream (Singal, 2005a). However, inclusion in the education system is not the same as inclusion in the mainstream. It is however arguable that special education is in fact regarded as superior in India due to its preferred status (Mukhopadhyay and Mani, 2002) and that it is inclusion in the mainstream that is currently seen as the resource – constrained inferior alternative. However the limited coverage of mainly urban-based, impairment specific special schools in India may result in the exclusion of children with disabilities who do not fit the categories of their institutions or who live in rural areas. Inclusive education may be the only way of facilitating educational access for these children.

Teacher Education Programmes

There is no need of reinforcing the fact that teacher education remains a very weak link with respect to equipping teachers to be prepared for an inclusive classroom environment. The teacher education diplomas and degrees offer “Education of children with special needs” as an optional subject, in order to prepare teachers to identify and diagnose disability. However it gives them a holistic perspective with respect to dealing with diversity or challenge negative attitudes. This reinforces the ‘difference’ of children with disabilities who, some believe, can only be taught by teachers qualified specifically for them (Signal, 2005a). Although, it is ultimately teacher treatment of students in the classroom, rather than the training per se, that would reinforce this difference. Interestingly, distrust in both the special and mainstream education systems leads some parents to keep children with disabilities at home for fear of their abuse or neglect in the classroom (Julka, 2005); which may then be interpreted by teachers as a lack of community interest in education for their children, as demonstrated in the PROBE Report (PROBE,1999). There is evidence to suggest that many teachers do not feel equipped to teach children with disabilities and complain that they need more time to instruct these students (Mukhopadhyay, nd). Many government programmes have included a teacher training component in an attempt to instigate institutional change. However, a ‘special needs’ focus and a lack of

training for management, combined with didactic training methodology do little to alter the classroom. The poor quality educational provision in many schools is reflected in the fact that many govt. job reservations for adults with disabilities remain unfilled. It is more likely to be directly related to the fact that very few children with disabilities get to, or stay in, school that there is a lack qualified, let alone confident candidates.

Infrastructural support

A small pool of resources (41% of GDP for education UNDP, 2005:256) despite a promised 6% by 2000 (GOI, 2002) combined with high demand, suggests that the development of the mainstream would be a more financially effective and efficient way to go (Peters, 2004; UNESCO, 2003). This could result in smaller classes and better teaching which would benefit all students (Singal, 2005). Arguably, resources would not be so limited after all if all specialist institutions were moved to the mainstream, which may explain why Thomas (2005) argues that, there are indeed sufficient resources in India to implement inclusive education. However, this solution could mean that the essential services which some special schools provide (and would still be needed) would be spread wider, and thinner.

Prospects of Inclusive Education

Inclusive education is a developmental approach seeking to address the learning needs of all children, youth and adults with a specific focus on those who are vulnerable to marginalization and exclusion. An increasing number of publications, policy papers, workshops etc. have supported the ideology of inclusion. Some organizations and people, however, doubt whether the ordinary classroom can provide quality education for disabled children. This debate has been on, ever since people began to voice their reservation against old segregated institutions and in turn raised their concern for equality of disabled children. These concerns must be taken seriously and dispelled by showing examples of positive experiences, which clearly demonstrate that inclusive education most definitely addresses quality issues in education.

Conclusion

It is important to remember that Inclusive education is at a very early stage of conceptualization and implementation in India. The fact that it is being discussed, debated and in

some places implemented although falteringly, demonstrates a willingness to engage with elements with elements of a new concept that has the potential to be developed in the future in a positive manner.

So long as the “struggle to achieve compulsory education for a majority of children takes precedence over meeting the needs of those with disabilities...” (Ainscow et al, 1995 cited in Singal, 2005b:338), change for children with disabilities will continue to be sporadic and painfully slow. The division of educational responsibility for children, between the MSJE for those with disabilities and the MHRD for those without, can only exacerbate this struggle, and highlight the ‘different’ nature of children with disabilities needs and the special needs focus of inclusive education with it. This implies that if inclusive education came under one ministry, most probably the MHRD, potentially both conceptualization and implementation could be clarified and promoted, while the needs of children with disabilities could finally be mainstreamed.

INCLUSIVE EDUCATION POLICIES AND PROGRAMMES IN INDIA

INTRODUCTION:

Inclusive education (IE) is a new approach towards educating the children with disability and learning difficulties with that of normal ones within the same roof. It seeks to address the learning needs of all children with a specific focus on those who are vulnerable to marginalization and exclusion. It implies all learners – with or without disabilities being able to learn together through access to common pre-school provisions, schools and community educational setting with an appropriate network of support services. This is possible only in flexible education system that assimilates the needs of diverse range of learners and adapts itself to meet these needs.

Inclusion is not an experiment to be tested but a value to be followed. All the children whether they are disabled or not have the right to education as they are the future citizens of the country. In the prevailing Indian situation resources are insufficient even to provide quality mainstream schools for common children, it is unethical and impracticable to put children with special needs to test or to prove any thing in a research study to live and learn in the mainstream of school and community (Dash, 2006).

SPECIAL EDUCATION VS INCLUSIVE EDUCATION:

The term “Special Need Education” (SNE) has come into use as a replacement for the term “Special Education”, as the older one was mainly understood to refer the education of all those children and youth whose needs arise from disabilities or learning difficulties. The Statement affirms: “those with special educational needs must have access to regular schools which should accommodate them within child centered pedagogy capable of meeting these needs”.

Moreover, the concept of “Special Need Education” extends beyond those who may be included in handicapped categories to cover those who are failing in school for a wide variety of other reasons that are known to be likely to impede a child’s optimal progress. Whether or not this more broadly defined group of children are in need of additional support depends on the extent to which school needs to support their curriculum, teaching and/or to provide additional human or material resources so as to stimulate efficient and effective learning for these pupils. (International Standard Classification of Education ISCED, 1997)

Indian scenario:

Till 1990s ninety percent of India’s estimated 40 million children in the age group- four-sixteen years with physical and mental disabilities are being excluded from mainstream education. The overwhelming majority of them are vagabonds not out of volition but because of callous school managements and over-anxious parents of abled children in a travesty of humanity and social justice. They have consistently discouraged children with disabilities from entering the nation’s classrooms. Social justice and equity which are dominant sentiments of the Constitution of India demand that India’s 35 million physically challenged, if not the 5 million mentally challenged, children should be given preferential access into primary and secondary schools. Fewer than five percent of children who have a disability are in schools. Remaining nine-tenths of them are excluded.

Against this backdrop of continuous neglect, there is an urgent need to find ways for developing potential of this large proportion of challenged children.

Historical Perspective:

In India special education as a separate system of education for disabled children outside the mainstream education system evolved way back in 1880s. The first school for the deaf was set up in Bombay in 1883 and the first school for the blind at Amritsar in 1887. In 1947, the number of schools for blind increased to 32, for the deaf 30 and for mentally retarded 3. There was rapid expansion in the number of such institutions. The number of special schools rose to around 3000 by the year 2000 (Department of Education, 2000). The Govt. of India in the 1960s designed a scheme of preparing teachers for teaching children with visual impairment. Similar schemes for teaching children with other disabilities were gradually developed. However, the quality of the trained teachers was in question because of lack of uniform syllabi of various courses, eligibility criteria for admission to these courses and also due to large extent of non-availability of teacher educators and literatures in the field. Therefore, in 1980s the then ministry of Welfare, Govt. of India, realized the crucial need of an institution to monitor and regulate the HRD programmes in the field of disability rehabilitation.

The National Policy on Education, 1986 (NPE, 1986), and the Programme of Action (1992) stresses the need for integrating children with special needs with other groups. The objective to be achieved as stated in the NPE, 1986 is "to integrate the physically and mentally handicapped with general community as equal partners, to prepare them for normal growth and to enable them to face life with courage and confidence"

Integrated Education

The concept of integrated education in India has emerged during the mid 1950s. It is based on the medical model of disability and it emphasizes placement of children with disabilities in mainstream schools. The major thrust is on attendance.

School Based Approach:

Consequent on the success of international experiments in placing children with disabilities in regular schools, the Planning Commission in 1971 included in its plan a programme for integrated education. The Government launched the Integrated Education for Disabled Children (IEDC) scheme in December 1974. It was a Centrally Sponsored Scheme

aimed to provide educational opportunities to children with special needs (CWSN) in regular schools and to facilitate their achievement and retention. Under the scheme, hundred per cent financial assistance is provided to for setting up resource centers, surveys and assessment of children with disabilities, purchase and production of instruction materials and training and orientation of teachers. The scope of the scheme includes pre-school training, counseling for the parents, and special training in skills for all kinds of disabilities. The scheme provides facilities in the form of books, stationery, uniforms, and allowances for transport, reader, escort etc.

MINISTRY OF HUMAN RESOURCE DEVELOPMENT (MHRD) ACTION PLAN:

An outline of MHRD action plan is presented below:

- To complement and supplement IEDC and Sarva Shiksha Abhiyan programmes in the movement from integration to inclusion.
- Enrolment and retention of all children with disabilities in the mainstream education system. (Free and compulsory education from 0 to 14 under draft Bill/free education 0 to 18 yrs under PWD Act).
- Providing need based educational and other support in mainstream schools to children in order to develop their learning and abilities, through appropriate curricula, organizational arrangements, teaching strategies, resource and partnership with their communities.
- Support higher and vocational education through proper implementation of the existing reservation quota in all educational institutions and creation of barrier free learning environments.
- Disability focused research and interventions in universities and educational institutions.
- Review implementation of existing programmes, provisions to identify factors leading to success or failure of the drive towards enrollment and retention of children with disabilities in mainstream educational settings. Address administrative issues arising out of review.

- Generating awareness in the general community, activists and persons working in the field of education and more specifically among parents and children that the disabled have full rights to appropriate education in mainstream schools and that it is the duty of those involved in administration at every level including schools to ensure that they have access to education.
- Ensure enrollment and intervention for all children with special needs in the age group 0-6 years in Early Childhood Care and Education Programs.
- Facilitate free and compulsory elementary education for children with special needs in the age group 6-14 (extendable to 18 yrs.) in mainstream education settings currently under the Sarva Shiksha Abhiyan (SSA) (SSA is a governmental program shared by both union and state governments for achieving universal elementary education in India by 2010) .

The Tenth Plan (2002-2007) aims to provide Universal Elementary Education by the end of the plan. It also aims to provide basic education for the un-reached segments and special groups. The special interventions and strategies like pedagogic improvement and adoption of child centered practices are focused on the groups like the girls, scheduled castes and scheduled tribes, working children, children with disabilities, urban deprived children, children from minority groups, children below poverty line, migratory children and in the hardest to reach groups.

National Curriculum Framework, 2005:

A policy of inclusion needs to be implemented in all schools and throughout Indian education system. The participation of all children needs to be ensured in all spheres of their life in and outside the school. Schools need to become centers that prepare children for life and ensure that all children, especially the differently abled children from marginalized sections, and children in difficult circumstances get the maximum benefit of this critical area of education. Opportunities to display talents and share these with peers are powerful tools in nurturing motivation and involvement among children. In our schools we tend to select some children over and over again. While this small group benefits from these opportunities, becoming more self-confident and visible in the school, other children experience repeated disappointment and progress through school with a constant longing for recognition and peer approval. Excellence and ability may be singled out for appreciation, but at the same time opportunities need to be

given to all children and their specific abilities need to be recognized and appreciated. This includes children with disabilities, who may need assistance or more time to complete their assigned tasks. It would be even better if, while planning for such activities, the teacher discusses them with all the children in the class, and ensures that each child is given an opportunity to contribute. When planning, therefore, teachers must pay special attention to ensuring the participation of all. This would become a marker of their effectiveness as teachers. Excessive emphasis on competitiveness and individual achievement is beginning to mark many of our schools, especially private schools catering to the urban middle classes. Very often, as soon as children join, houses are allocated to them. Thereafter, almost every activity in the school is counted for marks that go into house points, adding up to an end-of-the-year prize. Such 'house loyalties' seem to have the superficial effect of getting all children involved and excited about winning points for their houses, but also distorts educational aims, where excessive competitiveness promotes doing better than someone else as an aim, rather than excelling on one's own terms and for the satisfaction of doing something well. Often placed under the monitoring eye of other children, this system distorts social relations within schools, adversely affecting peer relations and undermining values such as cooperation and sensitivity to others. Teachers need to reflect on the extent to which they want the spirit of competition to enter into and permeate every aspect of school life performing more of a function in regulating and disciplining than in nurturing learning and interest. Schools also undermine the diverse capabilities and talents of children by categorizing them very early, on narrow cognitive criteria. Instead of relating to each child as an individual, early in their lives children are placed on cognitive berths in the classroom: the 'stars', the average, the below - average and the 'failures'. Most often they never have a chance to get off their berth by themselves. The demonizing effect of such labeling is devastating on children. Schools go to absurd lengths to make children internalise these labels, through verbal name calling such as 'dullard', segregating them in seating arrangements, and even creating markers that visually divide children into achievers and those who are unable to perform. The fear of not having the right answer keeps many children silent in the classroom, thus denying them an equal opportunity to participate and learn. Equally paralyzed by the fear of failure are the so called achievers, who lose their capacity to try out new things arising from the fear of failure, doing less well in examinations, and of losing their ranks. It is important to allow making errors and mistakes to remain an integral part of the learning

process and remove the fear of not achieving 'full marks'. The school needs to send out a strong signal to the community, parents who pressurize children from an early age to be perfectionists. Instead of spending time in tuitions or at home learning the 'perfect answers', parents need to encourage their children to spend their time reading storybooks, playing and doing a reasonable amount of homework and revision. Instead of looking for courses on stress management for their pupils, school heads and school managements need to de-stress their curricula, and advise parents to de-stress children's life outside the school. Schools that emphasise intense competitiveness must not be treated as examples by others, including state-run schools. A child has special educational needs if s/he has difficulty in learning. This may require special educational provision to be made for him or her. A child may have learning difficulty because of a disability which hinders her/his from making use of the existing educational facilities provided for all other children of her class. A child may have learning difficulty because of some other reasons too.

Inclusive Education in Sarva Shiksha Abhiyan:

Sarva Shiksha Abhiyan (SSA) was launched to achieve the goal of Universalisation of Elementary Education. This adopts a zero rejection policy and uses an approach of converging various schemes and programmes. The key objective of SSA is Universalisation of Elementary Education (UEE). Three important aspect of UEE are access, enrolment and retention of all children in 6-14 years of age. A zero rejection policy has been adopted under SSA, which ensures that every Child with Special Needs (CWSN), irrespective of the kind, category and degree of disability, is provided meaningful and quality education. It covers the following components under education for children with special needs:-Early detection and identification, functional and formal assessment, Educational Placement, Aids and appliances, Support services, Teacher training, Resource support, Individual Educational Plan (IEP), Parental training and community mobilization, Planning and management, Strengthening of special schools, Removal of Architectural barriers, Research, Monitoring and evaluation, Girls with disabilities.

SSA provides up to Rs.1200/- per child for integration of disabled children, as per specific proposals, per year. The interventions under SSA for inclusive education are identification, functional and formal assessment, appropriate educational placement, preparation of Individualized Educational Plan, provision of aids and appliances, teacher training, resource

support, removal of architectural barriers, monitoring and evaluation and a special focus on girls with special needs. Residential bridge courses for CWSN with the main objective of preparing CWSN for schools, thereby ensuring better quality inclusion for them. Facilities for home-based education for children with severe and profound disabilities are provided with the objective of either preparing CWSN for schools or for life by imparting to them basic life skills.

Identification and enrolment:

Household surveys and special surveys have been conducted by all states to identify CWSN. 3 million 38 thousand CWSN have been identified in 33 States/UTs. 20 thousand 30 thousand CWSN (66.84 percent of those identified) are enrolled in schools. Further 88009 CWSN are being covered through EGS/ AIE in 15 states and 77083 CWSN are being provided homebound education in 19 states. In all 72.27% of the identified CWSN in 2006-07 have been covered through various strategies.

Barrier-free access:

Making schools barrier free to access for CWSN is incorporated in the SSA framework. All new schools to be barrier free in order to improve access for CWSN, is incorporated in the SSA framework. 4.44 thousand Schools have ramps for CWSN. Focus is now on improving quality, monitoring of services provided to and retaining CWSN in school.

MODE OF SPECIAL EDUCATION IN SCHOOLS OF INDIA :

Children with disabilities are educated in India through special schools. There exist a few schools exclusively for blind and deaf under government sector. But there is not any special provision in mainstream government schools for education other disabled children like low vision, leprosy cured, hearing impaired, locomotory disabled, mentally retarded, mentally ill, autism affected, cerebral palsy affected and multiple-disabled. These children with disabilities are nurtured to some extent through the special schools of non-government sector.

FIGHTING EDUCATIONAL EXCLUSION:

Inclusion is a complex issue. The curriculum is a powerful tool (Swann, 1988) and may be part of the problem. On inclusion Reuven Feuerstein viewed that “Chromosomes do not have

the last word". However, his view on inclusion are challenging for everywhere. He argues there are three pre-requisites: a) The preparation of the child, b) The preparation of the receiving schools, c) The preparation of parents, but it could not be achieved without d) The preparation of the teachers.

a. The preparation of the child:

Some children with special needs may require some prior training before they are placed in a regular school. Special educators made available for the purpose can provide such training and thereafter CWSN may be admitted in mainstream schools. States of Andhra Pradesh and Uttar Pradesh have conducted exclusive residential bridge course for CWSN to prepare them for regular schools but in rest of the states it is not yet to be done. From 683 thousand, 100 thousand CWSN were identified in 2002-03. By 2006-07 3 million 38 thousand were identified. From 566 thousand CWSN enrolled in schools in 2002-03, the enrolment of CWSN currently in SSA stands at 2 million 20 thousand (Dec. 2006).The target for 2006-07 include enrolment of 3 million 38 thousand CWSN in 34 States.

b. The preparation of receiving schools:

Some mainstream secondary schools may be selected and developed as "Model Inclusive School" on priority basis. First of all barrier-free access to CWSN are made in all such institutions. Effort should be taken to provide disabled-friendly facilities in these schools. Development of innovative designs to provide an enabling environment for CWSN should also be made in these schools as a part of preparation programme. In India total 222 thousand schools have been made barrier-free countrywide under SSA.

c. The preparation of parents:

It has been seen that the parents/guardians of CWSN generally face problems, both social and psychological resulting into marginalisation and exclusion of CWSN in mainstream schools. Hence, it is important to undertake widespread awareness among the people especially parents of CWSN. They should be counseled so that they may prepare themselves to send his/her ward to mainstream schools. d. The preparation of teachers: In India teacher training in special education is imparted through both face-to-face and distance mode.

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I) Pre-Service Training:

In India, there is provision for pre-service teacher training in SE, but it is mainly concentrated in secondary level training. There are 159 institutions of secondary teacher training in SE whereas there are only eleven institutions in the country that imparts pre-service training at elementary or primary level in SE. The Rehabilitation Council of India (RCI) is the apex authority to develop, recognize and regulate the course curriculum of SE. The Madhya Pradesh Bhoj (Open) University, Bhopal is the single university in the country, imparting B. Ed. (SE) through distance learning mode. Recently, it has launched Post Graduate Professional Diploma in Special Education Course for general B.Ed. students. The successful candidate of this program becomes equivalent to B.Ed.-SEDE degree holder with specialization in opted disability area. As the Indian school system is one of the largest in the world and number of CWSN are very high, the prevailing situation of pre-service teacher training in special education needs to be strengthened or elaborate alternative mechanism for incorporating the elements of special education in general teacher training programs needs to found out.

The teacher training course curriculum of general pre-service training programs neither fully equip the teachers and teacher educators to deal with the CWSN nor it equip them to manage the mild and moderately disabled children in general classrooms. Towards this end, an MOU has been signed between the National Council for Teacher Educations (NCTE) and the Rehabilitation Council of India (RCI) leading towards a convergence so as to sensitize all teachers and resource persons. The NCERT (2000) has set up a group under the National Curriculum Framework Review to examine the pedagogic inputs and classroom reorganization required for CWNS.

Even, UGC National Educational Testing Bureau has already included “Special Education”, in curriculum of its Educational discipline. It includes details about special education, integrated education, education of mentally retarded (MR), visually impaired (VI), hearing impaired (HI), orthopaedically handicapped (OH), gifted and creative children, learning

disabled children and education of Juvenile delinquents. The Postgraduate Departments of Education in India is on way to strengthen the disability element in their respective curriculum.

Residential Bridge Courses for CWSN in A.P., U.P. & Rajasthan:

Andhra Pradesh, Uttar Pradesh and Rajasthan have developed a roadmap to implement residential Bridge Courses to develop skills of readiness for successful integration in regular schools. The other objectives of the course are: (i) equip with required skills among students with severe disabilities to use special equipment independently, (ii) develop adequate 3R's skills as well as academic competencies required for immediate inclusion in the regular classroom appropriate to the child's grade level and (iii) develop sense of independence, self-confidence and motivation for personal growth, to orient the children with various environments, not only for school inclusion, but also community and social inclusion.

II) In-Service Training:

Different kinds of teacher training programmes are being implemented under SSA to orient elementary teachers towards Inclusive Education (IE). The component IE has been incorporated as a part of 20 days mandatory training of in-service teachers under SSA. This aims at orienting every teacher to the concept, meaning and importance of inclusion. Further, the state SSA programme also taken up a 3-5 or 5-7 day teacher exclusively in I.E. Total 2 million 45.2 thousand teachers have been covered through regular teacher training programmes, which includes a 2-3 day capsule on inclusive education. 1 million 400 thousand teachers have been provided 3-5 days additional training for better orientation to Inclusive Education. 39816 teachers have been trained in 22 States with Rehabilitation Council of India for 45 days and act as Resource Persons in districts/blocks. 23 States have appointed 6147 resource teachers and 671 NGOs are involved in the IE programme in 31 States. Schools are being made more disabled friendly by incorporating barrier free features in their designs. 444 thousand schools have been made barrierfree and the work is on. 575 thousand CWSN have been provided the required assistive devices.

