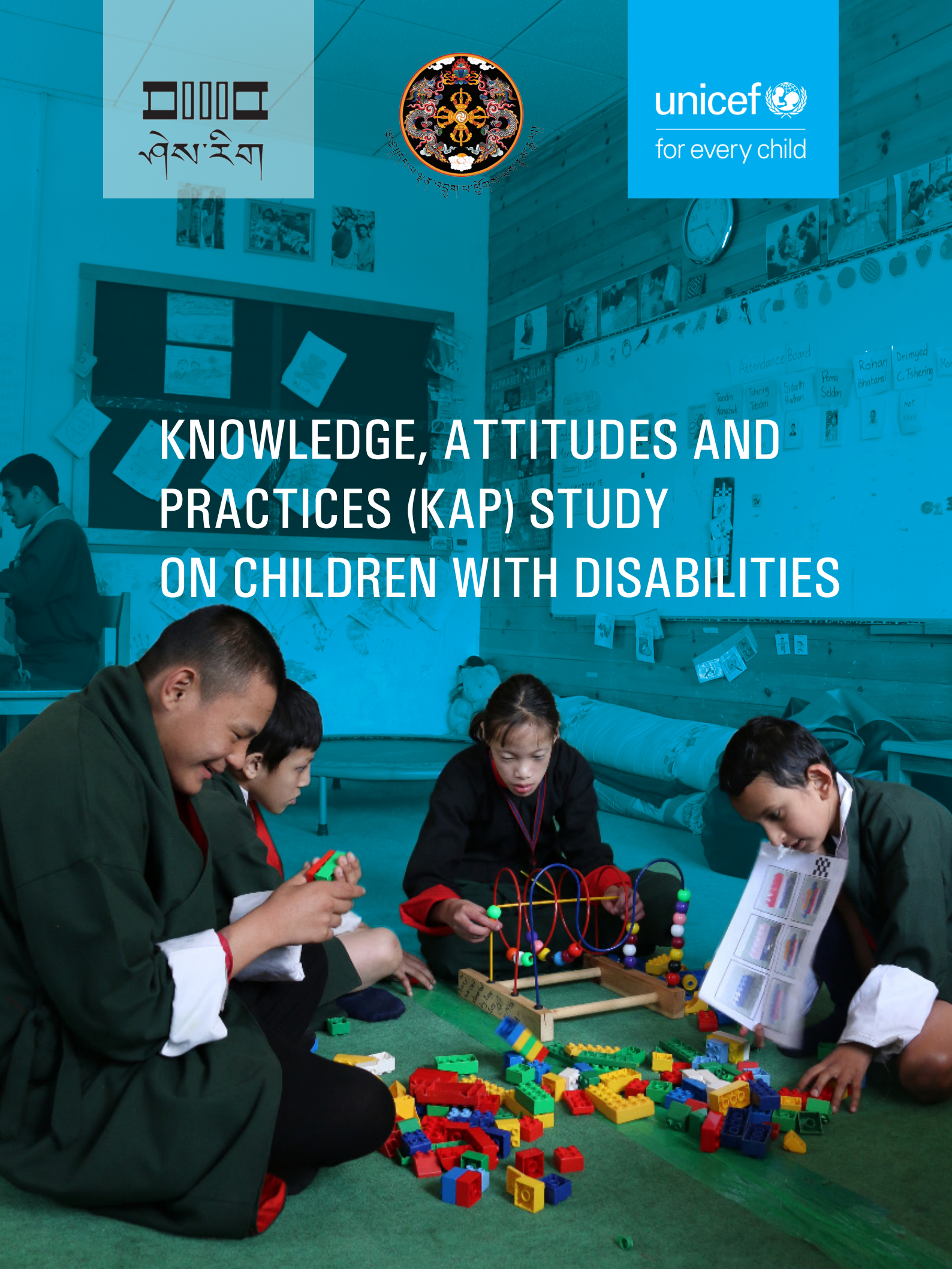
KNOWLEDGE, ATTITUDES AND PRACTICES (KAP) STUDY ON CHILDREN WITH DISABILITIES



Knowledge, Attitudes and Practices (KAP) Study on Children with Disabilities

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FOREWORD FROM THE MINISTRY OF EDUCATION

SECRETARY

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Royal Government of Bhutan
Ministry of Education

Cultivating the Grace of Mind

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Foreword

The Ministry of Education is pleased to present the "Knowledge, Attitudes and Practices (KAP) Study on Children with Disabilities" in collaboration with The University of Northampton and UNICEF. This report is based on a study designed to explore the current perceptions of the general public, people working in disability services, and decision makers regarding children with disabilities in Bhutan.

The research in this report has highlighted significant gaps in the knowledge that the community and key stakeholders have about disability in Bhutan. Understanding these gaps will assist us in developing strategies to improve access to services, both from the perspective of the service providers and from parents and families of children with disabilities.

This research provides us with key insights into the attitudes of people in Bhutan in regards to children with disabilities. With this information, the relevant agencies will be better prepared to tackle misconceptions and develop positive attitudes towards children with disabilities. In particular, the Ministry of Education will be in a stronger position to build support for inclusive education within our schools and across our communities.

The report provides a number of recommendations for changes in practice that will support children with disabilities in Bhutan. The Ministry of Education is committed to improving the access to and quality of services available for children with disabilities, and finds these recommendations to be a valuable guide.

The ECCD & SEN Division and UNICEF will lead the development of a "Communication for Development" strategy based on the findings of this report, which will carefully guide all stakeholders in making the improvements and changes recommended in the report in the most effective manner.

I would like to acknowledge the hard work of the officials in the ECCD & SEN Division, who have managed this important research project. I would also like to thank the team from The University of Northampton, the Technical Working Group members and our local consultant, Bhutan Interdisciplinary Research and Development (BIRD) for their dedicated work towards completing this valuable research, and UNICEF for providing the resources to make this possible. Our gratitude also goes to all participants in the survey for providing us with an insight into the knowledge, attitudes and practices of the people of Bhutan.

Karma Yeshey

(Secretary, Ministry of Education)

FOREWORD FROM THE UNICEF COUNTRY REPRESENTATIVE

Foreword

Children with disabilities are among the most marginalized and excluded groups in society. Therefore, disability and the need for inclusion are highlighted in the global Sustainable Development Goals for 2030, most notably in the Goals related to education, growth and employment, inequality, accessibility of human settlements, as well as data collection and the monitoring of the SDGs. This underlies the importance of working towards ensuring equity for children and persons with disabilities.

Despite the recognition of their rights to survival, safety and participation to develop to their fullest potential, which are enshrined in the Convention on the Rights of the Child and further reinforced by the Convention of the Rights of Persons with Disabilities, there continue to be disparities and gaps in the provision of necessary support to children with disabilities to realize these rights.

For Bhutan, the aspirations to narrow the gaps is a work in progress, and UNICEF is privileged to partner with the Ministry of Education for the first ever *Knowledge, Attitudes, and Practices (KAP) Study on Children with Disabilities*. This study provides the evidence and knowledge base for designing policies and programmes to overcome social barriers, and induce positive behaviour change to advance the cause of children with disabilities in the country.

Our partnership with the Ministry of Education is important, because education systems have the transformative potential to protect the most disadvantaged children. In addition, it is also critical that disability be addressed through a more convergent, cross-sectoral approach, enhancing coordination among key sectors such as health, education and other related sectors. And we have to involve persons with disabilities themselves.

In follow up to the *Two Stage Child Disability Study* from 2011, which was itself the first ever comprehensive survey measuring the prevalence and types of disabilities among children aged 2-9, we hope that that this *Knowledge, Attitudes, and Practices (KAP) study on Children with Disabilities* will be one big step towards reaching out to every child with disability and their families in Bhutan.

I have little doubt that the findings of the study will make a valuable contribution toward guiding policy and strategic dialogues in the country. UNICEF continues to be fully committed to work with all partners in support of reaching national and global goals for children with disabilities and their families.

Rudolf Schwenk
Representative
UNICEF Bhutan

ACKNOWLEDGEMENTS

The research team recognizes the effort and input provided by a range of people and services to this KAP study. We have received informed and ongoing support from colleagues from the Ministry of Education (Bhutan). This has been essential to our work. In a similar manner, the team has welcomed the guidance offered from personnel from UNICEF (Bhutan), whose patience and diligence has been much appreciated. The National Statistical Bureau of Bhutan and the Research and Ethics Board of the Ministry of Education have provided guidance regarding sampling and ethical procedure.

The team has received helpful advice from both the Technical Working Group and Stakeholder group; their diverse membership has enabled us to assimilate insights on children with disabilities (CWD) from different standpoints. The research team also values the role played by our associates, the Bhutan Interdisciplinary Research and Development (BIRD), especially in the fieldwork component of this study. The latter has been accomplished in an efficient manner by a team of enumerators, to whom we also extend our thanks. The project received guidance and reflections from an informal reference group, comprising a small number of internationally recognized practitioners and researchers in the field of CWD: we are grateful for their observations on our work as this study has progressed. Subsequent to the data analysis, a small group of practitioners in CWD in the United Kingdom, Australia and France responded to a request to provide suggestions for ground-level actions, based on the four areas of recommendation identified in the report: our gratitude is extended to them.

Within the University of Northampton, several personnel have supported the administration of this project, most especially within the Faculty of Education and Humanities: their contribution to ensuring its smooth running has been essential: our thanks is extended to these individuals.

Finally, we would like to recognize the participation and engagement of all those in Bhutan who contributed either as respondents to the household survey or as participants in the focus group discussions and informal interviews. The product of these activities informs the substance of this report; we therefore acknowledge these vital inputs, in the expectation that they have made a contribution to ensuring that CWD is maintained as a significant issue of policy focus in Bhutan in the coming years.

EXECUTIVE SUMMARY

Current research from Bhutan indicates that over 21 per cent of children aged 2–9 years have one or more disabilities. One of the challenges for Bhutan is to ensure that all children with special educational needs and disabilities receive appropriate education and social services.

This study recognized the internationally acknowledged definition for children with disabilities (CWD). The term 'children with disabilities' in this study is used to refer to children up to the age of 18 who have "long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others" (Convention on the Rights of Persons with Disabilities, Article 1). However, the intention of this study was to secure participants' knowledge, attitudes and practices (KAP) based on their own understanding of the term.[1]

This project provides a data set and accompanying commentary that can stimulate discussion, whilst becoming a catalyst for further policy and practice developments for CWD.

The project was commissioned by UNICEF (Bhutan) and the Ministry of Education of Bhutan in 2016 as a 'Knowledge, Attitudes and Practices (KAP) Study on Disabilities' in Bhutan.

The intention of the project has been to deliver a set of trustworthy data regarding the current extent, characteristics and provision (the knowledge, attitudes and practices) for CWD, together with a set of general recommendations for future action.

The study adopted a collaborative approach in all its phases and was underpinned by secure project leadership and management and a recognition of, and adherence to, a set of clearly defined ethical protocols.

The project comprised five phases:

Phase 1 scrutinized the existing literature on CWD;
Phase 2 used three instruments to gather data from an agreed sample;
Phase 3 comprised an interrogation of the data generated;
Phase 4 provided a full draft of the final report for scrutiny by UNICEF and Ministry of Education; and
Phase 5 constituted the delivery of a workshop, supported by appropriate resources, regarding the project's findings.

The study has generated data that provide evidence on the KAP of children with disabilities in Bhutan, primarily from the perspectives of families with CWD and those without. Key findings thus relate to both groups. In addition, data were secured from policy-makers, service providers and religious leaders.

Data were secured using both quantitative and qualitative instruments: a household survey questionnaire, a focus group discussion tool and informal interviews with key individuals working in the field.

[1] There is, however, a recognition that the terms 'disability', 'special educational needs' and 'learning difficulties' are frequently used interchangeably, both in the literature and by participants in this study.

Data reporting and analysis have been undertaken in recognition of the accepted view that 'Knowledge', 'Attitudes' and 'Practices' are interrelated, in that respondents who have a greater Knowledge regarding CWD will express Attitudes of concern regarding issues relating to CWD and incorporate them within their Practice.

Study findings

The survey revealed that knowledge regarding CWD was extremely limited. This applied to both legislation and provision of relevant services for this group of children. The term 'disability' was generally defined by respondents in narrow terms as representing mainly those individuals who have severe physical or sensory impairments, with a consequent tendency to marginalize those who experienced other forms of disability. This has implications for service delivery.

Attitudes towards CWD and their families were more positive among younger respondents and more highly educated respondents. The absence of knowledge related to CWD is a significant factor in the responses of the general population, who did not perceive intellectual impairment as a disability.

Families of CWD felt that the support that they received both in school and within their community was inadequate. They stated that most of the support came from within their wider family circle and that they felt isolated from other families living with disability.

Among the general population there was a consensus that educational and social provision for CWD in Bhutan was improving, and that the support provided by the state was adequate. This is in contrast to families with CWD, who were less positive and felt that they received less support than they required.

The data collected indicate that there are a range of enabling factors that provides a platform for potential future developments in support of CWD in Bhutan. It is important to recognize that these are at least inferentially associated with the overall national approach to supporting education and social welfare for all children in the country and linked to developments in provision during the last decade or more.

Engagement with schools and teachers during the research process, although not extensive, did suggest that there is some willingness to address issues of educational and social exclusion. There was also some evidence of an awareness of the need to provide disability related professional development for key personnel working with CWD.

However, such positive indicators are counterbalanced by omnipresent barriers, which co-incidentally are reflected in many other national settings worldwide.

These findings infer synergies between knowledge levels of CWD and resulting positive or negative attitudes towards these children. The connection to formal practices is less obviously demonstrated, given that the research did not constitute a prevalence study. Parental practice, however, was informed by acquired, experiential knowledge of their children with disabilities.

Recommendations and challenges

Following data analysis, four target areas have been identified from which recommendations regarding policy, provision and practice for CWD are made. These relate to systems challenges and change, families of CWD, the general population and professional groups.

The report acknowledges several challenges – both methodological and procedural – that the research team encountered. Whilst these do not prejudice the validity or reliability of the findings, they raise potential issues for development, especially in the application and use of qualitative evidence. In addition, the existing data set offers opportunities for future disaggregation, particularly between knowledge and attitudes.

A series of illustrative appendices is attached, containing a literature review, details of the research instruments used, composite data sets, the ethical measures applied, the training materials used for fieldworkers and an outline of a proposed communications strategy (and its links to existing 'Communication for Development' initiatives).

1. CONTEXT AND INTRODUCTION

1.1 Context

Bhutan is a country in the Himalaya region, described according to the World Bank criteria as a 'small state' (World Bank, 2012). In common with countries of similar profile, it has experienced rapid societal changes, particularly in the post-World War II era. Some of the most dramatic changes have been experienced in Bhutan's educational system. From only partial provision 50 years ago, the education service now caters for the entire population of Bhutan (Year 1–13).

The challenges of providing education for a heterogeneous student population (in respect of gender, poverty levels, language and learning aptitude and level) have been major issues in refining Bhutanese policy and practice. The Bhutan Ministry of Education (MoE), in its Education Sector Strategy 2020 (2003, p. 36) states that "all CWD [children with disabilities] and with special needs – including those with physical, mental and other types of impairment – will be able to access and benefit from education. This will include full access to the curriculum, participation in extra-curricular activities and access to cultural, artistic, recreational and leisure activities".

These challenges are noted in respect of children with 'special needs' in the *Bhutan Education Blueprint, 2014–2024* (MoE, 2014), which indicated that "government's initiatives to enhance educational access for children with special needs remains a formidable challenge for the education sector owing to the limited number of special schools, facilities, support services and capacity of the teachers" (p. 26). Such a statement was accompanied by a set of recommended interventions, including a needs assessment study on special needs, enhancing educational support services in the field of special educational needs (SEN), teacher training, and collaboration with parents and the general public to provide necessary support to children with SEN.

The two-stage child disability study (NSB/MoE/MoH/UNICEF, 2012) reported that "at least 21.7 percent of Bhutanese children aged two to nine years have been identified to have mild to severe disability", and that "This implies that there is more than 1 in every 5 children with disability" (p. 50). The report also referenced the challenges being encountered in establishing effective provision. It indicated that "…as of March 2014, there are only six integrated schools and two special education centres with 255 teachers catering to 366 children with special needs. The quantity and quality of the integrated schools and centres prevalent is less than ideal" (p. 50).

A proactive response to this situation has been apparent. A separate division was established in 2011 to address these core issues. National consultation revealed that "there is a clear need to make schools more 'inclusive' and 'flexible' to accommodate diverse learners with special focus on children with special needs" (p. 50), whilst a survey of teachers showed that 94 per cent expressed the need for professional development on teaching students with special needs. The intention in the future is to establish "equitable provision for diverse student population…with the goal of inclusion leading ultimately to improved social cohesion" (p. 50). The blueprint included yet a set of interventions to further these intentions.

Current research from Bhutan suggests that over 21 per cent of children aged 2–9 years have one or more disabilities (NSB/MoE/MoH/UNICEF, 2012). This figure is amplified by McKay and Dorji (2005), who has additionally indicated that 31 per cent of households with children with disabilities (CWD) experience

conditions of absolute poverty; the latter is commonly aligned with populations with special educational needs and disabilities (SEND), irrespective of country location (Singal, 2013).

One of the challenges for Bhutan is to ensure that all children with SEND receive appropriate education and social services (Ugyen and Cokl, 2010). In consequence, there has been considerable recent policy emphasis upon enabling full access and participation of CWD to such services. For example, UNICEF has supported the observation of International Day for Persons with Disabilities each year to advocate for the rights of persons with disabilities and to empower them further. This has helped to create a greater sense of awareness about the rights of CWD in Bhutan, as evidenced by the increasing enrolment of children in the Wangsel Institute, which has risen from only seven in 2004 to 77 in 2013. In a similar vein, CWD have been brought in increasing numbers by their parents to Changangkha Middle Secondary School, which offers inclusive education (UNICEF, 2013).

Nevertheless, it has been stated that more work is needed to promote a paradigm shift from the *medical* model of disability to a *social* model (Shakespeare, 2002; UNICEF, 2007; Samaha, 2007). In the Bhutanese context, the regional seminar on inclusive education (UNICEF, 2013) created enhanced awareness amongst key stakeholders to work towards a more inclusive approach in Bhutan.

The 2011 study indicated a "dearth of information on the nature, prevalence and more importantly the profile of children living with disabilities in Bhutan". This shortfall inhibits policy development and planning necessary to provide appropriate services to meet the needs of CWD. The project reported here represents a data set that can both stimulate discussion, whilst becoming a catalyst to further policy and practice developments, thus enabling the progress secured in the most recent decade to be further enhanced.

1.2 Introduction

It is against this contextual background that the present project has been configured. It was commissioned by UNICEF (Bhutan) and the Ministry of Education of Bhutan in 2016 and designated as a 'Knowledge, Attitudes and Practices (KAP) Study on Disabilities' in Bhutan. The scope of the study was threefold:

1. Provide an overview of the current position regarding knowledge, attitudes and practices of a range of stakeholders towards disabilities and disability services, with an emphasis on CWD in Bhutan.
2. Identify both achievements and barriers in provision, and to identify priorities for future development to inform a fit-for-purpose communication strategy on social inclusion.
3. Make recommendations to key stakeholder groups working with CWD and their families to promote the effective development and delivery of services.

The intention of the project has been to deliver a set of trustworthy data and attendant recommendations regarding the current extent, characteristics and provision (the knowledge, attitudes and practices) for CWD in Bhutan. In addition, it would contribute to the formulation of a communication strategy for CWD.

The work undertaken comprised five interlinked phases, each with a designated output. The study adopted a collaborative approach in all its phases and was underpinned by secure project leadership and management.

Phase 1 scrutinized the existing literature on CWD (both recognized academic sources as well as the so-called 'grey' literature) and resulted in a detailed review of the current situation in Bhutan. It also defined

and tested a set of three instruments that were subsequently used to generate data. In addition, an appropriate set of ethical protocols was established and ratified, and fieldworkers were identified and trained.

Phase 2 used the three instruments to gather data from an agreed sample; thus, a household survey, focus group discussions and a set of interviews with nominated key informants were operationalized. Data were to be collated and placed in a secure electronic repository.

Phase 3 comprised an interrogation of the data generated and preparation of illustrative data materials for subsequent use in the reporting stage of the project.

Phase 4 provided a full draft of the final report for scrutiny by UNICEF and Ministry of Education. It also comprised a set of recommendations, based on data evidence, to highlight ways forward in meeting the needs of CWD; a user-friendly research summary was also constructed to assist in a dissemination effort.

Phase 5 resulted in the delivery of a workshop, supported by appropriate resources, regarding the project's findings alongside the presentation of a framework for a communication strategy for CWD. These events principally involved key stakeholders from Bhutan.

2. KNOWLEDGE, ATTITUDES AND PRACTICES TO CHILDREN'S DISABILITY IN BHUTAN: A CONTEXTUALIZED LITERATURE REVIEW

A literature review was undertaken to prepare for the fieldwork to generate evidence relating to CWD. The resulting purposive scoping of published material suggested that, in respect of knowledge, attitudes and practices, several features characterize the contemporary landscape for CWD in Bhutan. The complete literature review is contained in Appendix 8 to this report.

To provide a context for the data-generation process and the results recorded in the body of this report, the following observations can be made:

1. There are some notable parallels between Bhutan, South Asia[2] and the remainder of the international literature in respect of KAP themes.
2. The literature is layered in its coverage of inclusion of CWD: the international literature is abundant, though mainly concentrated in specific geographical regions; similarly, that from South Asia is relatively confined to a restricted number of national locations and is much less widespread; coverage in Bhutan is at a very early stage in its development.
3. In the cases of South Asia and Bhutan, there is a tendency to rely upon reports and other official documentation rather than academic research. The former provides evidence of the actions of international agencies, charities or non-governmental organizations (NGOs); the literature appears to be less than is the case in other international settings.
4. In all three geographical groups (Bhutan, South Asia and the remainder of the international literature), literature was identified by using a keyword analysis in each literature grouping.
5. There is a broad correlation between the types of challenges facing educational systems at a global level. However, the literature scoping also highlights those issues encountered by countries with low or lower-middle gross domestic product (GDP), as well as those settings that face a range of environmental, cultural and physical challenges.
6. Countries with low or lower-middle GDP have a much shorter history of attempting to address the needs of CWD and are likely to rely on adapting models of inclusive practice drawn from those national settings with a longer-term tradition of development.
7. Even so, an 'inclusive approach' to CWD at a worldwide level is still relatively new, having emerged in the late 20th century as the preferred approach to securing equal and sustainable involvement of CWD in educational, social, cultural and economic processes.

The literature concerning knowledge about CWD in Bhutan reveals that the country is generally committed to a social model of disability and respects the rights of CWD by adopting inclusive education. Literature emerging from the last decade indicates that this focus is becoming more emphatic. However, this also indicates that, in practice, CWD often remain excluded from education and from wider community participation for a variety of reasons. This situation places particular importance on such forward-looking policy documents as the *Bhutan Education Blueprint* in respect of anticipated future actions for CWD.

[2] In this study, the term 'South Asia' includes these countries: Bangladesh, Brunei, Cambodia, China, Hong Kong (China), India, Indonesia, Laos, Malaysia, Maldives, Mongolia, Myanmar, Nepal, Pakistan, Philippines, Singapore, South Korea, Thailand and Vietnam. It does not refer to the UN regional classification of South Asia.

In respect of attitudes to CWD in Bhutan, the literature suggests a country that is in transition. Where CWD have been hidden from society in the past, more of them are now going to school and are more visible socially. Whilst segregation of CWD remains common, integration is currently rare and inclusion even more so; yet there appears to be strong policy commitment to inclusion, supported by UNICEF, with attempts having been made in recent years to translate policy into practice.

Bhutan has thus made discernible progress in its practices oriented to supporting CWD. The literature indicates that there are specific challenges still to be met in further developing inclusive orientations for CWD and that these are apparent in respect of knowledge, attitude formation and ground-level practice.

3. METHODOLOGY

3.1 Research orientation

A mixed-methods approach, using data collection tools to generate both quantitative and qualitative data, was adopted to ensure that multiple perspectives regarding CWD were gathered. These methods and instruments were considered to be complementary rather than hierarchical. Some triangulation of data was included, which provided an additional lens through which to view knowledge, attitudes and practices. Limitations regarding the low sample of CWDs and the volume and efficacy of narratives from the interviews and focus groups require that the findings may need to be interpreted with care.

The quantitative data collection tool was designed to elicit information concerning knowledge, attitudes and practices towards CWD from a sample of the Bhutanese population. A sample of 577 households was surveyed from nine dzongkhags (districts) to capture data. About one third of respondents lived in urban and two thirds in rural households, reflecting the overall national urban/rural ratio.

The household survey questionnaire (HSQ) was undertaken prior to setting up a series of focus group discussions and interviews, involving key participants and stakeholders who had direct involvement in the education, social care and welfare of CWD.

3.2 Research instruments

Data were first collected via the 11-page household survey questionnaire (see Appendix 1). Trained enumerators visited households in nine dzongkhags and completed the survey tool with the respondent in situ using an electronic tablet. The HSQ used both closed and open questions to gather data. The initial section of the tool gathered information to identify the location of the respondent and other demographic information.

It was intended that data would be collected regarding the composition of respondents' households; however, the enumerators in the field collected data regarding only the respondent and one other person in each household. This was identified only at the data analysis stage. Where families included a child with disabilities, demographic data were collected regarding these children and the impact of their impairments.

All respondents were asked questions on their knowledge, attitudes and practices regarding CWD. A Likert scale was used to gather attitudinal data via 27 questions across five domains: society and support, personal attitude towards disability, contribution of CWD to society, education and inclusion, and protection. A stratified multistage cluster sampling design was utilized (see Appendix 2), which has been regarded as appropriate within KAP studies.

In addition, narrative data were generated using focus groups (see Appendix 3). These were established to enable interested key stakeholders to discuss their experiences and present viewpoints regarding provision made for CWD in Bhutan. There were 12 focus group discussions, distributed across both urban and rural districts of Bhutan. Data from these groups were analysed using an accepted method to identify a set of key themes, which could subsequently be triangulated with other data sets. Finally, informal interviews were conducted with several key personnel, who were purposively identified, working directly with CWD.

Data collection, reporting and analysis were undertaken in recognition of the accepted view that 'Knowledge', 'Attitudes' and 'Practices' are interrelated, in that respondents who have a greater Knowledge regarding CWD will express Attitudes of concern regarding issues relating to CWD and incorporate them within their Practice (Masasa, Irwin-Carruthers & Faure, 2014). Such relationships might be negative, in that there may be considerable gaps between what is said (informed by Knowledge and Attitudes) and what is done (Practice).

Locally employed enumerators were used to collect data, using the instruments described; this group was trained by a team comprising experienced training consultants from the University of Northampton (UoN), with inputs from a local consultant and two UNICEF officers, supported and observed by UNICEF colleagues and Ministry of Education officials (see Appendix 4).

3.3 Pilot study

Following extensive preparation and training, a pilot of the HSQ was conducted on Day 4 of the enumerator training programme. Local enumerators conducted the pilot; each group was supported by a supervisor designated by the local consultant. During the pilot, enumerators were accompanied by observers from the UK consultancy, as well as UNICEF and Ministry of Education officials. The pilot was conducted in two locations selected by UNICEF Bhutan: Motithang Area (urban) and Hongtsho (rural), both within Thimphu District, Bhutan.

The local enumerators used tablets to collect data. In both locations, the pilot began with enumerators conducting listings of households to secure a verified sample. Enumerators reported their findings to their supervisors, and proceeded to gather data from households in the identified sample.

Following the pilot data collection, the local enumerators and supervisors fed back on the process in the field on both content and process. Overall, feedback from enumerators and observations by consultants, UNICEF and Ministry officials indicated that the training had been appropriate and that the HSQ had been fit for purpose. As a result of the pilot, some challenges were identified and these were addressed within the subsequent training, ahead of the main fieldwork. They included:

(i) lack of families with cwd in selected households during pilot;
(ii) absent heads of household at times when enumerators called;
(iii) quality of initial introductions;
(iv) difficulty with gathering data for the Likert scale (questionnaire section f); and
(v) enumerators' health and safety.

These challenges were resolved as follows:

(i) Lack of families with CWD in selected households during pilot

As the general population was to be sampled in the full survey and a robust rubric was applied to sampling, it was agreed that the full sample of households would be representative so this issue was unlikely to prevail.

(ii) Absent heads of household at times when enumerators called

During the pilot, particularly in the urban area, heads of households and indeed members of households were sometimes not at home when the enumerators called. The enumerators indicated the importance of knowing what times they should call at households, particularly outside work hours

when heads of households were likely to be in. It was acknowledged that their knowledge of local areas would be important in this regard.

(iii) Quality of initial introductions
Enumerators identified that their initial introductions to householders could sometimes be awkward and this could cause difficulty in gaining the confidence of a respondent. The pilot indicated the value of all enumerators using one model of wording for their initial introductions as well as the need for enumerators to be able to identify themselves as undertaking work on behalf of the consultants, UNICEF and the Ministry of Education. Enumerators were given a card to take into the field that featured the wording for their introduction. UNICEF and the local consultant agreed to liaise to ensure the enumerators had name badges that showed the organizations with which the local consultant was working for the KAP survey.

(iv) Difficulty with gathering data for the Likert scale (Questionnaire Section F)
Enumerators indicated that repetition of the Likert scale caused difficulties in data collection. Following the pilot, all enumerators were issued with a visual resource for the Likert scale on the back of their introduction card.

(v) Enumerators' health and safety
As employees of the local consultant, enumerators' safety and health were the responsibility of that organization. Nevertheless, following the pilot, protocols for enumerators' safety and health were highlighted for discussion in a training session.

3.4 Research ethics

A set of clearly identified principles informed the way in which the research team operated both in the field and in its approach to data management and reporting. These principles in turn provided the basis of the ethical management of the research activities and their supporting actions, including the reporting of outcomes.

All University of Northampton researchers from the Faculty of Education and Humanities are required to comply with a number of statutory protocols. These include the Disclosure and Barring Service, the nationally required procedure for child protection in the UK, and the University's own *Ethics Code and Procedures,* 2016. In the case of the latter, all external research projects require official approval, based on systematic protocols, and are subject to subsequent regular internal monitoring procedures.

In addition, the study's methodology and instruments were scrutinized by the Bhutanese Research Ethics Board of Health (REBH), which provided helpful inputs in refining the tools and gave approval for their use in the study.

All project team members in this proposal have participated in fieldwork directly involving vulnerable children and young people, including CWD. In undertaking this work all participating staff are required to regularly attend professional development aimed at updating their skills and awareness. Members of the UoN team also conduct research within the ethical frameworks and guidelines established by the British Educational Research Association and the European Educational Research Association.

4. RESULTS: (i) QUANTITATIVE DATA: ANALYSIS OF HOUSEHOLD SURVEY QUESTIONNAIRE

4.1 Orientation

This section presents the results of the household survey questionnaire undertaken across Bhutan in Otober 2016. Demographic information on the sample is presented before moving on to discuss information obtained on the knowledge, attitudes and practices regarding both the sample as a whole (n=575) and drawing comparisons between those respondents whose families included CWD (n=17) and those whose did not (n=558). Further analyses were undertaken to compare the attitudes of respondents by gender, age and education.

Quantitative data were collected in accordance with the methodology agreed with UNICEF and approved by REBH and the University of Northampton's Research Ethics Committee.

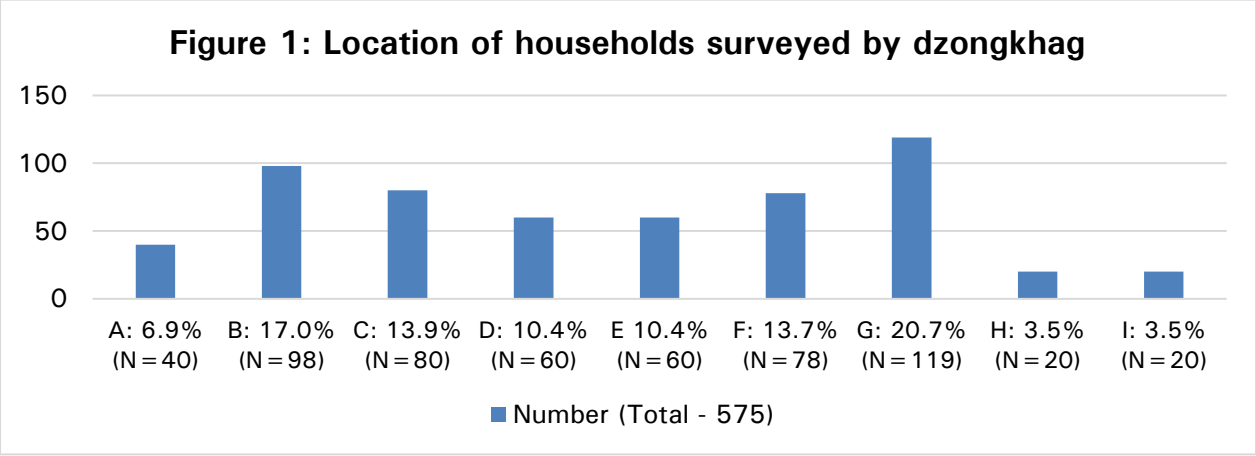
Bhutanese enumerators were trained to administer the HSQ tool by University of Northampton researchers prior to data collection in the field, which included a pilot study, designed to validate the instrument developed. Following this training, the fieldwork was undertaken during October 2016. Data collected were sent to the UoN team in late November 2016. Data cleansing was undertaken at the University of Northampton, resulting in a final data set comprising 575 responses. Data analysis was undertaken in December 2016/January 2017.

All percentages presented in this section are rounded to one (nearest) decimal place. Selected key data are presented graphically. The full quantitative data are presented in Appendix 9.

4.2 Demographic information about the sample

Households included in the study were selected by the Bhutanese enumerators from a total of 1,933 households within the identified dzongkhag/gewog (block)/chiwog (basic electoral precinct). A total of 577 households was surveyed by the enumeration team. However, two questionnaires were incomplete and deleted from the data set. As a result, the final sample comprised 575 households (29.7 per cent of the households within these chiwogs).

Respondents came from nine dzongkhags in Bhutan – Thimphu, Punakha, Bumthang and Trashigang in the north, and Chukha, Tsirang, Zhemgang, Mongar and Pema Gatshel in the south. Just over a third of respondents (n=98, 34.4 per cent) lived in urban households, while just under two thirds (n=378, 65.6 per cent) lived in rural households, reflecting the overall national urban/rural ratio. The geographical location of respondents by dzongkhag (and identifying the gewogs surveyed within each dzongkhag) is shown in Figure 1.



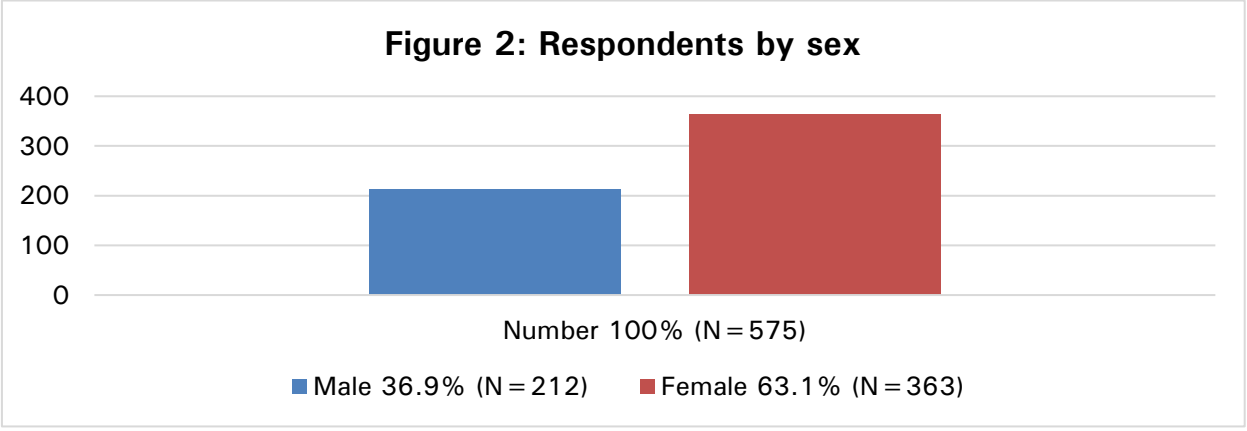
A: Bumthang	6.9% (N=40)	B: Chukha	17.0% (N=98)
C: Mongar	13.9% (N=80)	D: Pema Gatshel	10.4% (N=60)
E: Punakha	10.4% (N=60)	F: Thimpu	13.7% (N=78)
G: Trashigang	20.7% (N=119)	H: Tsirang	3.5% (N=20)
I: Zhemgang	3.5% (N=20)		

4.2.1 Respondents

Responses were sought from heads of households. Of the 575 respondents, 488 (84.8 per cent) identified themselves as the head of the household.

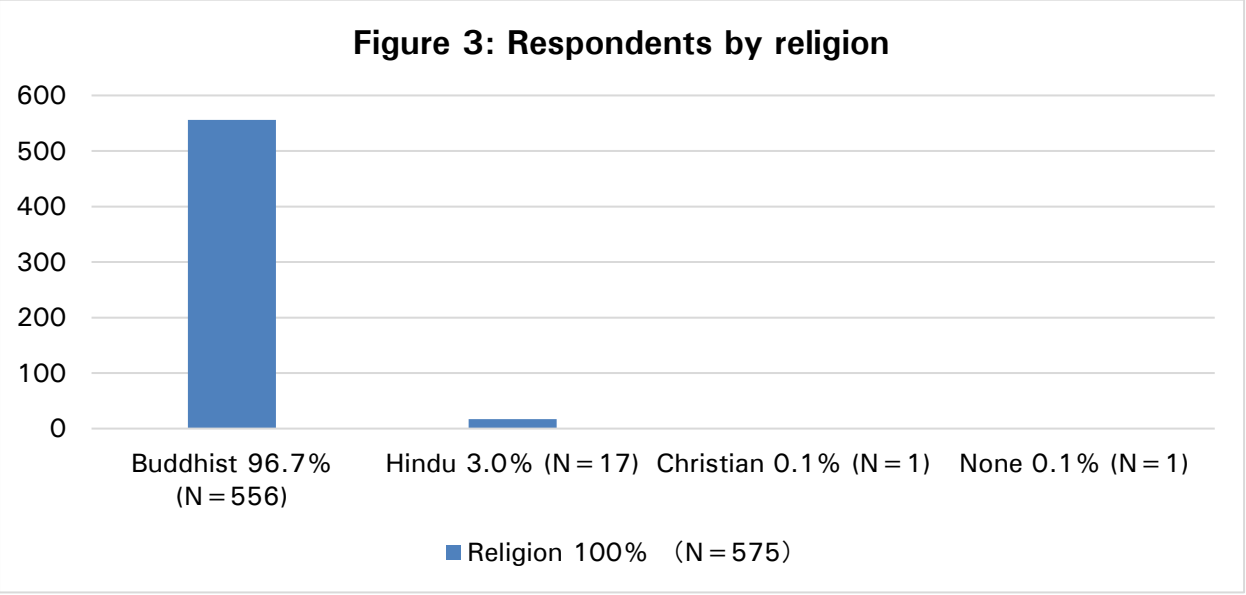
a) Sex of respondents

In total, 212 respondents (36.9 per cent) were male and 363 (63.1 per cent) were female (see Figure 2).



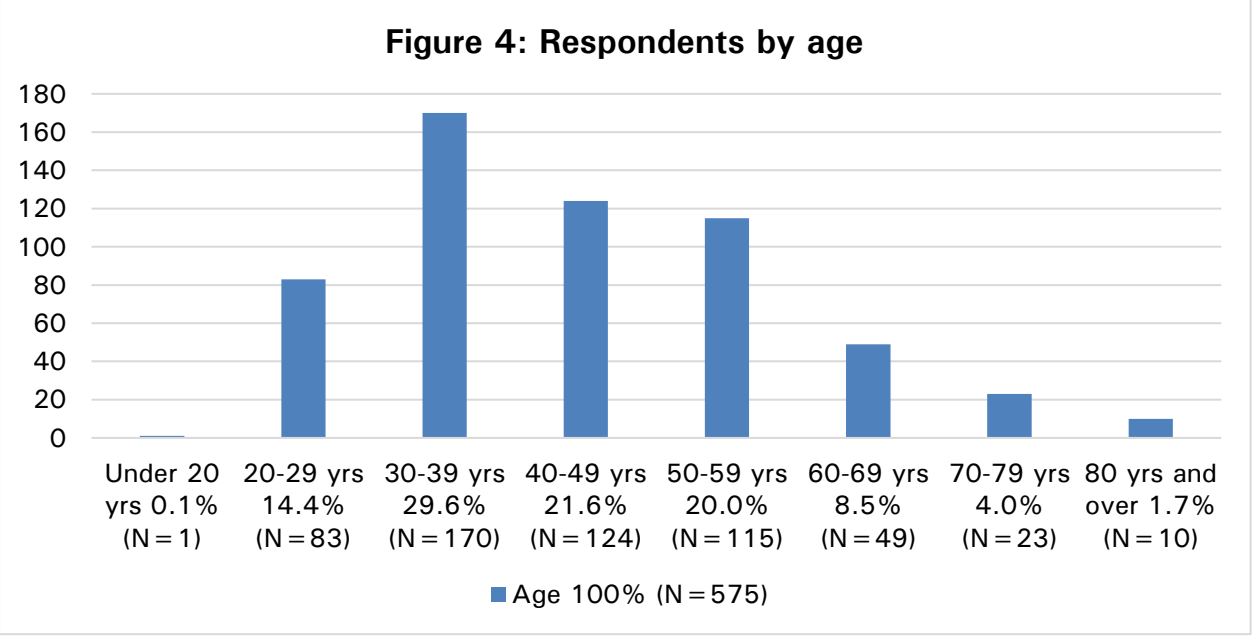
b) Religion of respondents

The overwhelming majority of respondents were Buddhist, with a small number of Hindus (mainly in the south), one Christian and one atheist (see Figure 3).



c) Age of respondents

Over half of respondents were aged between 30 and 49 years (51.2 per cent); there were also large numbers aged 20–29 years (14.4 per cent) and 50–59 years (20.0 per cent) (see Figure 4). The mode age of respondents was 42 years, mean age 44 years.



d) Respondents' educational status

The mean length of time in education of respondents was four years. Over 50 per cent had spent no time in education, and over 60 per cent were identified as having received no formal education (n=348, 60.5 per cent) (see Figures 5 and 6); of these, 73 per cent were women. Overall, 70.1 per cent of female respondents had received no formal education. Only 36 respondents (6.2 per cent of the sample) held a bachelor's or postgraduate degree, 36.1 per cent of whom were women.

Figure 5: Respondents: years in education

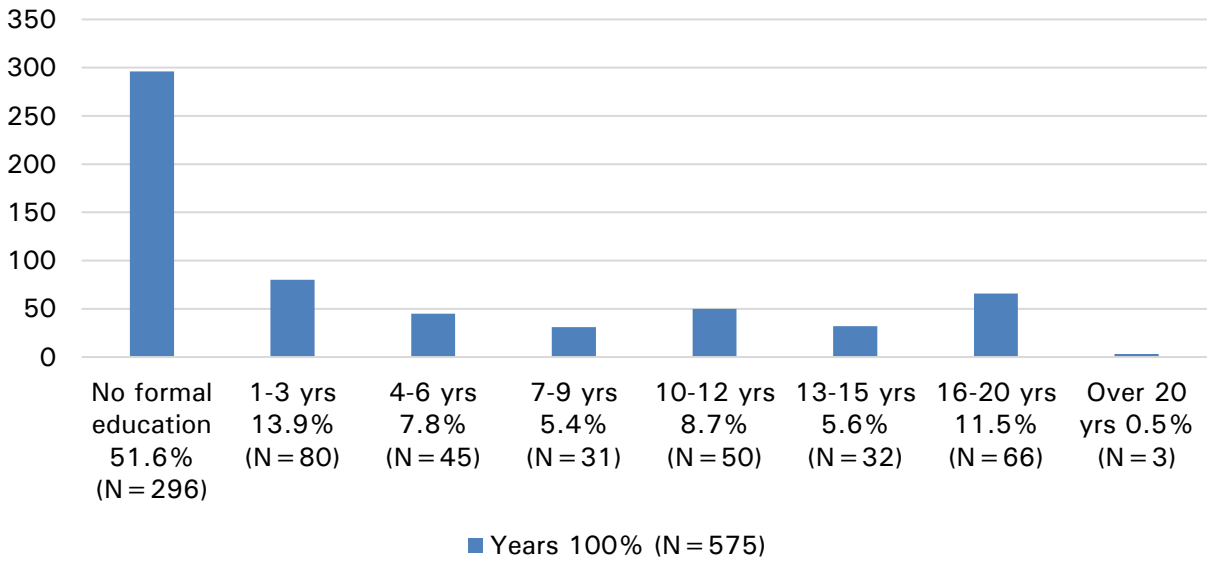
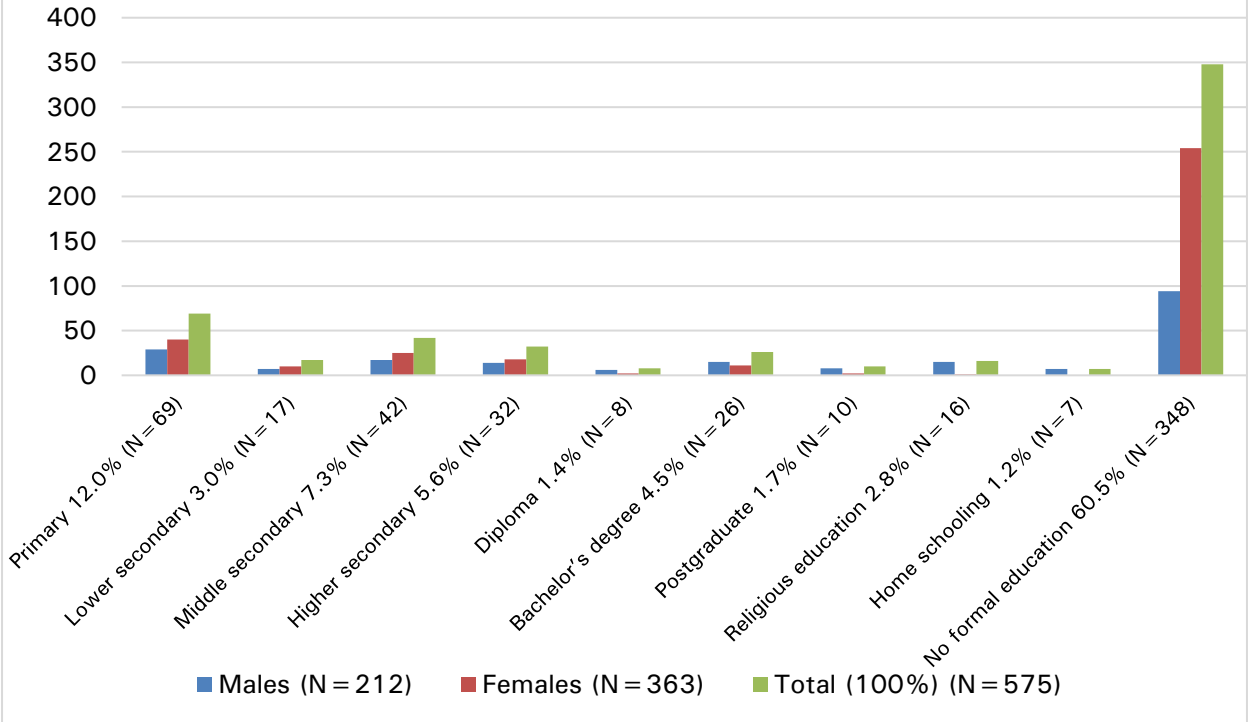
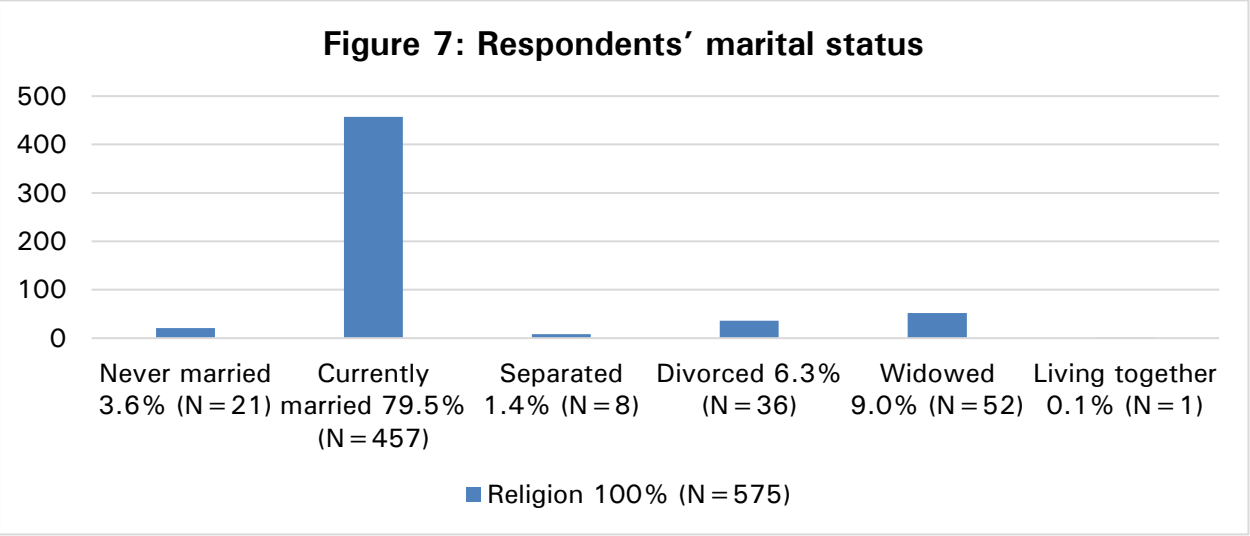


Figure 6: Respondents: education by type



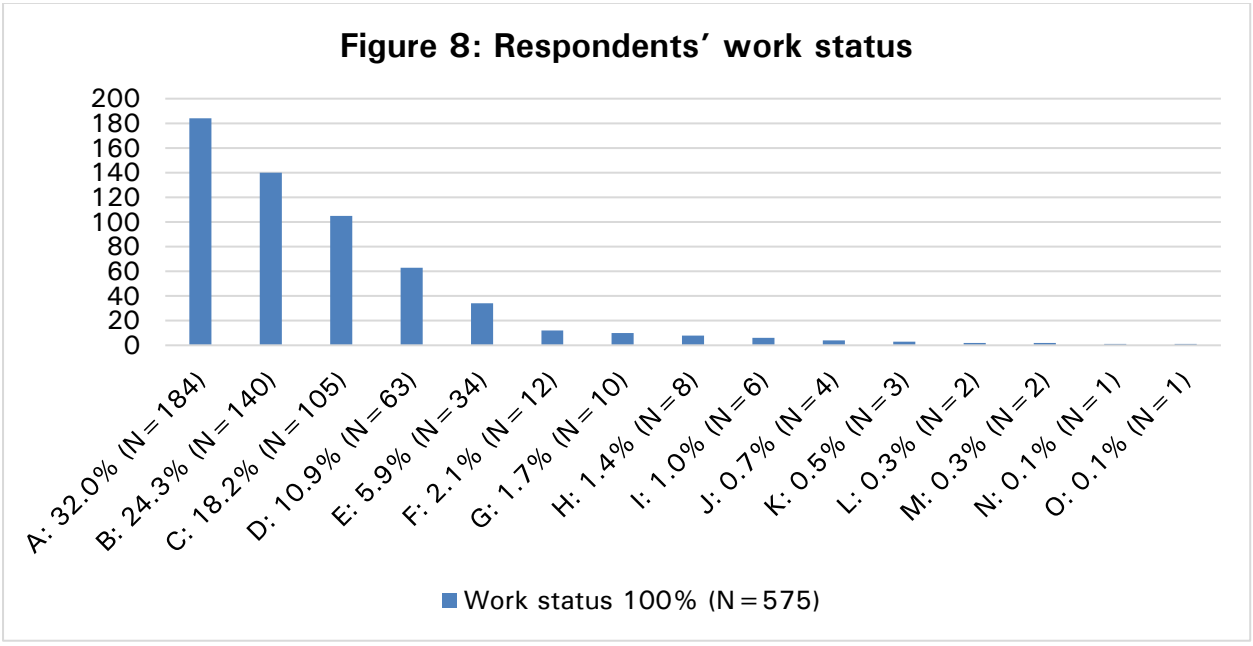
e) Respondents' marital status

Almost 80 per cent of respondents were currently married (n=457) (see Figure 7).



f) Employment

Farming or other skilled agricultural work was the most common occupation for respondents (n=184, 32.0 per cent). Almost a quarter of respondents described themselves as 'housewives' (see Figure 8).

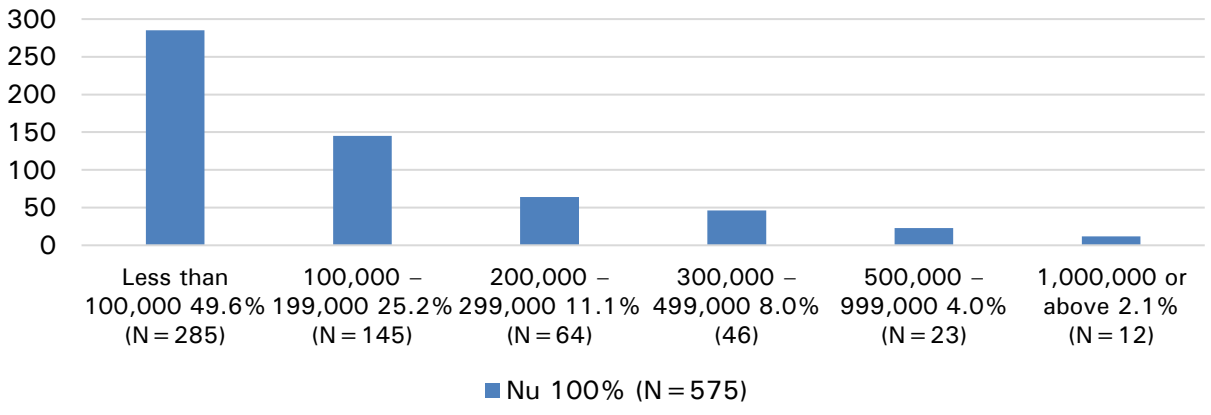


A: Skilled agricultural, forestry or fishery (including farming) 32.0% (N=184)			
B: Housewife	24.3% (N=140)	C: Self-employed	18.2% (N=105)
D: Professional	10.9% (N=63)	E: Service/sales	5.9% (N=34)
F: Military	2.1% (N=12)	G: Technical	1.7% (N=10)
H: Retired	1.4% (N=8)	I: Monk/other religious	1.0% (N=6)
J: Cook	0.7% (N=4)	K: Unemployed	0.5% (N=3)
L: Carer	0.3% (N=2)	M: Other (Tshogpa)	0.3% (N=2)
N: Craft	0.1% (N=1)	O: Manual	0.1% (N=1)

g) Income

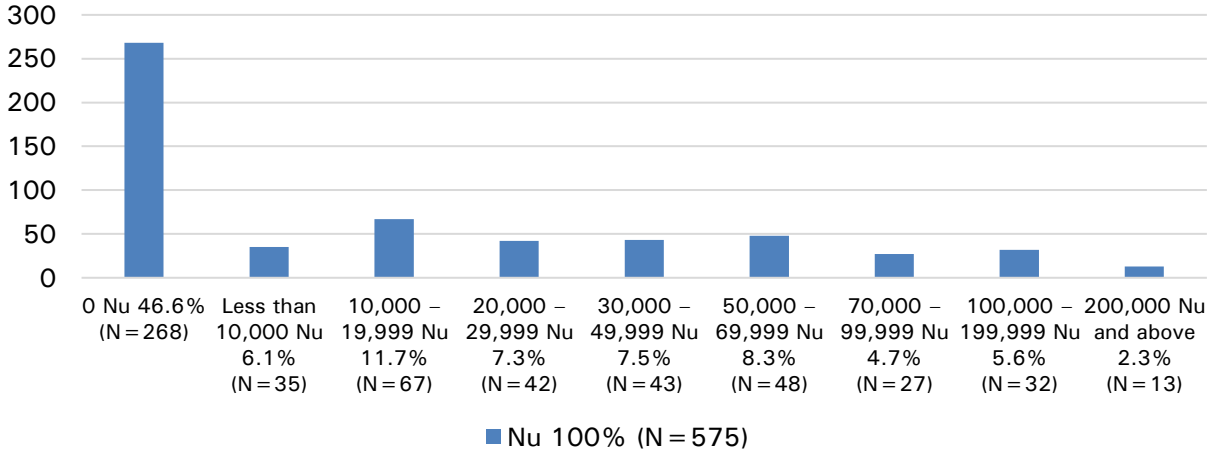
The mean gross household income from all sources (including religious fees) was 174,220 ngultrum ($2,590). Almost half of the sample had an annual gross household income of less than 100,000 ngultrum ($1,490); just over three quarters of respondents had an annual gross household income below 200,000 ngultrum ($2,973) (see Figure 9).

Figure 9: Household income from gross salary/wages

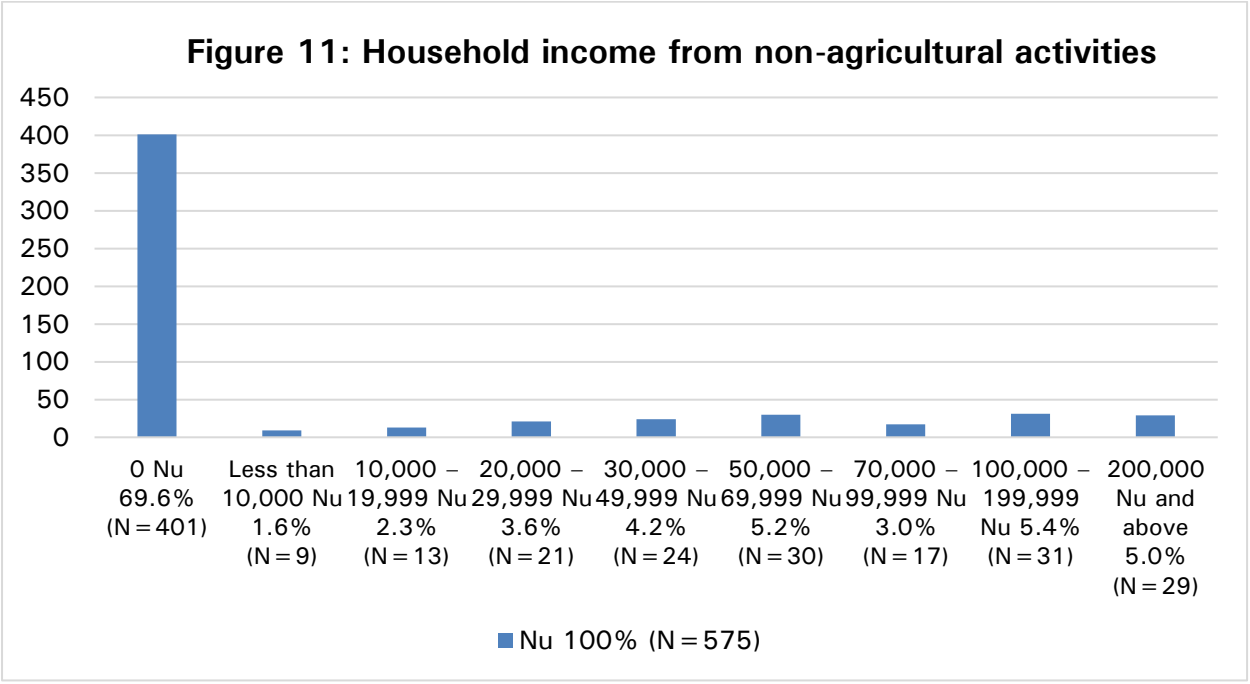


Just under half of the households (n=268, 46.6 per cent) received no income from the sales of agricultural, livestock or forestry products (see Figure 10). Almost half of those that did, received less than 200,000 ngultrum ($2,973) from this source. The mean income from this source among 307 households engaged in this activity was 51,200 ngultrum ($761).

Figure 10: Household income from sale of agricultural, livestock and forestry products



Almost 70 per cent of households surveyed received no income from any non-agricultural activities (see Figure 11). The mean income from this source among 174 households engaged in this activity was 126,672 ngultrum ($1,883).



4.2.2 Composition of respondents' households

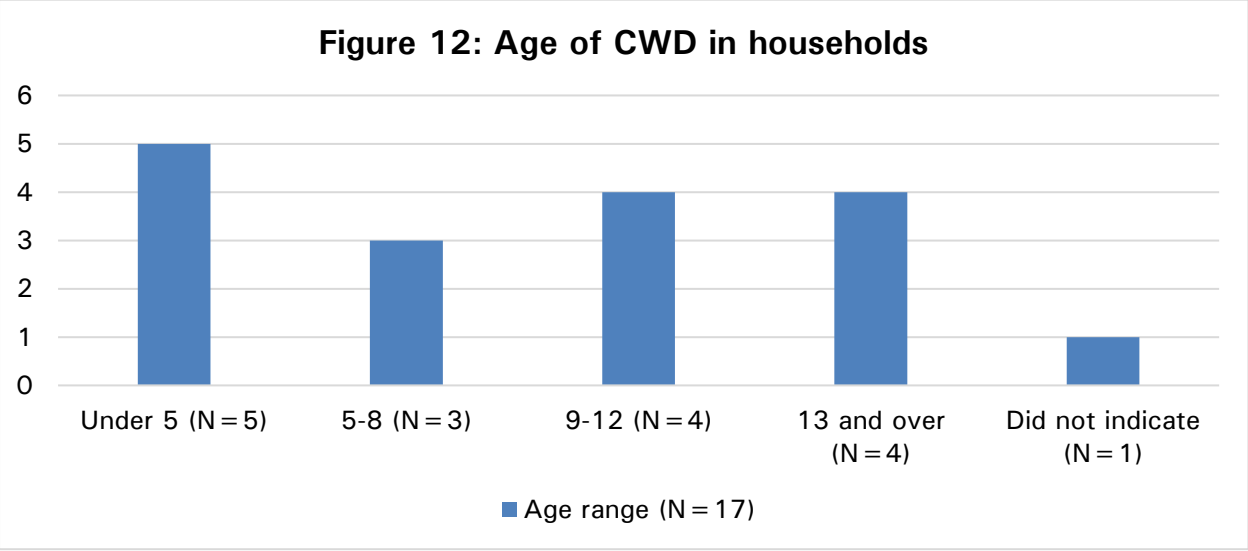
Unfortunately, we cannot present in-depth information regarding the composition of respondents' households as data were collected only on the respondent and one other person in each household. This arose as a problem post-piloting and was identified as an issue only at the data analysis stage. As a result, we only can state that 546 respondents (95.0 per cent) lived in multi-person households and that 29 respondents (5.0 per cent) lived alone.

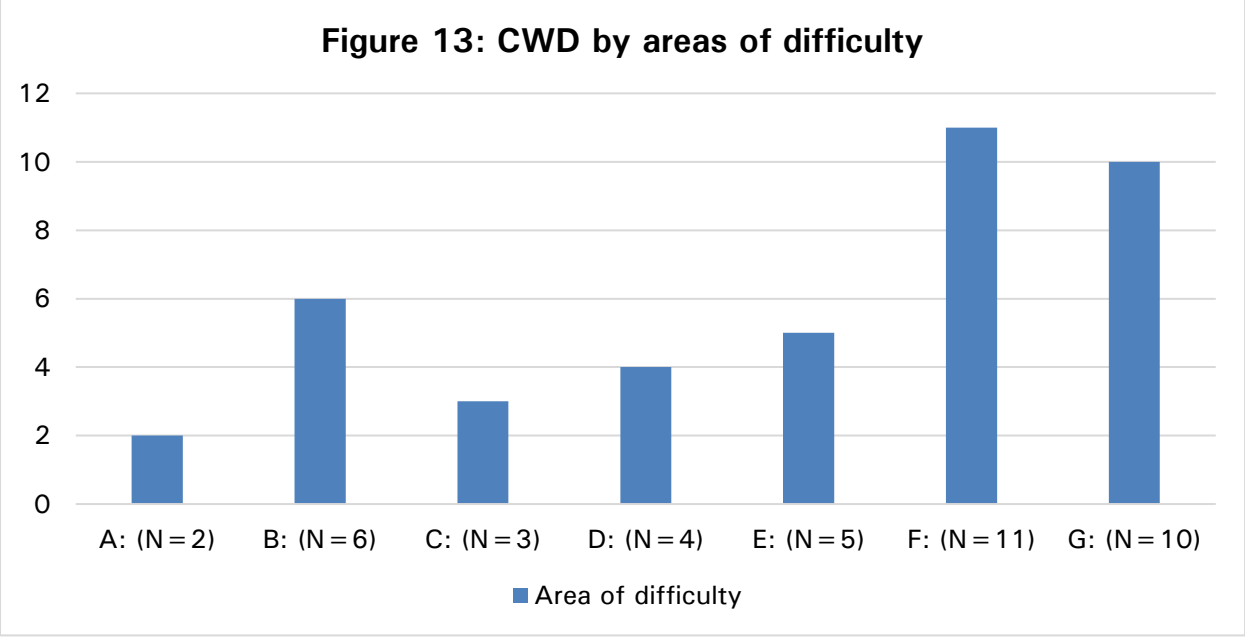
4.2.3 Families within the sample that include CWD

Seventeen families (3 per cent of the sample) identified that they had a child with a disability: eight with a boy and nine with a girl. Sixteen lived in rural areas (Chukha = 1, Mongar = 1, Pema Gatshel = 1, Punakha = 3, Trashigang = 5, Tsirang = 3 and Zhemgang = 2). One respondent lived in urban Thimphu.

a) Range of disabilities

One of these families provided very limited information about their daughter. The age range of CWD is 2 years to 17 years (see Figure 12). Over half of these children had difficulties in multiple areas of functioning (see Figure 13).





A: Difficulty seeing even if wearing glasses (N=2)
B: Difficulty hearing even if using hearing aid (N=6)
C: Difficulty walking or climbing stairs (N=3)
D: Difficulty remembering or concentrating (N=4)
E: Difficulty with self-care (N=5)
F: Difficulty communicating (N=11)
G: Difficulties in multiple areas (2 or more) (N=10)

b) Education and care

Forty-one per cent of these children (n=7) attended their local school; the same number (n=7) were not in education, and their mother (n=5) or grandmother (n=1) stayed at home to look after them during the day.

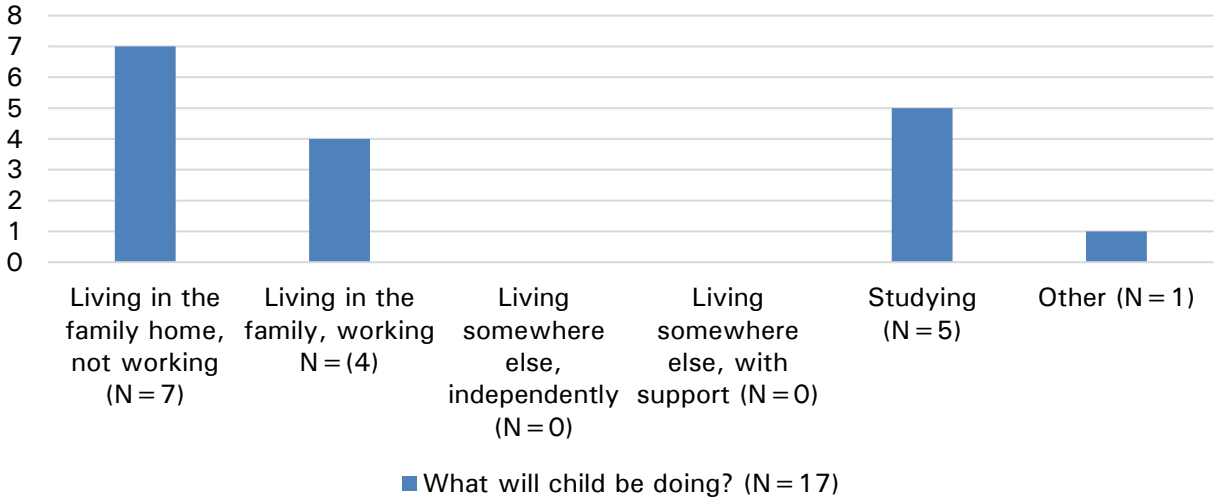
c) Play and socialization

With regard to the 17 CWD, 14 of them (82.4 per cent) played with other children within their family. Thirteen (76.5 per cent) played with other children outside the family: 11 visited their friends' homes to play, while two played with their friends only at school.

d) Future aspirations

With regard to what parents thought their children would be doing at the age of 18, the majority thought their children would still be at home, either working, studying or not working (see Figure 14).

Figure 14: What do you think this child will be doing at the age of 18?



e) Support for families living with disability

All 17 respondents with a child with disabilities identified their family as being their main source of support. Other sources of support identified were specialist medical (n=5), general medical (n=2), school (n=1) and neighbours (n=1). Three respondents felt that support had always been adequate, while 14 respondents felt that the levels of support received had been insufficient. Only 4 of the 17 respondents (23.5 per cent) knew of another family that had a child with disabilities.

4.3 CWD – knowledge

4.3.1 Understanding with regard to what disability is

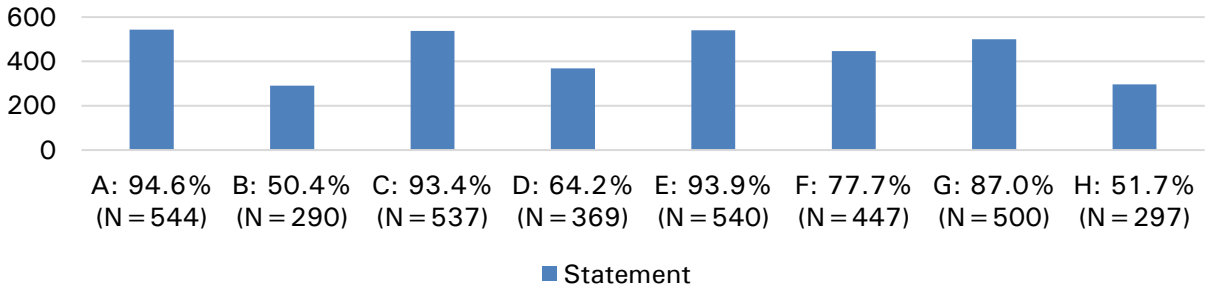
Respondents were asked to identify whether they agreed or disagreed with a number of statements regarding what comprised a disability. Data are first presented with regard to the whole data set (n=575). The responses of families that include CWD (n=17) are then compared with those that do not.

a) All respondents

A very high majority of respondents (>90 per cent) felt that individuals who had a total loss of vision, a total loss of hearing, or those who needed to use a wheelchair would be considered as having a disability.

Slightly fewer felt that those who had conditions limiting the use of their hands or those who needed a walking aid had a disability. Fewer than two thirds of respondents considered individuals who used hearing aids as having a disability; and only just above half of the respondents considered those needing glasses or those with learning difficulties as having a disability (see Figure 15).

Figure 15: Statements regarding what comprises a disability: whole data set (N = 575)



A: A person/child who has a total loss of vision has a disability 94.6% (N=544)
B: A person/child who has low vision and requires glasses has a disability 50.4% (N=290)
C: A person/child who has a total loss of hearing has a disability 93.4% (N=537)
D: A person/child who has poor hearing and requires hearing aids has a disability 64.2% (N=369)
E: A person/child who needs to use a wheelchair has a disability 93.9% (N=540)
F: A person/child who needs to use a walking aid (such as a stick) has a disability 77.7% (N=447)
G: A person/child who has a condition that limits the use of their hands has a disability 87.0% (N=500)
H: A person/child who has difficulties with learning at the same pace as others has a disability 51.7% (N=297)

b) Comparison of attitudes of families with CWD and those without

With regard to families with CWD, attitudes regarding what comprised a disability were generally similar to those of the whole sample. The only point of divergence was with regard to learning difficulties, where just over 70 per cent of this group considered this a disability, compared with 51.7 per cent across the whole sample. The differences between the responses of those families living with disability (n=17) and those that were not (n=558) were subjected to chi-square analysis. None of the differences between the two subsets' responses to these statements are statistically significant.

4.3.2 Awareness of Bhutanese legislation regarding CWD

a) All respondents

Respondents were asked if they were aware of any Bhutanese legislation regarding CWD. In response, 94 (16.3 per cent) said that they were, but few were able to give specific examples when asked what

legislation they were aware of (two respondents referred to 'Equality and Justice for CWD', one respondent made reference to *kidu*[3]).

Other respondents referred to the existence of, for example, special schools or the RENEW (Respect, Educate, Nurture and Empower Women) organization, or made statements such as "*there should be legislation since all are getting opportunities to education*", or "*they have a same opportunity as other children*".

b) Families with CWD

Four of the 17 respondents who were parents of CWD (23.5 per cent) said that they were aware of Bhutanese legislation regarding such children, but none could specifically name any legislation.

4.3.3. Awareness of Bhutanese services for CWD

a) All respondents

A total of 109 respondents (19.0 per cent) said that they were aware of local services for CWD within their communities. A number of respondents identified Early Childhood Care and Development (ECCD) programmes or specific schools in their areas. Some spoke of providing charity or food to families in their areas, and of governmental financial support and *kidu*. Others mentioned the provision of medical aids.

With regard to services at a national level, 203 respondents (35.3 per cent) said that they were aware of services. Respondents spoke of the provision of aids, health provision, educational provision, financial support and *kidu*. Specific reference was made to organizations such as:

- the Tarayana Foundation, a non-profit organization that helps the poorest and disadvantaged groups in Bhutan. This was named by eight respondents (1.4 per cent).
- the Muenselling Institute in Khaling, an institute for individuals with blindness or low vision. This was named by 36 respondents (6.3 per cent).
- the Wangsel Institute in Paro, a boarding school for children with hearing impairment. This was named by 19 respondents (3.3 per cent).
- the Draktsho Vocational Training Centre for Special Children and Youth in Thimpu. This was named by 21 respondents (3.7 per cent).

b) Families with CWD

Only two of the parents of CWD (11.8 per cent) said they were aware of any services for CWD in their areas – ECCD and hospital services. Twelve families (70.6 per cent) were aware of national services. Again, reference was made to Draktsho, Muenselling and Wangsel.

[3] *Kidu* or 'well-being of the people' is traditionally a royal prerogative and enshrined today in the constitution of Bhutan as a fundamental responsibility of the king.

4.3.4 Awareness of local groups or organizations

a) All respondents

With regard to local groups or organizations that assist CWD and their families, 83 respondents (14.4 per cent) said they were aware of such supports. Many respondents were unable to specify what these services were. Those who did, spoke about support from:

- local schools and health services;
- *kidu*;
- help from the local community and neighbours;
- support provided by the gewog tshogpa (village representative);
- Tarayana;
- UNICEF (including bus services); and
- Save the Children.

b) Families with CWD

Only one such family said they were aware of local groups or organizations, but were unable to identify what this source of support might be.

4.3.5 Awareness of health services

a) All respondents

In total, 299 respondents (52 per cent) stated that they were aware of health services that assist CWD and their families. Specific reference was made to Basic Health Units (BHUs) in localities, hospitals, medical treatment (such as check-ups and operations) at health facilities, hospital transport, home visits and the provision of aids and medication.

b) Families with CWD

Nine of these families (52.9 per cent) said they were aware of health services – again, reference was made to BHUs, hospitals and the provision of medication.

4.3.6 Awareness of education services

a) All respondents

With regard to education services that assist CWD and their families, 379 respondents (65.9 per cent) identified that they were aware of such services. The most well-known services were the Muenselling Institute (identified by 235 respondents, 40.9 per cent), Wangsel Institute (n=128, 22.3 per cent) and the Draktsho Centre (n=85, 14.8 per cent). Reference was also made to local education services, including Changangkha Middle Secondary School, Mongar Lower Secondary School, Tendruk Central School and the Trashiyangtse Institute for Zorig Chusum.

b) Families with CWD

Twelve families (70.6 per cent) were aware of national services. Again, reference was made to Draktsho, Muenselling and Wangsel.

4.3.7 Awareness of protection services and policies

a) All respondents

With regard to protection services, 152 respondents (26.4 per cent) stated that they were aware of social protection services that assist CWD and their families. Reference was made to *kidu*, Tarayana Foundation, Bhutan Youth Development Fund and support from the local tshogpa.

With regard to child protection services, 157 respondents (27.3 per cent) indicated awareness. Particular reference was made to Tarayana (n=71, 12.3 per cent), RENEW (n=54, 9.4 per cent), the National Commission for Women and Children (n=12, 2.1 per cent), the women and child protection unit and counselling services.

Only 58 respondents (10.1 per cent) said they were aware of any legislation relating to child protection for CWD. A handful however were able to identify, for example, children's rights legislation or the UN Convention on the Rights of the Child.

b) Families with CWD

Only three families (17.6 per cent) said they were aware of social protection services; two made reference to *kidu*. Four (23.5 per cent) were aware of child protection services (Tarayana and RENEW). One respondent stated that they were aware of child protection legislation, but were unable to identify it.

4.3.8 Referral systems

a) All respondents

In total, 114 respondents (19.8 per cent) said they were aware of referral systems to assist CWD and their families. Among systems described were the gewog system, e.g., gup (headman) and tshogpa, the dzongkhag *kidu* office, police, health services, education services and Tarayana.

b) Families with CWD

Only two families (11.8 per cent) said they were aware of any referral systems, making reference to health systems.

4.3.9 Religious institutions or services

a) All respondents

In total, 93 respondents (16.2 per cent) said they were aware of religious institutions or services that assist CWD and their families. Specific reference was made to Samtse Dratshang (Buddhist school), *rimdro* (the offering of food, gifts and services), Dratshang (religious bureaucracy), and monastic bodies.

b) Families with CWD

Four respondents (23.5 per cent) were aware of such religious institutions and services.

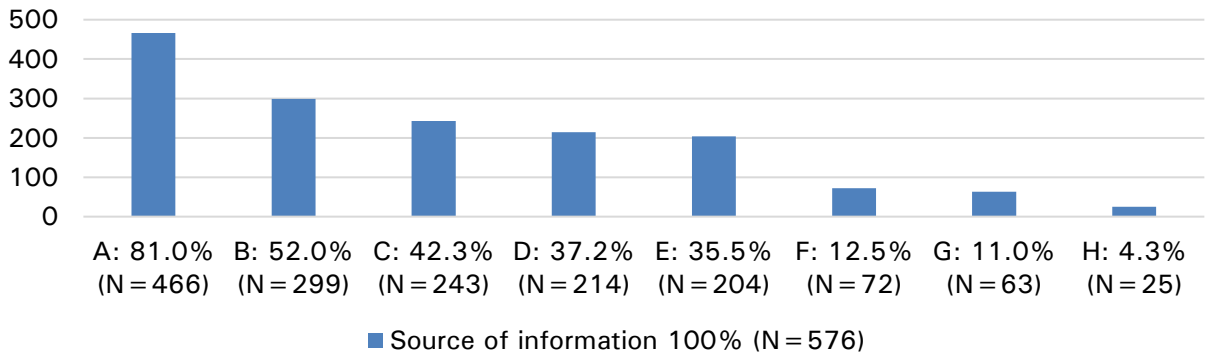
4.3.10 Information about disability

a) All respondents

Respondents were asked where they usually obtained information about disability. The most frequent source by a large margin was television, which was identified by over 80 per cent of respondents. Friends,

neighbours, family members and the radio were also commonly identified sources of information (see Figure 16).

Figure 16: Where do all respondents obtain information about disability?

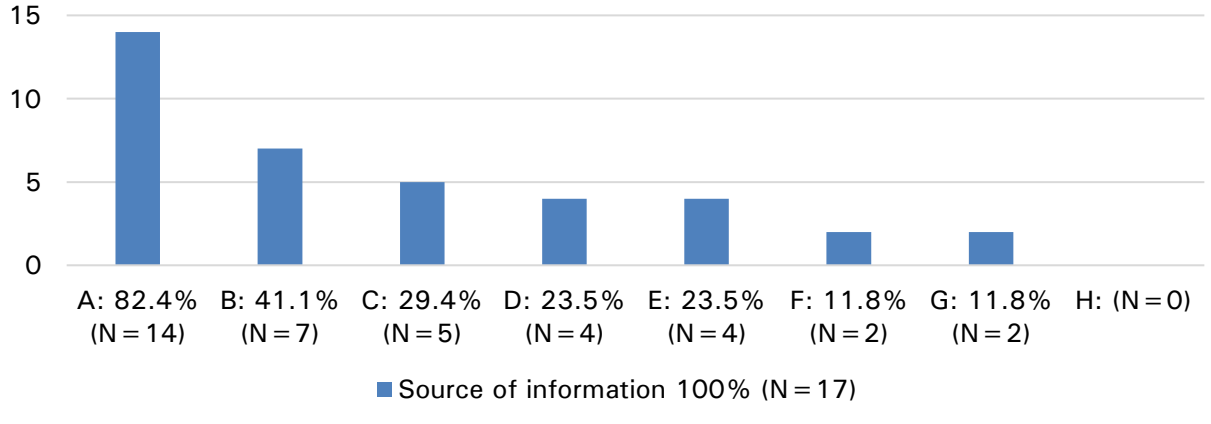


A: Television	81.0% (N=466)	B: Friends	52.0% (N=299)
C: Neighbours	42.3% (N=243)	D: Family	37.2% (N=214)
E: Radio	35.5% (N=204)	F: Newspapers	12.5% (N=72)
G: Government officials	11.0% (N=63)	H: Other sources	4.3% (N=25)

b) Families with CWD

Families living with CWD also identified television as their primary source of information about disability, with radio, family, friends and neighbours identified as secondary sources (see Figure 17).

Figure 17: Where do families with CWD obtain information about disability?



A: Television	82.4% (N=14)	B: Radio	41.1% (N=7)
C: Family	29.4% (N=5)	D: Friends	23.5% (N=4)
E: Neighbours	23.5% (N=4)	F: Newspapers	11.8% (N=2)
G: Other sources	11.8% (N=2)	H: Government officials	(N=0)

4.4 CWD – attitudes

Respondents were asked their opinions in respect of 27 statements regarding children and adults with disabilities, across five domains:

- Society and support
- Personal attitude towards disability
- Contribution
- Education and inclusion
- Protection

A seven-point Likert scale was used to gauge opinion. The categories offered to respondents were as follows: *Strongly agree, Agree, Slightly Agree, Neither Agree nor Disagree, Slightly Disagree, Disagree, Strongly Disagree*. An eighth category (*Don't know*) was also provided for use if respondents felt they had insufficient knowledge to give an opinion. The data were merged into four simplified categories:

- Agree (all degrees of agreement added together);
- Neither Agree nor Disagree;
- Disagree (all degrees of disagreement added together); and
- Don't Know.

Comparisons and contrasts are drawn between the opinions of those families that have CWD (n=17) and those that do not (n=558). Chi-square tests were carried out with regard to the responses across the four categories of these two groups to identify whether any statistically significant differences exist. The data for each statement are presented.

The caveat is that the number of respondents who were parents of CWD is small – it is therefore essential that suggestions within this data set are compared with the qualitative data gathered in the focus groups with families and individuals with disabilities.

4.4.1 Society and support

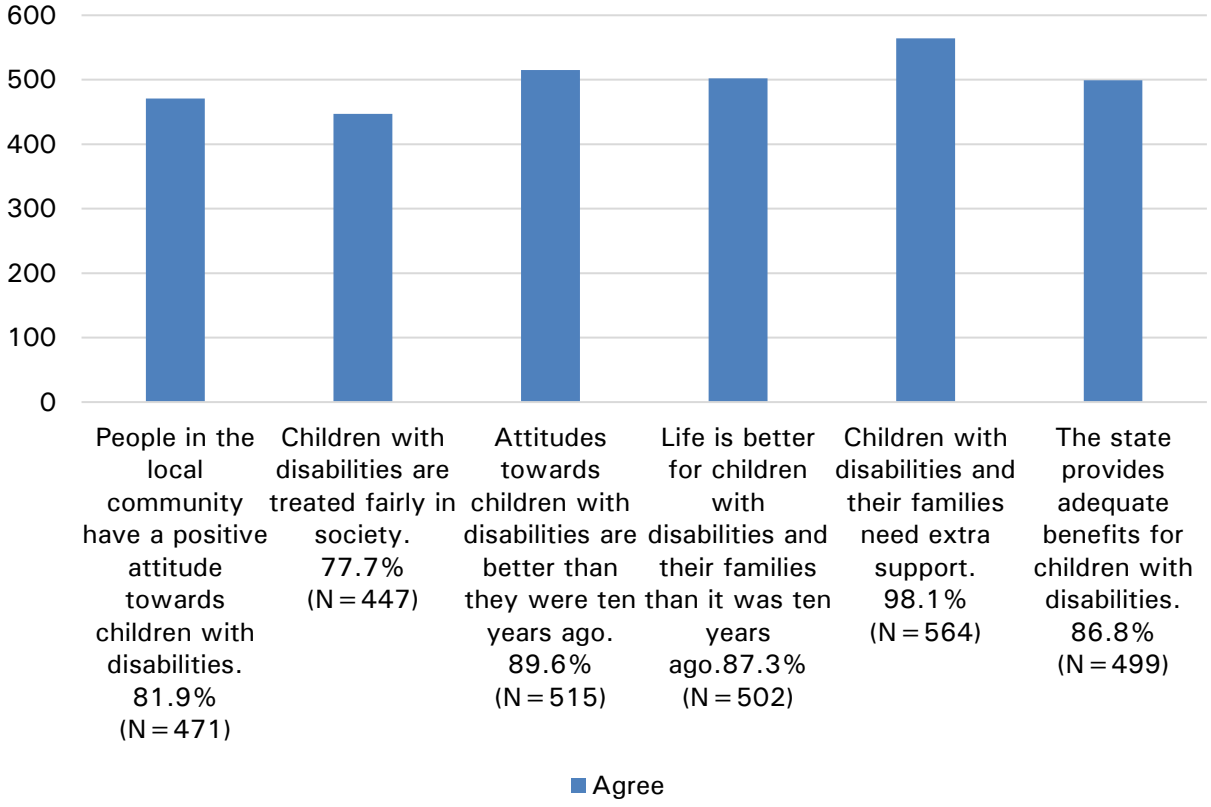
Respondents were asked their opinions on the following statements:
4.1.a) People in the local community have a positive attitude towards CWD.
4.1.b) CWD are treated fairly in society.
4.1.c) Attitudes towards CWD are better than they were 10 years ago.
4.1.d) Life is better for CWD and their families than it was 10 years ago.
4.1.e) CWD and their families need extra support.
4.1.f) The state provides adequate benefits for CWD.

a) All respondents

Respondents' attitudes with regard to societal attitudes and support were overwhelmingly positive and supportive of the current situation. Over three quarters of respondents felt that CWD were treated fairly both in society as a whole and within their local communities. Almost 90 per cent of respondents felt that attitudes towards CWD had improved over the last decade, and that life was now better for these children and their families.

Almost all respondents acknowledged that CWD needed extra support; however over 85 per cent of respondents felt that the benefits and support provided by the state were adequate (see Figure 18).

Figure 18: Responses of whole sample regarding society and support (N = 575)



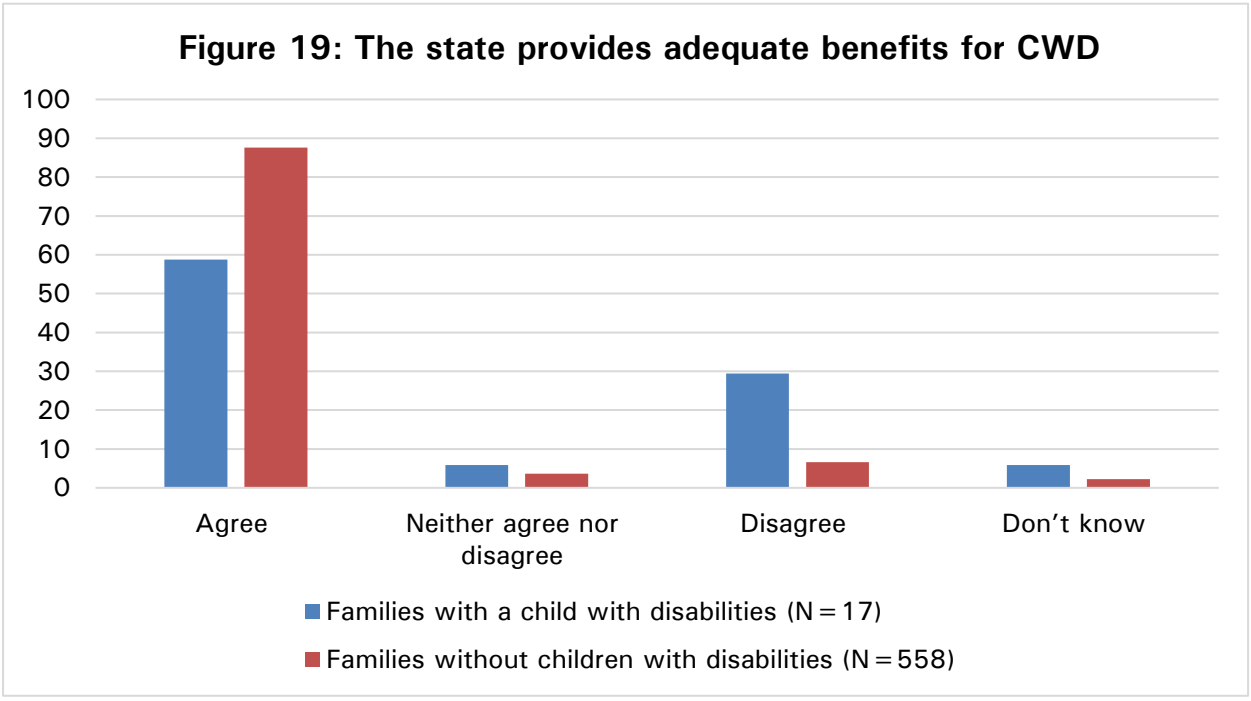
b) Comparison between families with and without CWD

Families with and without CWD held differing opinions on a number of these statements:

- While over 80 per cent of families without CWD felt that *local communities had a positive attitude towards CWD*, this view was shared by just over 60 per cent of families that had such children.
- Responses were similar with regard to the statement that *CWD are treated fairly in society*, in which families living with such children were less positive.
  Almost 30 per cent of families living with CWD disagreed with this statement, compared with approximately 15 per cent of families without such children.

There was agreement that attitudes towards CWD are better than they were 10 years ago, and that life is better for CWD and their families than it was 10 years ago. There was almost unanimous agreement also with the statement that *CWD and their families need extra support*.

However, there was a statistically significant difference between the two groups with regard to the statement that *the state provides adequate benefits for CWD* (see Figure 19). While almost 90 per cent of families without CWD agreed with this, with fewer than 7 per cent disagreeing, the picture was much more mixed for those living with such children: fewer than 60 per cent agreed and almost 30 per cent disagreed.



4.4.2 Personal attitudes towards disability

Respondents were asked their opinions on the following statements:
4.2.a) I would be happy to have a family with a child with disabilities living next door to me.
4.2.b) I would be happy to have a child with disabilities attending the same class as my child.
4.2.c) In the future, I would be happy for my child to marry a person with disabilities.
4.2.d) Children's disabilities are the result of past deeds.
4.2.e) CWD cannot lead as full a life as those without disabilities.
4.2.f) It is sometimes alright to treat CWD more favourably than other children.

a) All respondents

Attitudes were mixed with regard to the statement *I would be happy to have a family with a child with disabilities living next door to me*, with just over half of respondents (n=295, 51.3 per cent) agreeing, but a large minority (n=246, 42.8 per cent) saying they would not be happy with this situation.

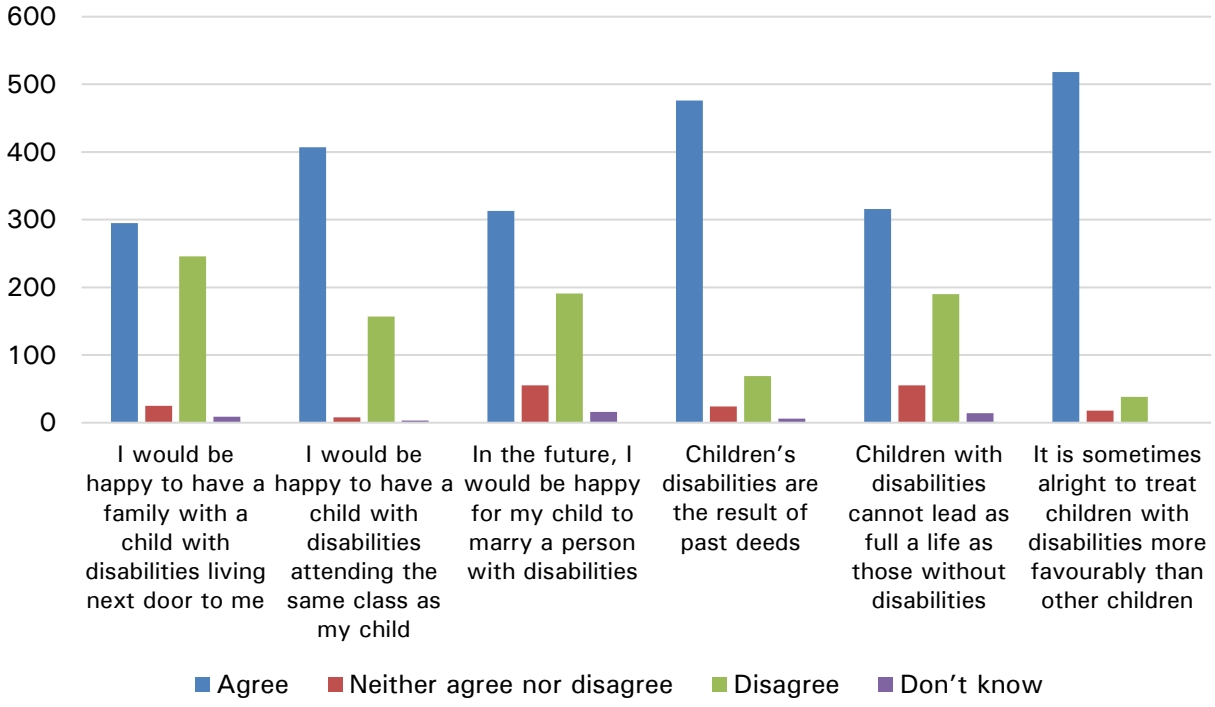
Responses to the statement *In the future, I would be happy for my child to marry a person with disabilities* were also mixed, with 313 respondents (54.4 per cent) agreeing and 191 respondents (33.2 per cent) disagreeing.

Responses to the statement *CWD cannot lead as full a life as those without disabilities* elicited similar responses: 55 per cent of the sample (n=316) agreed that such children's lives and experience were restricted, while 33 per cent (n=190) disagreed.

Respondents were more positive to the statement *I would be happy to have a child with disabilities attending the same class as my child*. Over 70 per cent agreed with this, while just under 30 per cent disagreed. There was even higher agreement within the sample to the statement *It is sometimes alright to treat CWD more favourably than other children*: over 90 per cent (n=518) agreed with this.

There was also high agreement to the statement that *Children's disabilities are the result of past deeds*, which is unsurprising within a Buddhist country. Over 80 per cent of respondents (n=476, 82.8 per cent) agreed with this, with only 12 per cent (n=69) feeling that this was not the case (see Figure 20).

Figure 20: Responses of whole sample regarding personal attitudes towards disability [simplified] (N = 575)



b) Comparison between families with and without CWD

There was high congruence between the personal attitudes of families with and without CWD.

- Almost 50 per cent of families with CWD stated that they would be unhappy to have a similar family living next door.
- Almost 30 per cent would be unhappy to have a child with disabilities attending the same class as their child.
- Attitudes between the two groups regarding the reason for children's disabilities were almost identical.

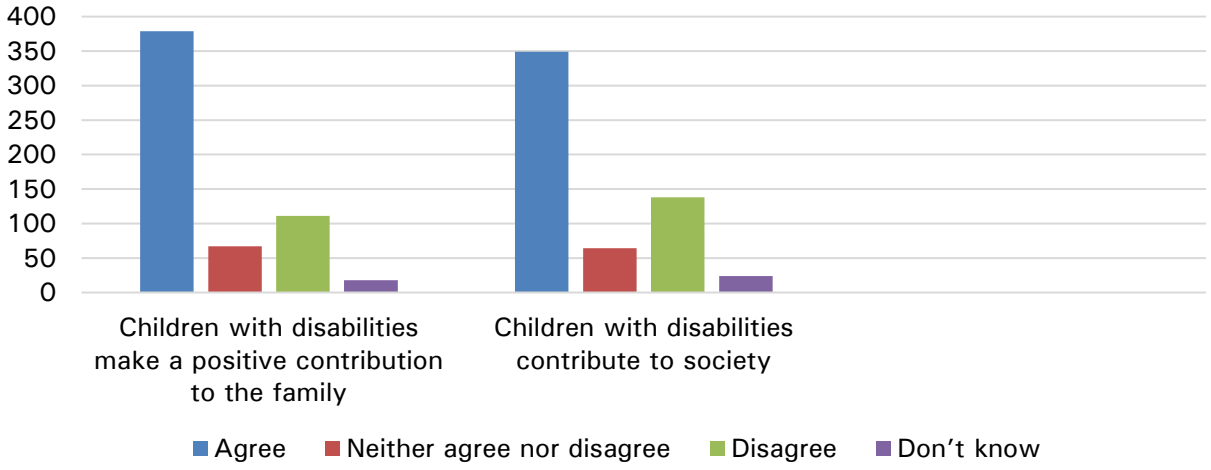
4.4.3 Contribution

Respondents were asked their opinions on the following statements:
4.3.a) CWD make a positive contribution to the family.
4.3.b) CWD contribute to society.

a) All respondents

Over 65 per cent of respondents agreed with the statement that *CWD make a positive contribution to the family*, while about 20 per cent disagreed; and over 60 per cent agreed with the statement that *CWD contribute to society,* with almost a quarter of respondents disagreeing (see Figure 21).

Figure 21: Responses of whole sample regarding contribution made by CWD (N = 575)



b) Comparison between families with and without CWD

Again, there was high congruence between families with and without CWD, with no statistically significant differences identified between the responses of the two groups to these statements about the contribution made by CWD.

4.4.4 Education and inclusion

Respondents were asked their opinions on the following statements:
4.4.a) All children should go to school, regardless of their needs or any disability.
4.4.b) CWD benefit from attending school.
4.4.c) CWD should attend the same schools as other children.
4.4.d) All CWD should attend special schools and not general mainstream classes.
4.4.e) Schools are better prepared/equipped to deal with CWD than they were 10 years ago.
4.4.f) CWD should be encouraged and supported to play with other non-CWD.
4.4.g) When CWD leave school, they have the same employment opportunities as their peers.

a) All respondents

There was almost universal agreement with three of the seven statements in this section:

- *CWD benefit from attending school* (n=567, 98.6 per cent)
- *All children should go to school, regardless of their needs or any disability* (n=561, 97.6 per cent)
- *Schools are better prepared/equipped to deal with CWD than they were 10 years ago* (n=519, 90.3 per cent).

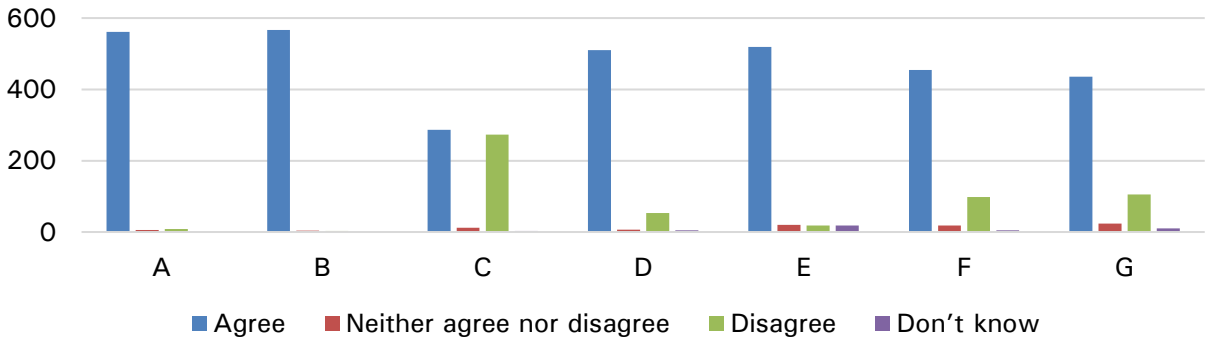
Over three quarters of respondents also agreed with the statements that *CWD should be encouraged and supported to play with other non-CWD* (n=454, 79 per cent) and that *when CWD leave school, they have the same employment opportunities as their peers* (n=436, 75.8 per cent).

Responses to the final two statements in this section were somewhat contradictory. With regard to the statement that *CWD should attend the same schools as other children*, there was an almost equal split

within the sample, with 287 respondents (49.9 per cent) agreeing to this and 273 (47.5 per cent) disagreeing.

However, with regard to the statement that *all CWD should attend special schools and not general mainstream classes*, there was high agreement, with 510 respondents (88.7 per cent) indicating that they believed this to be appropriate. It is difficult to reconcile these two standpoints (see Figure 22).

Figure 22: Responses of whole sample regarding the education and inclusion of CWD (N = 575)



A: All children should go to school, regardless of their needs or any disability
B: Children with disabilities benefit from attending school
C: Children with disabilities should attend the same schools as other children
D: All children with disabilities should attend special schools and not general mainstream classes
E: Schools are better prepared/equipped to deal with children with disabilities than they were 10 years ago
F: Children with disabilities should be encouraged and supported to play with other non-CWD
G: When children with disabilities leave school, they have the same employment opportunities as their peers

b) Comparison between families with and without CWD

There was high congruence between families with and without CWD, with no statistically significant differences identified between the responses of the two groups to these statements on education and inclusion.

With regard to the statement *CWD should be encouraged and supported to play with other non-CWD*, the parents of such children were in 100 per cent agreement, as compared with just over three quarters of households without CWD.

The contradiction identified above, regarding where CWD should go to school, appears even more marked in the positions held by families of such children. While over 70 per cent of such families held that *CWD should attend the same schools as other children*, they were almost unanimous in the view that *all CWD should attend special schools and not general mainstream classes*.

It is unclear if the responses to these two statements is indicative of some confusion regarding inclusion, or of a problem within the data collection process.

4.4.5 Protection

Respondents were asked their opinions on the following statements:
4.5.a) CWD are the subject of jokes or unacceptable or negative comments.
4.5.b) CWD are more likely to be the victims of bullying.
4.5.c) CWD are more vulnerable to physical and sexual abuse.
4.5.d) CWD are more likely to be neglected.
4.5.e) It is sometimes necessary to leave a child with disabilities in the house alone.
4.5.f) It is sometimes necessary to punish a child with disabilities for misbehaviour.

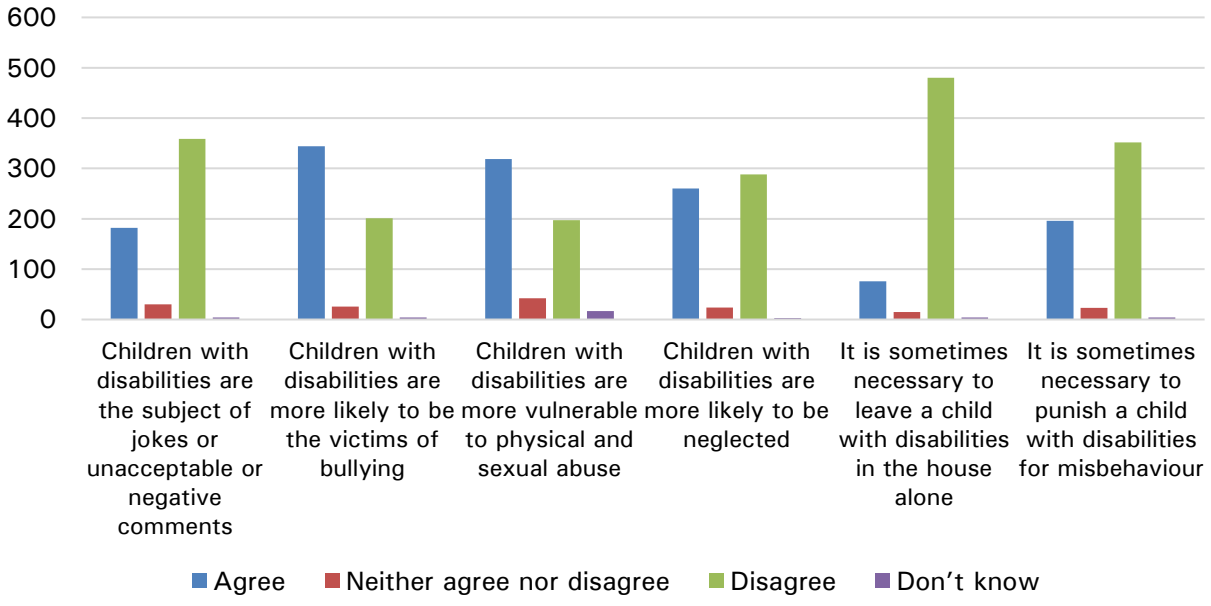
a) All respondents

Almost two thirds of respondents did not believe that *CWD are the subject of jokes or unacceptable or negative comments*, with just 31.7 per cent (n=182) feeling that this was the case. Just over half of respondents (n=288, 50.1 per cent) disagreed with the statement that *CWD are more likely to be neglected*.

However, higher numbers of respondents felt that *CWD are more likely to be the victims of bullying* (n=344, 59.8 per cent), and that *CWD are more vulnerable to physical and sexual abuse* (n=319, 55.5 per cent).

Over 60 per cent of respondents (n=352, 61.2 per cent) disagreed with the statement that *it is sometimes necessary to punish a child with disabilities for misbehaviour*, and over 80 per cent of respondents (n=480, 83.5 per cent) disagreed with the statement that *it is sometimes necessary to leave a child with disabilities in the house alone* (see Figure 23).

Figure 23: Responses of whole sample regarding the protection of CWD (N = 575)



b) Comparison between families with and without CWD

Almost half of families with CWD felt that such children are the subject of jokes or unacceptable/negative comments; over 80 per cent felt that such children were more likely to be bullied. This stands in contrast to the families without CWD, where these views were held by just 25 per cent and 60 per cent, respectively.

A slightly higher percentage of families that included CWD felt it could be appropriate at times to punish such children for misbehaviour (47.1 per cent compared with 33.7 per cent). With regard to the other statements, there was again close congruence between both subsets of the sample.

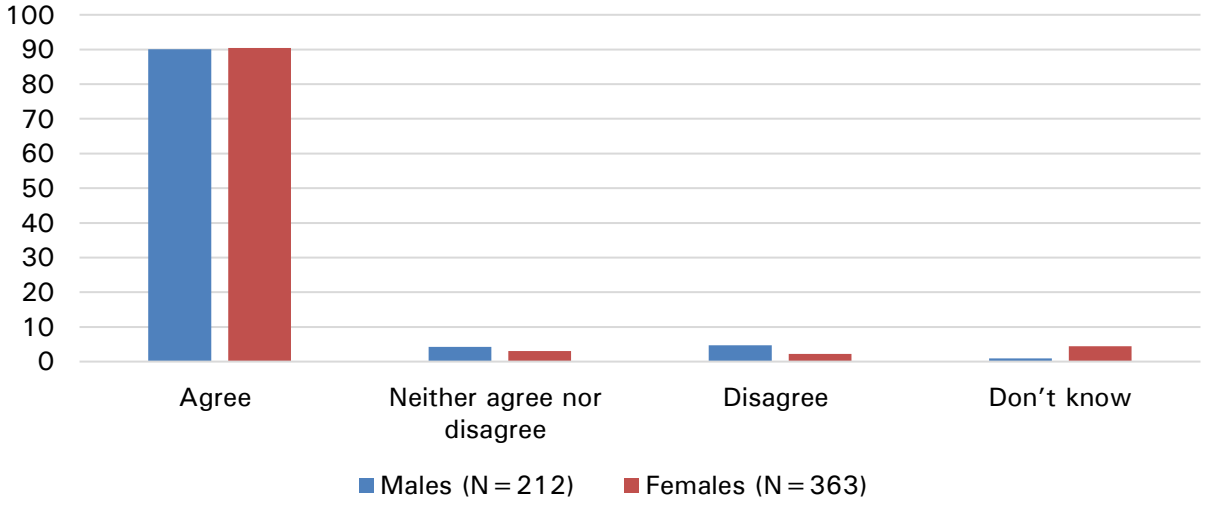
4.5 CWD – comparison of attitudes of respondents living near to CWD with those who do not

The research team considered the possibility of comparing the attitudes of families living near to CWD (i.e., within the same chiwog as those respondents who have CWD) with those who did not; this was to explore whether proximity to such families had an impact on attitudes. Unfortunately, as only a sample of households from each chiwog was surveyed, it was impossible to identify whether any of the households within each chiwog that did not participate in the study included CWD or not. Therefore, any inferences drawn from such comparisons would be unsafe and based on false premises.

4.6 CWD – comparison of attitudes of male and female respondents

The responses of male respondents (n=212) and female respondents (n=363) were compared. There was high congruence between male and female respondents, with a significant difference only in relation to one statement: that *schools are better prepared/equipped to deal with CWD than they were 10 years ago*. More than twice the percentage of males disagreed with this statement than females (4.7 per cent compared with 2.2 per cent) and female respondents expressed greater uncertainty, with 4.4 per cent saying they do not know, compared with 0.9 per cent of male respondents (see Figure 24).

Figure 24: Schools are better prepared/equipped to deal with children with disabilities than they were 10 years ago



4.7 CWD – comparison of attitudes of respondents by age

The attitudinal responses were also analysed using respondents' age as a variable.
Respondents were grouped into three subsets:

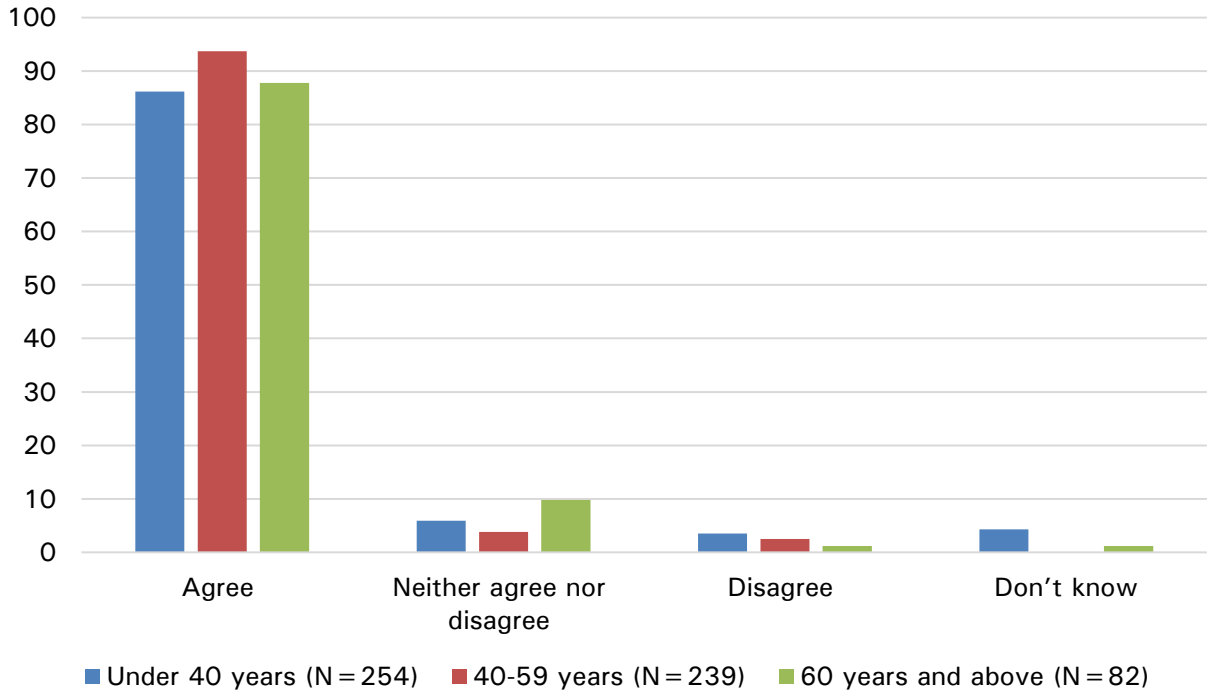
- Under 40 years (n=254)
- 40–59 years (n=239)
- 60 years and above (n=82)

Statistically significant differences were identified with regard to seven statements across all five domains.

4.7.1 Differences in attitudes regarding society and support by respondents' age

There were statistically significant differences between responses to two statements in this domain. With regard to the statement that *attitudes towards CWD are better than they were 10 years ago*, respondents aged 40 to 59 years expressed higher agreement than both younger and older respondents (see Figure 25).

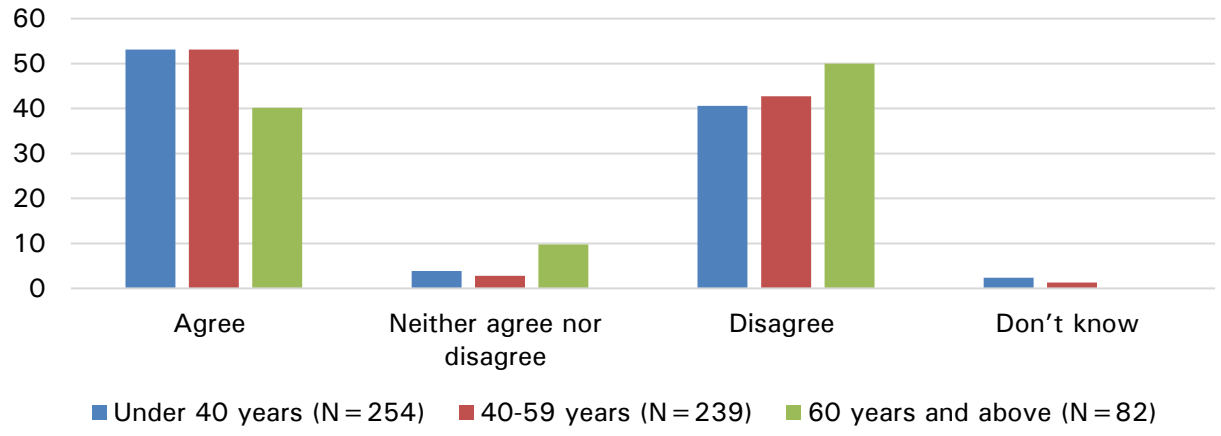
Figure 25: Attitudes towards CWD are better than they were 10 years ago



4.7.2 Differences in personal attitude towards disability by respondents' age

In respect of personal attitudes, respondents aged 60 years and above were less positive towards the statement that *I would be happy to have a family with a child with disabilities living next door to me*, with just over 40 per cent agreeing, and 50 per cent disagreeing. This was the reverse of the two younger groups, where over 50 per cent agreed and about 40 per cent disagreed (see Figure 26).

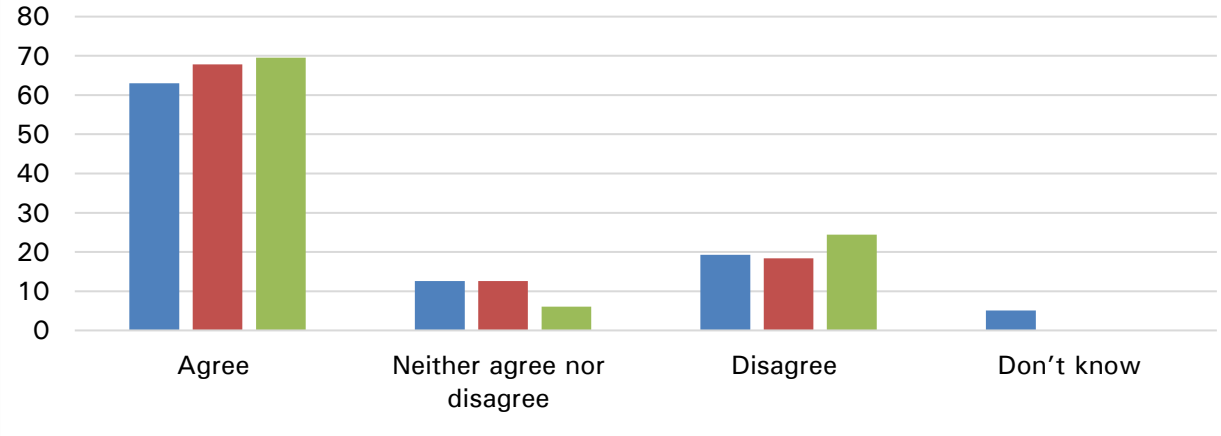
Figure 26: I would be happy to have a family with a child with disabilities living next door to me



4.7.3 Differences in attitudes towards the contribution made by CWD by respondents' age

Again, in this domain, respondents aged 60 and over were less positive, with about a quarter disagreeing with the statement that *CWD make a positive contribution to the family*; the figure for the other two subsets is less than 20 per cent (see Figure 27).

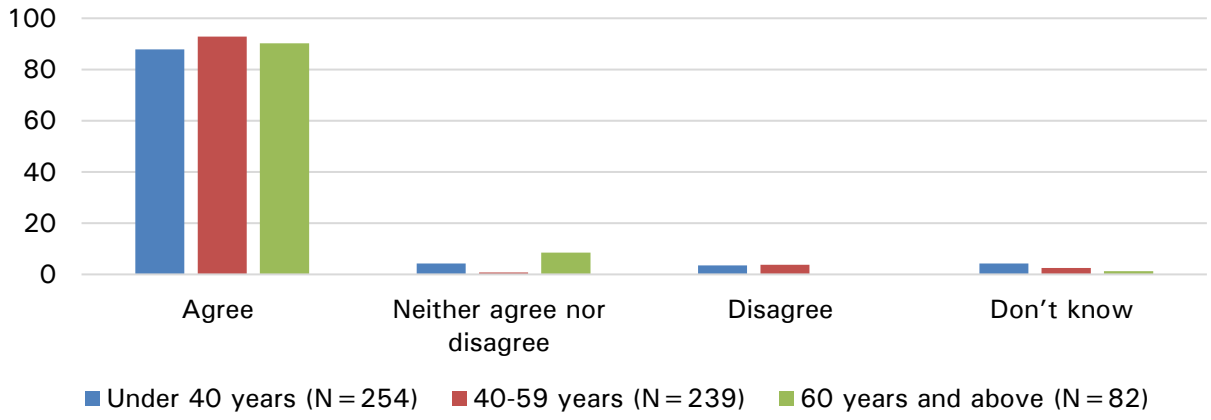
Figure 27: CWD make a positive contribution to the family



4.7.4 Differences in attitudes towards the education and inclusion of CWD by respondents' age

No older respondents disagreed with the statement that schools are better prepared/equipped to deal with CWD than they were 10 years ago (see Figure 28).

Figure 28: Schools are better prepared/equipped to deal with children with disabilities than they were 10 years ago

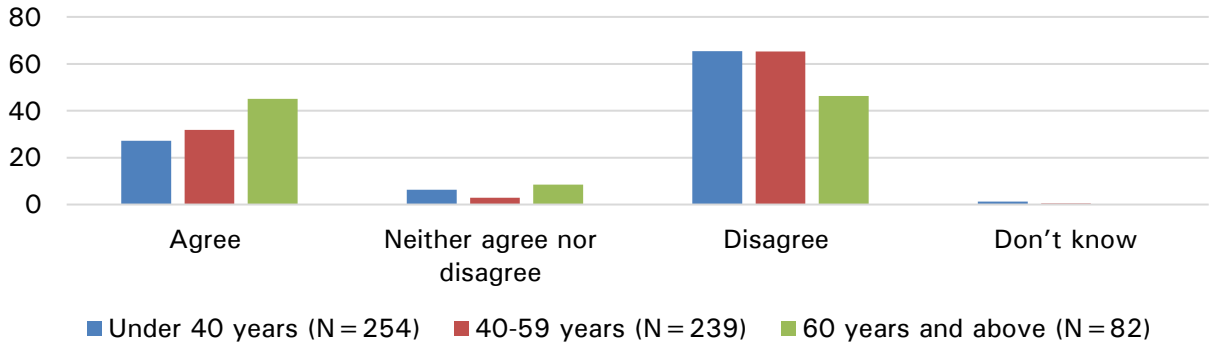


4.7.5 Differences in attitudes towards the protection of CWD by respondents' age

There were statistically significant differences between the three subsets with regard to the three statements within this domain.

Concerning the statement that *CWD are the subject of jokes or unacceptable or negative comments*, a much higher percentage of older respondents agreed: 45.1 per cent of respondents aged 60 years and older, compared with just under 32 per cent of those aged 40–59 years and just over 27 per cent of under 40s. There was also much less expressed disagreement with this statement from the older group (about 46 per cent, compared with about 65 per cent from the other two subsets) (see Figure 29).

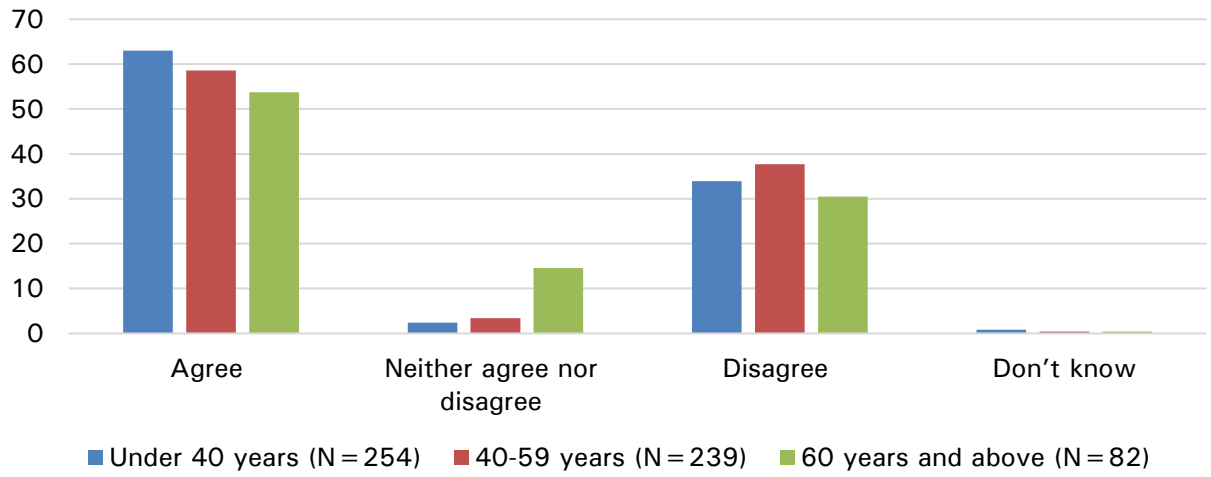
Figure 29: CWD are the subject of jokes or unacceptable or negative comments



The situation was somewhat reversed for the statement that *CWD are more likely to be the victims of bullying*. Here, younger respondents were in greater agreement with the statement (63 per cent, compared with under 59 per cent for those aged 40–59 years and under 54 per cent for those 60 years and over). They were also less equivocal, with just 2.4 per cent saying they neither agreed nor disagreed. This

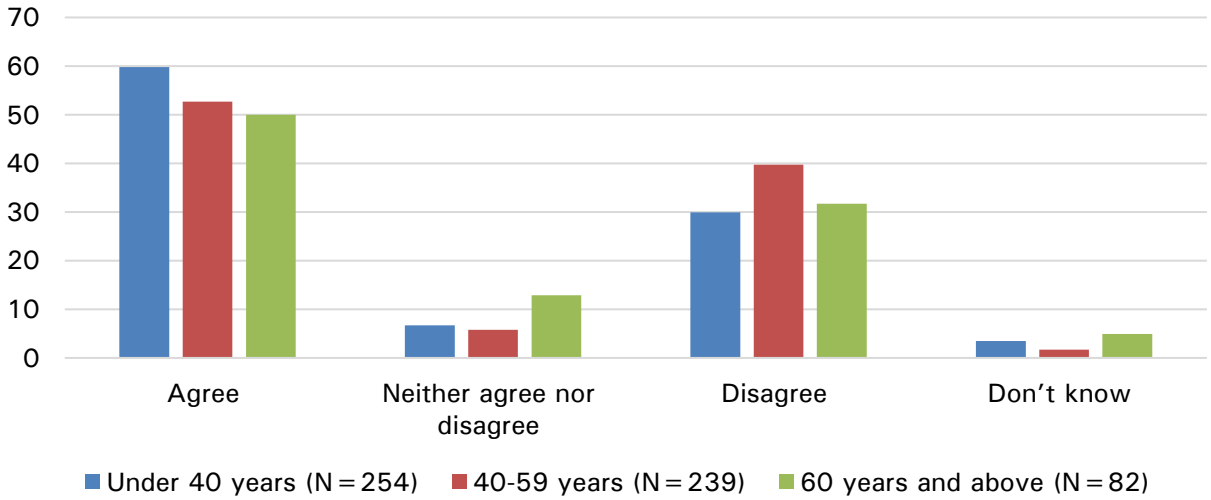
contrasts sharply with the 3.4 per cent of those aged 40–59 years and 14.6 per cent of those aged 60 years and over who gave this response (see Figure 30).

Figure 30: CWD are more likely to be the victims of bullying



Younger respondents were also in greater agreement with the statement that *CWD are more vulnerable to physical and sexual abuse*; almost 60 per cent of them agreed, compared with around 50 per cent of the other two subsets (see Figure 31).

Figure 31: CWD are more vulnerable to physical and sexual abuse



4.8 CWD – impact of education level on attitudes

In order to explore whether respondents' education level had any impact on their attitudes towards CWD, the responses of the least educated subset of the sample – those who had received no formal education

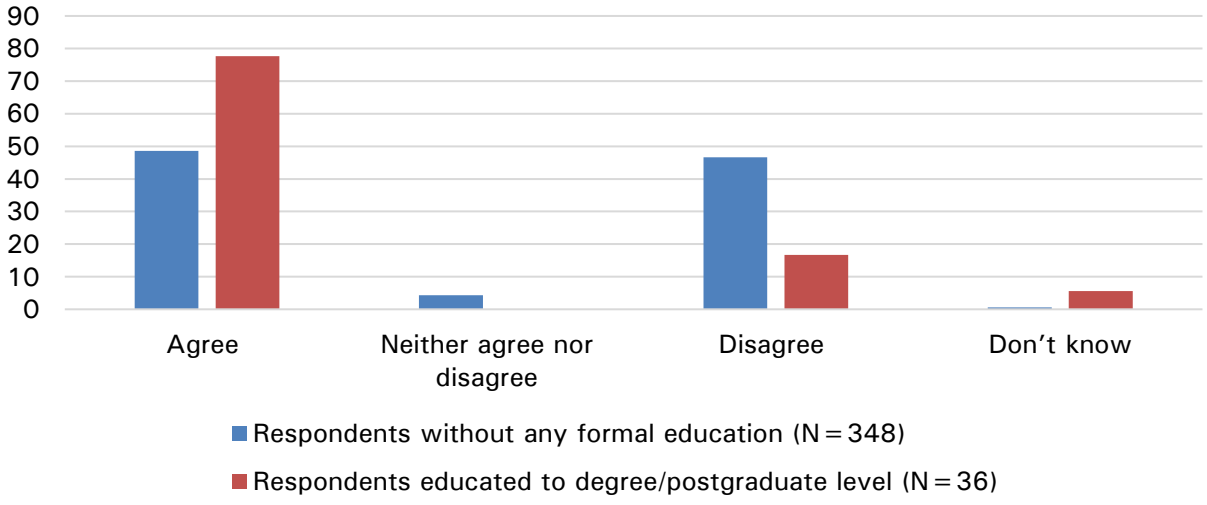
(n=348, 60.5 per cent) – were compared with those who were most highly educated – those who were educated to degree or postgraduate levels (n=36, 6.2 per cent).

Their responses to the 27 Likert scale statements were compared. There were no significant differences for the domains relating to Society and Support or Protection. However, significant differences were identified with regard to nine statements across the remaining three domains, which are discussed here.

4.8.1 Differences in personal attitude towards disability between respondents with no formal education and those educated to degree/postgraduate level

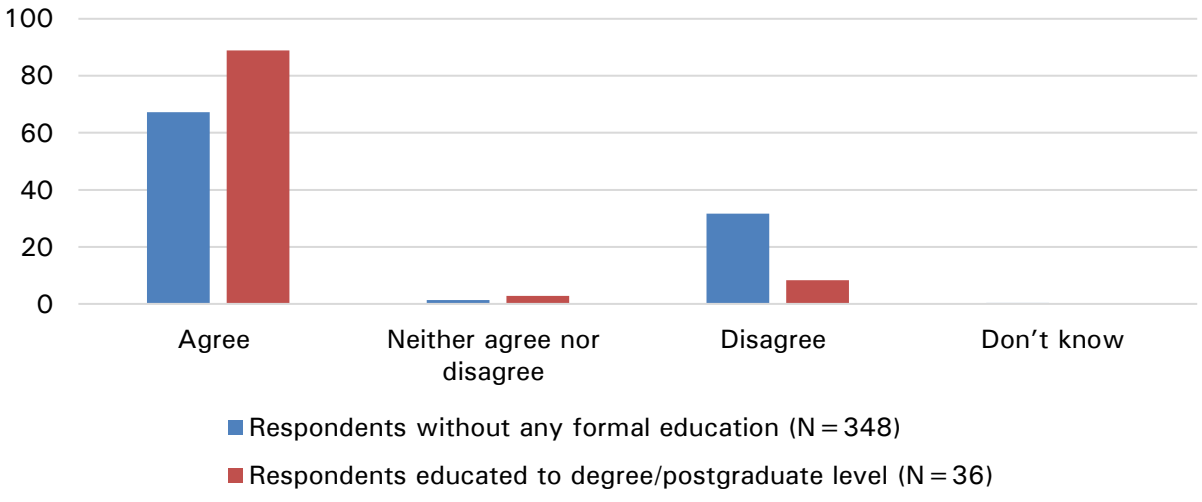
Significant differences were identified in five of the six statements in this domain. In respect of the statement that *I would be happy to have a family with a child with disabilities living next door to me*, those who were more highly educated were much more positive, with 77.7 per cent agreeing (as compared with 48.6 per cent of those with no formal education) and only 16.7 per cent disagreeing (compared to 46.6 per cent) (see Figure 32).

Figure 32: I would be happy to have a family with a child with disabilities living next door to me



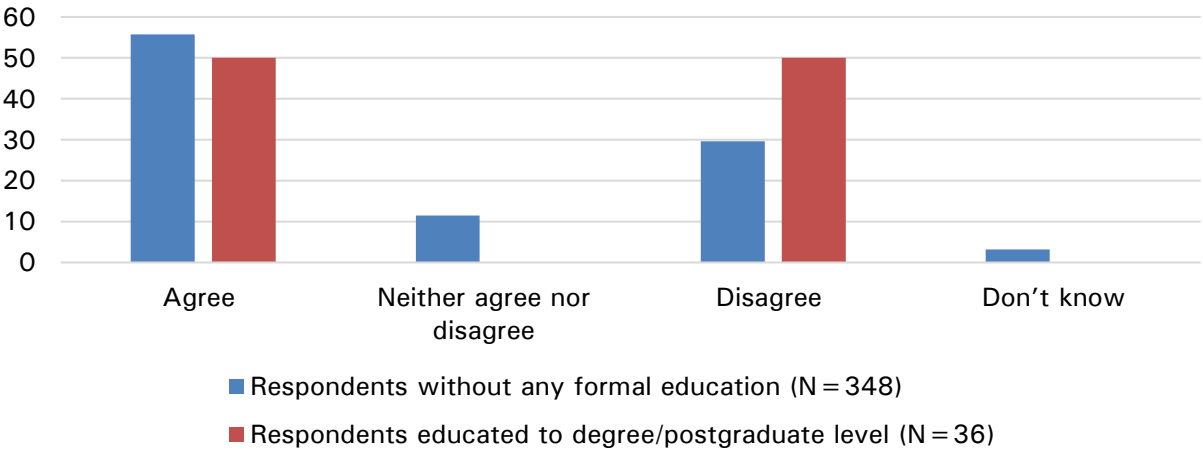
More highly educated respondents were also more positive to the statement *I would be happy to have a child with disabilities attending the same class as my child*: almost 90 per cent agreed (compared to just over 67 per cent) and only just over 8 per cent disagreed (compared to over 31 per cent) (see Figure 33).

Figure 33: I would be happy to have a child with disabilities attending the same class as my child



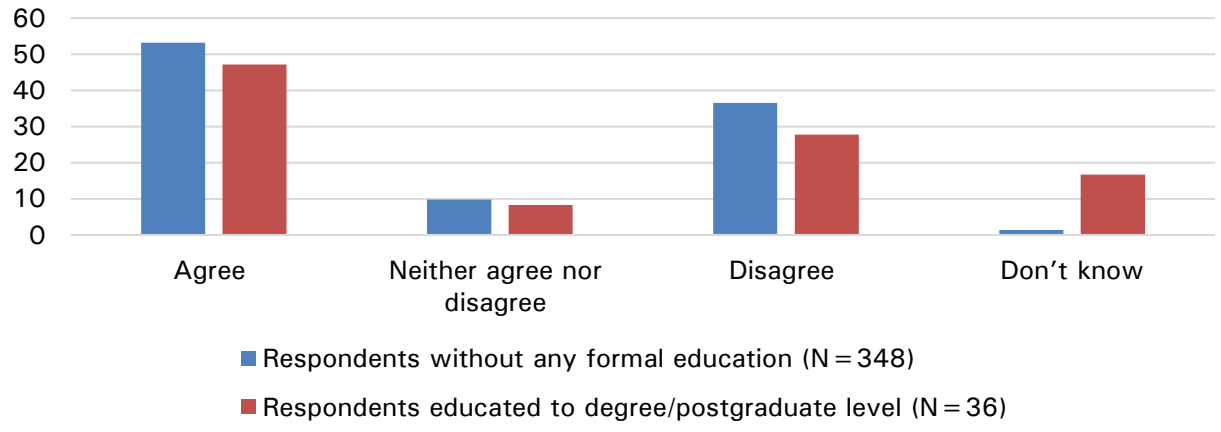
More highly educated respondents were again more positive about the ability of CWD to lead a full life. With regard to the statement that *CWD cannot lead as full a life as those without disabilities*, the responses were equally balanced from more highly educated respondents, with half agreeing and disagreeing, while only about a more than half of respondents without formal education third agreed and almost one , while two third disagreed. The responses were more equally balanced from those without formal education, with just under half agreeing and disagreeing (see Figure 34).

Figure 34: CWD cannot lead as full a life as those without disabilities



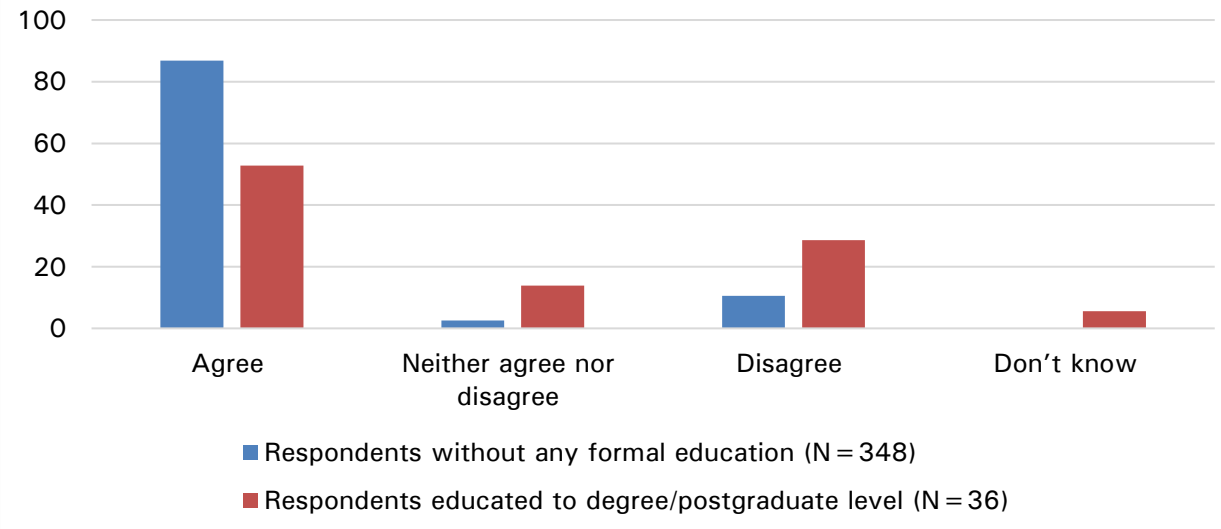
A more mixed picture was presented for the statement that *In the future, I would be happy for my child to marry a person with disabilities*. More highly educated respondents were less clear here in their responses, with 16.7 per cent stating that they did not know. Those without formal education were much clearer,with only 1.4 per cent giving this response (see Figure 35).

Figure 35: In the future, I would be happy for my child to marry a person with disabilities



There were significant differences in respondents' understanding of why children had disabilities (see Figure 36). Over 85 per cent of those without formal education felt that this was the result of past deeds, with only about 10 per cent disagreeing. This contrasted sharply with the responses from those educated to degree/postgraduate level, where only just over half of the respondents agreed, and almost 30 per cent disagreed.

Figure 36: Children's disabilities are the result of past deeds

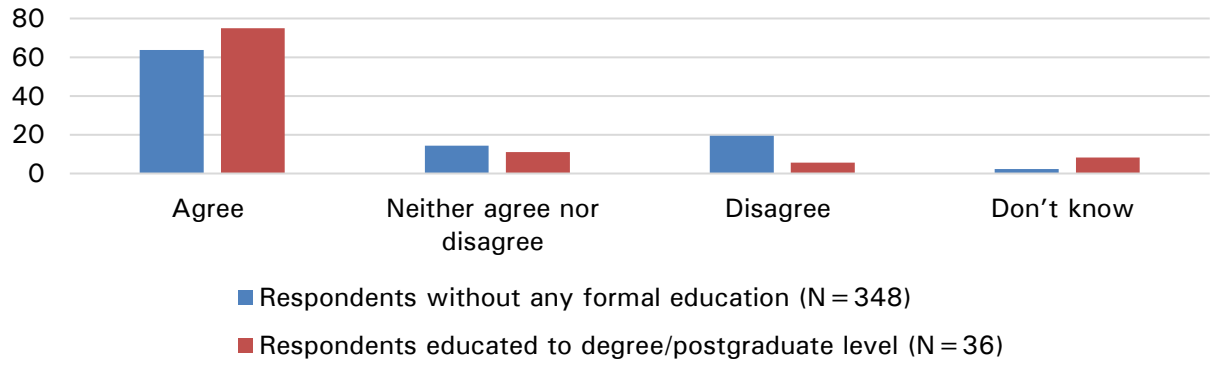


4.8.2 Differences in attitudes towards the contribution made by CWD between respondents with no formal education and those educated to degree/ postgraduate level

Statistically significant differences between the responses of the two sub-groups have been identified about two statements within this domain. Again, those respondents who are more highly educated gave more positive responses.

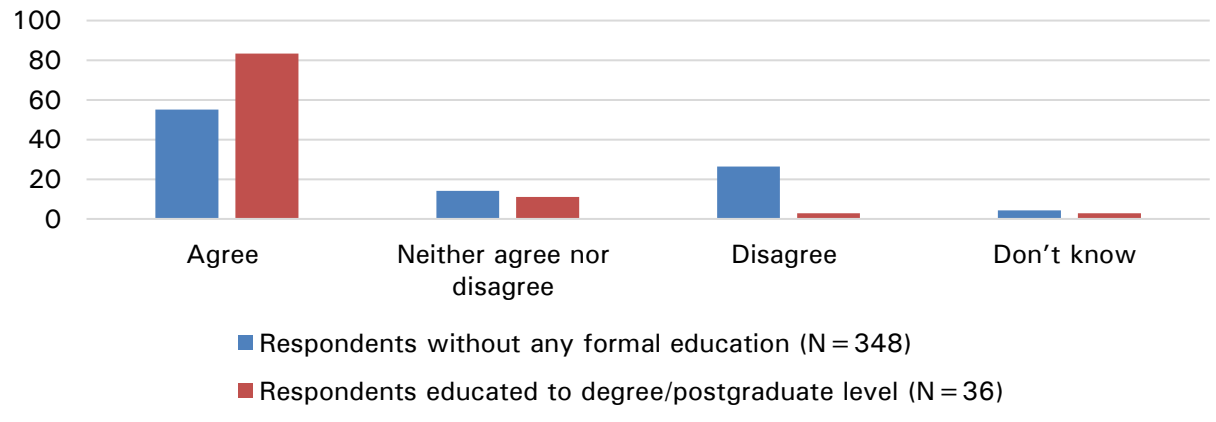
With regard to the statement that *CWD make a positive contribution to the family*, 75 per cent of those educated to degree/postgraduate level agreed, with only 5.6 per cent disagreeing. For those with no formal education, the figures were 63.8 per cent agreeing and 19.5 per cent disagreeing (see Figure 37).

Figure 37: CWD make a positive contribution to the family



With regard to the statement that *CWD contribute to society*, over 80 per cent of those more highly educated agreed, compared with just over half of those with no formal education; and while over 25 per cent of this latter group felt that such children did not contribute to society, this view was held by only one respondent from the degree/postgraduate sub-group (see Figure 38).

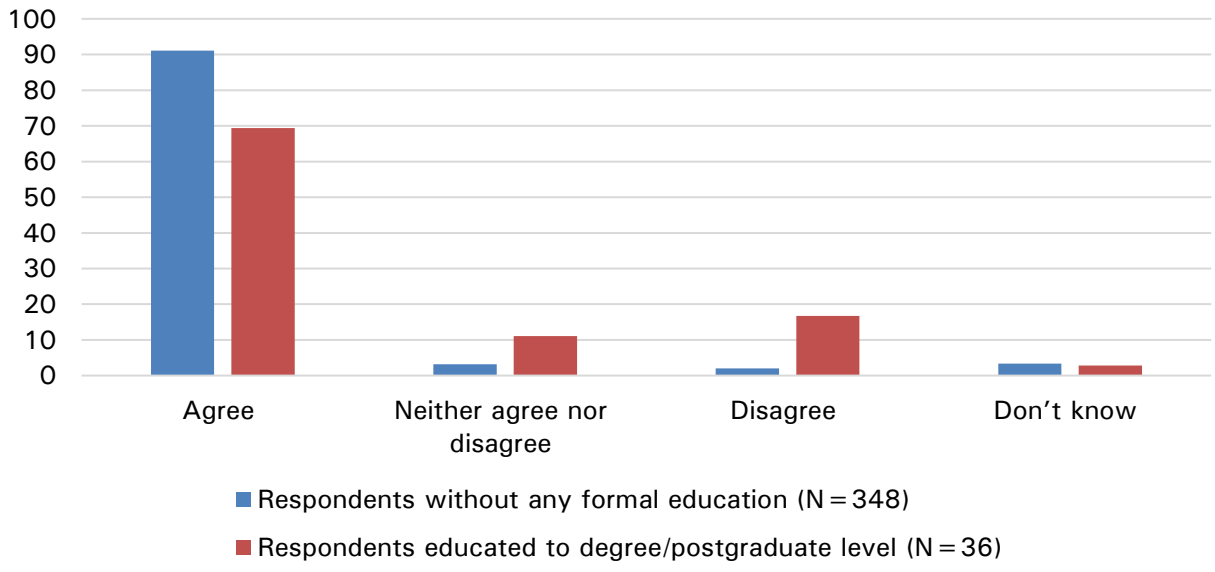
Figure 38: CWD contribute to society



4.8.3 Differences in attitudes towards the education and inclusion of CWD between respondents with no formal education and those educated to degree/postgraduate level

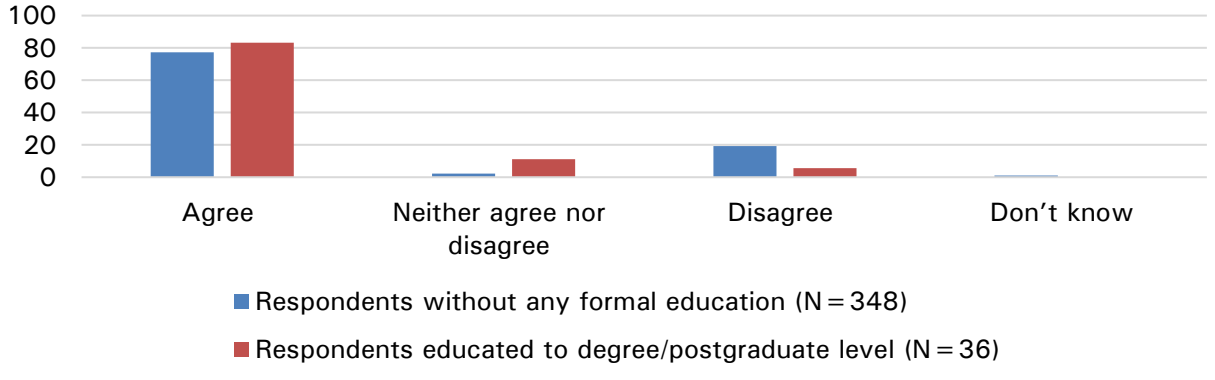
Statistically significant differences between the responses of the two sub-groups have been identified about the two statements within this domain. More highly educated respondents were more sceptical that *schools are better prepared/equipped to deal with CWD than they were 10 years ago*, with just under 70 per cent agreeing (compared to over 90 per cent of those with no formal education) and 16.7 per cent disagreeing (compared with 2.0 per cent) (see Figure 39).

Figure 39: Schools are better prepared/equipped to deal with children with disabilities than they were 10 years ago



More highly educated respondents also felt more strongly that *CWD should be encouraged and supported to play with other non-CWD*, with only just over 5 per cent of respondents disagreeing, compared with almost 20 per cent of those without formal education (see Figure 40).

Figure 40: CWD should be encouraged and supported to play with other non-CWD



5. RESULTS (ii) QUALITATIVE DATA: FINDINGS FROM THE FOCUS GROUPS

5.1 Research orientation

As with the quantitative material, qualitative data were collected in accordance with the methodology agreed with UNICEF and approved by the Bhutanese Research Ethics Committee and the University of Northampton's Research Ethics Committee. Bhutanese enumerators were trained to conduct the focus groups and the informal interviews by University of Northampton researchers during October 2016. The data were gathered during November 2017. Transcribed data were sent to the University of Northampton team in January 2017.

5.2 Research instruments

This section of the report presents narrative data from both the focus group discussions and the interviews, undertaken across Bhutan in October 2016.

Qualitative data were obtained through focus groups and interviews. These were convened to enable interested parties to discuss their experiences and overview the provision made for CWD in Bhutan. Twelve focus groups were conducted with service users and providers distributed across urban and rural districts of Bhutan (see Table 77), including some nominated key personnel involved with CWD.

The data from these processes were subjected to categorical coding to identify recurring and consistent themes that could provide insights into the lives and experiences of CWD and their families in Bhutan to inform a discussion of the situation for children with disabilities in the country.

In addition to providing professionals, parents and children opportunities to express their views and thereby inform the research, the data obtained from these focus groups enabled the research team to extend their interpretation of the findings of the national survey and to clarify meaning in respect of specific issues that were seen to be important in the provision made for CWD.

Data were collected from both urban and rural districts across Bhutan (see Table 77). Focus groups and interviews were managed by enumerators who had received training for this purpose. Field notes and audio recordings were maintained, transcribed, translated and forwarded to the research team in Northampton for analysis.

To maintain consistency with the presentation of the quantitative data obtained through the HSQ survey, the findings from the qualitative data will be presented in relation to the three areas of knowledge, attitudes and practices. This enables the differing perspectives of respondents from the focus groups to be identified and commented upon to provide a triangulated data overview of the situation in Bhutan.

In the analysis that follows, indicative verbatim commentaries from various stakeholders are inserted to illustrate the views held by various participants. Whilst these cannot be regarded as representative of a widespread position on any single issue regarding CWD, they are nevertheless useful in providing an indication of the varying views held on key matters of practice and provision and in several places offer

confirmatory evidence in support of HSQ findings. The illustrative extracts are identified by 'NC' (Narrative Comment) and are placed in *italic* script.

5.3 Knowledge

Knowledge about disability in Bhutan appears to be largely invested in professionals who have responsibility for the development and implementation of policy or the delivery of educational, social or health services. Amongst parents and children, the knowledge about disability, its causes and implications is limited and in some cases misinformed ("*Children who cannot walk, are limp or don't have hands"* NC). The association of 'disability' with mainly physical characteristics thus provides definite supporting evidence to the quantitative data obtained.

Service providers also are inclined to focus upon disability in its physical or sensory manifestations, identifying deficits that impede the abilities of individuals to function effectively within Bhutanese society. ("*We can most tell from the way that a child responds to visual or sound stimuli. And if a child had a physical disability then we can tell when we look at them. And when a child has a cognitive disability we can tell from the way they respond to our teaching"* NC).

Responses given in the focus group sessions and interviews by service providers indicate that a standardized means of assessing the needs of individuals described as disabled is not currently being employed ("*…it is difficult because an assessment tool or a screening process needs to be in place like RNDA* [rapid neurodevelopment assessment] *but these are only available in the 12 schools with SEN program and some ECCD centers"* NC). There is instead an emphasis on the physical attributes of individuals rather than a holistic interpretation of need being the norm (" *children who are able and normal can do a lot in terms of their six senses but disability is when the children have impairment in one or two senses. And they are not able to do as well as the other children. The common disabilities are physical ones like hearing impairment, visual disabilities and even psychological disabilities"* NC).

Disability is seen in limited terms as a child deficit and little consideration was given in responses to environmental influences or social factors; this echoes the key findings from the quantitative data presented. Whilst little attention was given to children with intellectual disabilities, it was implied in many responses that those children with physical of sensory disabilities were likely to have difficulties accessing learning ("*Blindness is the most challenging because for all the other disabilities they can at least see the world. But a child who cannot see is forever living in darkness"* NC). There were similar responses from representatives of the ministries in Thimpu, though this group did identify conditions such as autism spectrum disorders and intellectual disabilities as an area of concern ("*…some of the greatest challenges being developing knowledge and skills in dealing with autism and intellectual disabilities and training teachers in these areas"* NC).

Representatives from NGOs considered negative attitudinal issues to be an influential factor in the interpretation of disability and the labelling of children ("*our thinking and our attitude makes us think about what it means to be disabled…When we talk about disabilities, attitude is a very important factor. So, having a law in place is extremely important because with a law in place I feel that a change in attitude will follow"* NC).

They similarly believed that environmental factors that inhibit access to learning or to the local community were significant in exacerbating disabling conditions ("*…what we need to do is to provide job opportunities*

for children with disabilities because forget about those who don't have an education, even graduates don't get employed. Because parents spend so much in educating their children who have disabilities and when they finally do graduate they are ignored and often land up without a job. And they cannot go back to their village and work on their farms because they don't have that capability. So in such situations I think the government should step in and do something about it" NC).

Parents of disabled children and also those who did not have a disabled child tended to have a narrow understanding of disability generally formulated upon the basis of limited engagement with people with disabilities (" *I don't know anyone like that. All I know is what I have seen on TV"* NC). As would be expected, the parents of children with disabilities were knowledgeable about their own child's conditions and the implications of this upon daily life (" *I would like to talk about my son* ____ [name removed]. *He is having problems with vision, hearing and also faces difficulty while walking. The biggest challenge that he faces is coping up with his learning because he is not able to read or write properly and on top of that he does not feel the dotted book properly. Because of this his teachers are facing problems in identifying his needs and he is lagging behind compared to others"* NC. However, beyond their own child both their knowledge and their experience was limited.

Those parents who had no experience of bringing up a CWD focused upon physical and sensory impairments when asked to define disability and most stated that they had either no or limited experience of CWD ("*I don't think I will be able to say anything. I think it's basically those children who need extra attention. If children are limp or deaf then we have to take care of them but normal children don't need extra attention"* NC). Children, both with and without disabilities, had a similar interpretation of disability to that given by adults, and many had had similarly limited opportunities to engage with their disabled peers.

When asked about the causes of disability, responses fell into four categories. The first of these can be described as a fatalistic belief that disability resulted from bad karma with disability visited upon the child because of events in a previous life involving either the child or his parents ("S*ome children are born with a disability because of their karma"* NC). This belief was common not only amongst parents and children but also held by several of the professionals involved in the focus groups – observations that are supported by the HSQ data.

A second response related to inadequate neonatal care or poor diet during pregnancy (" *Due to improper diet during pregnancy or the age of the mother or it can be acquired due to an accident or a disease. I think we should also work on preventive measures for disabilities"* NC). This was closely aligned to a perception that in some instances the use of substances, including tobacco, alcohol or drugs, was a likely cause of having a CWD (" *Some take drugs due to which their brain gets damaged"* NC).

A final category of response identified poor hygiene, including that sometimes experienced in hospitals, as a contributory factor ("*I think it's due to negligence on the hospital's side also. They told us that the due date was quite far and so we should go back home. But as soon as we reached home my wife delivered the baby when she was in the toilet. I think the hospital staffs are very careless"* NC).

When asked to consider the impact of having a CWD upon family life, most respondents recognized that this situation was likely to cause stress to parents and families ("*I think many of us also face challenges in coping up with the community. We are being neglected on many occasions and in many fields especially while dealing with people who have negative thoughts on our children like when people say that children with disability will bring bad luck and all"* NC).

The perceptions of many respondents indicated that they are sensitive to the challenges faced by families with a CWD and their understanding of the potential impact upon their daily existence was largely in accord with those views expressed by parents living with disability. Reference to the time required to manage a CWD's daily routine, and the focus upon high levels of personal care was a feature of the discussion in all focus groups ("*There are a lot of challenges for that family, one of which is that no matter where they go there will have to be someone to take care of the child. Another is that you won't be able to live or die in peace because you will always be worried about the well-being of the child"* NC). Such views are consistent with evidence drawn from the HSQ.

Some respondents recognized that having a CWD would cause a financial strain on families, and that in some instances the opportunities to work in paid employment would be severely constrained ("*As a parent I think most of the children with disability come from poor families, which further weighs down on our income. I feel that we are not able to provide much resources and facilities for our children"* NC).

Asked about sources of information about disability, most respondents stated that they obtained information through the media, or in some instances through NGOs as well as UNICEF ("*From the news and from the hospitals also"* NC). Similarly, very few respondents were aware of any national or international policies or legislation that might inform issues of disability. This presented a further confirmation of findings obtained from the HSQ.

5.4 Attitudes

There was a consensus amongst respondents in all focus groups and interviews that CWD should attend school. The majority believed that wherever possible this should be a mainstream school, where CWDs could learn alongside their peers who do not have disabilities. Emphasis was placed upon the need for CWD to socialize and to learn from their peers ("*If they befriend each other and help one another it will be good for them. The parents of the children with disability will also worry less"* NC).

Some parents of children who do not have disabilities expressed a view that attendance should be in segregated provision ("*They should be classified according to their disability and put in a school that is specialized in that disability"* NC). When asked to elaborate upon their reasons, these were either because CWDs would demand too much teacher time or that there might be a danger that their own child would contract some aspect of the disability from their classmates ("*I feel that there will be a risk of contagion"* NC). This latter comment further suggests that there is a poor understanding on the part of a minority of respondents of the aetiology of disability.

Most respondents believed that providing opportunities for children to play together was important and that this could result in improved social opportunities and some improvements in learning (" *Yes, the children with disabilities can learn from the children without disabilities"* NC). Those who did have concerns were generally anxious for the safety of CWDs, though again some parents expressed a view that their children might be in danger of contracting illness (disability) from their disabled peers (" *You will be scared that your children might contact their diseases"* NC)

Concerns were expressed that CWD were often the subject of bullying in schools and in public (" *Normal children tell the children with disabilities to not come near them because they feel that they might get the disease and shoo them away by calling them names"* NC) and (" *There are chances that the able children*

will look down on the children with disabilities and end up insulting and bullying them" NC). Those CWD who participated in the research reported having been laughed at and in some instances physically bullied in schools. Equally of concern were the number of respondents who suggested that CWD were particularly vulnerable in social situations to the possibilities of falling victim to sexual abuse (" *She will be vulnerable to sexual assault from other men"* NC).

Few respondents felt that practical support was provided by religious leaders, though some knew that monks offered *rimdros* (prayers and blessings) for families with a child with a disability (" *I feel that they will help but till now I haven't seen anything like that"* NC) and (" *I haven't heard about them providing any support except for giving blessings (wang)"* NC).

An appreciation of the opportunities provided through *kidu* did exist, thus amplifying the HSQ data. Examples were provided of financial support or more often the purchase of clothing and equipment to support children and families (" *Kidu should be given based on poverty. Everyone wants kidu but only a few deserve it. For those who are in need, it really helps to bring some positive changes to their lives and the children with disabilities"* NC).

There was a general recognition that CWD require greater resourcing than others and a consensus that this should be provided and that the government often provided a good service in supporting families (" *I have a friend whose child is disabled and he is studying in this school. She doesn't have any one to support her son and she can't help as she is also disabled. In such cases I think kidu helps a lot and it should be given to such people who are in need"* NC).

5.5 Practices

There was a consensus amongst respondents that practice is to some extent inhibited by difficulties of gaining access to services in Bhutan (" *I think the greatest challenge that we face as of now is that we are not able to provide them the right medical support. If we consider the developed countries, they have occupational therapy for children with disabilities but we don't have that in our country. Our children even face difficulty in reading Braille due to which parents and teachers face difficulty in guiding them"* NC). These views confirm the findings emerging from the HSQ. Conversations with key informants suggest substantial progress has been made in the provision of services; both these and HSQ data illustrate that parents of CWD, and, especially those in isolated rural locations, have difficulty in identifying and accessing these facilities.

This situation is further impacted by poor infrastructure, resulting in limited access to some buildings and other facilities (" *When children have to use wheelchairs, they cannot get around easily. I think we are lacking in disable friendly physical structures. We need to construct ramps in schools that have children with disability, and paths for blind children which will enable them to be independent using canes and also make sure that the drains or any other holes are covered"* NC).

Many parents also expressed the view that health service professionals are not well trained to either assess or provide support to families who have a child with a disability, and that this has a detrimental effect upon the services they receive (" *I don't think they are well trained. It's really sad when you go for treatment for two consecutive years and then they finally tell you that there is nothing they can do for your child. They even went so far as to tell me that it was own karma and that I should learn to deal with it. I am never taking my child to the hospital again"* NC).

A widely held view was in evidence regarding the importance of educating and socializing CWD. There was evidence in the narratives of the effectiveness of mainstream schools in this regard, although an element of pragmatism was noted in several cases ("*I think that they should first be put in specialized schools to learn the basic skills and then when they are able they should be put in mainstream schools"* NC). There was a view amongst parents and children that teachers were willing to work with CWD, but that teachers have not received sufficient training to be effective in this area ("*Teachers here need to be well trained but what I heard and what I know personally is that they are not trained to teach children with disabilities. Almost all the teachers get trained from teacher training colleges and have had no other special trainings"* NC).

Service providers believed that some teachers in the specialist schools were better trained than their counterparts in mainstream provision ("*I feel that the children with disability should attend specialized schools because teachers are better suited to deal with them"* NC) and (" *If they went to specialized schools then all the students will be the same and it will be easier to interact amongst themselves"* NC). However, the CWD who contributed to the focus group discussions believed that their teachers served them well, despite recognizing that they had difficulties in fully understanding their needs ("*They teach equally like those who can see with a hope to make us same like them yet more time is consumed while teaching visually impaired and someone who can't hear"* NC). These observations are aligned with HSQ data and offer evidence of a thematic emphasis on training and development, as indicated in Section 7 on Recommendations.

A concern was expressed by some parents and service providers that the pace of learning in schools was too fast for children with disabilities and that this would cause them and the teachers difficulties in some classrooms ("*If it is a general teacher and they have a child with disability in their class of 40 students, then when the teacher is concentrating on that one student, the 39 students get neglected. And if the teacher is concentrating on the rest of the class, then they can't focus on that child. Then there is the problem with resources because that child needs something extra"* NC).

Only one focus group, conducted with NGOs, suggested that rural areas were less favourably served than urban locations (" *The facilities in the rural areas are less compared to the urban areas"* NC). The responses from paired focus groups (for example, parents from urban and rural environments) provided no evidence of significant differences of attitude or practices.

The qualitative data from both the focus groups and the individual interviews reveal some significant correlations with the findings of the HSQ. Each data set provides substantive evidence that there are several comparable thematic areas for potential scrutiny in the field of CWD. These are examined in the next section of this report.

6. DISCUSSION

6.1 Introduction

This section of the report provides an overview and commentary on the data generated during the fieldwork phase of the study. The intention is to provide a discussion that offers both a reflection on the cumulative data obtained, highlighting its key themes in relation to CWD, and a stimulus for ongoing conversation and debate amongst key stakeholders within Bhutan.

The study has sought to capture the following aspects:

1. Generation of knowledge regarding (a) the characteristics of CWD from the perspectives of service users and providers; (b) a review of legislation, policy and literature with regard to CWDs, both national and international; and (c) information relating to key services to support CWD.
2. A comparison of attitudes from a diverse sample of respondents.
3. Identification of effective practices that best support CWD in a range of service contexts in Bhutan.
4. A set of recommendations for potential future developments in support of CWD in Bhutan.

Of each of these four elements, the focus is placed principally on the characteristics of CWD from the perspectives of service users and providers.

The first part of this section covers a general overview of the current position regarding CWD in Bhutan; identification of both achievements and barriers in provision and possible priorities for future development; and recommendations to key stakeholder groups working with CWD and their families.

The second part of the section comprises a series of reflections on the data gathered to consider each of the above issues in the light of the literature relating to both international themes concerning CWD and their manifestation in the results obtained.

6.1.1 Overview of Knowledge, Attitudes and Practices relating to CWD in Bhutan

Knowledge

The survey revealed that knowledge regarding CWD was extremely limited. This applied to both legislation and provision of relevant services for this group of children. It also applied to the respondent's knowledge regarding referral routes for seeking advice support and access to provision for CWD. This situation was apparent for both families with CWD and those without. Those services with which respondents were most familiar were almost exclusively connected to the provision of medical support.

The term 'disability' was generally defined in narrow terms as representing only those individuals who have severe physical or sensory impairments, with a consequent tendency to marginalize those from other groups. Only half of the respondents indicated that they understood the term 'intellectual disability', about the same proportion who recognized wearing glasses as a disability.

This has implications for service delivery, notably that there is an emphasis primarily on providing support predominantly to those with a 'visible' disability. This situation is exacerbated by the previously mentioned lack of accessible, reliable and user-friendly information, with most respondents suggesting that they gain

insights into disability through television, although the origins and reliability of such information could not be ascertained.

Attitudes

For the population in general, attitudes were shaped in part by the lack of knowledge, as previously indicated. Attitudes towards CWD and their families were more positive among younger respondents (under the age of 60 years) and more highly educated respondents. For the latter, the data did not distinguish between those who had or had not received specialist training related to disability.

The absence of knowledge related to CWD is a significant factor in the responses of the general population who did not perceive intellectual impairment as a disability. The data suggest that the general population overwhelmingly considered that CWD were treated fairly. Moreover, they perceived CWD to be vulnerable, with respondents stating they should receive appropriate levels of protection, and that their disability should not result in the use of punishment or isolation.

In spite of such positive inferences regarding CWD, it was apparent that a significant minority of families identified that they would not be happy to have a family with a CWD as neighbours and that many would not want their child to marry someone with a disability, which may be a cultural manifestation of karma (Metz, 2014). They also expressed reluctance to see their children educated alongside those who have a disability. A further negative perception was obtained from families of CWD, who felt that the support that they received both in school and within their community was inadequate.

Practices

In the general population, there was a consensus that educational and social provision for CWD in Bhutan was improving, and that the support provided by the state was adequate. However, families living with CWD were less positive and felt that they received less support than they would wish. These families stated that most of the support that they received came from within their wider family circle and that they were isolated from other families living with CWD. Helpful though this was, these families still considered this to be inadequate to meet their needs. A majority of families felt their CWD would still be living at home with them at the age of 18, inferring their uncertainty about future prospects of independent living for their child.

6.1.2 Achievements and barriers

The data provide some evidence that there are a range of enabling factors that provide a platform for potential developments in support of CWD in Bhutan. It is important to recognize that these are at least inferentially associated with the overall national approach to supporting education and social welfare for all children in the country: this issue has been highlighted at various points in the literature and has been increasingly apparent during the last decade.

The research team has chosen here not to emphasize the term ‘achievement’ as it implies summative measurement and would potentially detract from the efforts that have been made to improve the lives of CWDs and their families. It would also imply that the notions of educational and social inclusion comprise fixed points at which finite quantification can be undertaken. This, as the literature review indicates, is a reductionist perspective, which does not promote future action in this field. Instead, interrogation of these

data suggests that there is a recognition by those in authority that there is a situation that requires attention in order to further improve the lives of CWD and their families. This awareness is acknowledged at ministry level and by many service providers and thus connects implicitly with the views expressed by families of CWD themselves in the HSQ and narrative data.

Engagement with schools during the research process suggests that there is some confidence regarding the willingness to address issues of educational and social exclusion. There is also some evidence of an awareness of the need to provide disability-related professional development for key personnel working with CWD, building on current developments.

However, such positive indicators are counterbalanced by omnipresent barriers, which co-incidentally are reflected in many other national settings worldwide. Principal amongst these is the diffuse understanding of the core issues that impact the lives of CWD and their families. Recognition of these is inhibited by the aforesaid absence of accessible information and the consequent lack of cohesion and concerted action across essential support services. The data assembled in this report provide evidence of a need for action in a range of areas associated with CWD.

6.1.3 Recommendations

Based on the findings from the composite data generated in the study and the perspectives of the research team itself, recommendations for consideration by key stakeholders are presented in the concluding section of this report.

6.2 Knowledge, Attitudes and Practices: emerging thematic issues

6.2.1 Introduction

Scrutiny of both quantitative (HSQ survey) and qualitative (focus groups/interviews) data sets highlight several themes which, with further exploration and analysis, can assist in providing several thematic issues capable of informing future discussion and subsequent policy formulation in the field of CWD in Bhutan. The research team at this point uses a purposive stance in its consideration of these data in this discussion, adopting an intuitive approach (Klein, 2003); this enables quantitative data to be interpreted from a more flexible standpoint. In this regard, a credible version of data scrutiny seeks to recognize the ground-level realities experienced by stakeholders involved with CWD by adopting the intuitive approach (Hogarth, 2001), drawing upon professional experience and knowledge, when 'situations are complex'.

Accordingly, the data were scrutinized to identify key thematic characteristics using keyword and key phrase searches alongside the research team's professional insights regarding the stakeholder narratives, observation and field notes and ancillary, supporting documents. The latter included cross-referencing with the material scoped within the literature review conducted as part of this study. This process resulted in seven broad themes, around which the present discussion has been constructed.

It should be recognized that the themes identified have significance because they provide a means of drawing upon the approaches used by education systems worldwide to implement and then evaluate support for CWD, within the contemporary context of educational and social inclusion (see, for example, EADSNE, 2003). As themes they are, of course, by no means exhaustive. However, they are indicative of the current situation in Bhutan and provide some confirmation that the ongoing challenges in meeting the

needs of CWD and the responses that are forthcoming within Bhutan have wider parallels in many other national settings, irrespective of their stage of development. Most importantly, these current recommendations are consistent with the suggested interventions highlighted in the Bhutan Education Blueprint 2014–2024, action on which is currently being undertaken. Each theme is now outlined.

6.2.2 Systemic challenges need systems solutions

There is a wide recognition, validated in the literature, that provision for CWD needs to adopt an ecological approach to service provision (Thompson, et. al., 2009; Mackelprang & Salsgiver, 2015). This is essential in the light of the complexity of educational and social needs, the conflicting demands of interest groups and the availability of professional knowledge and resources to provide effective support. In recognition of this, and an acknowledgement that for CWD the knowledge, attitudes and practices of local, regional and national settings are mutually dependent, 'eco-systemic' responses have become widespread (Suharto, 2006; WHO, 2007).

The Bhutan context, as exemplified in the data captured, mirrors the complex interactions between individuals, agencies and their interpretations of current legislation and the impact of cultural values. It shows that there is some awareness by non-professionals that CWD require additional support from diverse sources. For example, positive attitudes were discernible, in both qualitative and quantitative data, regarding the role of separate specialist education in the form of special schools.

For professional stakeholders there was an even greater recognition that integrated provision of services was central to maximizing the knowledge and skills about CWD that resided within specialist settings – whether these are under the auspices of education, health or social care. Moreover, the evidence, secured from these data, suggests that effective dissemination of credible and user-friendly knowledge regarding CWD makes whole-community approaches essential to moving forward from policy to action.

In respect of system change, attitudinal shift will only arise because of strategic actions across the entire professional and social community. This is likely to require a concerted effort to ensure that traditional cultural interpretations of disability, highlighted in the data assembled, are countered by systematic information giving. Nor is such an effort a short-term process: systems change, as theorists have noted, require sustained action over time. Such a situation is not unique to Bhutan: the history of disability in the UK, for example, illustrates that there remains a tendency to explain CWD through religious or moral beliefs (Humphries & Gordon, 1992).

6.2.3 Positive platform for development

Data secured from both quantitative and qualitative instruments reveal characteristics amongst families, professionals and different levels of administration that can justifiably be claimed to indicate that there is a viable context for policy reformulation with respect to CWD. The existence of a national sense of commitment to, engagement with and positive attitudes towards the needs of CWD provides a baseline from which positive attitudes could be diversified and enhanced.

This sense of community well-being should not be underestimated in responding to policy areas, which require resource commitment, frequently derived (in part at minimum) from nationally generated taxation. Given that inputs to meet the needs of CWD are often labour-intensive and thus high-cost items, such

provision needs to be regarded as morally worthwhile amongst the general population. The balance is not easy to achieve or maintain (Ebersold & Meijer, 2016).

Data generated in the present study provide some important, though inferential, information regarding an underlying sense of positive regard for CWD. This is somewhat prejudiced by the absence of a credible knowledge-base, especially that which can be easily accessed by the general population. The data reveal that widespread positive attitudes towards CWD are apparent amongst those respondents who have had exposure to disability and more prolonged formal education; these data infer a sense that these have become more pronounced over the last 10 or so years.

As in other national contexts, it is difficult to gauge what factors are associated with such orientations, although the role played by a focus on Gross National Happiness should not be discounted or underestimated. This is particularly so because of its focus on social well-being and the fundamental values of kindness, equality and humanity (GNH, 2017). The responses from non-CWD households suggest that such feelings are manifest in a belief that CWD need further support than that provided for non-CWD, with a significant proportion of households favouring educational and social inclusion.

6.2.4 Accessibility of knowledge

A major obstacle to making progress in supporting positive attitudinal shift in respect of CWD is the absence of knowledge among the general population about basic aspects of disability. This is compounded by low levels of awareness and knowledge of CWD needs amongst general (i.e., non-CWD specialist) professional groups in education, health and child care. Both issues are very high profile concerns identified in international research literature (SCOPE, 2014; WHO, 2011). The emphasis on knowledge dissemination is of paramount importance, as it leads to greater, more widespread understanding of the experiences of CWD and the barriers that they are facing in many aspects of their lives (Gerschel, 2003).

The evidence available from the fieldwork undertaken indicates that such global interpretations are echoed in Bhutan. The most apparent aspect of this, in the two groups mentioned above, is a failure to see CWD solely as having disabilities relating to physical functioning and well-being (vision, hearing or wheelchair-users for example). Few recognized cognitive/learning difficulties as a disability, for example. Such a lack of awareness is rooted in a failure to provide or access credible, authoritative and audience-friendly information – and/or an accompanying failure to provide such resources in the first place. With regard to the latter, it was noticeable that few respondents used official government materials or services to secure information about CWD.

There are also signals in these data that families with CWD, although they were better informed regarding disability, felt that it was difficult to access additional information on more specific aspects of disability relating to their child. So, even though such families possessed a more informed view regarding disability, they indicated a relative lack of awareness regarding local provision for CWD; they appeared inclined to view CWD via a medical model (Swain, French & Cameron, 2003). Combined with the challenge presented by the low profile given to professional development in CWD matters, the question of knowledge transfer constitutes a fundamental area for prospective future development.

6.2.5 Lived realities of families with CWD

There are indications that there is a need for further in-depth investigation into what has been termed the 'lived experience' of CWD. This has become an increasingly important part of the task of understanding the nature of disability itself from a social-interactive perspective; a significant body of international literature has emerged regarding this in the last 20 years, and is deserving of specific attention, given its implications for enabling self-determination in learning and social life for CWD (Griffin & Kearney, 2001; Case, 2010; ERC-VOICES, 2017).

The theme has also been recognized as prerequisite in policy formulations in inclusive education and social care and community approaches to CWD (DCSF, 2007). It incorporates the viewpoints and perceptions of the key end-users of disability services, the CWD themselves; it also includes evidence provided by family members. The literature clearly illustrates that there are perceptual and actual differences between how people who do not have disabilities feel about, and interact with, the issue of disability and the views and experiences of CWD and their families. The former frequently adopt an exclusionary position, viewing the inclusion of CWD as problematic (de Boer & Munde, 2014), whereas parents of CWD express more positive views regarding the inclusion of their child in 'mainstream' settings, whether in schools or in the wider community.

Parents of CWD in the present study reveal many of the challenges identified in the literature. Approximately half of CWDs are not being educated in school, the families seemingly preferring to adopt a protective approach, given the incidence, noted in these data, of bullying towards CWD. The families themselves can also be isolated from the supportive network provided by other families of CWD. It is noticeable that the findings correlate with research reported extensively in the literature, which indicates that families with CWD are themselves often the most knowledgeable about disability issues. They are especially aware that their child may be prone to bullying. The isolation of whole families of CWD within communities is also a matter of concern and has been increasingly a focus of attention (Keller & Honig, 2004; Giulio, Philipov & Jaschinski, 2014) and which is a feature of Bhutanese family groups too.

From a positive perspective, parents of CWD are an acknowledged resource, being very aware of the strengths and capabilities of their child (Rafferty & Griffin, 2005). Data from the present study provide confirmation of this situation, and suggest that a 'parents as partners' model of development has potential to make an important contribution to systems development. Thus, these families themselves were the prime source of support for CWD, and they are able to provide this because they are better able to recognize learning differences more distinctly, including a capacity to view 'disability' as a term that is diverse, complex and needing multidimensional interventions.

6.2.6 Local and national paradoxes

A frequently occurring theme, captured in scoping the status of national policy and provision in many countries, is a tendency for discrepancies between existing legislation and statutory policy and the practical realities experienced by local stakeholders (Mallet & Runswick-Cole, 2014). This exacerbates the marginalization of all disability stakeholders, whether CWD and their families, the professionals who work directly in support of them, and empowerment organizations and groups. Such situations are not exclusive to the field of disability, of course, but for CWD the 'gap' between policy intention and actual practice represents a more pressing problem. This is because CWD, as is noted in international surveys, are

amongst the most marginalized of all groups – whether within education or in society as a whole (WHO, 2011; UNICEF, 2013a).

The Bhutan data reported here suggest that this situation is apparent, at least in part, for many of those stakeholders involved with CWD. Whilst national policies for disability have regard for the key international agreements and conventions, local stakeholders were sometimes unaware of these important policy determinants, an issue highlighted by Nizamani (2005). In consequence, there is little overt evidence in these data that parents of CWD feel that schools and services are engaging with them in ways that are viewed as meeting international standards of effective practice.

In addition, few respondents indicated familiarity with the relevant national policies relating to CWD, indicating that they also made little use of centrally produced information. Schools were not necessarily viewed as sources from which information might be obtained. As a result, there appeared to be a 'gap' between the support intentions that lie within the national policy towards CWD and the realities of both CWD families as well as the professionals working with them. The need to establish a more connected approach through which stakeholders are enabled to express their priority needs and thus inform professional decisions, perhaps along the lines suggested by ecosystemic theory, seems to be apparent.

These data also reveal that, notwithstanding the progress made in policy orientations regarding CWD, there remains widespread and deeply held belief in the association between disability and individual life patterns. Most notably this involves connecting disability with negative events or behaviours linked to a previous existence. Whilst respecting the belief system from which such attitudes emerge, it nevertheless constitutes a significant barrier to a holistic view of CWD needs, based on current research and on international practices.

6.2.7 Professional leadership

A defining feature in supporting the growth of inclusive systems for CWD is the importance placed on leadership of change processes. The role of leader is signalled in every dimension of provision for CWD in the recent research literature. It has been highlighted as a core issue in education (Kugelmass & Ainscow, 2004), social care (West, et. al., 2015), health (Millward & Bryan, 2005) and in community development (Sherwin, 2010). Moreover, it is a feature that has assumed a high profile internationally, as it impacts on systems irrespective of geographical location or the actual stage in the development of services for CWD (EADSNE, 2013; USAID, 2010).

Relatively little focus on 'leadership' is apparent from the data generated in the present report. In part this can be explained by the focus of the study itself, which predominantly sought the viewpoints from households with and without CWD, alongside a small sample of CWD stakeholders. But it is the very absence of 'leadership' as a thematic issue in the data gathered that emphasizes its importance from a developmental perspective. The data vacuum that is apparent is in sharp contrast to the weight that is now being given to leadership internationally, in schools, health and social care settings, disability organizations and groups, as indicated in major meta-analyses conducted elsewhere (Black & Simon, 2014).

6.2.8 Education and training

The emergence of systems of provision for CWD require an informed and knowledgeable workforce. It also requires that parents, family and community support can access credible, user-friendly information regarding disability and inclusion. The needs of these audience groups will differ; however, the common features of the education and training effort for all of them are confirmed in practices elsewhere (for example, Carroll, Forlin & Jobling, 2003; Baker-Ericzén, Mueggenborg & Shea, 2009); these emphasize the need for professionals associated with CWD to understand the human rights and health needs of CWD (Shakespeare & Kleine, 2015). They also need opportunities to reflect on their own understanding of 'disability'.

As with other themes highlighted in this section, however, it should be borne in mind that the issue of professional development and training in the fields associated with disability provision remains somewhat piecemeal in many countries and its delivery is often problematic and contested. As a result, even over the last 20 years, there have been critiques that suggest that – even in those countries with high GDP and consequently proportionate funding for professional development – major challenges remain. These invariably connect to a need to address the knowledge, attitudes and practices of the professional groups involved (Purdue, et. al., 2009; LL4All, 2017).

Education and training is a major emergent theme in data generated in the present study. This is because of the obvious gaps that inhibit the operation of a systemic and holistic system of provision for CWD. Several notable areas were identified, each of which constitutes an essential component of training or professional development. Thus, the data suggest that there is currently no standardized way of assessing the needs of CWD and that, where assessment takes place, the process usually focuses on physical disabilities. In consequence, potentially significant disabilities amongst the child-age population were not being identified.

Moreover, even professional attitudes were sometimes informed by a cultural belief that disability was a result of events from a previous life. The role of schools, and especially the school leader, was noticeable mainly by its absence as a thematic descriptor in the data obtained – yet, as has been noted, it has become a focus for professional development in many diverse national systems for supporting CWD. A parallel set of inferences can be made regarding the data and commentaries from families of CWD and from households generally. Parent education (EENET, 2013) and awareness raising amongst the general public (Scior, et. al., 2012) are also integral components of effective inclusive provision for CWD.

This final theme is a potential cornerstone for future system-wide development in support of CWD. Consideration of the results of a structured enquiry into knowledge, attitudes and practices regarding CWD highlights its pivotal nature. Thus, comparable KAP studies undertaken in recent years in other national settings suggest that this is very much the case (for example, Titumir & Hossain, 2005; Deluca, et. al., 2014; UNICEF, 2015).

6.2.9 Summary

The themes identified from the KAP data in this study comprise points for discussion and debate. They are not exhaustive in coverage. The complex nature of CWD, which is informed by biological, psychological, social, cultural, economic and environmental factors, is such that a more extensive iteration of all associated factors and dimensions would make a KAP study of this scale impractical.

Findings from this KAP study suggest some synergies between the Knowledge-levels of CWD and resulting positive or negative Attitudes towards CWD. This is apparent more within those households with CWD. The connection to formal Practices is less obviously demonstrated, given the study's lack of direct focus on auditing the range and extent of professional practice. Parental practice, however, was informed by acquired, experiential Knowledge of CWD. In this respect, data interpretation was restricted by the absence of further in-depth narratives derived from the focus group discussions. In these circumstances, triangulation of quantitative and qualitative data sets in respect of practices was problematic.

The seven themes identified above can be viewed as headlines emerging from a deeper consideration of data and context. As such they can become catalysts to aid a considered and rational response to the needs being highlighted by the principal policy-makers and stakeholders in Bhutan.

7. RECOMMENDATIONS

7.1 Introduction

This final section uses the data obtained, additional field notes and observations, and the team's intuitive insights regarding their immersion in these materials and background in CWD policy and practice to present a set of recommendations. These are provided with some underpinning notes of caution on their purpose and usefulness.

The UoN team recognizes that all developments in support of CWD, irrespective of country location, represent actions that do not constitute 'solutions'. As has been acknowledged, the challenge of researching and meeting the needs of CWD is a complex activity, informed by a diverse set of factors. It is also a task that will have an extended timeline, incorporating short-, medium- and longer-term aims and objectives. Consequently, recommendations need to take account of the realities experienced by policy-makers and practitioners in Bhutan. Not least, they should have due regard for wider cultural, social, religious and economic issues that provide the context in which they take place (Barnes & Mercer, 2004). Thus, the team is acutely aware that any suggested actions will represent a stage in the linear development for CWDs, and that any suggestions will only be assimilated and become effective following extended discussion and engagement with all stakeholders. These recommendations are, ultimately, those from a research team who bring a Western lens to a unique country setting (Takayama, Sriprakash & Connell, 2015). The opportunities, challenges and limitations presented in these recommendations are duly recognized in doing this.

Based on the thematic analysis of data in the preceding Discussion (see Section 6), four target areas have been identified to which recommendations are directed (see summary in Appendix 6). It is expected that the team's projections will be amplified by other potential areas of development following subsequent conversations with key stakeholders. Further, there is a recognition that each recommendation is not mutually exclusive, with considerable synergy and interdependence between one or more being very apparent. Finally, they are presented in outline only, with a brief accompanying commentary: deliberation regarding specifics is a matter beyond the terms of reference of the study undertaken.

7.2 Recommendations

7.2.1 Recommendation Area 1: Responses to systemic challenges and changes (Themes 6.2.2 / 6.2.6)

(i) Define clearly roles/responsibilities/structures (national, regional and local) for CWD at policy and provision level.
(ii) Establish a national policy for social and educational inclusion of CWD.
(iii) Recognize a multi-agency, inter-sectoral approach.
(iv) Create greater public/professional awareness/understanding of CWD by a national campaign.
(v) Need for further research on emergent themes in CWD policy and provision.

Commentary

Provision for CWD requires national leadership and exemplification. There needs to be concrete and visible policies and structures at the centre, designed to establish a short-, medium- and longer-term strategy with an associated action plan (with prioritized objectives, outputs and indicators) to ensure that incremental development takes place in key areas identified.

This process should be informed by inputs from all CWD stakeholders. It should include an emphasis on integrated service provision and a national commitment to raising public awareness of CWD. Each of these actions is regarded as a vital component in developing wider access to appropriate services by CWD, as well as being aligned to accepted international approaches in inclusive provision.

In respect of future research, there is a pressing need to explore and develop, at a national level, the positive contributions that can be made by utilizing qualitative data-capture measures: these are likely to enable the voices of CWD and their families to be more accurately represented. They can contribute more constructively to future policy deliberations by doing this.

7.2.2 Recommendation Area 2: Families with CWD (Themes 6.2.4 / 6.2.5 / 6.2.8)

(i) Provide more visible and accessible support for CWD and their families.
(ii) Disseminate parent-friendly information on CWD.
(iii) Establish parent-to-parent groups (CWD).
(iv) Develop formal home–school links.
(v) Create parent training opportunities related to CWD.

Commentary

The effectiveness of national, regional and local developments for CWD (whether short-, medium- or long-term) will be most accurately evaluated by their impact on CWD themselves, as well as the families they live with. The most important principle in ensuring that the quality and availability of provision is enhanced is that professionals (for example, teachers, health and social care workers) should be appropriately trained to provide interventions that are in accordance with state-of-the-art practice in the field. It is also essential that knowledge about services, and a clearly defined system of accessing them, needs to be made more visible at local and regional level. Schools are ideally placed to function as disseminators of this information.

7.2.3 Recommendation Area 3: General population (Themes 6.2.3 / 6.2.4)

(i) Establish a CWD awareness campaign for general population.
(ii) Engage elders, heads of villages, religious leaders and other key local figures.
(iii) Involve civil organizations/NGOs in a systematic and integrated way.
(iv) Focus on enterprises/commercial sector as ‘CWD Champions’.
(v) Form ‘peer-support’ arrangements (CWD and non-CWD).

Commentary

Inclusive systems for CWD, now universally recognized as the optimum mode of structuring provision, can only thrive if whole communities recognize and engage with the challenges and possibilities that are afforded by their full inclusion. A starting point for this is the growth of a sense of national ownership of

the issue as a whole, so that attitude change can take place. Exemplification elsewhere suggests that a catalyst for this is to raise awareness amongst the general population.

Any changes will require a structured approach, with a recognition that such attitude shifts will inevitably be only apparent incrementally over time; this process is likely to be longer- rather than short- or medium-term. Any strategy will also need to incorporate ways of monitoring and measuring progress towards targets which might be several years in the future. The shorter-term gains also need to be subject to evaluation and successful practice identified, so that it can provide a stimulus for further efforts in support of CWD.

7.2.4 Recommendation Area 4: Professional groups (Themes 6.2.4 / 6.2.7 / 6.2.8)

(i) Review initial teacher preparation to include a disability focus; inputs also need to be reviewed for health and social care training.
(ii) Provide specialist training in disability (all associated professionals).
(iii) Review in-service development/training of school leaders.
(iv) Provide in-service training for existing teachers (whole-school development).
(v) Establish inter-agency forum for CWD professionals.

Commentary

At the heart of all successful national initiatives to address the needs of CWD and to promote their full social and educational engagement lies a trained and appropriately qualified workforce. This needs to start with general professional training. This should be directly linked to associated opportunities to examine current approaches in in-career development for all professional groups associated with CWD. It is important, as recognized in ecological theory, that a widespread review of all training should include opportunities to reflect on the nature of inter-agency practice, so that a common agenda – especially in respect of attitudinal principles and their relationship to a shared approach to supporting CWD – remain as a core aspect of the discussion.

APPENDICES

APPENDIX 1: SURVEY TOOL

HOUSEHOLD SURVEY QUESTIONNAIRE – BHUTAN

SECTION A - Identifying information

A1	Dzongkhag code			
A2	Gewog/Town code			
A3	Chiwog/EA code			
A4	Household serial number			
A5	Name of enumerator			
A6	Date	Day	Month	Year

Tick the boxes or fill in the shaded boxes below as appropriate.

COMPLETE ONE QUESTIONNAIRE PER HOUSEHOLD ONLY

SECTION B – Demographic and background information

B0	Participation in this survey is voluntary and you do not have to answer any questions that you do not wish to. Do you agree to participate?	Yes	
		No	

B1	Respondent's sex	Male	
		Female	
B2	Respondent's religion	Buddhist	
		Hindu	
		Other (please specify)	
		None	
B3	Respondent's age (in completed years)		
B4	How many years in total did you spend in education? (at school, college or university, monastic schools and nunneries, vocational training institutes, NFE etc)		
B5	Highest qualification obtained?		
B6	What is your current marital status?	Never married	
		Currently married	
		Separated	

		Divorced	
		Widowed	
		Living together	
B7	What is your current work status? Select **ONE** only.	Self employed	
		Professional	
		Technical	
		Clerical	
		Service/sales	
		Skilled agricultural, forestry or fishery	
		Craft	
		Plant/machine operator or assembler	
		Manual	
		Military	
		Retired	
		Student	
		Housewife	
		Unemployed (health reasons)	
		Unemployed (other)	

Household income

What is your average household income per year?

B8	Under Nu 20,000	
	Nu 20,000-29,999	
	Nu 30,000-39,999	
	Nu 40,000-49,999	
	Nu 50,000-59,999	
	Nu 60,000-69,999	
	Nu 70,000-79,999	
	Nu 80,000 and above	

Section C – Composition of household

Who else lives in the house with you?

		Relationship to head of household			Number
C1(a)	Adults (male)				
C1(b)	Adults (female)				
		0 – 5 years	6 – 12 years	13+ years	

C2(a)	Children (male)				
C2(b)	Children (female)				

Section D – CWD/practice

		Yes	No
D1(a)	Do any male children in your household have a disability?		
D1(b)	Do any female children in your household have a disability?		

If 'No', go to **Section E**.
If yes continue to **Question D2.**

		Type of disability	Age of child	Sex of child	Number
D2	What disability does this child/these children have? TICK ALL THAT APPLY	1. Physical disability (see **b** immediately below)			
		b. If 'Yes', please specify the nature of the physical disability			
		2. Sensory disability (sight, hearing)			
		3. Intellectual disability			
		4. Other (please describe)			

With regard to any disabled children in the family, please complete the following section.

D3	Where does this child/these children go to for learning and care?	Local school with other local children	
		Special school for CWD	
		Monastic School	
		ECCD Centre	
		Vocational Centre	
		CSO	
		Other (please specify)	
		Child does not go to school	
D4	If not at school or institution, does a parent or primary caregiver stay at home with the child during the day?	Yes	
		No	
D4(a)	If 'Yes', please specify	Mother	
		Father	
		Grandmother	
		Grandfather	
		Older sibling	
		Younger sibling	
		Other (please specify)	

D5	Does your child/CWD play with other children within the family?	Yes	
		No	
D6	Does your child/CWD play with other children (from outside the family)?	At home	
		At their friends' homes	
		Elsewhere (please specify)	
D7	What do you think your child will be doing at the age of 18 years?	Living in the family home, not working	
		Living in the family home, working	
		Living somewhere else, independently	
		Living somewhere else, with support	
		Studying	
		Other (please specify)	
D8	Who provides you with support and services with regard to your child with disabilities (tick as many as apply)	Family	
		Friends/neighbours	
		School	
		General medical (doctor/nurse)	
		Specialist medical (hospital, specialist therapist)	
		Officially provided local services	
		CSOs or DPOs	
		Religious organisation	
		No one	
		Other (please specify)	
D9	Which of these is your main source of support? (choose **ONE** only)	Family	
		Friends/neighbours	
		School	
		General medical (doctor/nurse)	
		Specialist medical (hospital, specialist therapist)	
		Officially provided local services	
		CSOs or DPOs	
		Religious organisation	
		No one	
		Other (please specify)	
D10	Have any of these support types ever been inadequate and impeded	Family	
		Friends/neighbours	
		School	

	your ability to meet the needs of your child with a disability?	General medical (doctor/nurse)	
		Specialist medical (hospital, specialist therapist)	
		Officially provided local services	
		CSOs or DPOs	
		Religious organisation	
		Financial	
		Other (please specify)	
D11	Do you know any other family that has a child with disabilities?	Yes	
		No	
D11(a)	If 'Yes' to D11, what disability does the child have?	1. Physical disability	
		2. Sensory disability	
		3. Intellectual disability	
		4. Other	

Section E – CWD/knowledge

Please indicate your agreement or disagreement with the following statements			
		Agree	Disagree
E1(a)	A person/child who has a total loss of vision has a disability		
E1(b)	A person/child who has low vision and requires glasses has a disability		
E1(c)	A person/child who has a total loss of hearing has a disability		
E1(d)	A person/child who has poor hearing and requires hearing aids has a disability		
E1(e)	A person/child who needs to use a wheelchair has a disability		
E1(f)	A person/child who needs to use a walking aid (such as a stick) has a disability		
E1(g)	A person/child who has a condition that limits the use of their hands has a disability		
E1(h)	A person/child who has difficulties with learning at the same pace as others has a disability		
E2(a)	Are you aware of any **Bhutanese legislation** regarding CWD?	Yes	
		No	
E2(b)	If 'Yes', what?		
E3(a)	Are you aware of any **services** for CWD in your community?	Yes	
		No	

E3(b)	If 'Yes', what?		
E4(a)	Are you aware of any **services** for CWD at national level?	Yes	
		No	
E4(b)	If 'Yes', what?		
E5(a)	Are you aware of any **local groups or organisations** that assist CWD and their families?	Yes	
		No	
E5(b)	If 'Yes' please specify		
E6(a)	Are you aware of any **health services** that assist CWD and their families?	Yes	
		No	
E6(b)	If 'Yes' please specify		
E7(a)	Are you aware of any **education services** that assist CWD and their families?	Yes	
		No	
E7(b)	If 'Yes' please specify		
E8(a)	Are you aware of any **social protection services** that assist CWD and their families?	Yes	
		No	
E8(b)	If 'Yes' please specify		
E9(a)	Are you aware of any **child protection services** that assist CWD and their families?	Yes	
		No	
E9(b)	If 'Yes', please specify		
E10(a)	Are you aware of any **legislation or policies** relating to child protection for CWD?	Yes	
		No	
E10(b)	If 'Yes', please specify		
E11(a)	Are you aware of any **referral systems** that assist CWD and their families?	Yes	
		No	
E11(b)	If 'Yes' please specify		
E12(a)	Are you aware of any **religious institutions or services** that assist CWD and their families?	Yes	
		No	
E12(b)	If 'Yes' please specify		
E13	Where do you usually obtain information about disability? Please indicate all that apply	Family	
		Friends	
		Neighbours	
		Government Officials	
		Television	
		Radio	
		Newspapers	
		Other (please specify)	

Section F – CWD/attitudes

		Strongly agree	Agree	Slightly agree	Neither agree nor disagree	Slightly disagree	Disagree	Strongly disagree	Don't know
F1	People in the local community have a positive attitude towards CWD.								
F2	I would be happy to have a family with a child with disabilities living next door to me.								
F3	I would be happy to have a child with disabilities attending the same class as my child.								
F4	In the future I would be happy for my child to marry a person with disabilities.								
F5	CWD make a positive contribution to the family.								
F6	CWD contribute to society.								
F7	Children's disabilities are the result of past deeds.								
F8	CWD cannot lead as full a life as those without disabilities.								
F9	CWD are treated fairly in society.								

F10	The state provides adequate benefits for CWD.								
F11	It is sometimes alright to treat CWD more favourably than other children.								
F12	All children should go to school, regardless of their needs or any disability.								
F13	All CWD should attend separate specialised schools and not general mainstream schools								
F14	CWD benefit from attending school.								
F15	CWD should attend the same schools as other children.								
F16	Attitudes towards CWD are better than they were ten years ago.								
F17	Schools are better prepared/equipped to deal with CWD than they were ten years ago?								
F18	CWD are the subject of jokes or unacceptable or negative comments.								
F19	CWD are more likely to be the victims of bullying.								
F20	CWD are more vulnerable to physical and sexual abuse.								
F21	CWD are more likely to be neglected								
F22	CWD and their families need extra support.								

F23	Life is better for CWD and their families than it was ten years ago.								
F24	It is sometimes necessary to leave a child with disabilities in the house alone.								
F25	It is sometimes necessary to punish a child with disabilities for misbehaviour.								
F26	CWD should be encouraged and supported to play with other non-CWD.								
F27	When CWD leave school, they have the same employment opportunities as their peers.								

Supervisor's Name:

Signature:

Status of Interview	
1. Completed	
2. Not found in home at time of interview	
3. Refused	
4. Partially completed	

APPENDIX 2: HSQ SAMPLING FRAME

UNICEF: CHILDREN WITH DISABILITIES HOUSEHOLD SURVEY

SAMPLING PROCEDURES

Domains of the Study: Country

Unit of Sampling: Household

Unit of Analysis: Individual

Master Sampling Frame: An updated master sampling frame of 2005 population and housing census of Bhutan (PHCB 2005) will be used as a master sampling frame. It has two mutually exclusive frames: one for rural area and the other for urban.

Determining Sample Size: The below formula (Daniel, 1999) for prevalence studies will be computed to calculate the sample size (n):

$$n = \frac{Z^2 p(1-p)}{d^2}$$

Where n = sample size;
Z = Z statistics for a level of confidence;
P = expected prevalence or proportion; and
d = precision.

The confidence level of 95% (Z = 1.96) will be used.

Clearly, the above sample size calculation formula is valid only if Simple Random Sampling method is used, which is not the case in this survey. This is a stratified multistage sampling design, and for this methodology to achieve the same precision, a larger sample size is required. Therefore, the calculated sample size using the above formula need to be multiplied by the design effect (deff) (Cochran, 1977). A design effect will be estimated and multiplied with the sample size resulted from the above formula.

Sampling Method: A Stratified Multistage Cluster Sampling design of probability sampling may be employed.

Strata: Stratify the whole country of 20 districts into three regions based on the number of households and their geographic location:

Western Region: Thimphu, Paro, Ha, Samtse, Chhukha, Punakha and Gasa.
Central Region: Wangduephodrang, Daga, Tsirang, Sarpang, Zhemgang, Trongsa and Bumthang.
Eastern Region: Lhuntse, Mongar, Pemagatsel, Samdrup Jongkhar, Trashigang and Trashi Yangtse.

First stage: Using Probability Proportional to Size, select at least 3 districts from each of Western, Central and Eastern strata based on the number of households.

Second stage: From each of the district selected in first stage, select at least 3 enumeration areas (EAs) (1 town in case of urban areas) using Simple Random Sampling Without Replacement (SRSWOR).

Third stage: From each of EA or town selected in the third stage, select at least 2 enumeration areas ('chiwog' in the case of rural areas) using SRSWOR. The units selected at this stage are primary sampling units (PSUs).

A frame of PSUs which lists the units covering the entire population exhaustively and without overlaps, and that provides information for the selection of units efficiently, such as maps and household listings will be collected.

Fourth stage: In each selected PSU, individual households may be listed and a sample selected with households as the ultimate sampling units using SRSWOR.

Sample allocation: Of 131,245 households, 43,436 (33%) households will be allocated to urban, while 87,809 households (67%) will be allocated to rural.

Listing operation: Listing of households in selected PSUs will be carried out prior to the survey and the eligible children in the selected households will be listed before administering the interview.

APPLICATION OF WEIGHTS

Three types of weights (where deemed fit) will be applied to increase accuracy of estimates: sampling weights, non-coverage weight adjustments and non-response weights.

Sampling weights: To compensate for missing data associated with units in the population that are not sampled. The sampling or base weight will be computed as the inverse of the probability of selection, and this weight will be attached to each sampled unit in the data file.

Non-coverage weights: To compensate for missing data because of households being excluded from the sampling for some reasons and thus had no chance of being selected for the survey.

Non-response weights: To reduce non-response bias in the estimates from the survey, non-response weighting adjustment will be used. Non-response can occur at two levels: item and unit non-response.

APPENDIX 3: FOCUS GROUP INTERVIEW QUESTIONS

Focus Group Schedule (i) - Children

Indicate the participants below (√):

	Female
	Male
	Age 12 (number = ……)
	Age 13 (number = ……)
	Age 14 (number = ……)
	Age 15 (number = ……)
	Age 16 (number = ……)
	Age 17 (number = ……)
	Age 18 (number = ……)

1. Which of these children has a disability?
(show pictures of Bhutanese children with and without disabilities)

(i) What does it mean to be disabled?
(ii) Which disabilities do you know about?
(iii) Are some disabilities 'worse' or 'better' than others? In what ways?
(iv) Further prompt:
- Tell us more… (*if previous response has been limited*)

2. Do you know anyone with a disability?
(i) If yes, tell us about them.
(ii) How could you tell if one of your friends had a disability?
(iii) Who decides if children have disabilities?

3. How do people get disabilities?
(i) Tell us more… (*if previous response has been limited*)

4. What might be difficult for mums and dads if they have a boy or girl with a disability?
(i) What might you find hard if your brother or sister had a disability?
(ii) What is life like for a child with disabilities?
(iii) Can CWD get around buildings in Bhutan easily?
(iv) If 'Yes', what helps them?
(v) If 'No' what could help them more?
(vi) Do you know about any laws that are there to help CWD?

5. Should CWD go to school?
(Show picture of CWD going to school)
(i) If 'Yes': why?
(ii) If 'No': why do you say that?
Check: So only children with no disabilities should go to school? Tell me more…
(iii) If 'Not sure': tell us more…
(iv) Can you think of any problems that CWD might have if they go to the same schools as children without disabilities? (*Show picture of children with and without disabilities at school together)*
(v) Is it difficult for teachers if they have CWD and children without disabilities in the same class?

(vi) Can you think of any problems that children without disabilities might have if CWD are in their class?
(vii) Are there good things for children about everyone being in school together, whether they have disabilities or not?

- If 'Yes': what might the good things be?
- If 'No': why not?
- If 'Not sure': tell us more…

(viii) Would it be better if CWD went to schools that are just for them? Why? / Why not?
(ix) Tell us more… (*if previous responses have been limited*)
(x) Do you think teachers are good at teaching CWD?
(xi) Who can help teachers to be good at teaching CWD?

6. What are these things for?

(Show pictures of equipment commonly used by children with different disabilities)

Should all children be able to use these things to help them to learn or only CWD?

(i) If 'all children': why do you say that?
(ii) If 'only CWD': why do / might CWD need special things to help them to learn?
(iii) If 'Not sure': tell us more…
(iv) Further prompts:

- Who should pay for these special things for CWD? Why?
- What happens if CWD do not have these special things?
- Is it fair to spend more money on some children than others?
- Tell us more… (*if previous responses have been limited*)

7. Do CWD stop other children from learning?

(i) If 'Yes': how do / might CWD stop other children from learning?
(ii) If 'No': why do you say that?
(iii) If 'Not sure': tell us more…
(iv) Further prompts:

- How could CWD and without disabilities help each other to learn? Tell us more…
- How might CWD help other children to learn better? Tell us more…
- Tell us more… (*if previous responses have been limited*)

8. Should all children play together?

(Show pictures of CWD and without disabilities playing together)

(i) If someone is disabled could that be difficult?

- If 'Yes', why?

(ii) If 'No': why do you say that?
(iii) If 'Not sure': tell us more…
(iv) Further prompts:

- What could make it difficult for CWD to play with other children?
  - How could we help them?
- What might make it difficult for children with no disabilities to play with CWD?
  - How could we help them?
- Would CWD rather play only with other CWD?
  - Is that good or bad?
    - Why?
- Would children with no disabilities rather play only with other children with no disabilities?
  - Is that good or bad?
  - Why?
- Tell us more… (*if previous responses have been limited*)

9. Do you know how doctors, nurses or other health workers might help CWD?
(Show pictures of different health workers)
(i) Which health workers help CWD?
(ii) What does each health worker do to help CWD?

10. How do doctors, nurses and health workers learn to help CWD?

11. Do Buddhist monks help CWD and their families?
(Show picture of Buddhist monks)
(i) If 'Yes', how?
(ii) If 'No', why not?

12. Does kidu help CWD?
(i) If 'Yes', how?
(ii) If 'No', why not?

13. Is there anything else you would like to tell us about CWD?

Focus Group Schedule (ii) - Adults

Indicate the participants below (√):

	Participants	Number
	Female	
	Male	
	Parents and caregivers	
	Service providers: teachers, principals, health workers, Other……	
	Community group	
	Stakeholder Ministry workers (Education, Health, Labour and Human Resources, College of Education, National Commission for Women and Children, Other……)	
	NGO workers working with CWD	
	Religious leaders	

1. What is a disability?
(i) What does it mean to be disabled?
(ii) Which disabilities do you know about?
(iii) Are some disabilities 'worse' or 'better' than others? In what ways?
(iv) Further prompt:
- Tell us more… (*if previous response has been* limited)

2. Do you know anyone with a disability?
(i) If yes, tell us about them.
(ii) How can you tell if a child has a disability?
(iii) Who makes a decision that a child has a disability?

3. In your opinion, what causes disability?
(i) Tell us more… (*if previous response has been* limited)

4. What challenges do you think a family faces if they have a child with a disability?
(i)What challenges do you think a family faces if they have a girl child with a disability?

(ii)What challenges do you think a family faces if they have a boy child with a disability?
(iii)What might be difficult for mums if their son or daughter is living with a disability?
(iv) What might be difficult for dads if their son or daughter is living with a disability?
(v) What is life like for a child with disabilities in Bhutan?
(vi) Can CWD get around buildings in Bhutan easily?
(vii) If 'Yes', can you give examples of what helps?
(viii) If 'No' what else should be done to make buildings more accessible for CWD?
(ix) Are you aware of any laws in Bhutan that aim to support the lives of CWD?
(x) If 'Yes' to (v) Are you aware of any international laws that aim to support the lives of CWD?

5. Should CWD go to school?

(i) If 'Yes': why?
(ii) If 'No': why do you say that?
Check: So only children with no disabilities should go to school? Tell me more…
(iii) If 'Not sure': tell us more…
(iv) Further prompts:

- Can you think of any problems that CWD might have in schools which children without disabilities also attend?
- Can you think of any problems that teachers might have if they have CWD and children without disabilities in the same class?
- Can you think of any problems that children without disabilities might have if CWD are in their class?
- Might there be advantages for CWD being in school with children who do not have disabilities?
  - If 'Yes': what might these advantages be?
  - If 'No': why not?
  - If 'Not sure': tell us more…
  - Might there be advantages for children with no disabilities being in schools with CWD?
  - If 'Yes': what might these advantages be?
  - If 'No': why not?
  - If 'Not sure': tell me more…
- Would it be better if all CWD went to schools that are only for CWD? Why? / Why not?
- Tell us more… (*if previous responses have been limited*)
- How well trained are teachers to teach CWD?
- Who can teachers get help from if they are teaching CWD?

6. Should CWD have different equipment or books from other children?

(i) If 'Yes': why do / might CWD need different equipment or books from other children?
(ii) If 'No': why do you say that?
(iii) If 'Not sure': tell me more…
(iv) Further prompts:

- What would useful additional resources for CWD be?
- Who should pay for additional resources for CWD? Why?
- What happens if CWD do not have additional resources?
- Are there implications for giving CWD additional resources? What are these?
- Is it fair to spend more money on some children than others?
- Tell us more… (*if previous responses have been limited*)

7. Do CWD prevent others from learning?

(i) If 'Yes': how do / might CWD prevent other children from learning?
(ii) If 'No': why do you say that?
(iii) If 'Not sure': tell us more…
(iv) Further prompts:

- Are there ways in which CWD and other children help each other to learn? Tell us more…
- How might CWD enable other children to learn better? Tell us more…
- Tell me more… *(if previous responses have been limited)*

8. Should all children have opportunities to play together?

(i) Might this depend on their disability?
- If 'Yes', why?

(ii) If 'No': why do you say that?
(iii) If 'Not sure': tell us more…
(iv) Further prompts:
- What might make it difficult for CWD to play with other children?
  - Can this difficulty / these difficulties be overcome?
  - If so, how?
  - If so, should it / they be overcome?
  - If not, can something be done to diminish it / them?
- What might make it difficult for children with no disabilities to play with CWD
  - Can this difficulty / these difficulties be overcome?
  - If so, how?
  - If not, can something be done to diminish it / them?
- Might CWD prefer to play only with other CWD
  - Is this a good thing or a bad thing?
  - Why?
- Might children with no disabilities prefer to play only with other children with no disabilities?
  - Is this a good thing or a bad thing?
  - Why?
- Tell us more… (*if previous responses have been limited*)

9. Are you aware of specialist health provision for CWD?

(i) If 'Yes' please tell us about this.
(ii) Do CWD in Bhutan have access to any of the following services:
- Speech and language therapy?
- Occupational therapy?
- Physiotherapy?
- Other therapies? If so what?

10. How well trained are health professionals to address the needs of CWD?

11. Do religious communities provide support for CWD and their families?

(i) If so, how?
(ii) If not, why not?

12. Does kidu help to support CWD?

(i) If so, how?
(ii) If not, why not?

13. Who do you mostly rely on for information and advice on disability in your locality?

(i) In your opinion, who is the most reliable person or source of information for support on disability? (Family, friends, neighbours, Government officials, TV, Radio, Newspapers, religious persons such as lamas and astrologers, others)
(ii) In your opinion, which would be the most effective channels in communicating disability in your locality?

14. Is there anything else you would like to tell us about CWD?

APPENDIX 4: RESEARCH TRAINING PROGRAMME

Enumerator training programme

Following extensive preparation, training for enumerators employed by Bhutan Interdisciplinary Research and Development (BIRD) was undertaken over five days between 30 September 2016 and 5 October 2016, including one day when the survey was piloted. The aim of the training was to ensure the enumerators were confident and well informed such that they could gather data in the field and transfer it in a manner that was rigorous, timely, secure and ethical, in accordance with the project requirements.

Professor Philip Garner and Dr. Jane Murray (University of Northampton) led the training with Sonam Tshering (BIRD), Ameena Mohamed Didi (UNICEF Bhutan) and Dechen Zangmo (UNICEF Bhutan), supported and observed by UNICEF colleagues and Ministry of Education officials. The first two days of training took place in Thimpu city centre and the third and fifth days took place at United Nations House in Thimpu. The fourth day of training was in the field.

Training was structured to give the enumerators comprehensive information about their task and to respond to any query they raised so that they had the knowledge, skills and understanding to carry out their task by the end of the training. At the end of training days 1,2 and 3, the University of Northampton team met with UNICEF and Ministry officials to review training in the light of the enumerators' understanding of their tasks and, accordingly, to make joint decisions regarding any necessary amendments for subsequent training days.

The training opened with personal introductions and each training day opened with an 'icebreaker', to encourage the enumerators to engage with each other and Ministry, UNICEF and consultancy colleagues. Question and answer sessions were frequent and in any case, all those attending training were encouraged to ask questions throughout the sessions so that responses could be given to ensure the enumerators understood what they were required to do to secure robust data and were confident to do it.

Topics covered in the training included:

- Introduction to the project
- KAP contexts – international
- Aims and objectives of training
- Familiarization with the household questionnaire
- Definitions, languages and terminology
- Attitudes to disability
- Examining individual questions in the questionnaire
- Key questions
- Points of contact
- Qualitative data collection
- Personal safety
- Project ethics
- Introduction to mobile data collection
- Piloting timetable and personnel allocation
- Piloting household questionnaire in two areas (one rural and one urban)
- Feedback from piloting: process
- Feedback from piloting: content

- Modification of instruments
- Clarification of timetable for field work
- Question and answer sessions
- Conclusion

The enumerators completed a training checklist to show they had completed each training task.

APPENDIX 5: RESEARCH ETHICS

Research ethics protocols observed by the UoN Team are as set out in the University's *The Code of Practice for Research Ethics*: *a Handbook of Principles and Procedures* (2016). The relevant extract, relating to principles, is illustrated below.

Ethics code and procedures

Introduction

1. The University of Northampton is committed to maintaining ethical research and practice throughout the institution and will expect and so far as possible require those working with the institution as partners or contractors to act ethically.

2. Professional and academic communities are placing increasingly exacting responsibilities on their members to improve the ethical standards of research and practice within their disciplines, and journal editors may require evidence that research projects have secured formal ethical clearance before agreeing to publish their findings.

3. *The Code of Practice for Research Ethics*: *a Handbook of Principles and Procedures* has been produced in response to this growing awareness of ethically sensitive issues in research and scholarly activity. Its intention is to provide advice for postgraduate research degree students at the University of Northampton and to promote a strong appreciation of ethical considerations in research. The procedures are intended to be facilitative, not restrictive or inhibitory.

4. The Handbook comprises two parts: Part A is a statement of ethical principles designed to articulate a common set of values to guide and support the professional conduct of academic research and research-related activities. It applies principally to all research involving human subjects and participants. Part B contains the procedures by which ethical issues are addressed.
5. For the purposes of this code, the following definitions are used for the various types of research and scholarly activities and are for the most part those articulated by the Roith Report (PCFC, 1990), which have gained wide acceptance within higher education:

    - Funded Research - research that is funded in whole or in part by an organisation other than the University of Northampton
    - Staff Research Programmes - an agreed programme of research undertaken by a member of staff under the auspices of the University of Northampton that is not Funded Research
    - Postgraduate Research Degrees - a research degree involving a programme of research undertaken by a postgraduate student registered at the University of Northampton
    - Undergraduate Dissertations and Postgraduate Taught Degree Dissertations - a research programme for a dissertation undertaken by an undergraduate or postgraduate student registered at the University of Northampton
    - Institutional Research - any research conducted or commissioned by the University of Northampton.
    - Basic Research - experimental and theoretical work undertaken to acquire new knowledge of the underlying foundation of phenomena and observable facts, without any particular application or use in view.

- Strategic Research - applied research that is in a subject area which has not yet advanced to the stage where eventual applications can be clearly specified.
- Applied Research - work undertaken in order to acquire new knowledge. It is, however, directed primarily towards practical aims or objectives.
- Scholarship - work which is intended to expand the boundaries of knowledge within and across disciplines by in depth analysis, synthesis and interpretation of ideas and information and by making use of rigorous and documented methodology.
- Creative Work - the invention and generation of ideas, images and artefacts including design. Usually applied to the pursuit of knowledge in the arts.
- Consultancy - the deployment of existing knowledge for the resolution of specific problems presented by a client, usually in an industrial or commercial context.
- Professional Practice - a variant of consultancy applied to certain well-defined professions, for example, law, accounting, architecture, nursing, and social work.

6. The following statement of principles places a considerable emphasis on the personal responsibility of researchers to act ethically and to promote ethical behaviour in all aspects of research activities. It is also recognised that statements of principles and procedures cannot expect to cover every aspect of a complex area such as research ethics. For these reasons, the Research Ethics Committee - which will operate and monitor the procedures described in this Handbook for postgraduate research degree students-, would welcome comments and suggestions for future enhancements from individuals, research units, or any other interested parties.

Part A: Principles

1 - Introduction

1.1 The primary responsibility for the conduct of ethical research lies with the researcher. It is a fundamental principle that staff and students engaged in research adopt a continuing personal commitment to act ethically, to encourage ethical behaviour in those with whom they collaborate, and to consult where appropriate concerning ethical issues.

1.2 The University of Northampton acknowledges the importance of the professional codes of conduct of external agencies and organisations, and accords them primacy as a default position.

2 - General responsibilities

2.1 Towards research participants

Researchers have a responsibility to ensure as far as possible that the physical, social and psychological wellbeing of their research participants is not detrimentally affected by the research. Research relationships should be characterised, whenever possible, by mutual respect and trust.

2.2 Towards other researchers

Researchers should avoid, wherever possible, actions which may have deleterious consequences for other researchers or which might undermine the reputation of their discipline. Those directing research

should bear in mind their responsibilities towards members of their research teams and should aim to anticipate and guard against the possible harmful consequences of the research for team members.

3 - Informed consent

3.1 Research should be based, as far as possible and practicable, on the freely given informed consent of those under study. However, it is recognised that in some cases it may be necessary to employ covert methods should these constitute the only means to obtain the required data. In such cases, please refer to section 4.

3.2 It is the responsibility of the researcher to explain as fully as is reasonable and appropriate and in terms meaningful to the participants:

- the aims and nature of the research
- who is undertaking it
- who is funding it
- its likely duration
- why it is being undertaken
- the possible consequences of the research
- how the results are to be disseminated

3.3 The power imbalance between researcher and researched should be considered. Care should be taken to ensure that the latter are not pressurised into participation. Research participants should be aware of their right to refuse participation at any time and should not be given the impression that they are required to participate. It should also be recognised that research may involve a lengthy data-gathering period and that it may be necessary to regard consent not as obtained once and for all, but subject to renegotiation over time.

3.4 The researcher should explain how far research participants will be afforded anonymity and confidentiality and participants should have the option of rejecting the use of data-gathering devices such as tape recorders and video cameras.

3.5 If there is a likelihood of data being shared with or divulged to other researchers, the potential uses of the data should be discussed with the participants and their agreement to such use should be obtained.

3.6 Where access to a research setting is gained through a gatekeeper external to the college, researchers should also obtain the informed consent of research participants, while at the same time taking account of the gatekeeper's interests. It should be borne in mind that the relationship between research participant and gatekeeper may well continue long after the research has been undertaken.

3.7 Where research participants are young children or other vulnerable groups such as elderly, disabled or sick people, or people with learning difficulties whose understanding is impaired in some way so that they are unable to give full informed consent, it may be necessary to use a proxy in order to gather data. In this case great care must be taken not to intrude upon the privacy of the vulnerable participants. The researcher should consult relevant professionals, parents, guardians and relatives, as appropriate. Researchers should attempt to obtain the informed consent of children and their parents and in relation to schoolchildren those who are acting in the place of a parent.

3.8 In addition to obtaining the informed consent of those under study, researchers should attempt to anticipate and guard against the possible harmful consequences of their research for participants.

4 - Deceptive and covert research

4.1 Researchers should not use deception in their research methods, as this violates the principle of informed consent and may invade the privacy of those under study, particularly in non-public spaces.

4.2 It is acknowledged that an occasion may arise when limited deception may be justified. A researcher considering any deceptive methods in research must seek advice from the Research Ethics Committee. The burden of proof will rest on the investigator to show that no alternative methods are possible and that the data sought are of sufficient value to over-ride the issues of free and informed consent. Where advice has been given, the potential implications arising from publication must be fully considered.

4.3 Covert research in non-public spaces - spaces where persons would not normally expect to be under observation - or experimental manipulation of research participants without their knowledge should be a last resort when it is impossible to use other methods to obtain the required data. It is particularly important in such cases to safeguard the anonymity of participants.

4.4 If covert methods are approved and employed, and informed consent has not been obtained prior to the research, every attempt should be made to obtain this after the research.

5 - Confidentiality and anonymity

5.1 The anonymity and privacy of research participants should be respected and personal information relating to participants should be kept confidential and secure. Researchers must comply with the provisions of the Data Protection Act and should consider whether it is proper or appropriate even to record certain kinds of sensitive information.

5.2 Where possible, threats to the confidentiality and anonymity of research data should be anticipated by researchers and normally the identities and research records of participants should be kept confidential, whether or not an explicit pledge of confidentiality has been given.

5.3 Whilst the researcher should take every practicable measure to ensure the confidentiality and anonymity of research participants, they should also take care not to give unrealistic assurances or guarantees of confidentiality. Research participants with easily identifiable characteristics or positions within an organisation should be reminded that it may be difficult to disguise their identity totally without distorting the data.

APPENDIX 6: RECOMMENDATIONS SUMMARY

Theme	Recommendation	Indicator(s)
6.2.2 / 6.2.6	**7.2.1 Area 1: Responses to systemic Challenges**	(i) Define clearly roles/responsibilities/structures for CWD at policy level (ii) Recognize a multi-agency, inter-sectoral approach (iii) Establish a national policy for the social and educational inclusion of CWD (iv) Create greater public/professional awareness/understanding of CWD by a national campaign (v) Need for further research on emergent themes in CWD policy and provision
6.2.4 / 6.2.5 / 6.2.8	**7.2.2 Area 2: Families with CWD**	(i) Provide more visible and accessible support (ii) Disseminate parent-friendly information on CWD (iii) Establish parent-to-parent groups (CWD) (iv) Develop formal home-school links (v) Create parent training opportunities related to CWD
6.2.3 / 6.2.4	**7.2.3 Area 3: General population**	(i) Establish awareness campaign for general population (ii) Engage elders, heads of villages (iii) Involve civil organizations/NGOs in a systematic and integrated way (iv) Focus on enterprises/commercial sector as 'CWD Champions' (v) Form peer-support arrangement (CWD and non-CWD)
6.2.4 / 6.2.7 / 6.2.8	**7.2.4 Area 4: Professional groups**	(i) Review initial teacher preparation to include a disability focus (ii) Provide specialist training in disability (iii) Review in-service development/training of school leaders (iv) Provide in-service training for existing teachers (v) Establish inter-agency forum for CWD professionals

APPENDIX 7: LOCATION MAP - BHUTAN

APPENDIX 8: KNOWLEDGE, ATTITUDES AND PRACTICES TO CHILDREN'S DISABILITY IN BHUTAN: A CONTEXTUALIZED LITERATURE REVIEW

1. CONTEXT AND INTRODUCTION

1.1 Context

Bhutan is a country in the Himalaya region, described according to the World Bank criteria as a 'small state' (World Bank, 2012). In common with countries of similar profile, it has experienced rapid societal changes, particularly in the post-World War II era. Some of the most dramatic changes have been experienced in Bhutan's educational system. From only partial provision 50 years ago, the education service now caters for the entire population of Bhutan (Y1–13).

The challenges of providing education for a heterogeneous student population (in respect of gender, poverty levels, language and learning aptitude and level) have been major issues in refining Bhutanese policy and practice. The Bhutan Ministry of Education, in its Education Sector Strategy 2020 (2003, p. 36) states that *" all CWD and with special needs – including those with physical, mental and other types of impairment – will be able to access and benefit from education. This will include full access to the curriculum, participation in extra-curricular activities and access to cultural, artistic, recreational and leisure activities"*, and in respect of the evident challenges has issued a National Policy on Special Educational Needs (2013) aimed at addressing these. Within this policy document, two objectives were defined, these being (1) to ensure that every child with special educational needs has equal access to quality education that is more appropriate, enabling and responsive; and (2) to empower the children with special educational needs to become independent, responsible and productive citizens.

The National Policy recognizes that in order to achieve such objectives it will be necessary to "Enhance awareness and sensitization on special educational needs through Non Formal Education Programmes and other avenues, and create awareness and advocacy on the rights and responsibilities of children with special educational needs" (RGoBMoE, 2013, p.9.)

Current research from Bhutan indicates that over 21 per cent of children aged 2–9 years have one or more disabilities (UNICEF & UNFPA, 2011). This figure is endorsed by McKay & Dorji (2005) who have additionally indicated that 31 per cent of households with CWD experience conditions of absolute poverty; the latter is commonly aligned with SEND populations, irrespective of country location (Singal, 2013).

One of the challenges for Bhutan is to ensure that all children with special educational needs and disabilities receive appropriate education and social services (Ugyen and Cokl, 2010). In consequence, there has been considerable recent policy emphasis on enabling full access and participation of CWD to such services. For example, UNICEF has supported the observation of International Day for Persons with Disabilities each year to advocate for the rights of persons with disabilities and to empower them further. This has helped create a greater sense of awareness about the rights of CWD in Bhutan, as evidenced by the increasing enrolment of children in Drukgyel School for the Hearing Impaired, which has risen from only seven in

2004 to 77 in 2013. In a similar vein, CWD have been brought in increasing numbers by their parents to Changangkha Middle Secondary School, which offers inclusive education (UNICEF, 2013).

It is nevertheless stated that more work is needed to promote a paradigm shift from the *medical* model of disability to a *social* model (Shakespeare, 2002; UNICEF, 2007; Samaha, 2007). In the Bhutanese context, the regional seminar on inclusive education (UNICEF, 2013) created enhanced awareness amongst key stakeholders to work towards a more inclusive approach in Bhutan. The 2011 study indicated a "dearth of information on the nature, prevalence and more importantly the profile of children living with disabilities in Bhutan". This shortfall inhibits policy development and planning to provide appropriate services to meet the needs of CWD. The project reported here represents a data set, which can stimulate discussion, whilst becoming a catalyst to further policy and practice developments, thus enabling the progress secured in previous decades to be further enhanced.

1.2 Introduction

It is against this contextual background that the present project has been configured. It was commissioned by UNICEF (Bhutan) and the Ministry of Education of Bhutan in 2016 and designated as a 'Knowledge, Attitudes and Practices (KAP) Study on Disabilities' in Bhutan, with a project reference REFP/2015/003. The scope of the evaluation was threefold:

1. Provide an overview of the current position regarding attitudes, knowledge and practices of a range of stakeholders towards disabilities and disability services, with an emphasis on CWD in Bhutan.
2. Identify both achievements and barriers in provision, and to identify priorities for future development to inform a fit-for-purpose communication strategy on social inclusion.
3. Make recommendations to key stakeholder groups working with CWD and their families to promote the effective development and delivery of services.

The intention of the project has been to deliver a set of trustworthy data and attendant recommendations regarding the current extent, characteristics and provision (the knowledge, attitudes and practices) for CWD in Bhutan.

The project team has sought to do so. The work undertaken comprised five interlinked phases, each with a designated output. The study adopted a collaborative approach in all its phases and was underpinned by secure project leadership and management.

Phase 1 scrutinized the existing literature on CWD (both recognized academic sources as well as the so-called 'grey' literature) and resulted in a detailed review of the current situation in Bhutan. It also defined and tested a set of three instruments that were subsequently used to generate data. In addition, an appropriate set of ethical protocols was established, and fieldworkers were identified and trained.

Phase 2 used the three instruments to gather data from an agreed sample; thus, a household survey, focus group discussions and a set of interviews with key informants were operationalized. Data were collated and placed in a secure electronic repository.

Phase 3 comprised an interrogation of the data generated and a preparation of illustrative data materials for subsequent use in the reporting stage of the project.

Phase 4 provided a full draft of the final report for scrutiny by UNICEF and Ministry of Education. It also comprised a set of recommendations, based on data evidence, to highlight ways forward in meeting the needs of CWD; a user-friendly research summary was also constructed to assist in a dissemination effort.

Finally, Phase 5 resulted in the delivery of a workshop, supported by appropriate resources, regarding the project's findings. This principally involved key stakeholders from Bhutan.

2. KNOWLEDGE, ATTITUDES AND PRACTICES TO CHILDREN'S DISABILITY IN BHUTAN: A CONTEXTUALIZED LITERATURE REVIEW

2.1 Introduction

The cornerstone of effective social, educational and vocational provision for CWD is the presence of knowledge and its articulation in child-centred practice, both informed by positive attitudes of individuals and communities. Given the far-reaching implications of these interconnected elements, it is understandable that these topics are prevalent in recent literature relating to policy and practice for children with disability. Moreover, the knowledge bases, attitudes and practices of non-disabled persons to those experiencing physical, psychological, cognitive or behavioural difficulties are neither homogeneous nor static.

On the other hand, there remain a number of well-known themes that populate the historical literature. Though these have been superseded in the main by more progressive thinking, they provide an important insight into the slow emergence of more positive attitudes and associated practices in the latter part of the 20th century and beyond. Plato recommended that 'deformed offspring' should be segregated in "mysterious unknown places" (Goldberg & Lippman, 1974). In the late Middle Ages, Luther and Calvin indicated that the mentally retarded and other persons with disabilities were possessed by evil spirits. The Darwinists of the latter part of the 19th century opposed state aid to the handicapped, arguing that their preservation would impede the process of natural selection (Hobbs, 1973).

As has been inferred, it is not the intention of this literature review to address the in-depth characteristics of historical aspects of attitude formulation, or the impact of knowledge systems on policy and practices in respect of CWD. This has been undertaken in several other studies (NDA, 2006). On the contrary, the review places a specific focus on providing an accessible account of the extant knowledge, in the literature, of the knowledge awareness, attitudinal characteristics and the actual practices of key stakeholders towards children and young people with disabilities. The review is structured in such a way that the reader is able to identify a set of thematic issues to inform subsequent fieldwork, based on a sample of responses from Bhutanese households to CWD.

2.2 Terms of reference and definitions

The terms of reference for this study, and therefore this literature review, indicated that the intention is to provide an overview of knowledge (including typology, causes, conventions and laws and available services relating to CWD), attitudes (of a range of key stakeholders) and recent and current practices (as seen from a range of perspectives, including those factors that inhibit effective provision).

Knowledge, Attitudes and Practices (KAP) towards disabled people have varied considerably from one

culture/community to another and are subject to changes over time. Kaliyaperumal (2004) provides a summary definition of each KAP element as follows, noting their interconnections:

> *Knowledge is the capacity to acquire, retain and use information; a mixture of comprehension, experience, discernment and skill; Attitudes refer to inclinations to react in a certain way to certain situations; to see and interpret events according to certain predispositions; or to organise opinions into coherent and interrelated structures (3); and Practices mean the application of rules and knowledge that leads to action (3). Good practice is an art that is linked to the progress of knowledge and technology and is executed in an ethical manner.*

This literature review adopts these definitions and maps the continuities and differences between their recent and contemporary characteristics in Bhutan and those obtaining more generally in the mainland South Asia region[4] and internationally. For the purposes of this review, literature relating to the following countries was identified for specific scrutiny: Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Singapore, Thailand and Vietnam. This choice was made because of the existence of credible regional literature surveys based on these national settings. In addition, however, a further set of materials was highlighted, and these were considered by the review team to offer opportunities for generic insights into aspects of knowledge, attitudes and practices across a wider geographical area. This country grouping comprised Bangladesh, China, Hong Kong (China), India, Maldives, Mongolia, Nepal, Pakistan, Philippines and South Korea.

The research team's response to the terms of reference indicated that a desk-based review of literature would provide three integrated sections covering each of these elements – addressing literature from international, mainland South Asia and Bhutanese sources. The review will provide a substantive context for fieldwork, which seeks to "Identify the overall situation on knowledge, attitudes and practices of various stakeholders towards disabilities and disability services in general as well as with particular focus on CWD in Bhutan" (UNICEF Bhutan) and included in the terms of reference for this study.

Subsequently the project team sought to adopt a focused approach to the key terms informing the KAP study: together with 'knowledge', 'attitudes' and 'practices' (as defined above), the terms of 'household', 'disability' and 'children' were also defined, in order to establish a working definition of each. The terms highlighted would inform the subsequent literature search. Accordingly, this review adopts the following meanings:

Household: this includes all of those who share a dwelling, whether related by kinship or otherwise. It is recognized that 'households' will vary in composition and structure.

Disability: we adopt the current World Health Organization (WHO) definition, which indicates that the term covers impairments, activity limitations and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations.

Children: The United Nations Convention on the Rights of the Child defines 'child' as "a human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier" (UN, 1989).

[4] For the purposes of this study, the term 'South Asia' includes the countries as identified in this literature review and does not refer to the UN regional classification.

This definition is utilized in this study.

2.3 Review methodology

The intention of this review is to provide an illustrative scoping of the literature regarding the knowledge, attitudes and practices in respect of CWD by utilizing a purposive selection from what is a significant body of materials. It is therefore not intended to be read as a comprehensive survey of the field: substantive efforts to do this have been made elsewhere (Winter & O'Raw, 2010; Lindsay & Edwards, 2012; Cologon, 2013). The review of literature provides an incremental synthesis (international, South Asian and Bhutanese) of wide-ranging material relating to attitudes towards children's disability within households and the wider community. For the purposes of this review, the latter is taken to mean "…a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographical locations or settings" (MacQueen et.al., 2001).

The review utilizes resources from several academic disciplines, including psychology, sociology, education and health studies. Its sources comprise government reports, NGO papers, monographs, journal articles and unpublished doctoral theses. The research team also draws upon what is termed the 'grey literature' (unpublished material), including online resources and media reports.

The review almost exclusively restricts itself to post-2000 materials. Exceptions are made when utilizing those sources that illustrate the historical dimensions of knowledge, attitudes and practices regarding disability and those long-standing international agreements or conventions to which Bhutan is a signatory. The texts utilized have been identified using a mixed-methods approach, including general internet searches (GOOGLE SCHOLAR), systematic keyword search of nominated databases (Educational Resources Information Centre, Current Index to Journals in Education, MEDLINE, National Centre for the Dissemination of Disability Research and the search engines available within the University of Northampton).

Materials from these sources were identified using a keyword search, developed by the research team and their professional associates. The latter formed a reference group for the project and comprised a group of five academic colleagues from UK, USA, Australia and mainland Europe. This group was identified according to a set of criteria, linked to the project's orientation and needs. Each had (a) over 15 years professional experience in the field of disability/special educational needs; (b) a record of published work in the field, which was primarily based on research; (c) held a doctoral qualification in a field appropriate to the study; and (d) experience of international research and consultancy.

The reference group worked with the core research team from UoN to identify a set of primary and secondary search terms (Knowledge, Attitudes, Practices, Household, Disability, Childhood) (see Figure A8.1).

Figure A8.1: Primary and secondary search terms

KNOWLEDGE Types & causes of disabilities / models of disabilities Awareness of disability Rights & international conventions Importance of statutory arrangements (country-based) Importance of legislation and policy (country-based) Approaches, services, skills Training & professional development ATTITUDES Parents Professionals Community/social Policymakers NGOs
Secondary-themes: Explanations for + or – attitudes: Personal responses (guilt, fear, need to provide protection, responsibility, expectations etc.) / societal acceptance or rejection (marginalisation) / religious & cultural beliefs / labelling theory / access to information / rights & social justice Influencing factors: Resource provision (professional) / legal frameworks (informing assessment/identification) / family support availability of networks / availability of respite / personal history/experience / media representations / cost / geography & location
PRACTICES Recognition of rights: implementation of legislation & international conventions Inclusion, exclusion & mainstreaming Early assessment and intervention Access/accessibility Curriculum differentiation & individualisation Collaboration between support services Stakeholder voices & empowerment Community involvement & participation Formal/informal/non-formal education Resources National regulation Leadership

2.4 Some international characteristics of Knowledge, Attitudes and Practices regarding children's disability

2.4.1 The recent international context

Knowledge about CWD in the fields of education and social care has changed significantly over the last 40

years, leading to shifts in attitudes and practice. Birch and Johnstone (1975) regarded that schools and communities should demonstrate the same readiness and accessibility to persons with disabilities as to the non-disabled. The period between that time and the present day has been characterized by an international drive to define and articulate the philosophy of inclusion.

A number of defining agreements, statements of intent and international conventions has helped to reinforce the view that, in contemporary nation states, CWD should have access to all resources and opportunities. Access was viewed as a right, as manifest in the United Nations Convention on the Rights of the Child (1989). In the Jomtien Declaration (1990), resulting from a World Summit for Children, there was a requirement that countries commit themselves to providing education to all children including those who were 'marginalized' on account of their disability (UN, 1989). The Salamanca Statement and its accompanying Framework for Action defined access to education as a basic human right for all, irrespective of their individual differences (UNESCO, 1994).

It is important to recognize that both the Salamanca Statement and the UN Convention emphasized the social aspect of inclusive education. Information regarding the nature and purpose of inclusive education has consequently been made available; access to the resulting knowledge bases is progressively resulting in a positive shift in the beliefs towards students with disabilities (Subban & Sharma, 2006). Later, Koster et al, (2009) suggested that the term 'social participation' should be utilized to capture this dimension of children's experience, as it extended the concept of 'inclusion' well beyond the confines of formal education. The post-2000 period has seen a widespread confirmation that the further development of inclusive approaches in education has to be supported by promoting understanding by offering opportunities to policy-makers, professionals and parents to access to knowledge about disability.

The literature surveyed reveals the extent to which it has emerged principally from specific geographical locations – notably the United States and Canada, Western Europe and Australasia. This is understandable, given that such geographical locations comprise concentrations of high GDP countries, which tend to have a longer tradition of research, development in the field of disability and special educational needs.

2.4.2 Knowledge

One of the effects of these and subsequent international developments has been that, during this period, individual countries have sought to formulate policies and practices, which have enabled CWD to participate more fully in educational, social and economic processes. At the outset, a trend in the majority of countries has been to adapt pre-existing institutional frameworks to integrate CWD into society. One example of this was the so-called mainstreaming approach, which enabled CWD to enrol in regular schools. However, these early efforts sometimes compounded the difficulties experienced by CWD because there was little concentrated effort to shift attitudes towards marginalized children and young people. This left them feeling still discriminated against and vulnerable in their communities, including its formal institutions. Efforts have not been made to adapt these establishments in such a way that these children can fully participate. Such a pattern has been evident globally; for instance, a study of children with 'special educational needs' in the UK (DCSF, 2007) reported that 55 per cent said that they had been treated unfairly because of their disability. These and other studies indicate that inclusion of CWD is not a straightforward or uncontested process. They still experience many physical, civic and social barriers to their full involvement in everyday life.

Nevertheless, international recognition of the Education for All movement has been a feature of post-2000 development, with attention directed specifically towards 'equalization of opportunity' confirmed by both the Dakar Forum for Action (2000) and the UN Convention on the Rights of Persons with Disabilities (2006). New initiatives within the UN have the overarching intention to incorporate people with disabilities into all current and future Millennium Development Goals efforts (United Nations, 2009). In so doing, there is recognition of an explicit link between disability and poverty. A focus on poverty reduction is also a goal of the WHO guidelines on community-based rehabilitation (WHO, 2010) and it is also highlighted in the *World Report on Disability* (WHO, 2011).

Thus, a feature of post-2000 development has been the broadening acceptance that 'inclusive practices' refer to an increasing acceptance that the concept relates to more than people with disabilities and learning difficulties (Winter & O'Raw, 2010). It is now understood more in respect of the barriers to learning and participation experienced as a result of gender, personal history, race, ethnicity, language, care status, socioeconomic status, sexuality, or religion (Gerschel, 2003). This is an important consideration, given that levels of knowledge about disabilities can vary as a result of the impact of one or more of these factors.

The international consensus, which has placed 'disability' more substantially at the forefront of the education and social policy agendas, has stimulated the emergence of an increased compendium of knowledge in the broadly termed field of disabilities. This is now substantial and is widely available through a range of repositories and databases.

In respect of causal factors, there has been a firm recognition of the linkages between disability, poverty and health. For instance, poverty is seen as both a cause and consequence of disability (Zimmer, 2008). Indeed, there is widespread acceptance that multi-factorial explanations are essential starting points for interventions. Such links are apparent in both high-GDP and low-GDP settings (Croot et. al., 2008).

Increased knowledge regarding causation has resulted in greater public awareness (SCOPE, 2014; WHO, 2011), with "Most countries that have developed support services have strong organizations of persons with disabilities and their families lobbying governments to reform policies on service delivery and to increase or at least maintain the resources allocated" (WHO, 2011, p. 147).

The policy implication of becoming a signatory to international conventions on disability and children's rights has been widely recognized (Thomas, 2011), and resulting legislation in nation states across diverse regions has been apparent (OECD, 2005).

In most cases, national legislation has incorporated recommendations regarding approaches to intervention and the subsequent arrangements for resourcing the preferred approaches. The latter has placed some emphasis on professional development and, specifically, the training of teachers, psychologists and health workers. Evidence available suggests that "inclusive education is most effectively promoted by a comprehensive strategy to teacher training as well as addressing community-based approaches which promote inclusive cultures, values, beliefs and attitudes" (Reiser, 2013).

2.4.3 Attitudes

The international literature is being significantly populated by research and policy commentaries relating to the ways in which attitudes towards disability are informed by existing knowledge levels; this relates to policy-makers, teachers, other professionals and to parents and the community at large. There is a

considerable body of research-led opinion, which is suggesting that the attitude of others to CWD represents the key factor in their social, educational and cultural inclusion within communities (Ainscow, 2005). Beliefs and expectations vary, both within and between these broad groupings. As with other aspects of the literature, that relating to attitudes indicates a fair degree of consistency of position, notwithstanding the country setting or relative stage of development (Al Zyoudi, Sartwai & Dodin, 2011; De Boer, Pijl & Minnaert, 2011; EADSNE, 2011).

The views of parents regarding disability, whether it relates to their own or to others' children, are highlighted as a crucial aspect in the literature. Parents of CWD are viewed as wanting their child to be included in educational and social settings (Leyser & Kirk, 2004), although there are indications that some are concerned about the absence of the necessary skills or awareness amongst mainstream communities (Rafferty & Griffin, 2005). Parents of non-CWD were more likely to view the inclusion of CWD in mainstream settings as problematic (De Boer & Munde, 2014). But, as with other groups, the attitudes of parents vary according to a range of factors, including the availability of support services, religious or cultural orientations and peer pressures (Hassanein, 2015).

The attitudes of professionals who come in close contact with children with disability reveals a similarly complex picture. For example, Finke, McNaughton and Drager (2009) indicate the extent of divergent opinions regarding autistic children. The existence of such diverse, even polarized, attitudes of teachers has been regarded as one of the major barriers in securing effective provision for CWD (Purdue et al., 2009), whilst commentators suggest that such attitudes might be subject to change following periods of professional development (Carroll, Forlin & Jobling, 2003). A similar situation has been noted with regard to other professional groups who interact regularly with CWD (Baker-Ericzén, Mueggenborg & Shea, 2009).

As indicated by Hassanein (2015) there is a range of factors that have been implicated over time as influencing the emergence of an attitudinal response to CWD from any given group. These can be grouped as those that prompt either positive or negative response reactions, which contribute to the formulation of an overall attitude. For example, the international literature indicates that there is evidence of a range of personal feelings informing responses to disability: the guilt experienced by parents is particularly noted (Lemacks et al., 2013). Such feelings can be reinforced by negative imagery and language, stereotypes and stigma persist for people with disabilities around the world (World Bank, 2009*)*. Moreover, there is substantial evidence suggesting that the general public lacks an understanding of the abilities of people with intellectual impairments (Siperstein et al., 2003). These negative views contribute further to the adverse labelling of those with disability (Gibson, 2008).

In contrast, the existence of a network of supports and resources can result in a more positive stance, both by teachers and by parents of CWD (Elkins, van Kraayenoord & Jobling, 2003). Other factors influencing the emergence of positive attitudes include access to training by professionals (Carroll, Forlin & Jobling, 2003) as well as the availability of respite care (Hatton et al., 2004)

2.4.4 Practices

As previously noted, since the Salamanca Statement there has been a steady refinement of societal and educational approaches to meeting the needs of CWD, premised by the global adoption of the principles of inclusive practice. This has been the dominating theme informing developments for disabled people within communities and has been well recorded in the literature during the period under review (Booth & Ainscow, 2002; UNESCO, 2005; Osberg & Biesta, 2010; EADSNE, 2012; ARACY, 2015). CWD, particularly

those experiencing mental health issues, have conversely been over-represented in exclusionary practices in most countries (UNICEF, 2007; Parker & Ford, 2013). Such children are regarded by practitioners as being the least likely to benefit from participating in inclusive environments (Cassady, 2011).

Effective practice in supporting CWD within communities, whether in formal settings, such as schools or kindergartens, or informally within social groups within neighbourhoods, has been a salient, omnipresent feature in the literature. School curriculum practices (Meijer, 2001), pre-school support (Skotko & Canal, 2005), access to support services (Parker, Gage & Sterr, 2011), leadership practices (Chapman et al., 2011) and the degree to which CWD are enabled to participate within community activities (Clarke, 2006) are further illustrations of the scrutiny given to emerging practices for CWD.

Of all of these trends, however, it is perhaps the rapid development of the direct involvement of CWD as stakeholders within the processes and events that most involve them. The 20 years that have followed the recognition of the Salamanca Statement have seen a growth in the importance of listening to children, encapsulated by the term 'the voice of the child'. Nowhere has this empowerment been more pronounced than in relation to CWD (Franklin & Sloper, 2009; Inclusion International, 2006; Stokes, Turnbull & May, 2013)

2.5 Knowledge, Attitudes and Practices: a scoping of the literature from South Asia

This literature review has identified a sizeable body of literature relating to KAP in those countries of mainland Asia as previously identified, together with a supporting set of material from a selection of offshore nations in Asia. The principal source group of literature comprised the following: Brunei, Cambodia, Indonesia, Laos, Malaysia, Myanmar, Singapore, Thailand and Vietnam. The supplementary group comprised: Bangladesh, China, Hong Kong (China), India, Maldives, Mongolia, Nepal, Pakistan, Philippines and South Korea. Finally in this preamble, it should be noted that much of the identified literature refers to regional, as opposed to country-based, issues relating to CWD.

At the outset, it is worth noting that this compendium of reports, papers and commentaries gives a firm indication that researchers are emphasizing a broadly similar set of challenges and opportunities to those mirrored by the international literature in the review. This observation appears to be common to material illustrating aspects of knowledge, attitudes and practices in respect of CWD in this region.

These South Asian parallels are neatly highlighted by the *Asia Pacific Database Summary* (IASSID, 2012), a review of literature relating to people with intellectual difficulties from the region under consideration – notwithstanding that the focus is only upon one category of disability. What is further apparent from this collection of sources is that, just as in the international literature drawn from beyond the South Asian region, there are imbalances in the origin of the studies illustrated: the IASSID database, with Cambodia and Thailand accounting for 97 of the 134 studies utilized.

The literature scrutinized is drawn primarily from the period 2000–2016, with minor exceptions. It is noteworthy that, in common with literature trends regarding disability and (particularly) inclusion internationally, there appears to have been a rapid growth in the volume of research and scholarship in the South Asian region during the period under consideration. Even so, it should be further noted that in the South Asian region there is "limited evidence of disability-inclusive development becoming established as

a research area that independently interests and supports researchers" (CBM/AusAID, 2010). Moreover, there is "little evidence of cross-fertilisation" and of researchers' "involving their participants and disabled people's organisations (DPOs) in emancipatory research practice" (ibid.).

2.5.1 Knowledge

Literature from the Asian region indicates a recent emergence of a knowledge base generated from within the geographic region identified. The literature contains several studies which consider South Asia generically as a region – those by Thomas & Thomas (2002), Takamine (2003), Nizamani (2005) and CBM/AusAID (2010) have enabled the growth of a secure knowledge base regarding CWDs in this area. This is of significance, given that it is indicated that the South *East* Asia Region has the second highest prevalence rate of moderate disability (16 per cent) and the third highest prevalence rate of severe disability (12.9 per cent), with the inference that both figures are underestimates (WHO, 2011).

Generic surveys conducted in the region have enabled the generation of substantial insight into CWD and the social and educational provision for them. What has emerged from this body of literature is that general societal awareness regarding these issues is at best nominal in most countries. Nizamani (2005) summarizes the gaps that exist in public and professional understanding, stating that:

> *Some key areas have been identified which need special attention based on the perceived needs and priorities of disabled Afghans. These include supporting disabled people's organizations, especially supporting women groups; raising awareness to educate and change public attitudes towards disabled people; prevention, early intervention and rehabilitation including health care and therapeutic Aids; the development of guidance for accessible environment and facilities, including access to information; education for all accessible vocational training programs and facilities; and an affirmative action plan to ensure that disabled people have equality of opportunity in employment options including sheltered employment further, the inclusion of disabled people in to society requires physical and programmatic access to culture and recreational activities including sport, as well as access to social welfare, accessible housing and transport (p. 4).*

Within the literature there is a particular emphasis upon the need to raise awareness of international or national legislation or conventions relating to disability as a key component in effective policy-making and provision (UNESCO, 2009; United Nations/ESCAP, 2010). This is viewed as a means by which some of the key concerns regarding knowledge, attitudes and practices relating to CWD can be formulated or refined. Thus, UNESCO (2009) places importance on the challenge of effectively defining what comprises 'disability' (pp. 102–117) and thereby ascertaining levels of provision required. This mirrors one of the focal points of research at a broader international level.

The current level of regional knowledge regarding categorization of difficulties in the region suggests that children faced with mobility difficulties are ranked as being of the greatest concern in most countries, and those with intellectual difficulties being rated lowest (WHO, 2012). However, there are indications in the literature of a widespread lack of knowledge and awareness of CWD and the challenges they experience in many countries: this is noted, for example, in the case of Vietnam (UNICEF, 2011), Thailand (UNESCO, 2009) and Pakistan (Qayyum, Lasi & Rafique, 2013). This common situation in many locations allows negative attitudes to prevail (see 2.5.2).

There has been a corresponding focus on researching the barriers that face CWDs themselves, alongside those challenges experienced by national policy-makers in establishing procedures via which provision can

be organized. The barriers frequently align with those specified in the international literature, although for CWD in South Asian countries it is recognized that some differences are apparent. For Asian countries, these relate to transportation difficulties, as noted in Thailand (Wanaratwichit et al., 2008) and Nepal (Shrestha, Shrestha & Deepak, 2009).

As a result, policy-makers are now more aware of the issues to be tackled. These have been comprehensively identified in the literature, and well summarized by UNESCO (2009):

> *Persons with disabilities have been prevented from accessing rights that are freely available to other members of society in such areas as health, education, employment, community participation and other basic social and political rights. They have also been denied access to the disability-specific services that they need in areas such as early intervention and rehabilitation. Failure to access these services, combined with prejudice and rejection, has resulted in economic and social exclusion for children and adults with disabilities and their families. This marginalization has meant that their needs have not been considered in the development of basic mainstream services such as education and health. Where services have been provided, it has usually been in the context of welfare or charity, often initiated by non-governmental organizations, with responsibility less likely to be taken by the government. Education has most commonly been provided in segregated special schools, to a minority of children in urban areas. This helps to explain the extremely low enrolment rates cited above (p. 8).*

Furthermore, a set of distinct political, economic, cultural and geographical factors often combine to exacerbate even the negative contexts for CWD in some South Asian settings (Groce et al., 2011). Nonetheless, the available literature on CWDs points to many commonalities between Asian country settings and those worldwide.

An important common theme deserving particular attention is the correlation between poverty, social marginalization and disability. The literature places considerable emphasis upon this, both in a regional context (Groce et. al., 2011; Ghosh & Magana, 2009) as well as in respect of individual countries (for instance, Cambodia: see Gartrell, 2010). Such a relationship reflects a linkage, which obtains more widely across countries worldwide (Palmer, 2011) and especially in those countries with low GDP (Grech, 2015).

2.5.2 Attitudes

The literature examined in this review indicates that a consideration of public and professional attitudes towards CWD is a matter that engages the attention of researchers and commentators. This is evident in the presence of a number of KAP survey reports in the literature base, as well as a selection of journal articles based upon them. There are again parallels with the broader international literature, in that negative or resistant attitudes are consistently being regarded as barriers to developing more positive approaches with CWD and to securing successful outcomes (Filmer, 2008). This applies to policy-makers, teachers, other professionals involved with CWD and to parents and the community at large.

A number of KAP surveys are reported within the literature (for example, Lakhan & Sharma, 2010; UNICEF, 2011; CBM, 2011; Todkar, Doijad & Gadgil, 2015). These highlight the attitudes of parents and families (Holroyd, 2003; Ghosh & Magana, 2009; Hersinta, 2012), other children (Tran, 2014), professionals (Kalyanpur, 2007; Daoudong, 2013) and the wider community (Gabel, 2004). In these instances, the negative reactions of each social or professional group to CWD are implicated in their failure to thrive, both social and educational. Worse still, such children end up being ostracized from communities and are

stigmatized on account of their differences. In this respect, the South Asian literature is consistent with that from other regions elsewhere in the world (Groce, 2004).

The South Asia-specific provides some additional information, which helps to highlight some of the historical and cultural factors that play a major part in attitude formation. Lauber & Rossler (2007), for example, suggest that professional groups adopt a 'stigmatizing approach' to those with mental health issues, and add the compounding problem that services to address the needs of those experiencing this often 'hidden disability' are infrequently available outside of urban locations in many South Asian locations. This is reflected on an individual country basis by, for instance, Kusumastuti, Pradanasari and Ratnawati (2014) in Indonesia and by Yousafai, Farrukh and Khan (2010) in Pakistan. There is also an emphasis upon the stress experienced by families, especially mothers, where CWD is born into a family (Katbamna, Bhakta, & Parker, 2000; Shin & Nhan, 2009; Wang, Michaels & Day, 2010; Huang & Kellett, 2012). This further contributes to the isolating effects of stigmatization.

Societal attitudes in Asian settings, in common with elsewhere in the world, have emerged as the product of long histories (Miles,1995; 1997; Chung, Jung, & Yang, 2012). Residual beliefs regarding disability, linked to cultural and religious beliefs, remain powerful influences (Kaur-Bola & Randhawa, 2012) and are difficult to change (Parker, 2001). Even so, the Asian literature contains a body of material, which presents guidance on what comprises the most effective practice in training and awareness-raising so that professionals and parents become more inclusive in their responses to CWD, as illustrated by Carter (2008) and UNESCO (2009). These suggest that actions regarding attitude change in respect of CWD have to be undertaken at every level – family, school and community – and that they need to involve all stakeholders.

2.5.3 Practices

The South Asian literature offers evidence that most country settings in the region are implementing practices that align with the principles of the relevant international conventions relating to CWD, most notably the UN Convention on the Rights of the Child and the UN Convention on the Rights of Persons with Disabilities (UN,1989; 2006). A scoping of the grey literature suggests that individual countries within South Asia are taking steps to develop practices, which approximate those being reported elsewhere internationally.

A major focus of attention is understandably placed on social and educational inclusion, an aspect of practice well illustrated in Laos (Holdsworth, 2003), Cambodia (Trani & Van Leit, 2010) and Hong Kong (Slee, 2004). The measures adopted relating to early assessment and intervention, differential resources and teaching approaches, inter-service collaboration and community involvement with CWD are each highlighted, the latter being a characteristic of these country-focused materials (see, for example, Suharto, 2006). Community-based rehabilitation is especially emphasized (Zhou & Kun, 1999; WHO, 2007; Alam, Bari & Khan, 2005).

The WHO (2007) review indicates that there is consistency between what are viewed as effective interventions to challenges in South Asian settings both across countries in the region and those approaches that are now well established in education systems elsewhere.

2.6 Knowledge, Attitudes and Practices: a review of the Bhutan literature

"Little is known about the nature, type and possible causes of childhood disabilities in Bhutan" (NSB/MoE/MoH/UNICEF, 2012, p. i). Notwithstanding this relative paucity of information, the third part of the literature review focuses on a range of Bhutan-specific sources concerning (6.1) Knowledge about CWD, (6.2) Attitudes about CWD and (6.3) Practices concerning CWD.

2.6.1 Knowledge

This section focuses on literature addressing those aspects concerning the knowledge about CWD in Bhutan. Disability is defined by the Royal Government of Bhutan (RGoB) (2012) as

> *…an inability or a reduced capacity to perform a task in a specific way…a limitation imposed on an individual by a loss or reduction of functioning, such as the paralysis of leg muscles, the absence of an arm, or the loss of the sight. In other words, disability can be interpreted as the incapability to perform as other children do because of some impairment in sensory, physical, cognitive or other areas of functioning. These limitations make children incapable of doing what other children do. Therefore, a ' disability' is the functional consequence of the impairment* (p. 19).

When a person's daily activity is inhibited by their disability in Bhutan, they may be regarded as deprived (Ura et al., 2012). For the Bhutanese population, disabilities are assessed and reported as a health status indicator within Bhutan's Gross National Happiness Indicators (Beaglehole and Bonita, 2015; RGoB, 2012). Cognitive disabilities are those most frequently identified amongst children in Bhutan (Mont et al., 2013). In international comparisons, Bhutan scores relatively poorly in measures of psychological well-being (Biswas-Diener, Diener and Lyubchik, 2015), though the diagnosis rates of mental illness are rising as health workers become better trained: anxiety, stress-related illness, epilepsy and depression account for 82 per cent of mental illness in children and young people in Bhutan (McKay & Dorji, 2005).

A higher prevalence of disabilities has been noted amongst poor children and the children of mothers with relatively little education; this particularly applies to children with moderate and severe disabilities (UNICEF, n.d.; Mont et al., 2013). Mont et al. (ibid.) propose that children's disabilities may therefore vary according to their mothers' education levels and, conversely, that better maternal education prevents mild disabilities from escalating. Moreover, UNICEF (n.d.) found a higher incidence of disabilities in younger children and those who live in rural areas.

Together with several Bhutanese government partners, UNICEF (2012) undertook a study focused on CWD aged 2–9 years; this was described as "a significant advance to better understand the extent, nature and degree of disability in Bhutan among children aged 2-9 years" (p. i). The study found an overall prevalence of 21 per cent of CWD, ranging from 26 per cent for the poorest children to 14 per cent for children from the wealthiest families. Mild disability accounts for 19 per cent of CWD, moderate disability accounts for 2 per cent of CWD and severe disability accounts for 0.7% (NSB/MoE/MoH/UNICEF, 2012). Amongst CWD, 14 per cent have a single impairment while 8 per cent present with co-morbidity. Prevalence of disability amongst children aged 2–5 years is 27 per cent, whilst the rate is 16 per cent amongst children aged 5–9 years. There appears to be no significant gender differences in each grouping. Nevertheless, the potential causes of disability appear under-researched in Bhutan (Mont et al., 2013).

Concern for child protection is evident in policy (Parliament of the Kingdom of Bhutan, 2011; Youth Development Fund Secretariat, 2014) and the need to educate the general population about disabilities, including parents and service providers, is recognized, since the absence of such knowledge often means Bhutanese children do not access services (Lham, 2013; UNICEF, n.d.). Yet official policy does not always appear to advocate as robustly as it might for CWD; for example, whilst Bhutan's Child Care and Protection Act (Parliament of the Kingdom of Bhutan, 2011) articulates the need to address "matters relating to children in conflict with law in the most favorable (*sic*) manner and in the best interest of the child" (p.1), most of the document focuses on children who have committed crime.

There also seems to be discontinuities between policy and practices regarding models of disability in Bhutan. Whilst a social model is promoted at policy level (Schuelka, 2013), a medical model prevails in practice because there is little recognition of the value of inclusive education amongst the general population (UNICEF, 2013b). In part, this may be due to 'attitudinal barriers' in tandem with specific social norms that seem to contribute to preventing CWD from accessing their rights (UNICEF, n.d.). Nevertheless, both social and medical models of disability are discussed increasingly openly in contemporary Bhutan (Schuelka, 2015).

Bhutan is a signatory to the UN Convention on the Rights of the Child (UN, 1989) and the country has signed – but not ratified – the UN Convention on the Rights of People with Disabilities (UNCRPD) (2006) (Schuelka, 2015). The Constitution of Bhutan is highly committed to supporting its citizens who have disabilities to access their rights (UNICEF, 2013a). However, there is no statutory disability act (UNICEF, n.d.) and civic amenities in Bhutan and its infrastructure are regarded as inadequate to enable the access of disabled people (Business Bhutan, 2012).

In Bhutan, the United Nations (UN) has been highly influential in promoting an approach to disability that is 'rights based'; in other words, it has been encouraging the adoption of a social model of disability (Schuelka, 2015). Moreover, Bhutan's development approach includes a focus on rights of equality in law for all people, including those with disabilities, and this focus is manifest in education, health and the workplace (Pellegrini &Tasciotti, 2014). Government services are monitored and evaluated according to seven indicators, which include consideration of human rights (RGoB, 2012).

Nevertheless, while school enrolment and completion rates have risen in recent years, 2 per cent of children were still not in school in 2012, with the lack of provision for children with special learning needs identified as one explanation (RGoBMoE, 2011; 2012). On the other hand, UNICEF et al. (2012) state that there are no specific data on out-of-school CWD. Tharchen, Chanbanchong and Savegpan (n.d.) estimate that there are more than 3,300 children in Bhutan with "immediate special learning needs" (p. 1). Although children with SEN and disabilities who are not in school pose a concern for Bhutanese teachers (Chhetri, 2015), poor institutional and human resources are often the reasons why CWD are denied access to education (UNICEF, n.d.). In addition, Chhetri (2015) found that there is a lack of awareness about inclusive education among parents of CWD.

All government policy, including education policy, is grounded in Buddhism (Givel, 2015) and, until the 1950s, formal education in Bhutan was exclusively the domain of Buddhist monasteries (Childs et al., 2012). However, in subsequent decades, educational provision has broadened and become more widely available, becoming more closely aligned with international policy (RGoBMoE, 2012). Contemporary education in Bhutan is free from 6–16 years, though there seems to be some disparity in the literature

regarding whether or not it is compulsory (RGoBMoE, 2014; UNICEF, 2013a). However, parents often support their children's education by providing stationery (RGoBMoE, 2014).
Access to education is generally characterized by gender parity (Schuelka, 2013) though school stationery costs for children aged 14–16 years tend to rise and parents tend to favour boys in that context (Choden and Sarkar, 2013). A concern for 'quality' is highlighted by a national assessment programme (Maxwell, Rinchen and Cooksey, 2010). Nevertheless, a legislative framework does not currently exist to secure entitlement for CWD to education (UNICEF, 2013a).

Early Childhood Care and Development (ECCD) provision is emergent but nonetheless progressive, informed by the MoE's 2014–2018 Five Year Plan for Bhutan and its Early Learning and Development Standards (Wangchuk et al., n.d.). In 2012, a National Policy on Special Educational Needs was developed by the Ministry of Education, aiming for "a caring, inclusive and enabling society" by ensuring that "…every child with special educational needs has equal access to quality" and empowering "all children with special educational needs to become independent, responsible and productive citizens" (RGoBMoE, 2012a, p. 7). Moreover, RGoBMoE (2014) "seeks to maintain an inclusive approach to improve educational access and meet the special needs of those with physical disabilities and learning difficulties" (p. 18).

In spite of this, Bhutanese educational policy and investment for supporting its people with disabilities has appeared to be geared towards perpetuating segregation in the form of segregated schools and SEN units, rather than promoting inclusion, perhaps because planning SEN special schools may be easier than promoting inclusion in mainstream schools (Pinnock, 2013; UNICEF, 2013a). This situation has seen changes in recent years, with more concrete developments being apparent initially in integration and currently, inclusive education. The National Policy on Special Educational Needs (RGoBMoE, 2012a) identifies the need for an accessible learning environment and additional support services for children with identified special needs, including "trained teachers, teaching approaches, equipment and care within or outside a regular classroom" (p. 6).

VanBalkom and Sherman (2010) indicated that teacher education in Bhutan is in need of significant reform, a view supported by Wangchuck et al. (n.d.), who confirm that early childhood educators need more training generally. In relation to inclusive education, Lham (2013) identifies that Bhutanese teachers believe their classes are too large and feel that they have insufficient knowledge, insufficient training and insufficient resources. Zangmo (n.d.) suggests that teachers are hampered in their work with CWD because of inadequate Braille and other specialist resources and weak IT skills.

Chhetri (2015) confirms many of Lham's (2013) findings. However, most of the teachers in Chhetri's study indicated that although they found it difficult to put their knowledge about inclusive education into practice, they had good theoretical understanding (Chhetri, 2015). Chhetri's teachers were also concerned about what they regarded as weak public understanding of education for children with disabilities, including lack of inclusion policies in schools, academic standards and their own professional development. In respect to the engagement of CWD in education, Pinnock (2013) also identifies the need for Bhutanese teachers to have more access to professional development in inclusive education, particularly regarding learner-centred teaching.

Nevertheless, UNICEF (2013a) identifies that the trajectory for improving the quality of inclusive education in Bhutan appears promising. RGoBMoE (2014, p. 18) noted that by 2014, there were two SEN centres and six integrated schools where 255 teachers support 366 children with SEN. UNICEF (2013a) suggested that these, together with SEN specialist teacher training courses, give teachers access to expertise about

disability and special educational needs. Furthermore, in 2014, a conference organized by the RKB Ministry of Health, RENEW, UNICEF and WHO focused on mental health issues for CWD (UNICEF, 2014) and the National Institute of Visually Impaired as well as a new NGO address some the needs of at least some disabled people in Bhutan (Zangmo, n.d.).

2.6.2 Attitudes

This section of the literature focused on the attitudes of parents, professionals, community members, policy-makers and NGOs in Bhutan. Some general points on attitudes towards CWD emerged from the literature and these are addressed first. Bhutan's religious and cultural history affects the attitudes of its people: this is manifest on the one hand by compassion as a national characteristic (Brooks, 2011); Schuelka (2015) noting that such compassion often means that parents of CWD "pamper" their children to the extent that they do not help them to learn life skills (p. 825).

On the other hand, Bhutan's religious and cultural history has resulted in a widespread belief in karma – "a wrong or base behaviour that is expected to negatively affect the state of one's reincarnated soul" (Metz, 2014, p. 224). UNICEF (n.d.) notes that this view of past karma translates to social norms, which result in CWD being regarded as unproductive and not worthy of equal treatment. The adoption of happiness as the aim for development has emerged in this religious and cultural context in Bhutan (Alkire, 2015; Ura et al., 2012). UNICEF et al. (2012) note that CWD and SEN in Bhutan are "often marginalized"; it advocates the need for stakeholders to ensure that these children "…have equal access to basic services such as education, health care and social protection" (p. i).

References to parents in Bhutan's annual education report diminished between 2009 and 2015 (RGoBMoE, 2009; 2014); nonetheless communication between parents and formal education institutions is viewed as important by the Bhutan government (RGoBMoE, 2014). The inclusion of parents of CWD alongside policy-makers, government leaders, legislators, politicians, educationists and teachers in a regional seminar focused on inclusive education run by UNICEF and the Paro College of Education in 2013 (UNICEF, 2013b) suggests that parents of CWD are valued in Bhutan by professionals whose work concerns CWD.

Chhetri (2015) found that many parents in rural villages do not regard education as important for their CWD, principally because they believe that their children cannot undertake tasks for themselves and will not be productive when they grow to adulthood. In contrast, when Thuji (2013) researched attitudes towards the role of civil society organizations in inclusive education development in Bhutan she noted that all responding parents believed children should be included in education in Bhutan. Chhetri (2015), meanwhile, found that parents of children who do not have disabilities prefer that their own children are not taught in the same class as CWD.

Schuelka (2015) found that medical factors as explanations for disability are beginning to usurp karma amongst the general population; this is particularly the case among parents of CWD. Moreover, he found that parents of CWD often believe that a medical cure can be found for their child's condition (Schuelka, 2015). Chhetri (2015) identified a conflict in respect of Bhutanese parents of CWD: many believe that the education of their child with disabilities is the school's responsibility but others regularly volunteer at their children's inclusive schools to support both the learning and personal needs of their child.

Thuji (2013) found that all responding teachers in her research, which focused on attitudes to the role of civil society organizations in inclusive education development in Bhutan, believed that CWD should be

included in the education system. However, Chhetri (2015) indicated that teachers in Bhutan "are greatly concerned about the acceptance of students with Special Educational Needs" (p. ii). Equally, Lham (2013) found that teachers believed that children with communication difficulties were less suited to inclusive classrooms than children with some other disabilities or SENs. A study by Solomon and Dorji (2009) investigated the attitudes of doctors and nurses to people with disabilities and suggested that "Bhutanese doctors and nurses appear to hold less positive attitudes toward persons with disabilities than their counterparts from western countries" (p. 32).

'Community vitality' is a key domain within Bhutan's Gross National Happiness Index (Ura et al., 2012), indicating that the country as a whole values community: 50–60 per cent of Bhutanese people enjoy 'sufficiency' in community relationships (Ura et al., 2012). The powerful influence of Buddhism within Bhutanese communities (Brooks, 2011) underpins Pinnock's finding (2013) that social attitudes regarding disability in Bhutan often mean that CWD do not go outside their homes. Schuelka (2015) notes that disability is regarded as a 'bad omen', so that people with moderate to severe disabilities, such as autism or cerebral palsy, are usually not visible in the community. UNICEF (2013a) observes that members of the community are reticent about getting involved in school life because they believe teachers should have responsibility for learning and teaching.

Nevertheless, in health contexts, McKay & Dorji (2005) advocated that community stakeholders may be particularly well placed to support people with mental disorders. Similarly, UNICEF (2013) recommended that Bhutan should continue to develop its education provision for CWD by drawing on extant community support networks. Nevertheless, Schuelka (2015) found some negative attitudes among Bhutanese communities towards people, including CWD. He noted disabled people were being abused with derogatory name calling in their communities; for example, the term *'tsagay'*, which translated into either 'my stupid little one' or 'retarded', although it can be used as a term of affection. Schuelka (2015) also found a readiness among Bhutanese people to mock physical differences in others, which his respondents stated were "quite emotionally damaging" (p. 826).

In Bhutan, since 2008, key national government policies have been influenced by the Gross National Happiness Commission, 2008 (Givel, 2015), which frames policy according to cultural and environmental preservation, economic equity and sustainability, and clean and transparent governance (Walcott, 2011). Within this context, Schuelka (2015) notes that some organized attempts are gathering momentum to shift community attitudes and perceptions concerning people with disabilities.

Emerging from the work of the Commission, the position of national policy-makers in Bhutan regarding CWD appears oriented to inclusion. This, according to UNICEF (2013b), is highlighted in the RGoB's 11th Five-Year Plan, alongside self-reliance. RGoBMoE (2014) seeks:

> *…to provide access to general education in regular schools for all CWD and special needs which includes physical, mental and other types of impairment. The Royal Government thus seeks to maintain an inclusive approach to improve educational access and meet the special needs of those with physical disabilities and learning difficulties* (p. 18).

National policy has so far tended to result in integration and specialist provision, rather than inclusion (UNICEF, 2013a, p. 52). National policy attempts to engage with inclusion have yet to translate to local policy and practice (Chhetri, 2015) and to that end, a workshop in Paro in 2013 attempted to link policy makers to practitioners to reify inclusive education in Bhutan (UNICEF, 2013a). Nevertheless, there seems to be an assumption among even national policy-makers in Bhutan that disabled adults will not work: in

the *Bhutan Living Standards* report, the term 'economically inactive' includes all who are "permanently disabled" (National Statistics Bureau, Bhutan & Asian Development Bank, 2012, p. 96). This policy perspective may be one reason for the reluctance of some parents to ensure their CWD attend school (Chhetri, 2015*)*.

As a prominent organization in Bhutan, UNICEF has advocated for CWD by promoting a social model of disability and inclusion (NSB/MoE/MoH/UNICEF, 2012; UNICEF, 2013b). Examples of their work in this area include funding and co-funding scoping projects, reporting on the country's progress and raising awareness about the rights of CWD. UNICEF has highlighted the annual International Day for Persons with Disabilities, which advocates for the rights of CWD and supported the Regional Seminar on Inclusive Education, held in Paro in 2013, which proposed a more inclusive approach to education in Bhutan (UNICEF, 2013b). UNICEF also advises stakeholders, including policy-makers, to give primacy to programmes that may secure equal access for CWD to education, health care and social protection (NSB/MoE/MoH/UNICEF, 2012).

Speaking on behalf of Ability Bhutan, a prominent NGO working to support CWD, Thuji (2013) indicated that NGOs and civil society organizations were regarded by teachers, parents, civil servants, students and people with disabilities as significantly more visible in their advocacy for the rights of people with disabilities in Bhutan than government, the United Nations or corporate organizations.

2.6.3 Practices

There is an absence of consistent concrete evidence that practices aimed at securing recognition of rights for CWD, their inclusion and mainstreaming are emergent in Bhutan, in spite of the proposals within the government's Education Blueprint (2014–2024). For example, reviews of teacher education in Bhutan, VanBalkom and Sherman (2010) make no reference to inclusion. UNICEF (2013a) confirmed that CWD are excluded, contrary to Article 7 of the UNCRPD (UN, 2006) and Young (2009) noted that CWD in Bhutan are excluded from learning that may improve their lives. It subsequently seemed a positive step that a 'division of special education services' was established in 2011 in the Department of School Education (RGoBMoE, 2012a). Furthermore, Pinnock (2013) notes an "increasing demand in Bhutan for children to be educated in mainstream settings". RGoBMoE (2012a) states its commitment to providing high quality SEN services in Bhutan to "…break the cycle of invisibility and deprivation by bringing every child with Special Educational Needs into the forefront of any developmental activity" (p. 6).

Bhutan established its first school for children with visual impairments in 1973 (RGoBMoE, 2012a) and it then planned to open inclusive schools in each dzongkhag (UNICEF, 2013a); by 2014, there were six integrated schools and two special education centres supporting 366 children with special needs in Bhutan (RGoBMoE, 2014). UNICEF (2013a) highlighted two schools that are educating CWD. Drugkyel is a mainstream school with a unit for children with hearing impairments where teaching is segregated, and although Changangka Lower Secondary School has a resource centre for children with severe disabilities, it has adopted inclusive practices for children with mild disabilities. It has been noted that its large class sizes and limited classroom space present challenges for such work (UNICEF, 2013a). Gordon (2013) reported that she felt "powerless and stunned" following a discussion with a school principal in Bhutan who observed:

> *Bhutan is way behind in being able to identify and assist youth with basic learning problems. Any help in this area would be most welcome. We need strategies to work with the learning*

disabled; they are left behind. Teachers lack the skills and with forty to fifty students in the class, it is impossible to attend to them (p. 297).

Early assessment and intervention for CWD are new practices for Bhutan, yet Pinnock (2013) noted that "opportunities to address disability in the early years must be taken". There is a view, highlighted by UNICEF (n.d.) that early detection and identification of children's disabilities is irregular. Mont et al. (2013) also supported early assessment as being important for Bhutan, alongside "parental education and outreach for early child development" (p. 18).

The Two-Stage Child Disability Study (NSB/MoE/MoH/UNICEF, 2012), conducted in 2010–2011, was the first to attempt to "…estimate the prevalence of childhood disabilities among children 2-9 years in Bhutan" (p. 33). Conducted in a country context in which "Little is known about the nature, type and possible causes of childhood disabilities" (p. i), the report was said to be a "significant advance to better understand the extent, nature and degree of disability in Bhutan among children aged 2-9 years" (p. i). The study investigated those factors associated with childhood disabilities and gathered unprecedented data on the prevalence of mild, moderate and severe disabilities, of disabilities according to functional domains and of children presenting with single disabilities and co-morbidity. The study adopted the Rapid Neurodevelopmental Assessment tool, which is now used for training workers across Bhutan's health and education sectors in early assessment and intervention for CWD.

Solomon and Dorji (2009) suggested that gaining a greater understanding of health workers' attitudes towards people with disabilities is likely to facilitate appropriate interventions. Nevertheless, UNICEF (n.d.) notes that a secure system for post-identification referral and follow-up is not yet in place in Bhutan. Early childhood care and development provision is also very new to Bhutan – only in 2013 did the Ministry of Health acknowledge the value of ECCD as an element in an integrated set of services for young children (UNICEF, 2013b). Only around 5 per cent of children aged 3–5 years were in pre-primary school provision (UNICEF, 2013c), though more than 30 new ECCD centres were opened in remote areas of Bhutan by 2014 (UNICEF, 2014).

In relation to access and accessibility for CWD, McKay & Dorji (2005) noted the need for facilities in urban areas to support "mentally retarded" children (p. 623). Zangmo (n.d.) meanwhile noted some particular challenges for those living with disabilities in rural areas of Bhutan: the country is mountainous, buildings are not adapted for disabled people, drivers drive too fast making it unsafe for disabled people and footpaths are poor. *Business Bhutan* (2012) reported that two special educators – Pema Chhogyel and Deki Zam – identify the main challenge for disabled people's access in Bhutan as its infrastructure: "…nothing is disabled friendly… ramps should be made available in public services areas like bank, post office, bus station and hospital". Chhetri (2015) supports this position for CWD, arguing for improved IT as well as "…adequate recreational facilities and play equipment for CWD in all common areas, such as children's parks and school play grounds" (p. 99).

In relation to school placement, UNICEF (2013a) stated that in the current situation "There is no clear authority which can be appealed to if a child with disabilities is denied access to school" (p. 44). Equally, UNICEF (2013a) advocates three practical approaches to support CWD to gain access to education. The first is the adoption of a 'School Improvement Plan approach' – a way to engage all stakeholders in finding ways to promote participation and engagement of CWD. The second is the use of distance learning techniques, though this is unlikely to maximize social inclusion, and the third is assessment support in the form of Braille and large print documents as well as providing additional time. Gordon (2013) found that

parents in Bhutan are desperate for improved provision for their CWD. On visiting a school for the deaf she noted that:

> *Parents with children who have other special needs that are unrelated to the deafness plead for them to be allowed to be admitted. This has created an extremely difficult and emotionally wrenching situation for the staff as they turn away children for whom they have no expertise to serve* (p. 297).

Curriculum differentiation and individualization are likely to be challenging for teachers in Bhutanese schools which "…implement 100% national based school curriculum" (Tharchen et al., n.d, p. 82). Schuelka (2015) argues that "Bhutanese schools construct disability through structure, curriculum, and pedagogy" (p. 821), whilst Chhetri (2015) notes that the values in Bhutan's Gross National Happiness agenda have "infused" the school curriculum (p. 2). Tharchen et al. (n.d.) go on to explain that every aspect of curriculum is centrally decided so that teachers have little or no autonomy. However, they found that 83 per cent of teachers believed that the curriculum frequently inhibits children's access to education if they have special educational needs. Pinnock (2013) identifies a 'lack of clarity' on how to secure appropriate practice in schools for CWD, Chhetri (2015) found that teachers wanted training in adapting the curriculum to their students' needs. Zangmo (n.d.) teaches girls with disabilities in a rural area and provides an enhanced curriculum:

> *Besides the Academic session, there are other activities that are taught in the school.*
> *1. ADL. This is one of the important living skill that is taught in the school to make each disabled person independent. We are taught how to cook, housekeeping and to be self-independent at home and outside.*
> *2 Orientation and Mobility training. This is a special training program given to the disabled by using white cane. Various workshops and seminars are being conducted to sensitize the public, create awareness and advocacy* (pp. 1–2).

The literature has somewhat divergent views regarding collaboration between support services for CWD in Bhutan. UNICEF (2013a) suggests that "There are many examples of good, collaborative practice between education stakeholders in Bhutan which can be supportive of the country's inclusive education aspirations" (p. 55) and goes on to describe health workers and the MoE working together to assess CWD. In contrast, Tharchen et al. (n.d.) describes "poor collaborations among the stakeholders" (p. 80). Paradoxically, UNICEF (n.d.) agrees with Tharchen et al. (n.d.), highlighting a lack of coordination across economic, health and education sectors as a "main challenge" to the provision of "quality inclusive education for CWD in Bhutan" (p. 2).

Moreover, UNICEF (2014) notes that the paucity of data and systems around child protection present "a real challenge" (p. 2). In this regard, the Parliament of Bhutan (2011) states that the relevant support services are Dzongkhag (district) child welfare committees and government employees and institutions. In schools, Pinnock (2013*)* noted that "efforts to improve curricula and teaching practice should happen in full collaboration between 'mainstream' teaching bodies and departments, and SEN/inclusion/disability experts", while Chhetri (2015) suggests there is value in professionals working together to develop children's individual education plans. UNICEF (2013a) is clear that "Inclusion needs the broadest, deepest network of support possible" (p. xv).

Pinnock (2013) highlights the importance of stakeholder voices and empowerment supporting CWD in Bhutan: "collaboration and idea sharing are key to changing attitudes and spreading good practice, practitioners need strong involvement in producing guidance". UNICEF (n.d.) lists a wide range of key

stakeholders who are instrumental in promoting equal opportunities for CWD in Bhutan: the Ministries of Education, Health, Works and Human Settlement, the National Commission for Women and Children, civil society organizations, including Draktsho, Ability Bhutan Society, Disabled Persons Association of Bhutan, Bhutan Foundation, religious leaders, parliamentarians, CWD and their families, the media and development partners. UNICEF (2014) outlines ways in which UNICEF has engaged these – and other - stakeholders in its work in 2014.

UNICEF (2014) also notes that national consultations conducted with children and adult stakeholders concerning protection for CWD identified that more advocacy was needed as well as increased awareness about challenges faced by CWD and their families, including discrimination and stigma. Thuji's study (2013) focused on 'The Role of Civil Service Organizations in Inclusive Education Development in Bhutan' to capture a range of stakeholders' voices and provides valuable insights. UNICEF (2013a) praises stakeholders in Bhutan for their "openness and willingness" to work collaboratively and listen to one another to support CWD (p. 55). It highlights the need to engage stakeholders' voices regarding issues concerned with CWD, including the development of an initial teacher education module focused on teaching children with special needs, teacher recruitment and retention, and the appropriateness of the use of English as a teaching medium for children with learning disabilities.

Alongside discussing informal and non-formal education for CWD in Bhutan, this section addresses formal education, albeit briefly, as the review has already touched on it. Tharchen et al. (n.d.) indicated that children's progress to a higher grade is decided as a result of their examination performance; since only a minority of principals and teachers adopt alternative assessment methods for CWD, Tharchen et al. (n.d.) maintain that such a practice raises the likelihood of CWD being excluded from education. Perhaps as a result of this, non-formal education in Bhutan tends to be oriented to adults who have missed out on education as children (Chhetri, 2015); it is differentiated to their needs and includes life skills, such as parenting (Mont et al., 2013; UNICEF, 2013a).

Non-formal education falls within the remit of the Ministry of Education (RGoBMoE, 2012). No literature was evidenced in a search for *informal* education supporting CWD in Bhutan per se and only one source was identified that addressed informal education in Bhutan generically. Lhomon Education (2011) reports on a workshop that considered non-formal as well as informal education and defines informal education as that which takes place "outside schools - informally in families, peer groups, and communities, and through the media, internet, and other means". The report explains that the workshop attendees believed that the Gross National Happiness agenda should include informal education.

The literature illustrates how resources are crucial and can be used to support CWD in Bhutan. Teachers are a key resource for supporting children to learn in schools (Barber and Mourshed, 2007). However, instead of "active and engaged learning and participation" advocated by Chhetri (2015, p. 99), the use of a transmission mode of teaching prevails in the large classes that are characteristic of most Bhutanese schools (VanBalkom and Sherman, 2010); this is likely to hinder some students accessing the curriculum, particularly those with disabilities. However, RGoBMoE has proposed collaboration with the RGoB Ministry of Labour and Human Resources to secure an adequate supply of trained teachers to support inclusion (UNICEF, 2013a); an increase in salary has been introduced to attract good quality candidates to a teaching career that is currently an unpopular option in Bhutan (VanBalkom and Sherman, 2010).

Chhetri (2015) found that Bhutanese teachers are not sufficiently trained to support the learning of students with SEN in either mainstream or special schools. As a consequence, they tend to lack confidence to teach

CWD. Therefore, Chhetri recommends that the MoE Special Education Unit provides training with the aim of giving all teachers and trainee teachers at least a basic grounding in inclusive education and SEN. However, Pinnock (2013) suggests that more knowledgeable teachers may be able to train others. She observed "some strong (inclusive) practice in SEN units and schools, which could be shared and developed in mainstream schools – if mainstream teachers are given time to think about children and be flexible". Chhetri (2015) also advocates the recruitment of teaching assistants and suggests that training parent helpers to assist as support workers in schools might be a viable option in a situation where training facilities are relatively weak.

The two final elements in this Bhutanese section of the review are national regulation and leadership: just one point is made for each. National regulation in Bhutan includes examinations, as discussed above. Aligning with this is an outcome focused model, UNICEF (2013a) identifies a tendency to rank schools, but warns against this practice since it argues that it "can work against inclusion" (p. 55). UNICEF (2013a) has also identified the need to 'sensitize' school principals to inclusive education.

2.7 Summary: KAP in literature concerning CWD in Bhutan

The picture concerning knowledge about CWD in Bhutan reveals that the country's policy is generally committed to a social model of disability and respects the rights of CWD by adopting inclusive education. Currently, however, in practice, CWD often remain excluded from education and from wider community participation, for a variety of reasons.

Concerning attitudes to CWD in Bhutan, the literature indicates that the country is in transition. Where CWD have been hidden from society in the past, more of them are now going to school and are more visible socially. Whilst segregation of CWD remains common, integration is currently rare and inclusion even more so; yet there appears to be strong policy commitment to inclusion, encouraged by UNICEF, and attempts have been made in recent years to translate policy into practice.
In recent years, Bhutan has made discernible progress in its practices oriented to supporting CWD; the literature indicates that there are particular challenges to be met in further developing inclusive orientations for CWD and that these are apparent in respect of knowledge acquisition, attitude formation and ground-level practice.

2.8 Conclusion

The purposive scoping attempted here suggests that, with regard to knowledge, attitudes and practices, the following features characterize the contemporary landscape for CWD:

1. There are some notable parallels between Bhutan, South Asia and the remainder of the international literature in respect of KAP themes.
2. The literature is layered in respect of its coverage of inclusion of CWD: the international literature is abundant, though mainly concentrated in particular geographical regions; similarly, that from South Asia is relatively confined to a restricted number of national locations and is much less widespread; and coverage in Bhutan is at a very early stage in its development.
3. In the cases of South Asia and Bhutan, there is a tendency to rely upon reports and other documentation derived as a result of the actions of international agencies, charities or NGOs. This

is less common in the case of literature from other international settings.

4. In all three groups, there has been an opportunity to gather evidence to indicate support for the original keyword analysis and its mapping of KAP for CWD against a set of search terms – this is apparent in each literature grouping.
5. There is a broad correlation between the types of challenges facing educational systems at a global level. However, this literature scoping highlights those issues encountered by countries with low or lower-middle GDPs, as well as those settings that face particular environmental, cultural or physical challenges.
6. Those countries with low or lower-middle GDP have a much shorter history of attempting to address the needs of CWD and are likely to rely on adapting models of inclusive practice drawn from those national settings with a longer-term tradition of development.
7. Even so, an 'inclusive approach' to CWD at a worldwide level is still relatively new, having emerged in the late 20th century as the preferred approach to securing equal and sustainable involvement of CWD in educational, social, cultural and economic processes.

Given that there is a broad continuity between the characteristics of KAP for CWD across the three literature groupings used in this review, the use of appropriately adapted interventions to support KAP in Bhutan is likely to offer resources by which the lived-experience of CWD might best be enhanced.

APPENDIX 9: QUANTITATIVE DATA TABLES

Table 1. Location of households surveyed by dzongkhag

Dzongkhag	Gewog	No.	%
Bumthang	Urban: town (n=20)	40	6.9
	Rural: Chumney (n=20)		
Chukha	Urban: town (n=40)	98	17.0
	Rural: Bongo (n=19)		
	Rural: Chapcha (n=19)		
	Rural: Phuntsholing (n=20)		
Mongar	Urban: town (n=20)	80	13.9
	Rural: Mongar (n=60)		
Pema Gatshel	Urban: town (n=20)	60	10.4
	Rural: Shumar (n=20)		
	Rural: Zobar (n=20)		
Punakha	Urban: town (n=20)	60	10.4
	Rural: Barp (n=20)		
	Rural: Talo (n=20)		
Thimpu	Urban: town (n=58)	78	13.7
	Rural: Geney (n=20)		
Trashigang	Urban: town (n=20)	119	20.7
	Rural: Bidung (n=20)		
	Rural: Kanglung (n=39)		
	Rural: Khaling (n=20)		
	Rural: Lumang (n=20)		
Tsirang	Rural: Mendrelgang (n=20)	20	3.5
Zhemgang	Rural: Trong (n=20)	20	3.5
TOTAL		**575**	**100**

Table 2. Respondents by sex

Sex	No.	%
Male	212	36.9
Female	363	63.1
Total	**575**	**100**

Table 3. Respondents by religion

Religion	No.	%
Buddhist	556	96.7
Hindu	17	3.0
Christian	1	0.1
None	1	0.1
Total	**575**	**100**

Table 4. Respondents by age

Age (years)	No.	%
Under 20	1	0.1
20–29	83	14.4
30–39	170	29.6
40–49	124	21.6
50–59	115	20.0
60–69	49	8.5
70–79	23	4.0
80 and over	10	1.7
Total	**575**	**100**

Table 5. Respondents: years in education

Years	No.	%
No formal education	296	51.6
1–3	80	13.9
4–6	45	7.8
7–9	31	5.4
10–12	50	8.7
13–15	32	5.6
16–20	66	11.5
Over 20	3	0.5
Total	**575**	**100**

Table 6. Respondents: education by type

Type of education	Males	Females	Total	%
Primary	29	40	69	12.0
Lower secondary	7	10	17	3.0
Middle secondary	17	25	42	7.3
Higher secondary	14	18	32	5.6
Diploma	6	2	8	1.4
Bachelor's degree	15	11	26	4.5
Postgraduate degree	8	2	10	1.7
Religious education (monastic order/nunnery)	15	1	16	2.8
Home schooling	7	0	7	1.2
No formal education	94	254	348	60.5
Total	**212**	**363**	**575**	**100**

Table 7. Respondents' marital status

Marital status	No.	%
Never married	21	3.6
Currently married	457	79.5
Separated	8	1.4
Divorced	36	6.3
Widowed	52	9.0
Living together	1	0.1
Total	**575**	**100**

Table 8. Respondents' work status

Work status	No.	%
Skilled agricultural, forestry or fishery (including farming)	184	32.0
Housewife	140	24.3
Self-employed	105	18.2
Professional	63	10.9
Service/sales	34	5.9
Military	12	2.1
Technical	10	1.7
Retired	8	1.4
Monk/other religious	6	1.0
Cook	4	0.7
Unemployed	3	0.5
Carer	2	0.3
Other (Tshogpa)	2	0.3
Craft	1	0.1
Manual	1	0.1
Total	**575**	**100**

Table 9. Household income from gross salary/wages

Ngultrum	No.	%
Less than 100,000	285	49.6
100,000 – 199,000	145	25.2
200,000 – 299,000	64	11.1
300,000 – 499,000	46	8.0
500,000 – 999,000	23	4.0
1,000,000 or above	12	2.1
Total	**575**	**100**

Table 10. Household income from sale of agricultural, livestock and forestry products

Ngultrum	No.	%
0	268	46.6
Less than 10,000	35	6.1
10,000 – 19,999	67	11.7
20,000 – 29,999	42	7.3
30,000 – 49,999	43	7.5
50,000 – 69,999	48	8.3
70,000 – 99,999	27	4.7
100,000 – 199,999	32	5.6
200,000 and above	13	2.3
Total	**575**	**100**

Table 11. Household income from non-agricultural activities

Ngultrum	No.	%
0	401	69.6
Less than 10,000	9	1.6
10,000 – 19,999	13	2.3
20,000 – 29,999	21	3.6
30,000 – 49,999	24	4.2
50,000 – 69,999	30	5.2
70,000 – 99,999	17	3.0
100,000 – 199,999	31	5.4
200,000 and above	29	5.0
Total	**575**	**100**

Table 12. Age of CWD in households

Age range (years)	No.
Under 5	5
5–8	3
9–12	4
13 and over	4
Did not indicate	1
Total	**17**

Table 13. CWD by areas of difficulty

Area of difficulty	No.
Difficulty seeing even if wearing glasses	2
Difficulty hearing even if using hearing aid	6
Difficulty walking or climbing stairs	3
Difficulty remembering or concentrating	4
Difficulty with self-care	5
Difficulty communicating	11
Difficulties in multiple areas (2 or more)	10

Table 14. Where does the child with a disability go to school?

Setting	No.
Local school	7
Special school	1
ECCD centre	2
Does not go to school	7
Total	**17**

Table 15. What do you think this child will be doing at the age of 18?

What will child be doing?	No.
Living in the family home, not working	7
Living in the family, working	4
Living somewhere else, independently	0
Living somewhere else, with support	0
Studying	5
Other	1

Table 16. Statements regarding what comprises a disability: whole dataset (n=575)

Statement	No.	%
A person/child who has a total loss of vision has a disability	544	94.6
A person/child who has low vision and requires glasses has a disability	290	50.4
A person/child who has a total loss of hearing has a disability	537	93.4
A person/child who has poor hearing and requires hearing aids has a disability	369	64.2
A person/child who needs to use a wheelchair has a disability	540	93.9
A person/child who needs to use a walking aid (such as a stick) has a disability	447	77.7
A person/child who has a condition that limits the use of their hands has a disability	500	87.0
A person/child who has difficulties with learning at the same pace as others has a disability	297	51.7

Table 17. Statements regarding what comprises a disability; comparison between respondents with and without CWD

	Families without CWD (n=558)		Families with disabilities (n=17)		Chi-square	Significance
Statement	No.	%	No.	%		
A person/child who has a total loss of vision has a disability	529	94.8	15	88.2	1.40 (df=1)	.25, not significant
A person/child who has low vision and requires glasses has a disability	282	50.5	8	47.1	0.08 (df=1)	.80, not significant
A person/child who has a total loss of hearing has a disability	521	93.4	16	94.1	0.01 (df=1)	.90, not significant
A person/child who has poor hearing and requires hearing aids has a disability	358	64.2	11	64.7	0.00 (df=1)	.995, not significant
A person/child who needs to use a wheelchair has a disability	524	93.9	16	94.1	0.00 (df=1)	.995, not significant

A person/child who needs to use a walking aid (such as a stick) has a disability	433	77.6	14	82.4	0.22 (df=1)	.70, not significant
A person/child who has a condition that limits the use of their hands has a disability	485	86.9	15	88.2	0.03 (df=1)	.90, not significant
A person/child who has difficulties with learning at the same pace as others has a disability	285	51.1	12	70.6	2.52 (df=1)	.20, not significant

Table 18. Where do all respondents obtain information about disability? (n=575)

Source of information	No.	%
Television	466	81.0
Friends	299	52.0
Neighbours	243	42.3
Family	214	37.2
Radio	204	35.5
Newspapers	72	12.5
Government officials	63	11.0
Other sources	25	4.3

Table 19. Where do families with CWD obtain information about disability (n=17)

Source of information	No.	%
Television	14	82.4
Radio	7	41.1
Family	5	29.4
Friends	4	23.5
Neighbours	4	23.5
Newspapers	2	11.8
Other sources	2	11.8
Government officials	0	0

Table 20. Responses of whole sample regarding society and support [8-point scale] (n=575)

		Strongly agree		Agree		Slightly agree		Neither agree nor disagree		Slightly disagree		Disagree		Strongly disagree		Don't know	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
4.1a	People in the local community have a positive attitude towards CWD.	172	29.9	211	36.7	88	15.3	36	6.3	16	2.8	25	4.3	20	3.5	7	1.2
4.1b	CWD are treated fairly in society.	145	25.2	199	34.6	103	17.9	24	4.2	41	7.1	38	6.6	14	2.4	11	1.9
4.1c	Attitudes towards CWD are better than they were 10 years ago.	244	42.4	217	37.7	54	9.4	32	5.6	3	0.5	10	1.7	0	0	15	2.6
4.1d	Life is better for CWD and their families than it was 10 years ago.	203	35.3	236	41.0	63	11.0	44	7.7	1	0.2	14	2.4	1	0.2	13	2.3
4.1e	CWD and their families need extra support.	348	60.5	205	35.7	11	1.9	4	0.7	2	0.3	1	0.2	4	0.7	1	0.2
4.1f	The state provides adequate benefits for CWD.	190	33.0	245	42.6	64	11.1	21	3.6	13	2.3	24	4.2	5	0.9	13	2.3

Table 21. Responses of whole sample regarding society and support [simplified] (n=575)

		Agree		Neither agree nor disagree		Disagree		Don't know	
		No.	%	No.	%	No.	%	No.	%
4.1a	People in the local community have a positive attitude towards CWD.	471	81.9	36	6.3	61	10.6	7	1.2
4.1b	CWD are treated fairly in society.	447	77.7	24	4.2	93	16.1	11	1.9
4.1c	Attitudes towards CWD are better than they were 10 years ago.	515	89.6	32	5.6	13	2.3	15	2.6

4.1d	Life is better for CWD and their families than it was 10 years ago.	502	87.3	44	7.6	16	2.8	13	2.3
4.1e	CWD and their families need extra support.	564	98.1	4	0.7	7	1.2	0	0
4.1f	The state provides adequate benefits for CWD.	499	86.8	21	3.6	42	7.3	13	2.3

Table 22. Comparison between families with and without CWD:
4.1.a. People in the local community have a positive attitude towards children with disabilities

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	11	64.7	460	82.4
Neither agree nor disagree	2	11.8	34	6.1
Disagree	3	17.6	58	10.4
Don't know	0	0	7	1.3

ChiSq. = 2.15 (df=3), p = .70: not significant

Table 23. Comparison between families with and without CWD:
4.1.b. CWD are treated fairly in society

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	10	58.8	437	78.3
Neither agree nor disagree	1	5.9	23	4.1
Disagree	5	29.4	88	15.8
Don't know	1	5.9	10	1.8

ChiSq. = 4.27 (df=3), p = .25: not significant

Table 24. Comparison between families with and without CWD:
4.1.c. Attitudes towards CWD are better than they were 10 years ago

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	16	94.1	499	89.4
Neither agree nor disagree	1	5.9	31	5.6
Disagree	0	0	13	2.3
Don't know	0	0	15	2.7

ChiSq. = 0.90 (df=3), p = .90: not significant

Table 25. Comparison between families with and without CWD:
4.1.d. Life is better for CWD and their families than it was 10 years ago

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	14	82.4	488	87.5
Neither agree nor disagree	3	17.6	41	7.3
Disagree	0	0	16	2.9
Don't know	0	0	13	2.3

ChiSq. = 3.22 (df=3), p = .50: not significant

Table 26. Comparison between families with and without CWD:
4.1.e. CWD and their families need extra support

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	17	100	547	98.0
Neither agree nor disagree	0	0	4	0.7
Disagree	0	0	7	1.3
Don't know	0	0	0	0

ChiSq. = 0.34 (df=2), p = .90: not significant

Table 27. Comparison between families with and without CWD:
4.1.f. The state provides adequate benefits for CWD

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	10	58.8	489	87.6
Neither agree nor disagree	1	5.9	20	3.6
Disagree	5	29.4	37	6.6
Don't know	1	5.9	12	2.2

ChiSq. = 14.55 (df=3), p = significant at .01

Table 28. Responses of whole sample regarding personal attitudes towards disability [8-point scale] (n=575)

		Strongly agree		Agree		Slightly agree		Neither agree nor disagree		Slightly disagree		Disagree		Strongly disagree		Don't know	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
4.2a	I would be happy to have a family with a child with disabilities living next door to me	116	20.2	126	21.9	53	9.2	25	4.3	26	4.5	99	17.2	121	21.0	9	1.6
4.2b	I would be happy to have a child with disabilities attending the same class as my child	158	27.5	199	34.6	50	8.7	8	1.4	26	4.5	84	14.6	47	8.2	3	0.5
4.2c	In the future, I would be happy for my child to marry a person with disabilities	95	16.5	139	24.2	79	13.7	55	9.6	23	4.0	72	12.5	96	16.7	16	2.8
4.2d	Children's disabilities are the result of past deeds	340	59.1	110	19.1	26	4.5	24	4.3	3	0.5	21	3.7	45	7.8	6	1.0
4.2e	CWD cannot lead as full a life as those without disabilities	81	14.1	130	22.6	105	18.3	55	9.6	44	7.7	99	17.2	47	8.2	14	2.4
4.2f	It is sometimes alright to treat CWD more favourably than other children	226	39.3	248	43.1	44	7.7	18	3.1	7	1.2	23	4.0	8	1.4	1	0.2

Table 29. Responses of whole sample regarding personal attitudes towards disability [simplified] (n=575)

		Agree		Neither agree nor disagree		Disagree		Don't know	
		No.	%	No.	%	No.	%	No.	%
4.2a	I would be happy to have a family with a child with disabilities living next door to me	295	51.3	25	4.3	246	42.8	9	1.6
4.2b	I would be happy to have a child with disabilities attending the same class as my child	407	70.1	8	1.4	157	27.3	3	0.5
4.2c	In the future, I would be happy for my child to marry a person with disabilities	313	54.4	55	9.6	191	33.2	16	2.8
4.2d	Children's disabilities are the result of past deeds	476	82.8	24	4.2	69	12.0	6	1.0
4.2e	CWD cannot lead as full a life as those without disabilities	316	55.0	55	9.6	190	33.0	14	2.4
4.2f	It is sometimes alright to treat CWD more favourably than other children	518	90.1	18	3.1	38	6.6	1	0.2

Table 30. Comparison between families with and without CWD:
4.2.a. I would be happy to have a family with a child with disabilities living next door to me

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	7	41.2	288	51.6
Neither agree nor disagree	2	11.8	23	4.1
Disagree	8	47.1	238	42.7
Don't know	0	0	9	1.6

ChiSq. = 2.92 (df=3), p = .50: not significant

Table 31. Comparison between families with and without CWD:
4.2.b. I would be happy to have a child with disabilities attending the same class as my child

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	12	70.6	395	70.8
Neither agree nor disagree	0	0	8	1.4
Disagree	5	29.4	152	27.2
Don't know	0	0	3	0.5

ChiSq. = 0.36 (df=3), p = .95: not significant

Table 32. Comparison between families with and without CWD:
4.2.c. In the future, I would be happy for my child to marry a person with disabilities

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	10	58.9	303	54.3
Neither agree nor disagree	3	17.6	52	9.3
Disagree	4	23.5	187	33.5
Don't know	0	0	16	2.9

ChiSq. = 2.24 (df=3), p = .70: not significant

Table 33. Comparison between families with and without CWD:
4.2.d. Children's disabilities are the result of past deeds

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	14	82.4	462	82.8
Neither agree nor disagree	1	5.9	23	4.1
Disagree	2	11.8	67	12.0
Don't know	0	0	6	1.1

ChiSq. = 0.31 (df=3), p = .975: not significant

Table 34. Comparison between families with and without CWD:
4.2.e. CWD cannot lead as full a life as those without disabilities

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	11	64.7	305	54.7
Neither agree nor disagree	1	5.9	54	9.7
Disagree	5	29.4	185	33.2
Don't know	0	0	14	2.5

ChiSq. = 1.05 (df=3), p = .80: not significant

Table 35. Comparison between families with and without CWD:
4.2.f. It is sometimes alright to treat CWD more favourably than other children

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	17	100	501	89.8
Neither agree nor disagree	0	0	18	3.2
Disagree	0	0	38	6.8
Don't know	0	0	1	0

ChiSq. = 1.93 (df=3), p = .70: not significant

Table 36. Responses of whole sample regarding contribution made by CWD [8-point scale] (n=575)

		Strongly agree		Agree		Slightly agree		Neither agree nor disagree		Slightly disagree		Disagree		Strongly disagree		Don't know	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
4.3a	CWD make a positive contribution to the family	74	12.9	189	32.9	116	20.2	67	11.7	18	3.1	50	8.7	43	7.5	18	3.1
4.3b	CWD contribute to society	61	10.6	184	32.0	104	18.1	64	11.1	18	3.1	71	12.3	49	8.5	24	4.2

Table 37. Responses of whole sample regarding contribution made by CWD [simplified] (n=575)

		Agree		Neither agree nor disagree		Disagree		Don't know	
		No.	%	No.	%	No.	%	No.	%
4.3a	CWD make a positive contribution to the family	379	65.9	67	11.7	111	19.3	18	3.1
4.3b	CWD contribute to society	349	60.7	64	11.1	138	24.0	24	4.2

Table 38. Comparison between families with and without CWD:
4.3.a. CWD make a positive contribution to the family

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	11	64.7	368	65.9
Neither agree nor disagree	3	17.6	64	11.5
Disagree	2	11.8	109	19.5
Don't know	1	5.9	17	3.0

ChiSq. = 1.48 (df=3), p = .70: not significant

Table 39. Comparison between families with and without CWD:
4.3.b. CWD contribute to society

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	11	64.7	338	60.6
Neither agree nor disagree	3	17.6	61	10.9
Disagree	2	11.8	136	24.4
Don't know	1	5.9	23	4.1

ChiSq. = 1.93 (df=3), p = .70: not significant

Table 40. Responses of whole sample regarding the education and inclusion of CWD [8-point scale] (n=575)

		Strongly agree		Agree		Slightly agree		Neither agree nor disagree		Slightly disagree		Disagree		Strongly disagree		Don't know	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
4.4a	All children should go to school, regardless of their needs or any disability	346	60.2	182	31.7	33	5.7	6	1.0	3	0.5	5	0.9	0	0	0	0
4.4b	CWD benefit from attending school	329	57.2	220	38.3	18	3.1	4	0.7	1	0.2	2	0.3	0	0	0	0
4.4c	CWD should attend the same schools as other children	56	9.7	154	26.8	77	13.4	12	2.1	31	5.4	104	18.1	138	24.0	3	0.5
4.4d	All CWD should attend special schools and not general mainstream classes.	341	59.3	146	25.4	23	4.0	7	1.2	8	1.4	26	4.5	19	3.3	5	0.9
4.4e	Schools are better prepared/ equipped to deal with CWD than they were 10 years ago	225	39.1	239	41.6	55	9.6	20	3.5	7	1.2	8	1.4	3	0.5	18	3.1
4.4f	CWD should be encouraged and supported to play with other non-CWD	153	26.6	250	43.5	51	0.9	18	3.1	16	2.8	48	8.3	34	5.9	5	0.9
4.4g	When CWD leave school, they have the same employment opportunities as their peers	228	39.7	124	21.6	84	14.6	24	4.2	38	6.6	57	9.9	10	1.8	10	1.8

Table 41. Responses of whole sample regarding the education and inclusion of CWD [simplified] (n=575)

		Agree		Neither agree nor disagree		Disagree		Don't know	
		No.	%	No.	%	No.	%	No.	%
4.4a	All children should go to school, regardless of their needs or any disability	561	97.6	6	1.0	8	1.4	0	0
4.4b	CWD benefit from attending school	567	98.6	4	0.7	3	5.2	0	0
4.4c	CWD should attend the same schools as other children	287	49.9	12	2.1	273	47.5	3	0.5
4.4d	All CWD should attend special schools and not general mainstream classes	510	88.7	7	1.2	53	9.2	5	0.9
4.4e	Schools are better prepared/equipped to deal with CWD than they were 10 years ago	519	90.3	20	3.5	18	3.1	18	3.1
4.4f	CWD should be encouraged and supported to play with other non-CWD	454	79.0	18	3.1	98	17.0	5	0.9
4.4g	When CWD leave school, they have the same employment opportunities as their peers	436	75.8	24	4.2	105	18.3	10	1.8

Table 42. Comparison between families with and without CWD:
4.4.a. All children should go to school, regardless of their needs or any disability

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	16	94.1	545	97.7
Neither agree nor disagree	1	5.9	5	0.9
Disagree	0	0	8	1.4
Don't know	0	0	0	0

ChiSq. = 4.20 (df=2), p = .20: not significant

Table 43. Comparison between families with and without CWD:
4.4.b. CWD benefit from attending school

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	17	100	550	98.6
Neither agree nor disagree	0	0	4	0.7
Disagree	0	0	3	0.5
Don't know	0	0	0	0

ChiSq. = 0.22 (df=2), p = .90: not significant

Table 44. Comparison between families with and without CWD:
4.4.c. CWD should attend the same schools as other children

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	12	70.6	275	49.3
Neither agree nor disagree	0	0	12	2.2
Disagree	5	29.4	268	48.0
Don't know	0	0	3	0.5

ChiSq. = 3.16 (df=3), p = .50: not significant

Table 45. Comparison between families with and without CWD:
4.4.d. All CWD should attend special schools and not general mainstream classes

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	16	94.1	494	88.5
Neither agree nor disagree	0	0	7	1.3
Disagree	1	5.9	52	9.3
Don't know	0	0	5	0.9

ChiSq. = 0.64 (df=3), p = .90: not significant

Table 46. Comparison between families with and without CWD:
4.4.e. Schools are better prepared/equipped to deal with CWD
than they were 10 years ago

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	15	88.2	504	90.3
Neither agree nor disagree	0	0	20	3.6
Disagree	0	0	18	3.2
Don't know	2	11.8	16	2.9

ChiSq. = 5.35 (df=3), p = .20: not significant

Table 47. Comparison between families with and without CWD:
4.4.f. CWD should be encouraged and supported to play with other non-CWD

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	17	100	437	78.3
Neither agree nor disagree	0	0	18	3.2
Disagree	0	0	98	17.6
Don't know	0	0	5	0.9

ChiSq. = 4.67 (df=3), p = .20: not significant

Table 48. Comparison between families with and without CWD:
4.4.g. When CWD leave school, they have the same employment opportunities as their peers

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	13	76.5	423	75.8
Neither agree nor disagree	0	0	24	4.3
Disagree	4	23.5	101	18.1
Don't know	0	0	10	1.8

ChiSq. = 1.30 (df=3), p = .75: not significant

Table 49. Responses of whole sample regarding the protection of CWD [8-point scale] (n=575)

		Strongly agree		Agree		Slightly agree		Neither agree nor disagree		Slightly disagree		Disagree		Strongly disagree		Don't know	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
4.5a	CWD are the subject of jokes or unacceptable or negative comments	27	4.7	75	13.0	80	13.9	30	5.2	41	7.1	140	24.3	178	31.0	4	0.7
4.5b	CWD are more likely to be the victims of bullying	79	13.7	165	28.7	100	17.4	26	4.5	8	1.4	103	17.9	90	15.7	4	0.7
4.5c	CWD are more vulnerable to physical and sexual abuse	83	14.4	160	27.8	76	13.2	42	7.3	15	2.6	103	17.9	79	13.7	17	3.0
4.5d	CWD are more likely to be neglected	48	8.3	96	16.7	116	20.2	24	4.2	29	5.0	126	21.9	133	23.1	3	0.5
4.5e	It is sometimes necessary to leave a child with disabilities in the house alone	10	1.7	30	5.2	36	6.3	15	2.6	14	2.4	192	33.3	274	47.7	4	0.7
4.5f	It is sometimes necessary to punish a child with disabilities for misbehaviour	12	2.1	76	13.2	108	18.8	23	4.0	19	3.3	175	30.4	158	27.5	4	0.7

Table 50. Responses of whole sample regarding the protection of CWD [simplified] (n=575)

		Agree		Neither agree nor disagree		Disagree		Don't know	
		No.	%	No.	%	No.	%	No.	%
4.5a	CWD are the subject of jokes or unacceptable or negative comments	182	31.7	30	5.2	359	62.4	4	0.7
4.5b	CWD are more likely to be the victims of bullying	344	59.8	26	4.5	201	35.0	4	0.7
4.5c	CWD are more vulnerable to physical and sexual abuse	319	55.5	42	7.3	197	34.3	17	3.0
4.5d	CWD are more likely to be neglected	260	45.2	24	4.2	288	50.1	3	0.5
4.5e	It is sometimes necessary to leave a child with disabilities in the house alone	76	13.2	15	2.6	480	83.5	4	0.7
4.5f	It is sometimes necessary to punish a child with disabilities for misbehaviour	196	34.1	23	4.0	352	61.2	4	0.7

Table 51. Comparison between families with and without CWD:
4.5.a. CWD are the subject of jokes or unacceptable or negative comments

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	8	47.1	144	25.8
Neither agree nor disagree	2	11.8	28	5.0
Disagree	7	41.2	352	63.1
Don't know	0	0	4	0.7

ChiSq. = 5.31 (df=3), p = .20: not significant

Table 52. Comparison between families with and without CWD:
4.5.b. CWD are more likely to be the victims of bullying

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	14	82.4	330	59.1
Neither agree nor disagree	0	0	26	4.7
Disagree	3	17.6	198	35.5
Don't know	0	0	4	0.7

ChiSq. = 3.90 (df=3), p = .30: not significant

Table 53. Comparison between families with and without CWD:
4.5.c. CWD are more vulnerable to physical and sexual abuse

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	10	58.8	299	53.6
Neither agree nor disagree	1	0.6	41	7.3
Disagree	5	29.4	192	34.4
Don't know	1	0.6	16	2.9

ChiSq. = 0.74 (df=3), p = .90: not significant

Table 54. Comparison between families with and without CWD:
4.5.d. CWD are more likely to be neglected

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	9	52.9	251	45.0
Neither agree nor disagree	0	0	24	4.3
Disagree	8	47.1	280	50.2
Don't know	0	0	3	0.5

ChiSq. = 1.09 (df=3), p = .80: not significant

Table 55. Comparison between families with and without CWD:
4.5.e. It is sometimes necessary to leave a child with disabilities in the house alone

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	1	5.9	75	13.4
Neither agree nor disagree	0	0	15	2.7
Disagree	16	94.1	464	83.2
Don't know	0	0	4	0.7

ChiSq. = 1.53 (df=3), p = .70: not significant

Table 56. Comparison between families with and without CWD:
4.5.f. It is sometimes necessary to punish a child with disabilities for misbehaviour

	Families with a child with disabilities (n=17)		Families without CWD (n=558)	
	No.	%	No.	%
Agree	8	47.1	188	33.7
Neither agree nor disagree	1	5.9	22	3.9
Disagree	8	47.1	344	61.6
Don't know	0	0	4	0.7

ChiSq. = 1.72 (df=3), p = .70: not significant

Table 57. Comparison between attitudes of male and female respondents

	Factor under consideration	Chi-square	p-value
4.1a	People in the local community have a positive attitude towards CWD	1.11 (df=2)	.70, not significant
4.1b	CWD are treated fairly in society	0.46 (df=3)	.95, not significant
4.1c	Attitudes towards CWD are better than they were 10 years ago	7.73 (df=3)	.10, not significant
4.1d	Life is better for CWD and their families than it was 10 years ago	5.52 (df=3)	.20, not significant
4.1e	CWD and their families need extra support	0.46 (df=2)	.95, not significant
4.1f	The state provides adequate benefits for CWD	5.30 (df=3)	.20, not significant
4.2a	I would be happy to have a family with a child with disabilities living next door to me	1.25 (df=3)	.75, not significant
4.2b	I would be happy to have a child with disabilities attending the same class as my child	5.48 (df=3)	.20, not significant
4.2c	In the future, I would be happy for my child to marry a person with disabilities	5.33 (df=3)	.20, not significant
4.2d	Children's disabilities are the result of past deeds	0.48 (df=3)	.95, not significant
4.2e	CWD cannot lead as full a life as those without disabilities	2.41 (df=3)	.50, not significant
4.2f	It is sometimes alright to treat CWD more favourably than other children	2.70 (df=3)	.50, not significant
4.3a	CWD make a positive contribution to the family	4.80 (df=3)	.20, not significant
4.3b	CWD contribute to society	5.57 (df=3)	.20, not significant
4.4a	All children should go to school, regardless of their needs or any disability	4.06 (df=3)	.30, not significant
4.4b	CWD benefit from attending school	4.74 (df=3)	.20, not significant
4.4c	CWD should attend the same schools as other children	6.57 (df=3)	.10, not significant
4.4d	All CWD should attend special schools and not general mainstream classes	0.45 (df=3)	.95, not significant
4.4e	Schools are better prepared/equipped to deal with CWD than they were 10 years ago	8.40 (df=3)	Significant at .05
4.4f	CWD should be encouraged and supported to play with other non-CWD	1.41 (df=3)	.75, not significant
4.4g	When CWD leave school, they have the same employment opportunities as their peers	0.24 (df=3)	.975, not significant
4.5a	CWD are the subject of jokes or unacceptable or negative comments	1.17 (df=3)	.80, not significant

4.5b	CWD are more likely to be the victims of bullying	3.22 (df=3)	.50, not significant
4.5c	CWD are more vulnerable to physical and sexual abuse	0.52 (df=3)	.95, not significant
4.5d	CWD are more likely to be neglected	5.86 (df=3)	.20, not significant
4.5e	It is sometimes necessary to leave a child with disabilities in the house alone	1.36 (df=3)	.75, not significant
4.5f	It is sometimes necessary to punish a child with disabilities for misbehaviour	3.42 (df=3	.50, not significant

Table 58. 4.4.e. Schools are better prepared/equipped to deal with children with disabilities than they were 10 years ago

	Males (n=212)		Females (n=363)	
	No.	%	No.	%
Agree	191	90.1	328	90.4
Neither agree nor disagree	9	4.2	11	3.0
Disagree	10	4.7	8	2.2
Don't know	2	0.9	16	4.4

ChiSq. = 8.40 (df=3), p = significant at .05

Table 59. Comparison between attitudes of respondents by age

	Factor under consideration	Chi-square	p-value
4.1a	People in the local community have a positive attitude towards CWD	7.72 (df=4)	.20, not significant
4.1b	CWD are treated fairly in society	1.91 (df=6)	.95, not significant
4.1c	Attitudes towards CWD are better than they were 10 years ago	17.56 (df=6)	Significant at .01
4.1d	Life is better for CWD and their families than it was 10 years ago	6.91 (df=6)	.50, not significant
4.1e	CWD and their families need extra support	1.95 (df=4)	.74, not significant
4.1f	The state provides adequate benefits for CWD	3.34 (df=6)	.80, not significant
4.2a	I would be happy to have a family with a child with disabilities living next door to me	12.76 (df=6)	Significant at .05
4.2b	I would be happy to have a child with disabilities attending the same class as my child	8.16 (df=6)	.25, not significant
4.2c	In the future, I would be happy for my child to marry a person with disabilities	10.70 (df=6)	.10, not significant
4.2d	Children's disabilities are the result of past deeds	12.31 (df=6)	.10, not significant
4.2e	CWD cannot lead as full a life as those without disabilities	3.18 (df=6)	.80, not significant

4.2f	It is sometimes alright to treat CWD more favourably than other children	4.43 (df=6)	.70, not significant
4.3a	CWD make a positive contribution to the family	13.55 (df=6)	Significant at .05
4.3b	CWD contribute to society	2.41 (df=6)	.90, not significant
4.4a	All children should go to school, regardless of their needs or any disability	4.01 (df=4)	.50, not significant
4.4b	CWD benefit from attending school	10.18 (df=6)	.20, not significant
4.4c	CWD should attend the same schools as other children	9.08 (df=6)	.20, not significant
4.4d	All CWD should attend special schools and not general mainstream classes	1.94 (df=6)	.95, not significant
4.4e	Schools are better prepared/equipped to deal with CWD than they were 10 years ago	17.14 (df=6)	Significant at .01
4.4f	CWD should be encouraged and supported to play with other non-CWD	11.01 (df=6)	.10, not significant
4.4g	When CWD leave school, they have the same employment opportunities as their peers	6.18 (df=6)	.50, not significant
4.5a	CWD are the subject of jokes or unacceptable or negative comments	16.77 (df=6)	Significant at .02
4.5b	CWD are more likely to be the victims of bullying	24.58 (df=6)	Significant at .001
4.5c	CWD are more vulnerable to physical and sexual abuse	12.95 (df=6)	Significant at .05
4.5d	CWD are more likely to be neglected	6.58 (df=6)	.50, not significant
4.5e	It is sometimes necessary to leave a child with disabilities in the house alone	2.94 (df=6)	.90, not significant
4.5f	It is sometimes necessary to punish a child with disabilities for misbehaviour	6.93 (df=6)	.50, not significant

Table 60. 4.1.c. Attitudes towards CWD are better than they were 10 years ago

	Under 40 years (n=254)		40–59 years (n=239)		60 years and above (n=82)	
	No.	%	No.	%	No.	%
Agree	219	86.2	224	93.7	72	87.8
Neither agree nor disagree	15	5.9	9	3.8	8	9.8
Disagree	9	3.5	6	2.5	1	1.2
Don't know	11	4.3	0	0	1	1.2

ChiSq. = 17.56 (df=6), p = significant at .01

Table 61. 4.2.a. I would be happy to have a family with a child with disabilities living next door to me

	Under 40 years (n=254)		40–59 years (n=239)		60 years and above (n=82)	
	No.	%	No.	%	No.	%
Agree	135	53.1	127	53.1	33	40.2
Neither agree nor disagree	10	3.9	7	2.8	8	9.8
Disagree	103	40.6	102	42.7	41	50.0
Don't know	6	2.4	3	1.3	0	0

ChiSq. = 12.76 (df=6), p = significant at .05

Table 62. 4.3.a. CWD make a positive contribution to the family

	Under 40 years (n=254)		40–59 years (n=239)		60 years and above (n=82)	
	No.	%	No.	%	No.	%
Agree	160	63.0	162	67.8	57	69.5
Neither agree nor disagree	32	12.6	30	12.6	5	6.1
Disagree	49	19.3	44	18.4	20	24.4
Don't know	13	5.1	3	0	0	0

ChiSq. = 13.55 (df=6), significant at .05

Table 63. 4.4.e. Schools are better prepared/equipped to deal with children with disabilities than they were 10 years ago

	Under 40 years (n=254)		40–59 years (n=239)		60 years and above (n=82)	
	No.	%	No.	%	No.	%
Agree	223	87.8	222	92.9	74	90.2
Neither agree nor disagree	11	4.3	2	0.8	7	8.5
Disagree	9	3.5	9	3.8	0	0
Don't know	11	4.3	6	2.5	1	1.2

ChiSq. = 17.14 (df=6), p = significant at .01

Table 64. 4.5.a. CWD are the subject of jokes or unacceptable or negative comments

	Under 40 years (n=254)		40–59 years (n=239)		60 years and above (n=82)	
	No.	%	No.	%	No.	%
Agree	69	27.2	76	31.8	37	45.1
Neither agree nor disagree	16	6.3	7	2.9	7	8.5
Disagree	166	65.4	156	65.3	38	46.3
Don't know	3	1.2	1	0.4	0	0

ChiSq. = 16.77 (df=6), p = significant at .02

Table 65. 4.5.b. CWD are more likely to be the victims of bullying

	Under 40 years (n=254)		40–59 years (n=239)		60 years and above (n=82)	
	No.	%	No.	%	No.	%
Agree	160	63.0	140	58.6	44	53.7
Neither agree nor disagree	6	2.4	8	0.0	12	14.6
Disagree	86	33.9	90	37.7	25	30.5
Don't know	2	0.8	1	0.4	1	0.4

ChiSq. = 24.58 (df=6), p = significant at .001

Table 66. 4.5.c. CWD are more vulnerable to physical and sexual abuse

	Under 40 years (n=254)		40–59 years (n=239)		60 years and above (n=82)	
	No.	%	No.	%	No.	%
Agree	152	59.8	126	52.7	41	50.0
Neither agree nor disagree	17	6.7	14	5.8	11	12.9
Disagree	76	29.9	95	39.7	26	31.7
Don't know	9	3.5	4	1.7	4	4.9

ChiSq. = 12.95 (df=6), p = significant at .05

Table 67. Comparison between attitudes of respondents with no formal education and those educated to degree/postgraduate level

	Factor under consideration	Chi-square	p-value
4.1a	People in the local community have a positive attitude towards CWD	0.69 (df=2)	.75, not significant
4.1b	CWD are treated fairly in society	4.91 (df=3)	.20, not significant
4.1c	Attitudes towards CWD are better than they were 10 years ago	6.31 (df=3)	.10, not significant
4.1d	Life is better for CWD and their families than it was 10 years ago	5.36 (df=3)	.20, not significant
4.1e	CWD and their families need extra support	0.63 (df=2)	.75, not significant
4.1f	The state provides adequate benefits for CWD	7.34 (df=3)	.10, not significant
4.2a	I would be happy to have a family with a child with disabilities living next door to me	21.41 (df=3)	Significant at .001
4.2b	I would be happy to have a child with disabilities attending the same class as my child	8.50 (df=3)	Significant at .05
4.2c	In the future, I would be happy for my child to marry a person with disabilities	27.34 (df=3)	Significant at .001
4.2d	Children's disabilities are the result of past deeds	43.11 (df=3)	Significant at .001
4.2e	CWD cannot lead as full a life as those without disabilities	9.78 (df=3)	Significant at .025

4.2f	It is sometimes alright to treat CWD more favourably than other children	1.84 (df=3)	.70, not significant
4.3a	CWD make a positive contribution to the family	8.53 (df=3)	Significant at .05
4.3b	CWD contribute to society	12.41 (df=3)	Significant at .01
4.4a	All children should go to school, regardless of their needs or any disability	0.98 (df=2)	.70, not significant
4.4b	CWD benefit from attending school	0.74 (df=3)	.90, not significant
4.4c	CWD should attend the same schools as other children	6.73 (df=3)	.10, not significant
4.4d	All CWD should attend special schools and not general mainstream classes	3.08 (df=3)	.5, not significant
4.4e	Schools are better prepared/equipped to deal with CWD than they were 10 years ago	27.67 (df=3)	Significant at .001
4.4f	CWD should be encouraged and supported to play with other non-CWD	12.08 (df=3)	Significant at .01
4.4g	When CWD leave school, they have the same employment opportunities as their peers	1.04 (df=3)	.80, not significant
4.5a	CWD are the subject of jokes or unacceptable or negative comments	1.66 (df=3)	.70, not significant
4.5b	CWD are more likely to be the victims of bullying	2.12 (df=3)	.70, not significant
4.5c	CWD are more vulnerable to physical and sexual abuse	0.14 (df=3)	.99, not significant
4.5d	CWD are more likely to be neglected	7.06 (df=3)	.10, not significant
4.5e	It is sometimes necessary to leave a child with disabilities in the house alone	0.46 (df=3)	.95, not significant
4.5f	It is sometimes necessary to punish a child with disabilities for misbehaviour	0.60 (df=3)	.90, not significant

Table 68. 4.2.a. I would be happy to have a family with a child with disabilities living next door to me

	Respondents without any formal education (n=348)		Respondents educated to degree/postgraduate level (n=36)	
	No.	%	No.	%
Agree	169	48.6	28	77.7
Neither agree nor disagree	15	4.3	0	0
Disagree	162	46.6	6	16.7
Don't know	2	0.6	2	5.6

ChiSq. = 21.41 (df=3), p = significant at .001

Table 69. 4.2.b. I would be happy to have a child with disabilities attending the same class as my child

	Respondents without any formal education (n=348)		Respondents educated to degree/postgraduate level (n=36)	
	No.	%	No.	%
Agree	234	67.2	32	88.9
Neither agree nor disagree	5	1.4	1	2.8
Disagree	108	31.6	3	8.3
Don't know	1	0.3	0	0

ChiSq. = 8.50 (df=3), p = significant at .05

Table 70. 4.2.c. In the future, I would be happy for my child to marry a person with disabilities

	Respondents without any formal education (n=348)		Respondents educated to degree/postgraduate level (n=36)	
	No.	%	No.	%
Agree	182	53.2	17	47.2
Neither agree nor disagree	34	9.8	3	8.3
Disagree	127	36.5	10	27.8
Don't know	5	1.4	6	16.7

ChiSq. = 27.34 (df=3), p = significant at .001

Table 71. 4.2.d. Children's disabilities are the result of past deeds

	Respondents without any formal education (n=348)		Respondents educated to degree/postgraduate level (n=36)	
	No.	%	No.	%
Agree	302	86.8	19	52.8
Neither agree nor disagree	9	2.6	5	13.9
Disagree	37	10.6	10	28.6
Don't know	0	0	2	5.6

ChiSq. = 43.11 (df = 3), p = significant at .001

Table 72. 4.2.e. CWD cannot lead as full a life as those without disabilities

	Respondents without any formal education (n=348)		Respondents educated to degree/postgraduate level (n=36)	
	No.	%	No.	%
Agree	194	55.7	18	50
Neither agree nor disagree	40	11.5	0	0
Disagree	103	29.6	18	50
Don't know	11	3.2	0	0

ChiSq. = 9.78 (df=3), p = significant at .025

Table 73. 4.3.a. CWD make a positive contribution to the family

	Respondents without any formal education (n=348)		Respondents educated to degree/postgraduate level (n=36)	
	No.	%	No.	%
Agree	222	63.8	27	75.0
Neither agree nor disagree	50	14.4	4	11.1
Disagree	68	19.5	2	5.6
Don't know	8	2.3	3	8.3

ChiSq. = 8.53 (df=3), p = significant at .05

Table 74. 4.3.b. CWD contribute to society

	Respondents without any formal education (n=348)		Respondents educated to degree/postgraduate level (n=36)	
	No.	%	No.	%
Agree	192	55.2	30	83.3
Neither agree nor disagree	49	14.1	4	11.1
Disagree	92	26.4	1	2.8
Don't know	15	4.3	1	2.8

ChiSq. = 12.41 (df=3), significant at .01

Table 75. 4.4.e. Schools are better prepared/equipped to deal with children with disabilities than they were 10 years ago

	Respondents without any formal education (n=348)		Respondents educated to degree/postgraduate level (n=36)	
	No.	%	No.	%
Agree	317	91.1	25	69.4
Neither agree nor disagree	11	3.2	4	11.1
Disagree	7	2.0	6	16.7
Don't know	12	3.4	1	2.8

ChiSq. = 27.67 (df=3), p = significant at .001

Table 76. 4.4.f. CWD should be encouraged and supported to play with other non-CWD

	Respondents without any formal education (n=348)		Respondents educated to degree/postgraduate level (n=36)	
	No.	%	No.	%
Agree	269	77.3	30	83.3
Neither agree nor disagree	8	2.3	4	11.1
Disagree	67	19.3	2	5.6
Don't know	4	1.1	0	0

ChiSq. = 12.08 (df=3), p = significant at .01

Table 77. Focus group sample

CWD			
Rural- Khaling	Male = 1	Female = 4	ages 12 to 18
Urban, Gelephu LSS	Male = 2	Female = 3	ages 12 to 18
Total CWD	Male = 3	Female = 7	ages 12 to 18
Children without disabilities			
Urban, Wangdue LSS	Male = 3	Female = 3	ages 12 to 18
Rural Singye Gewog, Sarpang	Male = 3	Female = 3	ages 12 to 18
Total Children without disabilities	Male = 6	Female = 6	ages 12 to 18
Parents of CWD			
Urban, Gelephu LSS	Male = 2	Female = 3	
Rural- Khaling	Male = 5	Female = 0	
Total Parents of CWD	Male = 7	Female = 3	
Parents of children without disability			
Urban, Bajo	Male = 2	Female = 2	
Rural Singye Gewog, Sarpang	Male = 2	Female = 6	
Total Parents of children without disability	Male = 4	Female = 8	
Service providers			
Rural Chiwog in Lhuntse	Male = 3	Female = 1	
Urban, Gelephu LSS	Male = 1	Female = 3	
Total Service providers	Male = 4	Female = 4	
Community and religious leaders			
Urban, Gelephu LSS	Male = 3	Female = 1	
Rural, Rinchengang, Wangdue Phodrang	Male = 3	Female = 1	
Total Community and religious leaders	Male = 6	Female = 2	
Ministries representatives			
Urban, Thimphu	Male = 4	Female = 3	
Total Ministries representatives	Male = 4	Female = 3	
NGOs			
Urban, Thimphu	Male = 4	Female = 0	
Total NGOs	Male = 4	Female = 0	
Total Number of focus groups	N= 12		
Total Number of respondents	Male N= 38	Female N =33	Total N = 71

APPENDIX 10: REFERENCES

This reference list comprises a listing of all material used both in the main report and in the accompanying review of literature.

Ainscow, M., 'Understanding the development of inclusive education systems', *Electronic Journal of Research in Educational Psychology*, no. 7, vol. 3 (3), 2005, pp. 5–20, www.investigacion-psicopedagogica.org/revista/articulos/7/english/Art_7_109.pdf, accessed 26 October 2015.

Al Zyoudi, M., A. Al Sartwai and H. Dodin, 'Attitudes of pre-service teachers towards inclusive education in UAE and Jordan (a comparative study)', *International Journal of Disability, Community and Rehabilitation*, vol. 10, no.1, 2011, www.ijdcr.ca/VOL10_01/articles/alzyoudi.shtml.

Alam, K. J., N. Bari and M. A. Khan, 'Community based rehabilitation practices and alleviation of poverty of people with disabilities in Bangladesh', Workshop on Community-Based Rehabilitation (CBR) and Poverty Alleviation of Persons with Disabilities, 2005, www.dpiap.org/national/pdf/Community_Based_Rehabilitation.pdf, accessed 3 November 2015.

Alkire, S., *Well-being, Happiness, and Public Policy*, The Centre for Bhutan Studies & GNH Research, Thimpu, 2015.

ARACY, 'Inclusive Education for Children with Disability. A review of best evidence in relation to theory and practice', The Australian Research Alliance for Children and Youth, 2015, www.aracy.org.au/publications-resources/command/download_file/id/246/filename/Inclusive_education_for_students_with_disability_-_A_review_of_the_best_evidence_in_relation_to_theory_and_practice.pdf, accessed 19 October, 2015.

Baker-Ericzén, M., M. Mueggenborg and M. Shea, 'Impact of training on child care providers' attitudes and perceived competence toward inclusion: What factors are associated with change', *Early Childhood Special Education*, vol. 28, no. 4, 2009, pp. 196–208.

Barber, M., and M. Mourshed, *How the world's best-performing school systems come out on top*, McKinsey and Company, London, 2007.

Barnes, C., and G. Mercer, eds., *Disability Policy and Practice*: *Applying the Social Model*, The Disability Press, Leeds, 2004.

Beaglehole, R., and R. Bonita, 'The Art of Medicine. Development with values: lessons from Bhutan', *Lancet*, vol. 385, 2015, pp. 848–849.

Birch, J., and B. Johnstone, 'Mainstreaming a new public policy in Education', presented at the Annual Convention of the America Association of School Administrators, Dallas, Texas, 1975.

Biswas-Diener, R., E. Diener, and N. Lyubchik, 'Wellbeing in Bhutan', *International Journal of Wellbeing*, vol. 5, no. 2, 2015, pp. 1–13.

Black, W., and M. Simon, 'Leadership for All Students: Planning for More Inclusive School Practices', *NCPEA International Journal of Educational Leadership Preparation*, vol. 9, no. 2, 2014, pp. 153–172.

Booth, T., and M. Ainscow, *Index for inclusion*: *developing learning and participation in schools*, Centre for Studies in Inclusive Education, Bristol, UK, 2002.

Brooks, J.S., 'Buddhism, Economics, and Environmental Values: A Multilevel Analysis of Sustainable Development Efforts in Bhutan', *Society & Natural Resources*, vol. 24, no. 7, 2011, pp. 637–655.

Business Bhutan, 'No Country for the Disabled', *Business Bhutan,* 17 March 2012, [online], http://businessbhutan.bt/no-country-for-the-disabled, accessed 5 November 2015.

Carroll, A., C. Forlin and A. Jobling, 'The impact of teacher training in special education on the attitudes of Australian preservice general educators towards people with disabilities', *Teacher Education Quarterly*, vol. 30, no. 3, 2003, pp. 65–73.

Cassady, J., 'Teachers' Attitudes Toward the Inclusion of Students with Autism and Emotional Behavioral Disorder', *Electronic Journal for Inclusive Education*, vol. 2, no. 7, 2011.

Carter, J., *Preparing for the Journey*: *A Cooperative Approach to Service Provision for Children with Intellectual Disabilities in Cambodia*, UNICEF, Phnom Penh, 2008.

Case, S., 'Refocusing on the Parent: What are the social issues of concern for parents of disabled children', *Disability & Society*, vol. 15, no. 2, 2010, pp. 271–292.

CBM, *Knowledge, Attitudes and Practice (KAP) Survey*: *Takeo Province, Cambodia*, CBM, Bensheim, 2011.

CBM/AusAID, *Developing a disability and development research agenda for Asia and the Pacific*, AusAid, Barton, ACT, 2010.

Chapman, C., et al., *Leadership that promotes the achievement of students with special educational needs and disabilities*, University of Manchester, Manchester, 2011.

Chhetri, K.K., *Investigating Teachers' Concerns and Experiences in Teaching Children with Special Educational Needs in Bhutan*, unpublished MA Dissertation, Queensland University of Technology, Brisbane, 2015.

Childs, A., et al., 'Science Education in Bhutan: Issues and challenges', *International Journal of Science Education*, vol. 34, no. 3, 2012, pp. 375–400.

Choden, P., and D. Sarkar, 'Gender bias in schooling: the case for Bhutan', *Journal of the Asia Pacific Economy*, vol. 18, no. 4, 2013, pp. 513–528.

Chung K., W. Jung and J. Yang, 'Cross-cultural differences in challenging behaviors of children with autism spectrum disorders: An international examination between Israel, South Korea, the United

Kingdom, and the United States of America', *Research in Autism Spectrum Disorders*, vol. 6, no. 2, 2012, pp. 881–889.

Clarke, H., *Preventing social exclusion of disabled children and their families*: *literature review paper produced for the national evaluation of the Children's Fund*, DfES, London, 2006.

Cochran, W., *Sampling Techniques*, Wiley, New York, 1977.

Cologon, K., *Inclusion in education towards equality for students with disability,* Macquarie University, Institute of Early Childhood, 2013.

Croot, E., et al., 'Perceptions of the causes of childhood disability among Pakistani families living in the UK', *Health and Social Care in the Community*, vol. 16, no.6, 2008, pp. 606–613.

Daniel, W., *Biostatistics*: *A Foundation for Analysis in Health Sciences*, Wiley, New York, 1999.

Daoudong, R., 'Knowledge and Attitude towards Inclusive Education of Children with Learning Disabilities: the case of Thai primary school teachers', *Academic Research International*, vol. 4, no. 4, 2013, pp. 496–512.

DCSF, *The Bercow Report, Review of Services for Children and Young People (0-19) with Speech, Language and Communication Needs*, DCSF, London, 2007.

De Boer, A., and V. Munde, Parental Attitudes Toward the Inclusion of Children With Profound Intellectual and Multiple Disabilities in General Primary Education in the Netherlands, *Journal of Special Education*, vol. 48, no. 2, 2014, pp. 135–148.

De Boer, A., S. Pijl and A. Minnaert, 'Regular primary schoolteachers' attitudes towards inclusive education: A review of the literature' Children, International *Journal of Inclusive Education*, vol. 15, no. 3, 2011, pp. 331–353.

Deluca, M., et. al., *Research Report Summary*: *Teacher Knowledge, Attitudes and Practices (KAP) on educating girls with disabilities in the Lakes Region, Kenya*, Leonard Cheshire Disability and Inclusive Development Centre, London, 2014.

Department of Education, Ministry of Health and Education, 'Education Sector Strategy: Realising the Vision 2020', 2003, http://planipolis.iiep.unesco.org/sites/planipolis/files/ressources/bhutan_education_sector_strategy_vision_2020.pdf, accessed 16 October 2017.

EADSNE, *Special Education across Europe in 2003*: *Trends in provision in 18 European countries*, European Agency for Development in Special Needs Education, Odense, Middlefart, 2003.

EADSNE, *Teacher Education for Inclusion across Europe – Challenges and opportunities*, European Agency for Development in Special Needs Education, Odense, 2011.

EADSNE, *The inclusive education in action project*, European Agency for Development in Special Needs Education, Odense, 2012.

EADSNE, *Organisation of Provision to Support Inclusive Education*, European Agency for Development in Special Needs Education, Odense, Odense, 2013.

Ebersold, S., and C. Meijer, 'Financing Inclusive Education: Policy Challenges, Issues and Trends' in *Implementing Inclusive Education*: *Issues in Bridging the Policy-Practice Gap (International Perspectives on Inclusive Education),* edited by A. Watkins and C. Meijer, Emerald Publishing, Bingley, 2016.

EENET, *Family Action for Inclusion in Education*, Enabling Education Network, Manchester University, 2013.

Elkins, J., C. van Kraayenoord and A. Jobling, 'Parents' attitudes to inclusion of their children with special needs', *Journal of Research in Special Educational Needs*, vol. 3, no. 2, 2003, pp. 122–129.

ERC-VOICES, 'Voices of Individuals: Collectively exploring Self-Determination', 2017, https://ercvoices.com, accessed 11 April 2017.

Filmer, D., 'Disability, poverty and schooling in developing countries: results from 14 household surveys', *World Bank Economic Review*, vol. 22, 2008, pp. 141–163.

Finke, E., D. McNaughton and K. Drager, ' "All children can and should have the opportunity to learn": General education teachers' perspectives on including children with autism spectrum disorder who require AAC', *Augmentative and Alternative Communication*, vol. 25, no. 2, 2009, pp. 110–122.

Franklin, A., and P. Sloper, 'Supporting the participation of disabled children and young people in decision making', *Children and Society*, vol. 23, no. 1, 2009, pp. 3–15.

Gabel, S., 'South Asian Indian cultural orientations toward mental retardation', *Mental Retardation*, vol. 42, no. 1, 2004, pp. 12–25.

Gartrell, A., ' 'A frog in a well': the exclusion of disabled people from work in Cambodia', *Disability and Society*, vol. 25, no. 3, 2010, pp. 289–301.

Gerschel, L., *Connected the Disconnected*: *Exploring issues of Gender, Race and SNE within an Inclusive Context*, David Fulton Publisher, London, 2003.

Ghosh, S., and S. Magana, 'A rich mosaic: Emerging research on Asian families of persons with intellectual and developmental disabilities', *International Review of Research in Mental Retardation*, vol. 37, 2009, pp. 179–212.

Gibson, C., 'Overcoming the stigma of the learning disability label: A story of survival and recovery', *ACA Special Education News,* Article LD-8-3, 2008.

Giulio, P., D. Philipov and I. Jaschinski, 'Families with disabled children in different European countries', Working Paper 23, 2014, www.familiesandsocieties.eu/wp-content/uploads/2014/12/WP23GiulioEtAl.pdf, accessed 13 April 2017.

Givel, M.S., 'Gross National Happiness in Bhutan: Political Institutions and Implementation' *Asian Affairs*, vol. 46, no. 1, 2015, pp. 102–117.

GNH Centre, *The Story of GNH*, GNH Centre, Thimphu, 2017.

Goldberg, I., and L. Lippman, 'Plato had a word for it', *Exceptional Children*, vol. 40, no. 5, 1974, pp. 325–334.

Gordon, J.A., 'Bhutan: Educational challenges in the land of the Thunder Dragon' *Ethnography and Education*, vol. 8, no. 3, 2013, pp. 286–300.

Grech, S., *Disability and Poverty in the Global South*, Palgrave Macmillan, Basingstoke, 2015.

Griffin, T., and P. Kearney, 'Between joy and sorrow: being a parent of a child with developmental disability', *Journal of Advanced Nursing*, vol. 34. no. 5, 2001, pp. 582–592.

Groce, N., 'Adolescents and Youth with Disabilities: Issues and Challenges', *Asia Pacific Disability Rehabilitation Journal*, vol. 15, no. 2, 2004, pp. 13–32.

Groce, N., et al., 'Disability and poverty: the need for a more nuanced understanding of implications for development policy and practice', *Third World Quarterly*, vol. 22, 2011, pp. 1493–1513.

Hassanein, E., *Inclusion, Disability and Culture*, Sense Publishers, Rotterdam, 2015.

Hatton, C., et al., *Supporting South Asian Families with a Child with Severe Disabilities*, Jessica Kingsley Publishers, Ltd, London, 2004.

Hersinta, M., 'How Religious Beliefs Influence Understanding on Disability: A Study of Muslim Family's Perception on Autism', Paper presented at the Jogja International Conference on Communication, UPN Veteran Jogjakarta, 21–22 November 2012.

Hobbs, M., *The future of children categories and their consequences*, Jossey Bass, San Francisco, 1973.

Hogarth, R., *Educating Intuition*, Chicago University Press, London, 2001.

Holdsworth, J., *Seeking A Fine Balance*: *Lessons from Inclusive Education in Lao PDR*, Save the Children UK, Vientiane, 2003.

Holroyd, E., 'Chinese cultural influences on parental caregiving obligations towards CWD', *Qualitative Health Research*, vol. 13, no. 1, 2003, pp. 4–19.

Huang, Y., and W. Kellett, 'Being concerned: Care giving of Taiwanese mothers of a child with cerebral palsy', *Journal of Clinical Nursing*, vol. 21, 2012, pp. 189–197.

Humphries, S., and P. Gordon, *Out of Sight. The Experience of Disability 1900-1950.* Northcote House, Plymouth, 1992.

IASSID, 'Asia Pacific Database Summary', A literature review conducted as part of a larger review of the research related to individuals with ID across the Asia Pacific Region, International Association for the Scientific Study of Intellectual and Developmental Disabilities, 2012, https://www.iassidd.org/uploads/legacy/images/documents/asia-pacific_database_summary.pdf, accessed 2 November 2015.

Inclusion International, *Hear Our Voices*: *a Global Report*, Inclusion International, London, 2006.

Kaliyaperumal, K., 'Guideline for Conducting a Knowledge, Attitude and Practice (KAP) Study, *Community Ophthalmology*, vol. 4, no. 1, 2004, pp. 7–9.

Kalyanpur, M., *A study on Integrating disability into the FTI process and national education plans in Cambodia*: *Case study undertaken for World Vision UK*, World Vision UK, Milton Keynes, 2007.

Katbamna, S., P. Bhakta and G. Parker, 'Perceptions of disability and care-giving relationships in South Asian communities' in *Ethnicity, Disability and Chronic Illness*, edited by W. Ahmad, Open University Press, Buckingham, 2000, pp. 123–138.

Kaur-Bola, K., and G. Randhawa, 'Role of Islamic religious and cultural beliefs regarding intellectual impairment and service use: a South Asian parental perspective', *Community Medicine*, vol. 9. no. 3, 2012, pp. 241–245.

Keller, D., and A.S. Honig, 'Maternal and paternal stress in families with school-aged CWD, *American Journal of Orthopsychiatry*, vol. 74, no. 3, 2004, p. 337.

Klein, G., *Intuition at Work*, Doubleday, New York, 2003.

Koster, M., et al., 'Being part of the peer group: A literature study focusing on the social dimension of inclusion in education,' *International Journal of Inclusive Education*, vol. 13, no. 2, 2009, pp. 117–140.

Kugelmass, J., and M. Ainscow, 'Leadership for inclusion: a comparison of international practices', *Journal of Research in Special Educational Needs*, vol. 4, no. 3, 2004, pp. 133–141.

Kusumastuti, P., R. Pradanasari and A. Ratnawati, 'The problems of people with disability in Indonesia and what is being learned from the world report on disability', *American Journal of Physical Medicine & Rehabilitation*, vol. 93, no. 1, 2014, pp. 563–567.

Lakhan, R. and M. Sharma, 'A Study of Knowledge, Attitudes And Practices (KAP) Survey of Families toward their Children with Intellectual Disability in Barwani, India*', Asia Pacific Disability Rehabilitation Journal,* vol. 21, no. 2, 2010, pp. 101–116.

Lauber, C., and W. Rossler, 'Stigma towards people with mental illness in developing countries in Asia', *International Review of Psychiatry*, vol.19, no. 2, 2007, pp. 157–178.

Lemacks, J., et al., 'Insights from Parents about Caring for a Child with Birth Defects', *International Journal of Environmental Research and Public Health*, vol. 10, no. 8, 2013, pp. 3465–3482.

Leyser, Y., and R. Kirk, 'Evaluating Inclusion: an examination of parent views and factors influencing their perspectives', *International Journal of Disability, Development and Education*, vol. 51, no. 3, 2004, pp. 271–285.

Lham, T., 'The attitude and perception of Bhutanese teachers towards inclusive education,' Paper presented at the Regional Seminar on Inclusive Education with focus on CWD, Paro College of Education, 3–5 December 2013.

Lhomon Education, 'Nonformal and Informal Education in Bhutan', Thursday, 20 October 2011, [online], http://sjieducation.blogspot.co.uk/2011/10/nonformal-and-informal-education-in.html, accessed 8 November 2015.

Lindsay, S., and A. Edwards, 'A systematic review of disability awareness interventions for children and youth', *Disability Rehabilitation*, vol. 35, no. 8, 2012, pp. 623–646.

LL4All, *Leading Learning for All. Professional Leadership Resources for Schools*, ASEPA, Perth, 2017.

Mackelprang, R., and R. Salsgiver, *A Diversity Model Approach in Human Service Practice*, Oxford University Press, Oxford, 2016.

McKay, A., and W. Dorji, 'Traditional Medicine in Bhutan', *Asian Medicine*, vol. 1, no. 1, 2005, pp. 204–218.

MacQueen, K., et al., 'What is Community? An Evidence-Based Definition for Participatory Public Health', *American Journal of Public Health*, vol. 91, no. 12, 2001, pp. 1929–1938.

Mallett, R., and K. Runswick-Cole, *Approaching Disability: Critical Issues and Perspectives*, Routledge, London, 2014.

Masasa, T., S. Irwin-Carruthers and M. Faure, 'Knowledge of, beliefs about and attitudes to disability: implications for health professionals', *South African Family Practice*, vol. 47, no. 7, 2014, pp. 40–44.

Maxwell, T.W., P. Rinchen and R. Cooksey, 'Evolutionary trajectories in school assessment systems: the case of Bhutan', *Asia Pacific Journal of Education*, vol. 30, no. 3, 2010, pp. 273–288.

Meijer, C., *Inclusive Education and Effective Classroom Practices*, European Agency for Development in Special Needs Education, Brussels, 2001.

Metz, T., 'Gross National Happiness: A Philosophical Appraisal', *Ethics and Social Welfare*, vol. 8, no. 3, 2014, pp. 218–232.

Miles, M., 'Disability in an Eastern religious context: historical perspectives', *Disability & Society*, vol. 10, 1995, pp. 49–69.

Miles, M., 'Disabled learners in South Asia: Lessons from the past for educational exporters', *International Journal of Disability, Development and Education*, vol.44, no. 2, 1997, pp. 97–104.

Millward, L.J., and K. Bryan, 'Clinical leadership in health care: a position statement', *Leadership in Health Services*, vol. 18, no. 2, 2005, pp.13–25.

Ministry of Education, Royal Government of Bhutan, *Bhutan Education Blueprint, 2014-2024*: *Rethinking Education*, Ministry of Education, Thimphu, 2014.

Mont, D., et al., 'Poverty, Maternal Education and Child Disability: Evidence from Bhutan', *Behinderung und internationale Entwicklung*, vol. 3, 2013, pp. 13–20.

National Statistics Bureau, Bhutan, and Asian Development Bank, *Bhutan Living Standards Survey 2012 Report*, National Statistics Bureau, Bhutan, and Asian Development Bank, Thimpu, 2012.

National Statistics Bureau, Ministry of Education, Ministry of Health, UNICEF, *Two Stage Child Disability Study among children aged 2-9 years. Bhutan 2010-2011*, National Statistics Bureau, Thimpu, 2012.

NDA, *Literature Review on Attitudes towards Disability*, National Disability Authority, Dublin, 2006.

Nizamani, G., 'South Asia Sub-Regional Report', Regional Training Workshop on Capacity Building for Persons with Disabilities Toward Rights-based Society in Asia Pacific Region, 10–14 April 2005, Bangkok.

OECD, *Students with Disabilities, Learning Difficulties and Disadvantages*: *statistics and indicators*, OECD/CERI, Paris, 2005.

Osberg, D., and G. Biesta, 'The end/s of education: Complexity and the conundrum of the inclusive educational curriculum, *International Journal of Inclusive Education*, vol. 14, no. 6, 2010, pp. 593–607.

Palmer, M., 'Disability and poverty: A conceptual review', *Journal of Disability Policy Studies*, vol. 21, no. 4, 2011, pp. 210–218.

Parker, C., and T. Ford, 'Editorial Perspective: School exclusion is a mental health issue, *Journal of Child Psychology and Psychiatry*, vol. 54, no. 12, 2013, pp. 1366–1368.

Parker, K., 'Changing Attitudes Towards Persons with Disabilities in Asia,' *Disability Studies Quarterly*, vol. 21, no. 4, 2001, pp. 105–113.

Parker, W., H. Gage and A. Sterr, *Services for Families with Disabled Children, A Scoping Study*, Final Report, University of Surrey, Guildford, 2011.

Parliament of the Kingdom of Bhutan, The Child Care and Protection Act, Parliament of the Kingdom of Bhutan, Thimpu, 2011, [online], https://www.mindbank.info/item/5709, accessed 8 November 2015.

Pellegrini, L., and L. Tasciotti, ' Bhutan: Between Happiness and Horror' *Capitalism Nature Socialism*, vol. 2**,** no. 3, 2014, pp. 103–109.

Pinnock, H., 'Education for CWD: Needs assessment in Maldives and Bhutan', Paper presented at the Regional Seminar on Inclusive Education with focus on CWD, Paro College of Education, 3–5 December 2013.

Purdue, K., et al., 'Supporting inclusion in early childhood settings: Some possibilities and problems for teacher education', *International Journal of Inclusive Education*, vol. 13, no. 8, 2009, pp. 805–815.

Qayyum, A., S. Lasi and G. Rafique, 'Perceptions of Primary Caregivers of CWD in two Communities from Sindh and Balochistan, Pakistan', *Disability, CBR & Inclusive Practice*, vol. 24, 2013, pp. 13–142.

Rafferty, Y., and K.W. Griffin, 'Benefits and risks of reverse inclusion for preschoolers with and without disabilities: Perspectives of parents and providers', *Journal of Early Intervention*, vol. 27, no. 3, 2005, pp. 173–192.

Reiser, R., *Teacher Education for CWD: Literature Review*, EENET, Manchester, 2013.

Royal Government of Bhutan (RGoB), *National Export Strategy, Vol 1.*, Royal Government of Bhutan, Thimpu, 2012.

Royal Government of Bhutan Ministry of Education (RGoBMoE), *Annual Education Statistics, 2009*, Policy and Planning Division, Ministry of Education, Thimpu, 2009.

Royal Government of Bhutan Ministry of Education, *Annual Education Statistics, 2011*, Policy and Planning Division, Ministry of Education, Thimpu, 2011.

Royal Government of Bhutan Ministry of Education, *Annual Education Statistics, 2012*, Policy and Planning Division, Ministry of Education, Thimpu, 2012.

Royal Government of Bhutan Ministry of Education, *National Policy on Special Educational* Needs, 2012a, [online], www.education.gov.bt/documents/10180/12859/Final-Draft-SEN-Policy-2012.pdf/2bd136d1-71af-41d7-8819-a2d177e75049?version=1.0, accessed 8 November 2015.

Royal Government of Bhutan Ministry of Education, *Annual Education Statistics, 2013*. Policy and Planning Division, Ministry of Education, Thimpu, 2013.

Royal Government of Bhutan Ministry of Education, *Annual Education Statistics, 2014*, Policy and Planning Division, Ministry of Education, Thimpu, 2014.

Samaha, A., 'What Good is the Social Model of Disability?', *Public Law and Legal Theory Working Papers*, No. 166, 2007.

Schuelka, M.J., 'The evolving construction and conceptualisation of 'disability' in Bhutan', *Disability & Society*, vol. 30, no. 6, 2015, pp. 820–833.

Schuelka, M.J., 'An Inclusive Education in Bhutan', *Current Issues in Comparative Education*, vol. 15, no. 1, 2013, pp. 145–156.

Scior, K., et al., 'Stigma, public awareness about intellectual disability and attitudes to inclusion among different ethnic groups', *Journal of Intellectual Disability Research*, vol. 57, 2012, pp. 1014–1026.

SCOPE, *Public Awareness Towards Disability*, SCOPE, London, 2014.

Shakespeare, T., 'The social model of disability: an outdated ideology?', *Research in Social Science and Disability,* vol. 2, 2002, pp. 9–28.

Shakespeare, T., and I. Kleine, 'Educating Health Professionals about Disability: a Review of Interventions', *Health and Social Care Education*, vol. 2, no. 2, 2015, pp. 20–37.

Sherwin, J., 'Leadership for social inclusion in the lives of people with disabilities', *International Journal of Leadership in Public Services*, vol.6, 2010, pp. 84–93.

Shin, J., and N. Nhan, 'Predictors of Parenting Stress Among Vietnamese Mothers of Young Children With and Without Cognitive Delay,' *Journal of Intellectual and Developmental Disability*, vol. 34, no. 1, 2009, pp. 17–26.

Shrestha, S., N. K. Shrestha and S. Deepak, 'A community assessment of poverty and disability among specific rural population groups in Nepal', *Asia Pacific Disability Rehabilitation Journal*, vol. 20, no. 1, 2009, pp. 83–98.

Singal, N., *Disability, Poverty and Education*, Routledge, London, 2013.

Siperstein, G., et al., *Multinational study of attitudes towards individuals with intellectual disabilities*', Special Olympics Inc., Washington, 2003.

Skotko, B., and R. Canal, 'Postnatal support for mothers of children with Down Syndrome,' *Mental Retardation*, vol. 43, 2005, pp. 196–212.

Slee, R., *Inclusive Education*: *a framework for school reform. Inclusive Education*: *a framework for school reform*, Hong Kong Institute of Education, M. A. V. Heung HK, 2004.

Stokes, H., M. Turnbull and J. May, *Young People with a Disability*: *Independence and Opportunity* (Research Report 39), Youth Research Centre, University of Melbourne, Melbourne, 2013.

Solomon, P., and S. Dorji, 'Attitudes Of Health Professionals Toward Persons With Disabilities In Bhutan', *Asia Pacific Disability Rehabilitation Journal*, vol. 20, no. 2, 2009, pp. 32–42.

Subban, P., and U. Sharma, 'Primary school teachers' perceptions of inclusive education in Victoria, Australia', *International Journal of Special Education*, vol. 21, no. 1, 2006, pp. 42–52.

Suharto, E., *Roles of social workers in Indonesia*: *issues and challenges in rehabilitation for people with disability*, National Vocational Rehabilitation Centre (NVRC), Cibinong, 2006.

Swain, J., S. French and C. Cameron, *Controversial Issues in a Disabling Society*, OU Press, Buckingham, 2003.

Takamine, Y., *Disability Issues in East Asia*: *Review and Ways Forward*, World Bank, New York, 2003.

Takayama, K., A. Sriprakash and R. Connell, 'Rethinking Knowledge Production and Circulation in Comparative and International Education: Southern Theory, Postcolonial Perspectives, and Alternative Epistemologies', *Comparative Education Review*, vol. 59, no. 1, 2015, pp. v–viii.

Tharchen, Chanbanchong T.C., and P. Savegpan, *A Study on Management of Inclusive Education in Bhutanese School Education System*: *Policy, Practices and Perceptions,* unpublished Master's Dissertation, n.d.

Thomas, M., and M. Thomas, ' An overview of disabilities issues in South Asia', *Asia Pacific Disability Rehabilitation Journal*, vol. 13, no. 2, 2002, pp. 62–84.

Thomas, N., '*Children's rights" policy into practice',* Centre for Children and Young People: Background Briefing Series, No. 4, Centre for Children and Young People, Southern Cross University, Lismore, NSW, Australia, 2011.

Thompson, J., et al., 'Conceptualizing Supports and the Support Needs of People with Intellectual Disability', *Intellectual and Developmental Disabilities*, vol. 47, no. 2, 2009, pp. 135–146.

Thuji, Z., 'Role of Civil Society Organizations in Inclusive Education Development in Bhutan,' Paper presented at the Regional Seminar on Inclusive Education with focus on CWD, Paro College of Education, 3–5 December 2013, Ability Bhutan, Thimpu, 2013.

Titumir, R., and J. Hossain, *Disability in Bangladesh. Prevalence, Knowledge, Attitudes and Practices*, Unnayan Onneshan, Dhaka, 2005.

Todkar S., V. Doijad and P. Gadgil, 'Knowledge, Attitude and Practices Among Persons With Disabilities (PWDs) at Civil Hospital Solapur, Maharashtra, India', *International Journal of Biological & Medical Research*, vol. 6, no. 1, 2015, pp. 4782–4784.

Tran, K.V., 'Exploring the experience of CWD at school settings in Vietnam context', *SpringerPlus*, 3:103, 2014, http://doi.org/10.1186/2193-1801-3-103, accessed 17 October 2015.

Trani, J-F., and B. VanLeit, *Increasing inclusion of persons with disabilities*: *Reflections from disability research using the ICF in Afghanistan and Cambodia*, Working Paper 11, Leonard Cheshire Disability and Inclusive development Centre, UCL, 2010.

Ugyen and U. Cokl, *The education system in Bhutan*, Austro-Bhutanese development and research cooperation, Austrian Agency for International Cooperation in Education and Research, 12, 2010.

UNESCO, The Salamanca Statement and Framework for Action on Special Needs Education, UNESCO, Paris, 1994.

UNESCO, The Dakar Framework For Action, UNESCO, Paris, 2000.

UNESCO, *Guideline for inclusion*: *Ensuring access to education for all*, UNESCO, Paris, 2005.

UNESCO, *Towards Inclusive Education for CWD*: *A Guideline*, UNESCO, Bangkok, 2009.

UNICEF, *An overview of child well-being in rich countries*, Report Card 7, Innocenti Research Centre, UNICEF, Florence, 2007.

UNICEF, *Children with disability In An Giang and Dong Nai*: *Knowledge – Attitude – Practice*, UNICEF, Bangkok, 2011.

UNICEF, 'Children and Young People with Disabilities', Fact Sheet, UNICEF, New York, 2013.

UNICEF, *Meeting the educational needs of CWD in South Asia*: *A gap analysis covering Bhutan and the Maldives*, UNICEF, Kathmandu, 2013a.

UNICEF, *UNICEF Annual Report 2013 – Bhutan*, UNICEF, New York, 2013b.

UNICEF, 'Bhutan Statistics', 2013c, [online], www.unicef.org/infobycountry/bhutan_statistics.html, accessed 8 November 2015.

UNICEF, 'Bhutan Annual Report 2014', 2014, [online], www.unicef.org/about/annualreport/files/Bhutan_Annual_Report_2014.pdf, accessed 8 November 2015.

UNICEF, *Knowledge, Attitude and Practice towards CWD in Turkey*, UNICEF, New York, 2015.

UNICEF, *Promoting Equal Opportunities for CWD in Bhutan*, UNICEF, Thimpu, n.d.

UNICEF and UNFPA, *Bhutan Multiple Indicator Survey 2010,* National Statistics Bureau, UNICEF and UNFPA, Thimphu, 2011.

United Nations (UN), UN Convention on the Rights of the Child, United Nations, New York, 1989.

United Nations, Convention on the Rights of Persons with Disabilities, 2006, [online], www.un.org/disabilities/convention/conventionfull.shtml, accessed 8 November 2015.

United Nations, Department of Economic and Social Affairs of the United Nations, Department of Public Information, The Millennium Development Goals Report 2009, United Nations Publications, 2009.

United Nations/ESCAP, *Disability at a glance 2010*: *a profile of 36 countries and areas in Asia and Pacific,* United Nations and ESCAP, New York, 2010.

Ura, K., et al., *An Extensive Analysis of GNH Index*, The Centre for Bhutan Studies, Thimpu, 2012.

USAID, *Best Practices for Inclusive Education for CWD*: *Applications for programme design in Europe and Eurasia Region*, USAID, Washington, 2010.

VanBalkom, W.D., and A. Sherman, 'Teacher Education in Bhutan: highlights and challenges for reform', *Asia Pacific Journal of Education*, vol. 30, no. 1, 2010, pp. 43–55.

Walcott, S.M., 'One of a Kind: Bhutan and the modernity challenge', *National Identities*, vol. 13, no. 3, 2011, pp. 253–265.

Wanaratwichit, C., et al., 'Access to services and complications experienced by disabled people in Thailand', *Asia Pacific Journal of Public Health*, vol. 20, 2008, Suppl. pp. 251–256.

Wang, P., C. Michaels and M. Day, 'Stresses and Coping Strategies of Chinese Families with Children with Autism and Other Developmental Disabilities', *Journal of Autism and Development Disorders*, vol. 41, no. 6, 2010, pp. 783–795.

Wangchuk, K.C., et al., 'The Status of Early Childhood Care and Development in Bhutan: An Internal Report for ECCD Situational Study', n.d., [online], www.rec.org.bt/wp-content/uploads/nivoslider4wp_files/The%20Status%20of%20Early%20Childhood%20Care%20and%20Development%20in%20Bhutan.pdf, accessed 5 November 2015.

West, M., et al. *Leadership and Leadership Development in Healthcare*: *The Evidence Base*, Faculty of Medical Leadership and Management, London, 2015.

Winter, E., and P. O'Raw, *Literature Review of the Principles and Practices relating to Inclusive Education for Children with Special Educational Needs*, National Council for Special Education, Trim, 2010.

World Bank, *People with disabilities in India*: *from commitments to outcomes*, World Bank, Washington D.C., 2009.

World Bank, *The World Bank in Small States*, Washington D.C., 2012, www.worldbank.org/en/country/smallstates/overview, accessed 12 October 2017.

World Health Organization (WHO), *Situation analysis of Community-based Rehabilitation in the South-East Asia Region,* WHO Regional Office for SE Asia, New Delhi, 2007.

World Health Organization, 'Disabilities', 2015, www.who.int/topics/disabilities/en, accessed 12 September 2015.

World Health Organization, *World report on disability*', WHO, Geneva, 2011, www.who.int/disabilities/world_report/2011/en/index.html, accessed 21 October 2015.

World Health Organization, *Situation analysis of community based rehabilitation in the South East Asia Region*, WHO, New Delhi, 2012.

World Health Organization, *Community-based rehabilitation and habilitation for inclusive society*, WHO, New York, 2010.

Young, M., 'Basic Capabilities, Basic Learning Outcomes and Thresholds of Learning', *Journal of Human Development and Capabilities*, vol. 10, no. 2, 2009, pp. 259–277.

Yousafai, A., Z. Farrukh and K. Khan, 'A Source of Strength and Empowerment? An Exploration of the Influence of Disabled Children on the Lives of their Mothers in Karachi, Pakistan', *Disability and Rehabilition*, 2010, pp. 1–10.

Youth Development Fund Secretariat, *A Strategic Plan for the Child Protection and Care Services (CPCS) for Youth Development Fund (YDF): 2014*, Youth Development Fund Secretariat, Thimpu, 2014.

Zangmo, D., 'Empowering Girls and Women with Disabilities in Rural Areas', n.d., [online], www.un.org/disabilities/documents/csw/csw56_zam.doc, accessed 8 November 2015.

Zhou, D., and N. Kun, 'Community-based rehabilitation in the People's Republic of China', *Disability and Rehabilitation*, vol. 21, no. 10–11, 1999, pp. 490–494.

Zimmer, Z., 'Poverty, wealth inequality and health among older adults in rural Cambodia', *Social Science & Medicine*, vol. 66, no. 1, 2008, pp. 57–71.

APPENDIX 11: PROPOSED CWD COMMUNICATIONS STRATEGY

The UoN team is committed to working in collaboration with colleagues from UNICEF and the Ministry of Education to formulate an effective communications plan. The focus of this will be to provide information to a range of stakeholders and audiences, in order to maximize the outputs from the study reported.

A range of key parameters in a possible Communications Strategy has been identified by the UoN team. In the period leading to the second team visit to Bhutan, the intention is to highlight the principal considerations under each of the 10 components envisaged. These will be reported in draft form as the strategy is formulated, with Bhutan colleagues providing inputs as appropriate.

GENERAL PRINCIPLES

1. Accessibility to specific target audiences (especially rural and 'hard-to-reach')
2. User-friendly and jargon-free
3. Credible and authentic
4. Based on inputs from stakeholders
5. Attractive in design (illustrations/use of space/colour, etc.)
6. Multimedia (e-versions and hard copy)
7. Use exemplification of practices
8. Contains contacts/sources of assistance and support
9. Recognize C4D approach
10. Build-in sustainability (any resources to be easily reviewed and renewable)

POSSIBLE CONTENT

1. Statement of purpose
2. Current situation/context
3. Communications objectives
4. Identification of key strategy developers
5. Identification of audiences
6. Highlighting core messages regarding CWD
7. Key communications methods
8. Work plan and timeline
9. Evaluation indicators
10. Sustainability and forward planning

THE WHAT, WHO AND HOW OF COMMUNICATION FOR CWD

<u>What is the CONTENT to be communicated?</u>

Summary of research findings and the Millennium Development Goal context for Bhutan
Supporting parents
CWD in professional training
How might communities help?
Developing a resource-bank

CWD as +resources

Who are the target audiences to be reached?

Parents
Community members (Dzongdags/Gups, etc.)
CWD-specific professionals
General professions – schools, services
Civil society organizations and NGOs

How are audiences to be reached?

Multimedia approaches
Hard copy single sheet – infograph
Awareness-raising badges/stickers
Flyers
CWD-specific events: promoting village or national days/festivals
Sponsored activity
Advice/input from Information and Media Officer
Articles/papers

APPENDIX 12: RESPONSES FROM INFORMAL REFERENCE GROUP

During the revision of draft versions of the report it was requested that the research team identify, based on their experiences in working on CWD issues in international settings, a further set of concrete, ground-level actions. These are based on responses from a small, purposively selected group of school leaders and CWD professionals from the UK, France and Australia. They are included as an appendix for illustrative purposes only; given that none of this group has had direct experience of CWD in a Bhutan context, their suggestions should be viewed with obvious caution, in respect of their cultural relevance. The suggestions are nonetheless indicative of a diverse range of possible ground-level actions in support of CWD and their families.

Report Recommendation: (i) Responses to systemic challenges and changes

Concrete actions could include:

1. Review national screening procedure(s)
2. Agree a national communication strategy to highlight CWD issues (content to be decided)
3. Establish a practitioner/researcher forum to explore small-scale pilot studies
4. Create a national resource base of CWD-related resources (for teachers, health and social care workers, parents and community members)
5. Instigate a periodic review, involving all key personnel, of CWD-related policies
6. Organize a national event, conference or festival relating to CWD, with multi-stakeholder perspectives
7. Review current school and services policies regarding CWD, from the perspective of their inclusivity
8. Prepare and publicize a 'Vision Statement' (or enhance existing document)
9. Reflect on (and review) current teacher training and training for health and social care professionals to ensure that it is mandatory for CWD issues to be included in all programmes
10. Audit existing expertise for CWD and identify gaps
11. Establish a project to review the extent and nature of vocational training for CWD
12. Establish a 10-year CWD Strategy and 5-year Action Plan
13. Are there/do there need to be sets of national 'standards' for quality provision for CWD? (Like the '8 Standards for ECCE' in India, for example)

Report Recommendation: (ii) Families with CWD

Concrete actions could include:

1. Create a catalogue of local resources/expertise available to parents/carers
2. Establish a nationwide set of 'CWD champions' who can become parent-advocates
3. Consider the development of parent-to-parent support groups
4. Develop accessible, single-source information sheets for parents
5. Promote the wider involvement of parents in schools
6. Nominate parent representatives within school and service governance
7. Establish parent-specific events with a positive CWD focus
8. Invite parent inputs to training activities
9. Provide direct and accessible information to parents regarding vocational

opportunities for their children
10. Encourage creative pro-CWD actions (e.g., 'My Story-Book) to promote greater empowerment

Report Recommendation: (iii) General population

1. National CWD Week and other ongoing publicity (including local events)
2. Identify key figures within Bhutan society (artistic, cultural, sporting, etc.) as public advocates for CWD
3. Shopkeeper and businesses campaign (visible logo of support)
4. Select 'Employer of the Month' based on advocacy for CWD
5. Plan and deliver artistic/cultural/sporting events to include CWD
6. Establish localized 'family support groups'
7. Secure practical (volunteer) input to make physical environments more inclusive for CWDs

Recommendation: (iv) Professional groups

Concrete actions could include:
1. Define principles/understandings/expectations for inter-agency work with CWD
2. Pilot further inter-agency collaboration at local level
3. Create a 'toolkit' for workers in rural settings
4. Consider a basic CWD 'curriculum' for all new professionals
5. Plan and deliver a national conference/event for CWD professionals
6. Create a national association for CWD professionals
7. Establish pupil-to-pupil support systems in schools and in social groups
8. Map existing links/contacts/networks beyond Bhutan in field of CWD
9. Identify key resources to support transition periods in the lives of CWDs

ACRONYMS AND ABBREVIATIONS

ARACY	The Australian Research Alliance for Children and Youth
BHU	Basic Health Unit
BIRD	Bhutan Interdisciplinary Research and Development
CBM/AusAID	Christian Blind Mission/Australian Aid
CWD	Children with Disability
DCSF	Department for Children, Schools and Families
DPOs	Disabled People's Organisations
EADSNE	European Agency for Development in Special Needs Education
ECCD	Early Childhood Care and Development
EENET	Estonian Educational and Research Network
GDP	Gross Domestic Product
GNH	Gross National Happiness
HSQ	Household Survey Questionnaire
IASSID	International Association for the Scientific Study of Intellectual and Developmental Disabilities
KAP	Knowledge, Attitudes and Practices
LL4All	LeadingLearning4All
MoE	Ministry of Education
MoH	Ministry of Health
NC	Narrative Comment
NDA	National Disability Authority
NGO	Non-Governmental Organization
NSB	National Statistics Bureau
Nu	Ngultrum
OECD	The Organisation for Economic Co-operation and Development
REBH	Research Ethics Board of Health
RGoB	Royal Government of Bhutan
RGoBMoE	Royal Government of Bhutan Ministry of Education
RKB	Royal Kingdom of Bhutan
RENEW	Respect, Educate, Nurture and Empower Women
RNDA	Rapid Neurodevelopment Assessment

SCOPE	Scope is a disability charity working with disabled people and their families in England and Wales.
SEN	Special Educational Needs
SEND	Special Educational Needs and Disability
UN	United Nations
UNCRPD	UN Convention on the Rights of Persons with Disabilities
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
United Nations/ESCAP	United Nations Economic and Social Commission for Asia and the Pacific
UoN	University of Northampton
USAID	United States Agency for International Development
WHO	World Health Organization

Members of the Technical Working Group formed for KAP study

1. Sherab Phuntshok, Chief Program Officer, ECCD & SEN Division
2. Tshering Lhamo, Dy. Chief Programme Officer, Special Education, ECCD & SEN Division
3. Phurba, Planning Officer, PPD MOE
4. Chhoki Penjor, Chief Programme Officer, NCWC
5. Tshering Choden, Data Analyst/Data Processing Office, National Statistics Bureau
6. Wangmo, Program Officer, Tarayana foundation
7. Sonam Yangden, Asst. Program Officer, Disabled Person's Association of Bhutan
8. Dorji Phuntsho, IT Asst., Disabled Person's Association of Bhutan
9. Tshering Penjor, Senior Research Officer, Research and Evaluation Division
10. Dorji Tshewang, Unit Head, ECCD & SEN, Royal Education Council
11. Karchung, Principal Curriculum Officer, Royal Education Council
12. Amrit Bdr. Subba, Program Officer, Career Education and Counseling Division, DYS
13. Sanga Dorji, Chief Physiotherapist, JDWNRH
14. Roma Karki, Sr. Program Officer, Disability Prevention and Rehabilitation Programme, MOH
15. Karma Phuntsho, Deputy Chief Physiotherapist, JDWNRH
16. Beda Giri, Technical Advisor, Ability Bhutan Society.
17. Gaden Chophel, Program Officer, Draktsho Vocational Training Centre for Special Children and Youth
18. Dawa Dukpa, Assistant Lecturer I, Paro College of Education
19. Sonam Yangden Tobgyel, Program Officer, Bhutan Foundation
20. Duptho Zangmo, Asst. Instructor I, Royal Academy of Performing Arts, Department of Culture
21. Pema Chogyal, Dy. Chief PO, Special Education, ECCD & SEN Division
22. Karma Norbu, Program Officer, Special Education, ECCD & SEN Division
23. Pema Norbu, Program Officer, Special Education, ECCD & SEN Division
24. Ameena Mohamed Didi, Education Specialist, UNICEF Thimphu
25. Bishnu Bhakta Mishra, Education Officer, UNICEF, Thimphu
26. Sangay Jamtsho, Education Officer, UNICEF Thimphu
27. Dechen Zangmo, M & E Officer, UNICEF Thimphu
28. Tobgye Tobgye, C4D Specialist, UNICEF Thimphu
29. Dr. Chandra Lal Mongar, Health & Nutrition Officer, UNICEF Thimphu
30. Charlie Cristi, AVID Volunteer, Inclusive Education Adviser, Special education, ECCD&SEN Division

Royal Government of Bhutan, Ministry of Education
P.O. Box no. 112, Kawajangsa
Thimphu, Bhutan
Tel:+975 2 325146
www.education.gov.bt

United Nations Children's Fund (UNICEF)
Bhutan Country Office, UN House
Peling Lam, Kawajangsa
Thimphu, Bhutan
Tel: +975 2 322424
www.unicefbhutan.org.bt

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