

Child Rearing Practices of Children with Disabilities

A thesis presented to the

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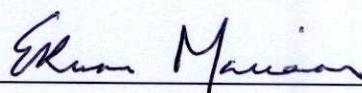
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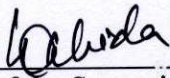
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Executive summary

Bangladesh is a developing country. About 7.7% of the children in this country have different types of disabilities. Good child rearing practice is the cornerstone for survival, health and development of young children with disabilities. Rearing a child with a disability requires extra time. Additionally, depending on the situation, additional energy, and patience are also required. This situation requires acceptance. Bringing families to the full scale of participation in helping children with disabilities grow and develop is a challenge to everyone concerned. Parents (or caregivers), particularly mothers play a significant role in this process. First and foremost, parenting is a skill that needs to be learned formally and informally through various means. The challenges of parenting children with disabilities requires certain skills which parents should receive from all corners to counter and cope with negative community attitudes and traditional beliefs towards disability. Special support and encouragement is essential for parents to counter social isolation that children with disabilities endure within the community where he/she lives.

In Bangladesh, gaps exist in previous research relating to the child rearing practices of children with disabilities. This cross sectional study was conducted among mothers of young children with disabilities. The study population consisted of mothers who receive medical care from selected organizations. The study aimed to explore child-rearing practices, to identify the knowledge of mothers about the concept of child development of young children and to find out about their beliefs regarding children with disabilities.

A total of 62 mothers of children with disabilities aged 1-8 years were purposively included in this study. The study was done from November 2010 to February 2011 at the Centre for the Rehabilitation of the Paralysed (CRP), BRAC Limb and Brace Centre (BLBC) and Institute of Child and Mother Health (ICMH), Matuail. All samples were interviewed. The study also included two case studies based on observations conducted within participants' homes. The data were analyzed by SPSS version 17.

Among the 62 total children, almost half (46.78%) were in the 3-<6 year age group, including 59.7% boys and 40.3% girls. Among all the children, 31.9% had only a physical disability and rest had multiple disabilities. The data showed that 41.9% of mothers provide healthy food and clean them. Only 4.8% of mothers care for their children with all the elements of caring practices such as feeding, cleaning, dressing, teaching, playing, and going for a walk. According to data, 22.6% of mothers perform the activities during feeding and dressing to teach their children independence. Regarding the mother's knowledge about child development, only 19.3% of mothers thought that children can feel and think immediately after birth. Among all participants, 88.7% of mothers knew that children can walk from 12-18 months, and 27.4% of mothers said that a child starts to say meaningful words in 12 months. The study showed that 83.90% of mothers thought that stimulation has importance in the physical development of children, and 52.8% of mothers thought that oil massage helps to improve circulation of the body. It was found that 53.2% of mothers thought that proper child rearing practices help children achieve functional abilities. The study also showed mother's beliefs regarding children with disabilities. It was found that 45.1% of mothers believed that these children would be productive in society if they get proper care and 21% of mothers thought that they need more attention than normal kids. The study did not find any association related to child rearing practices among the following: gender, mother's education, mother's occupation, socioeconomic status, or specific types of disabilities.

Although child rearing practices varied widely, the majority (88.7%) of mothers had some knowledge about motor development. However, most of them lack knowledge relating to speech and cognitive development for their young children. Therefore, it is necessary to raise awareness about the caring practices among mothers and other family members who have children with disabilities. Additionally, further study in this field is required to provide a nationwide perspective on this phenomenon.

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Glossary of Terms

BBS	Bangladesh Bureau of Statistics
BLBC	BRAC Limb and Brace Centre
CRC	Convention on the rights of the child
CRP	Centre for the Rehabilitation of the Paralysed
DCI	Distressed Children International
ECD	Early Childhood Development
EFA	Education for all.
GDP	Gross Domestic Product
H.S.C.	Higher Secondary school certificate
IED	Institute of Educational Development
IMCH	Institute of Mother and Child Health
JICA	Japan International Cooperation Agency
MDG	Millennium Development Goals
S.S.C.	Secondary school certificate
SD	Standard Deviation
SPPS	Statistical package for the Social Sciences
UN	United Nations
UNESCO	United Nations Educational, scientific and cultural organization
UNICEF	United Nations Children's fund
WHO	World Health Organization

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CHAPTER. I

Introduction

Disability is a phenomenon that has concerned human societies throughout history. Children, particularly those in the developing world, are among the most vulnerable groups. (Cherkose, Desta & Ayalew, 2000). Unless it is properly and timely addressed, children with disabilities will likely become the burden of family, society, and the whole nation. More importantly, it leads to a wide range of social, psychological, emotional, and physical problems for the life of the child.

Rearing a child with a disability requires extra time. Additionally, depending on the situation, additional energy, and patience are also required. This situation requires acceptance. Bringing families to the full scale of participation in helping children with disabilities grow and develop is a challenge to everyone concerned.

Early detection of impairments and developing strategies to uphold the normal development of children is a primary and extremely important step in addressing problems associated with disabilities. Parents (or caregivers), particularly mothers play a significant role in this process (Thornburn & Marfo, 1994). First and foremost, parenting is a skill that needs to be learned formally and informally through various means. Often young mothers acquire parenting skills from their home environment especially from their parents, grandmothers, elder sisters, etc. The challenges of parenting children with disabilities require certain skills that parents should receive from all corners, to counter and cope with negative community attitudes and traditional beliefs towards disability. Special support and encouragement is essential for parents to counter the social isolation that children with disabilities suffer from in the community where s/he is living.

There is limited evidence on how child rearing practices for children with disabilities impact child development. Therefore, it is necessary to conduct this study to address the problem and its consequences.

1.1 Background of the study:

According to a WHO world health report, in Bangladesh the total number of disabled children from birth until ten years is 3,153,886, or 7.7% of the population of that age group. Among them 41.5% children are physically impaired (Ackerman, Thormann, & Huq, 2005). Rearing practices are very crucial to assist in the development of these children. Every child should have a good start in life. The first few years of life are very critical in terms of development. The rate of development at this stage is higher than any other subsequent stages of development (Save the Children, 2006). The UN Convention on the Rights of the Child (CRC) states that the family has the key responsibility to ensure the fundamental rights of children. Family is the primary setting within which children are cared for and parented and where first significant relationships develop and the foundations of their development take place (United Nations High Commissions for Human Rights, 2007).

Early childhood experiences, particularly during the first few years makes the child unique. The foundation for learning, and one's overall development, is nurtured during early childhood (Berk, 2005). Caregivers hold the key to open a world of stimulating experiences for infants and toddlers – experiences that stimulate cognitive, emotional and physical development. The ability of caregivers to provide stimulating experiences to children depends on their knowledge of child development and practices in child rearing. The key determinants of quality childhood experiences are: child-rearing practices and caregiver knowledge about child development and child-rearing practices and beliefs related to these practices.

Child caring and rearing practices vary in different cultural contexts. In most cultures caregivers acquire knowledge, child-rearing practices and related beliefs through socialization. Their beliefs are culturally bound understandings of what children need and what they are expected to do. This study attempts to document child caring practices and beliefs (including misconceptions) among mothers of children with disabilities and child development knowledge (including gaps in knowledge).

1.2 Literature review:

1.2.1 Child rearing practices:

Child rearing may be defined as 'purposive activities aimed at ensuring the survival and development of children' (Save the Children Sweden, 2008). According to Saramma & Thomas, (2010) child rearing refers to bringing-up children by parents or parent substitutes. Good parenting goes beyond basic child care like feeding, cleaning, taking care of health and providing periods of rest. It encompasses various other issues which help the child to develop in order to increase social competence and to recognize feelings of themselves and others. It helps the child to understand and express emotion, to have a good sense of identity – self-confidence and self-esteem (Save the Children Sweden, 2008).

Parenting is a complex activity that includes many specific types of behaviour that work individually and together to influence a child's development. Although specific parenting behaviours may influence child development, looking at any specific behaviour in isolation may be misleading (Darling, 2010). Childrearing practices are embedded in culture and determine the behaviours and expectations surrounding a child. Childrearing consists of practices which are based on cultural patterns and beliefs. In simple terms, child rearing practices are a set of practices/activities that are performed by caregiver (Evans & Myers, 1994).

1.2.2 Historical perspective of child rearing practices:

The history of child-rearing practices is divided into a positive and nurturing concept and a negative and suppressive perspective of children (Hoghughi & Long, 2004).

From the 1600's through the Victorian age, it was thought that a child should be seen and not heard. Child rearing practices were strict at that time and only focused on social needs, not on a child's welfare. In the 1920's the scientific method of child rearing was popularized by self-styled child development experts like Myrtle Meyer Eldred. Her syndicated newspaper column, "Your Baby and Mine," advised that children be taught to self-soothe (Wondra, 2010). The post war boom created the nuclear family. By the 1970's, child development experts like Dr. Benjamin Spock advocated a relaxed disciplinarian style where children would find their own moral values and learn things in their own time. Many parents substituted the role of friend for their parental role (Wondra, 2010).

1.2.3 Factors affecting child rearing practices:

Child rearing practices differ from one parent to another. Different child rearing practices vary in achievement of optimum development. It is one of the causes for individual differences. Emotional control, temperament and behaviour in adult life depend on how he or she is reared up in his/her early childhood. To develop a child's knowledge and understanding, parents need to recognise their children's need through their entire life span. It arises either from a deficit in the child or the urge for positive enhancement (Hoghughi & Long, 2004). Social class, income and religion have a great effect on child rearing practices. Parents that were raised in middle or upper classes of society tend to teach social manners to their children. Culture may play a part in one's upbringing. A Japanese daughter is different from an American daughter (Artisan, 2010). Parents' motivation is another factor in child rearing practices. Parents own socialization gives them some knowledge of their children's condition and corresponding needs (Harknees & Super, 1996).

1.2.4 Resources for parenting/child rearing practices:

Quality parenting is very important for optimum child development. It can be inborn or acquired. Skills are required to meet the physical, emotional and social care needs of the children. Persuasive ability is needed to gain resources and management skills are required to make best use of them (Hoghughi & Long, 2004). Material resources are generally interpreted as the money, goods and services that are necessary for raising children. They include food, clothing, housing, medicine, toys, educational materials and a multitude of services (Venkatesan, 2004).

1.2.5 Dimensions of child rearing practices:

Parents do many things for their children's welfare. Care is an important dimension of child rearing (Hoghughi & Long, 2004). Care comprises a group of activities aimed at meeting the survival needs of children. Control consists of the range of activities concerned with setting and enforcing boundaries for the child in an age and culturally appropriate manner (Berk, 2005). Parents conduct developmental activities for their children to fulfil their potential in all areas of function. Parents should work with children in all functional areas such as physical health, social behaviour, mental health etc. (Harknees & Super, 1996).

1.2.6 Child rearing practices (style/typology):

Parenting styles are used to capture, control and socialize children (Baumrind, 1991). Parenting styles have two important elements of parenting: parental responsiveness and parental demandingness (Darling, 2010). Parental responsiveness refers to the extent to which parents intentionally foster individuality, self-regulation, and self-assertion by being familiar, supportive, and compliant to children's special needs and demands. Parental demandingness involves making children become integrated into the family as a whole, by their maturity demands, supervision and disciplinary efforts (Baumrind, 1991). Baumrind defines three distinct styles of parenting. The first is authoritarian parenting, which consists of high behaviour standards, punishment of misconduct and low communication. The second style identified is permissive parenting, which includes a lot of nurturing, high communication, rare punishment, guidance and control. Authoritative parenting is the last style in which the parents set limits and punishments but listen to the child and are able to be flexible (Bryant, 2010).

1.2.7 Importance of parents' knowledge on child rearing practices:

Parents need a wide range of skills and knowledge. One essential area in which parents need to become educated is in the area of child development. One of the most crucial reasons for parents to be educated about the development of their child is so they will be aware of whether their child's developmental milestone is being achieved at the expected rate (Mcfadden, 2010). If they have awareness in their child's current capabilities, parents can encourage and facilitate the continued healthy development of their child. If parents know what their child is able to cognitively and physically achieve, then they can provide appropriate activities for their child (Venkatesan, 2004). As a parent, it is natural that one would have increasing behavioral expectations as one's child grows and develops. As a result, it is important that every parent has realistic expectations. When parents are aware of the developmental stages of their child, they will be able to understand age appropriate behavior. As a result of having realistic demands, a child is more likely to successfully meet those demands (Hoghughi & Long, 2004).

Early intervention is often a key component in the successful handling of developmental delays. By addressing developmental delays at an early stage, both

parents and health care providers can help children in their child's developmental progress (Mcfadden, 2010).

1.2.8 Interference between child rearing practices and scientific knowledge:

Childrearing practices are different across cultures. It is universally accepted that all children have basic needs and a predictable pattern of development during their early years. Studies from different parts of the world reveal that all young children need adequate nutrition, health and care from birth onwards (Harkness & Super, 1996). The lack of this support during the early years has permanent negative effects on later development. Not only are there consequences for the child's physical well-being; in addition, these variables have an impact on the child's social and cognitive development. These factors are influenced by the economic and political context in which the child lives. Consequently these issues interfere with families' beliefs and child rearing practices (Evans & Myers, 1994).

1.2.9 Children with Disability:

Language is very powerful. Consequently, people's choice of words can spread social exclusion or promote positive values. The term 'children with disabilities' rather than 'disabled children' is used to emphasize children's individuality rather than their condition (UNICEF, 2007). The World Health Organisation has made the following distinctions between impairment, disability and handicap within the context of health experience:

"Impairment is any loss of abnormality of psychological or anatomical structure or function. Disability is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being". "Handicap is a disadvantage for a given individual, resulting from an impairment or disability, that limits or prevents the fulfilment of a role that is normal, depending on age, sex, social and cultural factors, for that individual" (United Nations, 1983).

1.2.10 Types of disability in children:

There are different types of disabilities which affects children. These consist of physical disability, sensory disability, visual impairment, hearing impairment, intellectual disability, mental health and emotional disability, developmental disability, learning disability etc. (Centre for the improvement of child caring, n.d.).

Physical disability:

According to Wikipedia (2010) "Any impairment which limits the physical function of limbs or fine or gross motor ability is a physical disability". People with physical disabilities have a physical impairment which has a substantial and long term effect on their ability to carry out day-to-day activities (Firststop, n.d.). A physical disability is any condition that permanently prevents normal body movement and/or control (Child and youth health, 2009).

Intellectual disability:

Intellectual disability is a broad concept that ranges from mental retardation to cognitive deficits too mild or too specific (as in specific learning disability) to qualify as mental retardation (Wikipedia, 2010).

Speech disability:

Speech disability defines a speech or language impairment as a communication disorder such as stuttering, impaired articulation, oral motor disorders, language impairment, or a voice impairment, that adversely affects a child's educational performance (Wikipedia, 2010).

Hearing disability:

Hearing disability refers to conditions in which individuals are fully or partially unable to detect or perceive at least some frequencies of sound which can typically be heard by most people. Mild hearing loss may sometimes not be considered a disability (Wikipedia, 2010).

Visual disability:

Visual disability (or vision impairment) is vision loss (of a person) to such a degree as to qualify as an additional support need through a significant limitation of visual capability resulting from either disease, trauma, or congenital or degenerative conditions that cannot be corrected by conventional means, such as refractive correction, medication, or surgery (Wikipedia, 2010).

1.2.11 Causes of disability in children:

There are different diseases and illness that cause disabilities in children. Neurological conditions involve damage to the central nervous system (brain or spinal cord). Major neurological conditions include cerebral palsy, seizure disorder (or epilepsy), and spina bifida, a congenital condition in which the spinal cord protrudes through the backbone resulting in partial or total paralysis below the site of the nerve damage (Meyerhoff, 2010). Musculoskeletal conditions include muscular dystrophy, juvenile rheumatoid arthritis, limb deficiencies or amputations, and a wide variety of other deformities or degeneration of muscles or bones (Venkatesan, 2004). Causes include infectious disease, congenital conditions or malformations, and developmental problems. A wide variety of disabilities, especially those associated with traumatic brain injury; result from vehicular accidents, gunshot wounds, burns, falls, and poisoning. Substance abuse and physical abuse by caretakers, infectious diseases, and substance abuse by the child or by the mother during pregnancy cause some disabilities (Centre for the improvement of child caring, n.d.).

1.2.12 Challenges in rearing children with disabilities:

Parents face many challenges in rearing a child with disabilities. Challenges may vary greatly depending on the severity of disability with their children. Parents need to adopt strategies to bring up children with disabilities. Rearing children with disabilities requires extra energy, time and patience (Cherkose, Desta, & Ayalew, 2000). Parents need certain skills to care for children with disabilities. They have to cope with negative community attitudes and traditional beliefs systems (Harkness & Super, 1996). It is extremely important to encourage good parenting by easing stress, providing up to date information and offering material or financial support especially to disadvantaged families. It will help their children with disabilities to acquire self-

care skills and have access to schooling. Furthermore, parents need to be informed on how to identify disabilities and be trained on the necessary skills to care for children with disabilities so early intervention can be provided (Venkatesan, 2004).

1.2.13 Literature review on child rearing practices:

The development of children is multi-determined and is affected by their health and nutritional status, their genetic potential as well the quality of their home environment. In poorly educated and traditional populations, parents tend to have unstimulating environments. They often are unaware that their child rearing practices can affect their children's cognitive and language development. They fail to appreciate the importance of playing and chatting with young children. They may be unaware of age appropriate activities to do with their children. Many parents inhibit exploration and use punitive discipline (Makame, 2001). Very often parents have a negative attitude towards their child with disabilities. The parents show their negative attitude. They feel reluctant to introduce their child to others. (Kolobe, 2003).

Every society has different child rearing practices used to facilitate child development. The practices depend on cultures, beliefs, and socio-economic as well as environmental factors. These different factors influence child development as societies at the same time have different perceptions and expectations on child development.

Child rearing practices vary in different countries according to their culture and beliefs. Indian mothers massage their babies daily and carry them close to their bodies. Co-sleeping during the early years is another characteristic of the close mother-infant relationship. Discipline is often strict and children are taught to obey their parents. Physical punishment is sometimes used to discipline, control, and teach the child appropriate behaviours (Matze, 2009).

Most of the mothers in the Maldives think that feeding and keeping the baby clean are the most important routine care-giving activities. Stimulation and interaction are not mentioned as routine activities. Only 19% of the population in the capital city reported playing with the child as a routine activity (UNICEF, 2000).

The Chinese conceptualize childhood as two distinct periods called the 'age of innocence' and the 'age of understanding'. During the age of innocence, Chinese mothers nurture their children and try to meet their every need because they believe children lack cognitive competence at that age and are not capable of much learning. When children reach the "age of understanding" at around age five to six years, stricter methods and training are suddenly implemented (Matze, 2009).

In the Caribbean, the parenting styles are a mixture of authoritarian/punitive control and affection. There physical punishment is persistent. Children suffer horrible consequences as a result of serial migration there. Parents do not know the benefits of play. There is little two-way verbal exchange between parents and children. Additionally, there are low levels of parent-child stimulation (The Caribbean Child Support Initiative, 2006). However, nowadays some practices in relation to play and discipline are changing to become more developmentally supportive behaviors.

A child's development can be restricted by social and environmental conditions. If the child does not have the opportunity to play and interact with other people around him/her, s/he cannot develop motor skills because s/he is not engaging with situations needed for development. This further affects cognitive development. Again lack of primary health care such as vaccines, clean and safe water, or presence of disease can delay the development of the child (Makame, 2001). Various studies have shown conclusively that parenting styles and practices have a permanent impact on the growth of the child, and also have influence on his/her individual characteristics when s/he grows into adulthood (Save the Children Sweden, 2008).

Any kind of disability makes childhood difficult not only for children but also for parents as they are encountering a range of unpleasant reactions (Venkatesan, 2004). Studies indicate that when parents identify disabilities in their children they usually encounter a range of mixed attitudes, emotional reactions and feelings toward their children. Parents may feel unfortunate for having a child who is not perfect. They may experience guilt, particularly if they have ignored their child. These feelings have both direct and indirect effects on the behavior and attitude of family members towards the child with disability (Harkness & Super, 1996).

Parents who have children with disabilities may be prone to various psychological problems. Studies reveal that because of imagined responsibility for the child's condition, parents feel insecure and guilt-ridden. They attempt to identify their own shortcomings which might have caused their child to have a disability. They feel ashamed of their children's backwardness and often try to hide them from friends and neighbors. Parents also face another psychological problem. Over time they acquire more knowledge and experience related to their child's disability and this leads to guilt. Parents may place blame upon themselves in not recognizing the problem with their children early enough. As parent of a child with disability noted, "shock and guilt never disappear but stay on part of the parent's emotional life" (Hoghughi & Long, 2004).

Due to lack of knowledge and awareness, parents may demand more behavior and intellectual achievement from their children which is beyond their child's ability. Sometimes they feel ashamed of the mistakes made in pushing the children beyond their capacity and lose patience with them. On the other hand, there are also some parents who take a very protective approach in their efforts to protect the child from challenging situations. The tendency toward overprotection may interfere with the development of whatever capabilities he or she may have. Parents may regret doing things for their children that the children might have learned for themselves (Berk, 2005).

Linkages are present between "Mothers' childrearing behaviors" and their 'infants' cognitive developmental status". For motor developmental status, the association seems to be stronger with the infants' characteristics than with maternal childrearing practices and behaviors (Kolobe, 2003).

1.3 Rationale:

Numerous studies support the position that child rearing practices are extremely important for children's holistic development. There is every reason to believe that the normal growth and development of children is dependent on the kinds of positive and negative experiences that children encounter during infancy and childhood.

Rearing styles form the foundation for child development. The degree of depth in a parent/child relationship is linked to how well parents are able to provide for their child's basic needs. Early childhood is a prime time to prepare children for later life.

The environment in which children are raised significantly affects their intellectual, physical, social, and emotional development. The National Longitudinal Survey of Children and Youth has found that positive parenting practices act as a protective factor for children living in "at risk" environments. At the same time, research has shown that negative outcomes for children (such as challenging temperaments/behaviours) are more likely present in families with poor parenting practices (BC Council for families, 2010).

Bringing up a child with disabilities or developmental difficulties requires extra efforts and time from parents and caretakers. It takes longer to see meaningful development on the part of the children. It requires patience. It is quite a challenging task when compared to bringing up non-disabled children. It requires more knowledge, special skills and a lot of effort on the part of parents. External input (professional, material and financial) is needed to support the efforts made by the parents. Favourable social and physical environment is also very important. Clinical experience and developmental research reveal the importance of environmental stimulation on children's social, emotional, physical and cognitive development (Gouley, 2010).

According to the Convention on the Rights of the Child (CRC) the Government should ensure that children survive and develop healthy. In article 24, it is mentioned that children have the right to receive quality health care, clean water, nutritious food a clean environment, so that they will be healthy (United Nations High Commissions for Human Rights, 2007). Deprivation of care and treatment are particularly damaging young children (EFA, 2007). In clinical experience of professionals it was observed

that children with physical disabilities who receive specialised rehabilitation services and proper care and nurturing display better physical improvement.

About 7.7% of the total children in Bangladesh are disabled. Mothers face a lot of difficulties to rear these children (Ackerman, Thormann, & Huq, 2005). Very little evidence has been found on current child rearing practices relating to mothers who have children with disabilities.

This study will examine the current child rearing practices in Bangladesh for children with disabilities. The results of the study might provide a better picture of child rearing practices in Bangladesh for children with physical disabilities. It could help to identify practices that might support children's holistic development and those that could have a negative impact. The research findings might help programmes develop strategies that could help close the gaps in the education and care of children with disabilities to enhance their optimal development. Additionally, the findings may help programme personnel take further steps to improve the quality of life for children with disabilities. The results might also help Government officials to better understand the issues of children with disabilities, and to assist them in creating policies that would enhance the well being of these children.

1.4 Operational Definitions:

Child rearing Practices:

Child rearing may be defined as 'purposive activities aimed at ensuring the survival and development of children. Good parenting goes beyond basic child care like feeding, cleaning, taking care of health and providing periods of rest. It encompasses various other issues which help the child to develop in order to increase social competence, to recognize feelings himself and others, to understand and express emotion, to have a good sense of identity – self-confidence and self-esteem, etc. (Save the Children Sweden, 2008).

Children with disabilities:

Children with disabilities have an impairment which has a substantial and long term effect on their ability to carry out day-to-day activities (Firststop,n.d.).

Physical disabilities:

A physical disability is any condition that permanently prevents normal body movement and/or control (Child and youth health, 2009).

Intellectual disability:

Intellectual disability is a broad concept that ranges from mental retardation to cognitive deficits too mild or too specific (as in specific learning disability) to qualify as mental retardation (Wikipedia, 2010).

Speech disability:

Speech disability defines a speech or language impairment as a communication disorder such as stuttering, impaired articulation, oral motor disorders, language impairment, or a voice impairment, that adversely affects a child's educational performance (Wikipedia, 2010).

Hearing disability:

Hearing disability refers to conditions in which individuals are fully or partially unable to detect or perceive at least some frequencies of sound which can typically be heard by most people. Mild hearing loss may sometimes not be considered a disability (Wikipedia, 2010).

Visual disability:

Visual disability (or vision impairment) is vision loss (of a person) to such a degree as to qualify as an additional support need through a significant limitation of visual capability resulting from either disease, trauma, or congenital or degenerative conditions that cannot be corrected by conventional means, such as refractive correction, medication, or surgery (Wikipedia, 2010).

Area:

Urban: A geographical area constituting a city or town.

Rural: An area outside of cities and towns.

Periurban: These are areas situated on the periphery or borders of large towns and cities.

Educational qualification:

Illiterate: Unable to produce a signature or write one's own name.

Primary: Schooling up to class 5.

Secondary: Schooling up to class 10.

S.S.C: Passed Secondary school certificate exam.

H.S.C.: Passed higher secondary school certificate exam.

Graduate: Has bachelor degree.

Others: Has Masters or Phd.

Family type:

Nuclear family: A nuclear family is a family group consisting of a father and mother and their children(Wikipedia, 2010).

Joint family: The joint family includes the father and mother, sons, grandsons and great-grandsons with their spouses, as well as the daughters, granddaughters and great-granddaughters (Wikipedia, 2010).

Feeding:

Active feeding: Type of feeding where a child can manage without any assistance of others (Person or device)

Passive feeding: Type of feeding where a child needs full assistance from others (Caregiver)

Assisted feeding: Type of feeding requiring some assistance from a caregiver

Dressing:

Active dressing: Type of dressing that a child can manage without any assistance of others.

Passive dressing: Type of dressing that requires full assistance from others (Caregiver)

Assisted dressing: Type of dressing that requires some assistance by a caregiver.

Type of care:

Optimum care: It consists of four or more elements of child care. These include feeding, cleaning, playing, teaching and going for a walk.

Not optimum care: It consists of less than four elements of child care. Deficiencies could be present in one or more of the following: feeding, cleaning, playing, teaching and going for a walk.

1.5 Objectives:

General objectives:

To explore the child rearing practices of mothers with children who have disabilities.

Specific Objectives:

- To find out the socio-demographic characteristics of children with disabilities.
- To explore the child-rearing practices that mothers provide to their children with disabilities.
- To explore mothers' ideas about the concept of child development for young children.
- To identify mothers beliefs and attitudes relating to children with disabilities.
- To determine any association between various socio-demographic characteristics and types of disabilities with child rearing practices.

CHAPTER II

Methodology

It was a mixed method study in which cross-sectional design was used. Both quantitative and qualitative methods were used to analyze the data. Two case studies of families with children with disabilities are included to highlight some meaningful findings. The study was conducted from September 2010 to May 2011 (Detail in Annex-7).

2.1 Sample

The purposive sampling procedure was used to collect the sample. There were some inclusion criteria for selecting the sample. Mothers who had children with disabilities aged between 1 and 8 years were taken as a sample for the study. 62 mothers of children with single or multiple disabilities were included under this study. Data were collected from three organisations: Centre for the Rehabilitation of the Paralysed (CRP), Mirpur branch, BRAC Limb and Brace Centre (BLBC), Institute of Mother and Child Health, Matuail.

2.2 Tools/instruments:

Data were collected through interviews and observations. Questionnaires were used for interviews and a checklist was used for observation. A field test was conducted with three participants to enhance the validity of the study. Before beginning the final data collection, it was necessary to carry out a field test. This helped the researcher to refine the data collection plan. During the interview the researcher informed the participants about the aim and objectives of the study. From the field test the researcher became aware of any parts or questions the participants had easily understood. The researcher only generalized the situation of the interview times; participants responded and considered whether the data collection was proceeding correctly. The answers that emerged from these selected questions helped the researcher to modify the questions where necessary. This also helped to structure the questionnaire (Devop, 1998). Finally the questionnaire was developed in Bengali (Annex- 4) and English (Annex- 3).

2.3 Study Procedure:

A written structured questionnaire was given to the mothers of children with physical disabilities. Questionnaires included both open ended and close ended questions that provided data about child rearing practice. All samples were interviewed but among them two samples' were observed at home for about 6 hours (10 am-4pm).

2.4 Data analysis:

Data were analysed using SPSS software programme Windows version 15.0. Data was initially checked for any inconsistencies. Descriptive statistics were calculated to show the result according to variables. The results were presented in tables and charts. A test of significance (chi square) was done to see any association between some selected demographic variables with child rearing practices. P value <0.05 was considered as significant.

2.5 Ethical issues:

Approval of the proposal was sought from the Research and Ethical Review Committee of IED, BRAC University before launching the study at the field level. Earlier, in a formal session, the thesis proposal was presented to the expert forum of IED, BRAC University and necessary feedback was incorporated in the proposal. Furthermore, formal permission was taken from different organizations to collect data from mothers of children (Paediatric patients) with physical disabilities. The researcher developed a consent form in English (Annex- 1) and Bengali (Annex-2) in order to take consent from subjects. During interviews the researcher took permission from each participant with signatures on a written consent form from the participants who were interested to take part in the study. Then the researcher also took the signature of a witness. The researcher clarified the role of the participants in the study. Participants were informed that the given information would not be shared with others. The researcher explained to participants how interview data would be used in the study and made sure that their identity remained confidential. The researcher also explained the benefits of the study to the participants and explained their right to decline answering any questions during the interview and to refuse participation in the study at any time.

CHAPTER. III

Results

3.1 Socio-demographic characteristics:

A. Age group distribution:

Sixty-two mothers of children with disabilities who came to different organizations for physiotherapy treatment for their children were selected for the study. The age of the children ranged from 1-8 years. Most of the children covered in this study ranged from three years to just under 6 years (29 or 46.78%). Fifteen children were from the age group 1-<3 years that was 24.19% of the total children. Eighteen children were from the 6-8 years age group. This comprised 29.03% of the total number of children. The mean age of the children was 53.08 months (± 23.5 SD).

Table I: Children with disabilities age group distribution.

Age group	Frequency	Percentage (%)
1-<3 Years (12-35 months)	15	24.19
3-<6 Years (36-71 months)	29	46.78
6-8 Years (71-96 months)	18	29.03
Total	62	
Mean age \pm SD (in months)	53.08 \pm 23.5	

B. Sex distribution:

Figure I: Sex of children with disabilities.

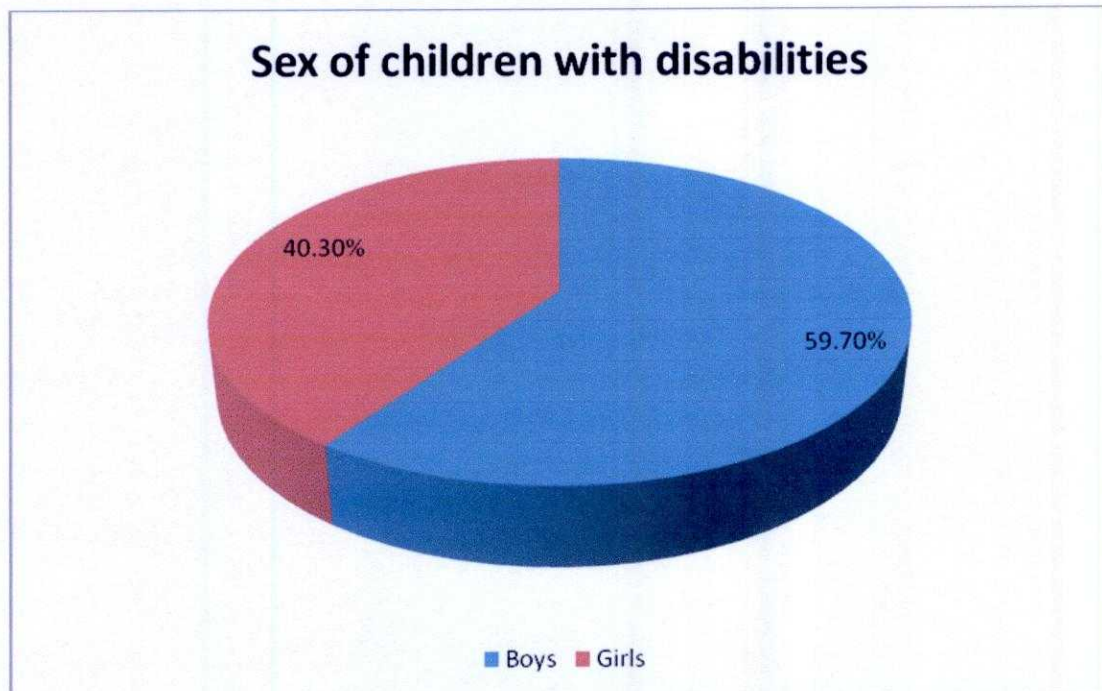


Figure I. shows that in the study both boys and girls were included. Among them 37 (59.70%) were boys and 25 (40.30%) were girls.

C. Characteristics of children:

Table II: Characteristics of children under the study

Variables	Frequency	Percentage (%)
Residence		
Urban	30	48.4
Periurban	13	21.0
Rural	19	30.6
Religion		
Muslim	54	87.1
Hindus	7	11.3
Christian	1	1.6
Number of siblings		
None	4	6.5
One	26	41.9
Two	20	32.3
More than two	12	19.3

This table shows that in the study 30 (48.4%) children were from urban contexts, 13 (21.0%) from periurban and 19 from rural areas, comprising 30.6% of total children. Most children were from a Muslim background (87.1%), but 11.3 % were Hindu and 1.6% of the total number were Christian. Out of 62 children 6.5% had no siblings, 41.9% had one, 32.3% had two and 19.3% children had more than two siblings.

D. Characteristics of parents of children with disabilities:

Table III: Characteristics of parents of children with disabilities

Variables	Frequency	Percentage (%)
Mother's education		
Primary	20	32.3
S.S.C.	22	35.4
H.S.C. and above	20	32.3
Mother's occupation		
Housewife	53	85.5
Service	9	14.5
Father's education		
Primary	7	11.3
S.S.C.	9	14.5
H.S.C. and above	46	74.2
Father's occupation		
Service	29	46.8
Business	17	27.4
Teacher	3	4.8
Farmer	1	1.6
Industry worker	8	12.9
Others	4	6.5

In this study, different education levels were found among the mothers. 32.3% of mothers completed primary level, 35.4% mothers passed S.S.C. and 32.3% mothers passed H.S.C. and above. Among 62, 11.3% fathers completed primary level, 14.5% fathers passed S.S.C. and 74.2% fathers passed H.S.C. and above. The occupational background of the mothers indicates that most are housewives (85.5%) while 46.8% of fathers are employed in service, 27.4% in business, 4.8% in teaching, 1.6% are farmers, 12.9% are industry workers and 6.5% are involved in other occupations.

E. Characteristics of the children's family:

The data shows that most of the children live in a single family (75.8%) and only 24.2% children live in a joint family. The data also shows the different ranges of family members in each family. The majority was 5-6 family members, totaling 43.5%. This was followed by 3-4 members (32.2%), 7-8 members (17.8%), and 9 and above (6.4%).

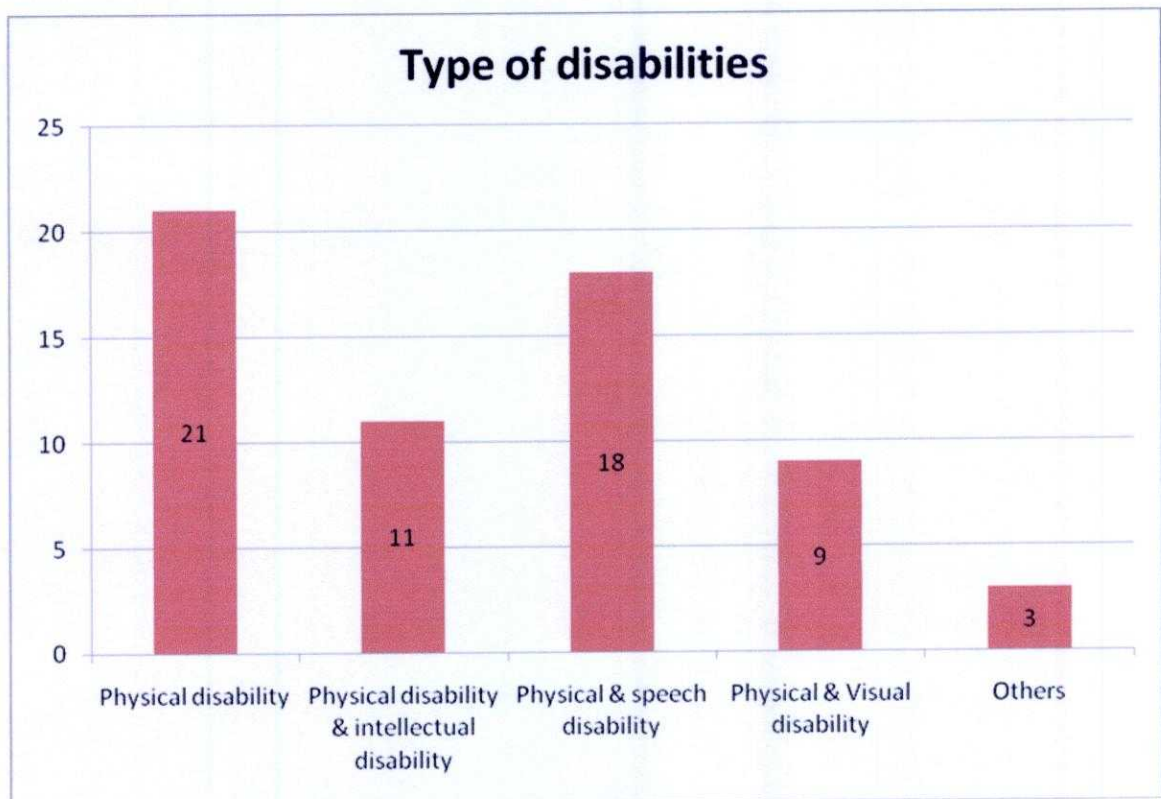
Table IV: Characteristics of children's family

Variables	Frequency	Percentage (%)
Type of family		
Single	47	75.8
Joint	15	24.2
Family member		
3-4	20	32.2
5-6	27	43.5
7-8	11	17.8
9 and above	4	6.4
Monthly income (Taka)		
Low (<8000)	6	9.6
Middle(8000-15000)	42	67.8
High(>15000)	14	22.6
Range	5000-45000	
Mean \pm SD	14838.71 \pm 7755.365	

Among the families, the average family income was 14838.71 Taka per month. The minimum income per family was 5000 Taka and the maximum income 45000 Taka (Mean \pm SD = 14838.71 \pm 7755.365).

3.2 Type of disabilities:

Figure II: Type of disabilities



It was found that among 62 children, 21(31.9%) have only a physical disability, 11 children (17.7%) have both physical and intellectual disability, 18 children (29%) have both physical and speech disability and only 9 children (14.5%) have both physical and visual disability.

3.3 Child rearing practices:

A. Routine caring practices offered by caregiver:

Activities that mothers carry out routinely with a baby provide insight into the quality of childcare practice. Therefore, the survey asked what parents do for their babies as part of the daily routine. The results revealed that 12.9% of mothers said they feed their child healthy foods regularly. However 41.9%, of mothers claimed they feed

healthy food and keep the child clean. Other categories revealed that 14.5% of mothers feed the children and play with them, 6.5% mothers take the child for a walk along with feeding and cleaning, 4.8% of mothers play, teach, feed and clean their child and only 4.8% mothers engaged in all activities.

Table V: Routine caring practices offered by caregivers

Activities	Frequency	Percentage (%)
Feeding healthy food regularly	8	12.9
Feeding health food regularly and cleaning them	26	41.9
Feeding healthy food regularly and playing with them	9	14.5
Feeding, cleaning and playing with them	9	14.6
Feeding , cleaning and taking the child for a walk	4	6.5
Feeding , cleaning , playing and teaching them	3	4.8
Feeding, cleaning, playing, teaching and going for a walk	3	4.8

B. Duration of play and keeping the child alone:

Table VI: Duration of play and keeping the child alone:

Variables	Frequency	Percentage (%)
Duration of playing with child (in hours)		
0 Hour	8	12.9
1-2 Hour	29	46.8
2-3 Hour	10	16.1
3 -4Hour	7	11.3
> 4 Hour	8	12.9
Mean \pm SD (in hour)	1.64 \pm 1.235	
Duration of keeping the child alone (in hour)		
0 Hour	6	9.7
< 1Hour	7	11.3
1-2 Hour	30	48.4
2-3 Hour	19	30.7
Mean \pm SD (in hour)	1.250 \pm .8186	

This table shows that most of the mothers (46.8%) participated in 1-2 hours of play. However, only 12.9% of mothers did not participate in play at all. Similarly, 16.1% of mothers engaged in 2-3 hours, 11.3% in 3-4 hours and 12.9% of children received more than 4 hours. On the other hand, 48.4% children played alone for 1-2 hours, 11.3% children were alone for less than 1 hour and 30.7% for 2-3 hours. A small number (9.7%) of children were not left unattended.

C. Feeding and dressing of children with disabilities:

Table VII: Feeding and dressing of children with disabilities

Variables	Frequency	Percentage (%)
Type of feeding		
Active feeding	3	4.8
Active assisted feeding	12	19.4
Using spoon/feeding device	5	8.1
Passive feeding	42	67.7
Time required to finish one feed (Minutes)		
15 Mins	6	9.7
30 Mins	30	48.4
45 Mins	17	27.4
60 Mins	9	14.5
Mean± SD (in minutes)	37.02±12.946	
Feeding given below 6 months		
Breastfeeding only	41	66.1
Breast feeding with infant formulae	11	17.7
Breastfeeding for only 3 months	7	11.3
Infant formulae only	3	4.8

The data show different types of feeding practices performed by mothers of children with disabilities. Most of the mothers (67.7%) performed passive feeding to feed the children with disabilities. Only 4.8% of children are fed actively, 19.4% of mothers practice active assisted feeding and 8.1% children use a spoon or feeding devices. Different ranges of time were needed for children to complete their feeding. 48.4%

children required 30 minutes, while only 9.7% require 15 minutes. In addition, 27.4% of children require 45 minutes, while nearly half (14.5 %) require 1 hour. Feeding below 6 months was also studied. 66.1% mothers only breastfeed their child, whereas 17.7% children combine infant formulae with breastfeeding. Only 4.8% of the children are given formulae only.

D. Interactive caring practices during routine care:

Table VIII: Interactive caring practices during routine care:

Activities	Frequency	Percentage (%)
Activities during feeding and dressing		
• Feeding and dressing only	20	32.2
• Feeding and dressing with talking	12	19.4
• Feeding and dressing with singing/rhyming	16	25.8
• Feeding and dressing with teaching of how to feed and dress	14	22.6
Activities for stimulating the child		
• Providing toys and colourful objects	23	37.1
• Telling them stories/singing songs	16	25.8
• Teaching them to speak by talking to them	17	27.4
• Helping them in what they do or letting them observe you while working	6	9.7

The table VIII shows activities during feeding and dressing and activities to stimulate the children. According to the data, 32.2% of mothers perform feeding and dressing only, 19.4% of mothers talk with children during feeding and dressing, 25.8%

mothers sing or rhyme when feeding and dressing and 22.6% of mothers teach children how to feed and dress during feeding and dressing. On the other hand, to stimulate the children, 37.1% of mothers use toys and colorful objects, 25.8% of mothers tell stories and sing songs, 27.4% mothers speak to their children, and 9.7 % mothers help or assist in performing activities to stimulate their children with disabilities.

3.4 Mother's knowledge regarding child development:

A. Mothers understanding of different milestones of development:

Table IX shows mothers' understanding of different milestones of development. The data reveal perceptions of mother's understanding of when a child can think and feel. According to the data, 8.1% mothers thought that a child can feel and think while in the womb, 19.3% thought that a child can feel and think immediately after birth. Others thoughts were between one to the months (32.3%) and after 3 months (40.3%). In addition, 88.7% of mothers thought that a child could walk from 12-18 months and 11.3% mothers said that child needs more than 18 months to gain ability to walk.

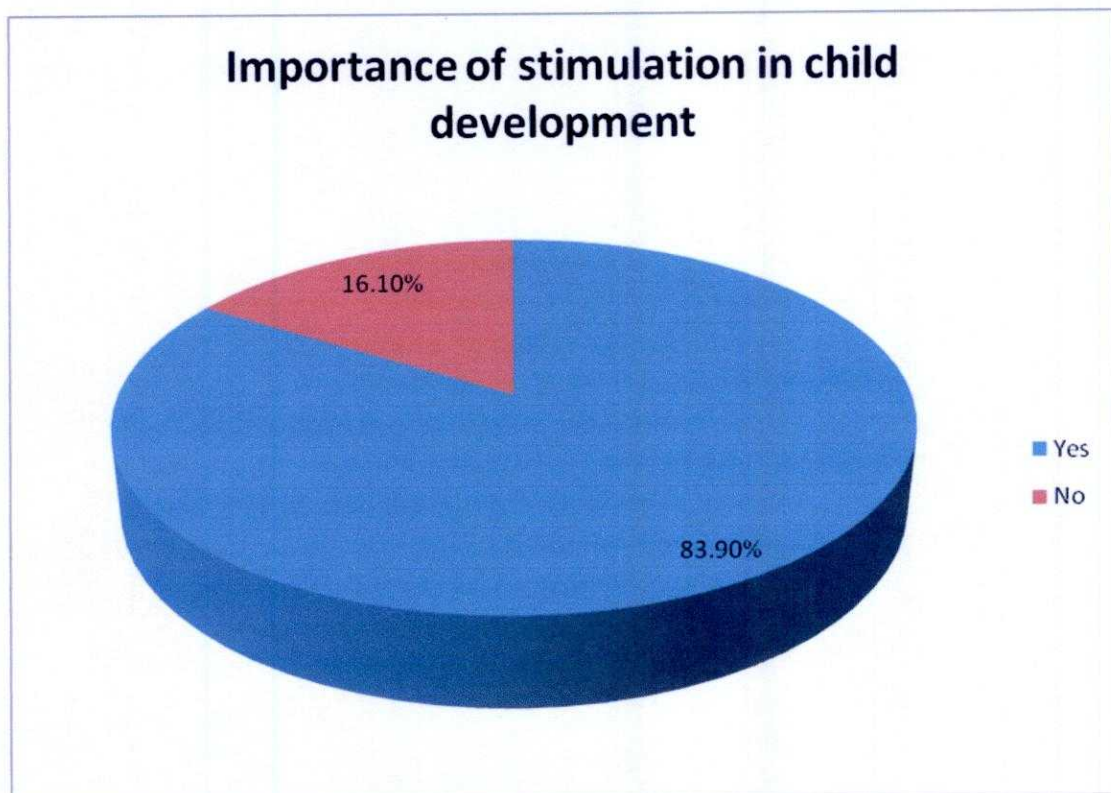
Mothers' understanding on child's ability to recognize parents was also described in table IX. As the table shows, 58.1% of mothers thought that children can recognize their parents within 3-5 months. Nearly half (25.8%) of the mothers reported that children can recognize their parents within 1-2 months and only 16.1% mothers thought that children need more than 5 months to gain that capacity. Moreover, mothers were also asked to describe when they believed child could use meaningful language. The data revealed that 59.7% mothers' thought that children can say meaningful words before 12 months, while 27.4% mothers said that in 12 months children start to say meaningful words. Very few mothers (12.9%) thought that children need more than 12 months to achieve the ability to use meaningful language.

Table IX: Mothers understanding of different milestones of development

Variables	Frequency	Percentage (%)
Mother's understanding of when a child can think and feel		
While in the womb	5	8.1
Immediately after birth	12	19.3
Between one to three months	20	32.3
After three months	25	40.3
Mother's understanding of when a child can walk (in months)		
12-18	57	88.7
>18	7	11.3
Range	12-24	
Mean± SD (in months)	14.95±3.936	
Mother's understanding of when a child can recognize parents (in months)		
1-2 Months	16	25.8
3-5Months	36	58.1
>5 Months	10	16.1
Range	1-6	
Mean± SD (in months)	3.42±1.510	
Mother's understanding of when a child can say meaningful words (in months)		
8-<12 Months	37	59.7
12 Months	17	27.4
More than 12 Months	8	12.9
Range	8-12	
Mean± SD (in months)	10.06±1.492	

B. Mothers' perception on importance of stimulation in physical development:

Figure III: Importance of stimulation in physical development



The data shows that 52 mothers (83.90%) believed that stimulation is important to the physical development of children. The rest (16.10%) did not think that stimulation has any importance in the physical development of children.

C. How stimulation helps in the physical development of children:

Among 52 mothers, 23.1% of mothers thought that stimulation helps in the movement of the children's limbs. Other perceptions were that stimulation helps in improving sensation (21.1%), encouraging movements (23.1%), doing exercises (23.1%) and doing activity of daily livings (ADLs).

Table X: How stimulation helps in the physical development of the child

	Frequency	Percentage (%)
By helping in the movement of limbs	12	23.1
By improving sensation	11	21.1
By encouraging movement	12	23.1
By encouraging exercises	12	23.1
By encouraging to try to do the ADLs	5	9.6

D. Mothers' perception on the importance of oil massage in physical development:

Figure IV: Importance of oil massage in physical development

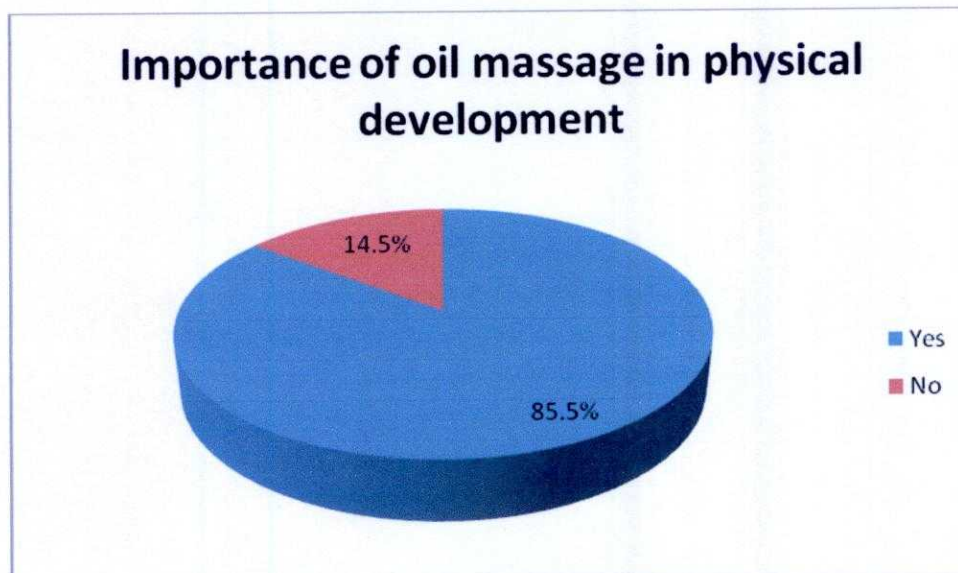


Figure V indicates that most of the mothers (85.5%) believed that oil massage is important to a child's physical development. Only 9 mothers did not believe that oil massage has any importance in child's physical development.

E. How oil massage helps in physical development of the child:

Table XI: How oil massage helps in physical development of the child

	Frequency	Percentage (%)
Helps to improve blood circulation	28	52.8
Warms the body	8	15.1
Increases the strength of the body	8	15.1
Strengthens the neck	9	17

Among 53 mothers, 28 (52.8%) mothers thought that oil massage helps to improve blood circulation and 15.1% of mothers' believe oil massage warms the child's body. Other perceptions were it helps to increase the strength of the body (15.1%) and also helps to strengthen the neck (17%).

F. Mothers' perception on the importance of child rearing practices in physical development:

Table XII: Parents' understanding of how child rearing practices helps in physical development

Parents' understanding of how child rearing practices helps in physical development	Frequency	Percentage (%)
Helps to protect a child from diseases	7	11.3
Helps to be a healthy child	5	8.1
Helps in achieving functional abilities	33	53.2
Helps to stimulate physical growth	3	4.8
Helps to perform exercises by ADLs	14	22.6

The table explained the mothers' understanding of the importance of child rearing practices in physical development. All mothers agreed that child rearing practices have great importance in physical development. As the table indicates, 53.2% of mothers thought that it helps to achieve functional abilities. Furthermore, 11.3% of

mothers thought that it helps to protect a child from diseases, while 8.1% mothers believed that it prepares a healthy child. Other thoughts were that it helps to stimulate physical growth (4.8%) and helps perform exercises by ADLs (22.6%).

G. Mothers' perceptions regarding children with disabilities:

The data shows that mothers have different perceptions about children with disabilities. According to the table, 11.3% of mothers believe that they are not useful for the community, while 45.1% mothers feel that they could be useful if they get proper care, love and affection. Some mothers (22.6) believe that they need help and kindness. Another perception (21%) was they need more attention than other children.

Table XIII: Mothers' beliefs regarding children with disabilities

Mothers' beliefs	Frequency	Percentage (%)
Not useful for the community	7	11.3
Can be useful if children have proper care, love and affection.	28	45.1
Need help and kindness	14	22.6
Need more attention than other kids	13	21

3.5 Association between different socio-demographic characteristics of children with disabilities and child rearing practices:

A. Sex

Table XIV: Distribution of children according to their sex

Sex	Optimum Care		Not Optimum Care		χ^2
	Frequency	Percentage (%)	Frequency	Percentage (%)	
Boy	3	8.1	34	91.9	0.463 (p > 0.05)
Girl	3	12	22	88	

The table XIV shows that. Among boys 8.1% are provided optimum care and 91.9% do not receive optimum care, and among girls 12 % have optimum care and the rest lack optimum care. The data shows that there is no significant difference between optimum care and not optimum care in sex ($\chi^2 = 0.463$, $p > 0.05$). There is no association between sex and child rearing practices.

B. Mothers' characteristics

The table XV explains that twenty mothers had completed primary education. Among them 10% of mothers provide optimum care and 90% mothers do not provide optimum care to their children with disabilities. Among the mothers who passed the S.S.C. only 4.5% of mothers provide optimum care and the rest do not provide optimum care. Apart from primary education, twenty mothers hold an education qualification of H.S.C. and above. Among them 15% of mothers provide optimum care and 85% of mothers do not providing optimum care. There is no significant difference in education qualification between optimum care and not optimum care ($\chi^2 = 0.519$, $p > 0.05$). The study also shows that among mothers who are housewives 11.3% of mothers provide optimum care and 88.7% do not provide optimum care to their children with disabilities. However, out of the mothers who are

service holders, not all of them provide optimum care to their children with disabilities. There is no significance difference between optimum care and not optimum care in occupation of mothers ($\chi^2 = 0.373$, $p > 0.05$), and no association between occupation of mothers and the level of care for children with disabilities.

Table XV: Distribution of mothers according to their education qualification and occupation.

Mother's Characteristics	Optimum Care		Not Optimum Care		χ^2
	Frequency	Percentage (%)	Frequency	Percentage (%)	
Education					
Primary	2	10	18	90	0.519 ($p > 0.05$)
S.S.C.	1	4.5	21	95.5	
H.S.C. and above	3	15	17	85	
Occupation					
	6	11.3	47	88.7	0.373 ($p > 0.05$)
Housewife	0	0	9	100	
Service					

C. Socio-economic status:

Table XVI: Distribution of participants according to their socio-economic status

Socio-economic status	Optimum Care		Not Optimum Care		χ^2
	Frequency	Percentage (%)	Frequency	Percentage (%)	
Low	2	33.3	4	66.7	0.069 (p > 0.05)
Middle	2	4.8	40	95.2	
High	2	14.3	12	85.7	

The table shows that in low income families about 33.3% of children receive optimum care and the rest lack optimum care. In medium income families the majority of the children (95.2%) do not have optimum care and only 4.8% of children receive optimum care from their family. In high income families 14.3% children have optimum care and 85.7% children do not have optimum care. There is no significant difference between optimum care and not optimum care in socio-economic status ($\chi^2 = 0.069$, $p > 0.05$). Therefore there is no association between socio-economic status and the level of care for children.

D. Type of disabilities of the children and rearing practices

Table XVII: Association between type of disabilities and child rearing practices

Type of disabilities	Optimum Care		Not Optimum Care		χ^2
	Frequency	Percentage (%)	Frequency	Percentage (%)	
Physical disability	2	9.5	19	90.5	.675 (p > 0.05)
Multiple disabilities	4	9.8	37	90.2	

The study also explains the impact of different disabilities on child rearing practices. The table XVII shows that there is no significant difference between optimum care and not optimum care in types of disabilities ($\chi^2 = 0.675$, $p > 0.05$). Among the children who have physical disability most of them (90.5%) do not receive optimum care. Similarly most of the children (90.2%) with multiple disabilities do not have optimum care. There is no association between type of disabilities and rearing practices of children.

3.6 Two selected cases of children with disabilities:

3.6.1 Case Study 1

Naumita, a 5 year old girl, lives in Mirpur in a nuclear family with her father, mother and only brother named Raju who is 8 years old. Naumita is a physically and intellectually challenged girl. Due to her psychomotor disability, she is unable to do ADL's independently and properly; activities a child could do at her age. For example, Naumita is unable to walk, put on clothes and bathe independently. She requires assistance for these activities. This assistance is primarily provided by her mother, as her mother is the principal caregiver. Naumita's 8 year old brother is well both physically and mentally, so Naumita's mother does not need to spend more time with her son. As Naumita is physically challenged, she receives the majority of her mother's free time. She is a house wife and her husband is a government employee.

On the day of the observation, Naumita's mother needed to make preparations in the morning before Naumita woke up. Afterwards she helped Naumita bathe, dress and eat. Then Naumita was left unattended because her mother was preoccupied with household tasks. During this period she was placed in a standing frame and remained in a standing position. That time Naumita played with toys alone. On a few occasions she suddenly shouted in fear after hearing sounds. After finishing the household work, Naumita's mother played with Naumita for thirty minutes. Additionally, she did some physical exercise that was prescribed by a physiotherapist. Following exercise, Naumita was fed through assisted feeding, which took 45 minutes. At times Naumita's mother displayed frustration due to Naumita's lack of desire to eat. Most of the time during mealtimes Naumita's mother engaged in rhyming activities with her daughter. This also occurred when Naumita was dressed, but during this activity Naumita's mother taught Naumita how to dress actively. Later Naumita's father took Naumita outside for a walk after coming from office. This time Naumita became very happy and she willingly went out and tried to walk while holding hands with her father. In these ways Naumita was attempting to learn how to overcome challenges. Her family members also try to assist her to make her active and overcome her difficulties

3.6.2 Case Study 2

Raton, a 3 year old boy lives with his parents and one brother aged 4 and one sister aged 6. They live in a nuclear family. His mother is a housewife while his father works as a businessman. Raton is a physically challenged boy while his brother and sister have no disabilities. Due to his disabilities Raton is unable to sit, stand or walk. Moreover, he is unable to eat actively and requires assistance for his ADLs. Raton's mother is the principal caregiver for him, but he also receives care from his sister.

During the observation, Raton mainly stayed in bed. He did often have the opportunity to sit, as he could only do this with the help of his mother. His mother gave total support for his dressing, bathing, feeding etc. As Raton has a brother and sister, his mother had to give sufficient time to them as well as conduct house hold activities. Consequently, Raton was left alone and played independently for most of the day. Sometimes Raton cried but his mother did not come take care of him. In fact, his crying caused his mother to become angry. Later in the afternoon after finishing the housework his mother gave him about 45 minutes to play and told him a story. During the day Raton's mother did the physical exercises twice that were prescribed by a physiotherapist. At the afternoon while his brother and sister went outside to play he had to remain in bed.

CHAPTER- IV

Discussion

The study was conducted with mothers of children with disabilities to explore their child rearing practices with these children. The study examined the socio demographic characteristics of the families. The data presented different age levels of children with disabilities with different ratios. The data shows that 24.19% of children were 1 to 3 years old and 46.78% children with disabilities were 3 to 6 years old. Data is insufficient regarding the age groups of children with disabilities in Bangladesh. The data also showed that among 62 children 59.70% are boys and 40.3% are girls. This indicates a boys/girls ratio of 1.48. However, according to statistics, the ratio of boys/girls under ten years old in Bangladesh is 1.04 (Bangladesh Bureau of Statistics, 2009).

The results also showed that 30.6% of children are from rural areas and 48.4% are from urban areas. However, existing statistics showed that about 75.5% people live in rural areas and the rest live in periurban and urban areas (Bangladesh Bureau of Statistics, 2009). As the study was conducted in three organizations in Dhaka, the variations of the results were reflected in the study. Socio-demographic status-religion was found to be mostly similar to the ratio of different religions. The results showed that 87.1% of children with disabilities are Muslim, which comprises 88% of the total population in Bangladesh (Bangladesh Bureau of Statistics, 2009).

The data showed that among the parents in this study, the mothers' education levels are the following: 1.6% illiterate, 17.7% primary completion, 12.9% secondary completion, 35.5% passed the S.S.C., and 17.7% passed the H.S.C. and 14.6% of Graduate and above. Among the fathers none were illiterate, 1.6% completed primary level, 9.7% completed secondary level, 14.5% passed the S.S.C., 16.1% passed the H.S.C. and 58.1% had either graduated or hold a higher qualification. As the data

occupations slightly differed from the country's average levels of education and types of occupation. The data showed that most of mothers and fathers' education level is high. These parents who are highly educated and aware of their child's condition came to the hospital or rehabilitation centre to assist in the rehabilitation of their children with disabilities, but according to UNICEF (2010) the total adult literacy rate in Bangladesh in 2008 was only 54%. The findings were similar to the context of the study area.

The findings also showed different characteristics of families. It showed that most families were a single type of family. There are different types of families in Bangladesh such as single/nuclear, joint and extended family etc. The numbers of single families are gradually increasing in Bangladesh (Chowdhury, 2010). The results also indicate family income. The average family income is 14838.71 Taka per month. At present about 36% of the population lives on less than \$ 1 a day in Bangladesh (Distressed Children International, 2009). The findings are slightly different from the national statistics. This study only covered the family of children with disabilities who came to selected organizations in Dhaka city.

It was identified that among the children with disabilities 31.9% of children had only physical disabilities. Other children had intellectual, speech, and visual disabilities as well as physical disabilities. According to a Japan International Cooperation Agency (2002) study in Bangladesh, 41.5% have physical disabilities and 19.6% have hearing and speech disabilities, 7.4% have intellectual and 3.4% have multiple disabilities.

The study reveals that different types of activities are performed by mothers to rear children with disabilities. However, only 4.8% of mothers play with their child during various activities. There is no previous data on this subject, but in a previous study it was found that in the Maldives only 28% mothers play with their children, 44% go for a walk and 42% teach their children (UNICEF, 2000). Play has been emphasised as an important aspect, as it helps to stimulate a child's mind, body and social interactions.

emotional development. Despite the development issue, play also has been used as a therapy for children in difficult situations like illness, developmental delay etc (Chiang & Hadadian, 2010).

In this study it was found that most of the children (46.8%) received 1-2 hours of assisted play time from their mother, 12.9% children did not get assistance from mothers, 16.1% of children got 2-3 hours, 11.3% got 3-4 hours and 12.9% children got more than 4 hours. On the other hand 48.4% children were kept alone for 1-2 hours, 9.7% children were not kept alone, 11.3% of children were kept alone for less than 1 hour and 30.7% for 2-3 hours. In a study in the Maldives it was found that 45% of siblings spent 1 to 2 hours with younger sisters and brothers and 19% and 11% spent 2-3 and 3-4 respectively (UNICEF, 2000).

The findings of this study described that mothers of children with disabilities practised different types of feeding for children with physical disabilities. Only 4.8% of children were fed actively, while 19.4% of mothers practice active assisted feeding, 8.1% of children use a spoon or feeding devices, and 67.7% of mothers perform passive feeding. Different ranges of time are required feed the children. According to the research, 48.4% of children require 30 minutes, only 9.7% require 15 minutes, 27.4% of children require 45 minutes and 14.5 % require 1 hour. Physical disabilities which are present during infancy and early childhood can have consequences on both the ability to feed and the development of feeding skills. Physical disability impairs the ability to self feed, so feeding periods take longer. Consequently, caregivers need patience and self esteem (Thomas & Bishop, 2010).

Feeding children under 6 months was also studied. As the findings indicate, 66.1% mothers engage only in breastfeeding, 17.7% children intake food from a combination of infant formulae with breastfeeding and only 4.8% children use infant formulae only. In Bangladesh 43% of children exclusively breastfed under 6 months in 2008 (UNICEF, 2010)

The study examines the interactive child rearing practices such as activities during feeding and dressing and activities to stimulate the children. The study revealed that 32.2% of mothers perform feeding and dressing only, 19.4% mothers talk with children during feeding and dressing, 25.8% of mothers sing/rhyme with feeding and dressing and 22.6% of mothers teach children how to feed and dress. On the other hand, to stimulate the children 37.1% mothers use toys and colorful objects, 25.8% mothers tell stories and sing songs, 27.4% of mothers speak to their children and 9.7 % of mothers help or assist in performing activities to stimulate their children with disabilities. There have been a number of studies that examined child-rearing practices of mothers that are associated with strong interactive rearing practices. One child-rearing characteristic that has been found to affect achievement is an interactive parenting style in which there is a good deal of verbal exchange between mothers and their children; this finding said that cognitive development and subsequent achievement in children was highest when mothers had a verbally interactive style of parenting with their children (Hoghughi & Long 2004).

The study also explored the knowledge of mothers of the children with disabilities regarding child development and child rearing practices. Child rearing and care is a highly valuable but challenging task for parents and families in general. This task becomes more challenging and at times threatening particularly in bringing up children with disabilities. It requires knowledge, skills, experience and a positive attitude primarily on the part of the parents and care givers. It requires ability, commitment and hard work. The knowledge and ability to prevent or detect problems and intervene at an early age of the child is crucial. The study showed the mothers' understanding about different milestones of development. According to the data, 8.1% mothers think that a child can feel and think while in the womb, 19.3% think that a child can feel and think immediately after birth. Other thoughts were between one to three months (32.3%) and after 3 months (40.3%). As stated in relevant literature, babies can "feel" (pain, happiness and discomfort) during the first few weeks of life. When babies feel discomfort they show their emotions through crying, signalling, hunger, anger and pain (UNICEF, 2000). The study also found that 88.7% mothers think that a child can walk from 12-18 months, 58.1% mothers think that children can

say meaningful words before 12 months. These findings are all supported by science.

The data showed that 83.9% of mothers agreed that stimulation is important for children's physical development. Of the total participants, 23.1% of mothers think that stimulation helps in the movement of children's limbs. Other perceptions are that stimulation helps in improving sensations, movements, exercise and ADLs. It is now widely known that early experiences, particularly those during the first several years of life, set the stage for ongoing development (Gouley, 2010).

The study identified the perception of mothers on the importance of using oil massage in physical development. According to the data, 85.5% of mothers believe that oil massage is relevant in a child's physical development, as oil massage helps to improve blood circulation, warms the child's body, increases the strength and also helps to strengthen the neck. Giving babies a massage with oil first and foremost helps them to relax. It has been proven that physical contact alone is highly beneficial to the physical and mental development of children (Pregnancy Care tips, 2011).

The mothers who were studied believed that child rearing practices has importance in child development. They thought that it helps to achieve functional abilities, to protect a child from diseases, to prepare a healthy child, to stimulate physical growth and to perform exercises by ADLs. Child-rearing practices are the single most important influence affecting children's development. Parents' cultural mores, level of education, social values, ideas about child-rearing largely determine how well a child's basic physical and intellectual needs will be met (Xie & Young, 1999).

The study shows that there is no significant difference between optimum care and not optimum care in sex ($\chi^2 = 0.463$, $p > 0.05$). It also shows that there is no association between child rearing practice and mother's education. Among mothers who completed primary level, 10% mothers provide optimum care and 90% mothers do

passed S.S.C. only 4.5% mothers provide optimum care. Out of the twenty mothers who hold at least an H.S.C qualification, 15% provide optimum care. There is no significant difference in education qualification between optimum care and not optimum care ($\chi^2 = 0.519$, $p > 0.05$). However, different studies show associations between child care and parents' education qualification. Parents with at least a college degree provide at least half an hour more childcare per day compared to those with less than high school degree (Lareau, 2003).

The study also shows that among mothers who are housewives 11.3% of mothers provide optimum care and 88.7% do not provide optimum care to their children with disabilities. Less optimum care is provided from mothers who work in service. The findings indicate that none of them provide optimum care to their children with disabilities. There is no significant difference between optimum care and not optimum care in occupation of mothers ($\chi^2 = 0.373$, $p > 0.05$). Child-rearing practices are not related to work status. When mothers' motivations and education are considered along with status, associations with child-rearing appear (Yarrow, Scott, Leeuw & Heinig, 1962).

The study also shows that in low income families about 33.3% of children receive optimum care and the rest do not receive optimum care. In high income families 14.3% of children receive optimum care and 85.7% of children do not receive optimum care. There is no significant difference between optimum care and not optimum care in socio-economic status ($\chi^2 = 0.069$, $p > 0.05$). In Korea, middle class parents show better care to their children than working people (Kim, 2006).

The results show that there is no association of disability type and level of care. It says that there is no significant difference between optimum care and not optimum care in type of disabilities ($\chi^2 = 0.675$, $p > 0.05$). Among the children who have physical disability most of them (90.5%) do not receive optimum care. Similarly most of the children (90.2%) with multiple disabilities do not have optimum care. However, according to Sethi, Este, & Charlebois (2000) child rearing practice is influenced by type and severity of disability.

11.3% of mothers think that they are not useful for the community, while 45.1% of mothers think that they can be useful if they get proper care, love and affection. Some mothers (22.6) think that they need help and kindness. Another perception (21%) was they need more attention than other children. In a UNICEF (2000) baseline survey in the Maldives it was found that 17% of caregivers provide loving care and affection to children with disabilities and 9% thought that they were not useful for family and society. Mothers' beliefs about children with disabilities have a great impact on childrearing practices and this impacts child development. Therefore, it is necessary to build awareness, positive attitudes and beliefs among parents and family members. This will improve parenting for children with disabilities and enable their child's holistic development.

CHAPTER. V

5.1 Limitations

The research has several limitations. The results of the study cannot be generalized to the whole population of mothers who have children with physical disabilities as the sample size was small and selected purposively. Due to time and resource constraints, the selected sample was very limited in number and purposeful sampling might not represent child rearing practices of all children with physical disabilities in Bangladesh. If the study could have been performed more in a home setting it could have given more authentic data. Furthermore, only mothers' practices were examined, but it is necessary to explore the childrearing practices of fathers, siblings and other family members. Finally, it was not possible to observe all the children that were included in the study. If this was possible to achieve, the outcomes would have been more authentic.

5.2 Conclusions

This cross sectional study was conducted to identify the child rearing practices of children with disabilities. Among the sample of 62 subjects, 46.78% of children were in 3-<6 year age group. It was found that 41.9% of mothers provide healthy food and clean them. Only 4.8% mothers practice all the elements of care for their children such as feeding, cleaning, dressing, teaching, playing and going for a walk. Only 22.6% of mothers perform activities to teach their children independence during feeding or dressing. Regarding the mother's knowledge about child development, only 19.3% of mothers thought that children can feel and think immediately after birth. 88.7% of mothers thought that a child can walk between the age of 12-18 months and 27.4% of mothers said that a child starts to say meaningful words at 12 months. The study showed that 83.9% of mothers viewed that stimulation/ interactive care is important in the physical development of children. The study also indicated that 52.8% mothers thought that oil massage helps to improve circulation of the body. Among all, 53.2% mothers thought that proper child rearing practices help children to achieve functional abilities. It was also found that 45.1% of mothers think that their disabled child can be a productive member of the community if they get proper care and 21% of mothers thought that they need more attention than normal kids. The study did not find any association between socio-demographic characteristics and types of disabilities with child rearing practice of children with disabilities.

Child rearing practices are a highly valuable and challenging task for parents. This task becomes more challenging particularly in rearing children with physical disabilities. It requires knowledge, skills, experience and a positive attitude primarily of the part of the parents and care givers.

It is necessary to raise awareness about children with physical disabilities among mothers and other family members. Government and Non-government organisations can conduct awareness raising activities. As the study shows that only 4.8% mothers performed all elements of childrearing practices to rear their children. They can provide necessary information and training on how to rear children and what elements should be included in their practices.

It will be useful to periodically organize programs and bring parents of children with physical disabilities together to share experiences and hold discussions with professionals and others concerned. It is necessary to develop programs and strategies to 'educate' parents of children with physical disabilities at large to understand and be aware of child rearing practices of children with physical disabilities. It is necessary to establish a community based project in which a home based awareness and education programme should be included that will facilitate comprehensive child development through play and toys with inclusion of disabled children. It is also important to develop a child rearing guide/manual that will describe clearly the child development requirements and milestones that can easily be used and interpreted by community facilitators, parents and guardians in all communities.

There were some limitations of this study that were mentioned in the previous section. Further study is recommended to help overcome these limitations. The researcher recommends that a further nationwide study with larger numbers and a randomized sampling procedure is required for investigation in order to produce more authentic findings and provide suggestions that relate to this issue. The critical factors that could affect child rearing practices and overall child development could be studied as further research. Future research could investigate how mothers' emotional and psychosocial background impact child rearing practices.

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Annexure

Consent form

The researcher, Md. Mahbubur Rahman is a student of M.Sc. in Early Childhood Development (ECD) at Institute of Educational Development (IED), BRAC University, Dhaka. This study is a part of the course requirements outlined in the curriculum.

The title of the study is "Child Rearing Practices of Children with Physical Disabilities" and purpose of the study is "To explore the child rearing practices to children with physical disabilities."

In this study, I agree to participate in this study, and have been clearly informed about the purpose of the study. I have the right to refuse to participate at any stage of the study, and am not required to provide justification for this, and will not have any negative implications for services.

I am also informed that, all the information collected from the interview used in the study will be kept safely and confidentiality maintained. Only the researcher and supervisor will be eligible to access the information and this data will only be used for the above stated research. Identifying information, such as name and address, will not be published anywhere in this study.

I can consult with the researcher and the research supervisor about the research process or to clarify any questions or concerns regarding the research project.

I have been informed about the above mentioned information and I consent to participate in the study.

Signature:

Signature of the participant.....

Date.....

Signature of the researcher.....

Date.....

Signature of witness.....

Date.....

গবেষনাকারী, মোঃ মাহবুবুর রহমান, ইন্সটিটিউট অব এডুকেশনাল ডেভেলপমেন্ট (আই,ই,ডি), ব্রাক বিশ্ববিদ্যালয় এর একজন ছাত্র।
এই গবেষণা এম এস সি ইন আরটি চাইল্ড হুড ডেভেলপমেন্ট অধ্যয়নের একটি অংশ।

এই গবেষণার শিরোনাম “শারীরিক প্রতিবন্ধি শিশুর লালন পালনের অনুশীলন” যার উদ্দেশ্য হল “শারীরিক প্রতিবন্ধি শিশুর লালন পালনের অনুশীলন সম্পর্কে অনুসন্ধান”।

এই গবেষণায় আমি একজন অংশগ্রহনকারী এবং গবেষণার উদ্দেশ্য সম্পর্কে স্পষ্টভাবে অবগত হয়েছি। আমি যেকোনো সময় গবেষণা থেকে আমার অংশগ্রহন বাতিল করতে পারবো এবং এই জন্য কারো কাছে জবাবদিহি করতে বাধ্য থাকব না।

আমি অবগত হয়েছি যে, গবেষণায় প্রাপ্ত সকল তথ্য নিরাপদে এবং গোপনীয়তা সহকারে সংরক্ষণ করা হবে। গবেষনাকারী শুধুমাত্র তার গবেষণার ফলাফল তৈরির জন্য অংশগ্রহনকারীর তথ্য ব্যবহার করতে পারবেন। আমার, নাম, ঠিকানা এই গবেষণার কথাও প্রকাশ করা হবে না।

আমি গবেষনাকারী এবং গবেষনাতদারককারীর সাথে গবেষণা সম্পর্কিত বিষয় নিয়ে আলোচনা করতে পারবো। অথবা এই সম্পর্কিত প্রশ্নের উত্তর জানতে চাইতে পারবো।

উপোরক্ত সমস্ত তথ্যাবলী জেনে স্বেচ্ছায় আমি এই গবেষণায় অংশগ্রহনে আগ্রহ প্রকাশ করে স্বাক্ষর করলাম।

অংশগ্রহনকারীর স্বাক্ষর:

গবেষনাকারীর স্বাক্ষর:

স্বাক্ষর:

Annex: 3

Questionnaire

Child

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 ID No. :

Research title:

Child rearing practices of children with physical disabilities

A. Socio-demography of children:

3. Sex: a) Male = 1 b) Female = 2

4. Address:

House no.....Road no.....Para/vill.....P.O.:.....

P.S.....Dist.....Tel/Mobile no.....

5. Residence:

a) Urban = 1

c) Rural = 3

b) Periurban = 2

d) Others = 7

6. Child's religion:

a) Islam = 1

d) Christian = 4

b) Hindu = 2

e) Others = 7

c) Buddhist = 3

7. Mother's occupation:

a) Housewife = 1

d) Industry worker = 4

b) Service = 2

e) Maid servant = 5

c) Teaching = 3

f) Others = 7

8. Mother's education:

a) Illiterate = 1

e) H.S.C = 5

b) Primary = 2

f) Graduate = 6

c) Secondary = 3

g) Others = 7

d) S.S.C = 4

9. Father's occupation:

a) Service = 1

e) Day labour = 5

b) Businessman = 2

f) Industry worker = 6

c) Teacher = 3

g) Others = 7

d) Farmer = 4

10. Father's education:

a) Illiterate = 1

d) S.S.C = 4

b) Primary = 2

e) H.S.C = 5

c) Seceondary = 3

f) Graduate = 6

11. Family type/characteristics:

a) Single = 1

b) Joint = 2

12. Number of family member:

13. Number of siblings:

14. Monthly total income of the family:

15. Type of house:

a) Mud made house =1

c) Building=3

b) Tin shed = 2

d) Others=7

B. Child rearing practices

16. What type of disabilities the child has ?

a) Physical disability = 1

d) Visual disability = 4

b) Intellectual disability = 2

e) Others=5

c) Speech disability = 3

17. Extent of physical problem the child have:

a) Unable to sit= 1

d) Unable to activity of daily
livings (feeding, bathing,
grooming etc.) = 4

b) Unable to stand = 2

c) Unable to walk = 3

e) Others = 7

18. What do you do for your child as part of the daily routine?

a. Feeding healthy food regularly
=1

d. Playing with the child = 4

b. Bathing and keeping them
clean =2

e. Spending time with the child /
be close to the child =5

c. Teaching them =3

f. Taking the child for a walk = 6

g. Others = 7

19. How long the child is getting assistance from you/ caregiver in a day for playing?

20. How long does the child remain alone?

.....

21. What kinds of feeding do you practice with the child?

- a) Passive feeding =1
- b) Assisted feeding =2
- c) Using feeding spoon/ special feeding device = 3
- d) Active feeding=4

22. How long does the child take to finish one feed (minutes)?

.....

23. What do you feed your child for first six months?

- a. Breast feeding only = 1
- b. Breast milk in combination with infant formulae = 2
- c. Breast feeding for only 3 months = 3
- d. Infant formula only = 4
- e. Others = 7

24. What kinds of dressing do you practice with the child?

- a. Passive dressing = 1
- b. Active assisted dressing = 2
- c. Active dressing = 3

25. What kinds of activities do you perform during feeding and dressing?

- a. Feeding and Dressing only = 1
- b. Feeding and Dressing with talking = 2
- c. Feeding and Dressing with singing/rhyming = 3
- d. Feeding & dressing and teaching of how to feed and dress =4
- e. Others=7

26. How do you stimulate the sense of your child?

- a. Providing toys and colorful objects = 1
- b. Telling them stories/singing songs = 2
- c. Teaching them to speak by talking to them = 3
- d. Helping them in what they do or let them observe you while working = 4

a. General medical care = 1

b. Therapy service from clinic/hospital = 2

c. Rehabilitation service including physiotherapy form specialized rehabilitation centre = 3

28. Do you follow up the child with physiotherapist regularly?

a. Yes = 1

b. No = 2

If yes what is the frequency of visit?

.....

29. Do you practice the exercises that were taught by physiotherapists?

a. Yes = 1

b. No = 2

If yes what is the duration of exercises?

.....

C. Knowledge and beliefs of mothers regarding early childhood development and disabilities

30. How soon a baby can feel and think?

a. While in the womb = 1

c. Between one to three months =

b. Immediately after birth = 2

3

d. After three months = 4

31. What do you know about physical development?

.....

32. When a child can sit, stand and walk (in months)?

.....

33. When a child can recognize parents (in months)?

.....

34. When a child can speak mother, father etc. in (months)?

.....

35. Do you know about the importance of stimulation in physical development of the child?

c. Yes = 1

d. No = 2

If yes how does it help?

.....
36. Do you think that oil massage is beneficial for physical development of the child?

a. Yes = 1

b. No = 2

If yes how does it help?

.....
.....

37. What are your beliefs about children with physical disability?

a. Not useful for the community = 1

b. Can be useful if get proper care, love and affection. = 2

c. They need help and kindness = 3

d. Need more attention than other kids = 4

38. Do you think that proper child rearing practices are important to reduce the physical disabilities of your child?

a. Yes

b. No

If yes, how will it help your child?

.....

Annex: 4

প্রদপত্র

শিশুর

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কোড :

ক শিশুর মাতা ও পরিবার সংক্রান্ত তথ্যাদি :

১. শিশুর নাম:

৩. লিঙ্গ: ক. ছেলে = ১ খ. মেয়ে = ২

৪. ঠিকানা: বাড়ি নং

রাস্তা

পাড়া/গ্রাম

পোস্ট

জেলা

ফোন/মোবাইল

৫. শিশু কোথায় বাস করে?

ক. শহর = ১ খ. উপশহর = ২ গ. গ্রাম = ৩ ঘ. অন্যান্য = ৭

৬. শিশুর ধর্ম:

ক. মুসলিম = ১ খ. হিন্দু = ২ গ. বৌদ্ধ = ৩ ঘ. খৃষ্টান = ৪ ঙ. অন্যান্য = ৭

৭. মায়ের পেশা:

ক. গৃহিণী = ১ খ. চাকুরী = ২ গ. শিক্ষকতা = ৩

ঘ. কারখানা শ্রমিক = ৪ ঙ. গৃহকর্মী = ৫ চ. অন্যান্য = ৭

৮. মায়ের শিক্ষাগত যোগ্যতা

ক. নিরক্ষর = ১ খ. প্রাইমারি = ২ গ. সেকেন্ডারি = ৩ ঘ. এস. এস. সি. পাশ = ৪

ঙ. এইচ. এস. সি. পাশ = ৫ চ. স্নাতক পাশ = ৬ ছ. অন্যান্য

৯. বাবার পেশা

ক. চাকুরী = ১ খ. ব্যাবসা = ২ গ. শিক্ষকতা = ৩ ঘ. কৃষক = ৪ ঙ. দিন মজুর = ৫

চ. কারখানা শ্রমিক = ৬ ছ. অন্যান্য = ৭

১০. বাবার শিক্ষাগত যোগ্যতা

ক. নিরক্ষর = ১ খ. প্রাইমারি = ২ গ. সেকেন্ডারি = ৩ ঘ. এস. এস. সি. পাশ = ৪

ঙ. এইচ. এস. সি. পাশ = ৫ চ. স্নাতক পাশ = ৬ ছ. অন্যান্য = ৭

১১. পরিবারের ধরন ক. একক = ১ খ. যৌথ = ২

১২. শিশুর পরিবারের সদস্য সংখ্যা:..... ১৩. ভাই-বোনের

সংখ্যা:.....

১৫. পরিবারের ব্যবহৃত ঘর কিসের তৈরি?

ক. মাটির তৈরি = ১ খ. টিনের ছাদের ঘর = ২ গ. পাকা দালান = ৩ ঘ. অন্যান্য = ৭

খ শিশুর পরিচর্যা সংক্রান্ত তথ্যাদী

১৬. আপনার শিশুর কি ধরনের প্রতিবন্ধকতা আছে?

ক. শারিরিক প্রতিবন্ধি = ১ খ. বুদ্ধি প্রতিবন্ধি = ২ গ. বাক প্রতিবন্ধি = ৩

ঘ. শ্রবন প্রতিবন্ধি = ৪ ঙ. দৃষ্টি প্রতিবন্ধি = ৫ চ. অন্যান্য = ৭

১৭. শিশুর শারিরিক সমস্যার ধরন

ক. বসতে পারে না = ১ খ. দাড়াতে পারে না = ২ গ. হাটতে পারে না = ৩

ঘ. দৈনন্দিন কাজ করতে পারে না (খাওয়া, গোসল, পোশাক পরিধান ইত্যাদি) = ৪ ঙ. অন্যান্য = ৭

১৮. আপনি আপনার শিশুর জন্য দৈনন্দিন কাজের অংশ হিসেবে কি কি করেন?

ক. পুষ্টিকর খাবার খাওয়ানো = ১ খ. গোসল করানো এবং পরিষ্কার রাখা = ২ গ. শিশুকে শেখানো = ৩

ঘ. শিশুর সাথে খেলা করা = ৪ ঙ. শিশুর সাথে সময় কাটানো = ৫

চ. শিশুকে বেড়াতে নিয়ে যাওয়া = ৬ ছ. অন্যান্য = ৭

১৯. আপনার শিশু দিনে কতটুকু সময় খেলার জন্য আপনার সহচর্য পায়?.....

২০. শিশু কতটুকু সময় একা থাকে?.....

২১. শিশুকে খাওয়ানোর জন্য কোন প্রক্রিয়াটি/ ধরণটি আপনি অনুশীলন করেন?

ক. নিজে নিজে খায় = ১ খ. খাওয়ার সময় আপনি সাহায্য করেন = ২

২২. শিশু একবার খেতে কতক্ষণ সময় নেয়?.....মিনিট

২৩. প্রথম ছয় মাস শিশুকে কি খাবার খাওয়ান?

ক. শুধুমাত্র মায়ের দুধ = ১ খ. মায়ের দুধ ও শিশু খাদ্য = ২

গ. মায়ের দুধ শুধুমাত্র প্রথম তিন মাসের জন্য = ৩ ঘ. শুধুমাত্র শিশু খাদ্য = ৪

ঙ. অন্যান্য = ৭

২৪. আপনি কিভাবে আপনার শিশুকে জামা কাপড় পরিধান করান?

ক. পুরপুরি পরিয়ে দিতে হয় = ১

খ. পরিধানের সময় কিছু সাহায্য করতে হয় = ২

গ. শিশু একাই পরতে পারে = ৩

২৫. শিশুকে খাওয়ানো এবং জামাকাপড় পরিধানের সময় তার সাথে কি কি করেন?

ক. শুধু খাওয়ান এবং জামাকাপড় পরিধান করান = ১

খ. খাওয়ানো এবং জামাকাপড় পরিধানের সময় কথা বলেন = ২

গ. খাওয়ানো এবং জামাকাপড় পরিধানের সময় শিশুকে গান শোনান = ৩

ঘ. খাওয়ানো এবং জামাকাপড় পরিধানের সময় শিশুকে কিভাবে খেতে হয় এবং জামাকাপড় পরতে হয় তা শেখান
= ৪ ঙ. অন্যান্য = ৭

২৬. আপনি কিভাবে আপনার শিশুর অনুভূতি গুলোকে উদ্দিশ্ত করেন?

ক. খেলনা এবং রঙ্গিন বস্তু দিয়ে = ১ খ. তাদের গল্প বলে অথবা গান গেয়ে = ২ গ. তাদের সাথে কথা বলে তাদের

কথা বলা শেখান = ৩ ঘ. তারা যা করে তা করতে তাদের সাহায্য করে বা আপনি যখন কাজ করেন তখন তাদেরকে

তা দেখতে দিয়ে = ৪

ক.সাধারণ চিকিৎসা সেবা = ১ খ.ক্লিনিক বা হাসপাতাল এর থেরাপি সেবা = ২ গ. স্পেশাল পুনর্বাসন কেন্দ্র থেকে
ফিজিওথেরাপি এবং পুনর্বাসন সেবা = ৩

২৮. আপনি কি নিয়মিত আপনার শিশুকে ফিজিওথেরাপিস্ট এর কাছে নিয়ে যান?

ক. হ্যাঁ = ১ খ.না = ২

যদি হ্যাঁ হয় তবে কতবার থেরাপিস্ট এর কাছে নিয়ে যান?

.....
.....

২৯.ফিজিওথেরাপিস্ট এর শেখানো ব্যায়ামগুলো আপনি কি বাসায় আপনার শিশুকে করান?

ক. হ্যাঁ = ১ খ.না = ২

যদি হ্যাঁ হয় তবে ব্যায়ামগুলো কতবার এবং কতক্ষণ করান?

.....
.....

প্রতিবন্ধি এবং শিশুর প্রারম্ভিক বিকাশ সম্বন্ধে মায়ের জ্ঞান এবং ধারণা

৩০. আপনি কি মনে করেন, বাচ্চা কোন বয়সে চিন্তা এবং অনুভব করতে শেখে?

ক.পেটে থাকা অবস্থায় = ১ খ. জন্মের সাথে সাথেই = ২

গ. জন্মের এক থেকে তিন মাসের মধ্যে = ৩ ঘ. জন্মের তিন মাস পরে = ৪

৩১. শিশুর শারিরিক বিকাশ সম্পর্কে আপনার ধারণা কি?

.....
.....
.....
.....

৩২. আপনি কি মনে করেন, বাচ্চা কোন বয়সে বসতে, দাড়াতে এবং হাঁটতে শেখে (কত মাসে)?

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.....
.....
৩৪. বাচ্চা কখন ছোটো ছোটো শব্দ বোলতে পারে, যেমন- মা, বাবা ইত্যাদি (কত মাসে)?

.....
.....
৩৫. আপনি কি মনে করেন শিশুর শারিরিক বিকাশের জন্য শিশুকে উদ্দিপনা করা গুরুত্বপূর্ণ?

ক. হ্যাঁ = ১ খ. না = ২

যদি হ্যাঁ হয় তবে কিভাবে তা সাহায্য করে?

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.....
৩৬. আপনি কি মনে করেন যে বাচ্চার শারিরিক বিকাশের জন্য তেল মালিশ করা উপকারি?

ক. হ্যাঁ = ১ খ. না = ২

যদি হ্যাঁ হয় তবে কিভাবে তা সাহায্য করে?

.....
.....
৩৭. প্রতিবন্ধি শিশুদের সম্পর্কে আপনার ধারণা কি?

ক. তারা সমাজের কোন কাজে আসে না = ১

খ. তারা যদি উপযুক্ত সেবা, ভালবাসা পায় তবে সমাজের কাজে আসবে = ২

গ. তাদের সাহায্য এবং করুণা দরকার = ৩

ঘ. অন্যান্য বাচ্চাদের থেকে তাদের প্রতি বেশি গুরুত্ব দিতে হয় = ৪

৩৮. আপনি কি মনে করেন যে উপযুক্তভাবে বাচ্চা লালন পালন আপনার বাচ্চার শারিরিক প্রতিবন্ধিতা কমানার ক্ষেত্রে গুরুত্বপূর্ণ?

যদি হয়, তবে এটি কিভাবে আপনার বাচ্চাকে সাহায্য করে?

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Annex: 5

Check List

1. Name of the child:

2. Age (in months):

3. Sex: a) Male b) Female

4. Address: House no..... Road
no..... Para/vill..... P.O.:..... P.S.....
Dist..... Tel/Mobile no.....

05. Family type/characteristics:

a) Nuclear

b) Joint

06. Number of siblings:

07. What type of disabilities does the child have ?

a) Physical disability

d) Hearing disability

b) Intellectual disability

e) Visual disability

c) Speech disability

f) Others.....

08. Extent of physical problem the child has:

a) Unable to sit

b) Unable to stand

- d) Unable to activity or daily
livings (feeding, bathing,
grooming etc.)

09. Who is taking care of the child?

- | | |
|-----------------|-----------------|
| a) Mother | e) Elder sister |
| b) Father | f) Maid Servant |
| c) Grandparents | g) Others..... |
| d) Aunt | |

10. What do you do for your child as part of the daily routine?

- | | |
|--------------------------------------|-----------------------------------|
| a. Feeding healthy food regularly | e. Spending time with the child / |
| b. Bathing and keeping them
clean | be close to the child |
| c. Teaching them | f. Taking the child for a walk |
| d. Playing with the child | g. Others..... |

11. How much time does the child have for assisted play?

.....

12. How long does the child remain alone?

.....

13. Who is involved in feeding for the child?

- | | |
|-----------------|-----------------|
| a) Mother | e) Elder sister |
| b) Father | f) Maid Servant |
| c) Grandparents | g) Others..... |
| d) Aunt | |

14. What kinds of feeding do you practice with the child?

- a) Active feeding
b) Assisted feeding
c) Using feeding spoon/ special feeding device =
d) Others.....

15. How long does the child take to finish one feed (minutes)?

.....

a. Passive dressing

b. Active assisted dressing = 2

c. Active dressing

d. Others.....

17. What kinds of activities do you perform during feeding?

a. Feeding only

b. Feeding with talking

c. Feeding and with singing/rhyming

d. Feeding and teaching of how to feed and dress

e. Others.....

18. What kinds of activities do you perform during dressing?

a. Dressing only

b. Dressing with talking

c. Dressing with singing/rhyming

d. Dressing and teaching of how to feed and dress

e. Others.....

19. How do you stimulate your child's senses?

e. Providing toys and colourful objects

f. Telling them stories/singing songs

g. Teaching them to speak by talking to them

h. Helping them in what they do or let them observe you while working

i. Others.....

20. Do you practice the exercises that were taught by physiotherapists?

e. Yes = 1

f. No = 2

If yes what is the duration of exercises?

.....

21. Other observations related to child rearing practices.....

.....

.....

.....

.....

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Annex: 6

Date: December 30, 2010

To

Incharge,

Physiotherapy Department,

CRP-Mirpur, Dhaka.

Subject: Approval for the access of program field for the research of Masters' in Early Childhood Development.

Dear Sir/Madam,

This is to inform you that Ms/Mr. Md. Mahbubur Rahman is a student of MSc. in the Early Childhood Development, IED-BRAC University need your support to conduct a research for his/her Masters program.

I would therefore request you to allow this student to use the field under your authority for the purpose of the research of Masters Thesis. I am ensuring you that, information, documents, data, manuals, materials, as well as the research findings shall remain confidential by the students and will not be used or disclosed without your consent.

With Regards



.....
Mahmuda Akhter
Head of Early Childhood Development Resource Centre
IED-BRAC University

Received
by

Shahidul Alam
Mohammad Shahidul Alam
Clinical Physiotherapist &
In-charge, Physiotherapy Dept.
CRP-Mirpur.

Date: December 29, 2010

To

Incharge,

BRAC Limb and Brace Centre (BLBC),

Dhaka.

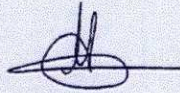
Subject: Approval for the access of program field for the research of Masters' in Early Childhood Development.

Dear Sir/Madam,

This is to inform you that Ms/Mr. Md. Mahbubur Rahman is a student of MSc. in the Early Childhood Development, IED-BRAC University need your support to conduct a research for his/her Masters program.

I would therefore request you to allow this student to use the field under your authority for the purpose of the research of Masters Thesis. I am ensuring you that, information, documents, data, manuals, materials, as well as the research findings shall remain confidential by the students and will not be used or disclosed without your consent.

With Regards



.....
Mahmuda Akhter
Head of Early Childhood Development Resource Centre
IED-BRAC University

Received.
Dr. Ehsanul Haque
MBBS, MPH
Medical Officer & Incharge
BRAC Limb & Brace Fitting Centre, Dhaka

Date: January 03, 2011

To

The Executive Director,

Institute of Mother and Child Health,

Dhaka.

Subject: Approval for the access of program field for the research of Masters' in Early Childhood Development.

Dear Sir/Madam,

This is to inform you that Ms/Mr. Md. Mahbubur Rahman is a student of MSc. in the Early Childhood Development, IED-BRAC University need your support to conduct a research for his/her Masters program.

I would therefore request you to allow this student to use the field under your authority for the purpose of the research of Masters Thesis. I am ensuring you that, information, documents, data, manuals, materials, as well as the research findings shall remain confidential by the students and will not be used or disclosed without your consent.

With Regards



*Received
by
09/01/2011*

.....
Mahmuda Akhter
Head of Early Childhood Development Resource Centre
IED-BRAC University

House 113, Road 2, Block A, Niketon, Gulshan 1, Dhaka 1212, Bangladesh
Tel: (880-2) 882-4180 (8 lines); Fax: (880-2)882-9157; E-mail: bu-ied@brac.net; Web: www.bracuniversity.net

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Annex: 7

Work Plan

Period: October 2010 to May 2011

IED, BRAC University

S/ L	Major Activities	Time Period (2010- 2011)																															
		October' 10				November' 10				December' 10				January' 11				February' 11				March' 11				April' 11				May' 11			
		W 1	W 2	W 3	W 4	W 1	W 2	W 3	W 4	W 1	W 2	W 3	W 4	W 1	W 2	W 3	W 4	W 1	W 2	W 3	W 4	W 1	W 2	W 3	W 4	W 1	W 2	W 3	W 4	W 1	W 2	W 3	W 4
1	Literature review																																
2	Mentor meeting, review & editing work																																
3	Proposal development																																
4	Proposal finalization and approval																																
5	Questionnaire development																																
6	Population/sample selection																																
7	Data collection/ field work																																
8	Data processing																																
9	Data cleaning, analyze and tabulation																																
10	Report writing and correction																																
11	Report finalization																																
12	Presentation																																
13	Report submission																																

* W-Week