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Models of disability and people with disabilities in Bangladesh: A review

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ABSTRACT: The paper aims to review the different disability models and evaluates government policies and legislation undertaken for improving the living condition of people with disabilities (PWD) in Bangladesh. This paper is based on secondary sources of data, i.e. government, non-government organization's study report, policy documents, journal articles, statistical reports, and research findings were consulted to collect data and construct the paper. The paper outlined some key policies and legislation already adopted by the government of Bangladesh for the betterment of PWD with limitations. The paper identifies significant social and structural barriers that Bangladeshi PWD in face in their typical daily lives includes poverty and deprivation, low level of education, employment and wage discrimination, health care and treatment, social security measures, social stigma and community attitude, housing, transportation, water and sanitation issues, gender disparity and oppression. Therefore, some critical policy implications are pointed out for breaking down those social and structural barriers.

Keywords: Disability, Models of disability, People with disability, Bangladesh

1. Introduction

People with disabilities (PWD) constitute a sizeable diversified minority group in Bangladesh. According to the 7th Five Year Plan (2016-2020) of the government of Bangladesh, it is estimated that approximately 9 percent of the total population are disabled, and nearly half a million are suffering from multiple disabilities. The previous NGO estimation suggested that the prevalence of disability in Bangladesh might vary, e.g. 5.6 percent (NFOWD & HI, 2005) to 7.8 percent (BPKS). According to the Bangladesh Bureau of Statistics (2009), the percentages of people with different types of disabilities are as follows: visual 31.3 percent, physical (including leprosy and goitre) 35.8 percent, hearing and speech 28 percent, and psychological disability 4.9 percent. In Bangladesh disability occurs for many reasons such as accidents, wrong pathological diagnosis, malnutrition of pregnant women, unavailability of trained birth attendants and nurses, polio, typhoid, crime and violence, acid burn, child marriage, marriage between close relatives and so forth (Edmonds, 2005, as cited in Hasan et al., 2018).

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However, there are some differences between the GO and NGO estimation of the number of PWD, types and causes of disability, and there remains a common understanding that they are facing multiple barriers that make their life more difficult. Studies also point out that PWD experiences notably higher levels of unmet needs, isolation and stress and in many cases, their fundamental rights and entitlements are denied. The poverty and deprivation among them are widespread and well documented as a large section of them do not have adequate access to health care, education, nutrition and fall at risk to diseases and injuries (NGDO, NCDW, BLAST, 2015, Sultana, 2010, DFID, 2000). Therefore, it is necessary to review different models of disability, evaluate the policy and legislation undertaken for PWD in Bangladesh and identify social and structural barriers they face in their daily lives.

2. Aim and methods

The article has three broad aims. First, it sets out a general understanding of the different theoretical underpinning of disability models. Second, it critically examines and evaluates government policies and legislation undertaken for the betterment of PWD. Third, it identifies different social and structural barriers they face in Bangladesh. This paper is based on secondary sources of data. Government, non-government and international organization's study report, policy documents, journal articles, statistical reports, and research findings were consulted to collect data and construct the paper.

3. Different models of disability: A theoretical underpinning

The significant models of disability include the religious model, psychological model, medical model, and social model. The 'religious model' viewed disability as a punishment inflicted upon an individual or family by an external force. There are used some beliefs to explain the causes of disability, which include the misdeed, sin committed by the disabled person, someone in the family or community group, or forbears. Sometimes the presence of 'evil spirits' is also used to characterize the behaviour of a mentally challenged person (Henderson and Bryan, 2011). Critiques argue that the adverse effect followed by this model often stigmatizes the whole family, lowering their status in the community and often even leads to social exclusion. The 'psychological models,' including the behavioural, cognitive, or psychoanalytic approaches, focus primarily on the person's mental response to impairments and suggest the role of psychologists helping disabled people to 'adjust' to their impairment. Therefore, it is provided with therapeutic work for improving coping strategies of the disabled person and their family members and mourning the 'loss' of function (Rath and Elliott, 2012). However, there is some practical utility of these approaches. It is often criticized that these helping activities can result in the discovering of a new disabled identity and self, which diminishes their confidence and dignity and portray a negative image of the disabled people to society. Therefore, some primary disabled persons and activists raise their voices against humiliation and exclusion and discard this model from the viewpoint of social inclusion.

There are two different models, i.e. medical and social models, which are used to analyze disability issues and formulate policies and programs for the betterment of children, women and people with disabilities. The medical model framed disability as an individual impairment to be

'cured' or contained, and a goal thought best achieved by placing people with disabilities under the direction and authority of the medical profession (Oliver, 1996). It is often argued that this model focuses on the individual disabled person and the negative experience of impairment and emphasis on to 'cure' the impairment which is not always possible and sometimes treated them as deviant from healthy people and considered them as weak and dependent on society's resources (Borsay, 2005). Consequently, the social model of disability has been emerged to challenge and critique the medical approach. For example, in 1976 the Union of the Physically Impaired Against Segregation first made the distinction between *impairment*, that is, functional limitations experienced by individual, and *disability*, which is a social state understood to be the outcome of social, political and economic processes that affect not only the lives of people identified as disabled but also those considered able-bodied (Oliver, 1996).

Thus, the social model of disability tries to identify socio-structural barriers and restrictions which exclude and discriminate disabled people in maintaining their current livelihood and general wellbeing (Reeve, 2004). However, this model is critical to understand the social construction of disability as reality and social oppression and discrimination involved with disability as live experiences, and it is also criticized that this model to some extent neglect the physical aspects of people with disability and how their potentialities and capabilities can be enhanced through utilizing advancement of modern treatment and technology (Palmer and Harley, 2011). For making a balance between the two major approaches, i.e. medical and social model, a new version, e.g. the bio-psycho-social model of disability known as International Classification of Functioning, Disability and Health model has been emerged which include health conditions, functional impairments, activity limitations and participation restrictions as well as environment (WHO, 2001). This model identified that disability refers to difficulties encountered in any or all three areas of functioning as follows:

- **Impairments** are problems in body function or alterations in body structure. Impairments are specific decrements in body functions and structures, often identified as symptoms or signs of health conditions. For example, paralysis, or blindness;
- **Activity limitations** are difficulties encountered by an individual in executing a task or action, for example, cannot walk or eating; and
- **Participation restrictions** are problems with involvement in any area of life – for example, facing discrimination in employment or transportation or cannot take part in school.

Thus, the ICF model of disability portrays a comprehensive understanding on the issue as it includes physical structure and function limitations, activity restrictions, participation limitations and environmental and personal factors contributing to the overall state of health and wellbeing of people with disabilities (WHO, 2013). This model focuses on significant areas of intervention required for improving the living condition of PWD, e.g. impairment, functional limitation, participation restriction and environmental constraints. Therefore, it is suggested for adopting new policies and programs accordingly.

4. Government efforts to address the disability issue

There are some excellent initiatives had been undertaken by the government of Bangladesh in collaboration with local and international NGOs for the betterment of PWD. For example, the National Forum of Organizations Working with the Disabled (NFOWD) was formed in 1991 to raise voices and promote rights of them. The NFOWD is currently working for the welfare of the disadvantaged persons with disability and offer physiotherapy, occupational therapy, speech and language therapy, counselling services for them. In the year 2014-2015, they operated 130 centers in the 64 districts all over the country. The National Policy for Persons with Disabilities was formulated since 1995 to prevent disability, protect their rights and rehabilitate and integrate into society. The Department of Social Service under the Ministry of Social Welfare had introduced disability allowance as means-tested services for the PWD since the financial year 2005-2006. In the year 2014- 2015, the number of beneficiaries increased to 400 thousands of PWD and the amount of benefit is BD Taka 500 (i.e. equivalent to $6.0 per month). However, these services are some reasonable attempts to address the poverty of PWD, and it hardly covers the necessary food and dietary requirement of an individual with a disability (DSS, 2015).

The National Social Welfare Policy was adopted in 2005, which also incorporates the disability issue as an essential agenda for achieving the development and welfare of the people. The policy primarily focused on prevention and rehabilitation issues of PWD and suggested for taking appropriate health measures, particularly in the rural areas, water and sanitation, providing antenatal and neonatal health care. The policy also emphasized on conducting disability detection survey and employment creation for PWD. However, the policy outlined some critical areas of intervention for improving the living condition of PWD; employment creation and community-based rehabilitation has got limited success. In 2000, the National Foundation for the Development of Disabled Persons (NFDD) was formed under the Ministry of Social Welfare to protect the rights of PWDs and take steps for the overall development of them. The foundation has undertaken some positive steps towards their development, e.g. free treatment, one-stop services, training, microcredit, assistive devices and counselling services for PWDs.

For ensuring the policy and development of PWD, the Disability Welfare Act was enacted in 2001 and subsequently modified and replaced as the Rights and Protection of Person with Disability Act in 2013, which focused on accessibility to education, employment, health care and safe environment, free from oppression issues. The national coordination committee and different local committees are formed and designed to implement the activities of GOs, NGOs and local organizations to promote the wellbeing of PWD. By contrast, it does not offer a strong commitment to alter the existing structural barriers to remove inequalities and fulfill their aspirations. It is necessary to introduce anti-discriminatory policy and legislation to combat the discrimination and exclusion of the PWD in Bangladesh. The Neurodevelopmental Disabled Persons Protection and Trust Act- 2013 was also enforced to address the mental health issues of people with disabilities. The effectiveness of this act is limited. Because, in our country, there is a minimal number of mental health professionals only available at the district level hospitals, not found at the grass-root level, e.g. village or union *Parishad* level.

5. Social and structural barriers faced by people with disability in Bangladesh

Despite some recent progress in the government initiatives, e.g. policy, programs and legislation, the PWDs are still facing multiple challenges, i.e. social and structural barriers that hamper their general wellbeing. These are described below:

Poverty and deprivation

Poverty is one of the significant barriers that the PWD is currently facing in Bangladesh. However, there remain constitutional and legislative obligation to ensure equal rights from the state and society, and they experience poverty, discrimination and disadvantage, which result in considerable economic hardship and loss of their creative capabilities (Sultana, 2010). According to the DFID report (2000), it is shown that more than 50 percent of the impairments of people in Bangladesh that result in disability is directly linked to poverty. The report points out that poverty, impairment and disability also have impacts on families, and there is a direct link between disability and poverty (Alam et al., 2005). Another study found that 68.9 percent of PWD cannot seek medical or rehabilitation assistance due to economic hardships. The study also found that 96.7 percent of PWD did not get any help from social or developmental organizations (DIB, cited in Alam et al. 2005). Some other study findings also mirror the situation, e.g. it is found that a significant number of PWD cannot fulfill their basic needs, i.e. around 22.27 percent are deprived of getting appropriate clothes, 25 percent are deprived of getting adequate food, 22.73 are deprived of quality housing, and 25 percent are deprived of health care (NGDO, NCDW, BLAST, 2015).

Low level of education, employment and wage discrimination

The 7th five-year plan report (2016- 20) of the government of Bangladesh recognized that very few PWD are involved in mainstream employment activities. The reasons include a low level of education and a lack of essential professional skills to be involved in economic activities. Because there is a lack of vocational training centers that can hardly provide adapted skill training to them. The development organizations also lack the knowledge or skills to include PWD in their skill development training initiatives. Besides insufficient specialist services like Braille, sign, and speech therapy, limits their inclusion scopes into the workforce. Many employers are also reluctant in employing PWD into their workforce, mostly due to their ignorance about the potentialities of them, negative attitude, the work environment not being accessible and their lack of interest to renovate or adapt the working environment befitting to the needs of PWD (NFOWD, 2005). Studies also point out that PWD who are involved in employment experiences of wage discrimination within the workplace. It is categorically mentioned that the majority of them were only able to do manual work as they had no formal education, and particularly people with intellectual disabilities were engaged in various farm and non-farm (e.g. earth digging, water supply) labour daily. However, they were paid less than their non-disabled counterparts (Nokrek et al. 2013). Another study also reveals that PWD was discriminated against job appointments, salary and promotion (NGDO, NCDW, BLAST, 2015).

Health care and treatment

Health care and treatment is an essential issue for the general mass people as well as for the PWD. According to the National Health Policy (2011), it is mentioned that Bangladesh stands as one of the 57 countries in the world suffering from a severe shortage of health workforce, i.e. physicians, dentists, nurses, health technologists. The World Health Organization (WHO, 2014) estimates point out that, Bangladesh has a shortage of more than 60,000 doctors, 280,000 nurses and 483,000 technologists. These shortages of health care workforce also affect the wellbeing of PWD. Study evidences suggest that due to poverty many PWDs cannot afford to travel long distances to reach the health service providers and receive appropriate services responsive to their health care needs. Professionals like a physiotherapist, occupational-therapists are a few in number and concentrated in the city areas. Therefore, specialized services, e.g. physiotherapy and occupational therapy for PWD, are scarce at the local level, e.g. village areas, *char* and *haor* areas of the country (NOFOWD, 2005). In the sphere of public services, the medical model of disability dominates where policy and programs are designed in the line of traditional approach, e.g. provision of disability allowance and some therapeutic services to maintain childlike dependency. Low access to adequate health and disability services ultimately increases the vulnerability of PWD.

Social security measures

The Govt. safety-net programs are an essential component of the social protection strategy for PWD in the country. Nevertheless, the amount of disability allowance and other services coverage is meagre to target the extreme poor with disability. The 7th Five-year plan (2016- 2020) report also recognizes that people with disabilities are handicapped in society due to physical, social and cultural barriers. The findings of a study demonstrate that only 31 percent of household heads with disabilities were receiving government safety nets, which reflect that a significant percent of PWD remain outside the service coverage from the public safety nets activities. There is an estimation which suggests that current schemes to address working-age adults are quite small, e.g. only about 290,000 persons have been covered out of 1.15 million people with a severe disability. The disability-friendly facilities are absent at schools and hospitals and roads (UNICEF, 2009).

Social stigma and community attitude

The social stigma attached to disability contributes to the family's tendency to hide family members with disabilities and not to seek appropriate care for them (cited in UNICEF, 2009). Study evidence also suggests that in many cases, family members or relatives consider them as a burden, and community members hold a negative attitude towards them (Hosain and Chatterjee, cited in Maloni et al., 2010). Studies also point out that community people use derogatory terms for people who are deaf, unable to speak or have mobility impairments, which prevent them from participating in social events, e.g. festivals and market places. People with intellectual disabilities are particularly vulnerable to being taunted and attacked in public places (Peter Davis, 2016; Sultana, 2010). The government report entitled 'Bangladesh unlocking potential: Poverty Reduction Strategy Paper' also recognized that in Bangladesh, people with disability live in an

unfriendly and hostile environment as they encounter noncooperation, ill-treatment, neglect and hostility at the family, community and society level. It is found that persons with disabilities do not get importance in the family because they thought them as unproductive. All of the theses increase their vulnerability and prevent them from fully participating in society.

Housing, transportation, water and sanitation issues

Study evidence reveals that housing is a crucial factor for a significant number of PWD living in rural areas and urban slum structures. While overcrowding is a problem in itself, Bangladeshis do not always choose to live in co-residence with are forced to do so by their economic condition. Living in overcrowded and inappropriate housing structure makes their living more difficult and reduces mental peace. Recent study findings show that 50 percent of PWD opined that transport vehicles are not disabled-friendly while 29 percent said buses and trains lack features for easy /wheelchair accessible. The housing structure is also not reasonably made to facilitate the accessibility of PWD. It is found that 94 percent of the PWD said that their family homes do not have a disabled-friendly washroom or toilet, and only 6 percent said that they have access to an adapted washroom or toilet in their family homes. Public health centers, such as Upazila Health Complexes and district general hospitals, remain inaccessible to PWDs. (NGDO, NCDW, BLAST, 2015). A qualitative review by Groce et al. (2011) lists potential barriers to WASH among PWD in the spheres of technical access barriers, e.g. facility structure and distance to facilities which suggest that in the rural areas, there is lack of appropriate washroom and sanitary facilities responsive to their physical impairments. The study attempted to break a ground that there remain inter-relationships between water and sanitation (WASH) and poverty, and poverty and disability, which might also impact on WASH access within the household (cited in Mactaggart et al., 2018).

Gender disparity and oppression

Study findings also show that women with disabilities face discrimination at the family, state, institutional and social level as they enjoy fewer opportunities in both public and private spheres of life, and they receive government aid at a very nominal level. It is categorically pointed out that female PWD is regularly denied rights to property inheritance and personal assets. It is further mentioned that discrimination extends to marriage, divorce, separation, maintenance, custody and guardianship. Women with disabilities are not given a choice in marriage and restricted to sexual and reproductive choices. Violence against women happens in the form of acid attacks, abduction and kidnapping, rape, trafficking, forced marriage, dowry violence, sexual harassment, even including domestic violence (NGDO, NCDW, BLAST, 2015).

6. Conclusion and policy implications

This paper supports the existing evidence that PWD faces multiple challenges and disadvantages compounded by social and structural barriers and environmental factors. They are deprived of basic needs, education and training opportunities, unemployment, lack of adequate health care facilities, social stigma and negative community attitude, housing and transportation facilities, gender disparity. However, the paper provides some valuable information and insights on the different forms of deprivations and disadvantages in the socio-economic, cultural and environmental aspects of their life, more qualitative and quantitative researches are yet to be

conducted for better understanding of the social and structural barriers that adversely affect the wellbeing of PWD and increase their vulnerability. Although the GOB has taken some positive measures to improve the condition of PWD through formulation of new policy, programs and legislation, some more drastic actions are required to break down the structural barriers, e.g. poverty and deprivation, inadequate education and training opportunities, unemployment and wage discrimination, social stigma and oppression, gender-based discrimination and violence. Therefore, it is suggested to adopt anti-discriminatory and anti-oppressive social policy and legislation to ensure their full access to health, education, housing and sanitation, transport. National coordination committee, Executive committee and other district-level committees should be strengthened to work on the issue effectively. Electronic and printed media, journalists, social workers and members of civil society should participate in raising the united voice to protect human rights issues of PWD. More proactive measures should be taken to ensure their participation in income-generating projects of GO, NGO, private sector employment.

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