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Problems and Prospects of the Mentally Retarded Persons in Auchpara Union of Bagmara Thana in Rajshahi District

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PROBLEMS AND PROSPECTS OF THE MENTALLY RETARDED PERSONS IN AUCHPARA UNION OF BAGMARA THANA IN RAJSHAHI DISTRICT

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BY

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CERTIFICATE

Certified that the thesis entitled **Problems and Prospects of the Mentally Retarded Persons in Auchpara Union of Bagmara Thana in Rajshahi District** has been completed by Mr Md Saiful Islam Khan, Lecturer of Hatgangopara Degree College, Bagmara, Rajshahi for the award of M. Phil. Degree and the work has been done under my supervision.

I now recommend for the examination of the thesis.

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22.9.2003

Professor Anwarul Hasan
Research Supervisor

DECLARATION

This thesis contains no material which has been accepted for the award of any other degree or diploma in any University and contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Md. Saiful Islam Khan
22.09.2003

Md. Saiful Islam Khan

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ABSTRACT

This research is a complete study of all the living mentally retarded persons of all the villages of a union in Bangladesh. The name of the union is Auchpara of Bagmara Thana in Rajshahi District. Total population of the union is 24,201 persons. Out of this population only 117 were identified as mentally retarded persons. The prevalence rate is 0.48 percent.

The researcher personally visited all these 117 mentally retarded persons and studied them. The major interest areas the researcher was to investigate their Health, Education, Employment, Housing and Social Security matters. Mainly observation and interview methods were followed. The researcher also used a questionnaire during case studies. The findings are shown in different tables of chapter II & Chapter III of this thesis.

It was found that severe illness during infancy and babyhood periods of the subjects are most important post-natal factors of their present mentally retarded conditions. Among the pre-natal factors illnesses and faulty treatments of the pregnant Mothers are important factors. Prolonged labour pains followed by birth hazards in the absence of qualified midwives are most important peri-natal factors.

It was found that poor medical facilities inside the Union are the main reason of many faulty treatments done to the subjects. Attitude, beliefs, habits and culture of the villagers towards health care behavior is slowly changing with the gradual development of infrastructure inside the Union.

The parents possess positive attitude towards Special Education, but they do not receive any

support either from the Government or NGOs. They also do not know how to teach their handicapped children at home by Portage Method or any other scientific method. What the handicapped children are learning are the contribution of the indigenous social system of rural Bangladesh.

All the adult mild and moderate mentally retarded persons, both male and female, were found get jobs in agriculture sector. It was also found that the employers like them and possess positive attitude to engage them in easy works. If the mentally retarded persons can be given some vocational training it will increase their employment opportunities in other sectors, too.

Though not up to the mark the housing and living condition of the mentally retarded persons were found of similar standard like other members of their families.

The Social Security of the mentally retarded persons was found of similar nature like all other places of the country. But if the Government gives them some monthly financial benefits it will be a great help to the families and the handicapped persons will also gain better social status.

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INTRODUCTION

Mental Retardation was relatively an unknown concept in Bangladesh until 1977. Earlier mentally retarded persons were considered as mentally ill persons. With the promotion of medical care facilities, immunization programs and awareness development, the mentally retarded persons are now having longer life span. As the mentally retarded persons of Bangladesh previously had a relatively shorter life, the problems related to them were lesser. Now a significant portion of the moderate and large portion of the severe mentally retarded persons are also reaching adulthood stages of their life span, therefore the related problems are also increasing.

Though the problems are slightly different for individual mentally retarded persons considering their degree of retardation, living places, socio-economic condition, etc., the problems can be generalized into five major problem areas. These are health, education, employment, housing and social security.

The birth of a severe mentally retarded child may jeopardize the daily living activities of all the family members. The nature of problems faced by the family members are positively co-related with the degree of retardation of the member.

There are many reports related to nature, number and seriousness of mental retardation in Bangladesh. But all the reports are based on randomly selected samples of different places of the country. To understand the real situation, this research is designed to study all the cases of mental retardation of all the villages of Auchpara Union of Bagmara Thana of Rajshahi District in Bangladesh. The researcher personally visited all the cases. He observed all of them, talked to their parents, guardians and neighbors. In selected cases he studied the avialable medical papers.

This research is a total study of the life of all the mentally retarded persons of the Union. This research is also an attempt to study the changing pattern of problems and prospects of the mentally retarded persons living in a remote rural area of Bangladesh.

However, before entering into the problems and prospects of the cases it is pertinent here to briefly describe the study area and basic concepts of mental retardation.

AUCHPARA UNION

LOCATION

Auchpara is the name of a small union of Bagmara Thana of Rajshahi District in Bangladesh. It is 40 km away in the northern side from the divisional city, Rajshahi. This union is an important one among the sixteen unions of Bagmara Thana. Bagmara is the second largest Thana of Rajshahi District, which is located between 24.30° and 24.41° north latitudes and between 88.41° and 88.58° east longitudes. There are 39 villages and 23 mouzas in Auchpara Union. The area of the Union is 26.46 sq. km. It is located in the western part of the Thana. This Union is attached to Zahanabad union in the south and Rayghati Union of Mohonpur Thana of Rajshahi district in the west. In the northern side, Tetulia union of Manda Thana of Naogaon district and Gobindopara union of Bagmara Thana is situated. Shuvodanga union of Bagmara Thana is in the eastern side of Auchpara Union. Location of the district, thana and the union are shown in different maps at the end of this thesis in the Appendics.

COMMUNICATION

The communication facilities of Auchpara union were very poor few years ago. The inhabitants of this union had to face lot of troubles to go to the nearby towns and to the Thana Head Quarter. At present, the condition has changed. Different roads, bridges and culverts were constructed and the communication pattern has significantly improved. The internal communication of the union and the communication from Auchpara to Thana Head Quarter and District Town has developed significantly.

Two *pucca* roads from Kamarpara and Keshorhat of Mahonpur Thana those connecting the Bagmara Thana Head Quarter from Rajshahi – Naogaon highway are situated in two sides of the Auchpara union. One from Kamarpara entered the union from the north – west corner and runs through Saidhara, Bamnigram, Indrapur, Hatkhujipur and Hatgangopara. The other road connecting the Thana Head Quarter in the southern side of the union. In addition there is another road from Keshorhat that entered the Auchpara union from the south – western side has passed through Birahi and Mugaipara towards the Thana Head

Quarter. Now, the villagers use these two roads and can easily go to the Thana and the District Head Quarters for business, treatment, education, employment, etc. Every morning two buses go to Rajshahi City from Hatgangopara Bazar of the Union. One of the buses starts from Baigacha at 7 am and the other from Damnas at 8 am. The same buses return for Baigacha and Damnas via Hatgangopara from the Rajshahi City Bus terminal in the afternoon and evening.

There are four post offices inside Auchpara union. The first post office was established in 1973 at Hatgangopara. The postcode of this post office is 6250 and attached to Bhawaniganj post office under Natore range. Later, other three post offices were established respectively at Khalgram, Belghoriahat and Khujipur at different times. The Belghoriahat and Khujipur post offices are connected with Hatgangopara post office. The Khalgram post office is connected to Machmoil post office. The people of this union get ordinary postal facilities using these post offices. But for Parcel, Guaranteed Express Service and International Mail Service, etc. people are to depend upon the Bhawaniganj post office of Thana head quarter.

Because of the miraculous influence of the mobile telephone, Auchpara union has become a part of the global village. In the year 2000, Grameen Bank first started handing over mobile phones to their selected members for the use in commercial purpose. General people are using these mobile telephones by paying a fixed amount of money. Now, some people have purchased individual mobile phone from Grameen Telecom Authority for their personal, as well as for business purposes. The people have availed themselves of this scope and are making communication home and abroad easily and comfortably. Mobile phone has suddenly brought extensive change in the life of the people.

POPULATION

The total population of Auchpara union is 24,201 persons. The number of the male is 11,851 and the female is 12,350. Approximately 95% of the total population are Muslims. The remaining 5% are Hindus. The researcher did not find any

Christian or Buddhist in this union. There are some families who do not have any religion but are influenced by Hinduism living at Hatgangopara, a central place of Auchpara union. Though influenced by Hindu religion, they do not know what the name of their race is or where their ancestors lived in and how they have come here. Sweeping the market places, removing the tools and taking part in different Hindu religious festivals with musical instruments are their main jobs.

Most of the people of the union live on agriculture. Many people are engaged in business. We find many government and non-government employees, teachers, physicians and people of many other professions in the union. Here life style is very simple. The life status and economic condition is changing because of recent electric supply and modern agricultural equipments. Significant uplift is taking place after the introduction of new schools and colleges.

ECONOMIC CONDITION

The economic condition of the people of Auchpara union is similar like other rural areas of the country. Most of the houses are Kancha houses. The numbers of semi pucca houses are few. The main occupation of the people of this area is agriculture. Paddy, jute, potato, wheat, banana etc. are the main crops. Whatever the other profession is somehow all people are involved in agriculture. There are some day labourers and landless people also living in the Union. The researcher has observed that some male young people of the poor families have accepted the career of rickshaw or van puller with new hopes after the development of the roads.

Even a couple of years back, the economic condition of the people of Auchpara union was worse to a great extent than present time. Many kinds of natural calamities like drought, flood etc. used to break out, as a result, the production of the crops became hampered, or produced crops were damaged. Most of the people led their lives with tremendous difficulty and misery. Now variegated facilities have been created and the scopes of the people of this union are in ongoing amelioration. Because of the modern equipments and of the connection of electricity, a great

change has arrived in the field of agriculture. Following Up-to-date irrigation system, developed apparatus and the seeds of high breed, the farmers are producing crops in plenty. There are around 300 ponds in Auchpara union. People are earning a lot of money by fish-farm in those ponds in scientific ways. Fisheries and ice mills have been established on the basis of fish-farms. Fish of thousands of takas is supplied to Dhaka and other remote cities besides nearby ones. Betel leaf of high kind is cultivated in this union. Besides agriculture, handicrafts also have started contributing to the economy. Women along with men, too, are earning lots of money by making different household things made of bamboo. Considerable uplift has been made in communication which are playing positive role in trades and commerce.

EDUCATION AND CULTURE

The government claims the literacy rate to be 65 % all over the country. It is not same in the Auchpara union. According to the survey of 1991 it was 18% in this union. The people have become much more conscious than before. Educative activities of the NGOs have played a positive role in the sphere of education besides the national policies aimed at making the education compulsory for all. In this union, there is one Degree College, a women's college, a technical college, 5 general high schools, a girl's high school, a technical high school, an Alim madrasa, 5 Dakhil madrasas, 7 government primary schools and 8 registered primary schools. Moreover there are 13 schools run by BRAC for primary education.

The following places in Auchpara union greatly contribute to the education and culture of this area. Different educational and cultural institutions have been established to enlighten of the whole union and the surrounding areas.

Hatgangopara: Hatgangopara is considered as the centre of education and culture of the northern part of the union and some villages of the neighboring unions. The only public library of the union and some adjoining unions is situated at Hatgangopara. The Degree College, the Women's College, the High School, the Primary Schools, the Grameen Bank, the Janata Bank, the Post Office, the well built Jame Mashjid, the Public Toilet, the Tahsil

office, the Jewelary Shops, the Political Party Offices, the Pharmacies, the Tea stalls, other shops, etc. are the institutions which possess significant influence in the people's mind to shape their personality pattern. Following are short descriptions of these institutions.

Hatgangopara Degree College– Hatgangopara Degree College is the highest educational institution in Auchpara union as well as the neighbouring unions. In the extention of education & culture, this college has been playing pivotal role since its establishment. Established in 1993, the college is an institution for Higher Secondary Education. In 1999, this college was promoted to degree level under the National University. In the year 2002 there were 434 students in this college. Out of them, 350 are male and 84 are female. In 2002 HSC examination 34.33% candidates from this college passed the public examination while the national average passing rate is around 23%.

The college is situated on 3.41 acre land beside the Kamarpara – Hatgangopara road. The Office of the college is a Pucca building. The class rooms are in Semi-Pucca Tin-Sheds. 36 teachers teach different subjects. In addition 1 Physical Education Teacher, 3 Demonstrators, 2 Librarians, 15 Office Staff are there to run the daily activities. The Principal of the College is Mr. S M Mahbubur Rahman, a noble, kind-hearted but strict and well-qualified personality, who obtained M.A. in Social Work from the University of Rajshahi. He has been discharging his sacred duty as a principal since the establishment of the college and due to his proficient manipulation; this institution has stood on a solid ground.

Hatgangopara High School – Established in 1925 this High School now enrolled 376 male and 151 female students. There are 13 teachers and 5 office staff. The High School is on a two acre land adjacent to the market centre and the Tahsil office.

Gangopara Balika Biddalaya – Gangopara Girls School was established in 1994 on a land measuring 1.28 acre. There are 11 teachers and 5 staff for 213 girl students. The Headmaster is Mr

Shohidul Islam Pramanik who obtained Masters in Political Science from Rajshahi University.

Hatgangopara Government Primary School – Established in 1935 on a land measuring 0.57 acre the school is managed by only 4 teachers which has enrolled 230 children. Since 1981, every year students obtained talent pool and general grade primary scholarships.

Barigram Sahitta Vaban o Shikkha Shangho – Established in 1983, the library now possesses more than 1800 books. The reading room remains open to all interested person from 5 to 9 pm in summer and 4 to 8 pm in winter. The books are issued to the members, too. It was claimed by the organizers that this is the only public library of the entire Thana. One Librarian handles the daily affairs. The books are mainly in the field of Law, History, Education, Literature, Children's classics, General Knowledge, Religion, etc. The library also subscribes daily newspapers.

The name Barigram indicates a village of another neighbouring Union of Bagmara Thana. The library was supposed to be at that village. Positioning it at Hatgangopara indicates that Hatgangopara is a centre for those villages, too. In addition to the library affairs, the Shangho also arranges cultural competitions, discussion meetings, get togethers, etc.

OTHER VILLAGES

Abhvagatapara: The village is situated on a kancha road connecting Hatgangopara with Keshorhat. The villagers use Hatgangopara as their central place for communication, shopping, treatments, education, etc. Some of the villagers are engaged in small trade of clothes, rice, cosmeetics and other agricultural products. All the families are associated with agricultural works. There are 125 families in the

village and the total area is 151 acres. Out of 682 total population 332 are male and 350 are female.

There is one primary school and one junior high school in this village. The villagers said that communication and electricity are their only problems. If they get a good road, and electricity is provided to the village houses, all problems will be solved.

Auchpara: The village is in between river Kampo and the beel area. This is relatively a thinly populated village where all the people are completely dependent on agriculture. And there is no other activity other than cultivation. None of the villagers has taken any initiative to do anything else.

The area of the village is 322 acres and there are 94 families. The total population is 438 persons. 224 male and 214 females. There is one primary school in this village. There is no club or social organization in this village. This is practically an isolated village, very much neglected without any road. For everything this village is dependent on Hatkhujipur.

There is another part of the village known as Sihali adjacent to Abhyagatapara. This area has a road connection. Sihali is again devided into two parts, hindupara and sihali. Presently there are only six hindu families.

Baikuri: The area of this village is 288 acres. There are 136 families. The total population is 806 of whom 409 are male and 397 are female. There is only one primary school and one club in the village. The village is close to a feeder road connceting Keshorhat with Machmoil. And the village is more attached to Machmoil and Subhodanga than Hatgangopara.

All the villagers are Muslim in religion. There is one village physician and six graduates in the village. The Headmaster of the Machmoil High School Mr Asadullah lives in this village.

Bamnigram: The area of the village is 332 acres. There are 217 families. Total population is 1106 persons of whom 542 are male and 564 are female. Many Hindu families live in this village. In Auchpara Union the largest number of Hindu people live here. There are five semi pucca residential houses. There are three deep tuble wells operated by electricity. There is one diesel engine operated rice mill.

There is no educational or socio-cultural institution in this village other than the small BRAC school.

Belghariahat: The total area of the village is 288 acres. There are 186 families. Total population is 1059 persons of whom 531 male and 528 are female.

This village is about two kilometers away from the Naogaon – Rajshahi highway and adjacent to Narayanpur village of Manda thana of Naogaon District. Therefore, the villagers maintain more contact with the markets of Manda Thana compared to their own Union markets, including Hatgangopara.

There is no primary school in this village and most of the children read in the only Ebtedaey-Fazil Madrasa of the village. The Madrashah is relatively large and enrolled about 350 students including 150 females. The researcher found few children go to the primary schools of the nearby villages. When asked, the elderly villagers, the young people, as weel as the children were found satisfied with the education and curriculum of the only Madrasa of the village and were found not conscious that there is no primary school in the village. However, BRAC operates one small school in this village.

There is one post office in this village, adjacent to the Madrasa, one of the four post offices of the entire Uinon.

Birahi: The total area of this village is 348 acres. There are 281 families. Total population is 1487 persons of whom 712 are male and 775 are female.

The village is divided in two parts, Mirzapur and Khodapur. The village is situated in the south western corner of the Union. The feeder road that connects Keshorhat-Machmoil-Bagmara has divided the village. The villagers are more oriented with keshorhat and Machmoil hat for most of their necessities. They come to the Union hdead quarter office at Hat Khujuipur only in relation to land revenue and official business.

There are one privated registered primary school, one BRAC school, one club –Mirjapur Jubo Samity in this village.

Bishnupur: Total area of the village is 189 acres. Now there are 97 families. Total population is 560 person of whom 256 are male and 304 are female. All the villagers are Muslim and now there is no Hindu family in this village.

The village is beside Kampa river. The village is connected with Khalgram by a bridge. A kancha road connects the village with Palapara and Rakshitpara in the north and north west. There is no school, no club or social organisation in this village.

Hatkhujipur: The total area of the village is 123 acres. There are 121 families. Total population is 620 persons of whom 322 are male and 298 are female. All the villagers are muslim and there is no hindu family.

This village is the seat of the Union Chairman. All the Local Government offices are situated in this village. Now the village is connected with Rajshahi – Naogaon Highway with a *Pucca* road. The road was built in the middle of 1996. Earlier, it was a *Kancha* road. The village is situated on the west bank of river *Kampo*.

There is one High School in front of the Union Board office. The Primary school was established in 1911 and is the first primary school of the entire union. The football ground in front of the school premises is quite big and is well utilized by the children.

One small-scale afternoon market assembles around the union council centre every day. The permanent shops of the market comprise few tea stalls, one carpentry workshop, few groceries, few very small stationary and tobacco shops. The Kancha Bazaar operates around these shops. In the afternoon, it is a place of meeting of the adult male members of the village, too.

There is one club in this village known as Hatkhujipur Godhuli Sangha. This club is a registered voluntary social welfare agency to uplift the cultural affairs of the villagers. Godhuli means the sunlight before sunset. And the club arranges dramas, games competition, etc.

There is one Union Family Welfare Centre, the most modern building of the union. The centre is now giving care and advice to many women. Every morning many women come to centre.

Dr. Abdullah Ansari is the Professor and Chairman of Applied Mathematics Department of Rajshahi University and he was born in this village.

Indrapur : Total area of the village is 177 acres. There are only 56 families. Total population is 326 persons of whom 152 are male and 174 are female.

There is one Dakhil Madrasa in the village, establish in 1980, the biggest organisation of the village. 275 students read in this Madrasa which is situated on the bank of river Kampo.

No other school, organization is there in this village. All the villagers are engaged in agricultural works. This is a small village and the houses are situated on both side of a Pacca road that connects Hatkhujipur with Keshorhat. The entire village road is covered by the shadow of the trees, mostly the fruit trees.

Now there is no Hindu family in this village. But the name of the village indicates that it was a Hindu village many years ago. Indrapur is also the connection between Auchpara village and all other places. There is a small ferry boat at the Indrapur Madrasa kheyaghat which maintains communication between Indrapur and Acuhapara village.

Kanaissar: Total area of the village is 418 acres. There are 257 families. Total population is 1287 persons of whom 603 are male and 644 are female.

Among the establishments there is one Forkania Madrasa, one club, four semi pucca buildings, two electricity operated deep tube wells and many kancha houses in this village. There are two village physicians and seven graduates in this village. The pacca road that connects Kamarpara-Hatkhujipur-Bagmara has divided the village. Now four Hindu families live here.

Khalgram: Total area of the village is 372 acres. There are 286 families. Total population is 1518 persons of whom 704 are male and 699 are female.

The village is situated in the south-eastern corner of the union. It is near Keshorhat Bazar of Mohonpur Thana. One high school (492 students including 188 female students), one Government Primary School, two BRAC schools, one Registered Club, one post office, one small bazaar, are the major features of the village. Thursday and Sunday Hat days are important days to the villagers. The Khalgram Hat is also famous for bi-cycle marketing. Hundreds of new and used bi-cycles are sold on the Hat days.

Konda: The total area of the village is 813 acres. And this is the biggest village of the entire union. It is also assumed that the population of this village is the oldest human settlement in the union. The lands where the houses are located seems little higher than the flood level of the entire area. There are 523 families. Total population is 2672 persons of whom 1316 are male and 1356 are female.

One high school, one government primary school, One Dakhil Madrasa, one BRAC school, one community clinic, two registered social welfare clubs, five semi pucca houses, four deep tube wells, three rice mills, few small mosques, etc. are the important features of the village.

There is a kancha road that connects the village with Keshorhat – Machmoil feeder road. This road also connects the Hatgangopara Bazar.

Kusalpur: Total area of the village is 101 acres. There are 85 families Total population is 478 persons of whom 239 are male and 239 are

female. From the viewpoint of population it is a small village. All the residential houses are kancha houses located in both sides of the only road of the village.

The village is in the northern corner of the union, adjacent to Mangalpur in the east and a village of Manda Thana of Naogaon District in the west. A kancha road that connects Naogaon-Rajshahi highway and the northern Unions of Bagmara has passed through this village.

One Dakhil Mardasa, establish in 1958, having 147 girls and 181 boys is the biggest institution of the village. Now one small BRAC school operates for the school dropouts, mainly small children. There is no medical facility and no social organisation in the village. The village use Hatgangopara for daily shopping, transports, medical care and high school education.

Majopara: The village is adjacent to river Kampo, very close to Hatgangopara Bazer. Hatgangopara is in the northern side of the river, Majopara is on the southern bank of the river. Total area of the village is 179 acres. There are 111 families. Total population is 789 persons of whom 373 are male and 416 are female. At present there is no hindu family in the village.

There is one Private Primary School and one Womens' college in this village. Majopara - Gangopara womens' college is running from this year on a piece of land measuring 1.00 acre. There are 11 teachers and 4 office staff for 35 female students. The principal, Md. Meser Ali Khan obtained Masters Degree in Islamic Studies from Rajshahi University.

Mangalpur: The village is situated in the northern part of the Auchpara Union, close to Hatgangopara Bazar. There is a kancha road from the recently upgraded pacca road of the union from Kanaissar to

Jiapara village of Gobindapara Union which has gone through Mangalpur village. This kancha road has divided the village in two parts. The residential houses are situated beside this road.

Total area of the village is 176 acres. There are 86 families. Total population is 619 persons of whom 296 are male and 323 are female. There is one BRAC school in this village.

There is no primary school, no club or social organisation. The small kancha mosques are the only institutions of the village, restricted only for the male villageres. Villagers drink tube well water. In general the socio economic condition of the villagers are not well like many other adjoining villages.

Mugaipara: The total area of the village is 249 acres. There are 146 families. Total population is 925 persons of whom 465 are male and 461 female. All the villagers are Muslim and now there is no Hindu family in this village.

This village is adjacent to Keshorhat – Machmoil feeder road and the villagers are more attached to these two places. The only connection they maintain is with the Tahsil office of Auchpara Union.

There is a High school having 225 students. There are one primary school and one BRAC school. There are two clubs, the *Udayan Sangha* and the *Ujjal Proshari Club*. Both the clubs are engaged in recreational programme, mainly games for the boys.

There are a few permanent shops and tea stalls near the schools, beside the feeder road. Grocery and stationary items are the major trading items. On Saturday and Tuesday, medium type Hat operates at this Bazaar. In the afternoon, people throng there, and spend their times in pastime.

Palapara: Total area of the village I s 254 acres. There are 157 families. Total population is 998 persons of whom 465 are male and 513 are female.

There is no school. The *Palapara Gram Unnayan Bohumukhi Samabai Samity,* a co-operative society and community clinic is the only institution of the village. Five villagers are graduate and all of them are engaged in teaching profession. There are two Palli Chikitsaks. There is one herbal medicine man, relatively a rich man, who manufactures Ayurvedic medicines as well as an agent of a famous Ayurvedic Medicine Company.

The people of Palapara maintain connection with Keshorhat and Hatgangopara. From Keshorhat the villagers can come to their home using Rickshaw Vans. There is a pacca road which connects the village with Hatkhujipur.

Rakshitpara: Total area of the village is 464 acres. Presently there are 388 families and the total population is 2080 persons. Of whom 1027 are male and 1053 are female. This village is very close to Keshorhat and there is a kancha but well maintained road.

The Government Primary School is a well built semi pucca building and appears very well maintained. Adjacent to the Primary school, the Dakhil Madrasa is situated which looks poorer beside the Primary School building. The children and the young boys utilize the school play ground very much.

Saidhara : Total area of this village is 351 acres. There are 222 families. Total population is 1134 of whom 565 are male and 569 are female. Now there are 17 Hindu families in the village and they live together with the Muslims in complete harmony.

One private but registered primary school, one Women's Dakhil Madrasa, one BRAC school, three semi pucca houses, one electricity powered deep tube well of Barendra Prakalpa and two diesel engined rice mills are the major institutions and assets of the village.

There is no club or social organisation. The Kancha mosques are the only meeting places for the muslim males. For females there is no organizaiton at all.

Samaspur: The total area of this village is only 63 acres and 44 families live here. The total population is 306 persons of whom 129 are male and 177 are female. The villagers could not tell the background of nomenclature of the village to the researcher. In Bengali, Samaspur is the combination of two words – *Samas* and *Pur*. *Samas* means collection, union, combination, etc. *Pur* means an area.

One registered private primary school, one hafezia Madrasa, one electricitry powered deep tube well and four semi pucca houses are the important establishemnts in the village.

Sarindi: Total area of the village is 413 acres. There are 347 families. Total population is 1764 persons of whom 866 are male and 898 are female.

One registered private primary school, two BRAC schools, three semi pucca houses, two electricity operated deep tube wells of Barendra Prakalpa, one mosque built in 1200 BS, one dighi of three acres are the important places of the village.

Takipur: The total area of this village is 453 acre and there are 368 families. Total population of the village is 1775 persons of whom 896 are male and 879 are female.

One Government Primary School with 228 students, one junior high school, one BRAC school, one registered club the *Provati Juba Sangha*, three semi pucca residential houses, three electricity operated deep tube wells, three diesel engined rice mills are important places or assets of the village. There is a kancha road which connects the village with Hatgangopara and Keshorhat of Mohanpur Thana.

The BRAC Schools: There are many BRAC schools in the villages of Auchpara Union. Each of these schools are managed by one teacher and they are mostly young women of the area. It was found that in each school there are 33 students who seat in U shape on the floor around the teacher. The books they read are

published by BRAC which are matched with the National Curriculum but little different. These books are more attractive and include more accurate pictures than the Government Text Books. There is no tuition fee, rather the books and other education materials are given free to the students. Each school was started after a survey by the BRAC field staff who considers the problems and prospects of the school drop outs, availability of an young women of the locality as teacher with a low pay, possibility of completion of the primary education of the entire group of 33 students within 3 years. It was also found that the students of these schools are more enthusiastic to attend the school (in many cases they were drop outs from the Primary Schools) and the teachers have developed rapport with the students. The parents of these students were also found aware of the schooling and the progress of their children. It was found that the children who have spent at least one year in the BRAC schools have obtained some practical knowledge about the environment, useful mathematics. They can read and write in Bengali and many children can read story books.

Table-1.1: The educational institutions of the Auchpara union at a glance:

Name of the institution	Total number
Degree College	1
Womens' College	1
High School	5
Girls' High School	1
Technical College	1
Technical High School	1
Govt. Primary School	7
Registered Primary School	8
Alim Madrasa	1
Dakhil Madrasa	5
Ebtedaey Madrasa	5
BRAC School	13

LIFE IN AUCHPARA UNION

The daily life patterns of the villagers are more or less same in all the villages in auchpara union. They wake up early in the morning. Clean teeth with charcoal dust or some *daton* or something else like toothbrush and paste or *mazon*. Clean their faces with water from the tube wells or a *kua*. They finish their toilets in the bush near their houses or in the toilet, if there is any. Most of the villagers use *kancha* toilets, which are situated outside the house in the corner usually near a bush or a ditch. The toilets are made of bamboo *chatai* walls on bamboo platforms with a jute bag hanging in one side as screen. The women finish their toilet earlier then men and usually during dawn. The women help their children to clean their faces later in the morning. Then women clean their courtyards with *jhata*. Cleaning of the courtyards is followed by preparation of breakfast food. Cooking is an important work for the women. They use firewoods, usually the dry branches of their own trees or trees of the village. Men rarely help women in preparing the food (Sufi & Yamashita, 1996).

Opening the *khoar* of the cattle and the poultry's are important works of the women parallel to the breakfast preparation. The rich women have helping hands, both male and female, to help them in the morning. If the housewife possesses helping hands, the male servants, popularly known as *kamla*, takes care of the cows and the poultry. On the other hand, the female helping hands, popularly known as *biti*, help their employers in the preparation of the breakfast. The rich housewives are to supervise preparation of a huge quantity of breakfast for the family members and the servants. Poor housewives prepare breakfast for her own children and the male members of the family. The families which are united and where some married sons live with their father in the same house, the wives of the sons, and the daughter in laws, remain serious to help their mother in laws in all such household works. Usually the eldest daughter in law is in the most delicate position compared to other daughter in laws. If the sons are the major earning members and if the fathers and mothers are too old, the daughter in law becomes dominant decision maker in relation to the internal household maters.

Social clicks are present in almost all the families. Conflicts and cold wars are present among the daughter in laws themselves and between the mother in laws and the daughter in laws. If there is a daughter in the family, popularly known as *nanad*, the situation are usually different in relation to the politics of the women.

Men wake up and want to get breakfast as soon as they clean their faces. The food is always served by the women. Children eat with the men or earlier, sitting closer to the oven. The researcher observed that very few children study their books before the breakfast. It was also observed that men have a short chat with the other family members and neighbors before they eat their breakfast. The food in the breakfast is normally the hand made round breads with some *goor* or some curry. If it is not bread then it is boiled rice with some curry. The poor families eat *muri* and *goor* or some *panta* with chilli or curry or *dal.* During winter, different types of the cakes are very common in all the families. However, the food is different according to the economic conditions of the families.

The children go to school after breakfast, if they are students. A large number of children are not students and half of them go to the fields to help the adult males in agricultural works. Some of the remaining half of the children go out with the cattles, and the remaining children loiter in the neighborhood or around the children who manage the cattles.

The men go to the fields either to work or to chat with the people in work. Rich male adults go to the outer courtyards followed by visit to the hat bazaar or the shop of the village. They take tea in the glass containers and discuss important issues with the neighbors, friends and relations. It is mentionable, in the villages, most people are relatives of each others.

After managing the children and the male, the women eat the remaining portion of the food as their breakfast. The housewives eat breakfast with their maid servants sitting near the oven. The oven is normally situated in the inner courtyards, with a low height roof over the oven without any wall of any kind. Cleaning

the utensils using ash near the tube well or the *kua* is very common. If there is no source of water inside the houses the women bring the utensils to a common water source of the *para* or the village. Here they exchange all the news of their own houses. This is a time consuming affair. It is a matter of great pleasure to know the secrets of other women and they return home with so many information. However, if there is something serious, the information is received by the women early in the morning before the breakfast through the other women. The women transmit the censored or uncensored information to the men. The men discuss these in their meetings during tea.

After cleaning the *bashons*, the women usually engage themselves in cleaning the rooms, beds, and the clothes. They quickly switch over to the stored food grains during some special seasons. If there is nothing to do with the stored food grains, the women initiate the lunch preparation. This is a time consuming, slow moving job. Peeling the vegetables and cutting these in fine pieces with *boti*, sitting on a *pira*, surrounded by bamboo baskets, *gamla* and *hari* are very common. If there is more than one woman, discussions take place in different angles, from future planning to evaluation of others.

The lunch is usually served in the middle of the day. The men eat at first and then the women. The poor men return to the work after lunch. The landlords take a nap. The women usually take lunch after serving the entire family. Some women get opportunity to take a little rest after the lunch, most of the women do not get any opportunity to take rest. During winter and during the first two Bengali months women do not get any rest after the lunch.

Afternoon tea is very unusual in these villages. The evenings come very quickly and the women manage the poultry before the evening. The supper is served very quickly after the evening. Eating supper is practically the end of the day. But now a days some villagers enjoy Battery operated Television in the neighbor's house. And it is assumed that the pattern of retiring in the evening will change when the villages will get electricity.

MENTAL RETARDATION

Mentally retarded persons are found in every country of the world. It is assumed that about 3% of the total world population is mentally retarded (WHO, 1968). If the stunted children and multiple handicapped persons are included, this number will be higher. The number of mentally retarded persons in Auchpara union is 117. It is 0.48% of the total population of the Auchpara union. Among them, the numbers of mild and moderate mentally retarded persons are relatively more compared to the severe and profoundly retarded persons. There are many visually handicapped, auditory handicapped, physically handicapped and multiple handicapped persons.

Though modern science has contributed significantly in the health sector, but nothing could be done to improve the condition of the mentally retarded persons. Yet there are many wrong notion about mental retardation. Mass awareness about mental retardation is very low. It is a great problem for a country. However, attitude of the people towards Mentally Retarded persons is changing in Bangladesh. Medical scientists, Educationists and psychologists have their different notions to mental retardation.

DEFINITION

With the change of attitude towards the mentally retarded persons throughout the world, the definition of mental retardation also has changed a lot. We find the most recent definition, given in the 7th World Congress of the International Association for the Scientific Study on Mental Deficiency as follows:

Mental retardation is not a disease or a single entity, rather a term applied to a condition of retarded mental development present at birth or in early childhood and is characterized mainly by limited intelligence combined with difficulty in adaptation. Hence, mental retardation is impaired mental ability. A retarded child learns more slowly, and at maturity his capacity to understand will be less than normal. He finds

difficulty in learning social adjustment and economic productivity (Sen and Dutta, 1985).

TYPES OF MENTAL RETARDATION

American Psychiatric Association (1968) classifies mental retardation into the following five categories according to the degree of retardation:

Borderline: IQ 68 through 83, corresponding to a maximum adult mental age of about 11 to 13 years. There are many borderline cases in the villages of Auchpara Union. It was observed that they are well integrated in the mainstream of the village life. From casual observation it is assumed that the number of such persons will exceed 200 including children and adults. But the researcher could finally identify only 11 such cases in the entire union.

Mild: IQ 52 through 67, corresponding to a maximum adult mental age of about 8 to 11 years. There are many children in the villages who are enrolled as students of the primary schools, but not being able to cope with the curriculum. The researcher assumes that they are mild mentally retarded. The total number of such children was not assessed. However, 57 such mentally retarded children were studied by the researcher in Auchpara union.

Moderate: IQ 36 through 51, corresponding to a maximum adult mental age of about 7 years. The number of such cases identified in Auchpara Union is 35. They were identified by the researcher with the help of the villagers of Auchpara union. These persons need help of the family members in their daily living including eating, dressing and cleaning.

Severe: IQ 20 through 35, corresponding to a maximum adult mental age of about 3 to 5 years. Usually their motor and speech developments are severely retarded. Sensory defects and motor handicapped condition are common among them. They can develop very limited skills for maintaining personal hygiene and self-help. Throughout their whole lives, they remain dependent on

others for basic care. It was reported that many villagers had such children who died in their early ages. Now there are at least 8 of them who were studied by the researcher.

Profound: IQ under 20, corresponding to mental age not more than that of the average 3 year old child. The profoundly retarded are totally dependent on others for their survival. The number of the profound mentally retarded children in Auchpara union is 6. They are experiencing many problems and leading their lives with great miseries. The researcher was informed that a good number of such cases died during their infancy period either naturally or due to wrong treatment.

It is difficult to administer standard psychological tests to assess the IQ of the subjects in the villages due to language problem, communication problem, degree and severity of the handicap conditions, etc. Secondly, living in rural areas of Bangladesh is so simple that people do not consider Borderline cases as Mentally Retarded at all. The Mild cases are treated as relatively slow learners but capable persons in the mainstream. Only the severe cases who need help of others in all Daily Living Activities are considered as mentally retarded persons in the villages of Auchpara Union.

Not only the villages of Auchpara Union, but in most villages of Bangladesh, the people do not need to travel very much, do not buy items from vending machines, do not make calls from card phones, and do not face any situation which needs much calculations or selections. On the other hand, there are so many people to help someone who needs any help of any nature. Therefore, it is not difficult for the rural Mentally Retarded persons to live in the integrated community.

CLINICAL TYPES

Apart from these above mentioned five categories of mental retardation on the basis of IQ, we find some specific clinical types of mental retardation. Each of these clinical types, discussed below, has its own distinctive symptomatic and etiological patterns.

Down's syndrome: Langdon Down in 1866 first described this type of clinical condition associated with moderate and severe mental retardation. The term Mongolism is often used in referring to this syndrome. Afflicted persons frequently have almond shaped eyes (Golden & Davis, 1974).

In addition to almond shaped eyes, the skin of the eyelids tends to be abnormally thick. The face and the nose are often flat and broad, as is the back of the head; and the tongue, which seems too large for the mouth, may show deep fissures. The iris of the eye is frequently speckled. The neck is often short and broad, as are the hands, which tend to have creases across the palms. The fingers are stubby and the little finger is often more noticeably curved than the other fingers.

Well over 50% of these persons have cataracts, which are not congenital but tend to make their appearance when the child is about 17 or 18 years in age (Falls, 1970).

Majorities of the Down's syndrome cases have Trisomy of chromosome 21 in group G, which results in a total of 47 chromosomes. A small proportion of cases have been attributed to mosaicism or to translocation. Down's syndrome is the only common form of mental retardation due to autosomal abnormality (Gregory and Smeltzer, 1977).

In Auchpara union the researcher found several Down's syndrome persons. None of them are engaged in any economic activity or family business. The male persons loiter in the villages, the female persons mostly remain inside their own

houses. The families do not know that these persons have chromosomal anomalies and they also do not bother for the anomalies.

Cranial Anomalies : Mental Retardation is associated with a number of conditions in which there are relatively gross alteration in head size and shape, and for which the casual factors have not been definitely established (Wortis, 1973).

In 'Macrocephaly', there is an increase in the size and weight of the brain, an enlargement of the skull, and visual impairment, convulsions, and other neurological symptoms resulting from the abnormal growth of glia cell that form the supporting structure for brain tissues. Other cranial anomalies include 'Microcephaly' and 'Hydrocephalus'.

The term "Microcephaly" means small headedness. It refers to a type of Mental Retardation resulting from impaired development of the brain and a consequent failure of the cranium to attain normal size. In an early study of the post-mortem examinations of brains of microcephalic individuals, Greenfield and Wolfson (1935) reported that practically all cases examined showed development to have been arrested at the fourth or fifth month of fetal life. Fortunately, this condition is extremely rare. The circumference of the head of the microcephalic child rarely exceeds 17 inches, as compared with the normal size of approximately 22 inches. Penrose (1963) also described microcephalic youngsters as being invariably short in structure but having relatively normal musculature and sex organs.

Microcephaly may result from a wide range of factors that impair the brain development, including intrauterine infections and pelvic irradiation of the mother during the early months of pregnancy (Koch, 1967). Miller (1970) noted a number of microcephaly in Hiroshima and Nagasaki that apparently resulted from atomic bomb explosions during World War II. The role of genetic factors is not yet clear. Treatment is ineffective once faulty development has occurred, and at present, preventive measures focus on the avoidance of infection and radiation during pregnancy.

"Hydrocephalus" is a relatively rare condition in which the accumulation of an abnormal amount of Cerebrospinal Fluid (CSF) within the cranium causes damage to the brain tissues and enlargement of the cranium. In congenital cases of hydrocephalus, the head is either already enlarged at birth or begins to enlarge soon thereafter, presumably as a result of disturbance in the formation, absorption, or circulation of the cerebrospinal fluid (Wortis, 1973).

The disorder can also develop in infancy or early childhood following the development of a brain tumour, subdural haematoma, meningitis, or such other conditions. Hence the condition appears to result from a blockage of the cerebrospinal pathways and an accumulation of fluid in certain brain areas.

The clinical picture in hydrocephalus depends on the extent of neural damage, which in turn, depends on the age of onset and the duration and severity of the disorder. While the expansion of the skull helps minimize destructive pressure on the brain, serious brain damage occurs nonetheless, leading to intellectual

impairment and such other effects as convulsions and impairment or loss of sight and hearing. The degree of intellectual impairment varies, being severe or profound in advanced cases. A good deal of attention has been directed to the surgical treatment of hydrocephalus, and with early diagnosis and treatment, this condition can usually be arrested before severe brain damage has occurred (Geisz & Steinhausen, 1974).

There are many cases of cranial anomalies in the villages of the entire Union. But severe cases of microcephaly and hydrocephalus are not there. The villagers reported some births, but all died in their very early age.

Cretinism: Cretinism provides a dramatic illustration of mental retardation resulting from endocrine imbalance. In this condition, the thyroid either has failed to develop properly or has undergone degeneration or injury; in either case, the infant suffers from a deficiency in thyroid secretion. Brain damage resulting from this insufficiency is most marked when the deficiency occurs during the prenatal and early postnatal periods of rapid growth.

In severe cases of cretinism the individual has a dwarf like, thickset body and short, stubby extremities. Height is usually just a little over 3 feet; the shortness is accentuated by slightly bent legs and a curvature of the spine. The individual walks with a shuffling gait that is easily recognizable and has a large head; thick eyelids give the person a sleepy appearance. Other pronounced physical symptoms include a broad, flat nose, large and floppy ears, a protruding abdomen, and failure to mature sexually. Most individuals with cretinism fall within the moderate and severe categories of mental retardation. Early treatment of

cretinism with thyroid gland extract is considered essential; infants not treated until after the first year of life may have permanently impaired intelligence.

As a result of Bangladesh Governments policy in relation to the compulsory use of iodized salt, general awareness development of early detection and correction of thyroid deficiency, severe cases of cretinism is gradually decreasing in Bangladesh. Similarly in other countries awareness is developing to use iodized salt (Sufi & Yamashita, 1996).

The researcher could not diagnose any specific case of cretinism in the villages of the Union as it is not a serious problem and not easily perceived by the villagers. But the researcher observed some cases who can also be the 'stunted babies' and need further investigation. However, iodized salt is available in the markets inside the Union, but people yet like ordinary salt.

Phenylketonuria (PKU): Phenylketonuria is a rare metabolic disorder, occurring in about 1 in 20,000 births; retarded individuals in institutions who suffer from PKU number about 1 in 100 (Holmes, 1972; Schild, 1972).

In PKU the baby appears normal at birth but lacks an enzyme needed to break down phenylalanine, and amino acid found in many foods. The genetic error manifests itself in pathology only when this condition, not being detected, lead to the accumulation of phenylalanine in the blood that eventually produced brain damage. The disorder usually becomes apparent between 6 and 12 months after birth, although such symptoms as vomiting, a

peculiar odour, infantile eczema, and seizures may occur during the early stages of life. Often the first symptoms noticed are signs of mental retardation, which may be moderate to severe depending on the degree to which the disease has progressed. Motor incoordination and other neurological manifestations relating to the severity of brain damage are also common, and often the eyes, skin, and hair of untreated PKU patients become very pale (Gregory and Smeltzer, 1977).

Most of the older PKU patients show severe to profound Mental Retardation with the median IQ of untreated adult phenylketonurics being about 20. Perry (1970) has reported the cases of two untreated PKU patients with superior intelligence. These findings have made PKU something of an enigma. It results from a liver enzyme deficiency involving one or more recessive genes (Burns, 1972). For a baby to inherit PKU, it appears that both parents must carry recessive genes.

The researcher after their observation believes that there is no case of PKU in the Auchpara Union. However, it needs further investigation by the medical professionals.

Cultural – familial Mental Retardation: Children who fall under this category are usually mildly retarded. They make up the majority of persons labeled as mentally retarded. These children show no identifiable brain pathology and are usually not diagnosed as mentally retarded until they enter school and have serious difficulties in their studies. As a number of investigators have pointed out, however, most of these children come from poverty stricken, unstable, and often disrupted family backgrounds characterized by a lack of intellectual stimulation, an inferior quality of interaction with others, and general

environmental deprivation (Birns & Bridger, 1977; Braginsky & Braginsky, 1974; Feurstein, 1977; Heber, 1970).

It is assumed by the researcher that there are many cases of cultural-familial mental retardation in the villages of Auchpara Union. Especially among the poor families, there are many children who were not exposed to many things of daily life, including motor vehicles or electricity. These children and their parents do not possess basic health education, too.

CAUSES OF MENTAL RETARDATION

Scientists have found that Mental Retardation may be caused by various factors. These factors may broadly be classified into the following categories.

BIOLOGICAL CAUSES

Genetic – Chromosomal Factors: Mental retardation tends to run in families. This is particularly true of Mild retardation. However, poverty and socio-cultural deprivation also tend to run in families. So it is difficult to conclude accurately the role exactly played by hereditary factors in causing such mild mental retardation.

Genetic and chromosomal factors play a much clearer role in the etiology of relatively rare types of mental retardation such as Down's syndrome. Specific chromosomal defects are responsible for metabolic alternations that adversely affect development of the brain. Genetic defects leading to metabolic alternations may of course, involve many other developmental anomalies besides mental retardation. In general, the mental retardates associated with known genetic – chromosomal defects are moderate to severe in degree.

It was not studied in the genetic laboratories, but the researcher assumes that there are at least 7 specific cases of severe handicapped conditions in the entire Union who have genetic chromosomal factors.

Infections and toxic agents: Mental Retardation may be associated with a wide range of conditions due to infection. If a

pregnant woman has syphilis or is afflicted with German measles, her child may suffer brain damage. Brain damage may also result from infections occurring after birth, such as viral encephalitis.

A number of toxic agents, such as carbon monoxide and lead, may cause brain damage during fetal development or after birth. Immunological agents, such as anti-tetanus serum or typhoid vaccine, taken by mother, may lead to brain damage of the fetus. Similarly, certain drugs taken by the mother during pregnancy may lead to congenital malformations. An overdose of drugs administered to the infant may result in toxicity and brain damage. In rare cases, brain damage results from incompatibility in blood types between mother and fetus – conditions known as Rh, or ABO, system incompatibility. Fortunately, early diagnosis and blood transfusions can now minimize the effects of such incompatibility.

There are many cases in the Auchpara Union who have become mentally handicapped because of infections and toxic agents. Many mothers had severe illnesses during pregnancy period and used drugs indiscriminately as was given by the village quacks. Such drugs include different types of Antibiotics, Homeopathic and Ayurvedic medicines.

Prematurity and trauma: Follow-up studies of children born prematurely and weighing less than about 5 pound at birth have revealed a high incidence of neurological disorders and often mental retardation. In fact, very small premature babies are many times more likely to be mentally retarded than normal infants (Mc Donald, 1964; Rothschild, 1967). Physical injury at birth can also result in retardation. Isaacson (1970) has estimated that in 1 birth

out of 1000 there is brain damage that will prevent the child from reaching the intelligence level of a 12 year old. Although normally the fetus is well protected by its fluid-filled bag during gestation, and its skull appears designed to resist delivery stressors, accidents do happen during delivery as well as after birth. Difficulties in labour due to malposition of the fetus or other complications may irreparably damage the infant's brain. Bleeding within the brain is probably the most common results of such birth trauma. Use of forceps during delivery may cause brain damage that may lead to mental retardation. *Anoxia* – or lack of sufficient oxygen to the brain stemming from delayed breathing or other causes – is another type of birth trauma that may damage the brain. *Anoxia* may also occur after birth as a result of cardiac arrest associated with operations, heart attacks, near drowning, or severe electric shocks.

Among the living and dead cases the large majority of the handicapped persons, both mental and physical handicapped, are due to birth trauma. Trial & Error births, prolonged labor, anoxia is very common in all the villages of the Auchpara union, as reported by the birth attendants.

Ionizing radiation: In recent years a good deal of scientific attention has been focused on the damaging effects of ionizing radiation on sex cells and other bodily cells and tissues. Radiation may act directly on the fertilized ovum or may produce gene mutations in the sex cells of either or both parents, which in turn, may lead to defective offspring. Sources of harmful radiation were once limited primarily to high energy X-rays used for diagnosis and therapy, but the list has grown to include leakages at nuclear power plants and nuclear weapons testing, among others.

It is assumed that radiation is not an important factor of birth of handicapped persons in the Auchpara Union, though some mothers told the researcher that they had X-Rays due to some injury during pregnancy period.

Malnutrition and other biological factors: Deficiencies in protein and other essential nutrients during early development can result in irreversible physical and mental damage. Protein deficiencies in the mother's diet during pregnancy, as well as in the baby's diet after birth, have been pinpointed as particularly potent causes of lowered intelligence. Malnutrition is very common among the poor mothers and it is assumed that this is a significant factor in the villages of the Union.

UNKNOWN PRENATAL INFLUENCE

Anencephaly and hemi-anencephaly are among the most common congenital brain malformations, invariably resulting in death at birth or shortly thereafter due to absence of one or both cerebral hemispheres or even greater portions of the central nervous system.

Malformations of gyri include argyria, macrogyria, and microgyria. The latter is a relatively common pathological condition found in the severely mentally retarded children.

Congenital porencephaly is characterized by large funnel-shaped cavities occurring anywhere in the cerebral hemispheres.

It was not possible to assess properly by the researcher but it is assumed from the birth histories of some babies, who have died, that those babies were cases of cerebral malformations and craniofacial anomalies in the study area.

REVIEW OF LITERATURE

Many scientific investigations on mental retardation are being carried out throughout the world. These investigations are concerned mainly with the prevalence and assessment of mental retardation, the etiology and treatment of mental retardation and rehabilitational programmes for the mentally retarded persons.

The work on the etiology of mental retardation was done by Pornswan Wasant at the Faculty of Medicine, Siriraj Medical School, Mahidol University of Thailand. Wasant (1989) found that the etiologies of mental retardation can be divided into genetic and non genetic categories. The genetic causes are chromosomal. Nongenetic etiologies are those that occur in prenatal, perinatal and postnatal period. The clinical evaluation of a child with mental retardation include detailed pregnancy history, developmental and family history and the clinical examination of the child. Thus the multidisciplinary approach is often necessary. The outstanding recent advances in the field of molecular biology, biochemistry and molecular genetics (genemapping, recombinant DNA technology) and prenatal diagnosis of chromosomal and biochemical genetic disorders give much hope in the prevention and treatment of mental retardation.

Marfo, Walker and Charles (1986) have concluded that children in developing countries are extremely vulnerable to many adverse biological and environmental factors which cause handicap conditions. The principal causes of childhood disability in these countries are related to such factors as malnutrition, poor medical care and preventive measure that adversely affect children and pregnant mothers.

Daniel and Frederick (1977) of IOWA State University studied prevalence of retardation. In their study entitled `Ethnicity, geographic locale, age, sex, urban - rural residence as variables in the prevalence of mild retardation', they found that ethnicity and geographic locale are significantly related with the prevalence of mental retardation.

Assessment of people with mental retardation is one of the big problem for the persons engaged in the services for the mentally retarded persons from the very beginning. Lot of recommendations and proposals have

been given by different authors. Hogg and Raynes (1987) have mentioned that four broad classes of approach to assessing people with mental handicap can be suggested : (1) norm referenced; (2) assessment of adaptive behaviour; (3) criterion referenced; (4) techniques of behavioral observation.

Oura,T. (1989) of the Osaka City Rehabilitation Centre of Japan in his study entitled **Early diagnosis and treatment** said that Chorionic villi sampling offers several advantages over amniocentesis in terms of early diagnosis at 9 gestational weeks in comparison to 16 weeks in amniocentesis, chromosome analysis without culture, sufficient amount of samples for DNA analysis. Indication of prenatal diagnosis still is a centre of hot debates, because positive result leads to artificial termination of pregnancy in most cases.

Gibbons (1985) summarized some research works done in the decade of seventies concerning the effects of disabilities and their associated stigmas on the social environment. The focus was on the stigmatization from the perspective of disabled persons themselves - how they perceive their stigma and how it affects their perceptions of and interactions with others who are also disabled. The research has indicated that non-disabled persons' reactions to people with disabilities are characterized by ambivalence. It is suggested that disabled persons themselves also have negative (as well as positive) attitudes toward their own stigma and others who share it. For some disabled persons, such attitudes appear to interfere with the social relationships they have with others who are also disabled.

Social factors of Mental Retardation attracted interest of many researchers in the western countries. Baratz and Baratz (1970), Herzog and Lewis (1970), and Hurley (1969) have investigated the relationship between poverty and Mental Retardation. The American President's committee on Mental Retardation (1970) pointed out the existence of a large number of Mentally Retarded children who live in the slums of USA. Eisenberg (1969) observed the effects of poor environment, lack of stimulation, etc. on Mental Retardation.

Recently the professionals engaged in the research work in this area in developed countries are mainly interested to evaluate the effectiveness

of various techniques and methods used for the upliftment and rehabilitation of the mentally retarded persons.

Different philosophies, methods and techniques are used in different countries for rendering services to the mentally retarded persons. Following discussion highlights three important approaches now adopted to deal with education, employment and rehabilitation of cases with mental retardation.

The SIVUS Group Dynamic Principles : SIVUS is an abbreviation of Swedish term "Social Individ Via Utveckling i Samvarkan" which means **Socio Individual Development Through Co-operation**. The SIVUS is based on group- dynamic principles, on knowledge of how all human beings develop both as individuals and at the same time as social beings. They are developing through their own propelling forces/ activities in order (in the frame of) to achieve a certain goal, to find a certain means that can satisfy their own needs, both materially and culturally. The process of these activities is : from their own needs, desires and interests; through their own efforts, activities or work; to their own experiences, ideas, theories, knowledge, results and development (Walujo, 1987).

It means the process is from practice, to theory and from theory again back to the new practice. This process of applying the achieved theory leads to achieving a better result and development in providing for his needs to survive and to live better and better.

The goal of the SIVUS project is supporting mentally retarded persons to function as independently as possible, both individually and socially, by considering every individual ability, both within the area of provision and services for the mentally retarded and in the society in co-operation with others.

The work method used in SIVUS is characterized by actively taking part in co-operation with others, organised in small groups having fixed members, supervisors; and principal activity coming from the group member's mutual interests, functioning as democratically as possible. With other words through a social integration to achieve normalization.

Portage Programme : This is the home based programme where parents teach mentally retarded children according to structured, step-by-step package (Hoel, Mathias and Rahman, 1988).

Generally the service involves a home teacher visiting an individual family at regular intervals, assessing the child periodically and deciding with the parent on developmentally appropriate activities for the parent to carry out with the child. The Portage system (which originated in Wisconsin, USA, but which has been adopted internationally) the home teacher has a resource of activity cards linked to a developmental checklist. The teacher uses the cards to devise up to three or four instruction and recording sheets for the parent to follow and fill in during the week before the next visit (Shearer and Shearer, 1976).

There are some standard packages developed in English language. In many countries the Portage programme is adopted in their own languages. In Bangladesh, Dr.Sultana Zaman and her associates of the Protibandhi Foundation have developed and standardised the Bengali version of the package which is widely being used, mainly in the rural areas. The out-put is commendable.

CBR (Community Based Rehabilitation) : This is a home based programme where field workers with basic training teach families and their disabled members basic rehabilitation techniques (Hoel, Mathias and Rahman, 1988).

CBR is recognised by increasing number of national and international authorities to be the most realistic and desirable approach to the enormous scale of disability in the developing world. WHO estimates 500 million people in the world, (or approximately one in ten) are disabled as a consequence of mental, physical or sensory impairment (Jones, 1988).

The CBR priority is simply expressed as "Rehabilitation reaching the majority of the disabled people in their own home and communities". And the CBR worker's role is to "mobilize people and to see what their needs are". CBR should provide the needed alternative to journeying to a large, probably distant, institution for treatment. This could enable disabled people to become self-reliant and trusted by their communities.

Families also benefit when the disabled children become useful, they are appreciated and it releases pressure on the family as a whole.

Though not recognised as a formal and official programme of the NGOs and Government, there are some programmes of some NGOs in the villages of Bangladesh which are somewhat like the CBR programme. These NGOs have trained their field workers at BIMR about the basic concepts of Mental Retardation in addition to their main training on rural development. These field workers have enlisted the mentally handicapped children and assessed their problems and prospects. The handicapped persons and their families were given specific programmes of training which will enable the disabled persons to engage in the family trade in their adulthood. In the informal way such attempts were always present in this country but now it is being supervised and appraised by the field workers of the NGOs. And the progress is satisfactory. The concerned families are now trying to train their children in the agricultural works, agro-based cottage industries, handicraft, pottery, poultry, etc. Before the advent of the field workers, these families were not serious about these handicapped children. Now the families know that it is possible to make the handicapped children self sufficient.

Zaman & Afroze (1979) studied the Risk factors related to Mental Retardation among children in Bangladesh. The research was a Pilot Study to find out pre-natal and post-natal physical and socio-cultural causes of mental retardation among a small sample of children in Bangladesh. A total of 30 cases of mental retardates were examined. Analysis of the data revealed that 56% of the subjects were moderately retarded. Genetic factors and prolonged labour were found as the main causes of retardation among the subjects. The higher educational level and higher socio-economic status of parents of the sample indicated that the study used a biased sample. It was concluded that survey studies need to be done with larger representative samples of children to find out the prevalence of mental retardation in Bangladesh.

Zaman and Ferial (1985) studied the Etiological factors of Mental Retardation in a rural area of Bangladesh. In this study 978 children and their mothers were interviewed belonging to 8 villages of Dhamrai Union of Dhaka district (24 miles from Dhaka City). Total number of household visited were 590. The study revealed that a number of disabilities and diseases such as night blindness, hearing problems,

seizures, etc. were associated with mental retardation and there was a significant relation between levels of intelligence and nutritional status of the children in the rural areas of Bangladesh.

Zaman and Munir (1988) mentioned that birth asphyxia causes multiple disabilities among a large number of children in Bangladesh.

In another study **Development of early intervention programme for the handicapped in** Bangladesh**,** Zaman and Munir (1987) concluded that early intervention is, in fact, effective. The authors also recommended for the developments of clinic for early diagnosis, early intervention programmes, portage guide to early education, WHO training manual for the disabled, self help group in rural area, distance training package for the outreach, etc. in Bangladesh.

Zaman and Akhtar (1982) in their study entitled **Effects of early and late intervention among** retarded **children: Bangladesh experience** mentioned that a handicapped child is still considered as a stigma in the family. Majority of the parents due to prevailing attitude, superstition and ignorance tend to either hide their retarded child or continue to have higher expectation and pressurize the child to behave normally and finally become frustrated when their children fail to meet their demands. In such a situation the need to discuss and evaluate the effects of early and late intervention is specially significant in Bangladesh.

Zaman and Akhtar (1990) in their study entitled **A comparative study of attitudes of mothers of MR children who have been working as special education teachers and those who have not been working** found that the mothers who were involved in teaching, taking care and management of retarded children in special education classes had more positive attitude towards their own child by being more caring, loving, accepting and adhering to discipline etc. as compared to mothers who were not teachers. This study reveals a significant fact that mothers of retarded children if involved in the management of other retarded children understand mental retardation better and this help them in accepting their own child as well. This study also revealed that the teachers who were not mothers were slightly better in taking care, following curriculum, adhering to discipline and acquiring knowledge on mental retardation thus displaying more positive attitude as compared to teachers who were mothers. This study thus proves that counselling

of the parents of mentally retarded children will be more effective, if the parents become involved in the management of other retarded children.

Zaman and Rahman (1982) in their study entitled **A comparative study of attitudes and personality traits of mothers of mentally retarded children with and without intervention programmes** revealed that the mothers of the mentally retarded with intervention have more liberal attitude even when compared to mothers of normals. It was also found that the mothers of MR children without intervention significantly overestimated the ability of the children as compared to mothers of retarded children with intervention.

Zaman, Banu, Huq and Ilyas (1987) in their study **Attitudes towards Mental Retardation in Bangladesh** investigated the opinion of general people towards mental retardation. Results of the study indicated that the three categories of subjects (general public, specialists and parents of the MR) differed significantly in their attitude towards, and knowledge about the mentally retarded persons. Persons of specialist group were found to have their most scientific attitude. It was interesting to note that the parents of MR were more scientific in their knowledge and ideas than the general public. Furthermore, the results revealed that the general public and parents of the MR from urban areas had more positive attitude and awareness than that of the rural subjects.

Zaman and Ara (1989) in their study **Comparison of main-streaming and special school system for mentally retarded children** compared improvement of social behaviour of two matched groups of mentally retarded children attending a special school and a normal school. Gunzberg's Progress Assessment Chart was administered to assess the social behaviour of both group before attending the school and after attending the school. The results indicated improvement in social behaviour of both the groups and no significant difference was found between the two groups.

Naila, Zaman and Habib (1985) in their study **Mental Retardation and associated disabilities in children attending a child development clinic** investigated 78 children mainly referred by various health professionals to a child development clinic. Social, Psychological and clinical assessments were made to detect developmental disabilities. 88.46% (69 children) cases were found mentally retarded. Speech

defects, motor problems, epilepsy and hearing defects were found in 53.80%, 44.87% and 6.41% cases respectively. Several preventable causes especially in the prenatal period were identified. Further research possibilities and intervention programmes for specific disabilities have been discussed.

Zaman (1990) carried out an investigation in five sites of Bangladesh with a view to validate the **Ten Questions** (TQ) with probes as a tool for screening childhood disabilities in communities where formal resources for disabled children are scarce, if available at all. The types of disability covered by the TQ are blindness, deafness, mental retardation, speech problems, epilepsy and movement disorders.

Play behaviour attracted attention of the professionals working in Bangladesh. Rumizuddin (1990) observed the play behaviour of the mentally retarded children for several years. He has mentioned two special sides of the games of the MR children. First, the MR children can not cope with the same age group and like to play with the younger children. Secondly, the MR children require help from others in constructive games as they lack in innovative capacity.

Games and sports for the mentally retarded children and adults attracted interests of the parents, professionals and the volunteers from the very beginning of the services for the mentally retarded in all the countries. The most challenging job of Special Olympics International was done by the US parents. Games and sports have special implications for MR children. The MR children obtain more benefit from games and sports than from special education classes. In games and sports the rate of concentration of the MR persons are much higher compared to the rate of concentration in special education. The rate is relatively higher in outdoor games compared to indoor games (Sufi, 1990).

Professor Peter Mittler (1989) Ex president of the International League of Societies for Persons with Mental Handicap (ILSMH), in his research paper entitled "Meeting the needs of adolescents and young adults with learning difficulties" concluded that. There are no simple prescriptions for meeting the needs of adults. It is not enough to advocate that all services should be community based or they should be based on principles of normalization or social role valorization. People can be isolated and lonely in the community, even

more than in an institution. They can also be victimised and discriminated against. Above all, they, like all of us, need human companionship and support.

Sufi, Yamashita and Nazneen (1996) studied all the mentally handicapped persons of a village named Bandaikhara of Naogaon District. The village is about 25 kilometers away from Auchpara Union. They found that the problems and prospects of the handicapped persons are little different in individual cases. The problems of the family members are related to the degree of handicapped conditions of the subjects.

OBJECTIVES OF THE STUDY

It is not exactly known what is the exact population of mentally retarded persons in Bangladesh. Until 1977, practically nothing was done for the mentally retarded persons in Bangladesh. At present about 3000 mentally retarded persons, living only in the urban areas of Bangladesh are affiliated with some Day Care Centers run by the NGOs. Approximately 99% of the total population of the mentally retarded persons of Bangladesh is beyond any professional care and stimulation. It is assumed that at least 80% of the total populations of all the mentally retarded persons live in the rural areas.

All the adult mentally retarded persons are voters in Bangladesh and large majority of them pay different taxes to the government. But Bangladesh Government yet could not announce any Policy Pograms for the mentally retarded persons of the country. To help facilitate formulation of a policy program for the mentally retarded persons in Bangladesh, this research is an attempt as a complete study of an union of the country. The Specific objectives are:

1. Find out the number, nature and seriousness of mental retardation in an Union of Bagmara Upazilla of Rajshahi District.
2. Become face to face with all the mentally retarded persons of the entire Union.
3. Observe the daily life of all the mentally retarded persons of the entire Union.
4. Obtain all information related to the problems and prospects of all the mentally retarded persons of the entire Union.
5. Investigate the Health condition of the mentally retarded persons.

6. Investigate the Educational matters of the mentally retarded persons.

7. Investigate the Employment patterns of the mentally retarded persons.

8. Investigate the Housing pattern of the mentally retarded persons.

9. Investigate the Social Security matters of the mentally retarded persons.

10. Study the prevalence of mental retardation in Auchpara Union.

11. Suggest ways and means to alleviate the problems of the mentally retarded persons, and

12. Recommend measures which are urgently need to uplift the quality of life of the mentally retarded persons.

SIGNIFICANCE OF THE STUDY

In recent years Bangladesh has attained food sufficiency and cloth sufficiency. Now the government is taking many initiatives in socio-economic development activities. Old age pension schemes, widow allowance, stipend for the female students, etc. are important government programs. Now, the time has come to do something to uplift the condition of the mentally retarded persons in Bangladesh.

To undertake any program to uplift the condition of the mentally retarded persons, government and international agencies need exact data related to the target group.

As this research is a comprehensive study of all the mentally retarded persons of all the villages of a Union in Bangladesh, the findings will help the Government officers, NGO workers, concerned professionals and the local leaders to avoid trials and errors with the mentally retarded persons.

Secondly, the findings will be helpful for the policy makers to announce an appropriate policy program for the mentally retarded persons in Bangladesh.

Chapter II
Method and Procedure

Chapter - II

METHOD AND PROCEDURE

To identify the Problems and Prospects of the Mentally Retarded Persons of Auchpara Union of Bagmara Thana in Rajshahi District, case studies of all the mentally retarded persons of the Union were done. For this purpose, a questionnaire was used. The respondents of these questionnaires were mainly the parents / guardians of the mentally retarded persons. This research followed case study method with the help of Observation and Interview methods.

THE SUBJECTS

This research includes case studies of 117 mentally retarded persons of Auchpara union of Bagmara Thana of Rajshahi District in Bangladesh. Case studies of these 117 mentally retarded subjects were done by the researcher himself.

All these 117 mentally retarded subjects are living in 39 different villages of Auchpara union. The villages are under 23 mouzas of this union. Mouza-wise distributions of these subjects are shown in table-2.1.

Out of these 117 subjects, 78 are male and 39 are female (Table-2.3). The age range of the subjects is 03-55 years and the average age is 14 years. Detail age-wise distributions of the subjects are shown in the table-2.4.

Subjects were of different levels of retardation from Mild to Profound. The levels of retardation of the subjects of the study are shown in table-2.5.

The mentally retarded subjects living with parents and other relatives in different categories of families are shown in the table-2.13 and 2.14.

Mainly the parents/guardians of the mentally retarded subjects were the respondents in this study. Though major respondents of this study were the fathers and the mothers, in some cases the siblings or other relatives were the major respondents. The details of the respondents are shown in the table-2.2.

MATERIALS USED

The study, mainly case studies were done using a Questionnaire. In this questionnaire there was one sections of questions for the parents/guardians. The questionnaire was mainly divided into two parts. One part was Information blank to collect primary information about the mentally retarded persons and their parents. And the other part of the Questionnaire was to assess different problems of the mentally retarded persons. The questionnaire had five sub-sections concerning health, education, employment, social security and housing of the subjects. There were about 50 questions related to the problems and prospects of the mentally retarded persons.

The Questionnaire was developed by the researcher himself with the help of his research supervisor in 1999 at Rajshahi University. The main bases for item selection of the questionnaire were the following:

1. Normal development pattern of the human beings as described in the books of developmental psychology.
2. Observation of different behavioral aspects of the mentally retarded children by the researcher himself during 1991-1998 in Auchpara Union and adjoining areas.
3. Open, informal and detail interviews with about 30 parents / guardians of the mentally retarded children of Auchpara Union.

4. Discussion with some general physicians, psychologists, psychiatrists, special education teachers, counselors, welfare staff, etc. who worked with the mentally retarded persons for several years in the country.

Development of the Questionnaire: The first draft of the questionnaire was applied on the parents and guardians of 30 mentally retarded children. The researcher also interviewed the parents and the guardians at the time of their filling up of the questionnaire. The questionnaire was then revised by the researcher on the basis of his own observation and the patterns of answers given by the parents / guardians. This revised questionnaire was then again applied on the same sample and it appeared to work more satisfactorily.

The revised draft was then reviewed by a group of psychologists, sociologists, psychiatrists and general physicians working in different programs for the mentally retarded persons. A final revision of the questionnaire was made on the basis of comments given by the experts mentioned above. The final questionnaire was then printed.

The Bengali version of the questionnaire and its English translation are shown in appendices I and II respectively at the end of this thesis.

Table -2.1.

Serial No	Mouza	Population			Identified Cases of Mental Retardation		
		Total	Male	Female	Total	Male	Female
01	Abhyagatapara	682	332	350	03	02	01
02	Auchpara	438	224	214	05	03	02
03	Baikuri	806	409	397	02	01	01
04	Bamnigram	1106	542	564	04	02	02
05	Belghariahat	1059	531	528	04	03	01
06	Birahi	1487	712	775	03	03	00
07	Bishnupur	560	256	304	09	05	04
08	Gangopara	812	408	304	04	02	02
09	Hatkhujipur	620	322	298	02	01	01
10	Indrapur	326	152	174	02	01	01
11	Kanaisar	1247	603	644	03	01	02
12	Khalgram	1518	704	814	14	10	04
13	Konda	2672	1316	1356	11	08	03
14	Kusalpur	478	239	239	02	01	01
15	Majopara	789	373	416	05	03	02
16	Mangalpur	619	296	323	05	03	02
17	Mugaipara	925	464	461	05	04	01
18	Palapara	998	485	513	07	06	01
19	Rakshitpara	2080	1027	1053	10	10	00
20	Saidhara	1134	565	569	03	01	02
21	Samaspur	306	129	177	01	00	01
22	Sarindi	1764	866	898	02	02	00
23	Takipur	1775	896	879	11	06	05
Total		**24,201**	**11,851**	**12,350**	**117**	**78**	**39**

The above table shows the mouza-wise number of the Mentally Retarded persons and the total population of Auchpara Union.

Table – 2.2: Respondents of the Study

Major Respondents	N	%
Father	37	31.6
Mother	57	48.8
Siblings	4	3.4
Other relatives	19	16.2
Total	**117**	**100.00**

When the researcher went to the Mentally Retarded persons for collecting information about them, in some cases the mother and in some cases the father provided information. Sometimes both the father and the mother jointly gave the information. The persons who gave maximum information have been considered to be the respondents. But sometimes, the father was not at home. In such cases, the information has been taken only from the mother. In the absence of the parents, sometimes siblings and sometimes other relatives gave information. In the present study, 31.6% respondents are fathers, 48.8% respondents are mothers, 3.4% are siblings and 16.2% are some other relatives. From the above table it is seen that maximum number of respondents are mothers.

Table – 2.3: Sex of the mentally retarded person

Sex	N	%
Male	78	66.7
Female	39	33.3
Total	**117**	**100.00**

The number of the identified Mentally Retarded persons in Auchpara Union is 117. Of them, the male Mentally Retarded persons are 78 (66.7%) and the female Mentally Retarded persons are 39 (33.3%). Surprising the number of male Mentally Retarded persons was found almost double than that of the female Mentally retarded persons in the study area.

Table – 2.4: Age range of the mentally retarded person

Age range in years	N	%
0 –5	10	8.5
6 – 10	35	29.9
11 – 15	32	27.5
16 – 20	21	17.9
21– 25	8	6.8
26 – 30	6	5.1
30+	5	4.3
Total	**117**	**100.00**

The total number of the Mentally Retarded persons divided into different age range is shown in the above table. It is seen that the number of Mentally Retarded persons in 0-5 years age range is 8.5%. This number is much lesser than 6-10 years age range. Maybe, it was not possible to identify all the Mentally Retarded persons in 0-5 years age range. But following the 6-10 years age range, the number declined. It is seen in the table above that the number of the Mentally Retarded persons above 30 years is only 4.3%. Therefore, it can be said that the Mentally Retarded persons do not live longer.

Table – 2.5: Degree of retardation of the subjects

Category	N	%
Borderline	11	9.4
Mild	57	48.8
Moderate	35	29.9
Severe	8	6.8
Profound	6	5.1
Total	**117**	**100.00**

The number and percentage of the Mentally Retarded persons of Auchpara-union according to their degree of retardation is presented in the above table. It is seen that the borderline Mentally Retarded persons are only 9.4%; Mild, 48.8%; Moderate, 29.9%; Severe, 6.8% and profound, 5.1%. It is seen that the number of severe and profound Mentally Retarded persons are much lesser than the number of mild and moderate Mentally Retarded persons in the study area.

Table -2.6: Present age of the fathers

Age range (in years)	**N**	**%**
20 – 25	4	3.4
26 – 30	9	7.7
31 – 35	11	9.4
36 – 40	21	17.9
41 – 45	18	15.3
46 – 50	14	12.0
51 – 55	7	6.0
56 – 60	5	4.3
60+	15	12.9
Died	13	11.1
Total	**117**	**100.00**

In this table the present age of the fathers of the Mentally Retarded persons divided into different age group has been presented. It is seen that the percentage of the fathers above sixty years is only 12.9% and 11.1% fathers are already dead.

Table -2.7: Profession of the fathers

Main Profession	N	%
Service	6	5.1
Agriculture	88	75.2
Business	11	9.4
Others	12	10.3
Total	**117**	**100.00**

Main professions of the fathers of the Mentally Retarded persons are shown in the above table. It was found that, service is 5.1%, agriculture is 75.2%, business is 9.4% and others is 10.3%. Therefore, it is seen that the occupation of most of the fathers of the Mentally Retarded persons is agricultural works.

Table -2.8: Yearly income of the fathers

Yearly income (in thousand Taka)	N	%
00 – 10	9	7.7
11 – 20	43	36.8
21 – 30	29	24.8
31 – 40	12	10.2
41 – 50	11	9.4
51– 60	12	10.2
60 +	1	0.9
Total	**117**	**100.00**

Yearly income of the fathers of the Mentally Retarded persons is shown in the above table. The researcher assessed the amount of this income through consultation with them. The researcher noticed that the amount of income of most of the fathers are very low.

Table -2.9: Educational qualification of the fathers

Educational qualification	N	%
Illiterate	74	63.2
Primary	36	30.8
Secondary	4	3.4
Graduate	2	1.7
Post Graduate	1	0.9
Total	**117**	**100.00**

In the above table, the educational qualification of the fathers of the Mentally Retarded persons has been shown. It is seen that most of the fathers are illiterate. Only 30.8% passed primary schools. The number of graduates and post graduates are very low.

Table -2.10: Present age of the mothers

Age range (in years)	N	%
16 – 20	3	2.6
21 – 25	8	6.8
26 – 30	19	16.2
31 – 35	22	18.8
36 – 40	26	22.2
41 – 45	14	12.0
46 – 50	12	10.3
51 – 55	3	2.6
55 +	10	8.5
Total	**117**	**100.00**

The present age of the mothers of the Mentally Retarded persons divided in nine age ranges are shown in the above table. It is seen that the number of the mothers in the age range 36-40 is 22.2% and there are 2.6% mothers in the 16-20 years age range.

Table -2.11: Educational qualification of the mothers

Educational qualifications	N	%
Illiterate	90	76.9
Primary	27	23.1
Secondary	00	00
Graduate	00	00
Post Graduate	00	00
Total	**117**	**100.00**

The details of the educational qualifications of the mothers of the Mentally Retarded persons have been presented in the above table. It is seen that 76.9% mothers are illiterate. 23.1% mothers have primary education. And there is no mother who has passed secondary or higher secondary levels.

Table -2.12: Yearly income of the mothers

Yearly income (in taka)	**N**	**%**
00 – 1000	61	52.1
1100 – 2000	18	15.4
2100 – 3000	17	14.5
3100 – 4000	7	6.0
4100 – 5000	6	5.1
5100 – 6000	6	5.1
6100 +	2	1.7
Total	**117**	**100.00**

The researcher noticed that in most of the rural areas, the role of mothers in the economic fields are not considered as like the income of the fathers. Yet, the income of the family means the income of the father. In some special cases, some types of income refer to mothers' income, These income include rearing poultry, sewing and handicrafts manufacturing, etc. In the above table, yearly income of the mothers of the Mentally Retarded persons is shown. It is seen that the amount of such income is very low. But the researcher observed that the women feel proud for such income of their own.

Table - 2.13: Persons with whom the subjects are living

Living with	N	%
Parents	96	82.1
Others	21	17.9
Total	**117**	**100.00**

The above table shows the persons with whom the Mentally Retarded persons live in Auchpara union. 82.1% live with their parents and 17.9% live with others (brothers, siblings, uncle, grand parents, husbands, wives, etc.) It is seen that the most of the Mentally Retarded persons live with their parents.

Table – 2.14: Categories of the families

Category	N	%
Joint Family	55	47.0
Single Family	62	53.0
Total	**117**	**100.00**

The categories of the families the Mentally Retarded persons live in are presented in the above table. It is seen that the number of the joint families is 47.0% and the number of the single families is 53.0%.

Table – 2.15: Marital prospects of the subjects

Response	N	%
Yes	59	50.4
No	18	15.4
Married	13	11.1
No answer	27	23.1
Total	**117**	**100.00**

All the parents / guardians were asked whether they are thinking arrangement of marriage of their mentally retarded children. It was found that 11.1% of the Mentally Retarded persons are already married. Parents of the remaining mentally retarded persons were asked whether they would try that their children get married. 50.4% said 'Yes' and 15.4% said 'No'. On the other hand 23.1% of the parents did not make any comment. It is seen that most parents are willing to arrange marriage of their children.

Table - 2.16 : Parents facing problems in family life

Problems	N	%
Yes, facing some problems	63	53.8
No, do not feel any problem	43	36.8
Information not available	11	9.4
Total	**117**	**100.00**

The parents of the Mentally Retarded persons were asked if there was any problem because of their children's retardation. 53.8% parents said 'Yes'; 36.8% parents said 'No'. The reaction of 9.4% parents is not known. It is seen that large majority of the families faces some problems for the retardation of their children.

Table – 2.17: Problems during pregnancy or at child-birth

Problems	N	%
Yes	43	36.8
No	55	47.0
Information not available	19	16.2
Total	**117**	**100**

The respondents were asked whether there was any problem to the mothers during pregnancy or child-birth. 36.8% said 'Yes' and 47.0% said 'No'. It was not possible to know the information about 16.0% mothers. Those who said 'Yes' mentioned different difficulty during the child-birth.

Table – 2.18: Father's age at birth of the mentally retarded child

Age Range (In years)	N	%
18 – 20	9	7.7
21 – 25	25	21.4
26 – 30	29	24.8
31 – 35	15	12.8
36 – 40	9	7.7
40+	30	25.8
Total	**117**	**100.00**

The age of the fathers at the time of birth of the Mentally Retarded children have been presented in the above table. It is seen that 7.7% fathers were in 18-20 years age range; 21.4% were in 21-25 years age range; 24.8% were in 26-30 years age range; 12.8% were in 31-35 years age range; 7.7% were in 36-40 years age range and 25.6% were in 40+ age range. The number of the fathers in 40+ age range is relatively higher.

Table – 2.19: Mother's age at birth of the mentally retarded child

Age Range (In years)	N	%
15 – 20	45	38.5
21 – 25	27	23.0
26 – 30	20	17.1
31 – 35	13	11.1
36 – 40	9	7.7
40 +	3	2.6
Total	**117**	**100.00**

Mothers' ages at the time of birth of the Mentally Retarded children have been presented in the above table. It is seen that the number of the mothers aging from 15 to 25 years is the largest group. Gradually this rate has declined. Therefore, it can be said that in most cases, immature mothers gave birth of the Mentally Retarded children.

Table – 2.20 : Marriage among close relation

Close -relation	N	%
Yes	19	16.2
No	98	83.8
Total	**117**	**100.00**

Family relationship between a father and a mother before their marriage is shown in the above table. It is seen that 16.2% parents are close relations, mainly cousins.

Table – 2.21: Main causes of retardation as viewed by the parents

Main Causes	N	%
Illness of mothers during pre-natal period	30	25.7
Infantile diseases of the children	45	38.4
Problems during child-birth	33	28.3
Other reason	04	3.4
Can't answer	05	4.2
Total	**117**	**100.00**

When asked to mention the main causes of the retardation of their children, the parents mentioned different causes. The assumed causes mentioned by the parents have been presented in the above table. 25.7% parents think that the causes of retardation are illness of mothers during pre-natal period. 38.4% think that infantile diseases of the children are the main causes of retardation. To 28.3% parents, the retardation is due to difficult and defective birth process. 3.4% mentioned other reasons like bad winds, devil powers, etc. It was not possible to know the opinion of 4.2% parents.

Chapter III
Results and interpretation

Chapter – III

RESULTS AND INTERPRETATION

COLLECTION OF DATA

In order to find out the problems and prospects of the mentally retarded persons in Auchpara union, a questionnaire was used. The questionnaire is attached in the Appendices of this thesis. The findings were tabulated mainly into five sections. These five sections are related to health, education, employment, housing and social security. Besides, there were two more sections. One was about general information of the mentally retarded persons which are shown in different tables of the preceding chapter. The other section includes questions which were asked to the parents / guardians of the mentally retarded persons. The findings were tabulated. Following section of this chapter includes the tables.

HEALTH

To identify the problems related to health, some questions were asked to the parents / guardians of all the mentally retarded persons. On the basis of their answers the researcher assessed the health condition. Following tables shows the findings.

Table – 3.1.1: Age of the children when the parents came to know that their children are retarded

Age Range (In year)	N	%
0 – 2	21	18.0
3 – 5	28	23.9
6 – 8	35	29.9
9 – 11	22	18.8
12 +	11	09.4
Total	**117**	**100.00**

$X^2 = 13.55$, df = 4, $P < 0.05$

The researcher asked the parents / guardians, at which age of their child they come to know that the child was retarded. It was found that 18% of the parents / guardians came to know the condition during 0-2 years age of the children; 23.9% during 3-5 years age range; 29.9% during 6-8 years age range; 18.8% during 9-11 years age range and 9.4% understood the problem when their children were over 12 years. The chi-square test in contingency table is highly significant. Hence, it is understood that large majority of the parents / guardians could not understand that their child was retarded until they reached childhood stages.

Table – 3.1.2: How the parents came to know that their child is retarded

(Multiple answers)

Most important symptoms	N	%
Slow Mental Development	55	47.03
Lack of Social Adjustment	74	66.63
Inability to do School Works	81	69.23
Inability to Perceive Problems and Social Situation	75	64.13
Delayed Physical Development	41	35.04
Inability to perform proper things at proper age	63	53.84

$X^2 = 17.22$, $df = 5$, $P < 0.05$

The most important symptoms which helped the parents / guardians to know that their child was retarded are shown in the above table. It is seen that slow mental development (47.03%), lack of social adjustment (66.63%), inability to do school works (69.23%), inability to perceive something (64.13%), delayed physical development (35.04%) and inability to perform proper things at proper age (53.84%) are the most important symptoms. Chi-square test was done and the findings are significant. It is understood that lack of social adjustment, inability to do school works and inability to perceive problems and social situation are the most important symptoms. Which helped parents to understand the retarded condition of their children.

Table – 3.1.3: Types of treatment done

(Multiple answers)

Treatment	N	%
Allopathic	44	37.60
Faith Healing	72	61.53
Homeopathy	63	53.84
Ayurvedic	68	58.11
Psychiatry	00	00
No treatment	32	27.35

$X^2 = 20.84$, df = 4, $P < 0.05$

When asked whether any treatment was given to the mentally retarded children, 37.60% parents / guardians answered that the treatment was allopathic; 61.53% said faith healing; 53.84% said homeopathy; 58.11% said ayurvedic; 27.35% said no treatment was given. The chi-square test in contingency table is highly significant. From the above table, it is seen that none of the retarded persons were treated by psychiatrists and most of the cases were subjects of two or more different types of treatments. That is the parents considered the subjects as ill and wanted to cure their retarded conditions.

Table – 3.1.4: Severe diseases of the subjects until babyhood

(Multiple answers)

Diseases	N	%
High Fever and convulsion	83	70.94
Diarrhea	72	61.53
Respiratory problems and cough	64	54.70
Pneumonia	27	23.07
Meningitis and convulsion	05	04.27
Infection	48	41.02
Polio	06	05.10
Information not available	32	27.35

$X^2 = 144.58$, $df = 7$, $P < 0.001$

The parents / guardians were asked to mention the severe diseases suffered by the mentally retarded persons until their babyhood. They informed the researcher the names of the diseases or the symptoms which are as follows: High fever and convulsion 70.94%, diarrhea 61.53%, respiratory problems and cough 54.70%, pneumonia 23.07%, meningitis and convulsion 4.27%, infection 41.02%, polio 5.1%. Information was not available related to 27.35% cases. The chi-square test in contingency table is highly significant. The above table shows that most of the retarded persons were attacked by High fever, Diarrhea and Respiratory problems during their infancy and babyhood.

The researcher asked about the range of high temperature. But most of the guardians failed to provide information. It was understood through discussion that the families do not possess thermometers to measure the temperature. But from the given description it is assumed that many children had high fever above 104^0F followed by convulsion.

Table – 3.1.5: Professional levels of the treatment providers

(Multiple answers)

Professional levels	N	%
MBBS	15	12.82
Paramedic	42	35.89
Village Physician	73	62.39
Homeopathy	81	69.23
Ayurvedic	76	64.95
Information not available	32	27.35

$X^2 = 69.94$, df = 5, $P < 0.001$

While severely ill, the subjects were treated by different categories of physicians. The above table shows that 12.82% were treated by MBBS, 35.89% were treated by paramedic, 62.39% were treated by village physician, 69.23% were treated by homeopathy, and 64.95% were treated by ayurvedic. Information was not available for 27.35% cases. The table presents that only 12% mentally retarded persons were treated by graduate physicians at the time of their severe illnesses. During interview it was informed by the guardians that in most cases they first consulted the village physicians. When the village physicians failed, they approached to the qualified physicians. In some cases the Allopathy, Homeopathy and Ayurvedic treatments were given simultaneously.

Table – 3.1.6: Ability of the guardians to buy necessary medicine

Ability level	N	%
Fully Capable	04	03.4
Capable	32	27.4
Moderately Capable	55	47.0
With difficulty	21	17.9
Unable	05	04.3
Total	**117**	**100.00**

$X^2 = 76.63$, df = 4, $P < 0.001$

The parents / guardians were asked whether they are capable to buy all the medicine or complete treatment course of the subjects. The above table shows the ability levels of the parents / guardians of the subjects to purchase necessary medicines or complete treatment. The number of the fully capable parents / guardians is 3.4%; capable 27.4%; moderately capable 47.0%; with difficulty 17.9% and 4.3% are unable. The chi-square test in contingency table is highly significant. From the findings, it is clear that most parents / guardians have difficulty to buy necessary medicines or complete the course of treatments.

Table – 3.1.7: Views of the parents towards the condition of the subjects

Views	N	%
Will be fully cured and pass the primary school level	01	0.9
May be cured and pass the primary school	17	14.5
Doubtful, but will continuing treatment	44	37.6
Will not be cured and stopped treatment	38	32.5
Sure that the subjects will not be cured at all and never attempted treatments	16	13.7
Accepted that the condition is permanent and no treatment is being done	01	0.9
Total	**117**	**100.00**

$X^2 = 16.79$, $df = 5$, $P < 0.05$

The parents / guardians were asked to mention their views related to the condition of mental retardation of their children. They were asked what they expect after treatment. Will the children become fully cured and develop intelligence enough to pass primary school level, etc. The answers of the parents / guardians are shown in the table above. The answers are self explanatory. It is seen that large majority of the parents are doubtful or sure that the condition will not improve.

Table -3.1.8: Drug dependence of the subjects

Takes Medicine Regularly	N	%
Yes	03	2.6
No	112	95.7
Information not available	02	1.7
Total	**117**	**100.00**

$X^2 = 97.85$, df = 2, $P < 0.001$

The researchers wanted to know from the parents / guardians whether their retarded child takes medicine regularly or not. It was found that, 2.6% said "Yes" and 95.7% said "No". The chi-square test in contingency table is highly significant. From this findings it is understood that large majority of the mentally retarded persons of Auchpara Union are free from drugs, specially psycho-tropic drugs.

Table – 3.1.9: Prevalence of physical handicap conditions

Physical Problems	N	%
Yes	41	35.0
No	76	65.0
Total	**117**	**100.00**

$X^2 = 10.47$, df = 1, $P < 0.05$

The researcher has seen many mentally retarded persons who have some physical problems. The above table shows that 35.0% mentally retarded persons of Auchpara Union have physical problems and 65.0% do not have physical handicap condition. The chi-square test of the above findings are highly significant and it is understood that large majority of the subjects do not have any physical problems.

Table – 3.1.10: Nature of physical handicap condition

Nature	N	%
Physically handicapped and possess severe motor disorders	13	31.71
Partially physically handicapped	21	51.22
Speech and hearing impairment	07	17.07
Total	**41**	**100.00**

$X^2 = 7.22,\ df = 2,\ P < 0.05$

All the 41 cases having physical handicap conditions were carefully studied by the researcher. It was found that 31.71% subjects are physically handicapped and possess severe motor disorders. Such motor disorders include spasticity. It was also found that 51.22% cases are partially physically handicapped. And 17.07% cases have speech or hearing impairment.

EDUCATION

Like all other places, many mentally retarded children go to the normal schools in their childhood in Auchpara Union. Then drop-outs. To assess the problems and prospects of education of the subjects some questions were asked to the parents / guardians. Answers given by them are shown in the following tables.

Table – 3.2.1: Enrollment in primary schools

Response	N	%
Yes, the child was enrolled in the primary school	51	43.6
No, never enrolled	57	48.7
Age of the subject is below 6 years	09	7.7
Total	**117**	**100.00**

$X^2 = 35.07$, df = 2, $P < 0.001$

All the parents / guardians were asked whether their children were enrolled in the primary schools or not. It was found that 43.6% of them were enrolled in the primary schools. 48.7% were never enrolled in the schools. It was also found that 7.7% of the subjects are aged below 6 years and not going to any school. The chi-square test in contingency table is highly significant.

Table -3.2.2: Present status of school attendance

Going to school	N	%
Yes	09	17.64
No	42	82.36
Total	**51**	**100.00**

$X^2 = 21.35$, df = 1, $P < 0.001$

It is seen in the table above that 17.64% of the 51 subjects who were enrolled in schools are now attending schools. It was also found that these subjects are relatively mild retarded compared to the others. They are also younger children. The chi-square test in contingency table is highly significant

Table – 3.2.3: Reasons of school drop-outs

(Multiple answers)

Causes	N	%
Cannot perform the school works	36	85.71
Other children disturb them	22	52.38
Teachers asked them not to go	17	40.74
Other reasons	13	30.95

$X^2 = 17.72$, df = 3, $P < 0.05$

In the above table, findings related to school drop-outs of the 42 subjects are shown. When the guardians were asked why the children now do not go to the school, 85.71% of them said that the children could not perform the school works; 52.38% said that the children were disturbed by the others, 40.74% said that the teachers asked them not to come to the school. On the other hand, 30.95% informed that they understood that their children will not benefit from the school and the curriculum because of the handicapped conditions of the children. They also mentioned that the children were needed at home as helping hands to family works, etc.

Table – 3.2.4: Attempt to give education at home

Response	N	%
Yes	16	13.7
No	70	59.8
Information not available	31	26.5
Total	**117**	**100.00**

$X^2 = 39.84$, df = 2, $P < 0.001$

The researcher wanted to know from all the parents / guardians whether they took any initiative of education of the mentally retarded children at home. 13.7% of them said "Yes" and 59.8% of them replied "No". On the other hand, 26.5% parents could not give any specific answer.

Table – 3.2.5: Advice taken from a teacher or somebody else

Response	N	%
Yes	13	11.1
No	73	62.4
Information not available	31	26.5
Total	**117**	**100**

$X^2 = 48.61$, df = 2, $P < 0.001$

All the parents / guardians were asked whether they discussed or obtained advice from teachers or anybody else for the education of their mentally retarded children. Responses given are presented in the above table. From the table it is understood that only 11.1% parents / guardians took advice from teachers or anybody else. But during close interview it was understood that the advice given were not expert opinions.

Table -3.2.6: Attitude towards special education

All the parents and guardians of the mentally retarded persons were asked whether special education is needed for their children. The respondents said either "Yes" or "No". Following table shows the responses.

Table – 3.2.6(a)

Response	N	%
Yes	99	84.61
No	18	15.39
Total	**117**	**100.00**

$X^2 = 57.07$, df = 1, $P < 0.001$

Table – 3.2.6(b)

All the 99 respondents who said "Yes" were asked why special education is needed for the mentally retarded children. Different respondents mentioned different reasons. The answers were generalized into five categories of responses. Some respondents gave more than one reasons for special education. Following table shows the responses.

(Multiple answers)

Responses	N	%
That they can also obtain some education equivalent to primary education	14	14.14
That they can calculate, read and write	28	28.28
That they can cope with the simple problems of daily life	91	91.91
That they are not exploited by others	56	56.56
That they can at least communicate their problems	99	100.00

$X^2 = 97.39$, df = 4, $P < 0.001$

From the above findings it is understood that 100% responds feel that special education is needed to enable mentally retarded children at least to communicate their personal problems to others. Secondly, the special education is needed that the retarded persons can cope with the problems of daily life.

Table – 3.2.7: Types of education and curriculum

All the parents / guardians were asked to mention what type of education is needed for the mentally retarded children and what should be the curriculum of such education. Only 55 guardians out of 117 could provide some answers. The given answers were categorized into four answers, which are shown in the following table.

(Multiple answers)

Responses	N	%
The education should be equivalent to general primary education	15	27.28
The curriculum should be special to teach them only the basic things which are needed for their survival	18	32.72
Curriculum and syllabus must have to be different for individual child. These should be child centered special education	13	23.64
Some portion of the education will be general. Some portion be designed for individual children	09	16.36
Total	**55**	**100.00**

$X^2 = 03.11$, $df = 3$, $P < 0.001$

Table – 3.2.8: Promoters of special education

(Multiple answers)

Promoters	N	%
Central Government	64	54.70
Union Parisad or local Government	57	48.71
NGOs	46	39.31
The families of all the retarded persons	36	30.76
Somebody else but now I do not know	31	26.49
Do not know	15	12.8

$X^2 = 38.77$, df = 5, $P < 0.001$

The researcher asked the 99 parents / guardians who answered "Yes" to question No. 3.2.7. The question was who will run or initiate the special education for the mentally retarded children. The statements given by the respondents are show in the above table. It is seen that 54.70% said Central Government; 48.71% said Union praised or Local Government; 39.31% said NGOs; 30.76% said that the families of all the retarded persons should become promoters. 12.8% respondents said that they do not know who should sponsor such education. The chi-square test in contingency table is highly significant. And from the given answers it is understood that large majority of the parents / guardians think that the Central Government or the Local Government should take initiative to run the special education for the mentally retarded persons. 26.49% respondents said that such special education be promoted by someone else other than the Government, Local Government or NGOs. But they do not know who it should be. After lot of discussion the researcher could understand that they expect some philanthropist should take initiative to set-up special schools in their villages.

Table – 3.2.9: Centre of special education

When all the 99 parents / guardians were asked where such special education centers are to be located, respondents provided different suggestions. Following table shows the responses.

Location of special education facilities	N	%
Integrated with the Government primary school in separate class rooms	63	63.64
Segregated special school	21	21.21
In the houses of the mentally retarded children. One centre for all the children of the entire village	11	11.11
In other places (Residential homes run by the Government or NGO, Special teachers should come to individual child's home or for 2-3 children of a village, etc.)	04	04.04
Total	**99**	**100.00**

$X^2 = 84.68$, $df = 3$, $P < 0.001$

EMPLOYMENT

Some questions were asked to the parents / guardians to know the problems and prospects related to employment of the mentally retarded persons. Given answers were transferred in numerical figures. The data resulting from the study has been presented in the following tables.

Table – 3.3.1(a): Ability of the mentally retarded persons to do something

Ability	N	%
Yes, the person is capable to do some economic activity	86	73.5
No, the person is totally unable	31	26.5
Total	**117**	**100.00**

$X^2 = 25.85$, df = 1, $P < 0.05$

The parents were asked whether their mentally retarded children are capable to do any work or not. In table 3.3.1(a) it is seen that 73.5% said "Yes", they are capable to do some work and 26.5% said "No", they are totally unable. It is seen from the table that large majority of the mentally retarded persons under this study can do something.

Table – 3.3.1(b)

All the 86 respondents who said "Yes" were asked to mention the names of works the retarded persons can do. Different respondents mentioned different kinds of works. Some respondents replied about more than one activity. Those are shown in the following table.

(Multiple answers)

Types of works	N	%
Farming or help in agriculture works	37	43.02
Feeding the cattle	31	36.04
Can help in marketing or selling agricultural goods	08	09.30
Can do household activities (cleaning the home, washing cloths, washing utensils, assist in the kitchen, etc.)	22	25.58
Poultry rearing	16	18.60
Sewing	06	06.97
Others: Can look after the smaller children, can help during harvesting, etc.	19	22.09

$X^2 = 38.81$, df = 6, $P < 0.001$

Table – 3.3.2(a): Self-sufficiency of the subjects

Responses	N	%
Yes, some initiatives were taken	18	15.4
No, did nothing	99	84.6
Total	**117**	**100.00**

$X^2 = 56.07$, df = 1, $P < 0.001$

All the parents / guardians were asked whether they took any initiative to make their children self-sufficient or independent. 15.4% respondents replied "Yes", some initiatives were taken. Whereas, 84.6% respondents replied "No", did nothing. It is seen from the data presented in the above table that large majority of the respondents did not take any initiative to make the mentally retarded children self-sufficient or independent.

Table – 3.3.2(b)

All the 18 respondents who said "Yes" were asked to mention the steps taken. They mentioned different steps. Some of them answered more than one step. Following table shows the answers.

(Multiple answers)

Steps taken	N	%
Bought some cows and were given to them for rearing at home	04	22.22
Some fruit trees were planted and they maintain the trees	03	16.67
Poultry at home	02	11.11
Being trained in agriculture works	06	33.33
Handicrafts manufacturing	03	16.67
Assist in family business. Mainly learning to measure goods at family shop situated in the market or very close to home	03	16.67
Female child learning how to boil and dry paddy	03	16.67
Being skilled in bamboo house building, clay house building, etc.	02	11.11

During interview the parents also said that there can be many other simple works for the mentally retarded persons. But the scope of those works are not there in Auchpara Union. When asked what those works are, the respondents said boys can work as assistants in tea shops, clean others houses, girls can learn handicraft manufacturing, etc.

Table – 3.3.3(a): Scope of employment in the locality

Responses	N	%
Yes, there are some opportunities	23	19.66
No, there is nothing	94	80.34
Total	**117**	**100.00**

$X^2 = 43.08$, df = 1, $P < 0.001$

The parents were asked whether the retarded persons have any employment opportunity in the locality. It is seen from the above table that 19.66% respondents said "Yes" and 80.34% said "No".

Table – 3.3.3(b)

All the 23 guardians who said that there are employment opportunities were asked to mention the opportunities. The given answers are shown in the following table.

Opportunities	N	%
Can involve in agricultural works	08	34.79
Establish cottage industries	05	21.74
Can manage small shops attached to their homes	04	17.39
Can involve them as a helping hand in the shops.	06	26.08
Total	**23**	**100**

Table – 3.3.4(a): Present employment status

Employment status	N	%
Yes, he/she is already employed	15	12.8
No, not employed	102	87.2
Total	**117**	**100.00**

$$X^2 = 64.69,\ df = 1,\ P < 0.001$$

All the guardians were asked whether the mentally retarded persons are employed or not, at present. The given answers are shown in the above table. 12.8% respondents said "Yes" and 87.2% respondents said "No". The chi-square test of contingency table of the responses shown in the above table is highly significant. It is seen from the table, the number of the employed mentally retarded persons are only 12.8% at present.

Table – 3.3.4(b)

Though the researcher observed that many retarded persons of the present study are able to do some sort of works. Only 15 were found engaged in jobs. Following table shows the nature of jobs done by the subjects.

Working places	N	%
In agricultural works of own family	09	60.00
In small shop attached to the house	01	06.67
As a cowboy in others family	03	20.00
As a part-time labour in fish-firm	02	13.33
Total	**15**	**100.00**

Table – 3.3.5: Causes of unemployment

Causes	N	%
Unable to do any work	05	04.90
Lack of job opportunity	11	10.78
Under aged	77	75.49
Other reasons: can not concentrate, hyperactive, depressed, physically handicapped, etc.	09	08.82
Total	**102**	**100.00**

$X^2 = 2.07$, df = 3, $P > 0.05$

The researcher has seen that many mentally retarded persons were not employed. When asked why the mentally retarded persons were not employed, the respondents showed many causes behind their unemployment. These causes are shown in the table above. 4.9% respondents said that they are unable to do any work; 10.78% have mentioned no work scope; 75.49% are under aged; and 8.82% mentioned other reasons.

Table–3.3.6: Steps needed to create employment opportunities

(Multiple answers)

Steps needed	N	%
Vocational training	69	58.97
Special education	45	38.46
Special financing	56	47.65
Can't answer	43	36.75

$X^2 = 24.75$, df = 3, $P < 0.001$

The researcher wanted to know what steps are necessary to create employment opportunities for the mentally retarded persons. The parents / guardians mentioned some measures which are shown in the table above. It is seen that 58.97% mentioned vocational training; 38.46% mentioned special education; 47.65% mentioned special financing. 36.75% respondents could not answer the question.

Table – 3.3.7: Expected organizations to create employment opportunity

(Multiple answers)

Organization	N	%
Government	84	71.79
Union Parisad	65	55.56
NGOs	70	59.82
Others : family, friends, philanthropists, etc.	19	16.20
Can't answer	21	17.94

$X^2 = 12.60$, $df = 4$, $P < 0.05$

All the 102 respondents whose mentally retarded wards are not employed were asked to mention the names of organizations they expect will create job opportunities. The answers are shown in the table above. It is seen that 71.79% expect the Government, 55.56% expect the Union parishad or local government, and 59.82% expect the NGOs. 17.94% respondents could not answer the question. The 16.2% respondents who said "Others" when interviewed mentioned that family, friends, philanthropists, etc. can create job opportunities for the mentally retarded persons in their locality.

Table -3.3.9(a): Necessity of work involvement

Views	N	%
Yes	90	76.9
No	27	23.1
Total	**117**	**100.00**

$X^2 = 33.92$, df = 1, $P < 0.001$

The researcher asked all the guardians to mention their views whether it is necessary for the mentally retarded persons to involve in work according to their abilities. The response they provided are presented in the above table. 76.9% respondents said "Yes" and 23.1% said "No". The views project that the parents / guardians think that the mentally retarded persons should be engaged in some jobs.

Table -3.3.9(b): Reasons of work involvement

All the 90 respondents who said that the retarded persons should participate in works or jobs mentioned different things to support their own views. The answers were generalized into three categories of response. Following table shows the response.

Responses	N	%
Financial support is necessary to survive. The retarded persons will be able to acquire money through participating in any work. They will be independent.	52	57.78
If they are in work, they will have better mental condition and physical condition. They will not be exploited.	17	18.89
They will not become burden of family, society and country. If they are in work, they will be able to contribute to the national economy.	21	23.33
Total	**90**	**100.00**

HOUSING

The researcher asked 10 major questions and some minor questions to the parents / guardians related to housing of the mentally retarded persons. Answers given by the parents / guardians regarding the housing have been presented through the following tables.

Table – 3.4.1: Living places

Living places	N	%
Integrated with other members of the family	110	94.0
Separately	07	06.0
Total	**117**	**100.00**

$X^2 = 90.67$, df = 1, $P < 0.001$

The guardians were asked whether the mentally retarded person live together with others or separately. The given answers are presented in the above table. It is seen in the table, 94% mentally retarded persons live together with others and only 6% mentally retarded persons live separately.

Table – 3.4.2(a): Separate rooms for the mentally retarded

Separate bed room	N	%
Yes, there is an independent room	37	31.62
No, she/he live in rooms with others	80	68.38
Total	**117**	**100.00**

$X^2 = 3.86$, df = 1, $P < 0.05$

The researcher asked the parents / guardians whether the retarded child has separate bedroom to live in. 31.62% respondents said "Yes" and 68.38% said "No". The chi-square test in contingency table is significant. Therefore, it is understood that most of the retarded persons live in common bedrooms with other family members.

Table – 3.4.2(b): Location of the separate living room

It was found that 31.62% retarded persons live in separate or independent bedrooms. The researcher wanted to know the location of such rooms. The answers given by the guardians are shown in the following table.

Location	N	%
Integrated inside the same house	26	70.27
In a room specially made for him	11	29.73
Total	**37**	**100.00**

$X^2 = 3.86$, df = 1, $P < 0.05$

Table – 3.4.3(a): Types of the houses

Type of house	N	%
Pucca House	01	0.9
Mud-built straw-roofed House	45	38.5
Mud-built Tin shed House	57	48.7
Semi-Pucca House	13	11.1
Hut, bamboo made house	01	0.9
Total	**117**	**100.00**

$X^2 = 115.69$, df = 4, $P < 0.001$

Categories of the houses where the mentally retarded persons are now living are shown in the above table. It is seen in the table that 0.9% live in pucca houses; 38.5% live in mud-built straw-roofed houses; 48.7% live in mud-built tin shed houses; 11.1% live in semi-pucca houses and 0.9% live in hut. The chi-square test in contingency table is highly significant and it is understood that most of the mentally retarded persons live in mud-built tin-shed houses, which are common type for large majority of the families in Auchpara Union.

Table – 3.4.3(b): Quality of beds

Bed	N	%
Standard wooden bed	81	69.2
On the floor	36	30.8
Total	**117**	**100.00**

$X^2 = 17.30$, df = 1, $P < 0.001$

The parents / guardians were asked where the mentally retarded child sleeps. 69.2% respondents said that he/she sleep "On the bed" and 30.8% said "On the floor". Hence, it is understood that although large majority of the mentally retarded persons sleep on the wooden beds a considerable number of them also sleep on the floor.

Table – 3.4.4 : Persons cleaning their rooms

Persons	N	%
Himself / herself	22	18.8
Somebody else (mother, servant)	95	81.2
Total	**117**	**100.00**

$X^2 = 45.54$, df = 1, $P < 0.001$

The respondents were asked who cleans the bedrooms. The information given is presented in the above table. It is seen from the table, 18.8% mentally retarded persons clean their rooms by themselves and the rooms of 81.2% mentally retarded persons are cleaned by somebody else.

Table – 3.4.5: Disturbed sleeping places

Sleeping here & there	N	%
Yes	11	09.4
No	106	90.6
Total	**117**	**100.00**

$X^2 = 77.13$, df = 1, $P < 0.001$

When asked whether the mentally retarded person sleeps here and there because of the inconvenience of living place at home, 9.4% respondents said "Yes" and 90.6% respondents said "No". The chi-square test in contingency table is highly significant. From the above table, it is seen that there are some retarded persons who sleep here and there for some difficulties in living at home. When asked the respondents informed that they sleep at school-varanda, market-place and at others home, etc.

Table – 3.4.6(a): Dress

The researcher asked all the parents about the standard of dresses of their retarded children. The researcher first came to know that most of the retarded children aged 9-10 years have at least 2-3 sets of dresses. Children aged 11-12 years male subjects have 2-3 lungees and 2-3 shirts. Female children have 2-3 frock, and salower or petticoats. Some of them have 1-2 sets of quality dresses. The retarded children wear these quality dresses during special occasions or while going to their relative's houses. During the study, the researcher observed that many retarded children wear dirty dresses most of the time. Again, some of them have no sandal or shoes. Parents / guardians gave the description of the dresses of the retarded persons, which are presented in the following table.

Standards of the dresses	N	%
Yes, they have standard garments of equal quality like all other family members.	43	36.76
No, the standard are inferior compared to other members of the family.	74	63.24
Total	**117**	**100.00**

$X^2 = 12.1$, df = 1, $P < 0.001$

Table – 3.4.6(b): Food

The parents / guardians were asked whether the food given to their retarded children are of equal standard like other members of the family. The answers are shown in the following table.

Answers	N	%
Yes, they are given the same standard food.	111	94.87
Sometimes, they are little ignored in food	06	05.13
Total	**117**	**100.00**

$X^2 = 12.1$, df = 1, $P < 0.001$

Table – 3.4.7: Proper living place for the mentally retarded persons according to parents

Places	N	%
Own family	85	72.64
Group home	22	18.82
Somewhere else	10	08.54
Total	**117**	**100.00**

$X^2 = 24.00$, df = 1, $P < 0.001$

The researcher asked the parents / guardians which is the proper living place for the mentally retarded persons. Their views have been presented in the above table. 72.64% parents / guardians think that the mentally retarded persons should live in with their own family, 18.82% parents / guardians think that they should live in the group homes and 8.54% parents / guardians think that they should live somewhere else. It is seen that though most of the parents / guardians feel that the mentally retarded persons should live in with their own families, yet there are some parents / guardians who think that they should live somewhere else. When asked which places they mean by "somewhere else", the respondents could not provide any suitable answer.

Table – 3.4.8(a): Interest of the family members towards integrated living

Opinion	N	%
Yes, strongly recommend integrated living	84	71.8
No, some special arrangement is needed	33	28.2
Total	**117**	**100.00**

$X^2 = 22.23$, df = 1, $P < 0.001$

When asked if the other members of the family like to live with the mentally retarded persons in the same house. 71.8% respondents said "Yes" and 28.2% of them said "No". It is understood that in some families some members do not like to live with the mentally retarded persons in the same house.

Table – 3.4.8(b).

Those who said 'No' to the above question, the researcher asked why some of the members of the family do not want to live with the retarded persons. The respondents mentioned many reasons. All the answers of the respondents were generalized into three categories. These are shown in the following table.

Responses	N	%
They feel that the severely retarded persons are burdens	05	15.15
In joint families, they think that if their own children live with the retarded children their children may behave like the retarded persons.	17	51.51
The retarded persons are having social adjustment problems. They create many peculiar problems in the family.	11	33.34
Total	**33**	**100.00**

$X^2 = 22.23$, df = 2, $P < 0.001$

Table – 3.4.9: Place where the mentally retarded person will live in the absence of parents

Place	N	%
In the same place where he or she is living now, mostly the parental houses.	62	53.0
There are separate arrangements or separate houses	05	04.3
Uncertain	50	42.7
Total	**117**	**100.00**

$X^2 = 46.30$, df = 2, $P < 0.001$

The researcher wanted to know from the parents / guardians of the mentally retarded persons where would they go in case of the absence of the parents/guardians. The responses of the respondents are shown in the above table.

53.0% said, in the same place where he or she is living now; 4.3% said that there are separate arrangements or separate houses; and 42.7% are having uncertainty. The chi-square test in contingency table is highly significant. Therefore, it is seen that a large portion of the parents / guardians do not know where the mentally retarded child will live in their absence.

Table – 3.4.10

The researcher wanted to know from the parents / guardians what should be done to create better housing opportunities for the retarded persons. Only 48 respondents expressed various kinds of impression. The other respondents did not express any opinion. The various kinds of suggestions of the respondents are shown in the following table under three categories.

Responses	N	%
Making Government houses for the retarded persons and financial support from the Government to the family of the retarded persons	29	60.42
Mass awareness program from Government and NGOs that general people become conscious about the rights of the retarded persons.	12	25.00
Families should take necessary steps for the retarded persons that they can live independently in separate houses.	07	14.58
Total	**48**	**100.00**

$X^2 = 22.23$, df = 1, $P < 0.001$

Considering the findings shown in the above tables, the researcher discussed the hosing issue of the mentally retarded persons in the following chapter.

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SOCIAL SECURITY

At present Bangladesh Government is not providing any pension or benefit to the Mentally Retarded persons. Sometimes they are also the subjects of social stigma. The researcher tried to investigate the situation in the study area. Following tables show the findings.

Table – 3.5.1: Attempt to hide the problems of the mentally retarded child to others

Attempt	N	%
Yes, they conceal the problems of the mentally retarded children to others	02	01.7
No, they disclose the problems of the mentally retarded children to others	115	98.3
Total	**117**	**100.00**

$X^2 = 109.13$, df = 1, $P < 0.001$

The parents / guardians were asked if they conceal the problems of the retarded children to others. 1.7% respondents said that they concealed the problems of the mentally retarded children to others and 98.3% said that they disclosed the problems of the mentally retarded children to others. Thus, it is clear that almost all the parents / guardians want to disclose the problems of their children to others.

Two respondents were asked why they tried to conceal the problems of the mentally retarded children to others. They informed the researcher that their social status might be hampered if they disclose the retardation of their children to others. They think that in future, negative impact may fall on the other children of the family.

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Table – 3.5.2: Others' behaviour with the mentally retarded persons

Behaviour	N	%
Behave normally	66	56.4
Annoy him/her	34	29.0
Avoid him/her	14	12.0
Irritate, humiliate, etc.	03	02.6
Total	**117**	**100.00**

$X^2 = 78.45$, df = 3, $P < 0.001$

How other people behave with the mentally retarded persons as perceived by the guardians is presented in the above table. It is seen that 56.4% respondents said that other people behave normally; 29.0% annoy them; 12.0% avoid them; 2.6% said that they irritate or humiliate them. Therefore, it is seen that 56.4% mentally retarded persons get normal behaviour from others and the remaining 43.6% mentally retarded persons are deprived from normal behaviour from others.

Table – 3.5.3(a): Participation in social visits.

Participation	N	%
Yes, they accompany with their parents while visiting a relative's house or attend different ceremony	81	69.2
No, they are not with their parents while visiting a relative's house or attending ceremonies.	36	30.8
Total	**117**	**100.00**

$X^2 = 17.30$, df = 1, $P < 0.001$

The parents / guardians were asked if they take their mentally retarded children with them when they visit any relatives' house or attend a ceremony. 69.2% respondents said that they take their mentally retarded children while visit relative's houses or attend different ceremony. On the other hand, 30.8% said that they do not take their handicapped while visiting relative's houses or attend ceremony. It was found that many parents do not take their mentally retarded children with them while visiting relatives' houses or attending different ceremony.

Table – 3.5.3(b)

All the 36 guardians who do not take their mentally retarded children with them were asked why they do not take them to relative's houses or to different ceremony. Respondents showed different causes. Some respondents mentioned more than one causes. The given answers were generalized into three categories. These are shown in the following table.

(Multiple answers)

Responses	N	%
Mentally retarded persons cannot show behaviour suitable to the society. Extra caretaker is needed to look after them.	22	61.11
Social prestige is hampered for them, others get annoyed. They trouble the environment of the ceremony.	08	22.22
If they are taken at the time of visiting, the enjoyment of visit or the ceremony is sometimes spoiled.	13	36.11
Sever handicapped condition of the children	12	33.33

$X^2 = 7.01$, df = 3, $P < 0.001$

Table – 3.5.4(a): Appropriate leaving places

Places recommended	N	%
Yes, they should live with his/her own family	91	77.8
No, they may not live with his/her own family	26	22.2
Total	**117**	**100.00**

$X^2 = 36.11$, df = 1, $P < 0.001$

The researcher asked all the parents /guardians of the mentally retarded persons which are the appropriate place of living of the mentally retarded persons, own home and family or some sort of institution. In reply 77.8% said that they should live with their family and 22.2% said that they should not live with their family. It is seen that although most parents think that the appropriate living places of the mentally retarded persons are their own home and family, some parents /guardians do not think so.

Table – 3.5.4(b).

All the 26 respondents, who said "No" to the question no. 3.5.4, were asked the reasons of their negative answers. The respondents described many reasons. Some respondents showed more than one reasons. The answers are shown in the following table.

(Multiple answers)

Responses	N	%
They create many kinds of problems; they interrupt the normal development of the other children of the family.	14	53.84
They cannot work; they only take their meal sitting idly, etc.	18	69.23
Other members of the family do not feel comfortable to live with them	09	34.61
They need special care in Daily living activities	13	50.00

$X^2 = 17.30$, df = 3, $P < 0.001$

Table – 3.5.5: Who should take care of the handicapped citizens ?

Authority	N	%
The members of the family	56	47.9
Government	27	23.1
NGOs	23	19.7
Some other else: relatives, neighbors, etc.	11	09.4
Total	**117**	**100.00**

$X^2 = 37.35$, df = 3, $P < 0.001$

All the parents / guardians were asked who should take care of the handicapped persons. The parents /guardians mentioned different organizations which are shown in the above table. 47.9% of the parents / guardians said that the members of the family should take all care. 23.1% said that government should take all care. 19.7% mentioned NGOs and 9.4% mentioned others. It is seen that most parents / guardians think that the responsibility of maintenance of the mentally retarded persons should not only rest on the family members but also on the others like Government, NGOs, etc.

Table – 3.5.6(a): Need of the government subsidy.

Appropriation	N	%
Yes, Government subsidy is necessary.	93	79.48
No, Government subsidy is not necessary.	24	20.52
Total	**117**	**100.00**

$X^2 = 40.69$, df = 1, $P < 0.001$

Parents / guardians' were asked whether government grants, supports are necessary for the mentally retarded persons. Opinion of the parents / guardians are shown in the above table. 79.48% said that Government subsidy is necessary and 20.52% said that Government subsidy is not necessary. In fact, most parents / guardians think government support for the mentally retarded persons is indispensable.

Table – 3.5.6(b).

All the 93 respondents who said "Yes" to question 3.5.6. (a) above were asked why they thought government support is necessary for the mentally retarded persons. The respondents gave many kinds of answers. Some of them made more than one answer. The answers are categorized in three groups and presented in the following table.

(Multiple answers)

Responses	N	%
Since they cannot participate in the financial activities like normal people, government grants are necessary for their maintenance.	62	68.13
It is possible to buy medicine, clothes, essentials, etc. with government grants. To improve their living standard, etc.	37	40.65
Government grants will help them to become self-employed.	23	25.27

$X^2 = 19.19$, df = 2, $P < 0.001$

Table – 3.5.6 (c).

All the 24 respondents who said "No" to the question no. 3.5.6 were asked why they thought so. They gave many kinds of responses. Their answers are presented in the following table.

Responses	N	%
The family has a lot of money, so there is no need for government garants.	16	66.66
If they are given government grants, they will grow as dependent on others.	03	12.51
Social prestige may be hampered if the family takes the government grants	05	20.43

$X^2 = 12.12$, df = 2, $P < 0.001$

Table – 3.5.7(a): Feeling of social Problems

Problems	N	%
Yes, they face many kinds of problems	83	70.94
No, they do not face any problems	34	29.06
Total	**117**	**100.00**

$X^2 = 20.52$, df = 1, $P < 0.001$

All the parents / guardians were asked whether they feel any social problem because of their children's retardation. 70.94% said that they face many social problems and 29.06% said that they do not face such feelings. In fact, most parents face some social problem of different degree and nature for the retardation of their children.

Table – 3.5.7(b)

The parents face many kinds of problems in the society due to the retardation of their children. The parents were asked what type of problems they face. All the 83 respondents mentioned different problems which were broadly categorized into three problems. The problems are shown in the following table.

(Multiple answers)

Types of problems	N	%
Problem with their neighbors. Because of the retardation of their children sometimes the neighbors insult the parents for some innocent act of the subjects.	66	79.51
They cannot take part in different ceremonies for the retardation of their children.	47	56.62
The marriage of other normal children or other members of the family sometimes become a problem	31	37.34

$X^2 = 12.79$, df = 2, $P < 0.001$

Table – 3.5.8(a): Social opportunities

Opportunities	N	%
Yes, they get all opportunities	71	60.68
No, they do not get all opportunities	46	39.32
Total	**117**	**100.00**

$X^2 = 5.34$, df = 1, $P < 0.05$

When the researcher asked the parents / guardians of the mentally retarded children whether their children get the opportunities of social mixing, sports and pastime like others. In response 60.68% said that they get all opportunities and 39.32% said that they do not get all opportunities. It is understood that many mentally retarded children are deprived from normal social interactions.

Table – 3.5.8(b).

The 46 respondents who said 'No' to the above question were asked why the mentally retarded children do not get the opportunities of social mixing, sports and recreation. The respondents described different things. The researcher generalized the answers into some categories. These are presented in the table below.

(Multiple answers)

Causes	N	%
Some normal children do not accept the retarded children to be their mates, because they cannot behave like the normal children, or cope with them.	25	54.34
Others avoid the mentally retarded children. Many of them do not want to mix with them.	18	39.13
Sometimes, the mentally retarded children are annoyed and humiliated by others.	12	26.08
They do not have special facilities suitable to their levels.	07	15.21

$X^2 = 11.67$, df = 3, $P < 0.001$

Table – 3.5.9: Problems of the female retarded persons as viewed by the parents

The parents of the female subjects were asked what problems they face because of the mentally retarded condition of their children and what things they are concerned about. The parents of all the 39 female mentally retarded persons mentioned certain problems. These are shown below.

(Multiple answers)

Problems	N	%
They are worried that their children may be sexually abused. They are also worried that their children have no knowledge of protecting themselves.	27	69.23
The subjects are not conscious about their own cleanliness. Many of them are completely dependent upon others for their regular cleanliness.	13	33.33
Sometimes there are problems related to their marriage and those who get married face many problems in marital adjustment.	18	46.15

$X^2 = 6.20$, df = 2, $P < 0.001$

Table – 3.5.10: Opportunities which should be created as viewed by the parents

The parents were asked what opportunities should be created for the mentally retarded persons for the normal maintenance of their lives. They gave different answers. The researcher generalized these answers into seven categories. Some respondents gave multiple answers. Many respondents could not give any answer. The given answers are presented in the following table.

(Multiple answers)

Opportunities	N	%
General people are to be made conscious about the mentally retarded persons.	48	41.02
The opportunities of suitable simple type works are to be created and reserved for them to make them financially self-sufficient. Specialized vocational training programs are necessary for the mentally retarded persons.	11	09.40
Suitable special education should be given to the mentally retarded persons	27	23.07
Regular health check-up should be arranged and necessary treatment is to be given	14	11.96
Specialized housing facilities are needed. In this respect, NGOs or Government may help the family of the mentally retarded persons.	08	06.83
Clubs and societies are needed in every village to increase the recreation facilities for the mentally retarded persons.	12	10.25
Can't answer, did not think	43	36.75

$X^2 = 69.18$, df = 6, $P < 0.001$

Chapter IV
Discussion and Conclusion

Chapter – IV

DISCUSSION

Bangladesh is a developing country with huge population. Though the country recently achieved self sufficiency in food and clothes, the government yet did not officially declare itself free from these two basic needs. Yet Bangladesh government is seeking aids from developed countries for many of its development programs. Bangladesh is not a social welfare state. The state yet does not guarantee many basic rights of its citizen. Though the government introduced some benefit programs for the aged people and the poor women in the country, large majority of these two categories of people are yet not receiving any government benefit. During discussion with the government officials of the study area, the researcher understood that the government officials are fully aware of the problems of the mentally retarded persons. But as there is no government support program for the handicapped people, the government officials can not do anything for them.

The researcher found many mentally retarded persons in the study area who pay different taxes to the government. All the adult mentally retarded persons are enlisted as voters. According to the constitution of Bangladesh (section 15(d) of Part-II) they have rights to get complete care from the government. But they are deprived from their basic rights.

The researcher found that there is no policy program of Bangladesh Government for the mentally retarded persons of the country. It was also found that government does not know exactly how many people in this country are mentally retarded. But seeing the recent introduction of benefit programs for the old aged and poor women in Bangladesh, the researcher assumes that in near future the government will also introduce benefit programs for the handicapped citizens through the Social Welfare Department.

The main objective of this research was to study the problems and of the mentally retarded persons of Auchpara union. The findings of the present study are shown in different tables of the preceding chapters.

The researcher does not claim that all the problems and prospects were covered in this study. But it is clamed that it is a complete study of all the mentally retarded persons of a union. The researcher was face to face with all of them and their guardians at their own houses. He has observed each subject on several days in different situations. He made follow-up studies of different aspects of the subjects during different months and seasons. Not only at their houses he has observed them in agricultural fields, in roads, in the village markets, during different types of interpersonal relations.

The following section of this chapter is a discussion on different aspects of the findings grouped under five broad sub-headings. These are Health, Education, Employment, Housing and Social Security. But before detail discussion the researcher attempts to discuss a little about the prevalence of mental retardation in the study area as well as of the country.

PREVALENCE

It is not very clear how many people of Bangladesh are mentally retarded. The Government data is not well update. Secondly, there is no report of any National Survey. The reports published by the Bureau of Statistics are also ambiguous because the Bureau of Statistics did not assess the real mental conditions of the persons and included under mentally ill persons in their reports. It is assumed that Bureau of statistic included all mentally ill, mentally retarded and persons with multiple handicapped conditions under the heading Mentally Handicapped in their reports. However, some independent sample surveys were done under private initiatives during 1988-2002 in different areas of Bangladesh under private initiatives. And it was found that the prevalence rate did not exceed 0.5% of the population in any area. Auchpara is no exception, the total population of the union is 24,201 and the researcher identified 117 cases of mental retardation. Which indicate 0.483% of the total population is mentally retarded.

HEALTH

Large majority of the people of Auchpara union are unaware of their rights and duties related to education and health care. They are not serious about health. This problem is more complicated for the mentally retarded persons of the union. The findings of the present study regarding health matters are discussed below.

Sometimes the parents of the handicapped babies observe the difficulties of their children but do not want to accept that the babies are handicapped. Usually it is the medical doctors who declare that the child is handicapped. In table 3.1.1 of the preceding chapter, we have seen that only 18% of the parents / guardians were able to know the problems during 0-2 years age of the children. It was seen that the large majority of the parents / guardians could not understand that their child was retarded until they reached the childhood stages.

Most parents do not know the normal development pattern and stages of the children in Auchpara union. The researcher talked to the parents of the mentally retarded children during his study and found their ignorances and faulty understanding of the normal growth of the children. When they see that the babies are not being able to walk, speak or communicate properly, they seek help of the medical professionals.

In table 3.1.2, some important symptoms which helped the parents / guardians to know that their child was mentally retarded were shown. It was found that lack of social adjustment, inability to do school works and inability to perceive social situations are the most important symptoms which helped parents to know that the children are handicapped. But in urban areas most of the parents get the opportunity to know the condition through qualified medical professionals relatively in earlier age of their handicapped children.

DISEASES AND TREATMENTS

Until last decade many children died during their infancy and babyhood periods because of wrong treatment. This situation has improved to some extent after 1992. During 1992-1995, at the initiative of SIVUS institute, some seminars and awareness meetings were arranged several times at Hatgangopara Bazar. In those seminars details discussions regarding factors of mental retardation were informed to the common people. Some training courses were also arranged for the village physicians of the union. These awareness programs improved the situation.

During interview, the researcher knew that many parents did not arrange treatment for their mentally retarded children at all. In table 3.1.3, it was seen that not a single mentally retarded child was treated by Psychologists. The treatment administered to them were not appropriate. The treatment given to them included Faith healing, Ayurvedic and Homeopathy. Which are cheaper, easily available and very common in Bangladesh. It is assumed that such treatments could not improve the condition, rather these treatments jeopardized the situation in most cases.

It was found that many diseases attack the children. But this problem is more acute for the mentally retarded children. Different diseases easily attack them and they can not inform their problems to the parents. The parents notice the situation only when the condition become acute.. The researcher has seen many sick mentally retarded children living in careless and dirty environments practically with out any treatment. The diseases with which the mentally retarded children were attacked until their babyhood are shown in table 3.1.4. of the previous chapter. It was seen that most of the mentally retarded children were attacked by very high fever at the early stages of their lives. Besides this they were attacked by Diarrhea, Cough, Pneumonia and different types of infections.

It was found that there is no graduated physician in Auchpara union. There is only one LMF and two paramedic physicians who provide private treatments. There are some trained village physicians, but large majorities of the physicians have no training at all.

In urgent needs people now a day go to the Thana Health Complex or to the medical facilities of Rajshahi city. There is a Health Complex at Bagmara Thana Head Quarter. But, considering the distance and communication problems most of the people of Auchpara union prefer to go to Mohonpur Thana Health Complex. It was found that they are not ignored at that Health Complex though they are taxpayers of another Thana. In this union, there is a Family Welfare Centre where a paramedic physician renders primary medical services to the mothers and their children. In the year 2002 in Auchpara union 3 new community clining were established. In these clinics, one Health Assistant attends the patients irregularly. They give medical suggestions to the people of their areas and supervise the immunization programs.

Nature of treatment given to the mentally retarded children who were attacked by different diseases was presented in table 3.1.5 of the previous chapter. It is seen from the data that in most cases, qualified physicians did not treat them. The graduate physicians treated only 12.82% children. In most cases village physicians including Ayurvedic and Homeopathic Physicians gave them treatments.

Through this study the researcher has come to know that the number of the mentally retarded persons who take Psychotropic medicines regularly is few in number. The researcher has seen many mentally retarded persons who have some physical problems, too. The researcher assumes that it is possible to solve their physical problems more with Physiotherapy, not by chemotherapy.

On analyzing the information given by the parents, guardians, neighbors, village physicians, etc. the researcher understood that high fever associated with convulsion, different viral attacks and severe infections during infancy and babyhood are important factors of

mental retardation in the union. It is also understood that the root of such diseases are mainly due to difficult and defective birth in the absence of trained midwives in the union. Large majority of the subjects were born through trials & errors after prolonged labour pain of the pregnant mothers in the hands of neighboring women. Such births ultimately caused asphyxia or brain injury to the infants. Which was mostly followed by meningitis including high fever associated with convulsion. And in most cases the diagnosis and treatment was wrong.

EDUCATION

The concept of special education for the mentally retarded children is relatively new in Bangladesh. Dr. Sultana Zaman of Psychology Department, Dhaka University, first introduced an integrated special education programme in 1977 in Dhaka city. Later some voluntary social welfare agencies spreaded her ideas in some other towns. Yet the Ministry of Education, Government of Bangladesh, has not included special education for the mentally retarded children in its programme. In 1992, the Social Welfare Ministry has opened the National Centre for Special Education in Dhaka. This centre is designed to uplift special education teachers and staff members through different training programmes. In 1995 this centre introduced B.Ed. in Special Education course with affiliation of the National University. The IER (Institute of Education and Research) of Dhaka University earlier introduced the Post Graduation course in Special Education.

It is assumed that at least 2 million mentally retarded children are in need of some special education in Bangladesh. Of these 2 million, approximately 80% live in the rural areas and yet there is no special education programme in the rural areas.

Presently three registered voluntary organizations are working for the mentally retarded persons in Bangladesh. These are Society for the Welfare of the Intellectually Disabled (SWID), Bangladesh, Bangladesh Protibandhi Foundation and the SIVUS Institute. Approximately 3000 mentally retarded children and adults are affiliated with the day care programmes of these three organizations, mainly in urban areas. Their total number is about 1% of the total mentally retarded population of Bangladesh.

There is no curriculum for the mentally retarded children approved by any ministry of the Government of Bangladesh. Also there is no national policy for the mentally retarded persons in this country. Therefore, all the agencies are progressing through trials and errors.

The existing special schools for the mentally retarded children are mostly independent day care centres not the integrated schools. Most of the schools have their own curricula and own philosophies according to the facilities available with the individual centre. In some schools it is the teacher centred education and in some schools it is the subject centred education, rarely it is child centred.

A good number of the mentally retarded children were given admission to the normal schools of the study area. But all of them either dropped out or were ultimately sent back from the schools. The findings related to educational attempts and opinion of the guardians related to education of the subjects were shown in different tables from tables from 3.2.1 to 3.2.10 of the preceding chapter. The views of the parents guardians and the situations are not similar for all children.

There are many general schools, inside the study area and may be the percentage is more compared to many other places in Auchpara Union. But the scope of special education in practically nil for the mentally retarded children in Auchpara Union.

If we consider the special education aspects of the while country, we find a very poor picture. In Bangladesh, yet the number of special education schools are not enough even in the Urban areas. In large majority of the towns, there is no special education school. It was mentioned earlier that yet 99% of the total mentally retarded population of the whole country are beyond any program or stimulation. And whatever the services are there, mostly the Day Centers are situated only in the large cities. Therefore, special educations of the rural mentally retarded persons are far beyond imagination.

Yet there is no National policy of the government for the mentally retarded persons. The mentally retarded persons are not only the citizen of the country. They are also the tax payer and voters. It is also

the conditional obligation of the Government to uplift the condition of the handicapped persons. But nothing was done in this country for their constitutional by the Government.

Ten years ago the NGOs working for the mentally Retarded persons proposed the Government that the special education of the mentally retarded persons should be integrated inside the government primary schools. It was proposed that in each government primary school, there should be one class room for special education. The handicapped children will attend all common programs of the school with other children and will follow special curriculum. Such integration could improve both way socialization of the mentally retarded and non-retarded children. Secondly, such arrangement could promote general awareness. But nothing was done for the education of the mentally retarded children by the government.

The matters related to the education of the mentally retarded children of Auchpara depicts the similar picture of other rural places of the county. If we seriously consider the overall situation, the strength of the Government machinery, resources, etc. we find it is not possible for the government to immediately start special education classes in all primary schools at this moment. But model centres can be stared on experimental basis. That is not being done by the Government.

The researcher thinks that it will not be wise to start a segregated special education school for the mentally retarded children in Auchpara at this moment. Because of the life pattern of the rural people, the communication problems, motor disabilities of the handicapped children, etc. Most of the mentally retarded children will not come to a special school. The researcher thinks that some home based special education program will be more helpful for the mentally retarded children. In this context the researcher strongly recommends Portage Program,

Portage Programme: This is the home based programme where parents teach mentally retarded children according to structured, step-by-step pacjage. Generally the service involves a home teacher visiting an individual family at regular intervals, assessing the child periodically and deciding with the parent on developmentally appropriate activities

for the parent to carry out with the child. The Portage system (which originated in Wisconsin USA, now which has been adopted internationally) the home teacher has a resource of the activity cards linked to a developmental checklist. The teacher uses the cards to devise up to three or four instruction and recording sheets for the parent to follow and fill in during the week before the next visit.

There are some standard packages developed in English language. In many countries the Portage programme is adopted in their own languages. In Bangladesh, Dr. Sultana Zaman and her associates of the Protibandhi Foundation have developed and standardized the Bengali version of the package. The parents of Auchpara Union can use the Bengali version of the portage program for Special Education of their mentally retarded children.

EMPLOYMENT

Mentally retarded persons may not become expert in all trades or works like general people. Yet if they are given opportunity, they can participate in many financial activities. The researcher has found many mentally retarded persons who are already engaged in works. Some of them help their parents in agriculture, household, poultry and cattle rearing and so on. But most of them are jobless and loiter in the neighborhood. If necessary steps are taken it may be possible to engage them with some employment opportunities.

In Bangladesh, the employment opportunity for the general population is very little. But there are many jobs which can be reserved for the mentally retarded persons. The jobs which do not need enough mental works are suitable for them. There can be a quota for the mentally retarded persons, too.

In Auchpara Union, the employment sectors related to agriculture, poultry, dairy, etc. are already engaging some mentally retarded persons. But if some specialized vocational training can be given, the mentally retarded persons can be also become skilled carpenters, repair workers, helping hands in shops, tea makers, food grain processors, handicraft manufacturers, etc. It is not necessary that a vocational training centre should be established to provide such trainings. The family members and friends can the help mentally retarded persons to learn the necessary techniques.

In addition, some mentally retarded persons can be grouped to perform special tasks or jobs. SIVUS group dynamic principles can be a good Philosophy towards employment of the mentally retarded persons.

Different philosophies, methods and techniques are used in different countries to employ the mentally retarded persons in different jobs. Following discussion highlights three important approaches now adopted to deal with this problem in Sweden.

The SIVUS Group Dynamic Principles: SIVUS is an abbreviation of the Swedish term "Social Individ Via Utveckling I Sambarkan" which means Socio Individual Development Through Co-operation. The SIVUS is based on group-dynamic principles, on knowledge of how all human beings develop both as individuals and at the same time as social beings. They are developing through their own propelling forces/ activities in order (in the frame of) to achieve a certain goal, to find a certain means that can satisfy their own needs, both materially and culturally. The process of these activities is: from their own-needs, desires and interests; through their own efforts, activities or work; to their own experiences, ideas, theories, knowledge, results and development (Walujo, 1987).

It means the process is from practice, to theory and from theory again back to the new practice. This process of applying the achieved theory leads to achieving a better result and development in providing for his needs to survive and to live better and better. The goal of the SIVUS project is supporting mentally retarded persons to function as independently as possible, both individually and socially, by considering every individual ability, both within the area of provision and services for the mentally retarded and in the society in co-operation with others. The work methods used in SIVUS is characterized by actively taking part in co-operation with others, organized in small groups having fixed members, supervisors; and principle activity coming from the group member's mutual interests, functioning as democratically as possible. With other words through a social integration to achieve normalization.

In Sweden, in many companies and industries, some simple jobs are given to a group of mentally retarded persons. These jobs include moving materials from one place to another place, packaging, assembling, etc. The group are heterogeneous groups comprising Mild, Moderate and severely retarded persons. They are working well.

In Bangladesh, if 5-6 mentally retarded persons of different degrees of retardation and different levels of physical strengths are grouped together under the supervision of an able villager, the

group can cultivate land and do many things together. Therefore, SIVUS Group Dynamic Method can be an effective attempt towards employment of the mentally retarded persons in rural Bangladesh, too.

HOUSING

To see the reality of housing and living condition of the subjects the researcher visited all the houses of the mentally retarded persons of Auchpara union. He found all the mentally retarded persons are living with the members of their families in the same house. Most of the mentally retarded persons have no special room. They live with some other member of the family sharing the rooms. But many mentally retarded children do not get enough care and opportunities like their normal siblings. Many mentally retarded persons sleep on the floor. Some mentally retarded persons were found spend their nights here and there, because they do not have sufficient space to sleep at home. A good number of parents / guardians do not have planned to provide them more comfortable accommodation as they do for their normal children. In some families, other siblings were found do not like to live with the mentally retarded sibling in the same house. The findings related to housing pattern were shown in different tables of the preceding chapter.

Bangladesh is a country which does not have a National Housing Policy for its citizen like the social welfare countries. In Norway, it is a Government Policy that every adult mentally retarded person can get an independent apartment from the Government, if he or she is not living with the patents. Not only the apartment, Norwegian Government provides part time helping hands and some pension money to the mentally retarded persons for their independent living.

In the Netherlands, the adult mentally retarded persons live in Large Scale Residential Institutions if the degree of retardation is severe. The staff members of these institutions take all care of the mentally retarded persons. Similar are the situations in Sweden, Japan and many other developed countries.

In Bangladesh, there is no residential institution for the mentally retarded persons run by the Government. In private level, there are few residential institutions but not well known. Many parents /

guardians feel that it has become necessary to establish some residential institutions, at least for short stay when parents want to leave home in emergency or visit outside. It was observed that many parents guardians can not leave home in emergency situation when they have a severely handicapped child.

However, Bangladesh is a country where most of the families are yet joint families in the rural areas. In rural areas, the problems of the parents are relatively lesser compared to the urban parents. Auchpara union is a rural area. The parents guardians are not having problems to leave behind their handicapped children at home when they need to go to the towns or some where. Their close relatives look after the handicapped persons. The researcher also observed that the socialization process of the rural mentally retarded persons is better. The problems of handling and taking care are also easier compared to a urban mentally retarded person. And Auchpara is a rural area and the problem of Housing and taking care are not yet severe problems for the guardians.

SOCIAL SECURITY

The concept of social security is different in different countries. Bangladesh is not yet a social welfare state like the Scandinavian, Benelux, West European or North American countries. Though the constitution of Bangladesh gives guarantee of a quality life for handicapped people of the country but it is far away in reality. Yet Bangladesh Government could not announce any National Policy for its handicapped citizen. It is seen that 80% Bangladeshi people are living in rural areas where the *Samaz* are more powerful than the Government. The *Samaz* leaders are the persons who also monitor and decide many aspects of the life of the handicapped people, in addition to the families.

Though the parents / guardians gave some opinion related to the social security matters of their own mentally retarded wards, the researcher perceived that the parents / guardians clearly know that they will have to take all responsibility of their handicapped wards. At this moment Government is not sharing their burdens nor is it possible for the Government to share any responsibility. But the parents / guardians expect that Government should help them to some extent.

Social awareness related to mental retardation is an important factor for quality life is of the mentally retarded persons. Yet many mentally retarded persons are humiliated, irritated, exploited in our society. The parents / guardians who have strong economic and social power in the society try their best to protect their wards from different humiliation and exploitations. But the situations of the poor people are miserable.

The parents / guardians of the female mentally retarded persons are always worried that their wards may be sexually abused. The birth of a mentally retarded child in a family sometimes becomes a social stigma and the prospects of marriage of other siblings are jeopardized in many cases. The parents / guardians of the mentally retarded persons are the most concerned persons and they feel more for them than others. The parents / guardians of Auchpara Union have given different opinions related to social security matters of the mentally

retarded persons, which are shown in the preceding chapter of this thesis. It was not specially studied but the researcher understood that the perceptual span of the parents / guardians of Auchpara are limited compared to the perceptual span of the parents / guardians of the metropolitan cities of the country. However, from the opinions given by the respondents it is understood that some monthly benefit scheme from the Government like old age pension and widow pension schemes for the handicapped people will definitely increase their status in the society and the family. They will get more acceptances in general. Such financial benefit schemes will also reduce some burdens of the parents / guardians.

In addition, the researcher feels that awareness programs about mental retardation using Government mass media needs to be strengthened that common people become properly aware of the rights of the handicapped people in this country.

LIMITATIONS OF THE STUDY

This research was designed only to study the problems and prospects of the mentally retarded persons of Auchpara Union of Bagmara Thana in Rajshahi District. The location of the study area is in the northwestern part of Bangladesh. The topography is different from the topography of the northeastern part, the southern coastal regions and many other low-lying areas of the country. The lifestyle, food habits, houses, etc. of the people of the study area are different from the people living in the hilly areas and the coastal areas of the country. Secondly, the problems of the mentally retarded persons of Kurigram District, which is also situated in the northern part of the country and about 350 km from the study area are different from the problems of the study area. In Kurigram area, the iodine deficiency is severe compared to Rajshahi area. In Kurigram area, river erosion causes such problems which are not present in the Rajshahi area. Naturally, the problems and prospects of the mentally retarded persons of the study area are different from the problems and prospects of the mentally retarded persons of many other areas of Bangladesh.

Though the study covered all the mentally retarded persons now living in the study area, it could not cover very well the problems of those mentally retarded persons who died in recent years or some years ago. The researcher talked to some villagers to enquire the problems faced by those mentally retarded persons who died but it was not possible to verify the given information.

It is assumed by the researcher that a large number of parents / guardians could not provide accurate information of the treatments given to the mentally retarded persons. They do not preserve any medical paper, prescription, etc. Secondly, the government offices of the Thana Head Quarter could not provide any paper or document which could be of help or could be included as secondary data.

CONCLUSION

Though this research was designed to study the problems and prospects of the living mentally retarded persons of all the villages of Auchpara Union of Bagmara Thana of Rajshahi District in Bangladesh. The researcher also inquired the cases of the mentally retarded persons who died recently or few years ago inside the study area. He was personally face to face with all the living mentally retarded persons, their parents, guardians, siblings, neighbors and village leaders. He discussed different aspects related to the subjects with the guardians and the family members. Considering his observation, informal and formal interviews and case studies, the researcher wants to conclude the following:

Health related problems are the most serious problems of the mentally retarded persons as it is related to their life and death. Though the existing medical services provided by the government do not restrict the mentally retarded persons to avail all possible facilities of Bagmara Thana Health Complex and its sub-centres, the distance and the communication problems are yet the strongest barrier. Until the roads inside the union are improved and free ambulance services are introduced, it is not possible for the sick mentally retarded persons of Auchpara union to avail the free and modern medical services rendered by the government.

Due to absence of expert professionals and graduate medical physicians inside the study area it takes longer time for the parents guardians to know that their wards are mentally retarded not mentally ill or sick. They usually come to know the reality of the subjects during childhood of the subjects. Meanwhile, the parents attempt many so-called treatments that jeopardize the health of the subjects.

Other than the Trisomy 21 cases, all other cases were found have records of birth hazards, severe diseases and illnesses associated with convulsive disorders during infancy and babyhood. The treatments provided were also faulty treatments.

Defective births through trials and errors in the absence of qualified medical professionals and trained midwives are one of the most important causes of mental retardation in the study area. Illnesses of the pregnant mothers and indiscriminate use of medicine is another important factor.

Almost all the subjects of the study area are free from psycho-tropic drug dependence for their survival and is opposite to the situation found in the urban areas.

Most of the subjects were enrolled in the primary schools but finally dropped out. Special Education opportunity is practically nil in the study area. But parents possess very high positive attitude towards special education.

The villagers possess positive attitude to employ the mentally retarded persons. At this moment the mild and moderately retarded adults, both male and female, are mostly engaged in agriculture oriented jobs in the study area. If some vocational training can be given to them, the employment scope will definitely increase.

The housing conditions of the subjects are not different from their siblings and other members of their families. However, there are some problems with the severely handicapped persons.

Though the social security matters are not up to the mark, but the subjects were found well integrated in their own families and societies compared to the urban mentally retarded persons.

RECOMMENDATIONS

Considering the problems and prospects of the subjects the researcher recommends the following to improve the quality of life of the mentally retarded persons.

The mentally retarded persons are also the taxpayers and voters of this country. But they are not being given enough care by the government that is protected and ensured by the constitution of Bangladesh. First of all, it has become essential that government should announce a Policy Program for the mentally retarded persons of the country. Clear policy program is needed in relation to their health, education, employment, housing and social security.

The Traditional Birth Attendants (TBA) living inside the union needs some training from qualified medical personnel. It is also necessary that at least one trained midwives are there in every village or at least for two villages.

Until the graduate medical physicians are not being easily available, some short courses can be arranged by the Health Directorate in every union for the rural physicians to improve their quality of services. Some control is also needed on the indiscriminate use of drugs including homeopathic and ayurvedic drugs.

Government should immediately include special education classes in all the Government Primary Schools. The handicapped children should take part in all the common activities of the schools but follow special curriculum inside a separate room during class hours. It will be unwise to encourage NGOs to set up segregated Day Centres for the handicapped children in the country, especially in the rural areas.

Now the government can introduce some monthly pension scheme for the handicapped persons in the country like the old age pension scheme and widow allowances. Introduction of such financial support schemes will help the families and the social status of the handicapped persons will also increase significantly. Such schemes, whatever the amount is, will bring tremendous awareness among the citizen towards the mentally retarded persons in the country.

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Appendices

APPENDICES

Appendix - I (A)
Questionnaire (The Bengali version)

প্রতিবন্ধীর সাধারণ পরিচয়

ছবি

নাম ঃ ----------

জন্ম তারিখ ঃ---------- বয়স ঃ ---------- লিঙ্গ ঃ ----------

ঠিকানা ঃ ----------

পিতার নাম ঃ ----------

বয়স ঃ ---------- পেশা ঃ ----------বাৎসরিক আয় ঃ ----------

শিক্ষাগত যোগ্যতা ঃ ----------

মাতার নাম ঃ ----------

বয়স ঃ ---------- পেশা ঃ ---------- বাৎসরিক আয় ঃ ----------

শিক্ষাগত যোগ্যতা ঃ ----------

মোট সন্তান সংখ্যা ঃ ---------- প্রতিবন্ধী কততম সন্তান ঃ ----------

প্রতিবন্ধী শিশু যদি পিতা-মাতার সাথে বসবাস না করে সে ক্ষেত্রে যার সঙ্গে বসবাস করে তার নাম, ঠিকানা ও সম্পর্ক ঃ ----------
---

প্রতিবন্ধকতার ধরন ঃ

স্তর ভিত্তিক	চিকিৎসামূলক
১. সীমারেখা ২. মৃদু প্রতিবন্ধী ৩. মধ্যম প্রতিবন্ধী ৪. সংঘাতিক প্রতিবন্ধী ৫. চরম প্রতিবন্ধী	১. ডাউন্স সিনড্রোম ২. ক্রেনিয়াল এনোমলিস ২.১ হাইড্রোসেফালী ২.২ মাইক্রোসেফালী ৩. ক্রেটিনিজম ৪. পি,কে,ইউ ৫. তেজস্ক্রিয় প্রতিক্রিয়া ৬. স্টানটেড বেবী ৭. অন্য কোন গ্রুপ

প্রতিবন্ধীর বর্তমান অবস্থা

(নির্দিষ্ট ঘরে (✓) চিহ্ন দিন)

আচরণগত অবস্থা	প্রতিক্রিয়ার মাত্রা					মন্তব্য
	খুব ভাল	ভাল	মোটামুটি	খারাপ	খুবখারাপ	
টয়লেট ট্রেনিং	,,	,,	,,	,,	,,	
পোষাক পরিধান ক্ষমতা	,,	,,	,,	,,	,,	
খাবার নিজে খেতে পারার ক্ষমতা	,,	,,	,,	,,	,,	
ঊসা	,,	,,	,,	,,	,,	
দাঁড়ানো	,,	,,	,,	,,	,,	
হাঁটা	,,	,,	,,	,,	,,	
শব্দ উচ্চারণ এবং কথা	,,	,,	,,	,,	,,	
শ্রবণ শক্তি	,,	,,	,,	,,	,,	
ঘ্রাণ শক্তি	,,	,,	,,	,,	,,	
স্বাদ সংবেদন	,,	,,	,,	,,	,,	
ত্বক সংবেদন (ঠাণ্ডা, গরম, চাপ, ব্যথা)	,,	,,	,,	,,	,,	
কোন নির্দেশ বুঝতে পারার ক্ষমতা	,,	,,	,,	,,	,,	
সাধারণ শারীরিক গঠন	,,	,,	,,	,,	,,	
বুদ্ধি	,,	,,	,,	,,	,,	
স্মৃতি শক্তি	,,	,,	,,	,,	,,	
	খুব বেশী	বেশী	স্বাভাবিক	কম	খুব কম	মন্তব্য
চঞ্চলতা	,,	,,	,,	,,	,,	
স্বাভাবিক বুদ্ধিও সমবয়সীদের তুলনায় সাধারণ জ্ঞান	,,	,,	,,	,,	,,	
	খুবই সন্তোষজনক	সন্তোষজনক	মোটামুটি	খারাপ	খুব খারাপ	মন্তব্য
স্কুলের সামগ্রিক আচরণ	,,	,,	,,	,,	,,	
বাড়ীতে সামগ্রিক আচরণ	,,	,,	,,	,,	,,	
সামাজিক প্রেক্ষাপটে সামগ্রিক আচরণ	,,	,,	,,	,,	,,	
খেলা-ধুলার সময় আচরণ	,,	,,	,,	,,	,,	
রাস্তাঘাটে চলার সময় আচরণ	,,	,,	,,	,,	,,	
বাড়ীতে অতিথি এলে আচরণ	,,	,,	,,	,,	,,	
অন্য আত্মীয়ের বাড়ীতে গেলে আচরণ	,,	,,	,,	,,	,,	
বাজারে/দোকান পাটে নিয়ে গেলে আচরণ	,,	,,	,,	,,	,,	
শিক্ষকদের সাথে আচরণ	,,	,,	,,	,,	,,	
বাবা-মার সাথে আচরণ	,,	,,	,,	,,	,,	
ভাই-বোনদের সাথে আচরণ	,,	,,	,,	,,	,,	
পরিচিতজনদের সাথে আচরণ	,,	,,	,,	,,	,,	
অপরিচিতজনদের সাথে আচরণ	,,	,,	,,	,,	,,	
চিকিৎসকের / কাউন্সেলর এর সাথে আচরণ	,,	,,	,,	,,	,,	
সমবয়সিদের সাথে আচরণ	,,	,,	,,	,,	,,	
পরিষ্কার পরিচ্ছন্নতা	,,	,,	,,	,,	,,	

প্রতিবন্ধীর স্বাস্থ্য সম্পর্কিত তথ্য

উত্তর দাতা ঃ পিতা / মাতা / ভাই-বোন / অন্য কোন আত্মীয়

১. আপনার সন্তানের কত বছর বয়সে প্রথম বুঝতে পারলেন যে, সে প্রতিবন্ধী ? ----------

কিভাবে বুঝলেন যে, সে প্রতিবন্ধী ?

ক) ধীর গতির মানসিক বিকাশ খ) সামাজিক সংগতি বিধানের অভাব
গ) স্কুলের কাজ আয়ত্ব করতে না পারা ঘ) কোন কিছু সহজে বুঝতে না পারা
ঙ) শরীরের অংগ প্রত্যংগ সঠিক ভাবে ব্যবহার করতে না পারা
চ) উপযুক্ত বয়সে অনেক কিছু শিখতে না পারা (যেমন, হামাগুড়ি, উপুড় হওয়া, হাঁটা ইত্যাদি।)

২. বিভিন্ন বয়সে প্রতিবন্ধীর জন্য কি চিকিৎসা করানো হয়েছিলো ?

বয়স	চিকিৎসার ধরন				
	ঝাড়ফুক	কবিরাজি	হোমিওপ্যাথী	এলোপ্যাথী	মানসিক চিকিৎসা
জন্ম - ১৪ দিন					
১৫ দিন ২ বৎসর					
২ বৎসর - ৬ বৎসর					
৬ বৎসর - ১২ বৎসর					
১২ বৎসর - ১৪ বৎসর					
১৪ বৎসর - ১৭ বৎসর					
১৭ বৎসর - ২১ বৎসর					
২১ বৎসর - ৪০ বৎসর					

৩. প্রতিবন্ধীর গুরুতর অসুখের বিবরণ ঃ

বয়স	গুরুতর অসুখের বিবরণ	মৃদু অসুখের বিবরণ
জন্ম - ১৪ দিন		
১৫ দিন ২ বৎসর		
২ বৎসর - ৬ বৎসর		
৬ বৎসর - ১২ বৎসর		
১২ বৎসর - ১৪ বৎসর		
১৪ বৎসর - ১৭ বৎসর		
১৭ বৎসর - ২১ বৎসর		
২১ বৎসর - ৪০ বৎসর		

৪. কোন অসুখে কি চিকিৎসা করানো হয়েছিল ?

অসুখের বিবরণ	কে চিকিৎসা করেছিল				
	এমবিবিএস	প্যারামেডিক	পল্লীচিকিৎসক	হোমিওপ্যাথী	কবিরাজি

৫. বর্তমানে কি চিকিৎসা চলছে ?

ক) এলোপ্যাথী খ) হোমিওপ্যাথী গ) কবিরাজি ঘ) মানসিক চিকিৎসা (গ্রাজুয়েট সাইকিয়াট্রিস্ট)

ঙ) অন্যান্য (বর্ণনা করুন) ----------

৬. চিকিৎসকের প্রয়োজন হলে কত দূর যেতে হয় ?

চিকিৎসকের ধরন	দূরত্ব
এমবিবিএস	
প্যারামেডিক	
পল্লীচিকিৎসক	
হোমিওপ্যাথী	

৭. প্রয়োজনীয় ঔষধ পথ্য কেনার সামর্থ্য আছে কি না ?

ক) পুরোপুরি সামর্থ্য আছে খ) সামর্থ্য আছে গ) মোটামুটি সামর্থ্য আছে ঘ) সামর্থ্য নেই ঙ) একটুও সামর্থ্য নেই

৮. আপনি কি মনে করেন যে, চিকিৎসা করলে আপনার সন্তান ভাল হয়ে যাবে এবং অন্যান্য শিশুর মত বুদ্ধিমান হবে, প্রাইমারী পাশ করতে পারবে ?

ক) সম্পূর্ণরূপে ভাল হবে এবং খুব ভালভাবে প্রাইমারী পাশ করতে পারবে
খ) ভাল হবে এবং প্রাইমারী পাশ করতে পারবে
গ) কিছুটা ভাল হবে এবং কোন রকমে প্রাইমারী পাশ করতে পারবে
ঘ) ভাল হবে না এবং প্রাইমারী পাশ করতে পারবে না
ঙ) একটুও ভাল হবে না এবং কোন ভাবেই প্রাইমারী পাশ করতে পারবে না।

৯. আপনার সন্তানকে কি এখন নিয়মিত প্রতিদিনই কোন ঔষধ খাওয়াতে হয় ? হ্যাঁ / না

যদি ঔষধ খাওয়াতে হয় তার বিবরণ ঃ

ঔষধের নাম	মূল্য	কোথায় পাওয়া যায়	কে অনুমোদন করেছে				
			অভিভাবক নিজেই	এমবিবিএস	প্যারামেডিক	পল্লীচিকিৎসক	অন্য কেউ (কে?)

ঔষধের বর্তমান মাত্রা	শুরুর সময় মাত্রা	মাত্রা বৃদ্ধির প্রক্রিয়া		
		অভিভাবক নিজেই	ডাক্তারের পরামর্শে	অন্য কোন ব্যক্তির পরামর্শে? (কে?)

ঔষধ না খাওয়ালে কি হয় ? ----------

১০. প্রতিবন্ধীর শারীরিক কোন সমস্যা আছে কি ? হ্যাঁ / না

যদি কোন সমস্যা থাকে তার বিবরণ ঃ ----------

প্রতিবন্ধীকে দেখাশোনা করে কে ? (যদি সম্পূর্ণরূপে অন্যের উপর নির্ভরশীল হয়) ----------

কি কি বিষয়ে দেখাশোনা / নার্সিং প্রয়োজন ? ----------

প্রতিবন্ধীর শিক্ষা সম্পর্কিত তথ্য

১. সে কি গ্রামের প্রাথমিক বিদ্যালয়ে ভর্তি হয়েছিল ? হ্যাঁ / না

কত দিন গিয়েছিল ? ----------

ভর্তির সময় কোন সমস্যা হয়েছিল কি ? হ্যাঁ / না

কি সমস্যা হয়েছিল ? ----------

২. বর্তমানে স্কুলে যায় কি ? হ্যাঁ / না

কি কারণে স্কুলে যায় না ?

ক) স্কুলের পড়ালেখা আয়ত্ব করতে পারে না খ) স্কুলের অন্যান্য শিশুরা তাকে বিরক্ত করে
গ) স্কুলের শিক্ষকরা নিষেধ করেছে ঘ) অন্য কোন কারণ ----------
---

৩. বাড়িতে তাকে লেখাপড়া শেখাতে চেষ্টা করেছেন কি ? হ্যাঁ / না

কিভাবে চেষ্টা করেছেন ? ----------

৪. তার লেখাপড়ার ব্যাপারে শিক্ষক বা অন্য কারও পরামর্শ নিয়েছেন কি ? হ্যাঁ / না

তারা আপনাকে কি পরামর্শ দিয়েছে ? ----------

৫. আপনার এলাকায় প্রতিবন্ধীদের জন্য বিশেষ শিক্ষার ব্যবস্থা আছে কি ? হ্যাঁ / না

কি ব্যবস্থা আছে ? ----------

৬. স্কুলে শিশু কিভাবে যাবে / আসবে ?

ক) নিজে নিজে হেঁটে খ) সাইকেলে করে কেউ পৌঁছে দিয়ে আসবে
গ) ভ্যানে অন্যদের সাথে ঘ) কোলে চড়ে যাবে
ঙ) অন্যভাবে ----------

৭. আপনি কি মনে করেন যে, প্রতিবন্ধীদের জন্য বিশেষ শিক্ষার ব্যবস্থা থাকা প্রয়োজন ? হ্যাঁ / না

কেন ? ----------

৮. কি ধরনের শিক্ষা ব্যবস্থা থাকা প্রয়োজন ? ----------

পাঠ্যসূচী কি হওয়া প্রয়োজন ? ----------

৯. এ ধরণের শিক্ষা ব্যবস্থা কে চালু করবে ?

ক) সরকার খ) ইউনিয়ন পরিষদ গ) এন.জি.ও ঘ) গ্রামের সব প্রতিবন্ধীদের পরিবারের পক্ষ থেকে
ঙ) অন্যকেউ (কে?) ----------

১০. বিশেষ শিক্ষা ব্যবস্থা কোথায় চালু করবে ?

ক) সাধারণ স্কুলের সঙ্গে খ) পৃথক স্কুলে গ) প্রতিবন্ধীর বাড়িতে
ঘ) অন্য কোথাও (বর্ণনা করুন) ----------

প্রতিবন্ধীর কর্মসংস্থান সম্পর্কিত তথ্য

১. আপনার প্রতিবন্ধী সন্তান কোন কাজ করতে পারে কি ? হ্যাঁ / না

কি কাজ করতে পারে ? ----------

২. আপনার প্রতিবন্ধী সন্তানকে স্বাবলম্বি করার কোন পদক্ষেপ আপনাদের পরিবার থেকে নিয়েছেন কি ? হ্যাঁ / না

কি পদক্ষেপ নিয়েছেন ? ----------

৩. আপনার এলাকায় আপনার প্রতিবন্ধী সন্তানের কোন কর্মসংস্থানের সুযোগ আছে কি ? হ্যাঁ / না

কি সুযোগ আছে ? ----------

৪. সে কি কোথাও কর্মরত ? হ্যাঁ / না

কোথায় ? ----------

৫. কেন কর্মরত নয় ?

ক) কাজ করতে অক্ষম খ) কাজের সুযোগ নেই গ) কেউ কাজে নেয় না

ঘ) কাজ করার বয়স হয়নি ঙ) অন্য কোন কারণ ঃ ----------

৬. তাকে কর্মসংস্থানের সুযোগ দিতে কি কি করতে হবে ? ----------

৭. কে এই সুযোগ সৃষ্টি করবে ? ----------

কিভাবে করবে ? ----------

৮. প্রতিবন্ধীকে কোন বৃত্তিমূলক প্রশিক্ষণ দিলে ভাল হয় ?

ক) কৃষি কাজে খ) কাঠের কাজে গ) গৃহ কর্মে ঘ) পোলট্রি

ঙ) পারিবারিক ব্যবসায় চ) ডেয়ারী ছ) হস্ত শিল্পে জ) বাসার সাথে ছোট দোকান

ঝ) অন্য কোন কাজ ----------

৯. আপনি কি মনে করেন প্রতিবন্ধীদের সাধ্যানুসারে যে কোন একটি কর্মে অংশ গ্রহণ প্রয়োজন ? হ্যাঁ / না

কেন ? ----------

১০. আপনার প্রতিবন্ধী সন্তান সরকার বা কোন সংস্থা থেকে ভাতা পায় কি ? হ্যাঁ / না

যদি অন্য কোন সাহায্য সহযোগিতা পায় তার বিবরণ ঃ ----------

প্রতিবন্ধীর বাসস্থান সম্পর্কিত তথ্য

১. আপনার প্রতিবন্ধী সন্তানকে পৃথকভাবে রাখেন না অন্যান্য সন্তানদের সাথে একত্রে রাখেন ?

ক) একত্রে খ) পৃথকভাবে (কোথায়?) ----------

২. প্রতিবন্ধী সন্তানের থাকার জন্য নির্দিষ্ট ঘর আছে কি ? হ্যাঁ / না

সে যে ঘরে থাকে সেটি কোথায় ?
ক) একই বাড়ির ভিতর সবার সাথে খ) তার জন্য পৃথকভাবে তৈরী ঘর

৩. প্রতিবন্ধী যে বাড়িতে বসবাস করে তার ধরন ঃ

ক) পাকা বাড়ি (মেঝে, ছাদ RCC) খ) মাটির ঘর খড়ের ছাদ
গ) মাটির ঘর টিনের ছাদ ঘ) পাকা মেঝে ও দেয়াল এবং ছাদ টিনের ঙ) ঝুপরি

সে কোথায় ঘুমায় ? ক) মেঝেতে খ) খাট বা চৌকিতে

৪. তার থাকার ঘর কে পরিষ্কার করে ? ক) সে নিজেই করে খ) অন্য কেউ (মা / কর্মচারী)

৫. বাড়িতে তার যথেষ্ট সুযোগ সুবিধা না থাকায় সে কি প্রায়ই যেখানে সেখানে রাত কাটায় ?

ক) হ্যাঁ (কোথায়?) ---------- খ) না

৬. আপনার প্রতিবন্ধী সন্তানের পোষাক কি কি আছে ? ----------

ঐ পোষাক কি বাইরের অনুষ্ঠানে যাবার সময় পরিবারের অন্যান্য সদস্যদের সমমানের ? হ্যাঁ / না

প্রতিবন্ধীকে কি পরিবারের অন্যান্য সদস্যদের সমমানের খাবার দেওয়া হয় ? হ্যাঁ / না

৭. আপনার মতে প্রতিবন্ধীদের বসবাসের জন্য উপযুক্ত স্থান কোনটি ?

ক) নিজ পরিবারে খ) গ্রুপ হোমে গ) অন্য কোথাও ----------

৮. পরিবারের অন্যান্য সদস্যরা তার সঙ্গে একই বাড়িতে থাকতে আগ্রহী কি ?

ক) হ্যাঁ খ) না (কেন ?) ----------

৯. আপনাদের অবর্তমানে সে কোথায় থাকবে ?

ক) এখন যেখানে থাকে সেখানেই খ) পৃথক বাড়ির ব্যবস্থা আছে
গ) অন্য কোথাও (কোথায়?) ---------- ঘ) জানা নেই

১০. প্রতিবন্ধীর বসবাসের আরও সুবিধার জন্য কি কি করা প্রয়োজন ? কিভাবে তা করা সম্ভব ?

সামাজিক নিরাপত্তা সম্পর্কিত তথ্য

১. আপনার সন্তানের সমস্যার কথা অন্যদের জানতে দেন কি ?

ক) হ্যাঁ খ) না (কেন?) ----------

২. আপনার প্রতিবন্ধী সন্তানের সাথে অন্যরা কিরূপ আচরণ করে ?

ক) স্বাভাবিক আচরণ করে খ) বিরক্ত করে গ) শারীরিক নির্যাতন করে ঘ) এড়িয়ে চলে

ঙ) অন্য কোন কিছু ঃ ----------

৩. কোন আত্মীয়ের বাড়িতে বেড়াতে বা কোন অনুষ্ঠানে আপনারা তাকে সাথে নেন কি ?

ক) হ্যাঁ খ) না (কেন নেননা?) ----------

৪. আপনি কি মনে করেন যে, প্রতিবন্ধীদের নিজ পরিবারের সাথে বসবাস করা উচিত ?

ক) হ্যাঁ খ) না (কেন?) ----------

৫. প্রতিবন্ধীদের ভরণ-পোষণের দায়িত্ব কার নেওয়া উচিত ?

ক) পরিবারের সদস্যদের খ) সরকারের গ) এন.জি.ও গুলোর

ঘ) অন্য কারও (বর্ণনা করুন) ----------

৬. প্রতিবন্ধীর জন্য সরকারী ভাতা দেওয়া আবশ্যিক মনে করেন কি ? হ্যাঁ / না

কেন? ----------

৭. আপনার সন্তান প্রতিবন্ধী হওয়ার কারণে সামাজিকভাবে আপনি কি কি সমস্যার সম্মুখীন হন ?

(বর্ণনা করুন) ----------

৮. হারিয়ে যাওয়ার ভয়ে তাকে বেঁধে রাখেন কি ? হ্যাঁ / না

প্রতিবন্ধী সন্তান কি অন্যান্যদের মত সামাজিক মেলামেশা, খেলাধুলা বা বিনোদনের সুযোগ পায় ?
ক) হ্যাঁ খ) না (কেন?) ----------

৯. প্রতিবন্ধী সন্তান মেয়ে হওয়ার কারণে তার কি কি সমস্যা আছে ?

কি কি বিষয় নিয়ে আপনারা চিন্তিত ? ----------

১০. সমাজের অন্যান্যদের মত স্বাভাবিক জীবন যাপনের জন্য প্রতিবন্ধীদের কি কি সুযোগ সুবিধা সৃষ্টি করা প্রয়োজন ? ----------

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সাধারণ প্রশ্ন

১. আপনার পরিবার যৌথ না একক ? ক) যৌথ পরিবার খ) একক পরিবার

২. আপনার পরিবারে মোট সদস্য সংখ্যা কত জন ? ----------

কতজন আয় করে ? ----------

সকলের সম্মিলিত বাৎসরিক আয় কত ? ----------

৩. আপনার প্রতিবন্ধী সন্তানকে বিয়ে করাবেন কিনা ? (যদি না হয়ে থাকে)

ক) হ্যাঁ (কিভাবে করাবেন ? কেন করাবেন ?) ----------

খ) না (কেন?) ----------

৪. সন্তান প্রতিবন্ধী হওয়ার কারণে আপনাদের পরিবারিক জীবনে কি কি সমস্যা হয় ? ----------

৫. গর্ভকালীন / প্রসবকালীন সময়ে কোন সমস্যা হয়েছিল কি ? হ্যাঁ / না

কি সমস্যা হয়েছিল ? ----------

৬. প্রতিবন্ধী সন্তান জন্মকালীন সময়ে আপনাদের (স্বামী / স্ত্রী) বয়স কত ছিল ?

ক) স্বামী ---------- খ) স্ত্রী ----------

৭. আপনারা কি স্বামী - স্ত্রী পূর্বেই রক্তের সম্পর্কে আত্মীয় ছিলেন ? হ্যাঁ / না

কি রকম আত্মীয়তা ? ----------

৮. কি কারণে আপনার সন্তান প্রতিবন্ধী হয়েছে বলে মনে করেন ? ----------

৯. আগামী ১০ বছর পর প্রতিবন্ধীর ভবিষ্যৎ কি হবে বলে মনে করেন ? ----------

১০. পরিবারে বা আত্মীয়দের মধ্যে এরূপ সমস্যা অন্য কারও আছে কি ? হ্যাঁ / না

কার আছে ? ঠিকানা ঃ ----------

প্রতিবন্ধী সম্পর্কে গবেষকের নিজস্ব পর্যবেক্ষণ ভিত্তিক মন্তব্য ঃ ----------

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Appendix – I (B)
Questionnaire (The English translation)

General Information of the Mentally Retarded Person

Photo

Name: ----------

Date of Birth: ---------- Age: ---------- Sex: ----------

Address: ----------

Father's Name: ----------

Age: ---------- Occupation: ----------Yearly Income: ----------

Educational Qualification: ----------

Mother's Name: ----------

Age: ---------- Occupation: ----------Yearly Income: ----------

Educational Qualification: ----------

Number of Total Children: --------Familial Succession of the handicapped child: --

In case of the retarded child's not living with his/her parents, the guardian's name, address & relation with him/her: ----------
----

Categories of retardation:

According to Degree	Clinical Type
1. Borderline	1. Down's Syndrome
2. Mild	2. Cranial Anomalies
3. Moderate	2.1 Hydrocephaly
4. Severe	2.2 Microcephaly
5. Profound	3. Cretinism
	4. Phenylketonuria (PKU)
	5. Ionizing radiation
	6. Stunted baby
	7. Others group

Present Condition of the Mentally Retarded Person

(Put a tick (✓) in the definite cell)

Behavioural Condition	Degree of reaction					Remarks
	Very Good	Good	Average	Poor	Very Poor	
Toilet Training	"	"	"	"	"	
Capability of dressing	"	"	"	"	"	
Capability of taking meal for oneself	"	"	"	"	"	
Sitting	"	"	"	"	"	
Standing	"	"	"	"	"	
Walking	"	"	"	"	"	
Pronunciation & talking	"	"	"	"	"	
Sense of hearing	"	"	"	"	"	
Sense of sight	"	"	"	"	"	
Sense of smelling	"	"	"	"	"	
Sense of taste	"	"	"	"	"	
Tactile sense (Cold, Warmth, Pressure, Pain)	"	"	"	"	"	
Realization	"	"	"	"	"	
General Structure of the body	"	"	"	"	"	
Intelligence	"	"	"	"	"	
Memory	"	"	"	"	"	
	Too much	Much	Normal	Light	Very light	
Movement	"	"	"	"	"	
General knowledge	"	"	"	"	"	
	Very Satisfactory	Satisfactory	Average	Poor	Very Poor	
Total behaviour at school	"	"	"	"	"	
Total behaviour at home	"	"	"	"	"	
Social behaviour	"	"	"	"	"	
Behaviour at playing	"	"	"	"	"	
Behaviour at roads	"	"	"	"	"	
Behaviour at guest's arrival	"	"	"	"	"	
Behaviour at relative's house	"	"	"	"	"	
Behaviour in the market	"	"	"	"	"	
Behaviour with teachers	"	"	"	"	"	
Behaviour with parents	"	"	"	"	"	
Behaviour with siblings	"	"	"	"	"	
Behaviour with the known	"	"	"	"	"	
Behaviour with the unknown	"	"	"	"	"	
Behaviour with physicians / counselors	"	"	"	"	"	
Behaviour with the mates	"	"	"	"	"	
Cleanliness	"	"	"	"	"	

Information about the Health of the Mentally Retarded Person

Respondent: Father / Mother / Sister-brother / other relatives

1. In which age of your child did you come to know that he/she is retarded? ------

   How did you come to know your child is retarded?

   a) Slow mental development b) Lack of social adjustment
   c) Inability to do school works d) Inability to perceive Problems and Social Situation.
   e) Delayed physical development
   f) Inability to perform proper things at proper age (such as, crawling, kneeling, walking etc.)

2. Treatment Given to the Retarded at Different Ages :

Age	Type of treatment				
	Faith healing	Ayurvedic	Homeopathy	Allopathic	Psychi atry
Birth – 14 days					
15 days – 2 years					
2 years – 6 years					
6 years – 12 years					
12 years – 14 years					
14 years – 17 years					
17 years – 21 years					
21 years – 40 years					

3. Description of the Major Illness of the Retarded :

Age	Description of Major illness	Description of Minor illness
Birth – 14 days		
15 days – 2 years		
2 years – 6 years		
6 years – 12 years		
12 years –14 years		
14 years – 17 years		
17 years – 21 years		
21 years – 40 years		

4. What Treatment was Given to Different Illnesses?

Description of the illness	Who Gave Treatment?				
	M.B.B.S	Paramedic	Village Physician	Homeopathy	Ayurvedic

5. What Kind of Treatment is Going Now?

a) Allopathy b) Homeopathy c) Ayurvedic d) Mental treatment (Graduate Psychiatrist)

e) Others (Describe) ----------

6. What Distance is the Retarded to Cross if Treatment is Necessary?

Type of the physician	Distance
M.B.B.S	
Paramedic	
Village physician	
Homeopathy	

7. Has he the Capability to Buy Necessary Medicine?

a) Fully capable b) Capable c) Medium Capacity d) No capacity
e) No capacity at all.

8. Do you think your child will be cured and intelligent like other children and will pass the primary school?

a) Will be fully cured and pass the primary school well.
b) Will be cured and pass the primary school.
c) Will be lightly cured and pass the primary school.
d) Will not be cured & will not pass the primary school.
e) Will not be cured at all and will not pass the primary school at all.

9. Is your Child to be Taken Medicine Daily Now? Yes / No

If yes, description follows :

Name of the Medicine	Price	Where Got	Who Prescribes?				
			The Guardian Himself	M.B.B.S	Paramedic	Village Physician	Anybody else (who?)

Doges of Medicine	Doges at the Beginning	Process of Increasing the Doges		
		The Guardian Himself	According to the Physician's Consultation	According to the Advice of Somebody Else

What happens if medicine is not taken? ----------

10. Has the Retarded Person Any Physical Problems? Yes / No

If any, description is as follows : ----------

Who care the retarded person? (If fully dependant on others) ----------

In what affairs care is needed / Is nursing necessary? ----------

Information about the Education of the Mentally Retarded Person

1. Was he admitted to a village primary school? Yes / No

   How many days did he go for? ----------

   Was there any problem in time of admission? Yes / No

   What problems arose? ----------

2. Does he go to school at present? Yes / No

   Why does not he go to school?

   a) Cannot perform the school task b) Other children disturbs him
   c) Teachers forbid d) Other reasons ----------

3. Have you tried to give him/her education at home? Yes / No

   How have you tried? ----------

4. Have you taken advice of a teacher or anybody else? Yes / No

   What advice have they given you? ----------

5. Is there any special arrangement for education for the retarded persons in your locality? Yes / No

   What arrangements? ----------

6. How will the child go / come to school?

   a) On foot himself b) Somebody will take him on the bi-cycle
   c) With others on van d) In somebody's lap
   e) In other way ----------

7. Do you think special arrangement for education is necessary for the retarded persons? Yes/No

   Why ? ----------

8. What kind of education is necessary? ----------

   What kind of curriculum is necessary to be? ----------

9. Who will run this type of education?

   a) Government b) Union Parisad c) NGOs
   d) From the family of all the retarded persons e) Somebody else (Who?) ----

10. Where will the special education be run?

   a) With ordinary schools b) In separate school c) In the house of the retarded person
   d) Somewhere else (Describe) ----------

Information about the Employment of the Mentally Retarded Person

1. Can your child do any thing? Yes / No

   What thing can he do? ----------

2. Have you taken any step from your family to make your retarded person employed? Yes/No

   What step have you taken ? ----------

3. Does your handicapped child have any scope of employment in your locality? Yes / No

   What scope does he have? ----------

4. Is he employed any where? Yes / No

   Where? ----------

5. Why not employed?

   a) Unable to do b) No scope for work c) No body takes him in work

   d) He is not in the age of doing anything e) Any other reasons : ----------

6. What things will be done to give him an opportunity of employment? ----------

7. Who will create such scope? ----------

   How will they do it? ----------

8. Which technical training is suitable for the handicapped person?

   a) In farming b) In carpentry c) In household affair d) Poultry

   e) Familial business with the house f) In dairy g) In handicrafts h) Small shop

   i) Any other things ----------

9. Do you think retarded person should participate in any job according to their skill? Yes / No

   Why? ----------

11. Do your handicapped child get any donation from the government of any organization? Yes / No

    If any, the description of that follows : ----------

Information about the Housing of the Mentally Retarded Person

1. You keep your child separate or together with other children?

   a) Together b) Separately (where?) ----------

2. Does the handicapped child have definite room to live in? Yes / No

   Where is the room where he lives in?
   a) In the same house with all b) In the room separately made for him

3. The type of house the retarded person lives in :

   a) Pucca house (floor, roof RCC) b) Mud-built house, thatched roof
   c) Mud-built house tin-shed roof d) Pucca floor & wall and tin-shed roof
   e) Hut

   Where does he / she sleep? a) On the floor b) On the bed steed

4. Who cleans his room? a) He / She himself / herself b) Anybody else (Mother/Employee)

5. Does he sleep at night here and there for want of accommodation at home?

   a) Yes (Where?) ---------- b) No

6. What garments does your retarded child have? ----------

   Is that dress of the same standard compared to other members? Yes / No

   Is he / she given the same food as given to the other members of the family? Yes / No

7. Which is the proper living place, according to you, for the retarded person?

   a) Own family b) Group home c) Any where else ----------

8. Do other members of the family agree to live in the same house with him/her?

   a) Yes b) No (Why?) ----------

9. Where will he / she live in your absence?

   a) In the place where he is living now b) There are separate arrangements of house
   c) Any where else (Where?) ---------- d) Unknown

10. What things else should be done for the handicapped person's dwelling? How is that possible? ----------

    ----

Information about the Social Security of the Mentally Retarded Person

1. Do you let others know the problems of your child?

   a) Yes b) No (Why?) ----------

2. How do others behave with your child?

a) Behave normally b) Annoy him / her c) Torture bodily d) Avoid him / her

e) Anything else : ----------

3. Do you accompany him / her while visiting a relative's house or attending a ceremony?

   a) Yes b) No (Why not?) ----------

4. Do you think the retarded person should live with his / her family?

   a) Yes b) No (Why?) ----------

5. Who should take the maintenance of the sustenance of the handicapped person?

   a) The members of the family b) Government c) NGOs

   d) Some other else (Describe) ----------

6. Do you think it compulsory to give government donation to the handicapped? Yes / No

   Why? ----------

7. What problems do you face because of your child's retardation?

   (Describe) ----------

8. Do you fasten him / her in fear of missing? Yes / No

   Does the retarded child get the opportunity for social mixing, sports and pastime like others? a) Yes b) No (Why?) ----------

9. What problems does the handicapped child have on owing to her being female?

   Which aspects are you anxious about? ----------

10. What opportunities for the retarded persons should be created for their normal lives like other of the society? ----------
    ----

General Question

1. Is your family joint or nuclear? a) Joint family b) Nuclear Family

2. How many members are there in your family? ----------

   Who earn? ----------

   What is the total income of all per year? ----------

3. Will you marry your retarded child off? (if not)

   a) Yes (How? Why?) ----------

   b) No (Why?) ----------

4. What problems do you face in you familial life for your child's retardation? ---

5. Was there any problem in time of pregnancy or child-birth? Yes / No

   What problems? ----------

6. How old were you (husband and wife) in time of the birth of the handicapped child?

   a) Husband ---------- b) Wife ----------

7. Were you (husband & wife) blood-relations before? Yes / No

   What kind of relation? ----------

8. What reasons do you think responsible for the retardation of your child? -------

9. What do you think the future of the handicapped child after coming ten years?

10. Is there any problem like this in your family or relatives? Yes / No

    Who has? Address : ----------

On the basis of observation, the researcher's own comment regarding the retarded person. ----------
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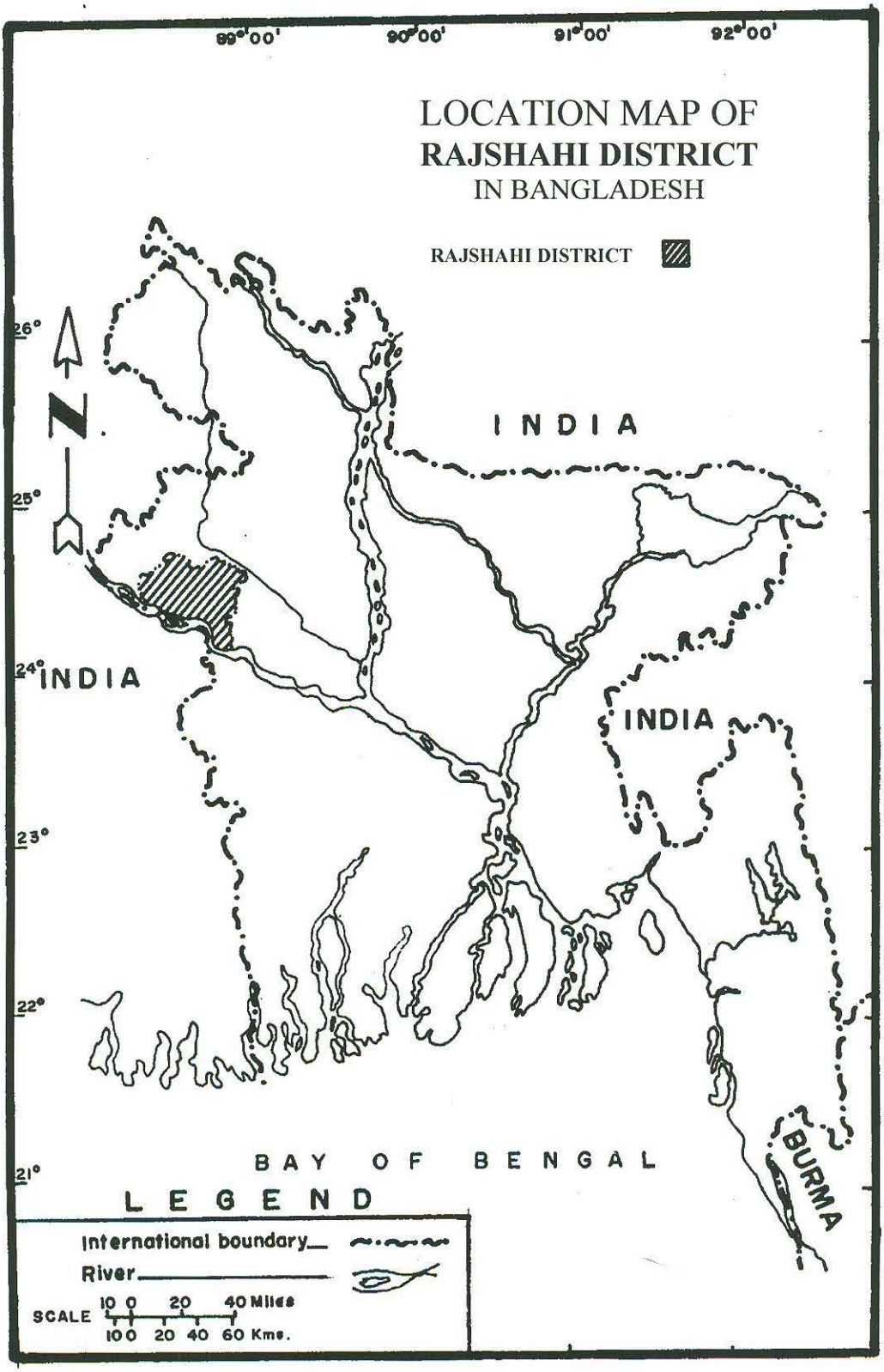
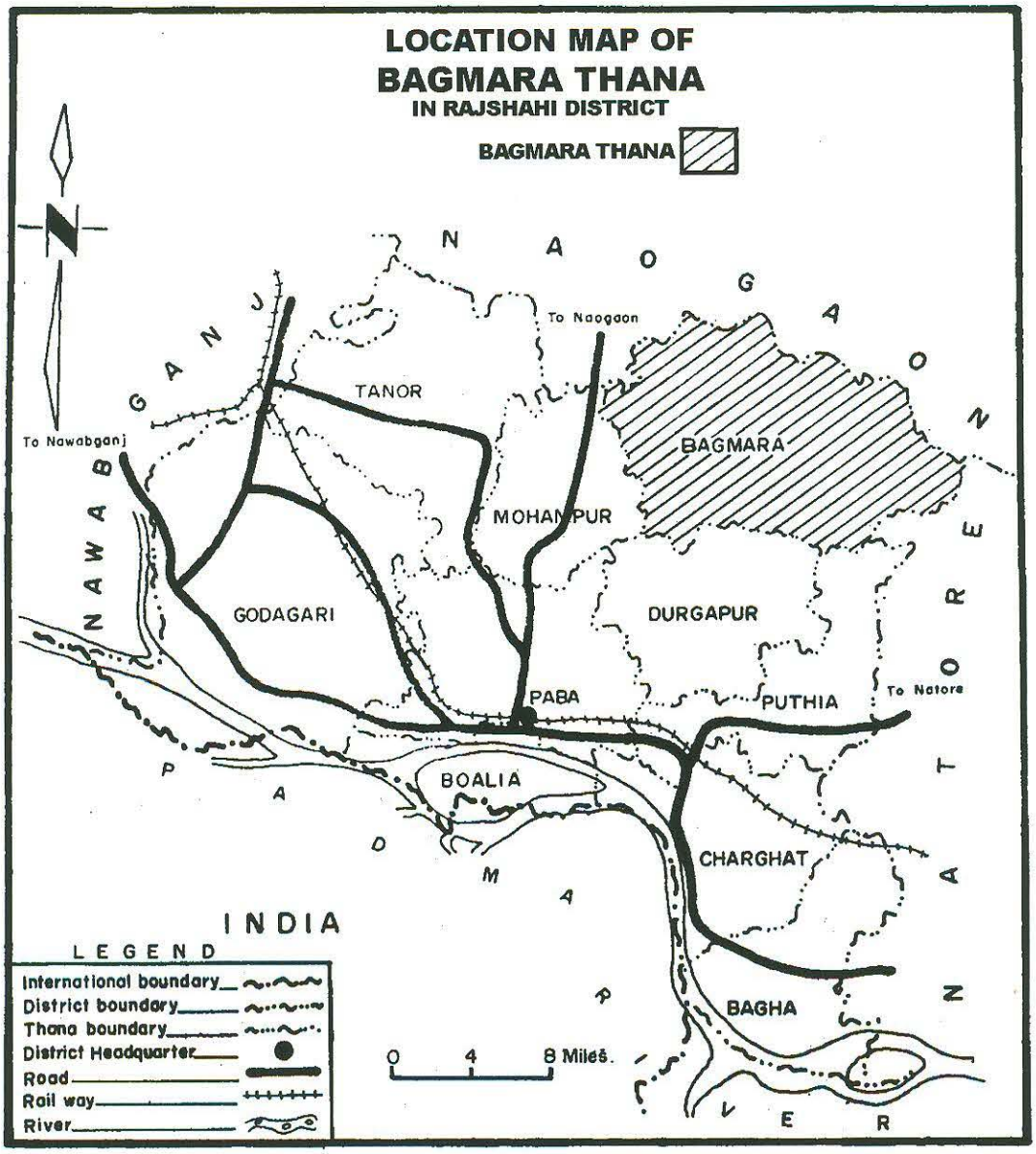
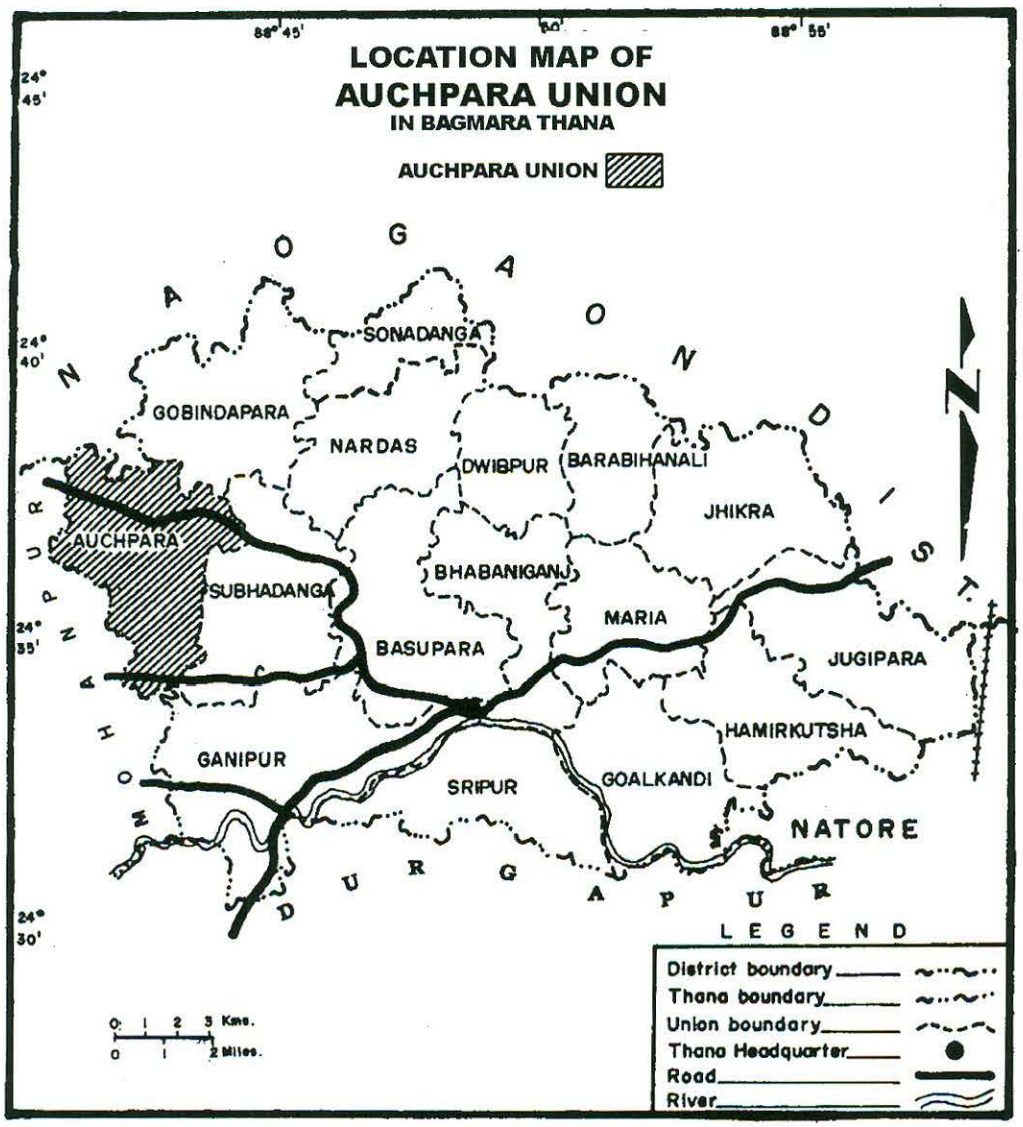
Appendix – II (A)



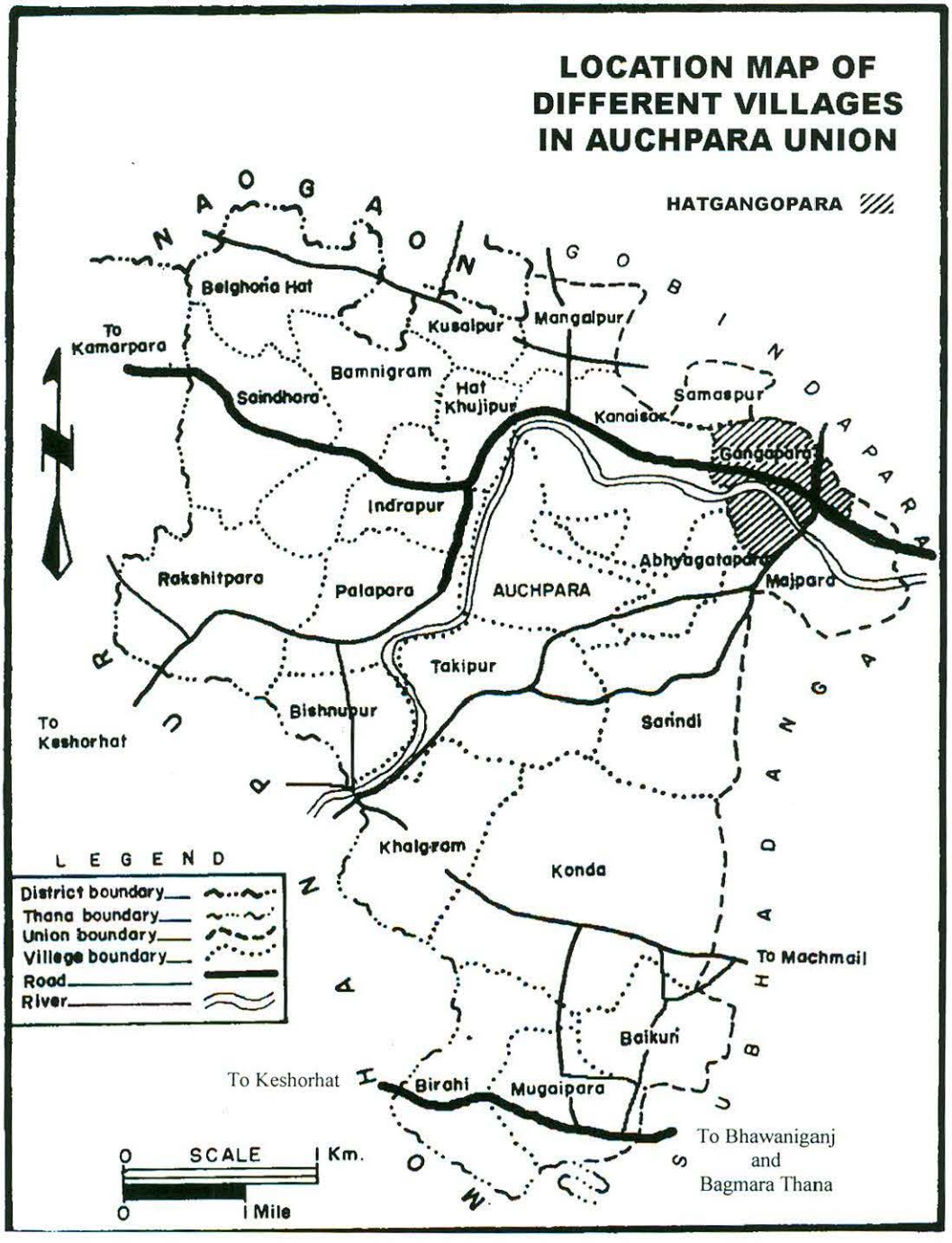
Appendix – II (B)



Appendix – II (C)



Appendix – II (D)



Appendix III

LIST OF THE MENTALLY RETARDED PERSONS IN AUCHPARA UNION

Serial No.	Name of the Mentally Retarded Persons	Mouza	Age	Sex	Category
01	**Munsur Ali** C/O Golam Mostafa	Abhyagatapara	40	Male	Moderate
02	**Saiful** C/O Munsur Rahman	Abhyagatapara	28	Male	Mild
03	**Ayesha** C/O Sanjeb Ali	Abhyagatapara	37	Female	Mild
04	**Monarul** C/O Shakim Ali	Auchpara	12	Male	Borderline
05	**Razia** C/O Noir Uddin	Auchpara	15	Female	Mild
06	**Sufia** C/O Akkas Ali	Auchpara	30	Female	Moderate
07	**Teyob Ali** C/O Enat Ali	Auchpara	22	Male	Moderate
08	**Afzal Hosain** C/O Zeher Ali	Auchpara	15	Male	Mild
09	**Rakibul** C/O Boyen	Baikuri	08	Male	Profound
10	**Mamtaz** C/O Nahir Uddin	Baikuri	25	Female	Mild
11	**Ashraful Islam** C/O Moez Uddin	Bamnigram	10	Male	Mild
12	**Sabina** C/O Azizul Haque	Bamnigram	12	Female	Mild
13	**Zahangir Alam** C/O Mahir Uddin	Bamnigram	12	Male	Mild
14	**Shapla** C/O Mahir Uddin	Bamnigram	08	Female	Mild
15	**Golam Rabbani** C/O A. Kalam	Belghariahat	07	Male	Mild

Serial No.	Name of the Mentally Retarded Persons	Mouza	Age	Sex	Category
16	**Lalbar** C/O Mofiz Uddin	Belghariahat	11	Male	Moderate
17	**Borhan Uddin** C/O A. Goni	Belghariahat	05	Male	Borderline
18	**Parul** C/O Abbas Molla	Belghariahat	18	Female	Moderate
19	**Shakim** C/O Kabir	Birahi	25	Male	Borderline
20	**Razu** C/O A. Salam	Birahi	07	Male	Mild
21	**Alam** C/O Mohir Pk.	Birahi	12	Male	Mild
22	**Mostafa** C/O Zeher Ali	Bishnupur	26	Male	Moderate
23	**Nargis** C/O Zeher Ali	Bishnupur	18	Female	Mild
24	**Rabbani** C/O Zeher Ali	Bishnupur	15	Male	Mild
25	**Moslema** C/O Zeher Ali	Bishnupur	10	Female	Mild
26	**Shamim** C/O Momin Uddin	Bishnupur	08	Male	Moderate
27	**Bulbul Hosain** C/O Hosain Ali	Bishnupur	10	Male	Moderate
28	**Dali** C/O Hosain Ali	Bishnupur	12	Female	Mild
29	**Afzal Hosain** C/O Sefatullah	Bishnupur	18	Male	Moderate
30	**Bilkis** C/O A. Latif	Bishnupur	12	Female	Severe

Serial No.	Name of the Mentally Retarded Persons	Mouza	Age	Sex	Category
31	**Rina** C/O Ahsan ali	Gangopara	16	Female	Moderate
32	**Badal** C/O Ahsan ali	Gangopara	12	Male	Mild
33	**Selina Akter** C/O A. Rahman	Gangopara	19	Female	Mild
34	**A. Salam** C/O Sekender Ali	Gangopara	14	Male	Mild
35	**Abdul Quddus** C/O Riaz Uddin	Hatkhujipur	10	Male	Mild
36	**Zharna Khatun** C/O Moslem Uddin	Hatkhujipur	10	Female	Moderate
37	**Afsar Ali** C/O Zahir Uddin	Indrapur	15	Male	Mild
38	**Nargis** C/O Osman Ali	Indrapur	14	Female	Moderate
39	**Duli** C/O Alef Ali	Kanaisar	12	Female	Moderate
40	**Belal Hosain** C/O A. Hamid	Kanaisar	15	Male	Moderate
41	**Rawshanara** C/O Nahir Uddin	Kanaisar	30	Female	Moderate
42	**Rokeya** C/O Enaetullah Sheikh	Khalgram	35	Female	Moderate
43	**Zalil** C/O Isahak Ali	Khalgram	08	Male	Severe
44	**Quamruzzaman** C/O Rafiqul Islam	Khalgram	30	Male	Borderline
45	**Hafizul** C/O Shamsuddin	Khalgram	12	Male	Borderline

Serial No.	Name of the Mentally Retarded Persons	Mouza	Age	Sex	Category
46	**Anisur Rahman** C/O Moharram Ali	Khalgram	22	Male	Moderate
47	**A. Samad** C/O Moharram Ali	Khalgram	24	Male	Moderate
48	**Marzina** C/O Haiat Ali	Khalgram	12	Female	Borderline
49	**Nazma** C/O Shamsuddin	Khalgram	07	Female	Severe
50	**Sayed** C/O Foyez Uddin	Khalgram	19	Male	Moderate
51	**Zatin** C/O Sudhir	Khalgram	08	Male	Moderate
52	**Tapon** C/O Sudhir	Khalgram	04	Male	Profound
53	**Afroza** C/O Shuktullah	Khalgram	12	Female	Mild
54	**Sohel** C/O A. Hakim	Khalgram	08	Male	Mild
55	**Isahak Ali** C/O Ahad Ali	Khalgram	20	Male	Moderate
56	**Mizanur Rahman** C/O Ataur Rahman	Konda	18	Male	Mild
57	**Zeher Ali** C/O Asir Pk.	Konda	35	Male	Moderate
58	**Rabizan** C/O Zahir Uddin	Konda	25	Female	Moderate
59	**Shahanara** C/O Moyez Uddin	Konda	22	Female	Moderate
60	**Habibur** C/O Moyez Uddin	Konda	10	Male	Mild

Serial No.	Name of the Mentally Retarded Persons	Mouza	Age	Sex	Category
61	**Anowar** C/O Zuranu	Konda	08	Male	Mild
62	**Sohel Rana** C/O A. Malek	Konda	08	Male	Moderate
63	**Ripa** C/O Ayenal	Konda	10	Female	Mild
64	**Mozammel** C/O A. Rahman	Konda	25	Male	Moderate
65	**Pathik** C/O Rabindranath	Konda	06	Male	Profound
66	**Mitthu** C/O A. Hakim	Konda	09	Male	Mild
67	**Mozaffar Hosain** C/O Abdul Ali	Kusalpur	22	Male	Moderate
68	**Sabina** C/O Azim Uddin	Kusalpur	05	Female	Severe
69	**Afzal Hosain** C/O Zahir Uddin	Majopara	09	Male	Mild
70	**Zalal Uddin** C/O Zahir Uddin	Majopara	07	Male	Mild
71	**Arfan Bibi** C/O Zahir Uddin	Majopara	45	Female	Mild
72	**Razifur** C/O Saidur Rahman	Majopara	16	Female	Severe
73	**Tuhin** C/O A. Hamid	Majopara	13	Male	Moderate
74	**Rahima Khatun** C/O Mazibar Rahman	Mangalpur	16	Female	Moderate
75	**Fahima Khatun** C/O Mazibar Rahman	Mangalpur	13	Female	Moderate

Serial No.	Name of the Mentally Retarded Persons	Mouza	Age	Sex	Category
76	**Shahin** C/O Mamtaz Hosain	Mangalpur	08	Male	Mild
77	**Lukman Hakim** C/O Makbul Hosain	Mangalpur	21	Male	Moderate
78	**Altaf** C/O Aminul Islam	Mangalpur	08	Male	Mild
79	**Saiful** C/O Edal Pk.	Mugaipara	16	Male	Moderate
80	**Mahbubur Rahman** C/O Muslem Ali	Mugaipara	14	Male	Mild
81	**Azad** C/O Fadil Sardar	Mugaipara	18	Male	Moderate
82	**Nurun Nahar** C/O Afaz Uddin	Mugaipara	12	Female	Mild
83	**Akter Hosain** C/O Yeachin Ali	Mugaipara	09	Male	Borderline
84	**Mahfuzur Rahman** C/O A. Aziz	Palapara	17	Male	Borderline
85	**Golam Azam** C/O Shahadat Hosain	Palapara	18	Male	Mild
86	**Sazedur** C/O Bablu	Palapara	08	Male	Severe
87	**Russel** C/O Bablu	Palapara	06	Male	Mild
88	**Firoz** C/O Anisar Rahman	Palapara	10	Male	Mild
89	**Anil Kumar** C/O Brazessar Pramanik	Palapara	32	Male	Borderline
90	**Sazeda Khatun** C/O Sukchad Pk.	Palapara	30	Female	Mild

Serial No.	Name of the Mentally Retarded Persons	Mouza	Age	Sex	Category
91	**Anwarul Islam** C/O A. Kafi	Rakshitpara	13	Male	Mild
92	**Monarul Islam** C/O A. Kafi	Rakshitpara	10	Male	Mild
93	**Ahsan Habib** C/O Yeachin Ali	Rakshitpara	16	Male	Borderline
94	**Zubaer** C/O Saman Ali	Rakshitpara	06	Male	Mild
95	**Zakaria** C/O Saber Ali	Rakshitpara	12	Male	Mild
96	**Maruf** C/O A. Owahed	Rakshitpara	03	Male	Severe
97	**A. Rakib** C/O Kefatullah	Rakshitpara	15	Male	Multiple
98	**Ruhul Amin** C/O Kefatullah	Rakshitpara	13	Male	Mild
99	**Hasan** C/O Kefatullah	Rakshitpara	11	Male	Mild
100	**Aminul Islam** C/O Salim Uddin	Rakshitpara	04	Male	Mild
101	**Shafiqul Islam** C/O Masir Uddin	Saidhara	07	Male	Profound
102	**Adori** C/O A. Samad	Saidhara	02	Female	Profound
103	**Bilkis Banu** C/O Boyez Uddin	Saidhara	14	Female	Mild
104	**Hafiza Khatun** C/O Dr. Anisar Rahman	Samaspur	21	Female	Moderate
105	**Quamrul Hasan** C/O Mr. Mokshed Ali	Sarindi	14	Male	Severe

Serial No.	Name of the Mentally Retarded Persons	Mouza	Age	Sex	Category
106	**Mahbubur Rahman** C/O Abdul	Sarindi	16	Male	Mild
107	**Masud** C/O Azad Ali	Takipur	06	Male	Profound
108	**Shahinur Khatun** C/O Saidur Rahman	Takipur	10	Female	Moderate
109	**Anzuara** C/O Anisar Ali	Takipur	10	Female	Borderline
110	**Dilbar** C/O Shahazan Ali	Takipur	08	Male	Mild
111	**Abul Hosain** C/O Nurmohammad	Takipur	16	Male	Mild
112	**Ziban** C/O A.Samad	Takipur	05	Male	Mild
113	**Bizli Khatun** C/O Samser Ali	Takipur	09	Female	Mild
114	**Marium** C/O Samser Ali	Takipur	18	Female	Mild
115	**Shahina** C/O Meher Ali	Takipur	15	Female	Moderate
116	**Nayon** C/O Moslem	Takipur	05	Male	Mild
117	**Mannan** C/O Samatullah	Takipur	22	Male	Moderate

Appendix IV

GLOSSARY

Almirah	A wardrobe made of wood.
Amabassa	The night without moon.
Aman	Type of paddy, Rice.
Aqiqua	Muslim religious ceremony celebration the naming of a child.
Ashar	A month in Bengali calendar.
Ashin	A month in Bengali calendar.
Azaan	The procedure for calling people to the mosque for prayer in Muslim religion.
Baishakh	A month in Bengali calendar.
Bari	A house.
BBS	Bangladesh Bureau of Statistics.
Bhadra	A month in Bengali calendar.
Bhajan	Hindu religious song.
Bill	A Huge land full of water, usually connected with a river.
Biri	Hand made indigenous cigarette.
BI & SE	Board of Intermediate and Secondary Education.
BIWTA	Bangladesh Inland Water Transport Authority.
Biztala	The place where rice seeds are planed first, before final cultivation.

BRAC Bangladesh Rural Advancement Committee.

Broto Religious works in Hinduism, Puja.

Burqa A loose garment used by Muslim women as a veil to cover themselves. It is put over the normal dress, and covers the body from head to foot. It has two netted holes for the eyes. An approved social custom. The Islamic injunction only enjoins upon women to keep away from the company of men.

BWDB Bangladesh Water Development Board.

CCDB A Christian missionary organization now involved also in many socio-economic uplift programme in rural Bangladesh.

Chaitra The last month in Bengali calender.

Char Islands inside the rivers.

Chara Bengali lyrics, short poems.

Chatai Mats made of thin slices of bamboo.

Chira Specially processed dry rice.

Chowki A hard, wooden bed made with four legs on which planks are nailed to give it a flat.

Dargah The resting place of a saint. It may mean the place where a holy man or a saint is living away from worldly hum and bustle. It may also mean the place housing the grave of a saint where people throng to beg for his blessings.

Dal Pulse, lentils.

Dhoop Smoke made from minerals on charcoal or timber fire. Used to remove mosquitoes from the house in Bengal. Hindu people also use this smoke during pujas.

Dhoti Men's wear in villages, covering only the lower part of the body from the waist down. It is typically a Hindu dress.

Dighi Water reserves large than ponds.

EPI Expanded Programme on Immunization.

Falgoon A month in Bengali calendar.

FPA Family Planning Assistant.

FWA Family Welfare Assistant.

FWV Family Welfare Visitor.

Gaan Sings.

Gamcha Typical Bengali towels.

Haat Weekly village market.

Halua Paste like sweets made of flour, oil, sugar.

Haor Huge watery areas.

Haree Cooking pots, specially make of aluminum.

Imam Literally, a Leader, a person who leads the congregation in the mosque.

Izaradar The annual lessee of markets, ferry Ghats, bridges, etc. who gets such places on lease from the Government and collects taxes from the users.

Jaistha A month in Bengali scalender.

Jatra A kind of folk, opera, a musical drama of a historical type.

Kancha Any structure which is made of clay, sand and where no concrete and bricks are used.

Kartik A month is Bengali calendar.

Kashor The sound created through bitting brass plates, used mainly during pujas.

Keertan Development Hindu songs to praise the gods.

Kheya Ghat Ferry Service stations to cross rivers or canals by country boat in the rural areas.

Khoi Pop corn type of food made from rice.

Kua tala Place beside a water wheel.

Lungi Typical Bengali male dress for lower portion of the body. About three yards of clothes are sewed which takes the form of a cylinder. The user ties the upper portion on their naval areas.

Matbar Literally, the reliable, In Bangladesh village social structure, the Maatbar is generally one of the prominent persons to the village, and is a member of the informal village council.

Maachan Support stage for seasonal soft plants made of bamboo and dry branches of trees.

Madrasa A place where lessons are given. It is a school with Islamic religious orientation. Madrasa has its own system of education and evaluation.

Magh A month in Bengali calendar.

Mahfil A meeting usually considered as religious meetings.

Maktab Muslim religious educational schools.

MBBS Bachelor of Medicine Bachelor of Surgery.

Mela Any general fair where village people gather and enjoy a day with their families buying sweets, etc. The occasion could be any annual celebration, both social and religious.

Milad Muslim religious program to appraise the prophet.

Muri Pop corn like food made from rice.

Nawab The king of the kings or zamminda4rs of Bengal, Bihar and orissa provinces of India during Mughal period.

Representative of the Emperor to rule these provinces against payment of a fixed annual revenue to the Emperor in Delhi.

NCO Non Commissioned Officer.

NGO Non-Government Organization.

Panjabi Men's ware larger than shirts, without coller with loose full sleeves.

Pan A large green leaf which is eaten by many people of the Indian sub-continent, usually taken with some spices, lime, etc. after eating the lunch. Some people frequently take this leaf.

Para A section of a village.

Polao Specialized fried rice. Fried in oil with some spices.

Ponjika Specialized Bengali calendar, year book describing the schedule of sun rise, sun sets, location of the stars and moon. Etc. More used by the hindu people in relation to pujas.

Pucca Any structure made of concrete and bricks.

Puja Development prayer to various Hindu Gods.

Purdah Literally, a curtain or covering to hide something. It referes to the women's observance of being veiled against strangers.

Quran Khani Complete recitation of the Holy Quarn by an individual or a group.

Ratri Night.

Saaree One piece full length dress of the women in Bangladesh.

Mondol The person who conveys messages of the community to all villagers in his won area.

Salish The arviter in adispute.

Samaj Local administration of a community of a village.

Salish The arbiter in a dispute.

Shawal A month in Arabic calender.

Sindoor A red coloured chemical used by the married hindu women from fore head to middle of the head in between the combed hairs. The windows do not use sindoor.

Sraban A month in Bangla calender.

Sufi Muslim phiolosophers. There are a number of fhiopsopher orders, and Sufis may be referred to the particular order. It is supposed that sufis have their own political organisation, which is supranationa, and various areas are allotted to Sufis exerted great influence on the politics of the kings.

Tal pata The large leafs of Tall trees. These trees are like Palm trees.

Taviz An amulet. The relogious men or saints are requested to write the Taviz. It is a piece of paper with ceretain verses of the quran inscribed on it . This paper is sewn into a tablet, and is tied on the arms or hung on the neck.

TBA Traditional Birth Attendant

Tol Indigenous primary schools for the children in India until 1873. Such schools were informal under the teaching of the Pundits (the learned men of the villages) arranged usually in the outer courtyards of the houses of the teachers. The education sys tem was a combination of teacher centered, student centered as well as subject centered education.

Ulu dhani Special type of sounds created by mouth.

UNICEF United Nations Children's Emergency Fund.

Upazilla The name of a Thana during 1982-91.

Urna Specialized one piece of loose cloth used by women to cover the chest and some times the head.