

**BACHELOR OF EDUCATION**

**SPECIAL EDUCATION**

**MODULE TITLE: ESP 101DEVELOPMENT OF SPECIAL NEEDS EDUCATION**

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Module Introduction

Welcome to our introductory module on Special Education. In this 2nd edition, we have combined what used to be EPS 151: Introduction to Special Education and EPS 152: Special Needs Education. This is in line with the new demands of the trimester system (term system) introduced most recently, away from the previous semester system which the University has since discarded. You do well therefore, to seize this opportunity and embrace the expanded module content for you to have a comprehensive understanding on the field of Special Education.

You may realize that the field of Special Education has evolved over time. This module therefore traces the origins and development of Special Education from the ancient times through the modern period to the contemporary period. It looks at the perceptions that people have had about children with special needs education . Other than the historical perspective, you will be equipped with skills to identify and analyse the policies and legislation in special education both at national level and global level.

In addition, this module introduces you to various categories of children with Special Education Needs (SEN) as well as the fundamental issues in the identification, screening, assessment and intervention among such children. Further, the module stresses the need for early intervention for special education to be effective among children with Special Needs Education.

Finally, the module will enhance your ability to identify and analyse barriers to access and participation related to the inclusion of persons with disabilities in the mainstream. An understanding of these issues is of particular importance to teachers, counsellors, community development workers and policy makers and other personnel interested in working with children and adults with special needs.

We hope this module will deepen your understanding in the field of special education and help you cultivate a health attitude towards children with Special Needs Education.

We hope that you will reflect on the content and activities in this module coupled with your experience in the areas of specialization to develop competencies to be able to develop and manage SEN related issues.

# **Module** Aim

The aim of this module is to enabling you as an educator to acquire knowledge, skills and attitudes necessary to organise education for children with special education. The module also introduces you to various categories of children with Special Needs Education, explores the identification, screening, assessment and intervention approaches available to specialist in the area of special education and tresses the need for early intervention for special education to be effective among children with SEN..



# Module Objectives

By the end of the module, you should be able to:

1. Define key terms related to the field of special education;
2. Trace the Origins and development of special education
3. Describe current trends in special education;
4. Describe the various categories of children with Special Educational Needs
5. Describe the identification and screening processes for various learners with SEN
6. Discuss the benefits and challenges of engaging in Early Childhood Learning among children with SEN
7. Discuss government policies in special education;
8. Discuss disability rights and laws;

# Structure of the Module

As you can see from the table of content below, the module is divided into eleven (11) units. Each unit is in turn divided into several sub-units. Each unit has a core text and an exercise at the end. You are required to read the text and thereafter attempt the exercise before proceeding to the next unit.

#

# Module Assessment

Continuous assessment 50%

1 Assignments 15%

1 Field report 20%

Residential school Test 15%

Final examination 50%



# Prescribed Readings

Ashman, (1989) Educating Children with Special Needs. Englewood Cliffs: Prentice

Hall

DES, (1980) A View of the Curriculum. London, HMSO.

Franz, M., (1981) Teaching Plans for the Handicapped children.New York: Academic

 Press

Lipsky, D.K., & Gartner, A., (1989) Beyond Separate Education, Quality Education

for All.Balatimore: Brooks.

Reynolds, C.R., & Mann, L., (1987) Encyclopaedia of Special Education, Volume1.

London: Heineman



# Recommended Readings

Kalabula, D M (1991) Integrating Visually Handicapped Children Into Zambian

 Ordinary Secondary Schools.(unpublished Ph. D Thesis. University of

Birmingham, UK)

Kokkala, H. (Ed) Providing Special Education For Those Who Need It In Developing

Countries. Department Of International Development Co-Operation: Ministry

 of Foreign of Finland.

Smith, D D (1998) Introduction to Special Education: Teaching In an Age of

Challenge. Third edition: Boston. Allyn and Bacon.

Snelson, P.D, (1983) Educational Development in Northern Rhodesia 1883 – 1945.

 Lusaka: NECZAM

Apart from this module, you are expected to read widely around all the topics covered in the module. You may find the references provided at the end of the module useful, but you could also explore other sources of information, particularly the Internet which has a lot of websites with invaluable information.



# Time frame

You are expected to spend at least 60 hours of study time on this module. In addition, there shall be arranged contacts with lecturers from the University from time to time during the course. You are requested to spend your time judiciously so that you reap maximum benefit from the course.

**Study Skills**

As an adult learner, your approach to learning will be different to that from your school days: you will choose what you want to study, you will have professional and/or personal motivation for doing so and you will most likely be fitting your study activities around other professional or domestic responsibilities.

Essentially you will be taking control of your learning environment. As a consequence, you will need to consider performance issues related to time management, goal setting, stress management, etc. Perhaps you will also need to reacquaint yourself in areas such as essay planning, coping with examinations and using the internet as a learning resource.

Your most significant considerations will be time and space i.e. the time you dedicate to your learning and the environment in which you engage in that learning.

I recommend that you take time now—before starting your self-study—to familiarize yourself with these issues. There are a number of excellent resources on the web. A few suggested links are:

* <http://www.how-to-study.com/>

The “How to study” web site is dedicated to study skills resources. You will find links to study preparation (a list of nine essentials for a good study place), taking notes, strategies for reading text books, using reference sources, test anxiety.

* <http://www.ucc.vt.edu/stdysk/stdyhlp.html>

This is the web site of the Virginia Tech, Division of Student Affairs. You will find links to time scheduling (including a “where does time go?” link), a study skill checklist, basic concentration techniques, control of the study environment, note taking, how to read essays for analysis, memory skills (“remembering”).

#

# UNIT 1

##

## Working Definitions of Special Education

## Introduction

This Unit introduces you to the working definitions in the field of Special Education. It is anticipated that by introducing you to the definitions in use in the field of special education, you will in turn be enabled to understand and contribute meaningfully to the welfare of children with SEN.

## Objectives



By the end of this unit you should be able to;

1. Define what special education is;
2. Use correctly Special Education terminologies; and
3. Discuss the importance of special education.

## Reflection



Have you ever thought about the meaning of ‘Special Education’? well, whether you have ever considered it or not, kindly posse a while, reflect and write down your definition of special education.

We want to imagine that within your definition, you focused on children with ‘disabilities’ or ‘special needs education’. We want to build on your definition and highlight what others consider as definitions of special education. We hope you will have a clearer understanding of the concept of special education by the time we get to the end of this module.

## Definition

Reger (1968) defined special Education as “an area within the framework of general education that provides appropriate facilities, specialized materials and methods, and teachers with specialized training for children considered handicapped.”

Kirk (1972) defined it as “ that aspect of education which apply to handicapped and gifted children and which comprise modification of or addition to school subjects and practices intended for the ordinary child.’’

Kirk and Gallagher (1979) defined it as “those additional services, over and above regular school program, that are provided for exceptional children to assist in the development of their potentialities and / or the amelioration of their disabilities.’’

Heward and Orlansky (1984) defined special education as “the individually planned and systematically monitored arrangement of physical settings, special equipment and materials, teaching procedures and the other interventions designed to helpexceptional children achieve the greatest possible personal self-sufficiency and academic success.’’

Williams (1988) defined special Education as “education intended for children with special needs,i.e. children who, for various reasons, cannot take full advantage of the curriculum as it is normally provided. These are usually children who are physically handicapped, who have learning difficulties or emotional and behavioural disorders.’’

Hallahan and Kauffman (1994) defined special education as “specially designed instructions that meets the unusual needs of an exceptional child.’’

The Educational Reform Document (1977) defines the same concept as “education designed and adapted to suit the needs of unfortunate handicapped childrenwho may be suffering from mental or physical disabilities.’’

Clearly, there are many schools of thought in the area of special education as shown by the variations in the definitions. Nearly all the definitions give a picture of what special education is. This has led to misunderstanding over the years. To alleviate this, the term special educational need is used. Williams (1988.) argues that “Special educational needs’’ is the current basis for providing education for those children who find difficulty from normal pedagogy.’’

## Implications of the Definitions

* Special education is part and parcel of the total education system.
* The differences in these definitions are in the terminologies used, differences are related to services provided but the range of students being served is the same.
* Special education differs from the regular education provided because it tries to take into account inter-individual and intra-individual differences(Kirk and Gallagher, 1997)
* Special education must be seen in terms of services that are provided and alterations that are made to teaching plans in order to meet a need.
* Definitions vary because of differences in perceptions, orientations and experiences of professional and teachers. Some professional might view special education as a service while others who teach might call it an education system. Therefore special education is a different issue to different people.
* The definitions also show a realisation that the curriculum that is offered to children in ordinary classrooms may not be appropriate for a child who cannot see, hear or who is slow in understanding things. Modification to such aspects, as the curriculum is necessary. For example, these can include changes to:
* Pace of instructions.
* Medium of instructions.
* Materials and equipment.
* Additional services of professionals (specialist teachers, psychologists and those from the medical field.)

## Terminologies in Special Education

So far mention has been made of three words, impairment, disability and handicap without explaining what each of them means. These terminologies may be confusing to most of us, especially that they are in most cases used interchangeably in the literature.

### Impairment

Technically, impairment is the first of a three part series of terms used in the area of disability. According to WHO (1980), an impairment is an identifiable defect in the basic functions of an organ or any part of the bodily system. In other words, impairment is the actual loss or abnormality that affects the body or mind. For example; a person who cannot see, cannot hear, or cannot move a limb because of some injury or defect in the organ or limb, has impairment.

**Illustration 2: Different impairments**

|  |  |  |
| --- | --- | --- |
| dwe00206g114 | C:\Users\QAR1\Pictures\St Mulumba & Mumbwa High Sch_SEN\Eunice Mubita_St Mulumba_SEN Pupil.jpg | imagesCA6STLH0 |
| Physical impairment | Visual Impairment | Hearing Impairment  |

### Disability

Disability is the second of the three part series of terms. It constitutes the physical or mental result of the impairment; the partial or total inability to perform mental or physical functions in the way human beings can normally perform them. It is a limitation, restriction, or disadvantages imposed on an individual’s function as a result of the impairment. For example a visually impaired person is restricted in the range and variety of experiences, the inability to get around; and the control of the environment and the self in relation to it. Research evidence shows that a disability can be short – term, long - term or permanent. Sometimes, the disability effects can be alleviated through medical or non- medical intervention. For example, a person may be visually impaired because he has astigmatism but wears glasses to correct this impairment, his functioning in his environment is not necessarily hindered and he is not disabled.

### Handicap

This results when an individual is placed at an actual or perceived disadvantage in the performance of normal life functions because of personal or societalexpectations andattitudes towards the impairment. For example, if all jobs required listening, reading prints, or running around, all deaf, blind and people without limbs would be handicapped. All jobs do not require normal hearing, normal vision, or limbs, but often times, persons with impairments listed above, are not even given opportunities to demonstrate their competence. When this happens, they are handicapped because of societal attitudes.

**Illustration**

A forty year old chess player is involved in an accident and in the process loses his eyes.

* Impairment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_loss of eyes
* Disability \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_decreased ability to use the eyes
* Handicap \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cannot use the eyes, cannot enjoy normal social activities( playing chess)

### Special Education Needs

Special education needs is the basis for providing education for children who find it difficult in profiting from normal education. It is a strategy to replace the previous principle or category of handicap or lame, delicate, disruptive, subnormal etc**.** special educational needs must be seen in terms of services which are provide and the alterations made to the teaching plans.

The terms "special educational needs "and exceptional children mean the same thing. Although variation are present, it is on and the same group.

### SpecialSchool

This is a residential or day school for children with special needs. Special schools are usually organized according to impairment categories such as schools for the blind or the deaf or for children with learning difficulties, physical or behaviour problems. Separate education for the disabled children has resulted in separate cultural identity.

Special schools are usually run and maintained by the government, churches and NGOs. The pupil teacher ratio in these schools is low. Most developing countries are only able to provide for a few children with special education needs as special schools are usually located in urban areas, making them un accessible to most children who may need such services.

|  |  |
| --- | --- |
| **Advantages**  | **Disadvantages**  |
| * Special schools can be developed into centres of excellence.
 | * Special schools are usually not available in the child’s immediate environment.
 |
| * Concentration of expertise on specific impairment.
 | * Expertise only available for a small group of pupils.
 |
| * Pupil-teacher ratio enables each child to have more attention.
 | * System of teaching is very expensive. It is therefore not affordable nor sustainable for all children.
 |
| * Children grow up with their own peers with disabilities and develop a common culture.
 | * Children find it hard to re-adapt to life with their own peers, families and communities.
 |

 Save the Children UK (2004)

### Special Unit

This is a class within ordinary schools where pupils with special needs are educated. These classes are handled by specialist teachers. This arrangement offers many opportunities for integration.

### Special Teacher

This is a specially trained teacher to the children with special educational needs. Within Zambia, such teachers are trained at the Zambia Institute of Special Education (ZAMISE), which offers Certificate and Diploma and the University of Zambia (UNZA), which offers a Bachelor of Education (Special Education) and Masters of Education (Special Education) or any other recognized institution at home or abroad.

### Concept of Normalization

When the field of special education began, the few services that were available were offered primarily in segregated settings, sometimes in special schools within a school district, but more often in residential schools, which in many cases became terrible institutions. These schools usually were geographically isolated in the rural parts of a state. Students often continued living in these facilities even after school age, frequently living their entire lives there. The students spent their time with other students of similar disabilities, rarely interacting with non-institutionalized peers or participating in the normal patterns of life. Even many children and adults with mild disabilities found themselves in these facilities.

Until the 1970s, much of the day-to-day work in institutions—such as caring for individuals with severe disabilities or performing farm or laundry work—was provided by residents with mild and moderate disabilities. Because of the widely held belief that individuals with disabilities would contaminate the “normal” population, many people spent their entire lives in these institutions, isolated from mainstream

society.

Normalization is an essential dimension of special education. Although the concept was suggested in 1959 by Bank-Mikkelsen of Denmark (Biklen, 1985), the word itself was coined by BengtNirje of Sweden (1969; 1976), who encouraged the United States to incorporate this principle in services to people with disabilities. According to Nirje (1985), normalization means “making available to all persons with disabilities or other handicaps, patterns of life and conditions of everyday living which are as close as possible to or indeed *the same as* the regular circumstances and ways of life of society” (p. 67; emphasis in original). The principle of normalization applies to every aspect of a student’s life. Nirje referred to a set of normal life patterns: the normal rhythm of the day, the normal rhythm of the week, the normal rhythm of the year, and the normal development of the life cycle(see also Wolfensberger, 1972; 1995).

Special education is framed and has developed with some guiding principles. For example, the principle of normalization is an essential dimension of Least Restrictive Environment. It demands that professionals and parents make choices that provide services that are as close to normal as possible. For one child, ordinary books and materials that have been adapted to his or her disability, receiving all special education services in the general classroom, and having an after-school job delivering newspapers. For a student with severe disabilities, it may mean that designer jeans have Velcro closings to fit over leg braces, that wheelchair wheels are wide enough to enable the student to play on the sandy playground during recess, and that a specially equipped bus does not have reference to special education painted on the side. Normalization also requires that the environment be; Similar to age-peers, Not harmful, Not controlling, Not dangerous, Not intrusive, Most respectful, Most appropriate, Most integrated, Most normalized.

## Application

* Do not restrict the student’s ability to physically and intellectually explore environments.
* Ensure that activities are age appropriate.
* Some restrictions may be necessary to protect the individual or may be extended until specific skills are mastered. Activities and freedom should be based on the individual’s ability and age; the individual should not be put in a dangerous situation.
* Rather than having others control the many aspects of their lives, individuals with disabilities need to develop skills necessary to control their world.
* Care must be taken to balance the “dignity of risk” principle and safety.
* Although teaching others is an intrusive activity, always respect the privacy and dignity of each student.
* Be sensitive, considerate, and respectful of the needs and wishes of students and their families.
* The essence of individualization is to develop students’ educational programs, taking into account their unique needs, abilities, learning styles, family circumstances, age, and all other relevant factors.
* Full acceptance by peers and others, the ability to be one’s self in group situations, and spontaneous inclusion are measures of integration. Make available to the student with disabilities opportunities for lives similar to those of others in their society.

## Tips for Teachers on Decisions about LRE

Allow the individual the dignity of risk (Perske, 1972). The principle that taking ordinary risks and chances is part of growing up and is essentially human. Frequently, students with disabilities are overprotected, deprived of the ordinary risks and challenges necessary for human development and essential to growing up. Students with disabilities should be allowed the dignity of risk to succeed or fail like others.

Most special educators cherish a vision of *all* children working and playing together whether at school or in their neighbourhoods. Although in some cases this is a challenging goal, the concept of integration is central to special education and the development of appropriate educational programs. Unfortunately, many people with disabilities are still isolated and segregated today, although this practice is disappearing. New principles focusing on inclusion and the community guide the design of services for individuals with disabilities.

Another fundamental principle of special education is that the learning environment is central to considerations about normalization, educational placement, and the creation of an appropriate education program. Special educators tend to focus on the environment as an important variable in the creation of learning programs for children. What does *environment* mean? There is no simple answer. A student’s educational environment is multifaceted. It includes the physical environment in which the student works, the human environment or the individuals with whom the student has the opportunity to interact, the affective environment or the feelings and emotional tone surrounding the student, and the geographical environment or the location of the school.

With all these possible interpretations and combinations, you can see why there might be disagreement over what *the* least restrictive environment is for a particular student. Some educators suggest that a general education classroom is the most restrictive educational placement for some students with special needs; others maintain that a special education classroom is always the most restrictive.

During the 1990s, a great debate about education programs for students with disabilities centered on the interpretation of LRE and the concept of full inclusion.

The principles of least restrictive environment, normalization, mainstreaming, and inclusion mean more than mere physical classroom placement. They describe a philosophical commitment to ensure that children with disabilities have opportunities for living normal lives and are integrated into the flow and pattern of our society. Schools must ensure an array of services so that the individual needs of children can be accommodated. A variety of professional opportunities are available for special educators to help educate and provide related services to all children with disabilities, and the balance between LRE and FAPE must be individually deter-mined for each child with exceptionalities.

## Exercise



Attempt to answer the questions below to test your understanding on Unit 1 topic:

1. Is it necessary to offer special education in school?
2. There is nothing special about ‘a child with special education needs’! Discuss.
3. What areas of the curriculum need attention when teaching students with special needs?
4. Distinguish these terms: disability, Impairment and handicap.

## Summary



This Unit introduced you to the working definitions in the field of Special Education. We you are now able to (i) define what special education is; (ii) use correctly Special Education terminologies; (iii) identify various categories of children under Special Education; and (iv) discuss the importance of special education. With this firm foundation, you are now ready to engage further in Special Education discourse.

# UNIT 2

## Organization and Development of Special Education

## 2.1 Introduction

With your acquired appreciation of the working definitions used in the field of Special Education derived from Unit 1, we now focus your attention to the organisation and development of Special Education. The Unit highlights key milestones in the development of Special Education as a way of helping you appreciate the level of challenges faced and achievement realized in the field of Special Education.



## 2.2 Objectives

By the end of this unit, you should be able to:

1. trace the organisation and development of special education in the world;
2. describe challenges faced in the care and treatment of persons with disabilities during various phases of special education;
3. explain the attitudes exhibited by people during different eras; and
4. discuss the growth of special education in general.

## 2.3 Phases in the care and treatment of disabled children

World-wide, particularly in the United Kingdom and the United States, the first forms of special Education appeared in the latter part of the 18th Century. Tomlinson (1982) points out that these early forms of special Education were often motivated by commercial rather than educational or charitable factors. The aim was frequently to make its recipients useful and productive members of society, usually in an economic sense.

In Europe, the historical writers have been able to trace at least four phases in the care and treatment of disabled children.

* Early History – before 1800
* Era of Institutionalisation – 1800 to 1900.
* Era of Public Schools – 1860s
* Era of Accelerated growth-public schools and normalisation - 1960 to present.

(Source: Gearheart, Weishahn&Gearheart (1988: 6).

**Characteristic features of these eras**

We shall now turn your attention to the first era in the history of special education called

era of early history.

## 2.4 Early History-before 1800

* This period was characterized with societal misunderstanding and superstition on issues of handicaps.
* In Roman history persons with disabilities were called fools and were used by the rich people as a source of entertainment.
* It was also believed that persons who were different from others in behavior or appearance were possessed by evil spirits.
* Exploitation or abuse – using the disabled in the circus to amuse people. For example, parading blind people to sing in the street.
* Marginalisation – also included excommunication of the people with disabilities. It also meant building homes and or huts for these people in the bush where they lived in isolation.(even in the biblical times Marginalisation and isolation existed e.g. the lepers).
* Infanticide – killing of babies that were born with impairments. These were usually damped in the forest and left to die or the parents would immediately strangle the newly born baby to death upon realizing that it had deformed body parts.
* Superstition. It was an abomination to have a child born with defects. In some societies it was regarded as a curse by the spirits and the parents were usually blamed, the disability of the child as seen as a punishment for the sins of the parents
* During this period, children who acquired a disability that interfered with their ability to contribute to the community were usually put to death or banned from the group. Abandonment usually resulted in death, as children could not provide food and shelter for themselves.
* Historical writers such as Zilboorg and Henry (1941) have provided information on how society treated persons with disabilities. These historians have stated that inhuman treatment was due to fear and ignorance.

## 2.5 Era of Institutionalization – 1800- 1900

* The idea of institutionalization came about as a result of a realization by the disabled, professionals and a change in the attitude of the general population to accept persons with disabilities.
* However, it has been argued that the disabled were isolated so that these physically unattractive or undesirable people could be put out of the public eye. Although this attitude is unacceptable today, it was better than infanticide.
* Isolation of persons with disabilities was prominent during this era
* Creation of human warehouses for all people with disabilities was common. The aim of creating these was to have the disabled put in one place for safety purpose.
* Locking away from public view
* Protection of the disabled
* Feeling sorry for the disabled.
* Setting family from the disabled.

During this era, society had offered children with disabilities protection- (by putting them in asylums) from the cruel world into which they could not survive with dignity.

## 2.6 Era of Public School – Special Classes 1960s

* During this period**,** political reformers and leaders in education and medicine began to champion the cause of children and adults with disabilities, urging that these ‘imperfect’ or ‘incomplete’ individual be taught skills that would allow them to become independent productive citizens**.**
* The philosophy of Locke and Rousseau relating to the importance of ‘the dignity of all individuals’ was accompanied by a positive shift in society’s attitude.
* There was increased care, treatment and educational services provided for all people with disabling conditions.
* During this era, effective procedures were devised for teaching children with sensory impairments (blind and the deaf). This was mainly due to the ideas of democracy and individual freedom that influenced people’s attitudes towards the disabled. The first special class for the deaf in a public school was held Boston in 1869.
* Taking care of the disabled.
* Recognition of abilities and talents of the disabled.

## 2.7 Era of accelerated growth. Mid-20th century

* Creation of disability laws, Acts and Policies. In 1945 the UN adopted the Universal Declaration of Human Rights.
* Acceptanceof the disabled as full human beings.
* Community participation in provision of services.
* There was active participation and equality.
* Fight for equal rights- development of African and UNO charters on human rights.
* Integration/mainstreaming is the process of bringing exceptional children into daily contact with non exceptional children in an educational setting. In Zambia, this became the major policy frame work in the 1970s as it was reflected in the Education Reforms Document 1977. It meant that children with special needs were going to be educated in the ordinary schools**.** It also meant providing a natural environment where pupils with special needs alongside their peers would interact and feel freed from the isolation that characterized most of the special education placement.
* There was increase of advocacy.
* Normalizationas the main bedrock. Normalization is the creation of as normal as possible a learning and social environment for the exceptional child or adults.

Many countries are able to find themselves in two or more eras at the same time. For instance Zambia today has characteristic features of almost all phases. Today in Zambia, it is common to find parents or families hiding away children with disabilities in their homes. There is also a lot of misunderstanding and superstitions among local people as to the causes of disabilities.



## Exercise

Attempt to answer the question below to test your understanding on Unit 2 topic:

1. Discuss the features of the four eras in special education and relate them to the Zambian society.

## Summary



The Unit focused on the organisation and development of Special Education. The Unit highlighted key milestones in the development of Special Education as a way of helping you appreciate the level of challenges faced and achievement realized in the field of Special Education. You are now ready to explore the history of SEN in Zambia in Unit 3.

# UNIT 3

## Origins and Development of Special Education in Zambia

## 3.1 Introduction

Having explored the various eras of special education in general in Unit 2, we now turn your attention to the local Zambian history of Special Education. It is hoped that through this unit you shall begin to appreciate the various stages this field has gone through.



## 3.2 Objectives

By the end of this unit, you should be able to:

1. trace the organisation and development of special education in Zambia;
2. describe challenges faced by persons with special education needs in Zambia;
3. discuss the growth of special education in Zambia.; and
4. explain why it is important to provide SEN services.

## 3.3 Reflection



1. Describe how children with special education needs are regarded in your local culture?
2. What labels are given to children with hearing impairment, visual impairment, speech impairment, intellectual impairment in your local language?

## 3.4 Origins and Development of SEN in Zambia

In Zambia, the first attempt to teach handicapped children was made in 1905 by Mrs IsieHofmeyer, wife of a missionary, at Magwero in the Eastern Province of Zambia. In this venture, five blind pupils were enrolled including the late Lazarus Tembo. After the death of the pioneer teacher Mrs Hofmeyer, another missionary Ms Ella Botes started a class in 1914 at Madzimoyo, not so far away from magwero. Initially twelve blind children were enrolled, when the number increased, her class expanded into a school, first at Nyanje in 1923 and then Magwero in 1929. This school became so important in the area that it not only served Zambian blind children but even enrolled pupils from as far as Zaire (D.R.C), Mozambique (Portuguese East Africa), and Malawi (Nyasaland), (Snelson, 1970).

The instructions in this first school comprised the study of the bible and the teaching of rudimentary handicrafts, particularly to adult pupils and their wives, because it was unusual to find married blind men and women enrolled in these school (enrolment age ranged between 7 and 35 years). The aim, as seen from the efforts made world-wide, was to enable these blind people become useful citizens and enable them gain a living (Kalabula, 1989).

Following the example given by the Dutch Reformed Church in the Eastern province of Zambia, other missionaries and philanthropic bodies joined in the race to establish schools to cater for the variety of handicapped children such as: the deaf and the physically handicapped. In the late 1950s, provision of facilities remained in the hands of these people until Zambia Council for the Handicapped under the auspices of the Ministry of Labour and social Services became responsible for handicapped children.

It was not until 1971, that the Ministry of Education became responsible for the education of the disabled children. Following a presidential decree in 1970 to mandate the Ministry of Education to take this important portfolio, LusakaCollege for Teachers of the Handicapped (now ZAMISE) and the special Education Inspectorate was created at the Ministry of Education Headquarters. Many teachers for the deaf, blind, physically and mentally handicapped children have been trained at ZAMISE. A degree programme was also introduced at the University of Zambia in 1996. Provision of education of the handicapped children has relatively expanded through integration and now inclusive Education.

## 3.5 Guiding Principles in Special Education.

There are three main principles: moral, political and economic.

### 3.5.1 Moral Argument

The moral argument refers to basic human rights. It is widely recognized, and enshrined in many documents, that all children have the right to education and that right hold regardless of disability or learning difficulty. If as a consequence some children need special steps to be taken for them to have effective access to schooling, then equity requires that such special that special educational provision is made to meet the individual needs of these children. Treating people as equals when they are not is neither equitable nor is it to offer equality of opportunity. The latter can only be achieved by unequal treatment, which in the school sector means special educational provision.

### 3.5.2 Political Argument

The political argument flows from this: if a nation does cherish all its citizens equally, it must ensure that everybody has effective access to social goods, including education. This duty is reinforced by the numerous national and international declarations committing governments to providing a free, appropriate education for every child. Fine rhetoric without commensurate act bases the political process, and it is incumbent on governments to fulfil the promises made with regard to educating all children. This is related to the coherence of a society’s value system. If a nation prides itself on its equitable regard for all its citizens, it can hardly tolerate the existence of a subgroup deprived of educational opportunities or relegated to a marginal position within the educational system.

### 3.5.3 Economic Argument

The economic argument is based on the fact that education fosters self-sufficiency and reduces individuals’ dependence on the state. This is widely accepted for the mainstream population but increasingly, it is being demonstrated to hold true for those with disabilities as well. Poverty and/ or dependence on welfare when available have been the norm for adults with disabilities**.** Education and training can liberate them, however, especially when linked to changes in society and labour market**.** A growing body of experience in developed and developing countries alike testifies to the possibilities for people with disabilities to become productive members of their communities. If a lifelong perspective is taken, education is an investment with a positive economic pay – off for those with pronounced disabilities or learning difficulties.

## 3.6 Exercise



Attempt to answer the question below to test your understanding on Unit 3 topic:

1. Discuss the policy activities that took place in Zambia during the era of accelerated growth in the history of special education.
2. Discuss the moral, political and economic arguments for providing special education.

## 3.7 Summary

We have discussed the origins and development of SEN in Zambian. This was achieved by (i) tracing the organisation and development of special education in Zambia; (ii) describing challenges faced by persons with special education needs in Zambia; (iii) discussing the growth of special education in Zambia.; and (iv) explaining the rationale for providing SEN services. With this historical background of SEN, we are confident that you are now able to explore emerging issues in the field of SEN. We now turn your attention to Special Eduaction Needs. Under this segment, we shall endeavour to describe what each SEN grouping is about, the etiological (causal) issues, how you can identify such children and potentially be of help in an education environment.

# UNIT 4

## Categories of Children with SEN

## Introduction

This Unit introduces you to the various categories of children considered to have Special Education Needs (SEN). This unit should also give you answer with regard to causes of disabilities. We hope that at the end of this Unit you will develop a positive attitude towards children with SEN.

## Objectives

By the end of this unit you should be able to;

1. Identify the various categories of children with SEN.
2. Discuss the causes of disabilities and;
3. Develop a positive attitude towards children with SEN.

## Reflection

Have you ever interacted with or seen a person with disability in your life? If you have, then in the space provided, describe the nature of their disability.

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Now that you have reflected on the nature of the disability of the persons you interacted with or saw at one time or another, your identified persons could fall in one of the following broad categories:

1. Communication Disorders;
2. Hearing Impaired;
3. Visual Impairment;
4. Intellectual Impairment;
5. Learning difficulties;
6. Physical Disabilities and Healthy impairments.
7. Behaviour and Emotional Disorders;
8. Gifted and talented;

Having gone with you, through the list of various categories, let us now examine in detail each of the categories identified above.

## Communication Disorders

To understand speech or language impairments, we must first understand the communication process people use to interact with others. Think of communication in terms of a game with at least two players (the sender and the receiver) and a message (The purpose of the interaction) (Marvin,1989). Communication occurs only when the message intended by the sender is understood by the receiver.

The sender may have an idea or thought to share with someone else, but the sender’s idea needs to be translated from thought to some code the other person can understand.

Communicationis the process of exchanging knowledge, ideas, opinions, and feelings (Owens, 1994). This transfer is usually accomplished through the use of feelings. Sometimes, however, communication can occur with the glance of an eye, a gesture, or some other nonverbal behaviour.

Speech sounds are **vocal symbols**. Letters of the alphabet are **written symbols**, **Sign language** uses gestural symbols. Symbols are used in combination with each other and are governed by rules. Signals, symbols, and the rules that must be followed constitute language and allow language to have meaning. Communication messages require the receiver to use eyes, ears, or even tactile (touch) senses (for example, those who use Braille) to take the message to the brain where it is understood. Receivers must understand the code the sender uses and be able to interpret the code so that it has meaning.

Communication is unsuccessful if the sender or receiver cannot use the signals or symbols adequately. And if either person has a defective mechanism for sending or receiving the information, the communication process is ineffective.

**Language** is a formalized method of communication involving the comprehension and use of the signs and symbols by which ideas are represented. Language also has rules that govern the use of signs and symbols so that the intended message has the correct meaning.

**Speech** is the vocal production of language. In most instances, it is the fastest and most efficient means of communicating. Understanding how we produce speech requires knowledge of the neurological, respiratory, vocal, and speech mechanisms that work together in our bodies to produce speech and language.

### Types of Speech or Language Impairments

There are two types of communication disorders. Although considered one special education category speech impairments and language impairments are really two separate, though related, disabilities.

#### *Speech Impairments*

Speech is abnormal when it is unintelligible, is unpleasant, or interferes with communication (Van Riper & Erickson, 1996). The three major types of speech impairments are voice, articulation, and fluency (for example, stuttering). Any one of these three speech impairments is distracting to the listener and can negatively affect the communication process.

1. Voice Problems.

 **Voice problem** is not very common, but when this speech impairment does occur it needs immediate attention from a professional. A voice problem may mean the absence or abnormal production of voice quality, pitch, loudness, resonance and duration. Voice is a measure of self; it is part of one’s identity. We can identify many of our friends, for example, simply by hearing their voices. Voice distinguishes each person from others, and we typically do not think about how it functions. But when it does not function as usual, such as when we have laryngitis, we find it frustrating. Our voices also mirror our emotions; we often can tell when people we know well are happy, sad, angry, or scared merely by hearing their voices( Smith, 1998).

Three aspects of voice are important: quality, pitch and loudness.

**Pitch** is the perceived high or low quality of voice. Men typically have lower voice pitch than women. A man’s voice whose pitch is high or a woman’s pitch that is low attracts attention. If the receiver of communication pays more attention to the voice than to the message, though, communication is impaired (Van Riper & Erickson, 1996). When young boys’ voice pitch changes during puberty, attention is drawn to the boys and their unintentional changes in voice. Of course, this pitch change is a normal part of development and disappears as the boy’s body grows and voice pitch becomes stabilized.

**Loudness** is the other main aspect of voice. In some cases, people are labeled with certain personality traits because of the loudness of their voices: In some cases, if the quality of voice is so distracting that the message is misunderstood or lost, speech therapy is probably necessary.

**Quality** disorder is called dysphonia. The voice can be hoarse, harsh or breathy.

1. Articulation Problems

**Articulation problems** are the most common speech impairments (Van Riper & Erickson, 1996). Articulation is the process of producing speech sounds. Articulation disorders refer to the abnormal production of speech sounds. The receiver of communication must understand the sounds of the words spoken to understand the full message. If speech sounds are incorrectly produced, one sound might be confused with another, changing the meaning of the message.

Articulation is related to the speaker’s age, culture, and environment (Boone &Plante, 1993). Articulation disorders include substitution, omission, addition and distortion. Compare the speech of a 3-year-old child, a 10-year-old, and an adult. Some of the most common articulation errors young children make are substitutions and distortions of the *s* and *z* sounds and substituting a *w* for an *l* and a *w* for an *r*.

1. Fluency Problems

Fluency is the flow of speech. Fluency and speech timing difficulties are associated with the rate and flow pattern of a person’s speech. A fluency problemusually involves hesitations or repetitions that interrupt the flow of speech. Stutteringis one type of fluency problem. Some young children (ages 3 to 5) often demonstrate dysfluencies(nonfluencies) in the course of normal speech development, but they are not usually indicative of a fluency problem. Adult speech is not always smooth and fluent either. Even the best of speakers find times when they are dysfluent—when they hesitate in the middle of sentences, repeat parts of words, speak very quickly, or insert fillers such as “you know,” “like,” or “umm” in their speech. Dysfluencies are likely to occur in exciting, stressful, or uncommon situations.

#### *Language Impairments*

Language is the second major area within the special education category referred to as speech or language impairments. It is the complex system we use to communicate our thoughts to others. Oral language is expressed through the use of speech sounds that are combined to produce words and sentences. Other language systems, such as manual communication or sign language, use gestures or other means of communication, but not speech sounds .Language impairment is Delayed or deviant development of comprehension and/or us of the signs and symbols used to express or receive ideas in a spoken, written, or other symbol system. A language disorder appears or exists without other disabilities. There are three aspects of language: form, content, and use and language impairment might exist in these aspects.

### Causes of Communication Disorders

1. Speech Impairments

In general, the known causes of speech impairments are varied and include:

1. brain damage
2. malfunction of the respiratory or speech mechanisms, or
3. malformation of the articulators.. For example, many individuals with severely misaligned teeth cannot articulate well.
4. A cleft lip or palate affects the ability to produce oral speech. Most cleft lips can be repaired through plastic surgery and do not have a long-term effect on articulation. A cleft palate, however, can present continual problems because the opening of the palate and the roof of the mouth allows excessive air and sound waves to flow through the nasal cavities. The result is a very nasal-sounding voice and difficulties in producing some speech sounds, such as *s* and *z.* A cleft palate is one physical cause of a speech impairment that requires the intensive work of many specialists (plastic surgeons, orthodontists, and Speech and LangugePathologists).
5. Voice problems are not as common in schoolchildren, although they can be symptomatic of a medical problem. For example, conditions that interfere with muscular activity, such as juvenile arthritis, can result in a vocal disturbance.
6. Voice problems also can be caused by the way the voice is used: Undue abuse of the voice by screaming, shouting, and straining can cause damage to the vocal folds and result in a voice disorder. Rock singers frequently strain their voices so much that they develop nodules (calluses) on the vocal folds, become chronically hoarse, and must stop singing or have the nodules removed surgically.
7. Stuttering, a lack of fluency in speaking may be characterized by severe hesitations or the repetition of sounds and words. Although professionals can describe stuttering, they seem unable to agree on or explain a single cause (Silverman, 1996). They can, however, describe conditions when nonfluency is more likely to occur in stutterers. For example, stuttering is more likely to occur when the conversational situation is very complex or unpredictable (Weiss, 1995). It appears that stress makes its likelihood more probable.stuttering has been seen to run in families. About 71% of stuttering is related to genetics.
8. Language Impairments.

Many problems that fall into the area of language impairments have multiple causes.

1. As with **aphasia,** they can result from brain injury or disease that damages the central nervous system.
2. They can result from the inability to hear well at the time language should be developing. For example, children with chronic **otitis media,** or ear infections, often have associated difficulties with language development, possibly because of the interruptions in hearing language during the typical developmental periods or because of related health problems.
3. Some researchers have found a family connection with language impairments (Lahey& Edwards, 1995).
4. However, most often, poor language development is caused by various environmental factors, including the lack of stimulation and proper experiences for mental development and learning language. Environmental factors also affect children’s abilities to acquire language and become proficient in its use. Some children do not develop language because they have no appropriate role models. Some are left alone too often; others are not spoken to frequently. Some are punished for speaking or are ignored when they try to communicate.
5. Language delay: Children with delayed language generally acquire language in the same sequence as their peers but do so more slowly. Many of these children do not have a disability and catch up with their peers.

## Giftedness and Talent Development

Individuals who have high levels of intelligence, are high achievers academically, are extremely creative, or have unique talents are not handicapped in the sense of having a disability. Certainly, they do not face the limitations or the difficulties that most children who receive special education services do. However, many of these individuals, because of their differences, are handicapped by society and our educational systems. They can be stifled by educational approaches that do not challenge or develop their cognitive abilities or that do not allow them to learn academic content at an accelerated pace. Sometimes directly and sometimes indirectly, peers, teachers, and parents discourage them from developing their abilities maximally. Some believe that the result is a significant loss to the individuals and to society in general (Gallagher, 1985). failure to help gifted children reach their potential is a societal tragedy, the extent of which is difficult to measure but which is surely great.

### Types of Giftedness and Talents

The field of gifted education is currently experiencing a time of transition (Coleman, 1996; Feldhusen, 1995). Accepted philosophies, beliefs about what the concept of “giftedness” means, and the value of gifted education are being challenged.

***Traditional Perspectives.*** As early as 1925, Terman studied individuals with exceptionally high cognitive aptitude. He considered children **gifted** who score in the highest 1 percent (having scores over 140) on an intelligence (IQ) test. Terman’s definition reflects a narrow view of giftedness in which high intelligence is closely associated with high academic achievement. In addition to tying giftedness to a score on an IQ test, Terman also believed that intelligence is a fixed characteristic, one people are born with and one that does not change positively or negatively across time. From his perspective, intelligence is determined solely by heredity; it is a trait inherited from your parents. Today’s professional educators are much less confident than Terman was in the results from standardized tests, believing that such tests can bias against individuals who are not from the dominant American culture. In contrast to Terman’s view, researchers now believe that intelligence, like any other trait, is influenced by both genetics and environment (Hunsaker, 1995). Gifted and talented children are those identified by professionally qualified persons who by virtue of outstanding abilities are capable of high performance. Children capable of high performance include those with demonstrated achievement and/or potential ability in any of the following areas singly or in combination:

1. General intellectual aptitude.
2. Specific academic aptitude.
3. Creative or productive thinking.
4. Leadership ability.
5. Visual and performing arts.

***Broadened Concepts.*** Most researchers today believe that giftedness is multidimensional, with high academic aptitude or intelligence being only one factor. For example, Renzulli (1978; Renzulli& Reis, 1997) suggested that those who have three clusters of characteristics—above-average intelligence, high **creativity**, and substantial task commitment—should be considered gifted.

Gardner, in 1983, proposed an even broader view of intelligence and giftedness. Although he first proposed his theory of multiple intelligences over fifteen years ago, in a book entitled *Frames of Mind* (Gardner, 1983), it is now receiving considerable attention. According to his multidimensional approach to intelligence, which provides an alternative view to the traditional one of IQ, “human cognitive competence is better described as a set of abilities, talents, or mental skills that we have chosen to call intelligences” (Ramos-Ford & Gardner, 1991, p. 56). Through careful study of human behavior and performance, Gardner concludes that there are seven dimensions of intelligence and that a person can be gifted in any one or more of these areas. Verbal – Linguistic, Logical – Mathematical, Visual – spatial, Body – Kinaesthetic, Musical – Rhythmical, Interpersonal and Intrapersonal

### Talent Development

The concept of **talent development** is gaining acceptance and may well be the focus of new innovative efforts for able youngsters. Feldhusen (1995) believes that the development of talent is the responsibility of the home, school, and community. It is for family members, stimulating teachers, peers who value developing abilities and experts who are successful in a variety of fields who serve as mentors to help students develop their aptitudes into outstanding abilities and achievements. Acceptance is the foundation all children need to develop their abilities; the vertical rays represent the wide array of learning experiences required to develop talent; these experiences lead to the necessary self-understanding of the talents and abilities possessed by gifted individuals; and finally the importance of commitment from individuals to develop their abilities into skills and talents is stressed. Feldhusen (1992) proposed four basic domains that schools can address: academic, artistic, vocational, and personal- social. What might the areas of focus be under this new endeavortoward talent development? Gagné (1996) proposed talent fields relevant to schoolchildren for development: academics, games of strategy (chess, puzzles, and video games), technology, arts, social action, business, and athletics. Gardner (Ramos-Ford & Gardner, 1991) would probably propose focusing on talent development for each of his seven multiple intelligences. Van Tassel-Baska (1995) advocated an integrated curriculum for talent development that includes the following dimensions: advanced content knowledge, higher-order thinking and processing skills, learning experiences developed along themes and ideas relevant to real-world issues

### Causes: Factors That Enhance or Inhibit Giftedness

Throughout the history of gifted education, people believed that genetics is the primary factor. The work of Terman, in the 1920s, also reflected this view. Today, however, researchers recognize the important roles that both the environment and heredity play in the development of the intellect (Hunsaker, 1995; Simonton, 1997).

Research has shown that factors such as cultural values and expectations, socioeconomic level, birth position (for example, firstborn), and number of children in the family are related to giftedness (Terman, 1925). Environmental stimulation also correlates with gifted abilities. But environmental factors can also diminish giftedness. For example, children whose early experiences are not rich or diverse often do not develop outstanding cognitive skills, and children who are not challenged in school do not develop their potential. Today, superior abilities are generally recognized as developing from an interrelationship between heredity and the environment.

Many factors enhance or inhibit giftedness. For example, boredom can inhibit giftedness; Intelligence and talent are not fixed. Although heredity plays a crucial, perhaps even dominant, role in an individual’s intellectual abilities and developed talent, other factors are also important, including the environment, the individual’s life experiences, and others’ expectations. Major environmental factors—wars, famines, social upheavals—can affect the potential of any individual. Certainly, prenatal malnutrition, isolation, neglect, abuse, insufficient infant stimulation, and poor medical treatment can have devastating effects on development of the intellect.

Another factor that can inhibit some aspects of giftedness is the way children grow up. As Renzulli (1978) observed, many young children are inherently creative, yet relatively few adults are. What happens to these children during their preschool and early elementary years? Were they really not creative in the first place? Or is creativity discouraged by our society? Teachers favor highly intelligent students who do well academically but are not able in other areas. Even children’s peer groups criticize divergent, independent, and imaginative behavior among their creative friends. Many educators tend to encourage realism instead of imagination:

## Behaviour and Emotional Disorders

Behavior disorders and emotional disturbanceare difficult to define. In fact, some think that people are identified ashaving this disability “whenever an adult authority said so” (Hallahan &Kauffman, 1997, p. 212)**.** A conditionof disruptive or inappropriatebehaviors that interferes with astudent’s learning, relationshipswith others, or personal satisfactionto such a degree that interventionis required.A termthat is often used interchangeablywith behavior disorder.

In other words, in many cases the application of the definition is subjective. The term means a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance:

* An inability to learn that cannot be explained by intellectual, sensory, or health factors;
* An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
* Inappropriate types of behaviour or feelings under normal circumstances;
* A general pervasive mood of unhappiness or depression; or
* A tendency to develop physical symptoms of fears associated with personal or school problems.

The term emotional or behavioural disorder means a disability characterized by behavioural or emotional responses in school so different from appropriate age, cultural, or ethnic norms that they adversely affect educational performance. Educational performance includes academic, social, vocational, and personal skills. Such a disability:

* is more than a temporary, expected response to stressful events in the environment;
* is consistently exhibited in two different settings, at least one of which is school related; and
* is unresponsive to direct intervention in general education, or the child’s condition is such that general education interventions would be insufficient. Emotional and behavioural disorders can co-exist with other disabilities. This category may include children or youths with schizophrenic disorders, affective disorders, anxiety disorder, or other sustained disorders of conduct or adjustment when they adversely affect educational performance

### Types of Behaviour disorders

Behaviour disorders and emotional disturbance are often categorized by whether they are primarily externalizing (typically aggressive) behaviour problems, internalizing (typically withdrawn) behaviour problems, and low-incidence disorders (e.g., schizophrenia). Of course, there are other ways of classifying these disorders( Smith, 1998). To us, using the classification scheme of externalizing behaviours and internalizing behaviours is both practical and of educational value. Regardless of the classification scheme used, some of these conditions are more disturbing to other people—though not necessarily more serious—resulting in some disorders not being identified early enough or being left untreated. Because externalizing behaviour disorders are so obviously disruptive to other people in the environment, they are often identified more quickly in school settings than internalizing behaviour problems (Landrum, Singh, Nemil, Ellis, & Best, 1995). As a result, children with internalizing disorders are not always identified and therefore do not always receive appropriate special educational services.

#### *1.6.1.1. Externalizing Behaviour Problems.*

Are aggressive behaviours expressed outwardly, usually toward other persons. Some typical examples are hyperactivity, a high level of irritating behaviour that is impulsive and distractible, and persistent **aggression**.

**Hyperactivity** is probably one of the most common complaints about children referred for evaluations as having behaviour disorders and emotional disturbance. Hyperactivity is difficult to define, however, because any definition must consider both the nature and type of activity. Judgment about whether a certain level of a specific activity is too much or “hyper” is often subjective. If, for example, the activity is admired, the child might be described as energetic or enthusiastic rather than hyperactive.

Hyperactivity may be manifested by fidgetiness or squirming in one’s seat, by not remaining seated when expected to do so, by excessive running or climbing in situations where it is inappropriate, by having difficulty playing or engaging quietly in leisure activities, by appearing to be often “on the go” or as if “driven by a motor,” or by talking excessively. (American Psychiatric Association, 1994, p. 79)

**Aggression** may be turned toward objects, toward the self, or toward others. aggression in two of the disorders it describes:

1. conduct disorders a recurrent pattern of negativistic, defiant, disobedient, and hostile behaviour toward authority figures… and
2. oppositional defiant disorder. is characterized by: losing temper, arguing with adults, actively defying or refusing to comply with the requests or rules of adults, deliberately doing things that will annoy other people, blaming others for his or her mistakes or misbehaviour, being touched or easily annoyed by others, being angry and resentful, or being spiteful or vindictive. (American Psychiatric Association, 1994: 91)

Aggressive behaviour, particularly when observed in very young children, is particularly worrisome. This is not just because of the behaviour itself—which should not be minimized—but because of its strong correlation to long-term problems (dropping out of school, delinquency).

**Delinquency,** or juvenile delinquency, is defined by the criminal justice system rather than the medical or educational system. Delinquency refers to illegal acts committed by juveniles, which could include crimes such as theft or assault.

#### *1.6.1.2 Internalizing Behaviour Problems.*

Internalizing behavioursare typically expressed through social withdrawal. Anorexia, bulimia depression and anxietyare examples of internalizing behaviours.

**Depression** is often difficult to recognize in children. Its components include guilt, self-blame, feelings of rejection, lethargy, low self-esteem, and negative self-image. Children’s behaviour when they are depressed may appear so different from the depressed behaviour of adults that teachers and parents may have difficulty recognizing the depression.

**Anxiety disorders** may be demonstrated as intense anxiety or separation from family, friends, or a familiar environment, excessive shrinking from contact with strangers, or unfocused, excessive worry and fear. Anxiety disorders are difficult to recognize in children.

#### *1.6.1.3 Low-Incidence Behaviour and Emotional Disorders.*

Some disorders occur very infrequently but are quite serious when they do occur. For example, schizophrenia, Tourette’s syndrome.

**Schizophrenia**, sometimes considered a form of psychosis or a type of pervasive developmental disability (American Psychological Association, 1994), is an extremely rare disorder in children. It usually involves bizarre delusions (such as believing thoughts are controlled by the police), hallucinations (such as voices telling the person what to think), “loosening” of associations (disconnected thoughts), and incoherence. Schizophrenia is most prevalent between the ages of 15 and 45, and experts agree that the earlier the onset, the more severe the disturbance in adulthood (Newcomer, 1993). Children with schizophrenia have serious difficulties with schoolwork and often must live in special hospital and education settings during part of their childhood.

**Tourette’s syndrome**. This disorder is characterized by multiple tics (sudden, rapid, recurrent, and stereotyped motor movements or vocalizations).These individuals might engage in uncontrollable movements at different locations in the body. Or, they may make strange noises or say inappropriate words or phrases. Or, they may have both motor and verbal tics. The verbal tics may be sounds like grunts, yelps, snorts, barks, or obscenities. This disorder causes considerable distress to the individual involved and impairs all aspects of the person’s life (American Psychiatric Association, 1994).

**Causes**

At least three general areas can contribute to behaviour disorders and emotional disturbance: biology, home and community, and school. Again, the reasons for problems in a particular child are difficult to identify, and the disability is likely to be the result of multiple and overlapping factors.

1. ***Biology.*** As researchers have discovered and continue to look for biological causes for some types of disorders (e.g., foetal alcohol syndrome [FAS], Down syndrome, autism, Tourette’s syndrome), they are seeking biological causes for behaviour disorders and emotional disturbance. Their efforts are beginning to yield some results. For example, there may be a biological dimension to a psychological disorder such as anorexia or bulimia. Mood disorders, depression, schizophrenia, and attention deficit disorder may have a genetic foundation (American Psychiatric Association, 1994).
2. ***Home and Community.*** Children, like older people, do not live in a social vacuum. They are members of an immediate family, an extended family, and a variety of communities (neighbourhood, church, clubs). All of these units comprise the environments that shape and influence each individual’s growth and development whether positive or negative. No single negative experience can lead to or aggravate emotional problems, but combinations of abuse, neglect, inconsistent expectations and rules, confusion, and turmoil over long periods of time can. So, too, can lack of supervision, erratic and punitive discipline, low rate of positive interactions, high rate of negative interactions, lack of interest and concern, and poor adult role models. For example, children whose parents are violent and have arrest records also tend to become violent and find themselves in trouble with the law (Hallahan & Kauffman, 1997). On the other hand, healthy interactions, such as warmth and responsiveness, consistent discipline, demand for responsible behaviour, along with modelling, teaching, and rewarding desired behaviours can promote positive behaviours in children. Many children who might otherwise be able to avoid emotional disturbance become vulnerable when faced with stressors such as family disruption, poverty, death, illness, and violence

Just as it is important to recognize the powerful influence home and community environments can have on child development, it is also important to understand that there is not always a direct correlation between parents’ and their child’s behaviour. Parents of these children often are wrongfully blamed for their children’s misconduct, unruliness, and disruptive actions (Ahearn*,* 1995). Educators must always remain professional and cautious in casting blame or judging fault.

1. ***School.*** Teachers have tremendous influence in their interactions with students. Teachers’ expectations influence the questions they ask students, the feedback they give, and the number and character of interactions with students. Problems can get better because of teachers’ actions, and they can get worse. In other words, what educators do makes a difference Rivera, 1993). Good teachers are able to analyze their relationships with their students and the learning environment, and they keep close watch on problems and potential problems.

## Learning Disabilities

Learning disabilities (LD) is disability in which the individual possesses average intelligence but is substantially delayed in academic achievement.

“**Specific learning disability**” means a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, that may manifest itself in an imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations. The term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. The term does not apply to children who have learning problems that are primarily the result of visual, of hearing, of motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantages. (U.S. Department of Education, 1992)

The National Joint Committee on Learning Disabilities’ definition is as follows: “Learning disabilities” is a general term that refers to a *heterogeneous group of disorders* manifested by significant difficulties in the acquisition and use of *listening,speaking, reading, writing, reasoning or mathematical abilities.* These disorders are intrinsic to the individual, *presumed to be due to central nervous system dysfunction,* and may occur across the *life span.* Problems in *self-regulatory behaviours, socialperception, and social interaction* may exist with learning disabilities but do not by themselves constitute a learning disability. Although learning disabilities *may occur concomitantly* with other handicapping conditions (for example, sensory impairment,mental retardation, serious emotional disturbance) or with extrinsic influences(such as cultural differences or insufficient or inappropriate instruction),they are not the result of those conditions or influences. (National Joint Committeeon Learning Disabilities, 1988:1)

### Types of Learning Disabilities

Because learning disabilities are manifested in different ways with different individuals, there is no uniform classification system for students with learning disabilities. Although these students have normal intelligence, they do not achieve academically as well as could be expected.

Learning problems specific and confined to one or two cognitive areas interfering with efficient learning is usually discovered only by working individually with that person. Practitioners typically do not further divide this large group of diverse learners into specific types. Although for many years researchers have worked to identify groups of individuals with learning disabilities, definitive groups have not yet been identified. Some researchers are focusing on subtypes by academic area, and others are focusing on psychological processes (Shafrir& Siegel, 1994). Other researchers are working to identify a clear neurological basis for many learning disabilities (Rourke, 1994). Despite the diversity in types of learning disabilities, however, professionals have observed some characteristics common to these individuals.

1. One is their difficulty in reading and writing.
2. Their academic achievement in reading is significantly below the levels of their non disabled classmates and is the most common reason for referrals to special education. In fact, reading problems are the basis for referral twice as often as mathematics problems (Kavale& Reese, 1992). Reading and writing, obviously, are important skills; in school, students must be able to read information from a variety of texts (social studies, science, literature) and write in varying formats (essays, reports, creative writing, notes).
3. As the complexity of academic tasks increases, students who are not proficient in reading and writing cannot keep pace with the academic expectations of school settings. A small percentage of students with learning disabilities have difficulties only in mathematics; however, most find *all* areas of academics challenging For example, those with severe reading problems were called dyslexic. Students with writing disorders were said to have **dysgraphia,** and those unable to learn mathematics readily had **dyscalculia.**

Causes of learning disabilities

People with learning disabilities comprise a heterogeneous group of individuals. Their learning disabilities are manifested in different ways and at different levels of severity. Unfortunately, researchers do not have much concrete information about the causes of learning disabilities (Bender, 1992; Hallahan, Kauffman, & Lloyd, 1996). As the field has wrestled with definitions of learning disabilities, so too has argued over the causes of the problem. At this point let us have a look at some factors responsible for learning disabilities.

1. Some students may have a central nervous system dysfunction that inhibits their learning.
2. Some may have proven brain damage—caused by an accident or by a lack of oxygen before, during, or after birth—resulting in neurological difficulties that affect their ability to learn.
3. Some may have inherited their disability (Decker &Defries, 1980, 1981; Oliver, Cole, & Hollingsworth, 1991). A gene has now been identified that may be responsible for reading problems (New Mexico Learning Disabilities Association, 1994).
4. Diet and various environmental factors have also been suggested as causes of learning disabilities.
5. Although not proposing that ear infections cause learning disabilities, Reichman and Healey (1983) did find an interesting connection between otitis media and children identified as having learning disabilities. They found that chronic and early incidence of otitis media was twice as common in children identified as having learning disabilities as in those without learning disabilities. They maintain that mild hearing losses could make these children at risk for developing delays in auditory, language, and academic skills. There does seem to be a connection between language impairments and learning disabilities (Wallace & Butler, 1995). Gibbs and Cooper (1989) found that 96 percent of their sample with learning disabilities had either a speech, a language, or a hearing problem.
6. Yet others (Englemann, 1977; Lovitt, 1977) maintain that some of these children may have serious difficulties learning academic material because early on they were poorly taught basic academic skills. Why do children with learning disabilities not learn as efficiently or in the same way their classmates do?
7. Some professionals (Hallahan & Bryan, 1981) believe that individuals with one type of deficit are unable to focus their attention constructively: Their **selective attention,** or ability to attend to relevant rather than irrelevant features of a task, is faulty. Such children might have difficulty dealing with distractors in arithmetic word problems. Others might have trouble distinguishing important from unimportant facts presented in a lecture and remembering them.

## Intellectual Impairment

Over the years, many definitions of **Intellectual Impairment** formally called **mental retardation** have been developed, but they are all very similar. Most refer in some way to intelligence and an impaired ability to learn. Some definitions also refer to limitations in the everyday behaviours necessary to function independently. Still others stress a certain age by which the condition must have begun, and some require that the disability be incurable. Some definitions require physical proof of the disability or a physical origin for the mental retardation. The 1983 American Association on Mental Retardation (AAMR) definition of mental retardation appeared in *Classification in Mental Retardation* (Grossman, 1983). (AAMR was formerly called the American Association on Mental Deficiency.) Although considered outdated, this definition is still used by many groups and is the basis for the definitions developed by many states.

Intellectual Impairment refers to significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behaviour, and manifested during the developmental period.

The definition is implemented by applying criteria to its three major components: intellectual functioning, **adaptive behaviour**, and developmental period. Deficits in intellectual functioning means that individuals must score below 70–75 on a standardized test of intelligence. Adaptive behavior is defined by how well an individual meets society’s expectations for social responsibility and personal independence in accordance with that person’s age and cultural group. The third component, developmental period, requires that the disability occur before age 18.

 In 1992, AAMR supported the development of a new definition of mental retardation. This one is less rigid; it is not as dependent on scores from, now often criticized, tests of intelligence, and is more modern by reflecting society’s changing attitudes about the needs of people with this disability.

*Mental retardation* refers to substantial limitations in present functioning. It is characterized by significantly sub average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work.

Types

Regardless of the definition used, mental retardation varies along a continuum. Most individuals with mental retardation score near the 70–75 cut-off score on IQ tests, have mild cognitive impairments, and usually require few supports. Typically, those individuals with lower IQ scores require considerable supports.

***Older Classification Systems.*** Since the development of the intelligence (IQ) test, around the turn of the century, people have been grouped, classified, and served on the basis of the score they received on one of these tests. One classification method, popular among educators in the 1960s and 1970s, distinguished educable mental retardation (EMR) from trainable mental retardation (TMR). These subgroups were directly linked to IQ scores. The EMR label was reserved for those individuals who scored between 50 and 80 (the ceiling was higher in those days), and the TMR label was used for those individuals who scored between 25 and 50. The use of EMR and TMR came into disfavour, possibly because educators knew that *all* people can learn and that education and training should not be separated. Also, perhaps they realized that suggesting that certain human beings were merely trainable sounded like an unfortunate comparison to animals. Since passage of IDEA in 1975, distinctions between education and training has blurred.

Today, we understand that all children are capable of learning and have the right to education. The 1983 AAMR definition attempted to address these problems by dividing mental retardation into four levels: mild, moderate, severe, and profound

(Grossman, 1983). These sub classifications were used to compare an individual with others who had mental retardation. Mild mental retardation, as for those in the EMR group, referred to a disability that was less severe. Notice that this classification system has two more groups: severe and profound. Before IDEA, these children were not likely to find their place in public schools, but since its passage in 1975, educators recognize their responsibility to educate all children, and these two new groups were added to the 1983 definition.

***Emerging Classification Systems.*** The 1992 AAMR definition provides a new classification

system based on an individual’s needs for supports. Unlike the older systems, individuals were no longer classified by their IQ scores. This might be one of the most significant differences between this definition and all previous ones. The 1992 definition describes a profile and intensities of needed supports on levels from least intense to most intense: intermittent (I), limited (L), extensive (E), and pervasive (P). These levels refer to the services and supports the individual, whatever his or her IQ, needs in order to function in the environment.

### Causes of Mental Retardation

Mental retardation is caused by many factors. Understanding a few facts related to causes of mental retardation can be helpful: Typically, factors interact in complex ways to cause mental retardation. Some authors suggested that the causes of mental retardation be grouped according to the time of onset (Smith, 1998) . Using this system, the causes of mental retardation are organized into three groups:

1. **Prenatal** causes, including chromosomal disorders, syndromes, inborn errors of metabolism, developmental disorders of brain formation, and environmental influences;
2. **Perinatal** causes, including intrauterine disorders and neonatal disorders; and
3. **Postnatal** causes, including head injuries, infections, toxic-metabolic disorders, malnutrition, environmental deprivation, and any other conditions causing mental retardation after birth.

**a. Prenatal Causes.**

Many cases of mental retardation have their onset before birth, during the prenatal period. The origin of some cases are genetic, others are not. For example, maternal infections and toxins ingested by pregnant women can seriously affect their unborn babies, and many of these cases are preventable. Let’s first turn our attention to genetic causes.

**Genetic Causes. Down syndrome** is an example of retardation with a biological cause. In England, Down syndrome occurs at a rate of 12.6 per 10,000 live births, and in the United States that rate is 7.63 per 10,000 births (Thomson, Ward, &Wishart, 1995). In England, it accounts for one-third of all children with severe learning difficulties, but here Down syndrome accounts for less than 10 percent of all individuals with mental retardation. It is, however, the most common specifically identified genetic cause of mental retardation (Jutkiewicz, 1994). Down syndrome is a chromosomal abnormality. Each human cell normally contains 23 pairs of chromosomes (a total of 46) in its nucleus. In the most common type of Down syndrome, trisomy 21, the 21st pair of chromosomes has three rather than the normal two. Certain identifiable physical characteristics, such as an extra flap of skin over the innermost corners of the eyes (an **epicanthic fold**), are usually present when the individual has Down syndrome. In Down syndrome, the child’s degree of mental retardation varies, in part depending on the speed with which the disability is identified, the adequacy of the supporting medical care, and the timing of the early intervention.

**Fragile X syndrome** is a recently identified inherited genetic disorder associated with mental retardation (Hagerman & Silverman, 1991; Schopmeyer& Lowe, 1992). Now that doctors know about this syndrome, it may prove to be the most common genetic form of mental retardation. The degree of cognitive, physical, and behavioral impairment in an affected individual may range from mild to severe. Fragile X syndrome may also be implicated in other disabilities, such as learning disabilities, attention deficit disorders, autism, and behavior and emotional disturbance (Santos, 1992).

**Phenylketonuria (PKU)**, also hereditary, occurs when a person is unable to metabolize phenylalanine, which builds up in the body to toxic levels that damage the brain. If untreated, PKU eventually causes mental retardation. Changes in diet eliminating certain amino acid proteins such as milk) can control PKU and prevent mental retardation. So, here is a condition rooted in genetics, but it is the chemicals in milk which become toxins to the individuals affected that cause the mental retardation.

**Toxins.** Alcohol, cigarettes, and other drugs taken by mothers during pregnancy can cause mental retardation in their children. Mothers who drink, smoke, or take drugs place their unborn children at serious risk for premature birth, low birth weight, and mental retardation. For example, one study found that women who smoked heavily during the last six months of pregnancy were 60 percent more likely to have children with mental retardation (Bergstein, 1996). The connections in these cases can be compounded by a combination of smoking and drinking alcohol during pregnancy. One of the top three known causes of birth defects is **fetal alcohol syndrome(FAS)** (Griego, 1994). FAS—a condition that manifests with mental impairments, behaviour problems, and usually some physical differences, particularly facial features— is caused by the mother’s drinking alcohol during pregnancy (March of Dimes, 1993). The children afflicted with this preventable condition and their families are often devastated (Dorris, 1989). FAS occurs when alcohol in the mother’s bloodstream crosses the placenta and enters the baby’s bloodstream.. Expectant mothers’ use of drugs places infants at risk for mental retardation in many ways, all dangerous for the baby. Although longitudinal research has not yet definitively identified the long-term effects of prenatal drug exposure, the risks are great (Mandell& Stewart, 1994). The first danger is with the toxin she is exposing her child to. For example, when a pregnant woman uses cocaine, crack, or heroin, the infant also experiences the drug. As with alcohol, these drugs can damage the developing baby and can result in serious mental, physical, and social problems. Many of them are born addicted to the drug and must go through the agony of withdrawal. In addition, drug-using parents are often unable to provide the care and nurturing required for healthy infant development after birth.

**Disease.** Viruses such as rubella, meningitis, and measles can cause mental retardation, although programs of immunization have decreased the incidence o mental retardation from these infections. However, immunization programs are still not provided for all children. The needle sharing that often accompanies some drug use is one of the culprits in the spread of AIDS, and that spread can be to unborn babies as well. Sexually transmitted diseases such as syphilis, gonorrhoea, and **HIV infection** (AIDS) can cause mental retardation in the unborn child. The HIV virus has been found in blood and other bodily fluids, especially semen and vaginal secretions, and in rare instances in breast milk. HIV infection is transmitted most frequently through needle sharing or unprotected sexual intercourse with an infected person. Many pregnant women who are HIV-positive pass the infection to their unborn children, who are then born with a variety of disabilities, including mental retardation. The consequences of HIV infection for infants are devastating. The central nervous system is damaged, opportunistic infections cause progressive disability requiring prolonged hospitalization, and psychosocial factors and nutritional deficiencies lead to a chaotic and painful time before early death.

**Neural Tube Defects.** Anencephaly—where most of the child’s brain is missing at birth—and spina bifida—an incomplete closure of the spinal column—can result from the health and condition of the expectant mother. For example, obese mothers are twice as likely as thinner mothers to have babies with neural tube birth defects (Tanner, 1996). With the recent rise in obesity, an estimated 10 percent of women in the childbearing years are at risk.

***b.* Perinatal Causes.**

Although not as common a cause as prenatal and postnatal factors, problems can develop at the actual time of birth. The birth process can be dangerous to both mother and child and can result in a variety of disabilities,

including mental retardation. Let’s look at a few of these.

**Birth Injuries.** Deprivation of sufficient oxygen (**anoxia** or **asphyxia**), umbilical cord accidents, obstetrical trauma, and head trauma can result in serious and permanent damage to the baby. The brain requires a certain amount of oxygen in order to function. Deprivation of oxygen will lead to death in a relatively short period of time. An even shorter period of oxygen deprivation or oxygen saturation can cause damage to the brain, often resulting in cerebral palsy (which may or may not result in mental retardation).

**Low Birth weight.** The survival of very tiny premature infants has led to a new cause and increased numbers of individuals with mental retardation (Haney, 1994). Medical advances of the 1980s now make the probability of infants born under two pounds surviving quite commonplace. The medical costs of these babies’ first few months of life can run into the hundreds of thousand dollars, but for many of these infants and their families the greater cost is the resulting disabilities. Fortunately, not all of these infants grow up to have a disability. For the others, their disabilities vary greatly. Some have visual problems; others have motor problems; some have subtle learning problems; and many have substantial cognitive impairments. Why do some of these children have substantial and continuing problems? There must be many reasons, but it appears that one answer may lie in a lack of strong parental support (Bates, 1996). On the average, children and teenagers who were low-birth weight babies lag behind their peers on every academic measure, and these problems persist.

***C.* Postnatal Causes*.***

Many cases of mental retardation begin after birth but during the early years of life, during the developmental period. The preschool years are crucial to the development of every child, and the events—experiences, illnesses, and accidents—that occur in this period can seriously impact the youngster.

**Child Abuse and Neglect.** Abused children have lower IQs and reduced response rates to cognitive stimuli (*Youth Record,* 1995). In a recent study conducted in Canada that compared abused children with nonabused children, the results of abuse become clear. The verbal IQ scores and the pulse rate changes between the two groups of otherwise matched peers were very different: The abused children had an average total IQ score of 88, whereas their nonabused peers’ average overall IQ was 101; and the more abuse, the lower was the IQ score. The link between child abuse and impaired intellectual functioning is now definite, but the reasons for the damage are not. Rather than the result of brain damage, the disruption in language development caused by the abusive situation may be the cause of permanent and profound effects on language ability and cognition.

**Toxins.** Toxins abound in our environment. All kinds of hazardous wastes are hidden in neighbourhoods and communities. In many cases, the environment was polluted before the dangers of chemicals and poisons were known. In some cases, the environment was polluted because of carelessness. One toxin now known to cause mental retardation is lead. Two major sources of lead poisoning can be pinpointed. One was exhaust fumes from leaded gasoline. The other source is lead-based paint, which is no longer manufactured. Unfortunately, it remains on the walls of older apartments and houses. Children can get lead poisoning from a paint source by breathing lead directly from the air or eating paint chips.

**Accidents.** Injury, **trauma**, and accidents are major causes of many types of disabilities, including mental retardation. Children under the age of 18 who suffer brain injuries—in automobile or cycle accidents, falls, near drownings—may acquire mental retardation.

## Physical Impairments and Special Health Care Needs

You realise that this topic has two major sub categories:

Children with physical impairments—those youngsters who have a problem with the structure or the functioning of their bodies—are referred to as having orthopaedic impairments, a condition that adversely affects a child’s educational performance. The term includes impairments caused by congenital anomaly (e.g., clubfoot, absence of some member, etc.), impairments caused by disease (e.g., poliomyelitis, bone tuberculosis, etc.), and impairments from other causes (e.g., cerebral palsy, amputations, and fractures or burns that cause contractures). (U.S. Department of Education, 1992) and:

Children with health impairments—who have limitations in their physical well-being and require ongoing medical attention—also have special needs at school. these children do not have strength, vitality or alertness, due to chronic or acute health problems such as a heart condition, tuberculosis, rheumatic fever, nephritis, asthma, sickle cell anaemia, haemophilia, epilepsy, lead poisoning, leukaemia, or diabetes, that adversely affects a child’s educational performance. (U.S. Department of Education, 1992)

### Physical Impairments

There are two types of physical impairments.

This organizational scheme created two major groupings: **neuromotorimpairments** and **muscular/skeletal conditions**.

#### *Neuromotor Impairments*

When the central nervous system (the brain and the spinal cord) is damaged, a serious neurological impairment that limits muscular control and movement often results. It is likely that all educators sometime during their careers will work with children who have some type of neuromuscular impairment; probably either epilepsy or cerebral palsy. Although less likely, they might also work with students who have spinal cord (neural tube) disorders.

1. Seizure disorders ***Epilepsy,***the most common type of neuromotor impairment in children. A person with **epilepsy** often has recurrent seizures resulting from sudden, excessive, spontaneous, and abnormal discharge of neurons in the brain. This can be accompanied by changes in the person’s motor or sensory functioning and can also result in loss of consciousness (Epilepsy Foundation of America, 1994a). **Seizures** may involve the entire brain (generalized seizures) or only a portion of the brain (partial seizures). It is treated with medications and frequently is well controlled without any effect on learning or motor skills.
2. **Cerebral palsy (CP**) *,* Cerebral palsy comprises a family of syndromes associated with disordered movement and posture. This condition is a result of damage, usually because of insufficient oxygen getting to the brain during its developmental period (United Cerebral Palsy Association, 1993). Cerebral palsy is most often congenital, with damage occurring either before (prenatally), during (perinatally), or immediately after (postnatally) the child’s birth. Some individuals, however, acquire cerebral palsy later, during the first three years of life. Acquired cerebral palsy is usually caused by brain damage resulting from accidents, brain infections, or child abuse. Cerebral palsy is not a disease, but rather a non-progressive and non-infectious condition.
3. **Spinal cord disorders** A neural tube birth defect, *spina bifida* is the improper closure of the protective tissue surrounding the spinal cord. It results in limited neurological control for organs and muscles controlled by nerves that originate below the level of the lesion. Increasing numbers of children have suffered traumatic head or spinal cord injuries resulting in permanent disabilities. Health care needs for both groups include good skin care, management of bladder and bowel care, and orthopaedic and physical therapy.

Typically, the result of injuries from accidents or abuse, *spinal cord injuries* can cause severe motor impairments and even paralysis.

1. **Polio** Caused by a viral infection, almost totally prevented in children immunized in the United States, *polio* attacks the spinal cord and can result in paralysis and motor disabilities. Health care needs parallel those for spinal cord disorders.
2. **Muscular dystrophy** An exceptionally rare, incurable, and progressive disease, *muscular dystrophy* weakens and (MD) then destroys the affected individual’s muscles. Health care needs centre on lung function support, prevention of pneumonia, and physical therapy. Multiple sclerosis A chronic disease typically occurring in adults, *multiple sclerosis* causes the myelin covering (MS) the nerve fibres of the brain and spinal cord to deteriorate, impeding the transmission of electrical signals from the brain to other parts of the body. Health care needs parallel those for MD.

#### *Muscular/Skeletal Conditions*

1. **Juvenile arthritis***Juvenile arthritis* is a disease caused by an autoimmune process resulting in swelling, immobility, and pain in joints. Health care needs include medication to suppress the process and orthopaedic and physical therapy to maintain function in small and large joints.
2. **Limb deficiencies Skeletal** problems in which the individual’s limb(s) are shortened, absent, or malformed. They may occur from congenital conditions or from injuries. Health care needs focus on adaptive interventions to support or improve functioning of the missing limb(s). Skeletal disorders *Dwarfism,* a condition caused by abnormal development of long bones, may result in varying degrees of motor disabilities. Health care needs may include human growth hormone to improve height.
3. ***Osteogenesisimperfector****,* sometimes known as brittle bone disease, is a condition in which normal calcification of the bone does not occur, leading to breakage and abnormal healing of bones with accompanying loss of height. Health care interventions include physical therapy and medical care.
4. ***Scoliosis****,* a curvature of the spine that occurs in children during puberty, may in severe form limit mobility of the trunk. Health care needs include monitoring of the amount of curvature of the spine and appropriate interventions to arrest the process. Although ranging in severity from mild to severe, these disabilities are usually very serious and affect these individuals in significant ways throughout their lives.

### Healthy Impairments

Many of us have experienced a serious illness sometime during our childhood; some illnesses, like appendicitis, even require surgery and hospitalization. In most cases, the illness is not long term and does not affect a substantial portion of our childhood or education. For some of us, the illness is serious and chronic. Some children do not require special education, and if they do (e.g., home-bound instruction), it is usually for only a short period of time.

**1. Chronic Illnesses.** For a small number of children, their illnesses are chronic, lasting for years, even a lifetime. Children with **chronic illnesses** often do not feel well enough to focus their attention on the instruction being presented. They also experience many absences, causing them to miss a substantial part of their education.

**a) Asthma** is a pulmonary disease and is the most common chronic illness of children. It is the leading cause of school absences among all the chronic diseases (Altman, 1993). A person with asthma usually has laboured breathing that is sometimes accompanied by shortness of breath, wheezing, and a cough. A combination of three events causes the wheezing: (1) tightening of the muscles around the bronchial tubes, (2) swelling of the tissues in these tubes, and (3) an increase of secretions in these tubes. Years ago, many people held a common belief that asthma is a psychological disorder. It is not; its origin is physical. Many factors (e.g., chalk dust, dirt in the environment) can trigger an asthma attack, including physical activity or exertion. Many of these students are unable to participate in sports or even in physical education activities. Teachers can fill a very special role by helping these individuals find other fulfilling activities in which to participate.

**b) Sickle cell anaemia**is a hereditary, life-threatening blood disorder. Although prevalent among African Americans and others whose ancestors are from the Mediterranean basin, it is not restricted to these groups of people. This condition causes the red blood cells to become rigid and take on a crescent, or sickle, shape. During what is called a “sickling crisis,” this rigidity and shape of the cells do not allow blood to flow through the vessels, depriving some tissues of oxygen and resulting in extreme pain, swollen joints, high fever, and even strokes. Some information about this condition is particularly important to educators who have students with sickle cell anaemia. First, there seems to be a correlation between the sickling crisis and emotional stress and strenuous exercise (Best et al., 1994; Heller et al., 1996).

**2. Infectious Diseases.** The second type of health impairment is **infectious diseases.** Many different diseases are contracted by schoolchildren. Most, like thecommon cold or the flu, are relatively short in duration and result in only a fewdays of missed school. The majority of infectious diseases that children contract atschool are not life-threatening or especially serious. Regardless, teachers can helpto reduce the spread of these diseases by practicing easy preventive measures.Most of these diseases, however, cannot be avoided for a variety of reasons. Forexample, some diseases are not contracted at school but are passed on to classmatesbefore the child became sick. We discuss two, serious and preventable,infectious diseases here.Human immunodeficiency virus (HIV) is a potentially fatal viral infectiontransmitted primarily through exchange of bodily fluids in unprotected sex or bycontaminated needles. It is the virus responsible for the deadly.

a) **acquired immunodeficiency syndrome (AIDS)** and can be communicated to a child by an infectedmother. Before blood-screening procedures were instituted, the virus was alsotransmitted in blood transfusions. The effects of the infection in children includecentral nervous system damage, additional infections, developmental delay,motor problems, psychosocial stresses, and death.

**b) Storch infections** are congenital and include many different viruses. Cytomegalovirus (CMV), a virus of the herpes group, is extremely common in children. Approximately 40 percent of children and most adults have been infected with the virus (Taylor & Taylor, 1989). Although usually harmless, infection from this virus in a foetus can lead to brain damage, blindness, and hearing loss.

Therefore pregnant women who do not have antibodies to the disease must protect themselves and their unborn children from CMV and other STORCH infections (syphilis, rubella, herpes, hepatitis).

STORCH stands for Syphilis, Toxoplasmosis, Others, Rubella, Cytomegalovirus and Herpes group

**Causes**

Just as there are many different illnesses, diseases, and conditions that result in disabilities, there are as many different causes, preventions, and treatments. Instead of discussing these specifically for each condition, we will focus on some common themes and use the conditions as examples.

There are almost as many causes for the conditions that result in physical impairments and special health care needs as there are conditions. They can be grouped into some general areas: infections, heredity, accidents and injuries, multiple factors, and “unknown.”

***Infections.*** The causes of some disabling conditions are clearly known and understood, although at this time they still cannot be cured. One such case is HIV infections. In children under age 13, the cause of HIV infection can be traced primarily to the risk behaviors of their parents. A few years ago, approximately 75 percent acquired the infection from their mothers before or at the time of birth and 20 percent acquired the infection from blood transfusions The virus is transmitted through bodily fluids. It appears that pregnant women who work in child care settings may have an increased risk of infection. Prenatal testing can determine whether CMV infection has occurred, but a vaccine is not yet available.

***Heredity****.* Genetic profiles are the cause of many disabling conditions. As we learn more about many of the conditions thought to have unknown causes, many cases appear to have a genetic link. Haemophilia, which occurs in only 1 in every 10,000 births, seems to be linked to the X chromosome because it is carried by the mother and passed on to the son. Muscular dystrophy, a relatively rare disease (with an incidence of about 2 in every 10,000 people) is another hereditary condition. It is a neuromotor disease in which muscle tissue is replaced by fat tissue, thus decreasing the strength and muscle use of the individual. In most cases of Duchene muscular dystrophy, the condition is carried by the mother and exhibited by some of her children.

***Accidents or Injuries.*** Americans must improve their vigilance against child abuse because the resulting injuries can lead to cerebral palsy, seizure disorders, spinal cord injuries, brain damage, and even death. For example, spinal cord injury in young children, often caused by automobile accidents, can also be the result of child abuse. (A common site of spinal cord dislocation is in the lower back, due to the effects of spanking.) In older children, the most common causes of spinal cord injury are car accidents, falls and jumps, gunshot wounds, and diving accidents. In these cases, the importance of safety equipment (e.g., seat belts, helmets, protective gear) and caution are vitally important.

***Multiple Factors.*** Seizure disorders can be the result of many conditions and circumstances. Dividing them into two groups—primary epilepsies (usually congenital) and secondary epilepsies (acquired)—can help in sorting out some of the common causes of this condition. **Primary epilepsy** appears at a young age, usually in families with some history of epilepsy. Often there is a stereotypical pattern of the seizure and a predictable response to specific medications. **Secondary(lesional) epilepsy** may appear at any age and can result from accidents or child abuse; degenerative diseases (e.g., Sturge-Weber syndrome); brain tumors and abscesses; lesions, head injury; lead poisoning, infections, like meningitis or encephalitis; or alcohol or drug withdrawal (Epilepsy Foundation of America, 1994a). Recall that cerebral palsy is caused by damage to the brain, whether by impaired development, injury, or disease. It may be congenital (present at birth) or acquired within the first three years of life. Let us look at these categories a little more closely. In congenital cerebral palsy, a developing infant may have been deprived of necessary amounts of oxygen when something went wrong during birth. Circumstances such as a placenta separating from the wall of the uterus too early, a twisted birth position, knotting or kinking of the umbilical cord, or other problems of labor and delivery may cause brain damage. Cerebral palsy may also result from the effects of premature birth; blood type (Rh) incompatibility; the mother’s infection with rubella, CMV, or other viral diseases; and attacks by other dangerous microorganisms. The later onset of cerebral palsy typically results from vehicle accidents, brain infections such as meningitis, poisoning through toxins such as lead (ingested in paint chips from walls), serious falls, or injuries from child abuse.

***Unknown Causes.*** With some unknown causes, the medical profession has some good ideas about why the condition exists. Such is the case with asthma: The basic causes of asthma are unknown, but it is believed to be the result of an allergic reaction to certain substances (allergens) in individuals who have a physical predisposition to the condition. The substances that can trigger allergic reactions vary by individual; for some people it may be foods, for others plants, environmental pollutants, chemicals, cigarette smoke, dust mites, cockroaches, viruses, or by daily activity of heightened periods of exercise. The medical profession is working hard to pinpoint some of these unknown causes. For example, the causes of neural tube, or spinal column, defects (like spina bifida) are not yet clear, although folic acid deficiencies and genetic factors are suspected. The defect occurs very early in the development of a foetus, between the twentieth and thirtieth day of fetal development, before a woman even knows she is pregnant. Past experience indicates that when medical researchers can pinpoint the cause of a condition, they are then much closer to finding a way to treat or prevent the condition. A good case in point is polio: The cause was pinpointed as a virus and a vaccine was soon developed to protect individuals from contracting the disease, but for those already affected they faced a lifetime disability requiring extensive supports.

## Hearing Impairments

People who are **deaf**, or profoundly hard of hearing, have hearing abilities that provide them with little useful hearing even if they use hearing aids. Although almost all persons who are deaf perceive some sound, they cannot use hearing as their primary way to gain information. People who are **hard of hearing** can process information from sound, usually with the help of a hearing aid.

Although the degree of hearing loss is important, the age when the hearing loss occurs is also important. Individuals who become deaf *before* they learn to speak and understand language are referred to as **prelingually deaf**. They either are born deaf or lose their hearing as infants. Approximately 95 percent of all deaf children and youth are prelingually deaf. Their inability to hear language seriously affects their abilities to communicate with others and to learn academic subjects taught later in school. One in ten of those who are prelingually deaf have at least one deaf parent. Children in this group typically learn to communicate during the normal developmental period. However, instead of learning oral communication skills, many learn through a combination of manual communication (sign language) and oral language.

Those whose severe hearing loss occurs after they have learned to speak and understand language are called **postlingually deaf.** Many are able to retain their abilities to use speech and communicate with others orally. What makes learning even more difficult for many deaf and hard of hearing students is that 25 percent of them have additional disabilities (Schildroth&Hotto, 1994). Additional disabilities may include visual impairments, mental retardation, learning disabilities, behaviour disorders, or cerebral palsy. These accompanying disabilities are often caused by the same disease or accident that caused the hearing

loss. For example, rubella (German measles), blood type (Rh) incompatibility between mother and child, and trauma at birth often result in more than one disability. Students whose deafness is inherited tend *not* to have multiple disabilities.

What is hearing loss? Hearing loss results when the ear and hearing mechanism are damaged or obstructed. Hearing losses range in severity, vary in type, and influence each person differently.

### Types of Hearing Loss

There are four general types of hearing loss: *conductive sensorineural, mixed and central.*

1. **Conductive hearing losses** are due to blockage or damage to the outer or middle ear that prevents sound waves from traveling (being conducted) to the inner ear. Generally, someone with a conductive hearing loss has a mild to moderate disability. Some conductive hearing losses are temporary. Preschoolers often experience a conductive hearing loss when they have head colds. Because of the high frequency of head colds among children, at any one time, between 50 and 80 percent of youngsters attending kindergarten through fifth grade may have a mild hearing loss. The infection causes excessive fluid to accumulate in the middle ear, interfering with the conduction of sound waves there. With a mild loss, the individual can still hear almost all speech sounds and can hear most conversations (Moores, 1996). If the hearing loss was caused by a head cold, once the ear infection clears up, the hearing difficulties also disappear. Most conductive hearing losses can be corrected through surgery or other medical techniques.
2. The second type of hearing loss, **sensorineural hearing loss,** occurs when there is damage to the inner ear or the auditory nerve and usually cannot be improved medically or surgically. Individuals affected by a sensorineural loss are able to hear different frequencies at different intensity levels; their hearing losses are not flat or even. Sensorineural losses are less common in young children than the conductive types.
3. Mixed hearing loss is where a person has both conductive and sensori – neural types.
4. Central hearing loss occurs when the parts of the brain responsible for hearing are defective.

### Causes of hearing impairments

1. ***Maternal Rubella.***

Rubella (German measles) contracted by a pregnant woman is a devastating disease for an unborn child. Depending on when the expectant mother contracts the virus, the child may be born with a profound hearing loss, a visual impairment, or other disabilities alone or in combinations. As with other congenital hearing losses (those present at birth), those caused by maternal rubella are typically sensorineural with damage to the inner ear or the auditory nerve. The children affected are prelingually deaf.

1. ***Meningitis.* Meningitis**

This is a disease that affects the central nervous system (specifically the meninges, the coverings of the brain and spinal cord, and its circulating fluid). Most cases that involve a hearing loss are bacterial infections rather than the more lethal viral meningitis. This disease often results in a profound hearing loss and is often associated with other disabilities. Meningitis is the most common cause of postnatal deafness in schoolchildren and is one major cause of sensorineural hearing losses that are not present at birth. These individuals’ hearing losses are acquired, and they may have developed some speech and language before they developed the hearing loss. Vaccines do exist that will prevent the disease, but at present there is no national immunization program for meningitis.

***3. Otitis Media.*** Infection of the middle ear and accumulation of fluid behind the eardrum is called otitis media. The condition can be corrected and treated with antibiotics and other medical procedures. If sustained for long periods of time or not detected in very young children, the condition may result in a language impairment that could affect future academic learning. Chronic otitis media can result in a conductive hearing loss by damaging the eardrum and in about 84 percent of the cases results in a mild to moderate hearing loss. Typically these youngsters are hard of hearing, and they profit from hearing aids because their hearing loss is conductive.

***4. Heredity.*** More than 150 different types of genetic deafness have been identified, and most likely the unknown causes of deafness are genetic. Genetic causes are congenital and sensorineural. Most children whose deafness is inherited are less likely to have multiple disabilities.

***5. Noise.***

 Indications are that young males are more likely to acquire noise-induced hearing losses because they frequently engage in activities such as mowing the lawn, firing a gun, riding a motorcycle, or fixing a car engine. Even infants and toddlers can sustain irreversible noise-induced hearing losses. Of the 28 million Americans with permanent hearing loss, about a third are victims of exposure to loud sounds (Marcotty, 1996). The loss can occur without pain or any notice; and although it usually takes years of exposure, noise can cause damage that can be detected early. For example, in one study of first-year college students, 61 percent had detectable hearing losses, probably from exposure to noise.

***6.Other Causes.***

As we eliminate or reduce the incidence of some causes of hearing loss, other causes are discovered. For example**, high-impact aerobics** is now thought to cause damage to the delicate structures of the inner ear (Rosenthal, 1990). Researchers believe that extended periods of arduous jumping and bobbing may displace the tiny granules called otoliths inside the inner ear. They float in a gel and transmit information to the hairlike stalks linked to nerve fibers, a part of the system that turns sound impulses into nerve signals for transmission to the brain. When the otoliths are displaced, both balance and hearing can be affected. More specific causes of hearing loss continue to be discovered.

## Visual Impairments

Damage to any part of the eye can result in serious limitations in one’s abilities to see and process information through the visual channel. These conditions can result in blindness or severe visual impairments. Many disorders can be corrected or reduced through medical technology, but not all can be resolved by medical treatment.

### Types of Visual Impairments

Many professionals in the field of visual impairments divide persons with visual impairments into two subgroups: low vision and blindness.

 Individuals with **lowvision** use sight to learn, but their visual impairments interfere with daily functioning.Corn (1989) defines low vision as “a level of vision which, with standard correction, hinders an individual in the planning and/or execution of a task, but which permits enhancement of the functional vision through the use of optical or non-optical devices, environmental modifications and/or techniques” (p. 28). In other words, children with low vision use their sight for many school activities, including reading. Barraga and Erin (1992), however, caution us not to assume that all children with low vision use print materials, because some use Braille.

**Blindness** means that the person uses touch and hearing to learn and does not have functional use of sight.Children without functional use of their vision may only perceive shadows or some movement; these youngsters must be educated through tactile and other sensory channels and are considered functionally blind. Blindness can occur at any age, but its impact varies with age. For those with visual impairments, like the deaf and hard of hearing, the age of onset (when the disability occurs) is important. Persons born with a severe impairment are **congenitally blind.** Those who acquire a severe visual impairment sometime after birth (usually after age 2) are called **adventitiously blind**. People who lose their sight after age 2 retain some memory of what they had seen. They remember what some objects look like. The later the disability occurs, the more they remember. Visual memory is an important factor in learning, for it can influence one’s development of concepts and other aspects important to learning. Despite the movement toward functional definitions of visual impairments, the non-functional definition, **legally blind**, is still in use.

Causes of visual impairments

The prevalence of visual impairments, particularly in children, varies country by country. For example, the incidence of blindness in developing countries is much greater than in more advanced nations, where access to medical treatment is readily available. In developing nations such as India and countries in Africa, the major causes of blindness are infectious diseases, malnutrition, and vitamin A deficiency. Worldwide, fully 80 percent of childhood blindness is caused by poor nutrition or infections; most of these situations can be prevented (American Foundation for the Blind, 1990).

1. Visual impairments may be congenital (present at birth) or acquired. Almost half of the children who are blind have the disability because of prenatal factors, mostly hereditary. Researchers are beginning to identify genes that cause some forms of blindness, which is the first step leading to a cure. For example, the gene that causes retinitis pigmentosa has now been located and isolated, with the hope of a cure in the near future.
2. Tumours in the retinal layer or along the optic nerve can also cause blindness and severe visual impairments in schoolchildren and cannot be corrected.
3. Fortunately, two causes of visual impairments have been reduced dramatically over the past ten years. Today, precautions are being taken to prevent any cases of ROP.
4. Rubella, also a significant cause of congenital visual impairments and multiple disabilities in the past, can today be prevented by a vaccine. Unfortunately, not everyone is immunized.
5. Many youngsters with visual impairments have multiple disabilities as well, with estimates of about one-half of these individuals having multiple disabilities (Heller et al., 1996). The rate of multiple disabilities is associated with the cause of the disability. For example, premature babies with very low birth weights are at high risk for mental retardation. Rubella babies often have multiple disabilities, but those with visual impairments because of a tumor round the eye do not.

## Exercise

1. What are the major causes of disabilities?
2. Do know someone with a disability which has been discussed above? What caused

 it?

## Summary

The unit has highlighted the major categories of special needs. We have given specific examples of disabilities and have also discussed the causes of disabilities. We hope by this time. The information in this unit is very important for future learning, especially the subsequent topics

# UNIT 5

## Challenges and benefits of categorisation of children with SEN

## Introduction

Unit two is a follow on the knowledge acquired in unit one. This unit will help you understand how the categories are arrived at. In this unit you will also learn the importance of categorisation but also the challenges it poses.

## Objectives

By the end of this unit you should be able to

1. Define labelling and categorisation;
2. Describe the process of come up with labels and categories;
3. Identify the pros and cons of categorisation in special education; and
4. Discuss the best approach to categorisation.

## Understanding Categorization

Classification is a complex issue involving emotional, political, and ethical considerations in addition to scientific, fiscal, and educational interests (Luckasson& Reeve, 2001). As with most complex issues, there are valid perspectives on both sides of the labelling question. The reasons most often cited for and against the classification and labelling of exceptional children are the following:

## Possible Benefits of Labeling

* Labelling recognizes meaningful differences in learning or behaviour and is a first and necessary step in responding responsibly to those differences. As Kauffman (1999) points out, “Although universal interventions that apply equally to all, . . . can be implemented without labels and risk of stigma, no other interventions are possible without labels. Either all students are treated the same or some are treated differently. Any student who is treated differently is inevitably labelled. . . . When we are unwilling for whatever reason to say that a person has a problem, we are helpless to prevent it. . . . Labelling a problem clearly is the first step in dealing with it productively”.
* Labelling may lead to a protective response in which children are more accepting of the atypical behaviour of a peer with disabilities than they would be of a child without disabilities who emitted that same behaviour. (A protective response—whether by peers, parents, or teachers—toward a [child with a disability](http://www.education.com/definition/child-with-a-disability/?__module=DeepLink&hit&id=11255) can be a disadvantage if it creates learned helplessness and diminishes the child’s chances to develop independence (Weisz, Bromfield, Vines, & Weiss, 1985)
* Labelling helps professionals communicate with one another and classify and evaluate research findings.
* Funding and resources for research and other programs are often based on specific categories of exceptionality.
* Labels enable disability-specific advocacy groups (e.g., parents of children with autism) to promote specific programs and spur legislative action.
* Labelling helps make exceptional children’s [special needs](http://www.education.com/topic/special-needs/?__module=DeepLink&hit&id=41649) more visible to policymakers and the public.

## Possible Disadvantages of Labeling

* Because labels usually focus on disability, impairment, and performance deficits, some people may think only in terms of what the individual cannot do instead of what she can or might be able to learn to do.
* Labels may stigmatize the child and lead peers to reject or ridicule the labelled child. (Not all labels used to classify children with disabilities are considered equally negative or stigmatizing. One factor possibly contributing to the large number of children identified as learning disabled is that many professionals and parents view “learning disabilities” as a socially acceptable classification [MacMillan, Gresham, Siperstein, &Bocian, 1996).
* Labels may negatively affect the child’s self-esteem.
* Labels may cause others to hold low expectations for a child and differentially treat her on the basis of the label, which may result in a self-fulfilling prophecy. For example, in one study, [student teachers](http://www.education.com/definition/student-teachers/?__module=DeepLink&hit&id=12173) gave a child labelled “autistic” more praise and rewards and fewer verbal corrections for incorrect responses than they gave a child labelled “normal” (Eikeseth&Lovaas, 1992). Such differential treatment could impede the rate at which a child learns new skills and contribute to the development and maintenance of a level of performance consistent with the label’s prediction.
* Labels that describe a child’s performance deficit often acquire the role of explanatory constructs (e.g., “Sherry acts that way because she is emotionally disturbed”).
* Even though membership in a given category is based on a particular characteristic (e.g., deafness), there is a tendency to assume that all children in a category share other traits as well, thereby diminishing the detection and appreciation of each child’s uniqueness (Gelb, 1997; Smith & Mitchell, 2001).
* Labels suggest that learning problems are primarily the result of something wrong within the child, thereby reducing the systematic examination of and [accountability](http://www.education.com/definition/accountability/?__module=DeepLink&hit&id=4606) for instructional variables as the cause of performance deficits. This is an especially damaging outcome when the label provides a built-in excuse for ineffective instruction (e.g., “Jalen hasn’t learned to read because he’s learning disabled”).
* A disproportionate number of children from some minority and diverse cultural groups are included in special education programs and thus have been assigned disability labels.
* [Special education](http://www.education.com/topic/special-education/?__module=DeepLink&hit&id=172) labels have a certain permanence; once labelled, it is difficult for a child to ever again achieve the status of simply being just another kid.
* Classifying exceptional children requires the expenditure of a great amount of money and professional and student time that might be better spent in planning and delivering instruction (Chaikind, Danielson, &Brauen, 1993).

Clearly, there are strong arguments both for and against the classification and labelling of exceptional children. On the one hand, most of the possible benefits are experienced not by individual children but by groups of children, parents, and professionals who are associated with a certain disability category. On the other hand, all of the potential negative aspects of labelling affect the individual child who has been labelled. Of the possible advantages of labelling listed previously, only the first two could be said to benefit an individual child directly. However, the argument that disability labels associate diagnosis with proper intervention is tenuous at best, particularly when the kinds of labels used in special education are considered. What Becker, Engelmann, and Thomas (1971) wrote more than three decades ago is still true today: “[The labels] rarely tell the teacher who can be taught in what way. One could put five or six labels on the same child and still not know what to teach him or how”.

Although the pros and cons of using disability category labels have been widely debated for several decades, neither conceptual arguments nor research has produced a conclusive case for the total acceptance or absolute rejection of labelling practices. Most of the studies conducted to assess the effects of labelling have produced inconclusive, often contradictory, evidence and have generally been marked by methodological weakness.

## Alternatives to Labeling

A number of alternative approaches to classifying exceptional children that focus on educationally relevant variables have been proposed over the years (e.g., Adelman, 1996; Hardman, McDonnell, & Welch, 1997; Iscoe& Payne, 1972; Sontag, Sailor, & Smith, 1977). For example, Reynolds, Zetlin, and Heistad (1996) proposed a system they call “20/20 analysis” as an alternative, nonlabeling approach to the traditional, categorically driven model of [special education](http://www.education.com/topic/special-education/?__module=DeepLink&hit&id=172). The lowest-achieving 20% and the highest-achieving 20% of students would be identified and eligible for broad (noncategorical) approaches to improvement of learning opportunities.

Some noted special educators have suggested that exceptional children be classified according to the curriculum and skill areas they need to learn.

But if we shouldn’t refer to these special children by using those old labels, then how should we refer to them? For openers, call them Rob, Amy, and Jose. Beyond that, refer to them on the basis of what you’re trying to teach them. For example, if a teacher wants to teach Brandon to compute, read, and comprehend, he might call him a student of computation, [reading](http://www.education.com/topic/study-help-language/?__module=DeepLink&hit&id=1233), and comprehension. We do this all the time with older students. Sam, who attends Juilliard, is referred to as “the trumpet student”; Jane, who attends Harvard, is called “the law student.” (T. C. Lovitt, personal communication, January 14, 2002).

In a system similar to this, called **curriculum-based measurement,** students are assessed and classified relative to the degree to which they are learning specific curriculum content (Deno, 1997; Howell &Nolet, 2000; Jones, 2001). Educators who employ curriculum-based measurement believe that it is more important to assess (and thereby classify) students in terms of acquisition of the knowledge and skills that make up the school’s curriculum than to determine the degree to which they differ from the normative score of all children in some general physical attribute or learning characteristic.

Even though curriculum-based assessment is being used more frequently, use of the traditional labels and categories of exceptional children is likely to continue. The continued development and use of educationally relevant classification systems, however, make it more likely that identification and assessment will lead to effective instructional programs for children, promote more educationally meaningful communication and research among professionals, and perhaps decrease some of the negative aspects of current practices.

## Exercise

1. What are the benefits of labelling and categorisation in special education?
2. What are the disadvantages of categorisation?

## Summary

At this point you should have a clear understanding of categorisation in special education.

We hope that you know the meaning of labelling and categorising, the benefits and challenges associated with the two concepts. If you are not sure, go through the unit again.

# UNIT 6

## Identification, Assessment and Intervention for children with SEN.

## Introduction

This unit will expose you to important issues of identifying learners with special needs. This process is important because it brings out vital information which help in deciding where and how the child will be educated

## Objectives

By the end of this unit you should be able to

* 1. Describe the process of identification, assessment and intervention
	2. Identify Challenges in identification and intervention options
	3. Describe some instruments used in assessment

## Reflection

How can you tell the degree of special needs and support to be offered to a learner?

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## Understanding Identification

The identification of children for special education has critical implications for individuals. Failure to be identified could mean the denial of needed services, but being identified as in need of special services may also mean removal from normal classrooms (at least part of the time) and a potentially stigmatizing label. A great deal is at stake in such assessment, so the multifaceted evaluation employed must have a high degree of reliability and validity.

Proposals to "assess" young children are likely to be met with outrage or enthusiasm, depending on one's prior experience and one's image of the testing involved. Will an inappropriate paper-and pencil test be used to keep some 5-year-olds out of school? Or will the assessment, implemented as an ordinary part of good instruction, help children learn?

The identification process includes (1) screening, (2) examination for the presence of risk indicators and protective factors, (3) systematic observations, and, if indicated, (4) a comprehensive evaluation. An effective early identification program must take into account the numerous biological, environmental, and cultural factors that may influence the course of a child’s development. Information from the identification process is the basis for making decisions about the need for further services and supports*.*

## Principles for Assessment and Testing

The NAEYC and the National Association of Early Childhood Specialists in State Departments of Education, NAEYC acknowledges three legitimate purposes for assessment:

1) To plan instruction and communicate with parents,

2) To identify children with special needs, and

3) To evaluate programs.

## Principles for testing

1. Tests should not be used if they do not bring about benefits for children. In what follows I summarize some additional principles that can ensure that assessments (and tests) are beneficial and not harmful.
2. The content of assessments should reflect and model progress toward important learning goals. Conceptions of what is important to learn should take into account both physical and social/emotional development as well as cognitive learning.
3. The methods of assessment must be appropriate to the development and experiences of young children. This means that - along with written products -- observation, oral readings, and inter-views should be used for purposes of assessment.
4. Assessments should be tailored to a specific purpose.

## Matching the Why and How of Assessment

The reason for any assessment - i.e., how the assessment information will be used - affects the substance and form of the assessment in several ways. First, the degree of technical accuracy required depends on use. Purpose must also determine the content of assessment. When trying to diagnose potential learning handicaps, we still rely on aptitude-like measures designed to be as content-free as possible. We do so in order to avoid confusing lack of opportunity to learn with inability to learn. When the purpose of assessment is to measure actual learning, then content must naturally be tied to learning outcomes.

Assessments that are used to guide instruction in a given classroom should be integrally tied to the curriculum of that classroom. The intended use of an assessment will determine the need for normative information or other means to support the interpretation of assessment results. Identifying children with special needs requires normative data to distinguish serious physical, emotional, or learning problems from the wide range of normal development. When reporting to parents, teachers also need some idea of what constitutes grade-level performance, but such "norms" can be in the form of benchmark performances – evidence that children are working at grade level - rather than statistical percentiles.

Assessments should be conducted only if they serve a beneficial purpose: to gain services for children with special needs, to inform instruction by building on what students already know, to improve programs, or to provide evidence nationally or in the states about programmatic needs. The form, substance, and technical features of assessment should be appropriate for the use intended for assessment data. Moreover, the methods of assessment must be compatible with the developmental level and experiences of young children.

## Identifying Children with Special Needs

The purpose of early identification is to determine which children have developmental problems that may be obstacles to learning or that place children at risk. Development in infants, toddlers, and pre-schoolers is characterized by broad variability in rates and patterns of maturation. For some children, differences and delays in abilities are temporary and are resolved during the normal course of development. For other children, delays may persist in different domains of functioning, necessitating the child's referral for targeted screening and/or comprehensive evaluation.

When identifying children with special needs, evaluators should use two general strategies in order to avoid confounding the ability to learn with past opportunity to learn.

1. A child's learning environment should be evaluated to rule out poor instruction as the possible cause of a child's lack of learning.
2. A second important strategy is to observe a child's functioning in multiple contexts. Often children who appear to be impaired in school function well at home or with peers. Observation outside of school is critical for children from diverse cultural backgrounds and for those whose home language is not English.

## Why Does Diagnosis of Disabilities Usually Occur in Elementary School?

There are two main reasons most diagnoses occur at this time:

1. Learning problems cannot be reliably measured until students have been formally taught in basic subject areas;

ii. and Many psychologists recommend waiting until children are at least six

years old before [evaluating intelligence](http://learningdisabilities.about.com/od/assessmentandtesting/a/spedtesting.htm) for more valid and reliable test scores.

As with [intelligence testing](http://learningdisabilities.about.com/od/glossar1/a/intelligencetes.htm), [achievement testing](http://learningdisabilities.about.com/od/glossar1/p/achievementtest.htm) is more reliable after that

time.

## Early Diagnosis and Labels challenges

Early diagnosis is a complex issue because of several important issues:

Early identification is important because [early intervention](http://learningdisabilities.about.com/od/infancyandearlychildhood/tp/detecttreatdisa.htm) can dramatically increase your child's chances for success in school. Diagnosis of young children is challenging because they grow at different rates. Some change rapidly during early developmental periods. Differences among students' language, cultural, and socialization skills at this age during the preschool years are to be expected, and they can also negatively affect assessment scores. [Assessing intelligence](http://learningdisabilities.about.com/od/glossar1/a/intelligencetes.htm) too early can yield a [general intelligence score](http://learningdisabilities.about.com/od/glossar1/g/whatisIQ.htm) that underestimates the child's true abilities.

Schools may diagnose young children as [Developmentally Delayed](http://learningdisabilities.about.com/od/glossar1/g/develdelay.htm) instead of using the term [Learning Disability.](http://learningdisabilities.about.com/od/whatisld/a/whatissld.htm) This enables schools to provide instructional and therapy services without labeling children as learning disabled.

Developmental Delay is considered a less restrictive label because it recognizes that children may catch up with peers with appropriate intervention. Developmental delays can be assessed through early intervention programs, by pediatricians, and through assessments conducted at public schools. These assessments help to determine if children are reaching [developmental milestones](http://learningdisabilities.about.com/od/developmentalstages/) when they should.

Common Assessments Used in Infancy and Early Childhood:

* [Battelle Developmental Inventory](http://learningdisabilities.about.com/od/intelligencetests/p/battelledevelop.htm)
* Wechsler Preschool and Primary Scales of Intelligence
* [Bayley Scales of Infant Development](http://learningdisabilities.about.com/od/intelligencetests/p/bayleyscales.htm)
* Peabody Picture Vocabulary Test
* [Vision and Eye Examinations](http://learningdisabilities.about.com/od/infancyandearlychildhood/qt/visionexamspk.htm)

## How Learning Disability Assessments are conducted

Parents, educators, or other adults who suspect LDs refer children to the school principal or counselor for evaluation. Before students are evaluated, schools arrange a formal meeting where parents, educators, and other professionals discuss the child's history and performance in school. This team also determines if there are other factors affecting the child's performance in school. If there are other factors, the team ensures they are addressed before assessment begins.

Assessments are usually conducted by school personnel. Evaluation teams may include school psychologists, teachers, educational diagnosticians, or occupational, physical, or speech therapists. If needed, outside professionals such as physicians, psychiatrists, social workers, or others may be involved.

## Assessments Used in Diagnostic Testing

Several types of assessments and procedures are used in testing for LDs:

1. a)[**I**ntelligence Tests**:**](http://learningdisabilities.about.com/od/glossar1/a/intelligencetes.htm) Also called IQ tests, these instruments measure
	1. aptitude. IQ tests include activities designed to provide a complete picture
		1. of how students learn. Typical tests include [language-based](http://learningdisabilities.about.com/od/glossar1/g/verbalintellige.htm) and [visual](http://learningdisabilities.about.com/od/glossar1/g/nonverbalintell.htm)
			1. [reasoning](http://learningdisabilities.about.com/od/glossar1/g/nonverbalintell.htm).
2. [Developmental and Social History:](http://learningdisabilities.about.com/od/glossar1/p/studenthistory.htm) Usually completed by parents or guardians, these narrative questionnaires provide important facts about the student's development.
3. [Records Review:](http://learningdisabilities.about.com/od/glossar1/p/recordreview.htm) Research on the student's background can help examiners rule out or identify other factors that may have caused the student's learning problems.
4. [Behavioral Observations:](http://learningdisabilities.about.com/od/glossar1/p/observations.htm)May identify factors in the classroom that are affecting the student's learning.
5. [Achievement Testing:](http://learningdisabilities.about.com/od/glossar1/p/achievementtest.htm)Determines the child's current skill levels in reading, math, written language, or content areas such as science and humanities.
6. [Adaptive Behavior:](http://learningdisabilities.about.com/od/medicalinterventions/g/adptbehvrdeffin.htm)Assesses a student's ability to perform tasks necessary to maintain self care, interact in socially appropriate ways, and to work in and around his school and home in a responsible and safe manner.

## Exercise

1. What are some instruments used in assessment?

2. What is the significance of assessment?

## Summary

You have come to the end of the Unit on identification, assessment and intervention. Assessment is an important pre-requisite for intervention particularly in early childhood education. We hope that by now you are able. a) Describe the process of identification, assessment and intervention b) Identify Challenges in identification and intervention options and Describe some instruments used in assessment.

# UNIT 7

## Early Childhood learning among children with SEN

## Introduction

This unit focuses on the significance of early learning for children with special needs. Early learning in SEN education has been emphasised because of its potential to minimise the effects of disability on the educational life of children. You will to a great extent need to refer to the knowledge from the preceding unit on identification and assessment.

## Objectives

By the time you finish studying this unit, you should be able to:

1. Describe the importance of early childhood education for SEN; and
2. Discuss elements of a good early learning program.

## Definitions

According to [UNESCO ECCE (Early Childhood Care and Education) Unit](http://www.unesco.org/en/early-childhood/), Early childhood is defined as the period from birth to 8 years old. A time of remarkable brain development, these years lay the foundation for subsequent learning.

Early childhood intervention is defined as a consistent, sustained and systematic effort to assist young disabled, developmentally vulnerable children from the birth to the age of five and their families (Meisels, 1990). Early childhood education is the organized practice of [educating](http://en.wikipedia.org/wiki/Education) those who are in [early childhood](http://en.wikipedia.org/wiki/Early_childhood), one of the most vulnerable stages in life. According to the NAEYC ([National Association for the Education of Young Children](http://en.wikipedia.org/wiki/National_Association_for_the_Education_of_Young_Children)), it spans the human life from birth to age eight.

## Importance of early learning for SEN

1. To prevent deficits

2. Prevent additional deficits due to lack of stimulation because of a primary disability. Improve existing disability by providing therapies or devices to help the child

3. To provide teaching and learning experiences.

## The early learning goal areas

The statutory early learning goals establish expectations for most children. They provide the basis for planning throughout the Early years, so laying secure foundations from birth for future learning. By the end of the early years, some children will have exceeded the goals. Other children, depending on their individual needs, will be working towards some or all of the goals - particularly some younger children, some children with learning difficulties and disabilities and some learning English as an additional language.

We now look at the education programmes followed by the early learning goals for each of the six areas of Learning and Development.

1. **Personal, Social and Emotional Development**

Children must be provided with experiences and support which will help them to develop a positive sense of themselves and of others; respect for others; social skills; and a positive disposition to learn. Providers must ensure support for children's emotional well-being to help them to know themselves and what they can do.

1. **Communication, Language and Literacy**

Children's learning and competence in communicating, speaking and listening, being read to and beginning to read and write must be supported and extended. They must be provided with opportunity and encouragement to use their skills in a range of situations and for a range of purposes, and be supported in developing the confidence and disposition to do so.

1. **Problem Solving, Reasoning and Numeracy**

Children must be supported in developing their understanding of Problem Solving, Reasoning and Numeracy in a broad range of contexts in which they can explore, enjoy, learn, practice and talk about their developing understanding. They must be provided with opportunities to practice and extend their skills in these areas and to gain confidence and competence in their use.

1. **Knowledge and Understanding of the World**

Children must be supported in developing the knowledge, skills and understanding that help them to make sense of the world. Their learning must be supported through offering opportunities for them to use a range of tools safely; encounter creatures, people, plants and objects in their natural environments and in real-life situations; undertake practical 'experiments'; and work with a range of materials.

1. **Physical Development**

The physical development of babies and young children must be encouraged through the provision of opportunities for them to be active and interactive and to improve their skills of coordination, control, manipulation and movement. They must be supported in using all of their senses to learn about the world around them and to make connections between new information and what they already know. They must be supported in developing an understanding of the importance of physical activity and making healthy choices in relation to food.

1. **Creative Development**

Children's creativity must be extended by the provision of support for their curiosity, exploration and play. They must be provided with opportunities to explore and share their thoughts, ideas and feelings, for example, through a variety of art, music, movement, dance, imaginative and role-play activities, mathematics, and design and technology.

## Early Childhood Special Education

Early Childhood Special Education (ECSE) is based on the premise that early and comprehensive intervention maximizes the developmental potential of infants and young children with disabilities (McDonnell & Hardman, 1988). Recommended practices in Early Childhood Special Education are a set of practices derived from research and professional consensus about how early childhood special education services should be provided.

## Indicators of Quality Early Childhood Special Education Programs.

The Recommended Practice components briefly overviewed below are practices that leaders in the field of early childhood special education view as indicators of quality( Child Development Centre, 2010).

* **Inclusion**

Programs that are considered exemplary or state of the art utilize all possible opportunities to place children with disabilities into inclusive settings with their non-disabled peers. Inclusion refers to serving children with disabilities in the same settings designed for children without disabilities. For preschool age children this would mean placement in regular community preschool or child care programs. However, inclusion is more than merely integrating children with disabilities into the same physical space as their non-disabled classmates. To be fully included, children with disabilities need to be socially included, that is, have opportunities to interact with other children and participate in the same activities as their typically developing peers. Placement of children in inclusive programs is also supported by federal legislation that calls for placement of children with disabilities in the "least restrictive environment."

* **Age Appropriate Placement**

Age appropriate placement refers to the placement of children with disabilities in environments with their non-disabled peers of the same or similar age. Placement is based on the child's chronological, not mental age, therefore, preschool aged children with disabilities would be served in the same setting as other preschool aged children. So, you should not see three- or four-year-old children being served in a public school unless there is a typical preschool program in operation at that site.

* **Collaborative IEP/IFSP**

The child's IEP/IFSP is developed by a team consisting of family members and other individuals involved in the child's educational program. The goals and objectives for the child are developed using a collaborative, transdisciplinary approach involving the ECSE consultant, related service personnel, the regular program teacher, and family members. In preparing the IEP/IFSP, team members view the child as a whole person, not as a collection of developmental domains. Each member is concerned with the needs of the whole child and does not focus only on the isolated skills within a specific domain.

* **Functional Curriculum**

The curriculum is developed with the child's IEP/IFSP as a foundation and is individualized to meet the unique needs of each child. The child should not be expected to adjust to a preconceived curricular content. Instead, the curriculum should be adapted to meet the child's needs. Skills selected for instruction should meet a clearly identifiable functional need in the child's life. That is, there should be a clear reason why each skill is being taught. These skills can be identified through criterion-referenced assessment instruments and ecological inventories or environmental assessments and should address the demands of the child's current and future environment. In early childhood settings, functional targeted skills would be those which would assist the child in interacting more independently and positively with the physical and social environment. A functional orientation gives preference to skills which will enable the child to participate more fully in an integrated setting as opposed to focusing on skills based on a developmental hierarchy or sequence. For most preschool age children with disabilities, intervention efforts emphasize opportunities to learn functional communication and social skills.

* **Activity Based Instruction**

The activity based instruction approach provides for direct instruction on specific skills within the context of functional and normal preschool activities. It provides opportunities for practice on target skills within the context of naturally occurring activities (Bricker, 1995). Activity based instruction as an instructional strategy to facilitate inclusion is discussed in more detail in our 'Best Practices" site.

* **Integrated Delivery of Related Services**

The provision of related services are woven into the child's daily schedule to allow the practice of skills with other functional skills within naturally occurring activities. These services are delivered within the regular classroom setting in a consultative manner rather than in isolation from the natural setting. In this model, therapists provide classroom staff with basic skills and instruction in techniques they will need to continue target skill practice when the therapist is not on site. Services are delivered in an integrated manner, maximizing the sharing of knowledge and methods across disciplines.

* **Data Based Instruction**

Federal guidelines require the collection of data to monitor child progress on IEP/IFSP objectives. In order to maximize the effectiveness of intervention techniques it is important to collect and analyze child progress data regularly. This analysis enables the team to make educated program decisions based on precise information. Data systems also fit within the environment, in that they are unobtrusive and can be used in natural settings throughout the day.

* **Transition Planning**

Transition planning for the preschool aged child refers to the systematic planning process developed and followed to assist the child in the transition from the preschool/child care setting to the next educational environment. The people most frequently involved in the transition planning process, in addition to the child's family, are the sending teacher, ECSE specialist, related service personnel, and the future receiving teacher. It is important for the intervention team to meet with staff from the receiving program to identify skills which will be required in the new setting and to ensure the teaching of those skills. It is critical for staff to look at skills that will equip the child to function as independently as possible in their future setting. Failure to address these skills may result in the child with disabilities not being adequately prepared to survive in least restrictive environments and consequently being retained or placed into more restrictive settings. Planning for transition should occur well before the actual move, enabling the sending teachers to identify survival skills needed in the future environments.

* **School-Family Partnership**

The family is the heart of early childhood programs and serves as a planning and decision-making participant in all aspects of their child's program. A good school-family partnership includes a system for regular communication and opportunities for family participation in the child's program. Quality programs also include procedures for helping families link into existing community resources.

* **Ongoing Program Evaluation**

Quality educational programs have a plan for the evaluation of program goals and objectives. This evaluation may examine such factors as child progress, parent satisfaction with the program, and the need for staff training. The information gathered will reveal program strengths and weaknesses and assist in making quality changes.

## Exercise

1. Why is early childhood education important to children with special needs?

2. Do you know an institution offering early childhood education? What components make

 up a good early learning program particularly for children with special needs?

## Summary

Early childhood special education has been discussed in this unit. The decision on placement is based on the assessment information. Are you able to a) Describe the importance of early childhood education for SEN b) Discuss elements of a good early learning program? If your answer is yes, then let us move on to the next unit.

# UNIT 8

## Partnerships in Education for SEN

## Introduction

Special education provision requires a multiprofessional or interdisplinary approach. It is to this effect that this unit will avail you with skills and information on working with other professional and stakeholders. A partner of special importance is the parents of children with special needs.

## Objectives

By the end of the unit you should be able to:

1. Discuss the significance of partnerships in special education
2. Discuss the involvement of parents in their children’s education
3. Describe the various roles of partners in special education provision

## Understanding Partnerships

Educating students with disabilities is a shared, collaborative team effort (Nielson,2002).

Depending on the student’s education plan and personal needs, many types of professionals are needed to provide the multidisciplinary services required by individuals with disabilities. A special educator might be a paraprofessional (teacher’s aide), a resource teacher, a consultant, an itinerant teacher, a special education classroom teacher, a job coach, an **assistive technology** specialist, a **home or hospital teacher,** a diagnostician, or an administrator. Furthermore, a teacher may assume several of these professional roles during his or her career. In addition, a special education professional might work in a related service as a school psychologist, a speech/language pathologist, an audiologist, an occupational therapist, a physical therapist, a counselor, a nurse or physician, a transportation specialist, a recreational therapist, a supported living worker, a personal care attendant, a vocational rehabilitation worker, or a lawyer.

Special education teachers and others who work with individuals with disabilities must be able to collaborate—work cooperatively—with professionals from a variety of disciplines. They work together in multidisciplinary teams comprised of those professionals each individual student needs. One method they use is **collaboration**. It is through this method and working together as a team that is ultimately the key to successful integration for individual students, given that students with disabilities require various combinations of services over their school careers.

Special education teachers collaborate in many areas that touch a child’s life. They use collaboration skills when working with parents and families, performing multidisciplinary assessments, working with a team to develop individualized program plans, coordinating the components of students’ individualized plans, and helping them make the transitions through the school years and from school to work.

## Including parents

Parents are an important factor in the success of special education. Parents have a role to play in the following aspects of their child’s development

1. To maintain open communication with the school on any issues that may affect the child’s school life. It is important that teacher listen to parents, they have a lot of knowledge about their child which can clarify on the child’s problems.( Nielson,2002)
2. Parents are expected to be fully involved in home work, daily assignments and any other projects that are planned. This is done in collaboration with the teacher who guides parents.
3. To grow emotionally and socially, students with disabilities need the support and acceptance of their peers, teachers and parents. Parents are expected to help their child learn to accept himself as much as they should accept their child with a disability.

## Guidelines for Implementing Multidisciplinary Teams

1. Create working relationships with the student’s entire support team. Partnerships must be developed between the school and the family, between the school and the medical providers, and among school personnel to coordinate services and share information.
2. Develop systems for collaboration and communication at the beginning of every school year (or as the child is being identified for special education services). At a meeting with all parties present, be sure to create understandings for as many “what-if” situations as possible, conduct a needs assessment (if necessary), develop an evaluation plan, create formal and informal channels for communication, and set dates for contacts and meetings.
3. Establish a school-based team that will coordinate services. Particularly for students who receive services from related services personnel who are not from the school district, key contact persons must be identified to coordinate services, approaches, and information.
4. Achieve mutual understandings of long-term goals for the child. Specific goals for transition, adult independence, and employment—held by each stakeholder—should be shared among and understood by all members of the child’s support team.
5. Implement ongoing evaluation procedures. The student’s progress must be monitored directly, consistently, and frequently, and the results must be shared with all members of the child’s support team.
6. Adjust the student’s program as needed. The student’s performance should determine any needed modifications in the educational program and must reflect any changes in the psychological, educational, and behavioural needs of the child.

## Exercise

Here are some questions to test your understanding of this unit

1. How can parents get involved in the education of their children?

2. Why does the success of special education programs depend on team work?

## Summary

In this unit we have looked at partnerships. With special emphasis on the school- parents collaboration. We hope you can confidently discuss the significance of partnerships in special education and discuss the involvement of parents in their children’s education.

# UNIT 9

## The Curriculum of Children with SEN in Zambia

## 9.1 Introduction

Curriculum for special needs has been a challenging issue in education. Scholars in this field have argued that designing a curriculum specifically for SEN in not inclusive particularly that the special needs learners will have to live in the same society and compete against the same jobs as those without special needs.

## 9.2 Objectives

By the end of the unit you should be able to

1. Describe the major aims of curriculum for special needs
2. Discuss the major elements of curriculum for special needs

## 96.3 What is Curriculum?

A curriculum may be regarded as a course of study to be followed in the process of acquiring education. In a modern concept a curriculum should retain the idea of acquiring knowledge by the learner from the point of view of cognitive development. The knowledge acquired is meant to be manipulated and applied in the process of thinking and problem solving. The curriculum is concerned with the acquisition of skills and their application. It is concerned with experiences and the relationship experience and attitude and values pupils must get in the process of education (Brennan, 1985).

A curriculum comprises all the opportunities for learning provided by the school. It includes all the formal programs, that is, the timetable and extracurricular and out of the school activities that the school deliberately promotes or supports. It also involves the climate of relationships, attitudes, styles of behavior and the general quality of life in the school.

**Aims**

A curriculum aims to:

* Help pupils to develop live enquiring minds; question and argue rationally and apply themselves to tasks.
* Help pupils acquire knowledge and skills relevant to adult life and employment.
* Help pupils use language and numbers effectively.
* Instill respect for religious and moral values, and tolerance of other races, religions and ways of life.
* Help pupils understand the world and the interdependence of individuals, groups and nations.
* Help pupils to appreciate human achievement and aspirations

## 9.4 Curriculum for Special Needs

Special education is part of the overall education system. This means that the objectives of the curriculum for no disabled children also apply to special education. The above should be borne in mind when talking about curriculum for special needs.

Not all special needs affect the curriculum. According to Nielson(2002) The curriculum for students with disabilities may parallel the regular curriculum but the regular teacher will need to modify teaching techniques and pace, course content, and evaluation methods to fit student’s special learning needs. The aims of the curriculum for special needs are twofold:

1. To enlarge the children’s knowledge, experience and imaginative understanding; his awareness of moral values and the capacity for enjoyment.
2. To enable children to enter the world after formal education active members of society and be responsible contributors, capable of achieving much independence.

The degrees to which theses aims are achieved vary between individuals.

Some children with severe learning difficulties will achieve the first aim only through small increments carefully taught and reinforced continually, but the nature of the aim is not changed. For other pupils with profound mental and physical handicaps, the second aim may not be achieved in terms of wide society, but progress towards it might be achieved as they interact with those who care for them, who constitute their society.

In democratic societies where issues of human rights are promoted, having a separated curriculum would be equal to exclusion. The schools have a specific responsibility for the formulation of specific aims directly related to the perceived curricular needs of the pupils. The specific aims must be consistent with the general aims of education. If the aims are to be achieved the schools must select activities, knowledge, values and experiences, which are to form the curriculum and assist the pupils to attain the curriculum aims. These become the objectives (Brennan, 1985). Education for special needs is clearly seen in the objectives of the curriculum and is associated with the teaching methods. This is affirmed in Education Reforms document (1977) where is stated that it is in special education where differentiation in material and methods in the curriculum process is important.

The objectives and the teaching methods must be realistically related to pupils for whom they are intended and must take into account individual potential and disabilities while remaining as close as possible to those for all pupils of the same age. The wide variety of special needs and their severities generate curriculum problems when it comes to deciding the specific aims and objectives.

## 9.5 Exercise

1. What distinguishes curriculum for special needs from the ordinary curriculum

2. What are the arguments against a special education curriculum parse?

## 9.6 Summary

You have come to end of the unit on curriculum. It is our hope that you can describe the major aims of curriculum for special needs and discuss the major elements of curriculum for special needs. We hope it is clear that special education has no curriculum parse but the curriculum used is an adaptation from the general curriculum.

**9.7 Module Summary**

We are glad that you have successfully completed the module in EPS 152 course. We hope that you can confidently:

1. Describe the various categories of children with Special Educational Needs
2. Describe the identification and screening processes for various learners with SEN
3. Discuss the screening for the assessment and interventions.
4. Discuss the benefits and challenges of engaging in Early Childhood Learning among children with SEN

It is our hope that the module has given knowledge and skills necessary in life and work.

# UNIT 10

## Understanding Inclusive Education

## Introduction

This Unit introduces you to the philosophy of inclusive education as an alternative approach to the education for the marginalized persons. Having understood the limitations of special education in unit 2, we shall explore the benefits and challenges of offering inclusive education.



## Objectives

By the end of this unit, you should be able to:

1. Define inclusive education
2. Differentiate inclusive education from inclusive schooling
3. Discuss the advantages and challenges of inclusive education

## Reflection



* Imagine how your life would be different if you could no longer walk or see or hear!
* Perhaps the doctors could operate on your legs, eyes, ear or “special exercises could be prescribed to make your legs work normally”.
* These can certainly help with some people but what if they don’t work or if these options are not available to you where you live. Do we just give up?

Perhaps in the absence of medical cure the following steps could be adopted:

* Teaching the person to walk using crutches or walking stick, sign language.
* Getting the person a wheelchair.
* Making sure that there are no steps up to buildings.
* Adapting the toilet so that the person can move from a wheelchair on to it.
* Ensuring that your brothers and sisters play with you.

While all these strategies may improve the welfare of the person with SEN, we would have not cured the impairment but we would have changed the environment around so that the effect of the impairment is less marked. It is therefore vital to realise that an impairment need not hold a child back. A disability need not become a handicapped!

All children learn through their interactions with other people – parents, siblings and peers

Through the experiences gained in the various environments in their lives – home, neighbourhood and school. This is just as true for children with impairments. But this is often forgotten as these children are seen as ‘different’.

* Many of the disabling effects of impairments can be reduced if children have the opportunity:
	+ to interact with peers and adults in their community;
	+ to experience a range of environments which minimise the impact of their impairment, such as buildings that have no steps; and
	+ to be taught by parents and teachers who help them to learn new skills.
* Hence the importance of making education available to all children.
* Inclusive education does provide a flat-form for achieving such a goal.

## Defining Inclusive Education

* Continuous process of increasing access, participation and achievement for the marginalised or excluded persons into the mainstream, (Ainscow 2007).
* A dynamic approach of responding positively to pupil diversity and of seeing individual differences not as problems, but as opportunities for enriching learning.

 (UNESCO 2005)*.*

* That is to say, inclusion has to be seen as a never-ending search to find better ways of responding to diversity.
* “**Presence**” is concerned with where children are educated, and how reliably and punctually they attend;
* “**Participation**” relates to the quality of their experiences whilst they are there and, therefore, must incorporate the views of the learners themselves; and
* “**Achievement**” is about the outcomes of learning across the curriculum, not merely test or examination results.
* It is about learning how to live with difference and learning how to learn from difference.
* In this way differences come to be seen more positively as a stimulus for fostering learning, amongst children and adults.
* This indicates the moral responsibility to ensure that those groups that are statistically most “at risk” are carefully monitored, and that, where necessary, steps are taken to ensure their presence, participation and achievement in the education system.
* Involves collecting, collating and evaluating information from a wide variety of sources in order to plan for improvements in policy and practice.
* It is about using evidence of various kinds to stimulate creativity and problem-solving.

## What inclusion is and is not

|  |  |
| --- | --- |
| Inclusion IS about  | Inclusion IS NOT about  |
| Welcoming diversity | Reforms of special education alone, but reform of both the formal and non-formal education system. |
| Benefiting all learners, not only targeting the excluded  | Responding only to diversity, but also improving the quality of education for all learners |
| Children in school who may feel excluded  | Special schools but perhaps additional support to students within the regular school system |
| Providing equal access to education or making certain provisions for certain categories of children without excluding them.  | Meeting one child’s needs at the expense of another child |

##

## Misconceptions about inclusion

* Inclusion is costly
* Implementing inclusion needs societal change in attitudes first
* Inclusion is a positive theoretical concept, but is not practical
* Inclusion requires special skills and capacities that are difficult to develop
* Inclusion is the responsibility of the Social Ministry and not of the Ministry of Education
* Inclusion is a disability-specific issue

Overcoming these misconceptions about inclusion is one of the challenges to change.

Inclusive education is about being appreciated, valued and respected in the social, economic, political and cultural life of an educational system; being recognized for the abilities and talents one does have; being given the same opportunities and encouragement to develop and grow into the kind of person one chooses; and, developing trusted relationships and friendships to develop to the best of one’s ability and create the kind of life that one values (UNESCO 2000).

Miles and Kaplan (2005) define inclusion as a process of increasing opportunities for presence, participation and achievement for all pupils within a similar educational setting and in their local schools with an emphasis on those at risk of exclusion and marginalisation. Stainback and Stainback (1996) on the other hand define inclusive education as a philosophy based on democracy, equality and human rights. Hence, inclusive schooling starts with a philosophy that all children can learn and belong in the mainstream of school and community life. It goes beyond to encompass a place where everyone belongs, and is accepted, supports and is supported by his/her peers and other members of the school and, community in the course of having his/her educational needs met. Diversity is valued; it is believed that diversity strengthens the class and offers all of its members a greater opportunity for learning.

Sebba and Ainscow (1996) define inclusion as follows:

* A process (rather than a state),by which a school attempts to respond to all pupils as individuals;
* Regards inclusion and exclusion as connected processes; schools developing more inclusive practices may need to consider both;
* Emphasises the reconstructing the curricular provision in order to reach out to all pupils as individuals;
* Emphasises overall school effectiveness;
* Is of relevance to all phases and types of school, possibly including special schools since within any educational provision teachers face groups of students with diverse needs and are required to respond to diversity.

As observed from Sight Savers International and many others, Inclusive education is anchored on the principles of education as a ‘Human Right’ as reflected in the *“Convention on the Rights of the Child (*1989*)”*. Some of the articles in the *Convention on the Rights of the Child (1989)* states that:

**Article 2** states that all rights shall apply to all children without discrimination on

any ground and specifically mentions disability.

**Article 3** states that in all actions the child’s best interests “shall be the primary

Consideration.”

**Article 23** states the right of disabled children to enjoy a full and decent life, in conditions, which ensures dignity, promotes self-reliance, and facilitates the child’s active participation in the community. It also states the right of the disabled child to special care, education, health care, training, rehabilitation, and employment preparation and recreation opportunities

**Article 28** states the child’s right to education on the basis of equal opportunity **Article 29** states that a child’s education should be directed at developing the child’s personality and talents and mental and physical abilities to their fullest potential.

In June 1994 representatives of 92 governments and 25 international organisations came together for the World Conference on Special Needs Education in Salamanca in Spain. They agreed on a statement and a framework for action on the education of children with disabilities. The Salamanca Statement says:

We believe and proclaim that:

* Every child has a fundamental right to education and must be given the opportunity to achieve and maintain an acceptable level of learning,
* Every child has unique characteristics, interests, abilities and learning needs,
* Education systems should be designed and educational programmes implemented to take into account the wide diversity of these characteristics and needs,
* Those with special educational needs must have access to regular schools which should accommodate them within a child-centred pedagogy capable of meeting those needs,
* Regular schools with this inclusive orientation are the most effective means of combating discriminatory attitudes, creating welcoming communities, building an inclusive society and achieving education for all, moreover they provide effective education to the majority of children and improve the efficiency and ultimately the cost effectiveness of the entire education system.

## Why it is important for CSEN to go to school

Schooling and education helps all children learn about the world around them and to become useful members of the community.

Some children with disabilities cannot learn to read, write and count like other children, but it is important that these children go to school for the following reasons:

* Education helps children to become independent adults.
* Education prepares children to be able to work and earn a living.
* Education teaches children how to get along with others, how to behave,

and how to work with others.

* Education develops the abilities children have.
* Education helps children to accept rules and take responsibility.
* Education helps children to form friendships and gives them the feeling of

belonging to a group.

* Education teaches children the activities that will help them to be useful
* members of a family and the community.

**Some reasons why children with disabilities don’t go to school**

* Poverty – the family cannot afford to send the child to school.
* Parents think that their child with disabilities does not need an education.
* Parents think it is more important to send the other children in the family to

school than their child with disabilities.

* Parents are ashamed or embarrassed by their child with disabilities.
* The child with disabilities does not want to go to school.
* The parents are afraid that their child with disabilities will be teased at school.
* The school is too far away from the family home.
* The child with disabilities can’t walk to school.
* Parents feel their child with disabilities won’t be able to go to school.
* The school principal or the teacher doesn’t want the child with disabilities in their school.
* Other parents at the school don’t want the child with disabilities to join the school because they are afraid the education of the other children will suffer.

## International Trends on inclusive education

In the last few years there have been four important international conferences on

education:

* 1990 World Conference on Education for All (Jomtien, Thailand)
* 1994 World Conference on Special Needs Education (Salamanca, Spain)
* 2000 World Education Forum (Dakar, Senegal), and
* 2006 UN Convention on the Rights of Persons with Disabilities.

In all these international protocols, education is acknowledged as a *‘fundamental human right.’* At the World Conference on Special Needs Education the participants agreed that:

"Experience in many countries demonstrates that the integration of children and youth with special educational needs is best achieved **within inclusive schools that serve all children** within a community. It is within this context that those with special educational needs can achieve the fullest progress and social integration." *Salamanca Framework for Action,* 1994.

Literature on inclusive education world-wide points us broadly to two educational systems, as illustrated in the two diagrams below, as adopted from EENNET (2003). The first one highlights the underlying assumptions for exclusive educational systems while the second diagram highlights assumption for inclusive education system. In the first diagram], the ‘child’ is viewed as a problem who require fixing to be able to access education in the mainstream, while the latter focuses on the education system as requiring fixing for all children to effectively access and participate in the mainstream education system.

Figure 1: Exclusive education system



Figure 2: Inclusive education system



Whereas it is acknowledged world-wide that inclusive education systems are the most effective means of combating discrimination and exclusion being experienced by many persons, the disabled included, the reality on the ground for many schools in Zambia is exclusive education. This has led to continued violation of human ‘Rights’ for many persons, including those with Special Education Needs. It must be pointed out that inclusive education is preferred to exclusive education on the following account:

* they are much cheaper than building a lot of separate schools for children

with special needs;

* they encourage the integration of children with special needs which helps

to build an inclusive society;

* they allow other children in the school to learn about the abilities of children with disabilities;
* they encourage the involvement of parents and the community; and
* they improve teaching.

The United Nations Convention on the Rights of people with disabilities recognizes and promotes inclusive education as a Right (article 24, 2006). Zambia has since signed (2009) and ratified (2010) the protocol but yet to domesticate it. According to the national policy on education, “Educating Our Future”, Ministry of Education assures to provide quality education for children with special education. The policy states that:

To the greatest extent possible, the Ministry will ‘include’ pupils with special educational needs in to the mainstream institutions and will provide them with necessary facilities.

Government through the same policy further commits itself to provide adequate trained personnel, equipment, infrastructure and appropriate technology to enhance the inclusion of children with special education needs into mainstream schools. The persons with disability act number 33 of 1996 states that failure to admit or enroll any child into a school on account of their disability is a discriminatory offence. It further states that learning institutions should provide appropriate equipment and devices for such children.

**Here some the views of teachers from ordinary schools with experience of teaching children with extra needs.**

*I took inclusion as a challenge for improving my own ways of teaching.*

**Hungary**

*We want our children to know that it is OK to be different. After all we are preparing them for life and society.*

**South Africa**

*Integration is socially beneficial to the whole school including the staff. It fosters an atmosphere of teamwork amongst the students and ideally between staff.*

**Norway**

*When students observe that their teachers are accepting and supportive of those who could be termed ‘different’, they too become more accepting.*

**Jordan**

*Teachers in rural areas increased their status within local communities because in many cases, they were providing the only services available to children with disabilities.*

**India**

*A lot of children are having their needs met who before would have just been pushed along or ignored. Teachers are addressing the whole situation differently by working together.*

**Canada**

## Exercise



Attempt to answer the question below to test your understanding on Unit 4 topic:

1. What is inclusive education? Discuss the challenges and benefits associated with this kind of education.

## Summary



In summary, while the Zambian government is showing commitment to improve the education system through the many international agreements ratified, local policies and legislation formulated, there is a big disparity between the commitment and service delivery. In addition, whereas literature acknowledges the value of inclusive education as a catalyst towards quality education, there appear to be little understanding on what inclusive education is and how it should be implemented in Zambia. This in turn perpetuates an education system which is un-responsive to the needs of children with children with SEN among others, leaving many without opportunities to access and participate in quality education. This Unit therefore, focused on orienting you in the field of inclusive education.

# UNIT 11

## Special Education Needs – A Human Rights Perspective

## 11.1 Introduction

While Unit 4 was dedicated to orienting you in the field of Inclusive Education, this Unittakes the Rights Based approach in attending to Special Education Needs. You will notice that inclusive education approach does provide enough space to fully realize the rights to education for most marginalized children, among which are those with SEN. We now introduce you to what Human Rights are, how they can be claimed and the various international protocols where Zambia is a signatory. It is hoped that through this discourse, you shall be empowered to champion the cause of children with SEN using the Rights Based approach.

## 11.2 Objectives



By the end of this unit, you should be able to:

1. Define that Human Rights are;
2. Discuss the origins of Human Rights;
3. Describe the various types of Human Rights; and
4. Describe the various international protocols on Special Education Needs

## 11.3 Reflection

TateyoyoLubasi is nine years old boy with special education needs, living in Kaoma with his grandmother, a widow taking care of seven other orphans. He has not begun any schooling because of lack of money for PTA fees. KweshakoPanono is thirteen years old, and has dropped out of school because of the need to help his family do farming in Kasama. At 16, ChachaKalala passed her grade nine exams and would like to go into grade ten but there is no secondary school close enough to her home in Sesheke that can take her into classes because she is visually impaired.

Tateyoyo, Kweshako and Chacha, are children with hopes of education but with no hope of receiving an education in the Zambian school system today. Are their rights being violated? Is there any responsibility of the Government of the Republic of Zambia to assure that they receive an education? Can they make any claim against the Government?

Perhaps, for you to appreciate the challenges faced by Tateyoyo, Kweshako and Chacha above, there is need to establish what we mean by human rights. What follows below is a description of what human rights is.

## 11.4 Human Rights

*Human being are born free equal in dignity and rights, are endowed with reason and conscience and should act towards one another in a spirit of brotherhood/sisterhood.*

Human rights are important because:

* They reflect a sense of fairness, justice and decency
* They help preserve human dignity: - Man was made in the image of God- and human beings are therefore special in their own image.
* Human rights are important for self-fulfilment:-i.e. use of our talents to the fullest potential.
* Human rights promote individual well-being.

Human rights are all about relationships between and among individuals and the state, and not an individual against a fellow individual. Human rights are not gifts from government to be withdrawn or withheld at will.

Article 28 of the Zambian Constitution provides that anyone who strongly feels that his or her rights guaranteed under the Bill of Rights (part 111 of the Zambian Constitution) have been, are being or are likely to be violated, can sue the state in the High Court. The High Court has powers to grant whatever remedy it sees appropriate for a particular kind of violation.

The Rights enshrined in the Zambian constitution include:

* Protection of the right to life
* Protection of the right to personal liberty
* The right to protection from slavery and forced labour
* Protection against torture, inhuman and degrading treatment
* Protection to deprivation of property
* Protection from any form of discrimination on the basis of race, sex, tribe, place of origin, marital status, political opinions, colour or creed
* Protection of privacy of home and other property
* Right to protection of the law
* Protection of freedom of conscience
* Protection of freedom of expression
* Protection of freedom of assembly and association
* Protection of the freedom of movement
* Protection of young persons from exploitation.

For most rights, derogations or limitations are so many and wide ranging that they negate the rights or render them meaningless.

There are three mechanisms through which Human Rights are protected in Zambia. These are:

1. Constitutional Protection of Human Rights
2. Institutional Protection of Human Rights
3. Political mechanisms (Extra-legal methods) of protecting Human Rights.

The constitution of any state is the supreme law and no one is above the law. The constitution makes Parliament and gives Parliament the power to make law through Acts of Parliament.

Any law passed in parliament is supposed to be “intra-vires”. i.e it should not contradict the provisions of the constitution. This ensures that the fundamental rights and freedoms guaranteed in the Bill of Rights of the constitution are fully protected and adhered to.

* Human rights are, literally, the rights that one has simply because one is human. This deceptively simple idea has profound social and political consequences.
* Human Rights are minimum standards of legal, political and civil freedom that are granted universally by the United Nations.
* Human Rights refer to the concept of human beings as having universal rights or status regardless of legal jurisdiction or ethnicity and nationality.
* Human rights, because they rest on nothing more than being human, are universal, equal, and inalienable. They are held by all human beings, universally. One either is or is not human and thus has or does not have human rights, equally.
* Human rights, being held by every person against the state and society, provide a framework for political organization and a standard of political legitimacy.
* Where they are systematically denied, claims of human rights may be positively revolutionary. Even in societies where human rights are generally well respected, they provide constant pressure on governments to meet their standards.
* Human Rights are safeguards for individuals against arbitrary use of power by the govt.

## 11.5 The Origins of Human Rights

All societies possess notions of justice, fairness, dignity, and respect. Human rights, however, are but one path to implement a particular conception of social justice. In fact, the idea of human rights -- the notion that all human beings, simply because they are human, have certain inalienable rights that they may exercise against society and their rulers -- was foreign to all major pre-modern Western and non-Western societies. Human rights entered the mainstream of political theory and practice in 17th-century Europe.

## 11.6 Types of Human Rights

The major types of human rights are political and civil rights economic, social and cultural and solidarity.

1. right to life
2. right to an adequate standard of living
3. freedom from torture and mistreatment
4. freedom of religion and of expression
5. freedom of movement
6. right to education
7. right to participate in cultural and political life
8. right to self determination

Human Rights are at times divided into negative and positive rights

* Negative rights refer to actions that the government should not take.
* Positive rights denote rights that the state is obliged to protect and provide. For example, the right to education, to a livelihood, to legal equality.

**11.7 Human Rights as an International Issue**

In the post-Cold War world, nearly all states, in all regions of the world, at all levels of development, proclaim their commitment to human rights. This situation, however, is historically unprecedented. Human rights have been an established subject of international relations for only about half a century. How a government treated its own citizens in its own territory was considered a matter of sovereign domestic jurisdiction. In fact, individual states and the international community were considered to be under an international legal obligation not to intervene in such matters. Human rights have a prominent place in the UN Charter adopted in 1945. And the new organization moved rapidly to elaborate authoritative international human rights norms. On December 10, 1948, the UN General Assembly adopted the Universal Declaration of Human Rights. This comprehensive list of rights codified the emerging view that the way in which states treat their own citizens is not only a legitimate international concern but subject to international standards. The United Nations is not a world government standing above states, but an intergovernmental organization. It can do nothing that its members -- sovereign states -- do not authorize. in December 1966. Along with the Universal Declaration they provide an authoritative statement of internationally recognized human rights. The very comprehensiveness of the Covenants, however, demanded that the United Nations shift its human rights in the political development and spread of human rights ideas and practices.

## 11.8 What is a human right?

The right to education is a human right. A right is something which you are entitled to, which you can claim. Having a right means that someone else has an obligation. If someone has the right to free education, then the government or school cannot require that you pay to access education (except through a broader system of tax collection). Human rights are universal and inalienable. They are inherent. We are born with them. They cannot be given, or taken away. As such, human rights are non-discriminatory, and should not be influenced by sex, ethnicity, nationality, etc. (although special measures, as long as they are reasonable and justifiable, can be introduced to ensure everyone has the equal opportunity to enjoy that right – see below). They are the foundation of freedom, justice and peace, and are the basic standards without which people cannot live a life of dignity. They are proclaimed in the Universal Declaration of Human Rights, and reinforced by many legally binding international covenants and conventions, as well as in national constitutions.

Although human rights are theoretically universal and inherent they can be denied through

violations in practice. Often people are unable to access their human rights because of

who they are, and where they live. Discrimination is rife in every society, limiting for

example, women’s ability to participate in public forums (or household decision-making),

or those from minority groups from receiving appropriate education. Discrimination, which prevents people from accessing their human rights, is an abuse, undermining the very concept of a universal right.

## 11.9 International law and the right to education

The right to education has been recognised since the Universal Declaration of Human Rights (UDHR) in 1948. Article 26 of the Declaration proclaims that:

‘*Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages. Elementary education shall be compulsory…education shall be directed to the full development of human personality and to the strengthening of respect for human rights and fundamental freedoms. It shall promote understanding, tolerance and friendship among racial or religious groups…*’.

The right to education has been enshrined in a range of international conventions, including the International Covenant on Economic, Social And Cultural Rights (ICESCR, 1966), The Convention on the Elimination Of All Forms Of Discrimination Against Women (CEDAW, 1979) and more recently, The Convention On The Rights of The Child (CRC, 1989). It has also been incorporated into various regional treaties (detailed in boxes on page 47 and 48). Beyond this many countries have made provisions for the right to education in their national constitutions.

While the right to education is universally recognised the way it is interpreted at national level differs substantially. This means that although every human being holds the same right regardless of any national law, the ways of securing this right differ greatly from location to location. For example, in some countries the right to education may be legally enforceable through national legislation, in others it will be important to look to international law and standards.

## 11.10 Understanding the right to education

In addition to being a human right in itself, the right to education is often considered an enabling right. It brings better health and employment opportunities, enhanced national growth, democracy, respect for human rights and equality. Because of its enabling quality there are many other human rights which link to the right to education – such as the right to freedom from forced labour, the right to work and the right to participate in decision-making.

There is no absolute agreement as to how to define the right to education but the aims and

objectives of education, as defined in the international covenants and treaties include the following:

* The development of human personality, a sense of dignity of individual talent, and mental and physical ability;
* Respect for human rights and fundamental freedoms, as well as cultural identity, language and values;
* Enable people to participate effectively in a free society;
* The promotion of understanding, tolerance, friendship among all groups, and to maintain peace; and
* To promote gender equality and respect for the environment;

## 11.11 Rights and obligations

These rights also suggest obligations: ‘*the 1993 World Conference on Human Rights reaffirmed that States are duty-bound to ensure that education is aimed at strengthening the respect of human rights and fundamental freedoms*’ and the ICESCR guarantees that the right to education will be exercised without discrimination of any kind. There is also a clear obligation on the part of the international community to support the right to education, as interpreted by the committee to the ICESCR (who are the authoritative body, charged with monitoring legislation related to the covenant). Finally, if free primary education, which meets the 4As standards, exists there are obligations on the part of parents and guardians to ensure that their children are in school.

## 11.12 Grounding the right to education locally

The right to education is an abstract concept and although the right itself may be enshrined in a series of national laws and international conventions, this is meaningless for people who have never experienced the right, and may not know that the right even exists for them. They are likely to be unaware of their constitution or how it can be legally enforced. Grounding the right to education locally means transforming the abstract concept into a concrete reality; it means looking at current provisions for the right to education, and exploring what local people need to make their right to education a reality.

## 11.13 Understanding the legal basis of the right to education:

It is important to do some initial research before introducing the right to education at local level. Although the right to education is universal the way national constitutions and legislation interprets this right will vary and may be limited. This could limit the ability to enforce the right nationally. For example, the state may or may not have ratified certain treaties, or enshrined the right to education in national legislation. The status of the right, and the level of detail given about the right within the constitution or national legislation, will influence how you plan and implement your work.

1. The first stage of this work is to raise awareness of the right, just letting people know that they have the right and are currently being denied it can be enough to raise people’s interest in being part of a process. And knowing that you have a right is empowering in itself.
2. The second stage is to make this right meaningful at local level. This means exploring current provision on the right to education, understanding what is offered in the constitution and what would need to be provided in order for the right to be realised.
3. The third stage is to build people’s skills, knowledge and confidence so that they can hold the government accountable to deliver on its obligation, and to fulfil the right to education.

## 11.14 Introducing the right to education to ‘rights-holders’

There are many ways to raise awareness on an issue. The method chosen will depend on the current links you have, and the scale of intervention. For example, the box to the right describes how a travelling caravan using street theatre was able to raise awareness of the right to education across an entire state in India. You could also use community meetings and links with local groups and schools. This initial stage involves communicating clearly that the right to education exists, and that it is the government’s responsibility to deliver this right. For people to be empowered, and claim their right they need to be aware of its existence. But just saying ‘you have the right to education’ on its own can be quite meaningless.

## 11.15 Making the right to education meaningful: The 4 As

A framework of ‘4 As’ namely: Available, Accessible, Acceptable and Adaptable has been developed to help people think through different dimensions of the right to education. By using a participatory process this framework can become a tool to enable people to think through what the right to education means to them, and compare their current reality to this ideal context.

## 11.16. Extracts on international Protocols

**African [Banjul] Charter on Human and Peoples' Rights, adopted June 27, 1981, OAU Doc.**

**CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982), entered into force Oct. 21, 1986: [excerpts]**

Preamble

The African States members of the Organization of African Unity, parties to the present convention entitled "African Charter on

Human and Peoples' Rights",

Article 1

The Member States of the Organization of African Unity parties to the present Charter shall recognize the rights, duties and freedoms enshrined in this Chapter and shall undertake to adopt legislative or other measures to give effect to them.

Article 17

1. Every individual shall have the right to education. 2. Every individual may freely, take part in the cultural life of his community.

3. The promotion and protection of morals and traditional values recognized by the community shall be the duty of the State.

Article 18

4. The aged and the disabled shall also have the right to special measures of protection in keeping with their physical or moral needs.

Article 19

All peoples shall be equal; they shall enjoy the same respect and shall have the same rights. Nothing shall justify the domination of a people by another.

Convention on the Rights of the Child

Adopted and opened for signature, ratification and accession by

General Assembly resolution 44/25 of 20 November 1989 entry into force 2 September 1990, in accordance with article 49

Article 23

1. States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions, which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.

2.States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

 3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development

Article 28

1. States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:

(a) Make primary education compulsory and available free to all;

(b) Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need;

(c) Make higher education accessible to all on the basis of capacity by every appropriate means;

**EDUCATION FOR ALL ( EFA)**

**BACKGROUND:**

At the World Conference on Education for All (Jomtien, Thailand 1990) some

1,500 participants, comprising delegates from 155 governments, policy – makers and specialists in education and health, social and economic development from around the

World, met to discuss major aspects of EFA. The World Declaration on Education for

All and the Framework for Action to meet Basic Learning Needs, adopted at Jomtien, foresaw the need for an end of decade assessment of progress as a basis for a comprehensive review of policies concerning basic education. A number of meetings, conferences and forums were held in 1990's to assess the achievement/progress and revise the targets, goals and policies in EFA. A brief overview of these meetings/conferences is as follows:

1.2 **Jomtien Conference 1990**

The Jomtien Conference clearly defined the basic learning needs of the child i.e. learning tools (such as literacy, oral expression, numeracy, and problem solving) as well as basic learning contents (such as knowledge, skills, values and attitudes). The framework for action to meet basic learning needs identified six main areas of action:

1. expansion of early childhood care and development activities;
2. universal access to and completion of primary education:
3. improvement in learning achievements:
4. reduction of adult illiteracy:
5. expansion of basic education and skills training for youth and adults.
6. increased acquisition by individuals and families the knowledge, skills and values for better living.

In addition, following five principles for promoting basic education were endorsed:

1. universalizing access and promoting equity;
2. focusing on learning,
3. broadening the learning environment;
4. improving the learning environment; and
5. strengthening partnerships.

Goals and targets agreed upon in the Jomtien conference were:

1. Universal access to and 80% completion of primary education by the year 2000.

2. Reduction of adult illiteracy rate to one half of its 1990 level by the year 2000, with sufficient emphasis on female literacy.

**The World Education Forum In Dakar (2000):**

Ten years after Jomtien, the countries and development agencies gathered in

Dakar and reaffirmed their commitment in providing Education For All (EFA).

The World Education Forum, convened by UNESCO, UNDP, UNFPA, UNICEF and the World Bank brought together 1,500 participants from 182 countries, as well as major development agencies. It ended with the adoption of the Dakar Framework for Action, wherein ministers of education and other government representatives, heads of United Nation agencies, the donor community and representatives of NGOs, indeed all participants, committed themselves to achieve the EFA goals and targets by the year 2015.

1.3 **EFA Goals And Targets:**

1. Expanding and improving comprehensive early childhood care and education, especially for the most vulnerable disadvantaged children;
2. Ensuring that by 2015 all children with special emphasis on girls and children in difficult circumstances have access to and complete free and compulsory primary education of good quality;
3. Ensuring that the learning needs of all young people and adults are met through equitable access to appropriate learning, life skills and citizenship programs;
4. Achieve a 50% improvement in levels of adult literacy by 2015, especially for women and equitable access to basic and continuing education for all adults;
5. Eliminating gender disparities in primary and secondary education by
6. 2005, and achieving gender equality in education by 2015, with a focus on ensuring girls’ full and equal access to and achievement in basic education of good quality; and
7. Improving all aspects of the quality of education and ensuring excellence of all so that recognized and measurable learning outcomes are achieved by all, especially in literacy, numeracy and essential life skills.

**The Standard Rules on the Equalization of Opportunities for
Persons with Disabilities**

* Adopted by the United Nations General Assembly, forty-eighth session, resolution 48/96, annex, of 20 December 1993
* UN STANDARD RULES on the equalization of opportunities for persons with disabilities (important ones)
* **Purpose and content of the Standard Rules on the Equalization of Opportunities for Persons with Disabilities**
* The Standard Rules on the Equalization of Opportunities for Persons with Disabilities have been developed on the basis of the experience gained during the United Nations Decade of Disabled Persons (1983-1992). Although the Rules are not compulsory s they imply a strong moral and political commitment on behalf of States to take action for the equalization of opportunities for persons with disabilities. The Rules offer an instrument for policy-making and action to persons with disabilities and their organizations. They provide a basis for technical and economic cooperation among States, the United Nations and other international organizations.
* The purpose of the Rules is to ensure that girls, boys, women and men with disabilities, as members of their societies, may exercise the same rights and obligations as others.
* Rule 6. Education
* States should recognize the principle of equal primary, secondary and tertiary educational opportunities for children, youth and adults with disabilities, in integrated settings. They should ensure that the education of persons with disabilities is an integral part of the educational system.
* General educational authorities are responsible for the education of persons with disabilities in integrated settings. Education for persons with disabilities should form an integral part of national educational planning, curriculum development and school organization.
* Education in mainstream schools presupposes the provision of interpreter and other appropriate support services. Adequate accessibility and support services, designed to meet the needs of persons with different disabilities, should be provided.
* Parent groups and organizations of persons with disabilities should be involved in the education process at all levels.
* In States where education is compulsory it should be provided to girls and boys with all kinds and all levels of disabilities, including the most severe.
* Special attention should be given in the following areas:
* Very young children with disabilities;
* Pre-school children with disabilities;
* Adults with disabilities, particularly women.
* To accommodate educational provisions for persons with disabilities in the mainstream, States should:
* Have a clearly stated policy, understood and accepted at the school level and by the wider community;
* Allow for curriculum flexibility, addition and adaptation;
* Provide for quality materials, ongoing teacher training and support teachers.
* Integrated education and community-based programs should be seen as complementary approaches in providing cost-effective education and training for persons with disabilities. National community-based programs should encourage communities to use and develop their resources to provide local education to persons with disabilities.
* In situations where the general school system does not yet adequately meet the needs of all persons with disabilities, special education may be considered. It should be aimed at preparing students for education in the general school system. The quality of such education should reflect the same standards and ambitions as general education and should be closely linked to it. At a minimum, students with disabilities should be afforded the same portion of educational resources as students without disabilities. States should aim for the gradual integration of special education services into mainstream education. It is acknowledged that in some instances special education may currently be considered to be the most appropriate form of education for some students with disabilities.
* Owing to the particular communication needs of deaf and deaf/blind persons, their education may be more suitably provided in schools for such persons or special classes and units in mainstream schools. At the initial stage, in particular, special attention needs to be focused on culturally sensitive instruction that will result in effective communication skills and maximum independence for people who are deaf or deaf/blind.

##### 2006 UN CONVENTION ON THE RIGHTS OF PERSONS WITH DISABILITY

##### Article 24 - Education

1. States Parties recognize the right of persons with disabilities to education. With a view to realizing this right without discrimination and on the basis of equal opportunity, States Parties shall ensure an inclusive education system at all levels and lifelong learning directed to:

(a) The full development of human potential and sense of dignity and self-worth, and the strengthening of respect for human rights, fundamental freedoms and human diversity;

(b) The development by persons with disabilities of their personality, talents and creativity, as well as their mental and physical abilities, to their fullest potential;

(c) Enabling persons with disabilities to participate effectively in a free society.

2. In realizing this right, States Parties shall ensure that:

(a) Persons with disabilities are not excluded from the general education system on the basis of disability, and that children with disabilities are not excluded from free and compulsory primary education, or from secondary education, on the basis of disability;

(b) Persons with disabilities can access an inclusive, quality and free primary education and secondary education on an equal basis with others in the communities in which they live;

(c) Reasonable accommodation of the individual's requirements is provided;

(d) Persons with disabilities receive the support required, within the general education system, to facilitate their effective education;

(e) Effective individualized support measures are provided in environments that maximize academic and social development, consistent with the goal of full inclusion.

3. States Parties shall enable persons with disabilities to learn life and social development skills to facilitate their full and equal participation in education and as members of the community. To this end, States Parties shall take appropriate measures, including:

(a) Facilitating the learning of Braille, alternative script, augmentative and alternative modes, means and formats of communication and orientation and mobility skills, and facilitating peer support and mentoring;

(b) Facilitating the learning of sign language and the promotion of the linguistic identity of the deaf community;

(c) Ensuring that the education of persons, and in particular children, who are blind, deaf or deafblind, is delivered in the most appropriate languages and modes and means of communication for the individual, and in environments which maximize academic and social development.

4. In order to help ensure the realization of this right, States Parties shall take appropriate measures to employ teachers, including teachers with disabilities, who are qualified in sign language and/or Braille, and to train professionals and staff who work at all levels of education. Such training shall incorporate disability awareness and the use of appropriate augmentative and alternative modes, means and formats of communication, educational techniques and materials to support persons with disabilities.

5. States Parties shall ensure that persons with disabilities are able to access general tertiary education, vocational training, adult education and lifelong learning without discrimination and on an equal basis with others. To this end, States Parties shall ensure that reasonable accommodation is provided to persons with disabilities.

## 11.17 Exercise



Attempt to answer the questions below to test your understanding on Unit 5 topic:

(**1**) What is a human Right?

(**2**) How would you justify the provision of SEN services using the rights perspective?

 (**3** What is inclusive education? Discuss the requirements of this kind of education.

 Discuss the United Nations Standard Rules on Equalization of Opportunities for

 persons with disabilities.

 (**4**) The 2006 UN Convention on Persons with disabilities is seen as a push towards the

 implementation of inclusive education. Discuss how Zambia could use this policy to

 implement inclusive education.

## 11.18 Summary



This Unittook the Rights Based approach in attending to Special Education Needs. In this discourse, you notice d that inclusive education approach does provide enough space to fully realize the rights to education for most marginalized children, among which are those with SEN. We are confident that you are now acquainted with the key concepts in the area of ‘Right to Education’ for children with SEN.



# 11.19 Module Summary

We are glad that you have successfully completed this module in EPS1030. We hope that you are confident enough to:

1. Define key terms related to the field of special education;
2. Trace the Origins and development of special education
3. Describe current trends in special education;
4. Describe the various categories of children with Special Educational Needs
5. Describe the identification and screening processes for various learners with SEN
6. Discuss the benefits and challenges of engaging in Early Childhood Learning among children with SEN
7. Discuss government policies in special education;
8. Discuss disability rights and laws;

Just in case you are doubtful on the issues highlighted above, kindly do revise your module again. We wish you the best as you now get ready to sit for your examination in this module and prepare to further engage with the issues raised in this module at a higher level till you complete your Bachelors of Education (Special Education) programme.