SURVEY OF SPECIAL EDUCATIONAL NEEDS AT UNRWA SCHOOLS

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CHAPTER 1

SPECIAL EDUCATIONAL NEEDS

The learning and teaching processes entail complex interrelationships between students and teachers, students and students and between students and their environment. Some barriers can affect the learning process of students resulting in poor performance at the academic level. These barriers include: (1) Deficiencies in basic living resources such as poverty, substandard housing, (2) Observable problems such as school adjustment problems, abuse by others, emotional upset, (3) General stressors and underlying associated psychological problems such as competence deficits, (4) Crises and Emergencies whether familial or at school level and (5) Difficult transitions which can be associated with stages of life or life circumstances (Center for Mental Health in Schools, 2003). There is no general consensus on the exact number of students who really need assistance in dealing with such barriers. Yet, there is a consensus that a large number of students face problems that are designated as “Special Educational Needs”.

The condition called Special Educational Needs (SEN) among children is a universal problem that occurs in all cultures, nations and language groups. It is becoming a growing problem that needs efficient and structured intervention. In fact, a major interest in the concept of SEN started growing since the years 1960s and 1970s especially as far as early identification is concerned. In addition, more efforts are being made lately to develop educational programs facilitating the integration of these students in regular schools rather than segregating them in special schools.

In fact, schools that are committed to excellence and success must have an array of activities that are designed to address such conditions. Increasingly, education reform and restructuring are changing the whole fabric of schools and calling upon all personnel to expand their roles and functions. As a result, school staff needs to acquire new ways of thinking about how schools should assess these barriers in order to plan effective ways to address them.

Palestinians have faced during the last decades consecutive wars and traumatic changes and transitions, which might have left their effect on the behavior and the learning potential of the students. In addition, the difficult economical, social and legal conditions of the Palestinians in Lebanon might have significant effects on the educational system specifically. Therefore, as part of their programs to improve the living conditions of Palestinian refugees in Lebanon, The United Nations Relief and Works Agency for

Palestine Refugees in the Near East (UNRWA) launched a project to conduct a comprehensive survey of SEN among UNRWA students aged 6-18 years in Lebanon, and to design and organize training for 250 UNRWA staff members on methods of identification and treatment of SEN students.

1.1. Definition of Special Educational Needs

A precise definition of Special Educational Needs is difficult. Different sources use different descriptions and different categorizations. Some experts believe that all students may, at some time in their lives, have some form of special educational need. The dilemmas associated with classification have been abundantly dissected in the United States and the United Kingdom special education research and policy literature. Despite the struggles, the fundamental intent of classifying students with disabilities or special needs in schools has primarily been to provide additional educational services and interventions to address individual children's needs.

The term "Special Educational Needs" refers to a broad category of children whose academic performance differs significantly from that of their peers because it is far below average, due to a particular disability (Maclaughlin, 2006). The children who need special education are not only those with obvious learning difficulties, such as those who are physically disabled, deaf or blind. They include those whose learning difficulties are less apparent, such as slow learners and emotionally vulnerable children.
The generic term SEN has been widely used in the United Kingdom for nearly 30 years to cover all children who have developmental difficulties that affect: their learning; their behavioral, emotional and social development; their communication; and their ability to care for themselves and gain independence (Lindsay, 2007).
The revised SEN Code of Practice in the United Kingdom introduced the notion of four "areas of need" (Maclaughlin, 2006):

1. Communication and interaction,
2. Cognition and learning,
3. Behavior, emotional, and social development, and
4. Sensory and/or physical.

However, the definitions of special educational needs as mentioned by Maclaughlin (2006) are somewhat circular, as can be seen in this quotation from the legislation: Children are said to have a learning difficulty if they:

1. Have a significantly greater difficulty in learning than the majority of children of the same age; or

2. Have a disability which prevents or hinders them from making use of educational facilities of a kind generally provided for children the same age in schools within the area of the local education authority;
3. Are under compulsory school age and fall within the definition at (1) or (2) above or would so do if special educational provision was not made for them (Maclaughlin, 2006).

The term Learning Disabilities (LD) was first introduced in 1963, and it described "children of normal cognitive capacity and motivation who nevertheless had trouble learning in school because of neurological dysfunctions" (Zurrif, 1997). These children were said to have problems in the perceptual, integrative, expressive, or sensorimotor processes necessary for learning, rather than in their basic intelligence. In fact, children with learning disabilities have acceptable intelligence.
The United States federal law Individuals with Disabilities Education Act (IDEA-2004) defines the term "specific learning disability" as "a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, spell, or to do mathematical calculations" (Lerner, 2006). It includes conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Such term does not include a learning problem that is primarily the result of visual, hearing, or motor disabilities; of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.

Another operational definition by the federal law states that a student has a specific learning disability if: (1) the student does not achieve at the proper age and ability levels in one or more specific areas when provided with appropriate learning experiences and
(2) the student has a severe discrepancy between achievement and intellectual ability in one or more of these seven areas: (a) oral expression, (b) listening comprehension, (c) written expression, (d) basic reading skills, (e) reading comprehension, (f) mathematics calculation, and (g) mathematics reasoning" (Lerner, 2006).
Nowadays, The term learning disabilities is a broad term that has been used to encompass problems with language, mathematics, and writing, visual and perceptual problems, and attention or behavior problems.

In conclusion, the term SEN refers to the category of children who are believed to possess the requisite potential for particular academic activities but have difficulty acquiring the associated skills. These children have acceptable level of intelligence but their academic performance is not as expected. Several categories of SEN have been described in the literature. These include but note restricted to: Learning Disabilities,

Emotional & Behavioral Disorders, Attention Deficit Hyperactivity Disorder, Autism, Physical Impairments and Chronic Diseases.

1.2 Prevalence of Special Educational Needs

The estimates of the prevalence of learning disabilities vary widely ranging from 1% to 30% of the school population, with about 5% receiving services in the schools (Lerner, 2006).

Over the past 10 years, the number of children identified as having learning disabilities has increased by 38%, though the overall population growth has only increased by 6%.

In a study conducted by Flynn (2006), over 5 per cent of all second-level students were found to suffer from special educational needs. In his study and among surveyed schools Flynn mentioned that (2006):

1. 90 per cent have students with mild general learning difficulties;
2. 82 per cent have students with specific learning difficulties, such as dyslexia;
3. 59 per cent of schools have students with emotional and or behavioral disorders;
4. 41 per cent have students with autism or autistic spectrum disorders.

He also found that a disturbing 89 per cent of schools have students with special educational needs who have not been formally assessed.

In another study conducted in China to investigate the prevalence of learning disabilities among Chinese children using the Pupil Rating Scale and Conners' Children behavior checklist, 10.3% of these children were found to have learning disabilities (Yao, 2003).

Another study shows that students with disabilities make up approximately 9.8% of the total school population (Wood, 1993): the largest percentage were students with learning disabilities, followed by students suffering from speech or language impairments followed by emotional disturbance as shown below:

- 4.79% Learning disabilities: these usually make up the largest group of students receiving special education services.
- 2.39% Speech or language impairments: these usually experience difficulty in one or more areas of communication, such as articulation, voice, fluency or language.
- 1.17% Mental retardation
- 0.89% serious emotional disturbance: these may need academic assistance as well as help with inappropriate behaviors and with the development of social skills.
- 0.18% Multiple disabilities
- 0.13% Hearing impairments: need special equipment and materials as well as an interpreter to enable them to succeed in the regular classroom environment.
- 0.12% other health impairments

- 0.11% orthopedic impairments: may have needs that require specially designed equipment or facilities and close monitoring by school staff. For the most part, orthopedic problems have a minimal impact or effect on the academic achievement and many students in this subgroup can be served in regular classrooms.
- 0.05% visual impairments: these need usually special materials and equipment and preferential seating. Their needs can be usually met with minimal additional effort in the regular class.
- 0.0% Deaf-blindness.

No available published data on the prevalence of SEN among students in the Arab World could be found.

1.3 Predisposing and Contributing Factors to Special Educational Needs

The reasons for school problems in children are usually multifaceted, numerous and overlapping. The etiologies and their prevalence in the total population are: (1) learning disabilities (7% to 10%), (2) emotional disturbances (5% to 10%), (3) attention-deficit/hyperactivity disorder (ADHD) (5%), (4) chronic illness (5%), and (5) mental retardation, (2% to 3%) (Phillips, 1999).

In fact, several barriers have been reported in the literature to affect the performance and the academic achievement of the student. The center for mental health in schools (2003) classified these barriers into different categories:

- **Deficiencies in basic living resources and opportunities for development:** such as dearth of food in the home, substandard housing, income at or below the poverty level and immigrant-related concerns.
- **Observable problems at school:** such as school adjustments problems (dropouts), relationship difficulties (insensitivity to others), language difficulties, abuse by others (physical or sexual), substance abuse, emotional upset and delinquency.
- **General stressors and underlying psychological problems**: associated with them such as deficits in the support systems, threats to self-determination, competence deficits (low self esteem, skill deficits), feeling unrelated to others, and psychopathology.
- **Crises and Emergencies:** whether familial and personal (home violence), or related to school and community (such as death of a colleague or classmate).
- **Difficult transitions:** associated with stages of schooling, or stages of life (puberty, job concerns) or changes in life circumstances (moving, death in the family).

In addition, emphasis on the child's family, social and academic histories, may provide essential clues to the origin of school problems (Phillips, 1999). A thorough family history of the student is essential. In fact, factors such as learning disabilities, school failures, mental illness, behavioral problems, and substance abuse or emotional disturbances in parents or other family members are very instrumental in the evaluation of a child for the presence of special educational needs (Phillips, 1999).

In addition, studies indicate that 50-70% of all variability in the phonological processes that cause specific reading disability can be attributed to genetic factors (Wong, 2004). The genetic research has demonstrated that the risk in the offspring of a parent with a reading disability is eight times higher than in the general population (Wong, 2004).

Other factors that affect the presence of special educational needs include trauma, evidence of slow mental development or adverse perinatal event. Maternal alcohol or drug intake may also contribute to cognitive deficits in children. Other specific risk factors for school performance problems include delay in reaching developmental milestones, impaired vision or hearing; poverty; adverse perinatal events; and personal or family trauma (Phillips, 1999).

Moreover, factors related to the school environment can also predispose to educational problems namely the use of inadequate teaching methods, relationship with educators and repetitive absences (HI, 2008).

Some health problems can affect the learning process to a certain extent. These problems include chronic disease, seizures, recurrent or persistent otitis media, lead poisoning and iron deficiency anemia (Phillips, 1999).

In summary, risk factors for Special Educational Needs as cited in the literature include the following (Phillips, 1999):

- Family History of learning disabilities, school failures, behavioral problems, substance abuse, or emotional disturbances in parents or other family members.
- Any adverse perinatal event or maternal alcohol or drug intake during pregnancy.
- Delay in reaching developmental milestones (physical and mental).
- History of trauma (personal or family related).
- General Stressors (abuse, violence, low self-esteem, psychological distress etc).
- Health problems such as chronic diseases, seizures, recurrent or persistent otitis media, lead poisoning, iron deficiency anemia.
- Impaired vision or hearing
- Poverty and deficiencies in basic living resources.
- School related factors (teaching methods, relationship with educators etc).

1.4 Types of Special Educational Needs

Special Educational Needs include different categories as cited below:

1.4.1 Learning Disabilities

Learning disabilities are characterized by difficulties in listening, speaking, writing, reasoning or computing. The term "learning disabilities" encompasses a variety of specific disabilities that are presumed to stem from some brain or central nervous system dysfunction (Phillips, 1999). For children with LD, the primary difficulty is one that involves reading. In fact, around 60 to 80 percent of children and adults diagnosed with LD have their most severe difficulties in learning to read (Obringer, 1985). Characteristics of children with learning disabilities at different stages of life (Lerner, 2006) include the following:

- **The Preschool level:** Because growth rates are so unpredictable at young ages, educators are generally reluctant to identify preschoolers under a categorical label such as learning disability. These young children are identified as having developmental delay. Among the characteristics displayed by preschool children with learning disabilities are inadequate motor development, language delays, speech disorders, and poor cognitive and concept development.
- **The Elementary Level:** for many children, learning disabilities first become apparent when they enter school and fail to acquire academic skills. The failure often occurs in reading, but it also happens in mathematics, writing, or other school subjects. Among the behaviors frequently seen in the early elementary years are inability to attend and concentrate; poor motor skills, as evidenced in the awkward handling of a pencil and in poor writing; and difficulty in learning to read. In the later elementary years, as the curriculum becomes more difficult, problems may emerge in other areas such as social studies or science. Emotional problems also become more apparent after several years of repeated failure and students become more conscious of their poor achievement in comparison with that of their peers. About 40% of all children with learning disabilities are in the 6-11 age group.
- **The secondary Level:** A radical change in schooling occurs at the secondary level, and adolescents find that learning disabilities begin to take a greater toll. The tougher demands of secondary school curricula and teachers, the turmoil of adolescence, and the continued academic failure combine to intensify the learning disability. Adolescents are also concerned about life after completing school. They may need counseling and guidance for college, career and vocational decisions. To worsen the situation, a few adolescents find themselves drawn into

acts of juvenile delinquency. Because adolescents tend to be overly sensitive, some emotional, social, and self-concept problems often accompany a learning disability at this age. About 60% of all children with learning disabilities are in the 12-17 age groups.

Certain subgroups of children, such as students with learning disabilities, may be at a "greater risk for developing mental disorders because they tend to have lower self-concepts and higher external loci of control and are less socially accepted and more anxious than their peers without learning disabilities" (Maag & Reid, 2006). Furthermore, co-occurring conditions such as depression may exist among students with learning disabilities (Maag & Reid, 2006). It is demonstrated that "students with learning disabilities, as compared to their peers without learning disabilities, experience greater levels of loneliness, stress, and anxiety" (Maag & Reid, 2006).

Learning disabilities as stated above include problems in the language, mathematics, and writing. Specific learning disabilities include the following:

1.4.1.1 Dyslexia

Dyslexia is often considered a neurologically based disorder characterized by an unexpected failure to read despite conventional instruction and adequate intelligence and socio-cultural opportunity. Dyslexia tends to run in families, and is three times as common in boys as in girls; estimates of its incidence in the general population vary but it is generally held to be between three and five per cent.

It comes in several forms. The most generally recognized subdivisions are:

- Auditory Dyslexia (Dysphonetic Dyslexia)
- Visual Dyslexia (Dyseidectic Dyslexia)
- Mixed or Classic Dyslexia (Dysphonetic and Dyseidectic Dyslexia)

Whatever the precise diagnosis, dyslexic children have difficulty in learning the symbols involved in a written language.

1.4.1.2 Dyscalculia

It is a difficulty allied to Dyslexia, where problems lie in understanding and using symbols or functions needed for success in mathematics. A child with dyscalculia frequently has average to above average intelligence but has difficulty with numbers or remembering mathematical facts over a long period of time. Some will have spatial problems such as aligning numbers into proper columns, as well as difficulty in performing other mathematical operations.

1.4.1.3 Dyspraxia

It is a difficulty with thinking out, planning and carrying out sensory / motor tasks. The child with dyspraxia may have a combination of several problems in varying degrees. These include:

- Poor balance
- Poor fine and gross motor co-ordination
- Difficulties with vision
- Motor planning and perception problems
- Tactile dysfunction
- Poor awareness of body position in space
- Difficulty with reading, writing, speech
- Poor social skills

1.4.2 Emotional & Behavioral Disorders

Emotional and behavioral disorders (EBD) can also affect school performance. It is estimated that 14 to 20 percent of students experience some form of behavior disorder during their school-age years (Phillips, 1999). These problems can range from minor disturbances to the dramatic symptoms displayed by children with oppositional defiant disorder or conduct disorder.

In fact, as generations of children experience abuse, neglect, divorce, broken families, poverty, homelessness, drug and alcohol abuse, and decrease supportive social programs, teachers in schools are faced with students whose behavior is out of control, students who can be depressed and withdrawn and not able to interact with others or learn (Culatta & Tompkins, 1999). School becomes less relevant for students who suffer from the absence of a parent, a pregnancy, drug addiction, or any other social problem.

Research shows that students who are deemed to have emotional and behavioral difficulties often underachieve and have some difficulties in sustaining concentration, which results in difficulties in learning.

In order to be considered as “hard” or “cool” by other students they resort to even more ‘disruptive behavior” (Tilstone & Layton, 2004).

The legal definition of children suffering from behavioral problems according to the IDEA: “seriously emotionally disturbed” is defined as a condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree, which adversely affects educational performance:

- An inability to learn which cannot be explained by intellectual, sensory or health factors;

- An inability to build or maintain satisfactory relationships with peers and teachers;
- Inappropriate types of behavior or feelings under normal circumstances
- A general pervasive mood of unhappiness of depression; or
- A tendency to develop physical symptoms or fears associated with personal or school problems.

Children who have emotional and behavioral disorders usually have serious learning problems (two or more years behind their peers academically), and have serious problems in being able to indulge in relationships. They tend to complain of psychosomatic illnesses (such as stomach pain, nausea and headache) and are often sad and anxious. They may exhibit behaviors that are surprisingly inappropriate to others.

When children with EBD are compared with normal peers, they usually tend to score lower on measures of intelligence, language age, and academic achievement especially in the language arts (reading, writing, spelling and so on). They also display inadequate social skills.

1.4.3 Attention Deficit Hyperactivity Disorder (ADHD)

It is one of the most prevalent childhood disorder occurring in 3 % to 5% of school-aged children (Jakobson & Kikas, 2007). Symptoms of ADHD include high levels of activity, impulsivity, and inattention, which may lead to difficulties in scholastic, social, and family contexts. Attention problems affect a child's ability to concentrate and learn. Situational stress, family discord or dysfunction, depression, anxiety, medication or illicit drug use, and illness may all cause attention problems. Of those with ADHD, more than 50 percent have at least one co-morbid condition (Phillips, 1999). Onset of ADHD will usually begin at about 18 months, becoming more noticeable by the age of 3 years and peaking around primary school age. Often hyperactivity is improved at puberty, but ADHD does not just disappear and usually continues into adult life, sometimes with a slight variation or reduction in symptoms.

Common characteristics of ADHD include:

- The student may exhibit “developmentally inappropriate degrees of inattention, impulsiveness, and hyperactivity”.
- The onset of problems is noticed as age 4.
- Boys will be three times as likely as girls to be diagnosed.
- Some children will exhibit the characteristic of hyperactivity; some will have attention deficit disorder without hyperactivity.

- The characteristic of hyperactivity appears to diminish by adolescence; yet the attention and impulse problems tend to persist.
- It is not uncommon to find a family member of a child with ADHD who also exhibited the same characteristics when younger.

If not treated, ADHD can result in the following symptoms depending on the age (Woodward, 2006):

- In Pre-School years: the child will exhibit disruptive behavior, impulsiveness, aggressiveness, low frustration tolerance, and temper tantrums.
- In School-Age years: the child will show academic difficulties, poor social interactions, attitude problems, lying, and poor self-esteem. They might even steal or lie.
- During Adolescence: they continued to have academic difficulties, school drop out, authority problems, increased risky behavior (smoking, substance abuse, early sexual activity, driving accidents/traffic violations), and overall feeling of worthlessness.
- During Adulthood: affected individuals will show exacerbation of underlying psychiatric conditions, frequent job changes and job losses, marital discord, multiple marriages, and problems with the law.

1.4.4 Autism

Autism encompasses a whole range of cognitive disorders, which fall within the Autistic Spectrum. Classic Autism is a complex developmental disability, which is the result of a neurological disorder that affects the functioning of the brain. Autism is four times more prevalent in boys than girls and knows no racial, ethnic, or social boundaries. Family income, lifestyle, and educational levels do not affect the probability of having autism. Although a single specific cause of autism is not known, current research links autism to biological or neurological differences in the brain. In many families there appears to be a pattern of autism or related disabilities, which suggests there is a genetic basis to the disorder although as yet, no one gene has been directly linked to autism.

Autism affects the normal development of the brain in the areas of social interaction and communication skills. Children and adults with autism typically have difficulties in verbal and non-verbal communication, social interactions, and leisure or play activities. The disorder makes it hard for them to communicate with others and relate to the outside world. In some cases, aggressive and/or self-injurious behavior may be present.
Persons with autism may exhibit repeated body movements (hand flapping, rocking), unusual responses to people or attachments to objects and resistance to changes in routines. Individuals may also experience unusual sensitivities in the five senses of sight, hearing, touch, smell, and taste.

1.4.5 Physical Impairments

Physical disabilities may hinder learning. These include hearing and visual impairments and orthopedic problems that affect mobility (Phillips, 1999).
Children with hearing or sight loss may attend special schools, specialist units within mainstream schools or be supported as individuals in mainstream schools.

1.4.6 Chronic Illnesses

Chronic illnesses affect learning when students experience sensory, physical or other health-related impairments that may require specific modifications in educational programming. These impairments include permanent medical conditions such as brain injury, autism, convulsive disorders and cerebral palsy. Chronic illness also encompasses medical conditions that may interfere with school (e.g., asthma, allergies, type 1 diabetes mellitus, repeated otitis media, thyroid disorders, cancer) (Phillips, 1999).

1.4.7 Other Disorders

Other disorders, including childhood depression, separation anxiety and adjustment disorders, can also cause poor school performance and may be mistaken for laziness, poor attitude or lack of parental guidance or discipline (Phillips, 1999). Behavioral or emotional difficulties range from low self-concept to aggression and motivational issues (Phillips, 1999).
Antisocial problem behavior is defined as “behavior that impedes adequate socialization and produces negative social outcomes such as peer rejection” (Merrell, K., 1993).

1.5. Assessment and Diagnosis of Special Educational Needs

Educational screening should be best done at school entry. However, there are certain difficulties with these screening tests, which include the cost and the time needed for administration. A way around both of these problems is to seek the help of the teacher. In fact, "several teacher rating scales have been developed, for example, the Pupil Rating Scale by Myklebust , the Student Rating Scale by Adelman & Feshbach and the Rhode Island Pupil Identification Scale" (Salvesen & Undheim, 1994). It was found that "the validity of the rating scales is at least as good as the best screening tests" (Salvesen & Undheim, 1994).

School personnel should play an important role in identifying (but not diagnosing) students who may have special needs. Students spend more time in school than in most other structured environments outside the home. Furthermore, "students' behaviors, interpersonal relationships, and academic performance— all important indicators of mood and the ability to cope—are subject to ongoing scrutiny in the school setting" (Maag & Reid, 2006). Behavior rating scales have proliferated during the past 20 years. Major factors affecting the increased use of rating scales include "their rather brief time demands, user-friendly administration and scoring, need for more regular educator and parent involvement in assessment and intervention activities, and generally improved psychometric qualities of a wide variety of rating scales" (Elliot & Busse, 1993).

School-based assessment of student characteristics through the use of teacher rating scales has become a widely utilized form of measurement, with one of the most popular uses of rating scales being to provide teacher ratings of student behavior. Compared with some other forms of behavioral assessment, teacher-rating scales are characterized by the following:

- They are relatively inexpensive in terms of initial cost and use of professional time.
- Most are easy to administer and score.
- They provide summative judgments of student behavior over a wide range of characteristics based on the teachers' observation of the student over time.
- They provide more objective and reliable information than clinical interviews or projective techniques (Merrell, 1993).

This is true since the ratings by teachers are based on contact with the students over longer time than direct observation techniques. They can provide information on low-incidence but significant problem behaviors. In addition, it is behavior and performance in the classroom that define the problem of learning disabilities and abnormal behavior.

Based on the above, assessment of students for the presence of learning disabilities or behavioral and emotional problems can be considered as best done using available rating scales.

One of the scales used for the assessment of learning disabilities and can be used also for the screening of students' behaviors is the Pupil Rating Scale (PRS). This scale was developed by Myklebust to identify children who have good mental ability, good hearing and vision, and adequate emotional adjustment, who do not have overriding physical handicaps, but who still do not learn and achieve in school. The Scale consists of five behavioral characteristics that teachers can observe and are highly relevant to identifying those children who have specific deficits in learning: Auditory Comprehension and Memory, Spoken Language, Orientation, Motor Coordination and Personal-social Behavior.

Each behavioral characteristic is divided into subscales. For example, Auditory Comprehension and Memory has four subscales: comprehending word meanings, following instructions, comprehending class discussions, retaining information. Teachers are usually asked to rate students for each subscale on a five-point scale where a rating of 3 is average, ratings of 1 or 2 are below average and ratings of 4 or 5 are above average. This scale was found to offer "validity and economy in surveying large populations of children" (Pihl & Nagy, 1980). The Pupil Rating Scale has been demonstrated to have a high predictive value whereby in a large comprehensive study of 2176 children, "Pupil Rating Scale scores identified the same deficient learners as a psychodiagnostic (educational, psychological, medical, electroencephalographic, and ophthalmologic) battery" (Pihl & Nagy, 1980).

Another well-known scale used for the diagnosis of children with behavior problems is the Burks Behavior Rating Scale (BBRS). Administered and scored in minutes, this scale identifies the nature and severity of pathological symptoms in children from pre-kindergarten through 12th grade (ages 4 through 18 years).

The BBRS has two forms: the Parent form and the Teacher form. The test questions are the same for both groups, but each group has distinct test norms. The use of multiple raters in the BBRS helps reduce bias and provides a more comprehensive understanding of the child's behavior problems.

The BBRS includes 110 items, each describing a behavior infrequently observed in children. A parent or teacher simply indicates, on a 5-point response scale, how often the behavior is seen in the child being evaluated.

The BBRS gives a score profile for 19 problem behaviors: (1) Excessive Self-Blame (2) Excessive Anxiety (3) Excessive Withdrawal (4) Excessive Dependency (5) Poor Ego Strength (6) Poor Physical Strength (7) Poor Coordination (8) Poor Intellectuality (9) Poor Academics (not included on Preschool and Kindergarten Edition) (10) Poor

Attention (11) Poor Impulse Control (12) Poor Reality Contact (13) Poor Sense of Identity (14) Excessive Suffering (15) Poor Anger Control (16) Excessive Sense of Persecution (17) Excessive Aggressiveness (18) Excessive Resistance and (19) Poor Social Conformity.

BBRS scores are used to:

- Pinpoint personality areas that require further evaluation or treatment
- Identify behaviors that may interfere with school functioning
- Identify children who will (or will not) benefit from special education
- Provide parents with information that is concrete, specific, and easy to understand

Normative data is based on a nationally representative sample of 2,864 individuals, including separate samplings of teachers (N = 1,481) and parents (N = 1,383). The BBRS was validated on a clinical sample of 860 individuals; demonstrated strong internal consistency, retest reliability, and content validity; and was validated against widely used concurrent measures

Regarding Attention Deficit Hyperactivity Disorder (ADHD), two well-known scales were cited in the literature. The first is the Conners' rating Scale and the second is the Du Paul ADHD Rating Scale.

The Conners' Rating Scale (CRS) is designed to evaluate problem behaviors by obtaining reports from teachers, parents, and adolescents. Long and short versions of this norm-referenced scale are available reflecting a variety of DSM-IV criteria for childhood disorders. The primary purpose of the CRS is to assist in the assessment of ADHD and related problem behaviors in children and adolescents aged 3 to 17 years (Angello et al, 2003).

The ADHD Rating Scale (Du Paul, 1991) is a 14-item questionnaire derived directly from the DSM diagnostic criteria for ADHD.

Each item is scored 0 (not at all), 1 (a little), 2 (pretty much) or 3 (very much).

The minimum score is 0 and the maximum is 42. This scale has been demonstrated to be highly reliable with adequate criterion-related validity, good internal consistency and inter-rater reliability (Arcellus et, al., 2000).

These scales will help in identifying students who suffer from learning disabilities, behavioral problems and attention and hyperactivity disorders. However, further individual diagnostic assessment is required by professionals. Therefore, the diagnosis and treatment of school problems depend on the collaboration of a multidisciplinary team of experts, which may consist of the school physician, school psychologist, classroom teacher, special educator, school nurse, school administrator, school counselor, social worker and other specialists. The child and the parents or guardians should also assume an active role on the team (Phillips, 1999).

1.6 Management of Special Educational Needs

Integrating pupils with special educational needs into mainstream classes is the preferred educational method. It is also the most cost effective. Teachers are expected to be able to identify children in their classes and provide special attention to them according to their needs. If provided with the right support and intervention, a child with learning disabilities can succeed in school and have a successful, and often a distinguished, career later in life. Parents and teachers can help the child achieve success by both fostering the child's strengths and knowing the child's weaknesses.
A decade ago, these children were primarily taught in separate classrooms, but currently the majority are being educated in general education classrooms with 43% receiving pull-out services for less than 21% of the school day (Gorman, 2001).

Pupils with special educational needs require more than others an environment which encourages and supports social development and also encourages them to take responsibility for their own actions. They also need to be given clear messages that they are valued as individuals in their own right, and that their achievements in all areas of development are of significance. Poor skills of interaction can be seen to be a cause of rejection, which in turn leads to the development of poor self-esteem and possible antisocial behavior.

To help children with sensory impairments and physical disabilities to become empowered, staff, parents and caregivers will need to carefully consider appropriate aids and adaptations to the learning environment to support development. For pupils with physical disabilities, wheelchairs, standing frames and prostheses are important amplifiers for motor capabilities, and glasses and hearing aids can assist the development of the senses for those with vision and hearing losses. Detailed analysis of the physical environment will also be necessary in order to reduce the impact of the disabilities.
Equally important, children with sensory and physical disabilities will at some stages of their lives need the assistance of others to access the opportunities that they need to assume control and to become autonomous. The assistance should be offered with caution and with a culture of "valuing" (Tilstone & Layton, 2004).
In conclusion, there is a need for the children and their peers to have:

- A basic understanding of the nature of the difficulties.
- Chances to express their feelings and to consider sameness and difference
- Appropriate educational opportunities
- Opportunities to make friendships
- Every possibility to be independent
- Practical and emotional coping strategies
- Plans for the future with positive outcomes.

Chapter 2

Overview of Palestinians' conditions living in Lebanon

2.1 General Living Conditions of Palestinians in Lebanon

Since 1948 with the first wave of forced migration and the Palestinian refugee population in Lebanon is confronting severe difficulties at the social, political and economical levels. Refugees continued to come to Lebanon in 1956 and 1967 mainly from Gaza and the West Bank; and later in 1970 when Palestinian movement leaders were expelled from Jordan.

Today, there are 400,582 registered Palestinian refugees in Lebanon, 52.7% of them live within camps while the remaining live outside. Originally, there were 16 official camps in Lebanon, out of these only 12 still exist (Table 2.1). The other four were either destroyed and never rebuilt or evacuated during the several Lebanese wars. All 12 official refugee camps in Lebanon suffer from serious problems - no proper infrastructure, overcrowding, poverty and unemployment. Lebanon has the highest percentage of Palestine refugees who are living in severe poverty and who are registered with the UNRWA Agency's "special hardship" program.

Table 2.1: Current Palestinian Camps in Lebanon with their corresponding inhabitants.

Camp	Number of Registered Refugees
Ein el-Hilweh	45,337
Nahr el-Bared	31,023
Rashidieh	25,580
Burj el-Barajneh	20,405
Burj el-Shemali	18,659
Beddawi	16,198
Shatila	12,235
El-Buss	10,107
Wavel	7,553
Mieh Mieh	5,037
Dbayeh	4,211
Mar Elias	1,411

(Retrieved from: http://www.un.org/unrwa/refugees/lebanon.html. Accessed on 20/3/2007)

Several characteristics govern the general conditions of the Palestinians living in Lebanon. These are summarized as follows:

- Palestinians are denied the right to get the Lebanese Nationality regardless of the period spent on the Lebanese territories. When needed, they are issued special travel documents.
- Lebanese laws prevent Palestinians from working in over 70 trades and professions. They are also denied ownership of land or property, belonging to unions or establishing private institutions. This has led to a very high rate of unemployment and a worsening of their social and economic conditions.
- Palestinian camps cannot be expanded, and building additional floors in the already existing buildings is not allowed. This has led to overcrowding and deterioration of the infrastructure within the camps.
- Some Palestinian refugees who came after 1948 to Lebanon are not registered with UNRWA and thus are deprived of most if not all of its services.
- The two main providers of services for Palestinians are UNRWA and the Palestinian Red Crescent Society.

2.2 Educational System in UNRWA schools

A valuable contribution of UNESCO to promotion of human rights has been the provision of education for the Palestinian refugees. Since 1950 "UNESCO in co-operation with UNRWA provided education and training services for refugee children and youth in Lebanon, Syria, Jordan, West Bank and Gaza.
Under an agreement with UNRWA, the Organization has been responsible for the professional guidance and supervision of the UNRWA/UNESCO education program, covering basic education (elementary and lower secondary), technical and vocational education, teacher training and a university scholarship program" (Samady).

UNRWA is the main provider of education for the majority of Palestinians living in Lebanon. In fact, according to the Lebanese laws, Palestinian refugees in Lebanon have limited access to public schools. Therefore, UNRWA took on its behalf the provision of free education for Palestinian refugees and it currently runs schools of its own and offers primary education, middle education and secondary education on a limited scale.
The UNRWA/UNESCO schools followed the curricula of the host countries. These schools were often set up near or in the refugee camps. Many of these schools had to operate on double-shift, due to lack of sufficient classrooms, in order to cope with the rapid expansion of the enrolment in both elementary and preparatory schools. There were also a large number of untrained teachers in the system, constituting about 90% of the teaching force in early 1960s. To remedy the situation, a major focus has been on teacher education.

UNRWA has its own financial constraints with overcrowded classes, lack of extra-curricular activities, poor school libraries and absence of teaching computing skills (HI, 2004). Currently, educational costs account for around 47% of UNRWA's budget, exceeding that allocated for health expenditure (UNRWA, 2004).

UNRWA operates 86 schools throughout Lebanon providing education for around 40,000 students. The educational curriculum follows the Lebanese system, with three major levels: primary, preparatory and secondary. In contrast to Syria and Jordan, UNRWA had to establish secondary-level schools in Lebanon. Enrolment in primary schools starts at the age of 6, children complete 6 years of primary schooling and 3 years of preparatory level. Following this, students have the choice between three years of secondary education or two years of vocational training (UNRWA, 2004).

In spite of the high expenditure by UNRWA on education, the educational attainment within the Palestinian population is still very low. It is estimated that around thirteen percent of the population have never had any form of education and one out of three children aged 10 or older is not enrolled in schools or has not completed his/her education. The level of education severely declines after the elementary level, only 6% complete secondary level and 5% continue to higher education. These numbers are lower than estimates derived for the Lebanese population (14% and 8% respectively) and even lower than those based on Palestinian population outside Lebanon (in Jordan, for example, the proportions are 9 and 11%, respectively) (FAFO, 2002).

The educational system is marked with a high enrolment rate (96%) until the age of 11 when it starts to decline. Variations in enrolment between men and women exist, women attain more basic education than men, but men's enrolment rate is higher in the secondary level. The reason for this high rate of dropouts is not related to economical reasons; rather it is due mainly to loss of interest in school (FAFO, 2002).

A concise description of the schools shows this cloudy picture: UNRWA classes are overcrowded (30-40 children per class) and very poorly equipped.
Children learn in an environment whereby many requirements for learning are not met. The supportive and motivational environment of the classroom is not present. The school program is very condensed with little recreational activities and near absence of extra curriculum activities. Children are not given the chance to learn in optimal conditions.
Because of the automated upgrading system, students pass grades acquiring minimum qualifications no matter how many school difficulties they have.
Thus, they accumulate problems over the years until many of them decide to leave school for lack of incentives.

Despite of the above, Palestinian refugees' educational status has improved throughout the last 40 years. This is shown by low illiteracy rates (7%) among young adults (15-30 years) compared to that of older refugees (50% illiteracy rates in 50 years and older individuals); and this is mainly attributed to the efforts on part of UNRWA (UNRWA, 2004).

It is worth noting that, a Counseling and Guidance Committee exists in each school. This is comprised of teachers and administrators from the school, and one professional counselor. Yet, this counselor covers all schools within each region, such that only six counselors are responsible for 86 schools throughout Lebanon. The number of counselors increased during the past year after the July 2006 war in Lebanon and the secondary effects on the psychological status of all people living in this country.

Chapter 3

Objectives & Methods

3.1 Objectives of The Project

This project aims at assessing the prevalence of Special Educational Needs among students aged 6 to 18 years, enrolled in UNRWA schools in Lebanon, and developing a comprehensive program for the diagnosis and management of these students within the school premises.

The specific objectives of this project are:

- To determine the types and frequency of occurrence (i.e. prevalence) of SEN occurring among UNRWA students in grades 1 to 12 (ages 6-18 years) in different locations over the Republic of Lebanon.
- To conduct a thorough assessment of the different factors that might lead to the development of SEN among children, and analyze the relationship between these factors and the occurrence of SEN. Such factors include contextual factors, geographic locations or other specific circumstances.
- To develop a diagnostic test that will enable the identification of students with SEN.
- To develop an electronic database of the identified SEN students.
- To develop an intervention plan for the management of SEN cases within schools. This plan will include:
    - The outlines of a psychosocial support program for students with psychosocial disorders.
    - The outlines of a remedial program to treat learning disabilities.
    - Recommendations for the mainstreaming of students with physical disabilities
- To conduct training for around 250 designated UNRWA- staff members in methods of the identification and treatment of students with SEN.
- To conduct follow up visits in order to assure the correct implementation of the intervention plan.

3.2 Methods

This project is divided into five main phases: quantitative assessment of the burden of SEN, development of students' database, development of an intervention plan, training of UNRWA staff and conducting follow up visits.

3.2.1.Quantitative assessment of the burden of SEN in UNRWA schools

3.2.1.1 Study Population

The target population of the study consisted of all students enrolled in UNRWA schools all over the Republic of Lebanon. However, the information was not collected directly from all of the students.

In fact, in order to draw a comprehensive and objective picture of the educational needs and status of the students, we needed to collect the opinion of the teachers and some information from the parents.

Therefore, participants in this study included:

1. The principal teacher in each class. The director of each school chose the teacher who had the greatest encounters with the students in each class. Each teacher was requested to fill an individual questionnaire for each student in his/her class. The teacher was given a period of one week to hand back the filled questionnaires.
2. The parents of the students who were requested to fill a questionnaire for each child enrolled in these schools. Distribution of the questionnaires differed among schools. Some schools sent the questionnaires with the students to their parents. Other schools were more cautious and called parents to school and handed them the questionnaires.
3. Students enrolled in grades 6 through 12 who were also requested to fill an individual questionnaire.

In addition, the principle or director of each school was also requested to fill a general questionnaire enquiring information on the general characteristics of the school as far as physical structure, human resources and school performance are concerned.

3.2.1.2. Instruments

Four different questionnaires were administered to the different groups. It is worth mentioning that the questionnaires were not anonymous. In fact, the name of the student, his/her father and mother's name and the school name and the grade and the section were all specified for each student.

The questionnaire for the students in grade 6 and above consisted of 104 questions targeting the following broad themes and categories:

1. Demographic characteristics (age, gender, and labor force participation).
2. Household conditions and characteristics (crowding index).
3. Health-related data (psychosomatic symptoms).
4. Health behaviors (cigarette and Hubble bubble smoking, alcohol consumption, and drug intake).
5. Mental health based on WHO-quality of life 5-item questionnaire (WHO-QOL) (WHO-Info Package, 1998).
6. Exposure to violence (at both the school and his/her home).

7. Social barriers imposed on the individual by the home environment, school, and community.
8. Life satisfaction and future aspirations in various domains including own educational achievement and satisfaction with school.
9. Life events.
10. The cognitive processing inventory for students (CPI-S), which self- rates the educational ability and performance of the student.

The questionnaire for the teachers consisted of 196 questions targeting the following broad themes and categories:

1. Pupil's rating scale
2. Burks Behavior rating scale
3. Conners and De Paul ADHD scale
4. Questions related to student (school problems, psychological problems, behavioral problems, physical disability).

The questionnaire for the parents consisted of 74 questions targeting the following broad themes and categories:

1. Household conditions and characteristics (crowding index, economic status).
2. Prenatal information and perinatal information (health behavior of the mother, problems encountered during pregnancy or during delivery).
3. Child development information (physical growth, mental growth, speech delay, and neuromuscular development and development of other milestones).
4. Life events (in the life of the child and family).
5. Family History (school problems, psychological problems)
6. Health related data for the child (targeting medical problems that affect educational process such as problems in the vision, hearing, seizures or other health related issues).
7. Educational problems of the child.

3.2.1.3. Training And Recruitment

A total of five teams were recruited to cover the five major areas i.e. Beirut, Saida, Tyre, Bekaa and North. Each team consisted of two field workers except Saida team, which consisted of three persons and Bekaa team, which consisted of one field worker. Thus a total of 12 interviewers were recruited in addition to one field coordinator who was also chosen at this stage based on his ability to lead a team and experience. The field coordinator also acted as gatekeeper and a coordinator between the main office and the field teams and supervised the field operation in each area.

Training and instruction materials were prepared. These detailed the procedures that the field workers were to follow during the data collection and served to clarify certain items in the interview schedules. A training workshop was carried out prior to fieldwork for the field coordinator and field workers. This focused on coding procedures, interviewing skills, editing and administrative issues.

Prior to fieldwork, a pilot study was carried out with the aim of testing and improving the questionnaire and testing the organization procedures. The pilot study results were evaluated, and minor changes were required.

3.2.1.4. Fieldwork Activities

Preparation for the implementation of the survey began in January-February 2007. Contacts with UNRWA Education Department leaders and with the representatives of each school were essential for the implementation of the study. Fielding the survey started in March 2007, and ended in April 2007 except for the schools in Ein El Helweh where there was a resistance and banning for the administration of the students questionnaires. After several meetings and negotiations with the responsible persons in the camp, the data collection resumed after crossing out 11 questions related to the following issues: alcohol intake, drug exposure, relationship with opposite sex, history of beating and humiliation at school and home. Data collection finished at the end of the month of May 2007. Several quality control measures were implemented in order to ensure the collection of high quality data including periodic visits by the field coordinator.

Data collection period faced several problems:

- Security issues in Nahr Bared camp due to the several events of strikes that occurred there.
- Problems with Islamic groups in Ein Helwh camp who refused the administration of the students' questionnaires.

3.2.1.5. Data Processing And Analysis

A team of research assistants was hired to edit the questionnaires and enter data. Data was entered using Pearson NCS Scanner, which has the advantage of reducing human error. Three data files were created: the teachers' data file, the parents' data file and the students' data file. These files were later exported to SPSS for data cleaning, editing and analysis.

Frequency distributions for the various socio-demographic, behavioral and psychosocial characteristics as well as learning disabilities, behavioral scale, ADHD scale and quality of life information were computed. Means and standard deviations (± SD) were computed for continuous variables. Learning disabilities, behavioral problems, quality of life, and ADHD were the main outcome measures while the socio-demographic, psychosocial, behavioral, and health-related characteristics were treated as independent variables. Chi-square tests were conducted to examine associations with the outcome for continuous and categorical variables, respectively. Logistic regression analysis was then conducted including those variables that were significant at the bi-variate analysis or were deemed, based on literature review, necessary to be included in the model. Prevalence odds ratios (OR) and associated 95% Confidence Intervals (CI) were calculated. A p-value less than 0.05 were considered statistically significant. Analysis was done using the Statistical Package for Social Sciences (SPSS) version 15.

CHAPTER 4

RESULTS

4.1. Demographic Characteristics

All of the 86 schools run and managed by UNRWA were targeted and participated in this study. These schools are distributed all over the Republic of Lebanon with the largest number of schools present in Saida (28%) followed by Beirut (23.2%)and Tripoli (23.2%), Tyre (18.6%) and the lowest number of schools are present in Bekaa area (7%). Table 4.1. shows the distribution of these schools by region.

Table 4.1. Distribution of Schools by Region

Region	**Number of Schools**	**Percentage**
Beirut	20	23.2%
Saida	24	28.0%
Tyre	16	18.6%
Tripoli	20	23.2%
Bekaa	6	7.0%
Total Number of Schools	**86**	**100%**

The studied population i.e. the number of students enrolled in these schools are 38370 students among which 19636 students are enrolled in grade 6 and above.
This indicates that the targeted number of questionnaires to be filled would be as follows:

1. 38370 questionnaires were supposed to be completed by teachers, however only 33405 were completely filled and handed back with a response rate of 87.1%.
2. 38370 questionnaires were supposed to be completed by parents; however, only 27978 questionnaires were fully completed and returned back with a response rate of 72.9%.
3. 19636 students were supposed to fill the student questionnaire; however, only 16387 completed the questionnaires i.e. with a response rate of 83.5%.

The general demographic characteristics of the population are extrapolated mainly from the parents' questionnaire. The parents of 27978 children filled the questionnaires. These children are distributed as 43.1% boys and 56.9% girls. Table 4.2 shows the main demographic characteristics of this population.
The majority of the families (64.3%) live inside the camps as opposed to 35.7% who live outside the camps. The majority of the families (78.2%) earn less than 900,000 LP per month with 38.3% who earns less than 300,000 LP per month. The mean number of

rooms per house is 2.8 with SD of 1.1 and the mean number of persons living within the same house is 5.9 with SD of 1.8.

4.2. General Characteristics of the Adolescent Population (Students in grade 6 and above)

The characteristics of the population of the students attending grade 6 and above within UNRWA schools are shown in table 4.3. This population is composed of 42.3% of boys and 57.7% of girls. The age of those who participated ranged between 10 and 25 years with a mean age of 14.6 years (SD of 5.3). The majority of the adolescent population (88.9%) lives with both their mothers and fathers.

The majority of the studied population (91.3%) is full time students, who are not currently working as opposed to 2.4% who have a paid job during school time. This means that the majority of students have enough time allocated to study. In addition, 79% of these students did not work during last summer. Of those who worked, 53.2% did so to help the family financially, 5.4% to pay for schooling extra expenses and 30.4% to buy personal stuff.

The population can be considered as practicing safe health behaviors since 94.7% of these students never smoked cigarettes, and 80.2% never smoked Nargile or Hubble-bubble.

As far as activities and social mixing are concerned, it was found that 79.6% have extra curricular activities. However, almost half of the population do not have interaction or friendship relationship with opposite sex whether at school or even in the community.

In fact, 41.8% do not have friends from opposite sex, 55.1% do not have friends from opposite sex at school and 32.7% do not have friends from opposite sex in the community.

Several events have marked the lives of these students whereby 26.9% experienced the birth of a newborn in the family, 27.2% were admitted to the hospital and 6.8% were diagnosed to have a serious disease. As far as death events are concerned, 4.7% experienced the death of one of the parents, 8.7% experienced the death of a brother or sister, 49.2% experienced the death of a relative and 9.8% experienced the death of a close friend. Other detrimental life events included the separation or divorce of the parents whereby 4.2 % of these students witnessed such distressful events. These characteristics are detailed in table 4.4.

The violence experience is also significant among these students. In fact, the violence as expressed by beating history (physical violence) was more significant at school than the house: 32.2% of the students report being beaten by a teacher or a principal, 12.4% report

being beaten by other students as opposed to 18.5% being beaten by parents and 14% being beaten by brothers or sisters. As far as moral violence is concerned, 28.3% of the students report being humiliated by a teacher or a principal at school and 14.1% report being humiliated by other students. Table 4.5 shows details of the violence events.

When asked about satisfaction from their lives, education and financial status, 9.7% reported not being satisfied from their lives in general, 26.6% reported that they are not financially satisfied and 12.8% reported not being satisfied from their education. In fact, 65.3% of the students reported facing difficulties in studying (8.4% to a great extent, and 56.9% to a certain extent). As far as future aspirations, 87.9% thought that their lives would improve if they have a better degree as opposed to 11.3% who thought that their life would be the same and 0.8% thought that their life would be worse.

4.3. Rating Scales

The students in grade 6 and above were administered a questionnaire including two scales. The first scale is the 5-item World Health organization Quality of life (WHO-QOL) scale (WHO-Info package, 1998), which was used to assess the Mental Health of these students. Responses to the WHO-QOL scale are reported on a 5-point Likert scale ranging from 0 (lowest QOL) to 5 (Highest QOL). These were summed up to create a continuous summary index ranging from 0 to a maximum of 25. The score was then divided into quintiles and those scoring in the lowest quintile were a priori determined to perceive their QOL as low in contrast to the upper 4-quintiles. In this study, subjects falling in the lowest quintile are referred to, thereafter, as ‘distressed’ individuals.

Out of the 15,442 students who fully answered the five items of this scale, 3370 students (21.8%) were found to fall in the lowest quintile and are therefore referred to as “distressed”. In fact, when asked about their satisfaction with life, 9.7% were not satisfied at all and 55.7% said that it was OK as compared to 34.6% who were very satisfied with their life. On the other hand, when asked directly, teachers thought that 11.23% of the students suffer from mental health problems.

Students were also asked to respond to the Cognitive Processing Inventory, which allows them to self-rate their academic and school performance. Out of the 16,387 students who completed all the items of the scale, 1,116 students (6.8%) rated themselves as having school problems.
When asked directly if they have difficulty in studying, 8.4% stated that they have difficulty studying to a great extent and 56.9% said that they have difficulty to a certain extent as compared to 34.7% who did not report any difficulty in studying.
In addition, when asked regarding satisfaction from their education, 12.8% were not satisfied as compared to 29.7% who were satisfied to a great extent.

Parents were requested to fill a questionnaire that included one single scale, which is the Conners scale for detection of Dyslexia. On this scale, children who scored 7 and above were referred to as suspected of being "dyslexic". In fact, out of 27,978 parents who completely filled all the scale items, 6,963 (24.9%) scored 7 and above. This means that according to the rating done by parents, 24.9% of the students are suspected of having Dyslexia.

Finally, teachers were requested to fill three types of scales, which allow assessing for the presence of learning disabilities, behavioral problems, attention and communication problems in students.
On the Pupil rating Scale (table 4.6), 18,978 out of 33,388 students (57.2%) were found to have learning disabilities. The Verbal scale was abnormal in 52.3% and the non-verbal scale was abnormal in 55.9%. It is worth mentioning that around 59.3% of those who have learning disabilities as rated by Pupil Scale are enrolled in grades 1 to 5. The rest i.e. 40.7% are enrolled in grades 6 to 12.
This percentage was higher than what teachers reported directly as 38.1% of the students suffer from learning problems in their opinion. On the same token, parents reported that 43.3% of their children suffer from difficulties in school.

The second scale that was used is the De Paul and Conners Rating Scale for assessment of Attention Deficit Hyperactivity Disorder. On this scale, 15,943 students out of 33,405 (47.7%) were found to have abnormal scores and are therefore suspected to have Attention Deficit Hyperactivity Disorder (Table 4.7).
By analyzing each category of the scale separately, 54.1% of the students were found to have attention problems, 39.1% were found to have excessive movement and 44% were found to have impulsivity.

The third scale utilized is the Burks Behavior rating Scale, which diagnoses the presence of behavioral problems in children and adolescents. The results of this scale (Table 4.8) showed that: 13.2% have excessive self blame, 8.5% have excessive anxiety, 9.5% have excessive withdrawal, 8.2% have excessive dependency, 10.4% have poor ego strength, 6.7% have poor physical strength, 8.8% have poor coordination, 20.8% have poor intellectuality, 24.2% have poor academics, 19.3% have poor attention, 10.9% have poor impulse control, 5.6% have poor reality contact, 5.2% have poor sense of identity, 7.9% have excessive suffering, 8.7% have poor anger control, 8.5% have excessive sense of persecution, 8.9% have excessive aggressiveness, 9.9% have excessive resistance, and 9.1% have poor social conformity.
It is worth mentioning that when requested about the percentage of students suffering from behavioral problems, teachers stated that 14.9% of students do so.

A more detailed analysis of the three above-mentioned scales was performed by class level or grade. Table 4.9 shows the distribution of abnormal components of the Pupil Rating Scale by class. The highest abnormalities were found in grades 3, 4 and 5 in almost the five categories of this scale i.e. Auditory Comprehension (highest abnormality in grade 4 followed by grade 5), Spoken Language (highest abnormality in grade 5 followed by grade 4), Orientation (highest abnormality in grade 4 followed by grade 3), Motor Coordination (highest abnormality in grade 5 followed by grade 3) and Personal Social Behavior (highest abnormality in grade 4 followed by grade 5). In addition, it was found that the lowest percentage of abnormalities was found in students in grade 12 followed by those in grade 11 in all categories of Pupil rating Scale.

Table 4.10 shows the distribution of abnormalities in the three main components of the ADHD scale i.e. Attention, Excessive Motion and Impulsivity by class. Generally, it was found that the highest rates of abnormalities exist in students in grade 5,4 and 3 in addition to grade 1. In fact, the highest rate of inattention was found in students of grade 1 (11.3%). This can be fully understood since this is their first year in school and students are not accustomed to sit still and listen. The lowest rates of abnormalities were also found among students in grade 12 followed by those in grade 11.

Table 4.11 shows the distribution of abnormalities in the 19 components of the Burks Behavior rating Scale by class. Comparable to the previous two scales, the lowest rates of abnormalities are found in students enrolled in grades 12 and 11.

4.4. Analysis of the schools' questionnaires

All the 86 different schools run by UNRWA all over Lebanon were visited and the principal or director were requested to fill a questionnaire that gathered different information related to these schools.
Results revealed that the success rate among students in governmental exams is quite good and improving with time (higher success rate in the academic year 2005-2006 as compared to 2004-2005) and grades (higher success rate in grade 12 as compared to grade 9). Table 4.12 shows the details.

The percentage of students who dropout from schools at the elementary level is 1.32%, whereas 3.30% of the students leave at the intermediate level and 0.94% at the secondary level.
As far as repeating classes, 12.7% of students repeat classes in the elementary level, 17.92% in the intermediate level and 9.5% in the secondary level.
Finally, the mean success rate is 80.51% in the elementary classes, 72.42% in the intermediate classes and 86.52% in the secondary classes. Table 4.13 shows the details.

As far as the human resources are concerned, 47 out of 86 schools (55.1%) have psychological counselor and 56 out of 86 schools (65.1%) have health counselor.
As far as physical structure is concerned, 45 schools (52.3%) have a library within the school with 77 schools (89.5%) having visual learning aids. Only 33 schools (38.4%) have special passages and facilities for physically handicapped students.

4.3. Learning Disabilities and Correlates

The prevalence of learning disabilities can be detected primarily from the Pupil Rating Scale, which shows that around 57.2% of the studied population are suspected to suffer from learning disabilities.

The prevalence of Learning Disabilities differed significantly among regions (highest prevalence in Saida region) and among classes (highest in grade 5). Living inside the camps also increased significantly the occurrence of Learning Disabilities.
Poverty or low income was also found to be a significant risk factor for the development of learning disabilities (table 4.14).

The health status of the student (table 4.15) was also found to significantly affect the presence of learning disabilities. In fact, students suffering from Epilepsy, chronic middle ear infection, hearing problems, visual problems, and Iron deficiency anemia were more prone to develop learning disabilities with a p value of <0.001.

The development of the child was also found to significantly affect the presence of learning disabilities. In fact, children who suffered from speech delay or who had slow physical, mental or motor growth were found to develop more learning disabilities (table 4.16).
The presence of behavioral problems and history of school failure in the family was found to significantly affect the development of learning disabilities in children (table 4.17). In addition, antenatal and perinatal events such as medical problems during pregnancy, maternal smoking and intake of medications during pregnancy were found to significantly affect the development of learning disabilities (table 4.18).

Violence as manifested by beating the students or humiliating them was found to be significantly associated with the development of learning disabilities (table 4.19). In fact, around 32.2% report being beaten and 28.3% humiliated by a teacher or other school personnel at least once as compared to 12.4% who are beaten and 14.1% humiliated by other students at least once.

4.4. Results of the Multivariate Regression Analysis

Multivariate logistic regression analysis was conducted controlling simultaneously for all variables that were significant at the bivariate level. Models also included variables that are established in the literature as significant correlates of learning disability. Table 4.20. presents the findings for the students' population.

Results revealed that males are 1.3 times more at risk of developing learning disabilities (OR=1.3, 95% CI= 1.21-1.40). Socioeconomic level also had a significant effect on the development of LD with those families earning less than 300,000 Lebanese Pounds being at 1.4 times more risk of developing LD (OR=1.4, 95% CI= 1.17-1.67). This is evident also in the crowding index with OR=1.15 and 95%CI= 1.10-1.19.

Among the medical problems that students suffer from as mentioned by their parents, only children or students with Epilepsy were found to have an increased risk of developing LD in the multivariate analysis (OR= 1.39, 95%CI=1.03-1.87). This was not true for the other medical conditions that were significant in the bivariate analysis such as chronic infection of the middle ear, iron deficiency anemia, visual problems and hearing problems.

The presence of school failure and behavioral problems in the family was significantly associated with the development of LD in the multivariate analysis (OR=1.49 95% CI= 1.38-1.62) and (OR=1.21, 95% CI = 1.01-1.44) respectively.

The development of the child had also a significant effect on LD as far as delayed speech (OR=1.26, 95% CI = 1.09-1.45) and delayed mental development (OR=2.16, 95% CI = 1.75-2.67) are concerned.

Health problems encountered during pregnancy and the intake of medications during pregnancy and alcohol or smoking were not significantly associated with LD.
As mentioned by parents, students who were declared to have problems in school and difficulties in learning by their parents were at increased risk of having LD (OR=1.19, 95% CI = 1.06-1.33) and (OR=3.42, 95% CI = 3.19-3.67).

4.5. Diagnostic Test

A diagnostic test was later performed by UNRWA educational department to students in grades 3, 4 and 6 who were found to have six and above abnormal results in Burks behavior Rating Scale and abnormal results in Pupil rating scale in Ein El Helweh area (Mintar, Naqoura, Qibya, Sammou, Falouja, Hittin schools). UNRWA educational

department developed the tests to be administered based on the curriculum of each class and taking into consideration to administer to students tests of the material that are supposed to already have learned and assimilated. The study team approved the developed tests.

Tests in both Arabic and English languages and tests in Mathematics were administered to students. Around 530 students underwent the tests, however, the results were commensurate with the results of this study whereby only 33 (6.2%) passed the Arabic test, 6 (1.1%) passed the English test and 14 (2.6%) passed the Math test.

This indicates that these students suffer from basic learning difficulties.

4.6. Limitations

Despite the fact that this study is the first one to examine the prevalence of special education needs of students in UNRWA schools, it has some limitations.

- One teacher in each class was selected to fill the questionnaires for all the students in that class. This might affect the objectivity of the data collected. The teacher might be too tired to complete objectively all the questionnaires (although given one week to do that). And, the teacher might not be aware of the performance of the specific student in all areas especially in higher classes where there is a teacher for each material.
- Subjectivity of the teachers in filling the questionnaires: depends may be if they like the student or not.
- The teacher's questionnaire was long and requesting detailed information of the student.
- No scales were previously tested in the Arabic context for validity and reliability.

CHAPTER 5

DEVELOPMENT OF ELECTRONIC DATABASE

An electronic database was developed using Excel sheets.
The database was divided by region and school and included the names of all the students who were suspected to have any form of special educational needs.
The tables are showing the names and indicating for each name the abnormality in any component of the screening scales (Pupil Rating Scale, Burks Behavior, ADHD scale).

CHAPTER 6

TRAINING OF UNRWA STAFF

With the beginning of the Academic Year 2007-2008, and after the data collection and analysis, capacity building training sessions for the UNRWA schools staff were launched. These training sessions aimed at sensitizing the staff in the schools regarding SEN and improving the skills of some teachers in identifying and dealing with students suffering from educational needs. Around 250 teachers and counselors attended the training workshops. The trained staff was selected by the educational field office in UNRWA taking into consideration to train at least one teacher/counselor from each of the different schools run by UNRWA over the Lebanese territories.
Workshops were performed in three different regions: Saida, Beirut and Tripoli.
Staff of Saida and Tyr schools attended the training workshops done in Saida. Staff of Beirut and Bekaa schools attended workshops organized in Beirut. Finally, the workshops organized in Tripoli included staff working in Tripoli UNRWA schools.

The training modules consisted of the following:

- Definition of Special Education Needs
- Different Categories of Special Education Needs
- Screening, assessment, and dealing with students suffering from SEN.
- Development of teaching tools and materials for special needs and modalities of integrating these tools and materials inside the curriculum.
- Development of Individualized Education Program (IEP).

CHAPTER 7

INTERVENTION PLAN

7.1. General Plan Description

The Intervention Plan will describe in details the different steps that will help in identifying and dealing with students suspected of having Special Educational Needs.
It is suggested to follow the below mentioned steps:

Identification:

The classroom teacher is usually the first one to notice the presence of certain disability or need in the student and refers him/her to special education assessment. This regular teacher will help also in gathering assessment information and coordination of special services.
Most of the students are noticed during elementary years to have special educational needs; yet, students can still be identified at any age.
There are two main indicators that will help in suspecting students who need special education. These indicators are:

- The student appears capable but experience extreme difficulties in some areas of learning. This results in a discrepancy between the actual achievement and the expected achievement.
- The student exhibits a variation in performance with a discrepancy among different areas of achievement. For example, a student may perform great in Math but read poorly.

Assessment & Diagnosis

The teacher can use different rating scales such as the one used in this research: Pupil Rating Scale and Burks Behavior Rating Scale.
These scales will identify students who need further assessment.
Thus, if special needs are identified, regular class teacher should refer the student for special education assessment. Parents should be notified at this stage and approve on further assessment and participate in the development of the Individualized Educational Program of their child.
Assessment is an individualized process that consists of gathering information for decision-making. It includes both formal testing and informal procedures such as observation, inventories and work sample analyses. This usually includes collecting information on three areas of performance: intellectual functioning, academic achievement and psychological assessment. This assessment is an individualized assessment.

Management

Following this individualized assessment, the student can be diagnosed of having special educational needs in a specific area. Here comes the role of mainstreaming team along with the regular teacher to gather more information on the educational needs and develop

a plan or a program depending on the needs of each student. This is when the development of the IEP for the student becomes more active. In addition, some of the students may need additional services such as counseling from a psychologist, referral to a social worker or physical rehabilitation.
Two approaches are available and reported in the literature for mainstreamed students who suffer from learning disabilities.

- Remediation approach: which consists of instructing the student in basic skills that are of need. This is usually most appropriate for elementary grades.
- Compensation approach: which attempts to bypass the student's weakness. This is usually done in the middle and secondary classes. For example, the teacher may compensate for the reading and writing problems of a student by administering class tests orally. Compensation techniques bypass deficiencies in basic skills in order to teach content area subjects.

In the following, we will discuss in more details the plan that should be followed with each type of special educational need: learning disabilities, emotional and behavioral disorders and physical disabilities. We will start first with a description of Individualized Education Program.

7.2. Individualized Education Program

An Individualized Education Program (IEP) is a written document summarizing a student's learning program and is required for every student who qualifies for special educational services. The IEP is most effective when it clearly spells out the supplementary aids, services, accommodations, and modifications to the curriculum that may be necessary to allow children to participate fully in their educational programs. In the IEP document, there are specific places where the supports needed to implement the IEP can be listed.

The major purposes of an IEP are:

- To establish learning goals for an individual student. It provides instructional direction.
- To determine the services the school must provide to meet those learning goals.
- To provide a basis for the evaluation of the student. Formally established learning objectives for students help determine the effectiveness and efficiency of instruction.
- To enhance communication among parents and other professionals about a student's program.

The components of an IEP:
IEPs are intended to serve as the guiding document for the provision of an appropriate education. In addition, IEP functions as an integral link between assessment and

instruction. Thus, the development of an IEP follows the collection of assessment data. The IEP then details the least restrictive, most appropriate placement and outlines the instructional program. The IEP must be evaluated and then rewritten annually as long as services are still necessary.

The major components of the IEP include the following key features:

- Statement of the child's present level of educational performance: A summary of a student's current functioning provides a basis for subsequent goal setting. Performance levels should be determined for all areas needing special instruction. Depending on the individual, relevant information could be gathered for academic skills, behavioral patterns, self-help skills, vocational talents or communication abilities. Performance levels should be viewed as summaries of an individual's strengths and weaknesses. It is advisable that present levels of educational performance include the following three elements:
    1. Statement of how the disability affects the student's involvement and progress in the general curriculum.
    2. Description of the student's performance levels in the skill areas affected by the disability.
    3. Logical cues for writing the accompanying goals for improvement.
- Statement of measurable annual goals, including benchmarks, or short-term objectives: These goals predict long-term gains that can be evaluated clearly during the school year. The annual goals should include the educator's (and the parent's) best guess of what the student can reasonably achieve within the school year. The following features can help determine realistic expectations:
    1. Chronological age
    2. Past learning profile
    3. Recent learning history and response to instruction.

  Teachers can conceptualize annual goals, which may range from outcomes that might be considered the most optimistic to the most pessimistic. Against these parameters, reasonable estimates can be derived.

  Annual goals should include four major elements:
    1. Goals must be measurable.
    2. Goals must tell what the students can reasonably accomplish in a year.
    3. Goals must relate to helping the student be successful in the general education curriculum and / or address other educational needs resulting from the disability.
    4. Goals must be accompanied by benchmarks or short-term objectives.
- Measurable goals provide a basis for evaluation.
- Statement of the special education and related services and supplementary aids and services to be provided to the child.

- Statement of the program modifications or supports for the school personnel that will be provided to the child.
- Statement of the program modifications or supports for school personnel that will be provided to the child.
- Explanation of the extent, if any, to which the child will not participate with the non-disabled children in the regular class.
- Statement of any individual modifications in the administration of statewide or district-wide assessments of student achievement.
- Projected date for the beginning of the services and modifications.
- Anticipated frequency, location and duration of those services and modifications.
- Statement of how the child's progress toward the annual goals will be measured.
- Statement of how the child's parents will be regularly informed of their child's progress toward the annual goal.
- Empowerment: An outgrowth of the movement toward inclusion has been the focus on the empowerment and the related self-determination of individuals with disabilities. For teachers, a commitment to empowerment as a goal involves the need to give more attention to assessing how well students are developing the ability to make choices, to become advocates for themselves and to exercise control over their lives. The central feature is self-determination. Self-determination refers to the attitudes and abilities necessary to act as the primary causal agent in one's life and to make choices and decisions regarding one's quality of life free from undue external influence or interference. Effective instruction: a model of effective instruction that highlights six specific teaching activities as associated with student achievement:
- A review or check of the previous day's work (re-teaching, if necessary)
- Presentation of new content/skills
- Guided student practice (with verification for understanding)
- Feedback and correction (re-teaching if necessary)
- Independent student practice
- Weekly and monthly reviews.

The IEP team members include: parents of the student, special education teacher, regular education teacher, representative of the school administration (a person with authority to commit necessary resources), a person who can interpret the evaluation results, the student when appropriate and other knowledgeable persons whom the parents or school may choose to invite.

Related Services: For some children, educational instruction is not enough to help them learn. These children also need support services called "related services." These related services may be:

- Audiology
- Speech therapy
- Psychological services (assessment)
- Physical therapy
- Occupational therapy
- Transportation
- Counseling (including rehabilitation counseling)
- Social work services
- Orientation and mobility
- School nursing
- Other services, as needed

7.3. Management of students with learning disabilities

General Recommendations when dealing with students suffering from learning disabilities include the following:

- Refer children with learning disabilities to the school guidance counselor if needed.
- Provide a support group for parents in the school. Alternate meetings with and without the child's teachers.
- Educate all teachers on the characteristics of learning disabilities to enable them to detect problems at early age.
- Provide alternatives to standard curriculum to use with individual students.
- Give homework each school night with directions for parents if necessary. Provide work for summer vacation so that regression does not take place.
- Use positive behavior management techniques to eliminate undesirable behavior.
- Tell parents specific skills and activities to work on to reinforce the educational program.

It is important for teachers to follow the following steps when dealing with students suffering from learning disabilities.

- Have students work at their own ability levels in each academic area. The levels may vary in reading, spelling, language, and math with one or more areas being lower than the others.
- Plan and provide a number of successful experiences, as tolerance for failure is low.
- Provide clear instructions and recognize that while the child may appear to understand, in fact, he or she may be confused. Avoid instructions involving more than two steps at a time.
- Be alert to possible signs of emotional disturbance or behavior problems.

- Give multi-sensory (auditory, visual, tactile, and kinesthetic or movement) approaches to instruction whenever possible.
- Communicate with the resource teacher to discuss which methods being employed seem to be most successful.
- Sequence learning tasks into steps that can be successfully achieved by the child. Reinforce successful achievement of each step.
- Use short assignments. At the lower elementary level, for example, if an entire work sheet on math problems appear frustrating, cut it into strips and allow the child to complete one step at a time.
- In reading the child might frequently confuse similar words. Ask the child to spell the word aloud and pronounce it again.
- Record the student's progress in graph or chart form. Share this with the student so that he or she may see the progress.
- Design teacher-made games for use as individual or small group activities to reinforce the skills being developed.
- Structure and consistency in the classroom environment, as well as daily routine, are extremely important. If changes in schedule are to occur, prepare the child ahead of time and reemphasize the change periodically.
- Utilize cross-age, peer and volunteer tutors.

7.4. Management of students with Emotional & Behavioral Disorders

Students with Emotional & Behavioral Disorders (EBD) are commonly included in general education classrooms. An effective and strong collaboration is essential between the general education teachers and special education teachers to assure consistency in the development and implementation of intervention method.

Effective instructions include:

- To provide appropriate structure and predictable daily routines.
- To establish a structured and consistent classroom environment.
- To establish a consistent schedule with set rules and consequences and clear expectations.
- To foster positive teacher-student interaction with adequate praise and systematic responses to problem behaviors.
- To implement frequently instructional sequences, which promote high rates of academic engagement.
- To create a classroom environment in which independent seatwork is limited and sufficient time is allotted for establishing positive social interaction.

Practical instructions to accommodate students suffering from ADHD include the following:

- Place the student away from distracting situations both visually and auditory.
- Provide structure for instruction as well as for transitioning from one activity to the next. For example, provide study guides prior to a test; use graphic organizers for delivering class instruction or for assisting the student in writing essays; provide a checklist of events that the student is to attend prior to viewing a movie or video.
- When providing the class information or directions for tasks, use a multi-modality approach. Use transparencies to emphasize major points or lecture topics; provide an outline for note taking prior to lectures; use as many hands-on activities as possible.
- Seatwork or individual tasks should be carefully monitored. Give students a checklist so that they would know exactly what tasks are to be done during seatwork time. Place the student with a peer helper. Check the student frequently to reinforce on-task behavior. Be sure that the student will be able to complete the assignment within his/her attention time frame.
- When giving homework assignments, be sure that the student can complete the amount given. Break it down into short segments; give only a small section to be completed at home; most important be sure that the assignment will result in success and not failure. These students have poor self-esteem and need positive reinforcement, not negative.
- Alternate class activities so that a long period of sitting is not required. Give students alternative for class movement so that they can physically move without the movement being considered inappropriate.
- Note taking may prove difficult. Provide copies of notes; allow students to tape record information; use graphic organizer for note taking.
- Allow students to tape record answers to tests instead of writing them. Be sure that tests are short. It is important to avoid lengthy tests or you can simply split them in half. Limit the number of distracters on multiple-choice items.
- Use a means of evaluating student performance other than traditional tests.
- Remember that these students are overly sensitive to criticism; therefore, frequent praise is necessary.

Teachers can help students improve their behavior in many different ways, from preventive measures to direct confrontation with the students.

Effectively managing the classroom is critical for teachers with students with emotional and behavioral disorders because of the potential disruptiveness of this group of students and their impact on the learning of other students.

1. Standard Operating Procedures: Classroom rules and procedures are a critical management tool for students with EBD. Rules should be developed with the input of

students and should be posted in the room. The process of determining the rules is as important as the rules themselves. Examples include:

- General Classroom Rules: Be polite and helpful, keep your space and materials in order, take care of classroom and school property.
- More specific Rules: Raise your hand before speaking; leave your seat only with permission, only one person in the rest room at a time.

2. Physical Accommodations: The physical arrangement of the classroom has an impact on the behaviors of students with emotional and behavioral disorders. The following considerations can help in maintaining an orderly classroom:

- Arranging traffic patterns to lessen contact and disruptions
- Arranging student desks to facilitate monitoring of all students at all times
- Physically locating students with tendencies toward disruptive behaviors near the teacher's primary location.
- Locating students away from stored materials that they may find tempting
- Creating spaces where students can do quiet work such as quiet reading area.

3. Preventive Discipline: Probably the most effective means of working with students who display EBD is preventive in nature. If inappropriate behaviors can be prevented, then disruptions will be minimal and the student can attend to the learning task at hand. Preventive discipline can be described as the teacher's realization that discipline begins with a positive attitude that nurtures students' learning of personal, social and academic skills. Rather than wait to respond to inappropriate behaviors, adherents to positive discipline take the initiative by interacting with students in a positive manner that removes the need for inappropriate behaviors. The 10 components of a preventive discipline program:

- Inform pupils of what is expected of them
- Establish a positive learning climate
- Provide a meaningful learning experience
- Avoid threats
- Demonstrate fairness
- Build and exhibit self-confidence
- Recognize positive student attributes
- Recognize student attributes at optimal times
- Use positive modeling
- Structure the curriculum and classroom environment.

7.5. Management of students with physical disabilities

Students with physical disabilities have the following characteristics:

- They tire more quickly than others in the class.
- They have repeated absences due to medical appointments or morbidities.
- They experience difficulty in performing gross motor tasks.
- They may be unable to or have difficulty completing manipulative activities such as holding the pencil, cutting, drawing etc.
- They have difficulties distinguishing differences in size, depth, and spatial relationships (common among children with cerebral palsy).
- They may be socially delayed due to a lack of interaction with other children.

It is recommended that teachers follow these steps when dealing with students with physical disabilities:

- To be aware of all the disabilities that the student has.
- To allow adequate time for the student to move from one place to another and be positioned in class.
- To be aware of the procedures needed to manage any emergency related to the student disability such as management of a seizure, an acute asthmatic attack etc.
- To preplan all emergency situations and be prepared.
- To work closely with all therapists involved in the education of the affected child.
- To make sure that all the physical structures in the class are stabilized such as chairs, wheelchairs etc.
- To work on eliminating physical barriers if available.
- Always to remember that the student may sometimes pass in phases of low vitality and to understand that.

7.6. Mainstreaming

Mainstreaming is the process of teaching students with disabilities in regular classrooms with students without disabilities, using supplementary aids and services to maximize their educational potential, thus ensuring the delivery of educational services in the least restrictive environment. To be successful, mainstreaming necessitates a full cooperation of regular and special education personnel; sharing resources, skills and time.

Some common elements of the definitions of Mainstreaming include (a) the involvement of students with disabilities as part of the regular education program, and (b) an emphasis on the social and instructional aspects of the integration process. Other components of the definition of mainstreaming are the inclusion of special services, placement in the least restrictive environment, and cooperation among educators. Whether for social or instructional purposes, mainstreaming requires that students with and without disabilities be educated together and that services be made available to supplement the education of students with disabilities. In the regular classroom, students with disabilities receive special supportive or related services as needed.

The principle of the least restrictive environment implies education of students with disabilities in settings and programs with peers without disabilities in accordance with their individual needs. For some students, the mainstream of the regular education setting is the least restrictive and most appropriate placement. For others, a more specialized setting outside of the regular classroom may be necessary to meet their educational needs. For all students, the ultimate goal of their individualized educational programs is to equip them with the educational, social, and vocational skills to enable them to function in the mainstream of society as their abilities allow.

Requirements for the physical mainstreamed environment are determined by the needs of the people who will use the facilities. Structural modifications to accommodate students with physical disabilities such as the widening of the doorways, the construction of entrance ramps, and remodeling of facilities to accommodate personal needs may be required. Also, students with physical disabilities may need special equipment such as wheelchairs, walkers, standing tables, and within-reach water fountains and phones, to take full advantage of the learning environment.

The physical and ecological characteristics include the following:

- Classroom light, temperature and ventilation: in general, classrooms need good and appropriately placed lighting, sufficient wall space of a subdued color and adequate ventilation. Teachers should make sure that all students work areas are well lighted and that glare is not a problem. Classrooms equipped with variable lighting equipment (such as brighter lighting for reading and study areas and softer lighting for discussion areas) are desirable. Teachers should also be able to maintain a moderate and desirable temperature in the room. It is important to make sure that internal temperature maintenance mechanisms are intact for some students with disabilities because changes in external temperature can pose significant problems in their ability to maintain body temperature. Although windows are a good source of light and ventilation, students may become distracted by outside events and noises when windows are opened. However, ventilation is necessary to prevent students from becoming sleepy and lethargic.

- Classroom noise level: some students may be easily distracted by noise and/or movement, making it necessary to place these students in quieter, less active areas of the classrooms. Carpeting, acoustical ceiling tiles, drapes, well-insulated walls and careful room arrangement can decrease the noise level within a classroom.
- Classroom furniture and special equipment: the furniture in the classroom should be comfortable, durable, and functional.\The desks, chairs, tables, and standing tables should fit students properly. Students with disabilities often have difficulties doing written work neatly, so their desks and chairs must fit them properly. In particular, students should be able to place both feet on the floor with their knees about even with the seat. The desks should be high enough for students to look down at the desk tops and be able to place their entire arms, from

elbow to hands, horizontally on the desks. Students with physical disabilities usually need assistance in order to use their abilities and to be comfortable while sitting or standing. The most effective way to assist students is called positioning. Some students benefit from the use of assistive devices(technologies). Assistive technologies are defined as "any device or technology-related service which provides an individual with access to, maintenance of, or improved abilities to function in learning, living, work or recreation environments.

- Classroom location, size and arrangement: the location of the mainstreamed classroom is important because of the message it conveys. If the classrooms are too close to the principal's office, the message received by teachers and students in the classrooms may be that they are in need of careful supervision. Or, if the mainstreamed classes are housed side by side or in a designated wing, the unintended message may be that students with disabilities should be grouped together. Another factor affecting the location of the classroom is the adequacy of emergency escape routes. Corridors must be wide enough so that wheelchairs will not obstruct the passage. Doorways of classrooms should be wide enough to accommodate wheelchairs. Appropriate door handles at convenient heights or correctly tensioned door closers permit easy entry and departure. Adequate clear wall space to the side of the door by the door handle is needed to aid students using wheelchairs as they are approaching and opening the door. Classroom crowding must be avoided since studies have shown that higher rates of aggressive behavior occurred under crowded conditions. The classroom should be large enough to accommodate individual, small-group and large-group instruction and to allow for barrier-free movement from one work area to another. The teacher-to-pupil ratio should be lower in mainstreamed classrooms as compared to regular classrooms. The seating arrangement within a classroom can affect the behavior of students. Students with disabilities should be seated in the spot most favorable to them. Students who require special equipment or who have mobility problems should be seated near the room's entrance as well as close to the group with which they are likely to work. A place should be provided for crutches, walkers, and wheelchairs. Children with severe vision problems should be seated where it is easiest for them to locate their seats. They should also be able to locate, retrieve, and return equipment they use so that they do not become dependent on the teacher for obtaining learning materials and equipment. Children with severe hearing problems should be seated near where the teacher stands when giving instructions and directions. In this area, light should fall on the teacher's face, that is students should not have to face into the light to see the teacher's face. Children with severe visual or hearing problems should be seated so that they are able to read material that is written on the chalkboard. Children who are easily distracted should be seated in quiet areas. They should be placed

near self-directed, quiet students. Sometimes, it would be helpful to seat easily distracted students near the teacher's desk. The classroom should be arranged so that the student movement creates the smallest disturbance possible when students move into smaller groups, walk to get supplies or go to different learning centers.

- Facilities beyond the classroom: The physical disposition of facilities beyond the classroom can affect the opportunities for socializing and the nature of social interactions between students with and without disabilities. Playground areas, congregational areas and lunch arrangements should be designed to facilitate social interactions between students with special needs and their peers. Easy routes from classrooms to play areas should be established including installation of ramps along the routes to assist wheelchair users. Students with disabilities should have access to all the playground areas.

Benefits of Mainstreaming

Mainstreaming is beneficial to both disabled and non-disabled students. In fact, disabled students will have the opportunity to participate in the regular school activities and remain in their classes with their peers who do not suffer from disabilities. This will have a positive effect on their psychological status, and will improve academic achievement and support social and emotional growth.

On the other hand, students without disabilities will be exposed to the real heterogeneous external environment. It is important to learn from an early age that physical, emotional and intellectual differences exist and this is normal. When aware of the presence of differences, children will tend to accept and appreciate differences in themselves and others. These children will be more ready to accept as adults the wide range of human behavior and achievement.

Mainstreaming cannot be successful without the collaboration of regular and special class teachers. Both have to work and collaborate together to provide appropriate and good quality services in the mainstream.

Disadvantages of Mainstreaming

Although mainstreaming has crucial benefits, some disadvantages exist. First of all, mainstreaming can be expensive since there is a need to train teachers and training is expensive. Other disadvantages include the possibility of poorer educational attainment of non-disabled children and the possibility of increasing time lost for them. This is without forgetting the negative attitude of most of the teachers regarding mainstreaming, which lead sometimes to the integration of this mainstreaming on the cheap.

Mainstreaming consists of:

- Providing equal access to educational opportunities for both students with and without disabilities.
- Teaching students the means and importance of appreciating differences among people.
- Sharing resources, skills and time.
- Providing an environment with positive attitudes.
- Realizing that students with disabilities belong in the regular classroom environment and should receive support services as needed.

Mainstreaming is not:

- Serving students with disabilities in regular classes without a well-planned support system in place
- Presenting regular class instruction to students with disabilities without allowing for modifications when necessary
- Placing all students with disabilities, regardless of their needs, into the regular education program
- Placing at risk the progress of students without disabilities in the regular classroom

CHAPTER 8

CONCLUSION & RECOMMENDATIONS

This study reveals a significant prevalence of Special Educational Needs among students in UNRWA schools, especially in the form of learning disabilities and emotional and behavioral problems. It is more prevalent in the primary grades as compared to middle and secondary school. Several factors are found to be contributing to the SEN. Some of these factors were measured and showed direct relationship, while others are related mainly to the setting and the system of UNRWA schools.

1. Factors directly affecting the prevalence of Learning Disabilities:
   - Male Gender
   - Poverty or low socioeconomic status
   - Living in the camps (especially more prevalent in Saida region)
   - Chronic diseases in the child especially Epilepsy
   - Positive Family History of school failure and behavioral problems
   - Delayed speech and mental development in the children
   - Absence of extracurricular activities
   - Slow motor and physical development of the child
   - Violence at school

2. Factors related to the setting of UNRWA
   - Crowded classes
   - Absence of preschool in the UNRWA system and following the Lebanese system
   - Double shift
   - The role of the teachers.

In view of the high number of students who were identified to have SEN, and in view of the restrictions and limitations in resources available currently in UNRWA, we will suggest two types of recommendations:

(1) Immediate Recommendations: what to do now.

(2) Long term Recommendations.

Immediate Recommendations:

- Identify students who will need further assessment. These students are those included in the electronic database provided to UNRWA. To decrease the probability of false positive and in view of the big numbers, it is suggested to choose for learning disabilities, those students who have positive result on PRS and at the same time positive result on the Academic section in the BBRS.
- Perform an individualized assessment for this child by the trained teacher.
- In case of abnormality, start developing IEP and act accordingly

Long-term Recommendations:

These recommendations are two level:

1. Screening and diagnosing students with disabilities: At the level of early screening and diagnosing students with disabilities an assessment center located at the field office has to be established that has the ability to assess and diagnose children with disabilities referred from UNRWA five areas. This center should have four specialists: a special education specialist, educational psychologist, speech therapist, and social worker. In addition, in every area a center has to be established having a number of teachers who obtained a teaching diploma in special education to be in touch with the centralized center and teachers in schools , to follow up the implementation of the individualized education plan (IEP) and to be responsible for the resource rooms. The number of these teachers varies in accordance with the number of schools and number of students in every area. Furthermore a number of special class teachers have to be assigned to handle the special class or remedial class that has to be established in every school.

2. Provision of services to support the academic success of these students: At the level of provision of services to support the academic success of these students, the program has to provide a continuum of services, i.e. a range of placement and service options to meet the individuals' needs of these students. This continuum with placements will range from least restrictive (regular classroom placement) to restrictive (self-confined class). As such there will be three levels to be offered in this program.
    - **Level one, Regular classroom with consultation to teacher**: students will receive a prescribed program under the direction of regular classroom teacher who is supported by on-going consultation from a special educator.
    - **Level two, Regular classroom and resource room**: students receive prescribed program under the direction of the regular classroom teacher; in addition he or she spends part time in a specially staffed and equipped resource room.
    - **Level three, Full-time special class:** students will receive prescribed program under the direction of a special class teacher.

The placement of any student at any level on the continuum of services is not to be regarded as permanent. The continuum concept is intended to be flexible, with students moving from one placement to another as dictated by their current educational needs. Teachers and administrators should periodically review specific goals and objectives for each child – they are required to do so at least annually- and make new placement decisions. When the performance review shows that certain goals have been achieved, the child should be returned to a more normal setting.

Practices that teachers can use to help exceptional children are: a) curriculum based assessment b) cooperative learning c) self management d) peer tutoring e) strategy instruction f) direct instruction and g) goal setting.

Curriculum based assessment: Supervisors of English language, Arabic, and Math have to periodically prepare tests that contain the important competencies needed for these children and administer them as a form of follow up of the performance of regular teachers and exceptional children

Cooperative learning: In cooperative learning the teacher has to organize students into groups and give them a task to solve cooperatively. The child with exceptionalities in this case will participate as a member of a cooperative learning team and as a result these children will learn from their peers and gain social acceptance.

Peer tutoring: Meaningful inclusion of a student with disabilities into the academic and social life of the regular classroom presents a difficult challenge. The regular classroom teacher is expected to deliver individualized instruction to the mainstreamed student, maintain effective programming for the rest of the class, and help the mainstreamed child become socially integrated into the classroom. An available source of tutoring help in every classroom is the students themselves. Class wide peer tutoring involves mainstreamed students as full participants in an ongoing whole-class activity. Where students with disabilities or low achievers who have not mastered a particular skill will get help in an interactive way from a few high – achieving students who are assigned as tutors.

In addition, school personnel involved in the education of students with disabilities must have a positive attitude about serving this group of students. They must view as "all students belong". As part of this sense of belonging, the language used to refer to individuals with disabilities becomes important. In addition to having personal philosophy of education that forms the basis for meeting the needs of all children, including those with special needs teachers must be aware of the code of ethics (a person first language) that is used to govern meeting the needs of students with special needs. All teachers should adhere to the professional ethics in meeting needs of the diverse groups of students in UNRWA schools.

Implementation of this program has to be divided into two short term and long term phases:

1. Phase one (Short Term):

a) Screening students of the first cycle.
b) Establishing remedial classes for the first cycle to avoid later problems with students that might affect the enrollment as well as the level of performance at the upper levels. Teachers who have to handle these classes should be those who undergone the training in special education offered by the people who did the study.
c) Establishing resource rooms
d) Training and preparing teachers, the supervisor of lower elementary, supervisor responsible for remedial classes, and special education supervisor to have special education diploma to serve students in the next academic year.

e) Establish a search committee to look for specialists in the fields of educational psychology, special education, social work, and speech therapy to be the nucleus of assessment center at Lebanon Field Office.

2. Phase Two (Long Term):

a) Preparation of the assessment center at Lebanon Field Office.
b) Preparation of the referral centers in the five areas.
c) Establish a special education diploma at Siblin center.

Yet some points have to be considered and might not help in implementing this program nor give quick results which are:

1. The double shift that exists in UNRWA schools
2. The number of students in every class (40) especially in the first cycle, where the most care has to be offered and the longer time and interaction is needed.
3. the absence of pre-schooling level in the schools run by UNRWA

Table 4.2. Demographic characteristics of the studied population

	N	%
Gender (N = 26258)		
Male	11312	43.1
Female	14946	56.9
Location (N = 25985)		
Inside Camp	16701	64.3
Outside Camp	9284	35.7
Salary (N = 25530)		
Less than 300,000 L.L	10705	38.3
300,000 - 900,000 LL	11158	39.9
900,000 - 1,500,000 LL	2853	10.2
More than 1,500,000 LL	814	2.9
	Mean	*SD*
Number of Rooms	2.2	1.1
Number of persons per house	5.9	1.8

Table 4.3. Characteristics of the adolescent population (students in grade 6 to 12)

	N	%
Gender (N = 15614)		
Male	6606	42.3
Female	9008	57.7
Live with (N =15738)		
Father and Mother	13983	88.9
Father or Mother	1085	6.9
Father / Mother and Spouses	362	2.3
Brothers / Sisters Grandfather / Grandmother	194	1.2
Other	114	0.7
Work currently (N = 16119)		
Yes, paid job	390	2.4
Yes, unpaid with the family	934	5.8
No	14713	91.3
Other	82	0.5
Worked during last summer vacation (N = 16141)		
Yes, paid job	2102	13.0
Yes, unpaid with the family	1225	7.6
No	12757	79.0
Other	57	0.4
Reason for working (N = 15762)		
Don't work	12100	76.8

To help the family	1949	12.4
To pay school tuition	198	1.3
To buy personal stuff	1115	7.1
For saving	248	1.6
Other	152	0.96
Cigarette smoking (N = 16094)		
Never smoker	15236	94.7
Occasional smoker	346	2.1
Ex-smoker	340	2.1
Current smoker	172	1.1
Narguilé smoking (N = 16116)		
Never smoker	12928	80.2
Occasional smoker	1967	12.2
Ex-smoker	378	2.4
Current smoker	843	5.2
Extra-cullicular Activities (N = 16147)		
Never / Rarely	3299	20.4
To a certain extent	9595	59.4
To a great extent	3253	20.2
Friends from opposite sex (N = 13834)		
0	5784	41.8
1	1412	10.2
2	1087	7.9
3 and more	5542	40.1
Friends from opposite sex at school (N = 13834)		
Never	7617	55.0
To certain extent	4229	30.6
To a great extent	1988	14.4
Friends from opposite sex in the society (N = 13834)		
Never	4526	32.7
To certain extent	6663	48.2
To a great extent	2645	19.1

Table 4.4. Description of Events in the lives of students in grade 6 and above.

Description of the event	N	%
Newborn in the family		
Yes	4402	26.9
No	11985	73.1
Admission to the hospital (N = 16387)		
Yes	4465	27.2
No	11922	72.8
Death of one of the parents (N = 16387)		
Yes	778	4.7
No	15609	95.3
Death of brother / Sister (N = 16387)		
Yes	1421	8.7
No	14966	91.3
Death of a relative (N = 16387)		
Yes	8067	49.2
No	8320	50.8
Death of a close friend (N = 16387)		
Yes	1613	9.8
No	14774	90.2
Divorce / Separation of parents (N = 16387)		
Yes	695	4.2
No	15692	95.8
Been diagnosed of serious disease (N = 16387)		
Yes	1119	6.8
No	15268	93.2
Diagnosis of a serious disease in the family (N = 16387)		
Yes	2519	15.4
No	13868	84.6
Change of house (N = 16387)		
Yes	3192	19.5
No	13195	80.5

Table 4.5. Description of Violence Events in the lives of students in grade 6 and above.

Violence Events	N	%
Beaten by a teacher / principal		
Never	9837	67.8
1-3 times	3354	23.1
A lot	1314	9.1
Beaten by other students		
Never	12782	87.6
1-3 times	1449	10.0
A lot	354	2.4
Humiliated by a teacher / principal		
Never	10519	71.7
1-3 times	2961	20.2
A lot	1188	8.1
Humiliated by other students		
Never	13899	85.9
1-3 times	1763	10.9
A lot	525	3.2
Beaten by parents		
Yes	3031	18.5
No	13356	81.5
Beaten by brothers / Sisters		
Yes	2302	14.0
No	14085	86.0

Table 4.6. Pupil rating Scale Results

	N	%
Auditory Comprehension (N =33388)		
Significant	15249	45.67
Not Significant	18139	54.33
Spoken Language (N = 33367)		
Significant	17320	51.91
Not Significant	16047	48.09
Orientation (N = 33354)		
Significant	11071	33.19
Not Significant	22283	66.81
Coordination of Movement (N = 33371)		
Significant	7470	22.38
Not Significant	25901	77.62
Personal Social Behavior (N = 33281)		
Significant	14136	42.47
Not Significant	19145	57.53
Learning Disabilities (N = 33162)		
Significant	18978	57.23
Not Significant	14184	42.77
Verbal Scale (N = 33351)		
Significant	17452	52.33
Not Significant	15899	47.67
Non Verbal Scale (N = 33208)		
Significant	18576	55.90
Not Significant	14632	44.10
Learning Disabilities (N = 16432) (Grade 6 and Above)		
Significant	9236	56.21
Not Significant	7196	43.79

Table 4.7. ADHD Rating Scale

	N	%
Attention (N = 33405)		
Significant	18094	54.17
Not Significant	15311	45.83
Excessive movement (N = 33405)		
Significant	13055	39.08
Not Significant	20350	60.92
Impulsivity (N = 33405)		
Significant	14697	44.00
Not Significant	18708	56.00
ADHD (N = 33405)	N	%
Significant	15943	47.70
Not Significant	17462	52.30

Table 4.8. Burks Behavior Rating Scale

	N	%
Excessive Self-Blame (N = 33195)		
Not Significant	29007	86.83
Significant	4165	12.47
Very Significant	233	0.70
Excessive Anxiety (N = 33153)		
Not Significant	30580	91.54
Significant	2651	7.94
Very Significant	174	0.52
Excessive Withdrawal (N = 33184)		
Not Significant	30240	90.53
Significant	3048	9.12
Very Significant	117	0.35
Excessive Dependency (N = 33070)		
Not Significant	30654	91.76
Significant	2637	7.89
Very Significant	114	0.34
Poor Ego Strength (N = 33229)		
Not Significant	29937	89.62
Significant	3368	10.08
Very Significant	100	0.30
Poor Physical Strength (N = 33263)		
Not Significant	31174	93.32
Significant	2102	6.29
Very Significant	129	0.39
Poor Coordination (N = 33200)		
Not Significant	30452	91.16
Significant	2753	8.24
Very Significant	200	0.60
Poor Intellectuality (N = 33243)		
Not Significant	26451	79.18
Significant	6545	19.59
Very Significant	409	1.22
Poor Academics (N = 33226)		
Not Significant	25328	75.82
Significant	6186	18.52
Very Significant	1891	5.66
Poor Attention (N = 33179)		
Not Significant	26972	80.74
Significant	5843	17.49
Very Significant	590	1.77
Poor Impulse Control (N = 33224)		
Not Significant	29780	89.15

Significant	3207	9.60
Very Significant	418	1.25
Poor Reality Contact (N = 33154)		
Not Significant	31547	94.44
Significant	1801	5.39
Very Significant	57	0.17
Poor Sense of Identity (N = 32993)		
Not Significant	31678	94.83
Significant	1597	4.78
Very Significant	130	0.39
Excessive Suffering (N = 33060)		
Not Significant	30763	92.09
Significant	2535	7.59
Very Significant	107	0.32
Poor Anger Control (N = 32746)		
Not Significant	30508	91.33
Significant	2633	7.88
Very Significant	264	0.79
Excessive Sense of Persecution (N = 33154)		
Not Significant	30575	91.53
Significant	2665	7.98
Very Significant	165	0.49
Excessive Aggressiveness (N = 33133)		
Not Significant	30421	91.07
Significant	2775	8.31
Very Significant	209	0.63
Excessive resistance (N = 33172)		
Not Significant	30101	90.11
Significant	2976	8.91
Very Significant	328	0.98
Poor Social Conformity (N = 33148)		
Not Significant	30363	90.89
Significant	2876	8.61
Very Significant	166	0.50

Table 4.9. Distribution of Pupil rating Scale Components by Class

Class	Auditory Comprehension		Spoken Language		Orientation		Motor Coordination		Personal Social Behavior	
	N	%	N	%	N	%	N	%	N	%
1	1071	7	1246	7.2	910	8.2	631	8.4	1013	7.2
2	1287	8.3	1484	8.6	1154	10.4	741	9.9	1220	8.6
3	1687	11.1	1882	10.9	1373	12.4	927	12.4	1630	11.5
4	1851	12.1	2086	12.0	1391	12.6	913	12.2	1769	12.5
5	1813	11.9	2109	12.2	1322	11.9	939	12.6	1755	12.4
6	1668	10.8	1857	10.7	1209	10.9	795	10.6	1460	10.3
7	1762	11.6	1972	11.4	1280	11.6	745	10.0	1600	11.3
8	1584	10.4	1819	10.5	1055	9.5	726	9.7	1385	9.8
9	1484	10.4	1685	9.7	866	7.8	641	8.6	1333	9.4
10	707	4.6	785	4.5	333	3.0	246	3.3	628	4.4
11	206	1.4	216	1.2	102	.9	91	1.2	199	1.4
12	129	0.8	179	1.0	76	.7	74	1.0	143	1.0
	15249	100	17320	100.0	11071	100.0	7469	100.0	14135	100.0

Table 4.10. Distribution of ADHD rating Scale Components by Class

	Attention		Excessive Motion		Impulsivity	
Class	**N**	**%**	**N**	**%**	**N**	**%**
1	1727	11.3	2034	10.0	1797	9.6
2	1456	9.5	1813	8.9	1616	8.6
3	1581	10.3	2091	10.3	1909	10.2
4	1558	10.2	2223	10.9	1992	10.6
5	1645	10.7	2247	11.0	2124	11.4
6	1338	8.7	1920	9.4	1896	10.1
7	1373	9.0	1989	9.8	1942	10.4
8	1215	7.9	1731	8.5	1534	8.2
9	1159	7.6	1732	8.5	1679	9.0
10	1213	7.9	1331	6.5	1159	6.2
11	658	4.3	806	4.0	679	3.6
12	387	2.5	432	2.1	380	2.0
Total	15310	100.0	20349	100.0	18707	100.0

Table 4.11. Distribution of Burks behavior rating Scale Components by Class

Class	1	2	3	4	5	6	7	8	9	10	11	12	Total
Excessive Self Blame													
Significant	347	452	356	368	383	481	421	479	503	189	105	81	4165
Very Significant	10	28	24	5	22	26	17	36	30	21	4	10	233
Excessive Anxiety													
Significant	185	288	227	246	216	279	300	390	328	97	35	60	2651
Very Significant	3	34	26	22	31	8	9	12	24	0	2	3	174
Excessive withdrawal													
Significant	206	337	317	361	354	299	281	440	327	66	40	20	3048
Very Significant	0	9	30	3	10	32	16	12	3	0	2	0	117
Excessive dependency													
Significant	184	325	307	299	259	302	245	397	252	35	28	4	2637
Very Significant	3	25	23	1	12	8	16	9	15	0	2	0	114
Poor Ego Strength													
Significant	188	385	371	433	341	443	292	466	372	44	20	13	3368
Very Significant	2	5	25	4	23	2	19	8	8	0	4	0	100
Poor Physical Strength													
Significant	143	212	218	265	235	228	221	278	220	29	24	29	2102
Very Significant	2	32	17	6	30	2	21	10	7	0	2	0	129
Poor Coordination													
Significant	245	322	367	408	297	284	249	299	223	34	23	2	2753
Very Significant	16	45	18	12	36	27	24	14	6	0	2	0	200
Poor Intellectuality													
Significant	400	585	778	782	786	956	650	807	621	111	39	30	6545
Very Significant	28	50	50	82	65	62	33	17	22	0	0	0	409
Poor Academics													
Significant	427	459	750	793	775	737	755	774	536	104	47	29	6186
Very Significant	146	221	377	321	235	280	136	69	94	11	1	0	1891
Poor Attention													
Significant	395	576	725	636	629	692	602	689	662	149	44	44	5843
Very Significant	58	66	84	122	84	70	28	42	26	8	2	0	590
Poor Impulse Control													
Significant	212	357	344	383	281	364	345	394	343	122	32	30	3207
Very Significant	23	44	60	41	61	42	43	35	60	5	3	1	418
Poor Reality Contact													
Significant	86	185	151	199	140	182	234	331	232	39	17	5	1801
Very Significant	1	5	14	1	27	0	1	4	3	0	1	0	57
Poor Sense of Identity													
Significant	83	174	213	201	138	139	193	237	187	21	8	3	1597
Very Significant	2	20	13	17	32	10	17	7	7	0	5	0	130
Excessive Suffering													
Significant	159	292	291	305	196	299	255	361	296	42	24	15	2535

Very Significant	2	30	24	3	12	3	18	7	5	0	3	0	107
Poor Anger Control													
Significant	123	286	284	280	276	280	261	396	321	74	29	23	2633
Very Significant	12	47	32	26	39	40	22	27	14	3	2	0	264
Excessive Sense of Prosecution													
Significant	150	308	325	298	259	297	300	374	250	57	33	14	2665
Very Significant	2	13	24	12	23	26	19	22	22	2	0	0	165
Excessive Aggressiveness													
Significant	188	291	309	420	228	326	269	382	303	27	30	2	2775
Very Significant	7	55	21	16	31	15	22	18	20	1	3	0	209
Excessive Resistance													
Significant	171	311	379	362	307	372	292	395	292	62	20	13	2976
Very Significant	9	54	40	39	51	26	34	23	45	1	6	0	328
Poor Social Conformity													
Significant	191	292	407	398	274	285	308	397	255	40	16	13	2876
Very Significant	5	45	29	4	40	12	9	3	16	0	3	0	166

Table 4.12. Success Rates in Governmental exams by Class

	Minimum Success Rate (%)	Maximum Success Rate (%)	Mean Success Rate (%)
Grade 9 (Brevet) 04-05	30.0	93.0	65.28
Grade 9 (Brevet) 05-06	32.0	100.0	69.30
Life Sciences 04-05	100.0	100.0	100.00
Life Sciences 05-06	100.0	100.0	100.00
Humanities 04-05	90.0	100.0	95.00
Humanities 05-06	95.0	100.0	97.50
Economics 04-05	98.70	98.70	98.70
Economics 05-06	100.00	100.00	100.00

Table 4.13. Rates of Dropout, Repeat and passing classes by level

	Minimum Rate %	Maximum Rate %	Mean Rate %	Std. Deviation
Leave Elementary	.0	4.3	1.32	1.02
Repeat Elementary	2.0	40.0	12.70	7.55
Pass Elementary	60.0	92.7	80.51	8.63
Leave Intermediate	.0	16.8	3.30	3.56
Repeat Intermediate	1.0	41.0	17.92	8.37
Pass Intermediate	3.7	88.4	72.42	15.87
Leave Secondary	.1	2.0	.94	.72
Repeat Secondary	1.0	25.0	9.50	9.80
Pass Secondary	75.0	98.0	86.52	8.55

Table 4.14. Prevalence of Learning Disabilities by General Conditions

LD and General Characteristics	N	%	P-value
Live with (N = 15738)			
Father and Mother	13983	6.42	<0.001
Father or Mother	1085	5.44	
Father / Mother and Spouses	362	8.56	
Brothers / Sisters Grandfather / Grandmother	194	8.25	
Other	114	12.28	
Class			
1	1418	49.01	<0.001
2	1745	56.73	
3	2078	59.44	
4	2274	62.49	
5	2227	67.44	
6	1938	58.69	
7	2165	64.8	
8	1920	61.82	
9	1842	58.72	
10	898	44.65	
11	275	27.78	
12	198	35.55	
Region (N = 33405)			
Beirut	5609	57.43	<0.001
Saida	10521	59.05	
Tyre	6039	53.59	
Tripoli	9138	57.16	
Bekaa	2098	58.35	
Location (N = 19763)			
Inside Camp	12,294	57.80	
Outside Camp	7,469	54.21	<0.001
Salary (N = 19414)			
Less than 300,000 L.L	7,911	64.57	<0.001
300,000 - 900,000 L.L	8,674	52.28	
900,000 - 1,500,000 L.L	2,233	45.63	
More than 1,500,000 L.L	596	49.66	
Extra-cullicular Activities (N = 12789)			
Never / Rarely	2,607	57.08	<0.001
To a certain extent	7,554	54.81	
To a great extent	2,628	56.85	
Financial Satisfaction (N = 12830)			
Never / Rarely	3,331	51.56	<0.001
To a certain extent	6,673	61.72	
To a great extent	2,826	54.67	

Table 4.15. Prevalence of Learning Disabilities by Health Condition of the student

LD and Child medical History	N	%	p-value
Epilepsy (N = 21133)			
Yes	278	72.30	<0.001
No	20,855	56.76	
Chronic Infection of the Middle Ear (N = 21133)			
Yes	1,498	63.28	<0.001
No	19,635	56.48	
Iron Deficiency (N = 21133)			
Yes	1,728	61.92	<0.001
No	19,405	56.52	
Visual Problems (N = 21133)			
Yes	3,962	59.41	<0.001
No	17,171	56.40	
Hearing Problems (N = 21133)			
Yes	830	64.10	<0.001
No	20,303	56.67	
Meningitis (N = 21133)			
Yes	66	63.64	0.273
No	21,067	56.94	
Other Chronic Conditions (N = 21133)			
Yes	1,733	59.49	0.026
No	19,400	56.74	
Regular Intake of Drugs (N = 21133)			
Yes	1,145	63.14	<0.001
No	19,988	56.61	

Table 4.16. Prevalence of Learning Disabilities by Child Development

LD and Child Development	N	%	p-value
Slow physical growth (N = 21133)			
Yes	1,461	66.46	<0.001
No	19,672	56.26	
Slow mental growth (N = 21133)			
Yes	910	85.49	<0.001
No	20233	55.68	
Slow motor growth (N =21133)			
Yes	665	71.73	<0.001
No	20,468	56.48	
Speech Delay (N = 21133)			
Yes	1,411	71.44	<0.001
No	19,722	55.93	

Table 4.17. Prevalence of Learning Disabilities by family History

LD and Family History	N	%	p-value
Problems in school learning (N = 21132)			
Yes	5,228	70.22	<0.001
No	15,904	52.60	
Failure in School (N = 21133)			
Yes	6,821	72.03	<0.001
No	14,312	49.78	
Behavioral Problems (N = 21133)			
Yes	863	73.58	<0.001
No	20,270	56.26	
Mental Problems (N = 21133)			
Yes	1,117	69.29	<0.001
No	20,016	56.27	

Table 4.18. Prevalence of Learning Disabilities by perinatal events

LD and events during pregnancy	N	%	p-value
Health problems during pregnancy (N = 21133)			
Yes	2674	60.17	<0.001
No	18459	56.50	
Medications during pregnancy (N = 21133)			
Yes	2,472	60.52	<0.001
No	18,661	56.49	
Alcohol during pregnancy (N = 21133)			
Yes	44	61.36	
No	21,089	56.95	
Smoking during pregnancy (N = 21133)			
Yes	3492	63.12	<0.001
No	17641	55.75	

Table 4.19. Prevalence of Learning Disabilities by violence

LD and Beating History	N	%	p-value
Beaten by a teacher / principal (N = 11,431)			
Never	7,652	52.65	<0.001
1-3 times	2709	61.98	
A lot	1070	66.82	
Beaten by other students (N = 11482)			
Never	10004	55.36	<0.001
1-3 times	1170	59.91	
A lot	308	66.56	
Humiliated by a teacher / principal (N = 11563)			
Never	8235	53.67	<0.001
1-3 times	2396	61.10	
A lot	932	66.31	
Humiliated by other students (N = 12828)			
Never	10936	54.92	<0.001
1-3 times	1435	58.68	
A lot	457	67.18	

Table 4.20. Multivariate Logistic Regression analysis: Odds ratios (OR) and 95% Confidence Intervals (CIs)

VARIABLE	OR	CI
Gender		
Male	1.3*	(1.21:1.40)
Female		
Location		
Inside Camp	0.87	(0.78:0.96)
Outside Camp		
Crowding Index	1.15*	(1.10:1.19)
Events during pregnancy		
Health problems during pregnancy		
Yes	0.996	(0.84:1.19)
No		
Medications during pregnancy		
Yes	1.01	(0.85:1.20)
No		
Alcohol during pregnancy		
Yes	0.73	(0.18:3.05)
No		
Smoking during pregnancy		
Yes	0.92	(0.81:1.04)
No		
Problems during child's growth		
Slow physical growth		
Yes	0.99	(0.87:1.13)
No		
Slow mental growth		
Yes	2.16*	(1.75:2.67)
No		
Slow motor growth		
Yes	1.04	(0.85:1.28)
No		
Delayed Speech		
Yes	1.26*	(1.09:1.45)
No		
Current students' problems according to parents		
Mental Problems		
Yes	0.86	(0.75:1.01)
No		
Emotional Problems		
Yes	0.92	(0.80:1.07)
No		
Problems in School		
Yes	1.19*	(1.06:1.33)
No		
Difficulties in School		
Yes	3.42*	(3.19:3.67)
No		

Table 4.20. Multivariate Logistic Regression analysis: Odds ratios (OR) and 95% Confidence Intervals (CIs) (continued)

VARIABLE	OR	CI
Family History		
Problems in school learning	1.02	(0.93:1.11)
Yes		
No		
Failure in School	1.49*	(1.38:1.62)
Yes		
No		
Behavioral Problems	1.21*	(1.01:1.44)
Yes		
No		
Mental Problems		
Yes	1.09	(0.92:1.28)
No		
Chronic conditions		
Epilepsy		
Yes	1.39*	(1.03:1.87)
No		
Chronic Infection of the Middle Ear		
Yes	0.99	(0.87:1.13)
No		
Iron Deficiency		
Yes	0.98	(0.87:1.10)
No		
Visual Problems		
Yes	0.96	(0.88:1.04)
No		
Hearing Problems		
Yes	0.88	(0.74:1.05)
No		
Meningitis		
Yes	0.79	(0.44:1.43)
No		
Salary		
Less than 300,000 L.L	1.4*	(1.17:1.67)
300,000 - 900,000	0.97	(0.82:1.16)
900,000 - 1,500,000	0.88	(0.73:1.07)
More than 1,500,000*		

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APPENDIX A

دراسة الحاجات التعلمية الخاصة
استمارة المعلمين والمعلمات

يرجى الإجابة على هذه الأسئلة على ورقة الأجوبة المرافقة.
لا تضع/ي أي إجابة على هذه الورقة

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2	اسم التلميذ الثلاثي
3	المدرسة
4	الصف
5	الشعبة

الرجاء تقييم التلميذ عبر اختيار إجابة واحدة فقط لكل سؤال

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D	يفهم جميع المفردات الخاصة بصفه وبالصف ذو المستوى الاعلى		
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الرجاء تقييم كل بند بوضع حرف للجملة الو صفية المناسبة على ورقة الأجوبة المرافقة.

إذا لاحظت هذا السلوك لدرجة معقولةCالرقم	**إذا لم تلاحظ هذا السلوكAالرقم**
إذا لاحظت هذا السلوك لدرجة كبيرةDالرقم	**إذا لاحظت هذا السلوك لدرجة بسيطةBالرقم**
إذا لاحظت هذا Eالرقم	

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