DISABILITY & SOCIAL RESPONSES IN AFGHANISTAN & PAKISTAN.

Introduction & Bibliography, mainly non-medical, with historical material and some annotation.

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1.0 INTRODUCTION

Social responses in the shape of formal disability services in Pakistan and Afghanistan, and the literature accompanying their development, increased substantially during the past half-century. Public awareness of disabilities, and of the means for disabled people to live fuller lives, may also have increased, but that is harder to prove. Large gaps remain in public information about the everyday lives of disabled people, their contributions to society, their needs, their interests and preferences, and the daily obstacles they encounter, whether obvious or hidden. Whatever planning is done for the better use of resources, whether by government or non-government organisations, seems to neglect many of the sources of published and unpublished information, probably through lack of awareness that they exist. The obscurity is increased by the fact that most of the daily care, routine and perceived burden concerning disabled children, women or elderly people is part of the 'female world', sheltered within four walls and largely unknown to male planners.

The present bibliography, listing some **800** items, is based on an accumulation of materials during a period of 25 years' work with disability and special education, in Pakistan, Afghanistan, Britain and elsewhere, plus material gleaned from reference lists of published papers. It is far from comprehensive, yet it should give a start to anyone interested in studying the field. Some of the materials listed might be found with some difficulty, and only in one or two major cities; yet they are even less likely to be found by someone who is unaware of their existence.

Ranging from doctoral theses to speeches at non-academic meetings, the items listed have sharp differences of quality and usefulness. Higher quality is not exclusively found in formal academic research, as against the private voice telling of individual experience -- probably all parts of the spectrum are needed for developing a fuller understanding of disability in the region. In this bibliography, very little 'selection' has been made on grounds of perceived quality. The compiler's experience has been that an item quite useless for most purposes may finally become useful in some unexpected way, if only by securing one name or date missing from more lucid work. However, newspaper and magazine articles have mostly been omitted, though they might occasionally be useful.

The contents here mostly address some sort of responses by society to disability, and are "mainly non-medical", since Medline is already freely available on the internet listing 40 years' worth of global health and medical literature, much of it with professional abstracts. Yet it is hard to draw a line between 'medical' and 'non-medical' material, and more medical or public health material has been shown from earlier decades, where it serves to indicate the development of available information. Nutritional deficiencies are prominent in maintaining or increasing the impairments associated with some diseases (see e.g. notes on lathyrism below, under subheading "Crossing Borders and Periods"). Many children's learning ability is weakened by

a combination of physical and environmental factors. Some general childhood material is included for its relevance to early learning and special education. It is also a reminder that the child with a disability is primarily a child; but ideas of childhood, and what a child is, vary a great deal across the world, so it is useful to see some material on childhood in this region.

Similarly, it has not been easy to decide how far to include 'mental health' material here. Mental retardation is sometimes addressed by psychiatrists, and is easily included, unless the item takes a purely biomedical or pharmaceutical stance. Most mental illness can be disabling, in the sense that the sufferer is less able or unable to carry out normal activities; or the responses by the community may be perceived as disabling, i.e. someone who finds that their family members or neighbours show fear or derision, or remove from them their normal responsibilities, may thereby be made to carry a greater burden than the depression or psychosis they are already bearing. These phenomena have some representation here, but far from a comprehensive listing.

1.1 Access to Material

KINDLY NOTE: the compiler/annotator, as a private individual without institutional affiliation, regrets that he is not in a position to **supply** the materials listed. That is the task of librarians, documentalists, archivists, publishers, or scholarly institutions in various countries.

Some two thirds of the materials listed have been formally published in international journals, or by a regular publisher, university, international organisation or government. The final third has appeared in less formal ways. In the past decade the chances have improved of being able to track authors on the internet and contact them directly by email. Further, many authors recycle their own work in various places, sometimes with revision, increasing the chances that even distant researchers may come to know the main points an author wishes to convey. A certain amount of 'free borrowing' also occurs between authors, in a region where useful knowledge is deemed to derive from Allah for the benefit of all, rather than being the private property of one mind. There is certainly more than one cultural viewpoint on this practice.

University libraries, particularly in Islamabad, Peshawar, Lahore and Karachi can be useful sources. Some disability-related materials can be found at the National Institute of Psychology, Quaid-i-Azam University, Islamabad, and the National Institute of Special Education, Islamabad. UNICEF offices also have some relevant material. Offices of national disability organisations are among the possible sources of relevant unpublished or grey literature. Increasingly, the major institutions and organisations have websites and email contact addresses. For Afghan material of all sorts, a very useful source is the library of ARIC, the ACBAR Resource & Information Centre. Based at Peshawar, this centre has methodically been accumulating and documenting the fortunes and misfortunes of the Afghan nation for 20 years or more, and has an online public access catalogue.

1.2 Language & Representation

Materials listed here reflect the status and dominance of English language in academic and official communications, even though only a small minority of Afghans and Pakistanis read English comfortably. Separate bibliographies of disability-related writings in Urdu, Dari, Pushto and other regional languages remain to be compiled.

To some extent, the material compiled in this bibliography represents the cumulative deposit of concepts, knowledge, skills and design that is involved in professional practice with social aspects and social responses to disability in Pakistan and Afghanistan. However, for various reasons it is not a representation that reflects fairly the contributions of individuals or particular organisations. There are many people in these two countries who have laboured in this field for long years with all their heart and skill -- but whose name

appears nowhere in the bibliography, or perhaps appears once as a co-author of an obscure item. Some have been too busy working practically, and have not written at all. Others have written but have not been published, or have written in Urdu, and regretfully are not known to the compiler. Some have done excellent practical work, or published very useful research papers, but their field may have been bio-medical or surgical, and has not been listed here. The voices, activities and campaigns of disabled people also began to achieve more prominence in the 1990s, and they have much to say about social responses as they perceive them -- but there is not yet an adequate representation of such voices and activities in the mainly anglophone literature.

These imbalances are acknowledged and regretted. The present work should be regarded as merely a beginning, and the defects should be remedied by those who know more and understand better the disability movements and professional or volunteer work within the region.

1.3 Services in Afghanistan

Western visitors seeing the present seriously damaged country may gain the impression that disability knowledge, skill and services have no earlier history and must "start from scratch"; but such an impression would be mistaken. Archaeology of the Indus valley civilisation of about 4000 years past gives evidence of planned urban public hygiene and sanitation, and possibly the surgical practice of trepanation (Zysk, 1991, 12-13, 56, 121). Afghanistan was a cross-roads where medical and surgical knowledge from China and North India interacted with knowledge from Persia and Greece. One of the classic South Asian compilations of medical theory and healing knowledge, the *Caraka Samhita*, has been associated with the ancient university at Taxila, and the court of King Kanishka at ancient Peshawar, possibly in the 1st century CE (Zysk, 33; Wujastyk, 1993, 759), within the Kushan empire, incorporating most of the current region of Afghanistan and Pakistan.

Among the Jataka (transl. 1895-1907, ed. Cowell), stories of the Buddha's earlier lives, there are over 100 references to Taxila, where noble young men went for higher education. In the Kama-Jataka (No. 467; Cowell, Book XII), a young man (the Bodhisatta) had returned from Taxila "after mastering all branches of learning", and he found the king of Benares terribly ill and all the physicians unable to cure him. The enlightened youth perceived that the king was consumed by lust for power, and this was the origin of his disease symptoms. He persuaded the king to admit that this was the cause, and counselled him on the folly of his desires. The king was cured, and congratulated the young counsellor on "the medicine of his wisdom".

The region saw many centuries during which available healing skills and practices were in advance of those in Europe. The first resource bases may have been Buddhist monasteries, with training and monitoring of practitioners and some itinerant monks taking healing skills to the wider community (Zysk, 5-6, 39-44). Buddhist influences eventually declined, and Muslim forces arrived from South-West Asia with a developing civilisation that would, after some centuries, bring new developments in medicine and therapies, as formulated e.g. in the great compendia of Ibn Sina (see Gruner, 1930) and of al-Razi, and in hospital practices (Askari, 1957).

Local herbal knowledge and therapies continued, with itinerant healers, bone setters, cataract operators, midwives and shrine-keepers passing on their skills to their sons and daughters; but perhaps over centuries the transfer was decreasingly monitored for quality, and there was less institutional mechanism for expanding and testing knowledge and skills. Europeans brought a few specific disability-related innovations more than a century ago. For example the British cleric Thomas Hughes provided tactile reading material to blind Afghans, using William Moon's embossed script (based on a different principal from the better-known Braille) as early as 1879 at Peshawar, which was then the winter capital of Afghanistan (Editorial, 1879).

However, formal services directed toward disabled people were still very scantily available in the 1970s, and

the turbulence across the country in the past 25 years has not encouraged much development, apart from services for people with war-related physical damage. A recent report suggests that

"Certainly the number of disabled Afghans who could benefit from formal rehabilitation services has vastly exceeded the resources available at any time within living memory. In the early 1990s several field surveys were conducted by an experienced paediatrician and development agent, of resources in the capital Kabul and the provinces of Takhar and Wardak, before commencing the Disabled Afghans Project (1993-1995) with Swedish aid (Kristiansson, 1990, 1991). For a population of between one and two million, Kabul had a small number of institutional resources for physical disability, such as the Wazir Akbar Khan Hospital physiotherapy and orthopaedic departments, the ICRC Rehabilitation Centre, the Physiotherapy School, Indira Gandhi Pediatric Institute, the Afghan Red Crescent Society, and some manufacturers of wheelchairs, crutches etc. For a modest number of blind people the International Assistance Mission ran a blind school and sheltered workshops, while the NOOR Institute provided eye surgery. This level of services, inadequate though it was for the population, was many times higher than existed elsewhere in Afghanistan. Takhar and Wardak had a few general hospitals but there seem to have been no specialised disability services. Kristiansson (1991, p. 15) noted that the concept of disability was always linked to war injury, especially amputation. Enquiry about which disabilities were common was understood to mean 'how many amputees are there?', and other disability categories were considered uncommon. Similar thinking seems to have persisted during formation of the Interim Government in 2002, in which the earlier 'Ministry of Martyrs' became the 'Ministry of Martyrs and Disabled'." (Miles, 2002) See web version, 2003, at: http://www.uni-kassel.de/fb4/zeitschriften/beh3w/ausgaben/2003_1.pdf

A few further documents since 2002 can be found by internet search, with information on disability services. A National Disability Policy draft has recently been formulated, and the (interim) government may be able to proceed with planning and raising funds for a move forward. (At the time of writing, August 2004, the prospects remain insecure).

1.4 Service Development in Pakistan

(a) *Disability and education, 1860 - 1970s*

Government efforts to provide formal health care to rural populations, by employing indigenous healers with some extra training, began in the 1860s in the Punjab, against some opposition from allopathic professionals and administrators. That period also saw a published report on what was probably the earliest disability institution in the region, the collection of people with microcephaly at the shrine of Shah Daulah at Gujrat (see historical section, e.g. Ewens; Gray; Johnston; Lodge Patch; Miles 1996; Steel; and others). Outreach with ophthalmic treatment by 'camp hospitals' in rural Sind and Baluchistan began in 1908, developing into the famous annual two-month eye clinic at Shikarpur, Sind, financed by a Hindu philanthropist (Holland, 1958). The earliest formal special education centres in what is now Pakistan were a government blind school at Lahore, opened in 1906 (Makhdum, 1961, p. 19), and the "Ida Rieu School for blind, deaf, dumb and other defective children at Karachi" registered in 1923 (Report on Public Instruction, 1925, p. 91). S.A. Makhdum, father of a child with impaired hearing and the first historian of Pakistan's disability services, recorded a movement by similar parents in the 1940s to press for more services. This resulted in the formation of a "Deaf and Dumb Welfare Society" at Lahore in 1949. A special school opened soon afterwards (Makhdum, 1961, pp. 6-7).

Many thousands of children with mild to moderate disabilities were casually integrated in ordinary schools with little attention or resources devoted to them. Leitner (1882), in a survey of indigenous schools in the Punjab (on both sides of the Pakistan-India border), noted that there was no whole-class teaching "retarding the industrious for the sake of the dullard." Each boy went at his own pace; but the 'dullard', sometimes having mild hearing or visual impairment (see Hamid, 1922) or learning disability, was at greater risk of failure followed by painful punishment. Leitner named seven blind men who were notable teachers. Scores

of other teachers also had disabilities, as well as the blind men or youths fulfilling traditional roles as reciters and teachers of the Quran. Deliberate integration by an energetic English headmistress at Lahore was described c. 1872, in the education of a ten year old blind Muslim girl, Asho, who later became the first teacher at the North India Industrial Home for the Blind (Hewlett, 1898, p. 50), and was still active, as "Bibi Ayesha" in 1930 (Mark, 1930). Soon after Pakistan's Independence in 1947, a more extensive integration of blind children began in a Middle School at Pasrur (Grant, 1963).

At Independence, Pakistan had very few special schools. A conference in 1951 noted three for blind children; and six for 'deaf and dumb', of which four were in East Bengal (Proceedings, 1956, p. 379). Formal policy resources for this field amounted to a chapter on the education of handicapped children, inherited from the Central Advisory Board of Education (1944, pp. 76-82). This emphasized that many children with mild disabilities could and should be taught in ordinary schools; for others, remedial teaching could enable them to rejoin normal classes. It admitted that most of the work to date had been by voluntary enterprise. The Board noted that an India-wide enquiry to Provincial governments in 1936 had met the attitude that whatever funds were available should be spent in extending education among normal children. This view the Board rejected. It believed the State should take responsibility, both on moral grounds and because an investment in training disabled children would reduce their subsequent requirements.

To implement such advice in the early years of Pakistan, with its East and West wings 1,000 miles apart and massive refugee resettlement problems, proved difficult. The First Five-year Plan (1957, p. 587) conceded that special provisions for disabled children might eventually appear, along with ordinary school medical examinations, meals, recreational facilities etc; yet,

> "However desirable these services or activities may be, none of them is immediately essential to the basic programme of education. To attempt them nationally at the present time would require great expenditure, and diversion of trained personnel which would inevitably slow down and weaken the more urgent process of establishing the basic school system."

A Commission on National Education (Report, 1960, pp. 251-52) reverted to British India's policy for the previous century, i.e. that the training of disabled children could be left to philanthropists. The Commission did, however, suggest that Government should provide specialised training for teachers of disabled children. Two decades later, the National Education Policy (1979, p. 28) could still say only that "whatever progress has been made in the field of special education is the outcome of the efforts rendered by the philanthropic organisations." Such organisations had in fact made rather modest progress.

Educational backwardness, mental retardation and juvenile delinquency were studied in ordinary school populations in the 1950s by psychologist Abdur Rauf (1952, 1955, 1975), father of Child Guidance Clinics in Pakistan. The first mental handicap day schools were started in 1962, at Karachi by A.S. Muslim and at Lahore by Syed Yaqoob Shah. Both men were fathers seeking formal help for their own disabled child (Muslim, 1993; Pakistan Society for the Welfare, 1993). In 1975, Pakistan's first conference of rehabilitation experts considered many approaches, taking into account the economic resources of the country, the importance of the traditional network of mutual support in families, and the idea that handicap is socially constructed and so needs social solutions (Proceedings of the first conference, 1975). The suggestion began to be heard, during the 1970s, that services should move 'into the community'. However, formal efforts in this direction made little headway until the 1980s.

(b) *Special school progress*

Abdullah's review (1981) found 10 schools for blind children, 24 for deaf children and 15 for mentally handicapped pupils. Survey data complied by Akbar (1989) reflects progress over 40 years, from a total of 3 special schools in 1947 to 158 such school in 1988. Akbar estimated that in September 1988, 10,373 pupils aged 5 to 14 years were in special schools; 69% were boys, 54% hearing impaired, 24% physically disabled, 13% mentally handicapped and 9% visually impaired. Schools averaged between 30 and 50

pupils, though a few were much bigger. Teacher/pupil ratio in federal, provincial and non-government schools was 1:14, 1:11 and 1:15. Teaching skills were limited, there was little equipment in the schools, and much of it was in disrepair. From his mailed, self-administered questionnaire responses, Akbar found that pupils were 'severely disabled'; yet other sources and personal experience suggest that many pupils have mild to moderate levels of disability. Very few with multiple handicaps or behavioural problems were reported in a mailed questionnaire survey by Lari (1987, p. 72, 74). Some respondents to Miles's survey (1991) claimed as many as half of their pupils were severely mentally handicapped.

The Directorate General of Special Education estimated that there were 7,000 pupils in special schools in 1986. It aimed to increase this to 91,000 in 1992 by pumping resources into existing schools and by a double shift system, as well as opening its own schools; and hoped that 917,000 children with mild learning problems would be accommodated in 86,000 ordinary schools (apparently ignoring the large number who were already casually integrated there). However, by early 1988 the Director General (one of four DGs in four years) lamented that "as a result of the economy cut, Rs. 69 million have been provided in the current financial year as against the required budget of Rs. 213 million" (Ahmad SN, 1988). The Seventh Five Year Plan in fact showed a steady decline of budget from 1988 to 1993 (Planning Commission, 1988, p. 462). Expansion ended, and a period of consolidation began. The uncertainty engendered by fluctuations in political power in recent years also dampened innovation. The influx of conflicting western trends, some supporting new special educational methods, others militantly opposed to special schools, has increased the confusion (Miles & Miles, 1993).

It is interesting to note that by 2001, some of the wilder views of western consultants, bent on sweeping away special education and introducing 'Inclusion' in every corner of Pakistan (but without proposing how the resources of skill and finance would be found for this revolution), were giving way to more moderate positions that took account of the actual situation in the country. For example, the Swedish educationist Eklindh (2001, p. 19), while keen to see Pakistan move toward inclusive education, underlined the point that the special schools contained valuable resources of experience and skills gained by teaching children with disabilities, and these would be essential for developing better educational services for all.

(c) *'Community' Experiments in the 1980s*

Several community-oriented disability schemes began in the early 1980s, with a base in 'health' and 'treatment'. In the Punjab, the WHO's Community Based Rehabilitation (CBR) scheme was field-tested in urban and rural locations. The scheme focused on briefly trained "Local Supervisors" advising families on home rehabilitation of disabled persons, using a simplified instruction manual in Urdu, with some efforts also to influence attitudes in the neighbourhood and to involve local schools and health centres. Evaluation reports showed conflicting views about the usefulness of the programme, with Nordic visitors being much more optimistic than local professionals who were actually running the trial program (Social Work Department, 1986; Finnstam, Grimby, Nelson & Rashid, 1988; Jaffer & Jaffer, 1990).

Another community rehabilitation development project (CRDP), begun in 1982 in the NWFP, was run by the Frontier Association for the Mentally Handicapped with the Mental Health Centre, Peshawar, as resource base, and with UNICEF funding (Miles, 1990). At the Mental Health Centre (MHC) a playgroup for children with mental handicap and emotional and behavioural difficulties had begun in 1974, became a school in 1978, and then added physical disability treatment. MHC staff mobilised people in other cities to start small schools for such children, giving training and support to people recruited as teachers in those schools. This mobilisation process was consolidated in the CRDP, employing Rehabilitation Development Officers to promote the formation of autonomous local associations concerned with disability, and to assist them in realising locally-defined goals (Safdar & Shah, 1987). These local organisations in fact chose to start physical disability treatment centres, employing local people who received several months training at the MHC, and some ongoing support. Other experiments at the MHC aimed to improve training in skills for work with children having cerebral palsy, and to communicate these to parents (Miles & Frizzell, 1990).

During the early 1980s, the Government of Sind experimented with educational integration by attaching special units to ordinary schools, to cater for disabled children. This process has not been adequately documented; but in 1987 at a training course on mental handicap at Hyderabad, Sind, teachers were present from 10 out of 17 or more special units. There were also some efforts in the Punjab to translate Portage Project materials, but the results were not generally disseminated at that time. Some epidemiological studies were undertaken in Lahore and Karachi, mostly by local informants or from doorstep self-reported information. The Peshawar-based CRDP began to produce and disseminate information materials in English and in Urdu for attitude change in communities and mid-level professionals, much of it concerning mental handicap. Studies were also carried out on casual school integration of disabled children, which were used later by UNICEF in inservice teacher training workshops. From 1984, some training of community workers took place in the Punjab specifically for rural rehabilitation. This was confined to physical disabilities and used existing primary health centres as a base, two factors which promised greater progress (Ogilvie, 1989, 1993).

By the end of the 1980s, a majority of non-government urban disability service centres were running a project which they felt could be called "CBR" or "outreach". Most such projects concentrated on a single disability. Many were trying to do their usual work transferred to clients' homes and other community locations rather than in their base institution. Community involvement in the work was often weak. To overcome their single disability specialisation, some partnerships developed. In the NWFP and Baluchistan, the influx of two million Afghan refugees, many being war-disabled, put heavy pressure on existing rehabilitation resources in the early 1980s. By 1990 it had brought an increase of service facilities and workshops particularly for physical disabilities, and vocational skills for adults. The needs of children and adults with mental handicap were comparatively neglected, though the Peshawar-based CRDP had a coordinating role with other agencies interested in community extension, and demands were beginning to increase for the government to give substantial and ongoing financial support to community-directed work (Peters & Rehman, 1989).

The Federal government responded in several ways. In 1986 it inaugurated 46 special education centres in rented buildings across the country, staffed by doctors, psychologists and teachers, some of whom were recruited from non-government service centres. A National Institute of Special Education, and some other national-level organisations opened. NISE began providing short training and orientation courses. Apart from this large investment in centre-based work, the government ruled that *Zakat* would be deducted by law rather than relying upon the individual Muslim's voluntary response. Properly constituted local *Zakat* committees should apply it to charitable ends, including the welfare of disabled people. In theory, this step might increase community responsibility for people with disabilities rather than leaving them to the vagaries of individual charity. However the effects on the availability of practical services and on public attitudes remain to be studied, or to be published in English. The government also made sporadic efforts to influence public attitudes using the mass media, and by publishing a translation of the well-known manual *Disabled Village Children* (Werner, 1989). Regular use of sign language on television news was one of the few innovations including deaf people in the life of the nation and familiarising the public with this form of communication. Advised by the International Labour Organisation, the Federal Government has also experimented with vocational training schemes, which over time may impact positively on public perceptions of disabled people. At the end of the decade, however, the government made no claim to be involved in CBR.

(d) *The 1990s: evaluation & reflection?*

The early 1990s saw more self-critical or defensive appraisals. Leotard (1993) described the mistakes made in Baluchistan when trying to extend rehabilitation services to physically disabled people. Murk (1993) noted the problems of trying to initiate CBR for physically disabled children in the sprawling, ethnically divided slums of Karachi. Monitoring and evaluation of CBR work in the Punjab, and the use of information in

community-directed projects in NWFP, were also subjected to close scrutiny (Jaffer, 1993; Miles, 1993). There has clearly been a significant increase of resources for, and knowledge about, CBR in its many meanings.

In a survey in 1990 among leaders of Pakistan's mental handicap work, staff skills for CBR were identified as one of the most serious shortages. However, capacity for training CBR workers grew during the 1990s. A CRDP staff trainer and principal of the MHC school, after an overseas training course in CBR management, trained a dozen Peace Corps volunteers whom the Federal Government then posted to special education centres with the aim of fostering community links. In Lahore, between December 1992 and October 1996, Amin Maktab ran 15 workshops in 'Outreach Program Strategies', on the basis of its extensive outreach activities, with workshop participants from more than 40 disability organisations across Pakistan. Other training activities have taken place in Lahore and in Karachi. The Rehabilitation Centre for Physically Disabled (RCPD) at Peshawar trained and gave supervision to a considerable number of workers in local centres across the North West Frontier and also developed work with disabled Afghans, an ongoing need as fighting continues in the cross-border region (Rahman, 2004).

There has been very little research on the effectiveness of CBR or community outreach in Pakistan. The desire of funding agencies to hear of increasing numbers of disabled people 'reached', is seldom matched by funding for research that might show whether the reaching brought real and lasting benefits; whether one method, or one type of worker, was more effective than another; how much of the improvement would have occurred naturally with children's maturation, or disabled adults' self-help during the period observed; how the cost of one approach compared with that of others; and many similar questions. Two outreach projects have made some study of such questions, at Lahore (Akbar & Rubab, 1995), and at Dera Ismail Khan (Nasir-ud-Din, 1995). Up to now, however, the research capacity has hardly matched the difficulties of identifying causality while measuring small increases of skill in disabled children or adults across periods of several months or years, in family and community situations where it is impossible to control variables even were it ethically permissible to do so.

Apart from the substantial difference of economic resources and political priorities, there are sociological and philosophical factors which might cause Pakistan to develop disability services in directions other than those taken by western nations. Pakistan is a profoundly religious country, in the sense that, ultimately, law and right and meaning in life are widely believed to derive from Allah. Children are considered to be born as parts of an extended family network within a wider community of mutual duty and obligation, rather than as little individuals with personal rights. The duty and entitlement of support and care is traditional and religious, rather than being laid down by the State.

There is a theoretical 'equality' of persons before Allah; but that is quite different from the idea of constructing a society where individuals are 'equal before the law'. Notions of individual rights and equality that may seem self-evident to westerners often look flimsy and artificial in Pakistan. While western technology is coveted, the family life and social conduct of westerners, as communicated in the mass media or reported by expatriate Pakistanis, often looks deeply unattractive. It is by no means obvious that disabled European children and adults have more satisfactory lives than disabled Pakistanis, apart from differences attributable to technology and modern medicine.

1.5 Crossing Borders and Periods

With a few items, some cross-referencing is given between modern and historical Afghanistan and Pakistan, to obtain a clearer picture of persistent disabling conditions across the region through some centuries, especially where the track has been poorly documented. Thus, for example, the ill effects of an unvaried diet of the grass pea, *lathyrus sativus*, have been known in South Asia since antiquity. Progressive documentation was sketched recently by Miles (2003), tracing histories of lathyrism, iodine deficiency

disorders, cataract, polio and leprosy in South Asia. During the British period, probably the earliest description of the symptoms of lathyrism was by Francis Buchanan (undated) during his travels in Bihar and Patna Districts, 1811-1812, though he was not convinced that lathyrus sativus was the cause. Much more detailed studies were made by James Irving, civil surgeon of Allahabad (1859, 1860, 1861, 1868), during which he received reports of lathyrism from the Sind and Multan, in what is now Pakistan; and also heard that the native troops in the first British expeditionary force to Kabul had similarly suffered paralysis through eating kesari dal (lathyrus sativus) as a regular supplement to the reduced food ration that was available.

Later, McCarrison (1926) and Mackenzie (1927) published notes on lathyrism in Gilgit Agency, in the far north of Pakistan. Reports of lathyrism in Afghanistan appeared by Rouault de la Vigne & Ahmad (1953) and Arya et al (1988), based in Kabul. A recent report by Simpson (2002) suggests that lathyrism is endemic in the Wakhan salient or corridor, extending from the North East corner of Afghanistan, above Chitral and Gilgit in Pakistan. Over 200 years, lathyrism reports have been scattered, often appearing in obscure publications that are now inaccessible. The broad epidemiological impact remained invisible when observers were unaware of earlier work, or of work in a neighbouring country. It can now more easily be brought into focus, using the tools of modern information technology.

Acknowledgements

As already noted, the collection of material began some 25 years ago, and continues to the present. It is now impossible to mention by name all the Pakistanis, Afghans and foreign aid workers who contributed items or assisted the compiler in various ways; so this must be a non-specific but nonetheless genuine acknowledgement of participation and help. However, the general "Annotated Bibliography of Afghanistan" by DN Wilber, 4th edn revised MJ Hanifi (1982) New Haven, HRAF Press, was a useful source for earlier Afghan material.

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The compiler will be grateful for information on any errors and omissions in this Bibliography. Information should be sent to: M. Miles, m99miles@hotmail.com

1.6 Main Abbreviations

Amer.	American
Assoc.	Association (of, of the)
Brit.	British
CDAP	Comprehensive Disabled Afghans' Project
Cncl	Council (of)
Coll.	College
Commis.	Commission
Dept	Department (of)
DGSE	Directorate General of Special Education, Min. Hlth, Spec. Educ. & Soc. Welf., GoP
DGSW	Directorate-General of Social Welfare, West Pakistan
disab.	disability
Educ.	Education
educnl	educational
GoP	Government of Pakistan
Govt	Government (of)
Hlth	Health
IAMS	Indian Annals of Medical Science
IMG	Indian Medical Gazette
Inst.	Institute (of)
Intl	International
J.	Journal (of, of the)
JPMA	J. Pakistan Medical Association
Med.	Medical
MHC	Mental Health Centre (Peshawar)
MHSESW	Ministry of Health, Special Education & Social Welfare
Min.	Ministry of
Mngmt	Management
Natl	National
NIP	National Institute of Psychology
NWFP	North West Frontier Province, Pakistan
p., pp.	page, pages
Ped.	Pediatric
Plng	Planning
PPA	Pakistan Psychological Association
PPS	Pakistan Psychiatric Society
Psychl	Psychology
q.v.	see elsewhere in bibliog.
rehab.	rehabilitation
sci.	science(s)
spec.	special
Soc.	Social
Socy	Society
Transl.	Translator, translation
Univ.	University (of)
Unpubl.	Unpublished
UP	University Press
Welf.	Welfare