CHAPTER-5

REHABILITATION LEGISLATION AND POLICY MEASURES TOWARD DISABLED

5.1 CONCEPT OF REHABILITATION: Discrimination invades society like a disease. Disability by itself is a trauma, both for the afflicted and for the parents. While overcoming the disability, the parents, the afflicted and the society surrounding the disabled person face tremendous stress. Rehabilitation is achieved only when all of them put in their efforts consciously. Over the years there has been a paradigm shift in the perception of the society towards the persons with disabilities; from charity and sympathy to opportunity and empathy and now recognition of their equal rights and full participation. The rehabilitation process starts with this realization.

The concept of rehabilitation has been widened during the last decades from the earlier definition as ‘third phase of medicine’. The separation of the concept of rehabilitation from the concept of disability is to some extent not natural. However, it is worth since not all the disabled necessarily require rehabilitation. However, the question of rehabilitation arises only if dehabilitation has occurred. Dehabilitation is a process spread over time. The disabled person is at a disadvantage in society. They are gradually alienated from their family, society and work and may opt out or are compelled to leave their normal social milieu. They may enter an institution, beggar colony or the criminal world. To prevent dehabilitation or to facilitate rehabilitation, treatment of the physical disability would obviously be necessary accompanied by social education of the patient, his family and the society at large so that not only could he take his normal place in
society, but society would also be willing to accept him and assist him in rehabilitation or preventing dehabilitation.

“The WHO Expert Committee on Disability Prevention and Rehabilitation has proposed that it would be better to assess disability from the point of view of need for rehabilitation. As an example, while the disabled from all causes make up some 10% of the world’s population, it is estimated that only 1.5% are in need of rehabilitation”. Such an approach could prevent core of the disabled becoming an insurmountable problem.

The history of rehabilitation has not emerged out in a single day. The concept started from “charity” to “shramadan (voluntary labor) to social movement to social reform, social service to social welfare, and social welfare to social work. Under social service to social welfare, few other concepts are important in between as such social defense, social security and social welfare. The moment concept of welfare state came into existence, there was a police state. Under welfare state, social welfare broadens in its philosophy. The term “welfare”, the term ‘welfare’ means “the state or condition with regard to good fortune, health, happiness, prosperity, etc”.

According to Dasgupta (1976 : 27) the concept of welfare has observed: ‘By welfare we refer to the entire package of service, social and economic that deal with income support, welfare provisions and social security on the one hand, and view the whole range of social service on the other’.

According to Wilensky and Lebeaux (1957 : 17) define social welfare as those formally organized and socially sponsored institutions, agencies and progress which
function to maintain or improve the economic condition, health or inter-personal competence of some parts or all of the populations².

According to Friedlander (1963 : 4), “Social Welfare” in the organized system of social services and institutions, designed to aid individual, and groups to attain satisfying standards of life and health, and personal and social relationships which permit them to develop heir full capacities and to promote their well-being in harmony with the needs of their families and the community”³.

“Social Welfare in a broader sense”, as conceived by Skidmore, Thackerey and Farley (1991 : 3-4), “encompasses the wellbeing and interests of large number of people including they physical, mental, emotional, spiritual and economic needs ... Social Welfare includes the basic institutions an processes related to facing and solving social problems”⁴.

Durgabai Deshmukh, the first chairperson of Central Social Welfare Board in the country (1960 : VII) unequivocally said: “The concept of social welfare is distinct from that of general social services like, education, health, etc. social welfare is specialised work for the benefit of the weaker and more vulnerable sections of the population and would include special services for the benefit of women, children, the physically handicapped, the mentally retarded and socially handicapped in various ways”⁵.

Gandhiji conceptualized social welfare as Sarvodaya meaning “the well being of all in all phases of life”. The aim of sarvodaya was to establish as egalitarian society which was free from exploitation of man by man.
According to Geetha privileged sections must strive towards the fulfillment of the duty to serve the poor, handicapped and underprivileged. Social work which emerged out of the need to provide poor relief in a systematic manner gradually grew into a profession having expert knowledge to technical skills for effective provision of help to needy.

Social welfare programs play a vital role intended to cater to the special needs of a person and groups who, by reason of some handicap, social, economic, physical or mental, are unable to avail themselves of, or are traditionally denied, the amenities and services provided by the community. In this sense, welfare services are meant to benefit the weaker, dependent or underprivileged sections of the populations. The beneficiaries of these services may be physically handicapped persons, such as the blind, the deaf, or the crippled, socially dependent individuals, like the orphan the widow or the destitute, mentally retarded persons, economically under-privileged groups. Such as those living in slum areas and women handicapped by restrictive social traditions or practices.

A comprehensive social welfare programs would include social legislation, welfare of women and children, family welfare, youth welfare, physical and mental fitness, crime and correctional administration and welfare of the physically and mentally handicapped.

5.1.1: Philosophy of rehabilitation: The patient must be regarded as a human being, rather than a disabled body. Every aspect of rehabilitation as a wage-earning member of the community should be planned as early as possible in the treatment. Some patients who are so severely disabled physically and so psychologically affected confined to a hospital respirator, a rehabilitation centre, or sheltered workshop if such facilities exist. A
severely disabled patient can be fully rehabilitated into the community which is more difficult in economically poor countries. In western communities the difficulty of re-educating local people to accept the disabled person as a contributing member, may be considerable.

Growing out of stern necessity imposed by world wars, and rapid spread of democratic ideals, this new social approach towards the handicapped has become crystallized the philosophy of “Rehabilitation”. The new science of Rehabilitation which implies “the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable”.

Disability and disease has been identified as a major cause for rehabilitation. The relationship between the disability and rehabilitation is not simple. Rehabilitation in terms of social support, Social acceptance, social avoidance, etc., may be present even when there is no apparent disability. In Leprosy particularly, the very process of “labeling” is fraught with serious implications for the incumbents. On the other hand, certain types of disabilities may not have socially compelling repercussions, what restrict the role of an individual in economic sphere. On the other hand some leprosy patients with disabilities may not undergo advance stages of rehabilitation.

The term ‘disability prevention’ includes all measures in the three levels of prevention described below. Disability prevention is not limited to health sector interventions. It also includes all types of social, vocational, educational, legislative and other interventions. The best results will be achieved only if all these interventions are combined.
- **First Level Prevention**: It includes measures aimed at reducing the occurrence of impairment.

- **Second Level Prevention**: Once an impairment has occurred, measures can be taken to prevent the development of disability.

- **Third level prevention**: Once a disability has occurred and is found to be irreversible, measures can be taken to prevent its transition into handicap.

"Rehabilitation" refers to "The combined and coordinated use of medical, social, educational and vocational measures for training or retraining the individual to the highest possible level of functional ability"\(^{10}\). However, this is only a partial view of rehabilitation as it excludes preventive and curative measures which are important to reduce the "disability" problem\(^{11}\). On the other hand, "rehabilitation as understood today is the creation of the ILO whose recommendation No.99 of 1955 laid down the guidelines for vocational rehabilitation. It covers the essential elements and scope of vocational rehabilitation, the principles and methods to be applied, the vocational guidance, vocational training, placement and follow up of the disabled, as well as an outline of the administrative organization of vocational rehabilitation services, and methods of enabling disabled persons to make use of these services"\(^{12}\).

Ancient Hindu religion emphasized that by helping poor and disabled one would attain "heavenly bliss". The golden age of Guptas (320-380 AD) was considered unique in the treatment of the disabled because in this period workshops were established for the vocational rehabilitation of the physically and socially handicapped. Both Buddhism and
Jainism emphasized compassion and regard for the disabled and later on the Muslim rulers provided food, shelter and clothing for the disabled persons as a mark of charity.

The Philosophy of Rehabilitation is not a new one in our cultural heritage. Sympathy and Respect were always shown to the sick and poor persons. The History of Hindu literature testifies that many disabled persons of India were highly respectable persons. Surdas, who was blind since birth, become a great musician. The sage Astavakra had multiple curvatures in the body was well versed in Vedanta and became a great philosopher. Kautilya’s Arthashastra written in 4th century B.C. mentioned that there were modified laws to protect the disabled in Kautilys’s palace. He also arranged home visits by his officers for those who would not come out of their houses.

The dawn of modern rehabilitation medicine can be traced back to early part of this century. In 1906 a German Orthopedic surgeon by name Konrad Bisalshi established the importance of medical aspects in rehabilitating crippled children. He started a full fledged rehabilitation centre in Germany. Subsequently the impact of World War I (1908-1911) was so much that the Government and to cater to the problems of many disabled survivors. Dr Fred Albee in 1918 started a rehabilitation centre in Colorado, USA. Soon the philosophy of rehabilitation was evolved involving medical and paramedical personnel. It became clear that physio-therapists, occupational-therapists, social scientists, psychologists, bio-engineers along with the doctors and nurses can contribute significantly in reducing the problems of disabled. After the II World War, Dr Howard A. Rusk emphasized the concept of team approach in rehabilitation medicine. While these changes were going on in the developed countries, there was no noteworthy
service for the disabled in developing countries. In India the wave of modern medicine came after she achieved her independence in 1947. The first comprehensive rehabilitation centre was opened in Bombay (All India Institute of Physical Medicine and Rehabilitation) in 1955 under the joint collaboration of the United Nations and Government of India.

The problems of the handicapped persons remained unsolved until after World War II, when the attention of the government and the public was drawn to the necessity of establishing centers for the rehabilitation and resettlement of the disable veterans of war. Only after Independence, did the problem of the civilian handicapped come into the limelight. As a result, several voluntary and government-subsidized welfare organizations have sprung up. Growing out of stern necessity imposed by world wars, and rapid spread of democratic ideals, this new social approach towards the handicapped has become crystallized the philosophy of “Rehabilitation”. The new science of Rehabilitation which implies “the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable.”

The rehabilitation of disabled under social work philosophy point of view can be categorized to social action... According to Kenneth, L.N. Prey (1945: 348), it is “the systematic, conscious effort directed to influence the basic social condition and problems out of which arise the problems of social adjustment and maladjustments to which our service as social worker is directed”.

5.1.2: Definitions of Rehabilitation: Rehabilitation has been defined as the combined and coordinated use of medical, social, educational and vocational measures for training
and retraining the individual to the highest possible level of functional ability. It includes all measures aimed at reducing the impact of disabling conditions and enabling the disabled to achieve social integration. Social integration has been defined as the active participation of the disabled people in the mainstream of community life. Rehabilitation involves intervention from disciplines such as physiotherapy, occupational therapy, audiology and speech therapy, psychology, Sociology, Social Work, special education, vocational guidance and placement. Medical treatment is also an important aspect of rehabilitation.

The term ‘rehabilitation’ refers to a process aimed at reducing the impact of disability for an individual, thus, ‘enabling him or her to achieve independence, social integration, a better quality of life and self-actualization. “Rehabilitation means restoration to the best possible level of functioning in social and working life’”^{13}.

“Rehabilitation” refers to a process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric or social functional levels^{14}.

Rehabilitation is the utilization of the existing capacities of the handicapped person, by the combines and coordinated use of medical, social, educational and vocational measures to the optimum level of his functional ability^{15}.

According to Howard Rusk, the father of rehabilitation medicine...

‘Rehabilitation Medicine term relates to whole range of health problems including functional, psychiatric disturbances and the problems created by alcohol consumption, mental retardation, and drug addiction’.  

222
Rehabilitation was defined by the National Council on Rehabilitation in 1942 as “the restoration of the handicapped to the fullest physical, mental, social, vocational and economic usefulness of which they are capable”. WHO expanded this definition to include “…all treated patients, restoring them to normal activity to resume their place in the home, society and industry”.

The 1969 WHO Expert Committee on Rehabilitation defined rehabilitation as follows: “The combined and coordinated use of medical, social, educational and vocational measures for training and retraining the individual to the highest possible level of functional ability.”

According to PWD Act, 1995, under section 2 (w), “rehabilitation” refers to a process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intelligence, intellectual, psychiatric or social functional levels”; the rehabilitation services rendered to persons with disabilities are known as disabled rehabilitation.

5.1.3: Objectives of Rehabilitation: The main objectives of rehabilitation are: Improvement or prevention of deterioration of physical disabilities, Improvement of social and economic status and Assurance of a positive attitude and cooperation from the community at large.

5.1.4: Approaches of Rehabilitation:

5.1.4.1: Social Work Approach of Rehabilitation: Rehabilitation is an approach/method/means of social work for needy people. The basic functions of social work are restoration, provision of resources and prevention. These are interdependent
and intertwined. Restoration of impaired social functioning has to two aspects curative and rehabilitative. The curative aspect eliminates the factors responsible for the individual's impaired social functioning. The individual is helped to adjust to the needs of the new situation which is known as rehabilitative aspect. Provision of resources has two aspects, the developmental and the educational, the earlier one is designed to enhance effectiveness of the resources and to improve personality factors for effective social interaction, whereas, the later is designed to acquaint the public with specific conditions and needs for new or changing situations. The third function of social work is prevention of social dysfunction.

Rehabilitation social work practice is carried out at different levels of society. Its intervention takes place at the level of the individual, family, group, community and society at large. The individual level intervention attempts to restore the social functioning of the individual.

5.1.4.2: Rehabilitation of disabled under Ecological Social Work approach: Their problems are seen as deficits in the environment and not as personal deficits of the individuals.

5.1.4.3: Rehabilitation of disabled under Radical Social Work Approach, it is not satisfied only with care of the disabled and the deviants it aims in changing the system by bringing basic changes in the social institutions and relationships instead of dealing with adjustment problems and seeing them as victims of unjust social order.

5.1.5: Models of Rehabilitation: PWD are valuable human resource for the country and seek to create an environment that provides those equal opportunities, protection of their rights and full participation in society. The focus of the policy shall be on the
following: Institution Based Rehabilitation and Community Based Rehabilitation. Local or regional variations in the demography of disability and the availability of funds, equipment and personnel make it difficult to define a standardized general strategy for rehabilitation although key elements can be identified. They are as follows:

5.1.5.1: Institution Based Rehabilitation: Rehabilitation measures can be classified into four distinct groups:

1. Physical rehabilitation;
2. Vocational rehabilitation;
3. Economic rehabilitation; and
4. Social Rehabilitation.

5.1.5.1.1: Physical Rehabilitation: It categorized into Psychological Rehabilitation and Medical Rehabilitation.

Psychological Rehabilitation: It means restoration of personal dignity and confidence of the disabled person.

Medical Rehabilitation: It means restoration of functions of vital organs or limbs of the body through medical treatment. Psychological rehabilitation services are provided to disabled children and members of their families, especially parents. It includes early detection and intervention, counseling & medical interventions and provision of aids & appliances. It will also include the development of rehabilitation professionals.
Medical rehabilitation is the utilization of medical and paramedical skills to help treat the patient. The role of medical rehabilitation is to limit disability\textsuperscript{19}.

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
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<td>13.3</td>
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<td>Treatment</td>
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<td>8.8</td>
<td>8.8</td>
<td>41.5</td>
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<td>Corrective surgery</td>
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<td>44.3</td>
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</tr>
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<td>Counseling</td>
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<tr>
<td>Minimize the disability</td>
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<td>2.5</td>
<td>2.5</td>
<td>64.3</td>
</tr>
<tr>
<td>Provided aids &amp; appliances</td>
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<td>400</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

What type of rehabilitation/ help you got from the hospital/centre after disability detected? This question is answered by the respondents with the answers like; 1) early detection 2) treatment 3) corrective surgery 4) physiotherapy 5) counseling & awareness in confidence building 6) minimized the disability 7) restored to normalcy 8) provided aids & appliances 9) others 10) none

5.1.5.1.2: Occupational/Vocational Rehabilitation: Vocational rehabilitation presupposes a more humane approach to the handicapped. This foundation was already supplied by Buddhism and Jainism. The golden age of the Mauryas, especially during the reign of Chandragupta stands out unique in establishing workshops for the vocational rehabilitation of the physically handicapped as well as other socially and economically handicapped members of the kingdom\textsuperscript{20}.
All the states of the United States provide vocational rehabilitation programs for disabled adults. The public program of vocational rehabilitation had its beginning in World War I, was started officially in 1920, and has expanded tremendously since World War II. Many state rehabilitation programs have recently been expanded to include mentally retarded and psychiatrically disabled adults, as well as the physically handicapped. Rehabilitation personnel are also cooperating with the schools. They take those individuals who either finish the school program or exceed the age limits for school attendance and provide them with additional vocational training, counseling, and supervision21.

Vocational rehabilitation is a process that assists individuals with impairments to overcome their handicaps and tries to reintegrate them into society into a job or vocation using their residual physical and intellectual capacities22.

The vocational rehabilitation program includes evaluation (medical, psychological, and vocational), training (school, sheltered workshop or on-the-job), and eventful job placement23. It includes Vocational education and Vocational Training.

**Vocational Education:** In a school the child faces a new society, different from his home. It is here where he interacts with his teachers, peers and others who may have a direct or indirect effect on his thinking and behavior. He gets aware of the world around him, develops certain attitudes certain things in his environment, gets systematic information necessary for his individual and social growth and masters certain skills.

In India the National Policy on Education has formulated a “scheme of integrated education of disabled children”. The scheme has made the following recommendations
for an integrated education system. This scheme envisages that “no child of school-age should be excluded from educational provision on ground of severity of handicap”.

**Vocational training:** the precise nature of vocational training would depend on local attitudes and opportunities for work. Vocational training is essential in countries with large scale unemployment, such as India, since employers find it hard to understand why they should accept disabled people. Vocational training comprises teaching persons how to overcome their disabilities so as to be able to work without damaging anesthetic hands, eyes or feet or if disabilities prevent persons from resuming their original job to retain them for another job. Retraining is also necessary when a person’s work is harmful or closed to him. If unskilled person could be trained in some suitable craft according to their aptitude and ability. Adaptive physical training is aimed at development of physical, psychological, functional and mental abilities of disabled people. Physical training activities include adaptive physical education, motive recreation, and sportive events. In order to ensure effective physical training activities, centers and departments are being equipped with gyms and swimming pools.

Vocational rehabilitation is the need of the hour. Disabled people must require the vocational rehabilitation from the government, and non-governmental agencies. Vocation is crucial in human life. If the disabled are given job or occupation certainly their status will not go down. The respondents are getting the following vocation related services from the various institutions. They are; 1) normal education 2) special education 3) inclusive education 4) open learning 5) Institutional training 6) Implant training 7) Apprenticeship training 8) Adjustment training 9) short term skill training 10) sign language 11) mobility training 12) call center training 13) telephone operator training 14) ADL training 15) capability training 16) EDP training, etc. The table number 05.02 shows the details.
### Table: 05.02
Statement of type of vocational rehabilitation/help the respondents got from the centre

<table>
<thead>
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<th>Valid Type</th>
<th>Frequency</th>
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<tr>
<td>Special education</td>
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<td>7.3</td>
<td>21.3</td>
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<tr>
<td>Inclusive education</td>
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<td>2.8</td>
<td>24.0</td>
</tr>
<tr>
<td>Open learning</td>
<td>14</td>
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<td>3.5</td>
<td>27.5</td>
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<td>Institutional training</td>
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<td>11.0</td>
<td>38.5</td>
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<tr>
<td>Inplant training</td>
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<td>Adjustment training</td>
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<td>Short term skill training</td>
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<tr>
<td>Sign language</td>
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<td>11.0</td>
<td>66.3</td>
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<td>Mobility training</td>
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<td>Telephone operator training</td>
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<td>Capability training</td>
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<tr>
<td>EDP training</td>
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<td>Others</td>
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</table>

5.1.5.1.3: **Economic Rehabilitation:** This is compulsory for the disabled for a dignified life in society. Disabled people are considered unproductive human resources. Quite often people think, disabled means double loss of society viz. loss of manpower as disabled can not do anything, and loss of money because they become burden on family/society. This is myth, because many disabled have proved their mental, intellectual and physical ability in various fields. The disabled can lead an independent life, if they are provided adequate opportunities at right time. Agriculture, self-employment and wage paid employment are the basic tools to fulfill the desire of economic independence. In the past, agriculture was placed on the top position as an
income generation option and self-employment and wage employment. There has been a growing global consciousness on integrating and mainstreaming PWD. The UNO declared year 1981 as International Year for the Disabled. The ‘Asia and Pacific Decade of the Disabled Persons’ (1993 to 2002) has also emphasized the integration of this most marginalized section of the society, into the mainstream socially and economically. Economic rehabilitation of Persons with disabilities comprise of both wage employment in organized sector and self-employment. Supporting structure of services by way of vocational rehabilitation centers and vocational training centers will be developed to ensure that disabled persons in both urban and rural areas have increased opportunities for productive and gainful employment.

**Economic factors:** The importance of this is also fairly obvious. If the person is not dependent on his family and especially if the reverse is the case, then his status is far more secure. The options available in economic rehabilitation include: *Job placement, Sheltered employment, Pension schemes, Care homes.*

**Strategies for economic empowerment of PWDs:**

1. **Wage Paid Employment in Public Sector:** Each individual, whether he/she is illiterate, literate, less educated or highly educated; prefers wage employment, particularly Government employment, because of assured income, secure position, better status in society, good future prospects, less hard work, fixed working hours and many other facilities such as LTC, medical expenses reimbursement, children education allowance, pension, gratuity, encashment of leave. Though, the Govt. has given 3% reservations in jobs. Though the Government has provided reservation, relaxations in
education, vocational training and professional courses but there is acute shortage of professionally & technically qualified PWD.

2. **Wage Paid employment in Private sector**: Development of appropriate skills in PWD will be encouraged for their employability in private sector. Vocational rehabilitation and training Centers engaged in developing appropriate skills amongst them keeping in view their potential and abilities will be encouraged to expand their services.

3. **Self-employment**: Considering slow pace of growth in employment opportunities in the organized sector, self-employment of PWD will be promoted. This will be done through vocational education and management training. Further, the existing system of providing loans at softer terms from the NHFDC will be improved to make it easily accessible with transparent and efficient procedures of processing. The Government will also encourage self-employment by providing incentives, tax concessions, exemptions from duties, preferential treatment for procurement of goods and services by the Government from the enterprises of PWD, etc. Priority in financial support will be given to Self Help Groups formed by the PWD.

The Government had started self-employment finance scheme from 2nd five year plan. Thereafter number of schemes such as SSI Finance (1956), DRI (1972), IRDP (1978), TRYSEM (1977), SEEUY (1983), STED (1984), SEPUP (1986), SUME (1989), PMRY (1993), SGSRY (1995), SJSRY (1997) and SGSY (1999) were launched gradually. The government is assisting self-employment ventures. Financial institutes, such as NSFDC, SIDBI, KVIC, KVIB and banks etc. are also providing assistance for this purpose. Government of India, Ministry of social justice and empowerment has
started exclusive NHFDC scheme to give loans to cross disability sector, including Cerebral Palsy and Mentally Retarded for self-employment and higher education on low interest rates.

Table: 05.03
Statement of type of employment services that the respondents have availed from the rehabilitation centers/institutions

<table>
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<tr>
<th>economic rehabilitation</th>
<th>Frequency</th>
<th>Percent</th>
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<th>Cumulative Percent</th>
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<td></td>
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<tr>
<td>Private job</td>
<td>97</td>
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<td>Government job</td>
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<td>Temporary job</td>
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<td>15.5</td>
<td>15.5</td>
<td>42.6</td>
</tr>
<tr>
<td>Self-employment assistance</td>
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<td>53.9</td>
</tr>
<tr>
<td>None</td>
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<td>99.8</td>
<td>100.0</td>
<td></td>
</tr>
<tr>
<td>Missing</td>
<td>999</td>
<td>.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>400</td>
<td>100.0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Our disabled respondents are really getting some helps from rehabilitation centers. They are getting private job, government job, temporary placements, self-employment and assistance to do some entrepreneurship. 24.3% of respondents have got private jobs and 15.5% respondents got temporary job in private and government and semi-government sector.

5.1.5.1.4: Social Rehabilitation: It means restoration of family and social relationship.

- Adaptation to social and living conditions: development and restoration of essential self-care skills, including hygienic care, food assumption, basic household chores (basic cooking, washing, ironing, cleaning, use of household appliances);

- Adaptation to social environment: development of social and communication skills (communication with the family, friends, strangers, familiarity with services and officials who can be applied for help, visiting shops, theatres, money management
skills), basic personal safety skills at home and elsewhere; legal counseling for families of disabled children;

- **Training on how to use technical rehabilitation aids** and prosthetic and orthopedic devices;

- **Consulting on accessibility of the environment and on adaptation of housing facilities and workplaces**, assistance in the selection of technical aids and assistive technologies.

- **Social and cultural rehabilitation** (art therapy, music therapy, game therapy, other kinds of recreational therapy).

**Cultural and Social factors:** An essential component of the social rehabilitation of the disabled is the prevention of social displacement for which education is the basic need. Other secondary approaches are counseling, domiciliary rehabilitation, re-training, re-settlements care of residual disabilities and so forth.

**a. Counseling:** Physical rehabilitation measures including counseling, strengthening capacities of PWD and their families, physiotherapy, occupational therapy, psychotherapy, surgical correction and intervention, vision assessment, vision stimulation, speech therapy, audiological rehabilitation and special education shall be extended to cover all the districts in the country by active involvement and participation of State Governments, local level institutions, NGOs including associations of parents and PWD.

**b. Domiciliary rehabilitation:** “Domiciliary rehabilitation may be defined as the process by which a person is provided with the capital and material required enabling him to cope with economic crisis in his work. Enabling the case to remain in his home and
usual occupation in this way helps to facilitate social acceptance and the retention of the family ties.

c. **Re-settlement:** The phrase ‘re-education for re-settlement’ is more appropriate than rehabilitation. Self employment is cheap compared to sheltered employment and does not carry the risks of social displacement in the event of failure.

d. **Health Education:** “Health education may be defined as a set of activities based on process of communication and learning, designed to encourage people to behave in a healthy, non-harmful way”.

e. **Barrier free access:** From time immemorial PWD are denied their rights at every stage of their life. In order to ensure that PWD realize their rights it is essential that the Government Officers and the NGOs understand the role they have to play in the management of disability at the district level.

f. **Barriers placed by the society for disabled:** Disability is a human rights issues and it must be looked into in that context. People are disabled not because of their physical or mental handicaps but because of the barriers put up by the society to establish differences between disabled and non-disabled. These barriers fall in four broad categories.

   i. Environmental Barriers
   
   ii. Institutional Barriers
   
   iii. Attitudinal Barriers
   
   iv. Information Barriers
Table: 05.04

Statement on the social rehabilitation services that the respondents have availed

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling</td>
<td>46</td>
<td>11.5</td>
<td>11.5</td>
<td>11.5</td>
</tr>
<tr>
<td>Health education</td>
<td>3</td>
<td>.8</td>
<td>.8</td>
<td>12.3</td>
</tr>
<tr>
<td>Domiciliary rehabilitation</td>
<td>108</td>
<td>27.0</td>
<td>27.0</td>
<td>39.3</td>
</tr>
<tr>
<td>Re-settlement</td>
<td>21</td>
<td>5.3</td>
<td>5.3</td>
<td>44.5</td>
</tr>
<tr>
<td>Barrier free facilities</td>
<td>13</td>
<td>3.3</td>
<td>3.3</td>
<td>47.8</td>
</tr>
<tr>
<td>Others</td>
<td>133</td>
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<td>81.0</td>
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<tr>
<td>None</td>
<td>76</td>
<td>19.0</td>
<td>19.0</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>400</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

The above table 05.04 shows that the respondents are getting rehabilitation services from various rehabilitation institutions. The respondents are getting rehabilitation assistance like counseling, health education, domiciliary education, re-settlement, barrier free facilities, etc. 27% respondents are getting domiciliary rehabilitation service.

5.1.5.2: Community Based Rehabilitation (CBR): In India CBR is the only method by which a large population can be rehabilitated. In a developing country like India, the CBR project, to be successful, must be cost effective, individual-need based and result oriented. In the 1950s and 1960s, a shift in the trend of services from institutions to community for the disabled persons took place in the developed countries such as the United States. Since then, community participation in the rehabilitation of the disabled is gaining momentum. This change of outlook has promoted growth of concepts like normalization, education in a least restrictive environment, home based skill training and additional support services for parents, family and community.
The enthusiasm generated by the community based service movements stimulated the World Health Organization (WHO) to bring out two technical reports in 1958 and 1969, which suggested that rehabilitation should be a natural and essential component of health care. The Alma Ata Declaration of 1978 further endorsed the view that rehabilitation services should be part of ‘Health for All’ by 2000 AD. The Community Based Rehabilitation approach received global recognition with the 1982 United Nation’s declaration of the Decade of Disabled Persons and the adoption of the World Program of Action Concerning Disabled Persons.

5.1.5.2.1: Philosophy of CBR: The philosophy of CBR was to integrate disabled people into the societal mainstream rather than create special environments for them. WHO recommended that CBR should be set in the context of community services, especially in relation to primary health care.

CBR from a human rights perspective: CBR represents a better solution than institutionalization. CBR allows PWD to participate in rehabilitation programs while continuing to live with their families or, in any case, within their communities. Institutionalization should represent an exception to this general rule, and be required only when no other alternative exists. For instance, the Convention on the Rights of the Child recommended the development of programs which promote alternatives to institutionalization, and encouraged States parties to make every effort to provide assistance for children with disabilities and support services for their families, to the maximum extent on an out-patient or community basis, thereby avoiding removal of children with disabilities from their families for placement in institutions. Furthermore,
admission in institutions can only be based on the consent of the patient or, alternatively, on the basis of specific procedures established by law.

The shift from institutionalization to CBR must in no case result in reduced allocation of resources for the promotion of rehabilitation and social inclusion of PWD. Under international human rights law, States are under an obligation to take steps ‘to the maximum of their available resources’ with a view to achieving progressively the full enjoyment of economic, social and cultural rights. Furthermore, although the progressive realization of economic, social and cultural rights may be limited by resource constraints, the obligation to guarantee that human rights “will be exercised without discrimination” is an immediate one. Thus, limited financial resources have to be used in a non-discriminatory way, to promote equal opportunities for disabled persons vis-à-vis able-bodied persons and to facilitate social integration of all PWD, and not only of some of them.

Furthermore, the fact that CBR programs are managed and implemented at the community level or by civil society organizations can never absolve States from their duty to ensure full compliance with their obligations under human rights law. States are in fact under an obligation to ensure that not only the public sphere, but also the private sphere, are subject to regulation to ensure the equitable treatment of PWD. Over the years, institution based services, which have a longer history, have developed into high cost program in most countries, and face serious problems resulting from mounting staff costs, wastage of man power and low efficiency of services. As a result, in many developing countries the CBR approach is viewed as a cost efficient alternative to rehabilitation institution. At the same time, this approach aims at greater coverage of the
population of disabled people. Unlike the 'conventional' system for rehabilitation, in which rehabilitation was provided in institutions, in CBR the delivery of primary rehabilitation therapy to PWD takes place at the community level, through the combined efforts of disabled persons themselves, their families and organizations, the community in which they live and the appropriate health, educational, vocational and social services.

5.1.5.2.2: Forms of CBR: CBR programs today exist in two forms, based on who performs the tasks of rehabilitation functions. In the first form, the rehabilitation functions are entrusted to the members of the family and the community without any outside assistance – it is therefore an entirely non-institutional approach. In the second form, the rehabilitation functions are performed with external assistance, as in extension services of rehabilitation centers.

5.1.5.2.3: Concept of CBR: The concept of CBR has been elaborated in the 1980s as a strategy to enhance the quality of life of all children and adults with disabilities. Its goal is to promote rehabilitation, equalization of opportunities and social inclusion of PWD within their communities.

When the concept of CBR was originally developed, the human rights dimension of CBR strategies was not fully taken into account. However, in the course of the implementation of CBR programs, it has become increasingly clear that international human rights law has an important role to play in efforts aimed at ensuring the full participation and equalization of opportunities for PWD. This growing awareness is now reflected in a new joint position paper on CBR drafted by the international Labor Organization (ILO), the United Nations Educational, Scientific and Cultural
Organizations (UNESCO), the United Nation Children’s Fund (UNICEF) and the World Health Organization (WHO), which expressly refers to the International Bill of Rights and the United Nations Standard Rules as the legal and moral foundations for the concept of CBR.

The concept of CBR was promoted by WHO. It views CBR as an integral part of primary health care. In 1994 three UN agencies issued a joint statement on CBR. CBR has been defined by ILO, UNESCO and WHO as: At first glance, the concept of CBR would seem to promise substantial coverage of disabled people, but there are doubts about the validity of this assumption. The trend of progressing impoverishment of rural people and the growing abandonment of extended family systems leave little economic or manpower resources in families to look after the needs of their disabled members, thereby making disabled people a burden on their families. In such a situation, the motivation required for effectively shouldering the responsibilities of caring for disabled people within the context of their families will not be easy found. The burden of caring for disabled person and the stigma attached to having a disabled member in the family can sometimes make the community refuse to co-operate in any rehabilitation program. An apparent advantage in coverage in CBR programs may thus be nullified in practice.

5.1.5.2.4: Definitions of CBR: The joint statement states that CBR is implemented through the combined efforts of disabled people themselves, their families and communities and the appropriate health, education, vocational and social services.
'CBR', as defined by WHO, 'involves measures taken at the community level to use and build on the resources of the community, including the impaired, disabled and the handicapped persons themselves, their families and their communities as a whole'.

“CBR is a strategy within community development for the rehabilitation, equalization of opportunities and social integration of all people with disabilities”.

5.1.5.2.5: **Features of CBR:** At the national level, CBR should form part of country’s policy to assist all people who have any type of disability. The methods of implementing CBR will vary from country to country. At regional and district level, CBR should be supported with referral services and by transfer of knowledge to communities. At community level, CBR programs should belong to the community, and should be implemented under the control of the community, as represented by the local government or authority. The model of CBR developed by WHO has following four main features:-

1. It is designed to deliver services to disabled people in their own communities.
2. It uses simplified rehabilitation technology, presented in a manual, “Training in the community for PWD” translated into 30 languages.
3. It promotes community involvement, self reliance, self sufficiency and awareness, by supporting the use of local resources.
4. It emphases the vital roles at national, regional, district and community level, of planning, managing and monitoring CBR programs.
5.1.5.2.6: Approaches to CBR: According to Kisan Joseph (1995), described five approaches to CBR, each of which produces its own set of models. The approaches are given below.

**Professional Approach:** This approach is based on applying a professional discipline to the treatment of disability. The WHO model emphasizes medical rehabilitation in a health care system, for example, correcting the disability by reconstructive surgery is one of the functions of rehabilitation centers established in hospitals.

1. *Location based approach*
2. *Program origin approach*
3. *Community participation approach*
4. *The CBR worker approach*

5.1.5.2.7: Aims of CBR: The objectives, principles and implementation of CBR programs have to be interpreted and evaluated in the light of human rights standards. The consequences of this shift are perspective reinforce the importance of: Empowerment, Inclusiveness, Participation, Awareness-raising, Accountability.

5.1.5.2.8: Objectives of CBR project:

1. Survey, identification and assessment of all categories of disabled persons in the project area.
2. Home based Early Intervention and Special Education for all categories of disabled persons.
3. Referral services to all categories of disabled persons.

5. Enhancement of living conditions of parents of intellectually disabled, and other disabled persons, through Income Generation Program conducted by the Self-help-Groups of disabled persons formed under the CBR Program.

6. Supply of Aids and Appliances such as Hearing Aid, Braille materials, Teaching Aid, Wheel Chair, Tricycle, Crutches etc, to the disabled persons.

7. Helping the disabled persons to avail facilities and concessions given by the Government under various schemes.

8. Sustenance of the CBR work after the end of the project period.

5.1.5.2.9: CBR in Indian scenario: The 1980s witnessed the growth of the CBR approach in India, which sought to promote not only better coverage, but also self sufficiency, productivity and integration of disabled people into the societal mainstream. Coverage is an essential principle in the CBR approach, which seeks to shift from 'everything for a few' to 'something for everyone'. The District Rehabilitation Centre (DRC) scheme was started by the Government of India to provide services to all categories of disabled persons in Urban and Rural sectors through Center-based and Camp approach respectively. But the number of DRC was quite few. Recently the Government has started a number of programs such establishment of 'District Centers', implementation of 'National Program for the Rehabilitation of Persons with Disability'(NPRPD), and 'Education for all' in a large number of districts of the Country. These programs are reaching a vast population of the Country in the rural area. But the success of these programs depends upon the sincerity and dedication of the Government
officers entrusted to implement the programs. The GOI is also providing grants to NGOs through the MSJ&E to run CBR programs. But this grant is given to a very small number of Organizations. Fund is always a constraint with the Government.

Few foreign funding agencies are providing assistance to NGOs for implementing CBR programs through project approach. But the number of Organizations receiving such funding is very few. Such funding is available for a limited period of time as a result of which most of the programs are discontinued. If community involvement is not properly ensured during implementation of the CBR programs, then after the end of the project, all the service programs are discontinued.

An analysis of the present situation in India suggests that efforts of the NGOs to implement CBR programs on their own or with the help of the foreign funding agencies help only a very small percentage of the disabled persons and are demonstrative in nature. The amount funding from the foreign agencies is also gradually decreasing. Therefore, to cater to the needs of the disabled persons in the rural India, the Government will have to expand its program for the CBR of the disabled persons in a big way. To reach people with disabilities in a significant way, the people in the community who are willing to be trained and help the disabled should be utilized fully. The Government should plan and organize training programs for such persons on regular basis and create an army of volunteers to help the disabled. A review of the programs for the disabled through the District Red Cross Societies (DRCS) in different part of the Country shows that it is a great success. Efforts should be made by the Government to implement the CBR program for the disabled through the DRCS.
In a country like India, with continuing extended and joint family networks in rural areas, utilization of families for rehabilitation is feasible. Self-help Groups (SHG) of families and of disabled people in the community can facilitate information sharing and mutual support to meet day-to-day needs and to initiate other activities. As such at present the Government is promoting the formation of SHG for income generation program of the poor people. The same approach should be followed for the disabled persons and their families which will provide them an opportunity to generate more income for their family. Participation in the activity of the SHGs also will give them a scope to share their difficult experiences of managing a disabled child with similar others and learn from their experiences.

5.1.5.3: Community Based Vocational Training (CBVT):

5.1.5.3.1: Concept of CBVT: Majority of the disabled have no access to the Institutionalized training program due to distances, disability and destitution. The main objective was to provide basic skills in one of the operations of an occupation depending on local employment market requirements. Syllabus was prepared with weekly and daily targets of skill to be attained. The training whether institutional or non institutional are also community based. Even though there are several skill training programs that could be organized for shorter durations on a similar model, the name CBVT is assigned to a skill development program where the skill to be developed require not less than three months of training. As the name implies, the training program is designed to suit the local employment market and the training is provided at a central place accessible to the user, viz., and the rural disabled. It may be a central village or a place, to which transport arrives in the morning and the disabled persons are able to go back home by the evening. The approximate cost of expenditure may be worked out on the bases of local conditions.
taking into consideration the local market, availability of raw material, cost at the time of actual training etc.

5.1.5.3.2: Steps of CBVT: The different steps in the execution of the CBVT are given below.

1. The Centre will make preliminary contacts with local NGOs interested in the welfare of the disabled and encourage them to conduct an Evaluation Camp to screen suitable disabled persons for providing training.

2. The Centre will make a study of employment opportunities available in the area, general education attainment in the community, availability of training facilities and other infrastructure with a view to start a short-term training program in an identified operation of an occupation.

3. Depending on the information collected, syllabus with weekly and daily targets of skills to be achieved should be worked out.

4. Select a local trainer and orient him through the regular trainer of the Centre in management of the disabled, and techniques of transfer skills.

5. Persuade the local N.G.O. To provide space to conduct the training for three months, pay honorarium to the local trainer and where feasible meet the cost of raw material required.

6. The Centre should provide all technical know-how in the conduct of the training and also Tools and Equipment, Scholarship, conducting the test and certification.

7. The Centre will also provide post-training follow up to ensure placement services either in the form of wage paid employment or self-employment.

8. The Centre may also arrange either through donations or otherwise Tool-kits to those completion of the training.
Table: 05.05

Statement of CBR services that the respondents have availed in their community

<table>
<thead>
<tr>
<th>Service</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parental education</td>
<td>48</td>
<td>12.0</td>
<td>12.0</td>
<td>12.0</td>
</tr>
<tr>
<td>Early intervention program</td>
<td>2</td>
<td>.5</td>
<td>.5</td>
<td>12.5</td>
</tr>
<tr>
<td>Home based special education</td>
<td>13</td>
<td>3.3</td>
<td>3.3</td>
<td>15.8</td>
</tr>
<tr>
<td>Vocational training</td>
<td>83</td>
<td>20.8</td>
<td>20.8</td>
<td>36.5</td>
</tr>
<tr>
<td>Disability assessment camps</td>
<td>21</td>
<td>5.3</td>
<td>5.3</td>
<td>41.8</td>
</tr>
<tr>
<td>Distribution of aids &amp; appliance</td>
<td>20</td>
<td>5.0</td>
<td>5.0</td>
<td>46.8</td>
</tr>
<tr>
<td>Information on disability</td>
<td>3</td>
<td>.8</td>
<td>.8</td>
<td>47.5</td>
</tr>
<tr>
<td>Self help groups</td>
<td>50</td>
<td>12.5</td>
<td>12.5</td>
<td>60.0</td>
</tr>
<tr>
<td>Adjustment training</td>
<td>14</td>
<td>3.5</td>
<td>3.5</td>
<td>63.5</td>
</tr>
<tr>
<td>Referral services</td>
<td>61</td>
<td>15.3</td>
<td>15.3</td>
<td>78.8</td>
</tr>
<tr>
<td>Others</td>
<td>19</td>
<td>4.8</td>
<td>4.8</td>
<td>83.5</td>
</tr>
<tr>
<td>Some of them</td>
<td>32</td>
<td>8.0</td>
<td>8.0</td>
<td>91.5</td>
</tr>
<tr>
<td>None</td>
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</tr>
<tr>
<td>Total</td>
<td>400</td>
<td>100.0</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The above table 05.05 depicts that the respondents are getting social or community based rehabilitation services from social institutions. The important rehabilitation services which the respondents are getting are vocational training (20.8%), referral services (15.3), help of self help groups (12.5%), and parental education (12%).

5.1.5.3.3: Responsibility of Rehabilitation: It is the collective responsibility of the able bodied to rehabilitate these handicapped individuals. The role of rehabilitation is to minimize disability and handicap, and help a handicapped person lead a useful life within his limitations, in other words, to make a disabled person into a “differently abled” person\textsuperscript{25}. 
If means are provided whereby the child can compensate for the disabilities that he suffers, often his social development will go on quite as steadily and as hopefully as that of the normal child²⁶.

Government can provide services to interior parts of villages and backward areas. It has electronic media though which it can reach people and make people aware of the services. There are many branches through which the Government can rehabilitate disabled are as follows:

1. Village development
2. Revenue department
3. Medical & health
4. Rehabilitation of the handicapped
5. Education dept.
6. Information & Technology
7. Industrial development
8. Civil services.

Among these important branches are revenue, welfare, education, health, village development, panchayat raj and employment. The department and welfare of disabled should have co-ordination with all these branches. Wherever the vacancies arise it should be alert to take part and see that the disabled should be got benefited. The Government Organizations, NGO’s and people working for the rights of disabled should play an important role.

They should follow rules and principles formed by R.C.I. After PWD act there is necessity for skilled workers. These workers should take more interest in enhancing the abilities of the handicapped and should encourage them to participate in cultural
programs, sports, educational programs. Many corporate offices are appointing disabled who has talent and skill. Film & TV should produce films, documentaries and serials to give a boost and message to the disabled to enable their energies.

5.2: DISABILITY RELATED LEGISLATIONS IN THE WORLD:

5.2.1: Philosophy behind disability legislation: The historical processes have been guided by three general philosophies: utilitarianism, humanitarianism and human rights.

5.2.1.1: Utilitarianism: the central theme of utilitarianism is that usefulness determines the value of a person or thing to society (Sussman, 1965). The utility of a person or thing is relative to each given society; however, the core criterion for usefulness has always been the greatest good or happiness for the greatest number in society. Usefulness had a different meaning among primitive societies compared with modern societies. In primitive societies, the disabled person was often seen as a burden to the social group because he or she could not contribute to the welfare of the group. During times of severe hardship, the disabled were simply abandoned or killed. Even though the expression of the utilitarian philosophy among many primitive societies was barbaric and cruel, it was regarded by those cultures as a necessity for survival (Pardeck and Chung, 1992).

Primitive societies had a very limited view of the world. They viewed disability as the work of evil spirits and supernatural forces as an expression of the disfavor of the gods. The disabled were often seen as a hazard to primitive societies and were thus sacrificed to appease the gods (Brothwell and Sandison, 1967; Galdston, 1963). In medieval age, disabilities were viewed as a consequence of original sin and a sign of
God's disfavor. Individuals were seen in terms of good and evil; the disabled were largely viewed as evil (Newman, 1987). Such ambiguities are seen as the basis of present day conflictual attitudes toward disabilities, which all too frequently result in policies of isolation, segregation, and discrimination (Gellman, 1959; Galdston, 1963).

5.2.1.2: Humanitarianism: this philosophy attached central importance to the well being of all people. That is, each person has worth and is not subordinated to political and biological theories. Given this progressive view, new thought in all fields began to emerge.

5.2.1.3: Human Rights Philosophy: The human rights philosophy has elements of the humanitarian philosophy with its emphasis on the intrinsic value of the individual. What separates the humanitarian philosophy from the human rights view, however, is the fact that the intrinsic worth of the individual is protected by law.

The physically handicapped are different in some ways, but by no means in all ways from us. By denying them their rights we are negating the basis of a welfare State.

5.2.2: History of Disability legislation: The current welfare provision for the disabled is still conspicuously full of legacies of earlier definitions of disability. The history of legislation in Britain, as in most Western industrialized countries, shows clearly the interaction of two, not always compatible, social movements: humanitarian concern and economic pressures. The earliest sympathy, expressed initially in the activities of voluntary charity, was for the most visible and 'innocently, disabled, and particularly for those whose needs could be clearly defined within the welfare ideologies
of the time, and who could be presented as having a potentially hopeful future—crippled children, the blind and the deaf. These were groups with an immediate emotional appeal to the public whose charitable money was sought, and groups whose social welfare could be seen as a measure of a society's progress.

Powerful voluntary societies, such as those for the blind, became pressure-groups demanding provision as of right rather than as charity, while at the same time guarding their own spheres of interest. The blind whose welfare was the concern of the first legislative measures specifically for the disabled in this country, the Blind Persons Act of 1920—are still statutorily a class apart.

The second thread woven into the history of legislative provision is the economic, given impetus by the need during two world wars for maximum use of manpower, and by the post-war concern for disabled ex-servicemen. Early legislation in Britain selected out the war-disabled and the industrially disabled as the groups for whom special provision should be made: their needs were similar (principally for aids to mobility and dexterity, and training and employment) and the same principles of compensation could be seen to apply. Thus, the first practical prevision of official rehabilitation help was the setting up of Government Instruction Factories for ex-servicemen of the First World War, a program which was later extended to the industrially injured.

The Elizabethan poor law—1601: it is a milestone in the rehabilitation of needy people in UK. This shifted from church responsibility to government responsibility for relief of needy people. This law distinguished the poor in three classes. The disabled fall under secondary class of the poor as "impotent poor". They were people unable to work
- the sick, the old, the blind, the deaf-mute, the lame, the demented (Mentally-ill) and mothers with young children. This is the first step in the rehabilitation of disabled as codification of legislation started.

In 1942 the Beveridge Report offered its comprehensive plan for ensuring that all members of the community would at all times be free from want, the new concept of rehabilitation services as a right 'for all disabled persons who can profit fro it irrespective of the casue of their disability’ still used economic factors as the paramount argument.

Rehabilitation was defined as the process by which the disabled became ‘producers and earners’, and when the national Insurance Act, 1946, became part of the implementation of the Beveridge recommendations, the differences between ‘workers’ and ‘others’ and between ‘industrial’ disease or injury and that produced by other causes was perpetuated and solidified. The disabled ‘producers and earners’ are defined by the Disabled Persons (Employment) Acts, 1944-58; an individual must be ‘a person who on account of injury, disease or congenital deformity, is substantially handicapped in obtaining or keeping employment, or in undertaking work on his own account, of a kind which apart from his injury, disease or deformity would be suited to his age, experience and qualifications.’ He must also ‘desire to engage in some form of remunerative employment or work’ and ‘have a reasonable prospect of obtaining and keeping such employment or work’. The welfare of those for whom vocational rehabilitation is assumed not to be applicable was originally legislated for in the National Assistance Act, 1948.
According to National Assistance Act, 1948, Britain, the handicapped are ‘those persons who are blind, deaf or dumb, and other persons, who are substantially and permanently handicapped by illness, injury or congenital deformity, or such other disabilities as may be prescribed by the Minister’

The more recent history of legislation for the disabled again shows the influence of two social movements. The first is the movement towards an holistic approach to social welfare, recognizing that all the various areas of life are interconnected, and that health and welfare, in particular, affect each other closely. This is, of course, hardly a new idea: since the end of the last century, when the surveys of Booth and Rowntree demonstrated that sickness, old age and disability were major causes of deprivation, all the major movements of social policy (the liberal legislation of 1906 onwards, the erection of the ‘welfare state’ from 1944 onwards) have been towards a closer connection between health and social welfare. A new impetus towards ‘integrated care’ has been provided by the many comprehensive medical care may be wasted unless it is co-coordinated with social and vocational help, and that poverty and unemployment are still correlated with chronic sickness and disability

In Britain, the legislation for the assistance of the sick and disabled has widened in its scope. Whereas the earlier provisions dealt with isolated problems: the problems of mobility, or of vocational help; or with specific disabilities, the present tendency is to legislate for all disability groups and to cover as many areas of life as possible. All urging integration of services to achieve more effective rehabilitation of the disabled.
Both governmental and non-governmental agencies are recognizing that disabled citizens are not asking for charity. Instead, they seek an opportunity to obtain the rights of full and equal membership in our society.\(^40\)

A positive societal attitude is at the crux of the movement for equal rights for those with disabilities. A major impetus was the formation of governmental policy in an attempt to modify public attitudes toward the disabled community.\(^41\)

Mainstreaming aims to integrate handicapped persons into the activities of the community as completely as possible. Least restrictive alternatives seek to achieve the highest degree of independent living attainable for handicapped persons. Developmental progress recognizes that people can grow physically, intellectually, socially, and emotionally, regardless of the severity of his handicap.\(^42\)

5.2.3: International Initiatives for Disabled: From its early days the United Nations has sought to advance the status of disabled persons and to improve their lives. The concern of the United Nations for the well-being and rights of disabled persons is rooted in its founding principles, which are based on human rights, fundamental freedoms and equality of all human beings. As affirmed by the United Nations Charter, the Universal Declaration of Human Rights, International Covenants on Human Rights and related human rights instruments, persons with disabilities are entitled to exercise their civil, political, social and cultural rights on an equal basis with non-disabled persons. The contribution of United Nations specialized agencies to advance the situation of disabled persons is noteworthy: the United Nations Educational, Scientific and Cultural Organization (UNESCO) by providing special education; the World Health Organization
(WHO) by providing technical assistance in health and prevention; the United Nations International Children's Fund (UNICEF) by supporting childhood disability programs and providing technical assistance in collaboration with Rehabilitation International (a non-governmental organization); the International Labour Organization (ILO) by improving access to the labour market and increasing economic integration through international labour standards and technical cooperation activities. The international initiatives have been identified in several phases in view of the changing approaches of understanding and measures undertaken for their inclusion in the society.

5.2.3.1: Phase- I, 1945-1955: In the 1940s and 1950s, the United Nations promoted Welfare perspective on disability, focusing on rights of disabled through a range of social welfare approaches. Advocating prevention and rehabilitation issues followed several measures vigorously. The Social Commission of the United Nations provided assistance to Governments in disability prevention and the rehabilitation of disabled persons through advisory missions, workshops for the training of technical personnel and the setting up of rehabilitation centers.

5.2.3.2: Phase- II, 1955-69: This phase witnessed a shift from a welfare perspective to one of social welfare. A re-evaluation of policy in the 1960s led to de-institutionalization and spurred a demand for fuller participation by disabled persons in an integrated society. Operational activities in the field of disability changed through implementation of various United Nations programs on prevention and rehabilitation. The United Nations in its Article 19 addressed the provision of health, social security, and social welfare services for all persons, aiming at the rehabilitation of the mentally and physically disabled so as to facilitate their integration into society.
5.2.3.3: Phase- III, 1970-75: In the 1970s, the growing international concern with human rights for persons with disabilities was specifically addressed by the General Assembly in the Declaration on the Rights of Mentally Retarded Persons. The Right of Mentally Retarded Persons Declaration stipulates that mentally retarded persons are accorded the same rights as other human beings, as well as specific rights corresponding to their needs in the medical, educational and social fields. Emphasis was put on the need to protect disabled persons from exploitation and provide them with proper legal procedures. In 1975 the Declaration on the Rights of Disabled Persons proclaims the equal civil and political rights of disabled persons. This Declaration sets the standard for equal treatment and access to services, which help to develop capabilities of persons with disabilities and accelerate their social integration.

5.2.3.4: Phase- IV, 1976-1980: The General Assembly recommended that all Member States take into account the recommendations outlined in the Declaration on the Rights of Disabled Persons when formulating policies, plans and programs. It also proclaims 1981 as International Year for Disabled Persons, stressing that the Year should be devoted to fully integrating disabled persons into society and encouraging relevant study and research projects to educate the public on the rights of disabled persons. It called for a plan of action at the national, regional and international levels, with an emphasis on equalization of opportunities, rehabilitation and prevention of disabilities. In 1978 The Secretary-General establishes the intergovernmental Advisory Committee for the International Year of Disabled Persons.

5.2.3.5: Phase - V, 1980-82: The International Year of Disabled Persons, 1981, was celebrated with numerous programs, adopting recommendations of research projects,
policy innovations and other rehabilitation programs. Many conferences and symposiums were held during the Year, including the First Founding Congress of Disabled People International, held in Singapore from 30 November to 6 December. In 1982, the General Assembly took a major step towards ensuring effective follow-up to the International Year by adopting, on 3 December 1982, the World Program of Action concerning Disabled Persons. The World Program transformed the disability issue from a "social welfare" issue to that of integrating the human rights of persons with disabilities in all aspects of development processes. The Program restructured disability policy into three distinct areas:

- Prevention;
- Rehabilitation; and
- Equalization of opportunities.

In a broad sense, implementation would entail long-term strategies integrated into national policies for socio-economic development, preventive activities that would include development and use of technology for the prevention of disablement, and legislation eliminating discrimination regarding access to facilities, social security, education and employment. At the international level, Governments were requested to cooperate with each other, the United Nations and non-governmental organizations. Together, the Program and the International Year had launched a new era—one that would seek to define "handicapped" as the relationship between persons with disabilities and their environment. It was imperative that the barriers created by society to full participation by persons with disabilities be removed.
5.2.3.6: Phase - VI 1983-92: In the World Programme of Action, the General Assembly proclaimed 1983-1992 the United Nations Decade of Disabled Persons. It prompted a flurry of activity designed to improve the situation and status of the disabled. Emphasis was placed on raising new financial resources, improving education and employment opportunities for the disabled, and increasing their participation in the life of their communities and country.

The Sub-Commission on Prevention of Discrimination and Protection of Minorities had included disabled persons in international human rights discourse since its establishment. In 1984, it appointed Leandro Despouy of Argentina as Special Rapporteur to study the connection between human rights violations, violations of fundamental human freedoms and disability. He biannual report to the Sub-Commission on the particular human rights situation of disabled persons recommended the establishment of an international ombudsman in 1991.

At this juncture, the General Assembly of the United Nations noted with concern the plight of disabled persons in some countries and asked member countries to ensure that persons with disabilities would enjoy the same rights to employment as all other qualified citizens and that the United Nations itself would declare employment opportunities open to all persons, regardless of sex, religion, ethnic origin or disability.

In August 1987, a mid-decade review of the United Nations Decade of Disabled persons was conducted at a global meeting of experts in Stockholm, Sweden. The meeting recommended the importance of recognizing the rights of persons with disabilities. Since the pace of progress during the first five years had not been as fast as
initially expected, the experts agreed that the disability issues should be further addressed within a wider interdisciplinary context—namely, a comprehensive well-coordinated information and evaluation campaign; establishment of a data base on disability; and creation of technical cooperation programs.

On 17 December 1991, the General Assembly adopted the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care. The twenty-five principles define fundamental freedoms and basic rights for these people. They deal with, inter alia, the right to life in the community, the determination of mental illness, provisions for admission to treatment facilities, and the conditions of mental health facilities. They serve as a guide to Governments, specialized agencies and regional and international organizations, helping them facilitate investigation into problems affecting the application of fundamental freedoms and basic human rights for persons with mental illness.

On 16 December 1992, the General Assembly appealed to Governments to observe 3 December of each year as International Day of Disabled Persons. The Assembly further summarized the goals of the United Nations regarding disability and asked the Secretary-General to move from consciousness-raising to action, placing the Organization in a catalytic leadership role, which would place disability issues on the agendas of future world conferences.

The Standard Rules are an international instrument with a human rights perspective for disability-sensitive policy design and evaluation as well as for technical and economic cooperation.

5.2.3.7: Phase - VII, 1993-2002: The Vienna Declaration and Program of Action (1993) states that place of disabled person is everywhere. It states that these persons should be guaranteed equal opportunity through the elimination of all socially determined barriers, be they physical, financial, social or psychological, which exclude or restrict their full participation in the society. In the same year, the Economic and Social Council endorsed the proclamation of 1993-2002 as Asian and Pacific Decade of Disabled Persons, a decision taken by the Economic and Social Commission of Asia and the Pacific, in order to implement effectively the World Program of Action in the Asian and Pacific region.

The United Nations conducted a comprehensive comparative study of global disability policies and programs in 1997 and issued it as a Report of the Secretary-General, "Review and appraisal of implementation of the World Program of Action concerning Disabled Persons." This study indicated that a broad human rights framework must be further developed and established for disability policies and programs to promote social, economic and cultural rights as well as the civil and political rights of persons with disabilities.

Major international conferences and summits that were organized during the first half of the 1990s on a range of development agendas adopted action plans and programs in which participation, inclusion and improved well being of persons with disabilities were accorded a special emphasis.
Most recently, the fifty-sixth session of the Commission on Human Rights adopted resolution 2000/51 of 25 April 2000, entitled "Human Rights of Persons with Disabilities." The resolution invites treaty bodies and their Special Rapporteurs to include the rights of persons with disabilities in the monitoring of the implementation of the relevant human rights instruments. The resolution also urges Governments to include the question of human rights of persons with disabilities in their reporting requirements under the existing human rights treaties and calls for cooperation with the Special Rapporteur on Disability of the Commission for Social Development and the High Commissioner for Human Rights to examine possible measures to strengthen the protection and monitoring of the human rights of persons with disabilities.

5.2.4: Rights of Disabled Persons: Disability rights are being incorporated in international, national, and states’ legislations. The Declaration of the Rights of Disabled Persons was proclaimed by the General Assembly of the United Nations on December 9, 1975 in its thirteenth session, 2433rd plenary meeting, Resolution No.3447 and calls for national and international action to ensure that it will be used as a common basis and frame of reference for the protection of these rights. However, the United Nations is aware of the fact that certain countries, at their state of development can devote only limited efforts to this end. The UN declaration of the Rights of the Disabled Persons is as follows:

- The term “disabled person” means, any person unable to ensure by himself or herself, wholly or partly the necessities of a normal individual and/or social life as a result of a deficiency, either congenital or not in his or her physical or mental capabilities.
• Disabled persons shall enjoy all the rights set forth in this Declaration. These rights shall be granted to all disabled persons without any exception whatsoever and without distinction or discrimination on the basis of race, color, sex, language, religion, political or other opinions, national or social origin, state of wealth, birth or any other situation applying either to the disabled person himself or herself or to his or her family.

• Disabled persons have the inherent right to respect for their human dignity. Disabled persons, whatever the origin, nature and seriousness of their handicaps and disabilities, have the same fundamental rights as their fellow-citizens of the same age, which implies first and foremost the right to enjoy a decent life, as normal and full as possible.

• Disabled persons have the same civil and political rights as other human beings.

• Disabled persons are entitled to the measures designed to enable them to become as self-reliant as possible.

• Disabled persons have the right to medical, psychological and functional treatment, including prosthetic and orthotic appliances, to medical and social rehabilitation, education, vocational training and rehabilitation, aid, counseling, placement services and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the process of their social integration or reintegration.

• Disabled persons have the right to economic and social security, and to a decent level of living. They have the right, according to their capabilities, to
secure and retain employment or to engage in a useful, productive and remunerative occupation and to join trade unions.

- Disabled persons have the right to live with their families or with foster parents and to participate in all social, creative or recreational activities. No disabled person shall be subjected, as far as his or her residence is concerned, to differential treatment other than that required by his or her condition or by the improvement which he or she may derive there from. If the stay of a disabled person in a specialized establishment is indispensable, the environment and living conditions therein shall be as close as possible to those of the normal life of a person of his or her age.

- Disabled persons are entitled to have their special needs taken into consideration at all stages in economic and social planning.

- *Disabled persons shall be protected against all exploitation, all regulations and all treatment of a discriminatory, abusive or degrading nature.*

- Disabled persons shall be able to avail themselves of qualified legal aid when such aid proves indispensable for the protection of their persons and property. If judicial proceedings are instituted against them, the legal procedure applied shall take their physical and mental condition fully into account.

- Organizations of disabled persons may be usefully consulted in all matters regarding the rights of disabled.

- Disabled persons, their families and communities shall be fully informed by all appropriate means of the rights contained in this Declaration.
5.2.5: **International Year of Disabled Persons (IYDP):** The United Nations General Assembly in 1976 proclaimed 1981 as the IYDP. It carried the theme “Full Participation and Equality for all disabled persons”. The main objectives of IYDP were:

- To help all disabled persons in their physical and psychological adjustment in society.
- To promote efforts to provide disabled people with proper assistance, training, care, guidance and work opportunities for full integration into society.
- To encourage studies and research projects designed to facilitate participation of disabled persons in daily life.
- To educate and inform people of the right of disabled persons to participate fully in economic, social and political aspects of life.
- To promote effective measures for preventions, early detection and rehabilitation of disabled people.

5.2.6: **Legislations around globe:** United States of America has Americans with Disabilities Act of 1990, which took effect by July 26, 1992. According to this act, an individual with a disability is a person who has a physical or mental impairment that substantially limits one or more major life activities, has a record of such an impairment or is regarded as having such an impairment (The U.S. Equal Employment Opportunity Commission, 1997). The major aim of this act is to provide a clear and comprehensive national mandate for the elimination of *discrimination against individuals with disabilities*; to provide clear, strong, consistent, enforceable standards; addressing discrimination against individuals with disabilities. It prohibits private employers, state and local governments, employment agencies, and labor unions from discriminating
against qualified individuals with disabilities in job application procedures, hiring, firing, advancement, compensation, job training, and other terms, conditions and privileges of employment. Several states have developed complementary or independent legislation to ensure the rights of disabled persons.

**Americans with Disabilities Act (ADA):** In 1990 the congress passed the Americans with Disabilities Act. Accessibility guidelines for buildings and facilities were finalized and because effective in 1992. The law stated that “Title III of the ADA prohibits discrimination on the basis of disability in places of public accommodation by any person who owns, leases or leases to, or operates a place of public accommodation”\(^{43}\).

In United Kingdom of Britain, the main enactment remains the **Disability Discrimination Act 1999 (DDA)**, supplemented by the Special Educational Needs & Disability Act 2001. It works to eliminate the discrimination in the field of employment against disabled persons and gives disabled people rights in the areas of employment, access to goods, facilities and services, and buying or renting land or property. Special Educational Needs & Disability Act 2001 deals with the special educational needs of disabled children, discrimination against disabled, and training of special teachers.

Australian disability act is known as **Disability Discrimination Act, 1992**. The objective of this act is to eliminate, as far as possible, discrimination against persons on the ground of disability in the areas of work, accommodation, education, and existing laws.
5.3: DISABILITY RELATED LEGISLATION IN INDIA: The Government of India had appointed a National Committee to coordinate all the IYDP activities. The Committee had formulated a National Plan of Action for IYDP. The Plan supported the theme of “Full Participation and Equality.” Its specific objectives were:

- To lay the foundation and develop a network of services for disabled by preparing a perspective development plan for comprehensive rehabilitation with a rural bias.
- To develop a strong national disability prevention program.
- To evolve a National Policy to provide disabled persons with proper assistance, educational training, care, guidance, employment measures, work opportunities, to achieve full social integration and also extend legal protection.
- To encourage national institutions and institutes of Technology to develop new approaches and technologies so that more facilities can be provided to rehabilitate disabled persons.
- For the integration and full participation in community life, change the current trend to institutionalize disabled and motivate the family and the community to care for the disabled.
- To develop a planned network of information and service to eradicate social prejudicial attitudes towards the disabled and to publicize the right of disabled persons to participate in and to contribute to various aspects of economic, social and political life.
- To initiate programs that would significantly benefit disabled persons.
• To collect and disseminate all relevant data on the disabled and their needs.

The National Plan of Action also suggested a separate program for children below 14 years in India, which include following suggestions:

• To establish at least half a dozen centers in the country to carry out differential diagnosis of disabilities, offer advice on care at home, placements in schools and other similar matters.

• To bring substantial number of handicapped children to schools.

• To devise schemes to encourage integration of handicapped children in ordinary schools.

• To develop schemes of scholarships for handicapped children to cover a part of the cost of their education.

• To undertake program for the training teachers with a view to improving standards of teaching of the young handicapped.

At present there are following laws in our country to safeguard the rights of disabled persons:

5.3.1 Constitutional Framework in India: The Constitution of India applies uniformly to every legal citizen of India, whether they are healthy or disabled in any way (physically or mentally) and guarantees a right of justice, liberty of thought, expression, belief, faith and worship and equality of status and of opportunity and for the promotion of fraternity. To safeguard the interests of the disadvantaged sections of the Society, the Constitution of India guarantees that no person will be denied 'equality' before the law
(Article 14 of the Indian Constitution). Relevant Articles in Indian Constitution providing constitutional guarantees to all including disabled are:

**Article 15(1):** It enjoins on the Government not to discriminate against any citizen of India (including disabled) on the ground of religion, race, caste, sex or place of birth.

**Article 15(2):** It states that no citizen (including the disabled) shall be subjected to any disability, liability, restriction or condition on any of the above grounds in the matter of their access to shops, public restaurants, hotels and places of public entertainment or in the use of wells, tanks, bathing places (ghats), roads and places of public resort maintained wholly or partly out of government funds or dedicated to the use of the general public.

**Article 17:** No person including the disabled irrespective of his belonging can be treated as an untouchable. It would be an offence punishable in accordance with law.

**Article 21:** Every person including the disabled has his life and liberty guaranteed.

**Article 23:** There can be no traffic in human beings (including the disabled), and beggar and other forms of forced labour is prohibited and the same is made punishable in accordance with law.

**Article 29(2):** The right to education is available to all citizens including the disabled. No citizen shall be denied admission into any educational institution maintained by the State or receiving aid out of State funds.
Article 32: Every disabled person can move the Supreme Court of India to enforce his fundamental rights and the rights to move the Supreme Court.

5.3.2: Legal Framework for Disabled:

5.3.2.1: Design Act 1911: Under the Designs Act, 1911 which deals with the law relating to the protection of designs any person having jurisdiction in respect of the property of a disabled person (who is incapable of making any statement or doing anything required to be done under this Act) may be appointed by the Court under Section 74, to make such statement or do such thing in the name and on behalf of the person subject to the disability. The disability may be lunacy or other disability.

5.3.2.2: Succession Act, 1956: It applies to all Hindus. It provides that physical disability or physical deformity would not disentitle a person from inheriting ancestral property. Similarly, in the Indian Succession Act, 1925 that applies in the case of interstate and testamentary succession, there is no provision, which deprives the disabled from inheriting an ancestral property. The position with regard to Parsis and the Muslims is the same. In fact a disabled person can also dispose his property by writing a will provided he understands the import and consequence of writing a will at the time when a will is written. For example, a person of unsound mind can make a Will during periods of sanity. Even blind persons or those who are deaf and dumb can make their Wills if they understand the import and consequence of doing it.

5.3.2.3: Marriage Acts: The rights and duties of the parties to a marriage whether in respect of disabled or non-disabled persons are governed by the specific provisions contained in different marriage Acts, such as the Hindu Marriage Act, 1955, the Christian Marriage Act, 1872 and the Parsi Marriage and Divorce Act, 1935. Other marriage Acts,
which exist, include; the Special Marriage Act, 1954 (for spouses of differing religions) and the Foreign Marriage Act, 1959 (for marriage outside India). The Child Marriage Restraint Act, 1929 as amended in 1978 to prevent the solemnization of child marriages also applies to the disabled. A Disabled person cannot act as a guardian of a minor under the Guardian and Wards Act, 1890 if the disability is of such a degree that one cannot act as a guardian of the minor. The Hindu Minority and Guardianship Act, 1956, as also under the Muslim Law, take a similar position.

5.3.2.4: National Building Code of India 1983 with proposed Amendments:

The Ministry of Urban Development and Poverty Alleviation has issued a public notice proposing amendments to the Unified Building Byelaws, 1983, pertaining to the National Capital Territory of Delhi. These steps has been taken with a view to providing a barrier-free environment in public buildings for persons with disability and are applicable to all buildings, recreational areas and facilities used by the public. Domestic residences are exempted in this notification. The notice seeks to identify the disabilities which include impairments that confine individuals to wheelchairs and "impairments that cause individuals to walk with difficulty or insecurity" and "individuals using braces or crutches, amputees, arthritics, spastics and those with pulmonary and cardiac ills". It also takes into account hearing and sight disabilities. Main features are: "Every building should have at least one access to main entrance/exit to the disabled which shall be indicated by proper signage. This entrance shall be approached through a proper ramp together with stepped entry' The access path from the plot entry and surface parking to building entrance will have even surface without any step. Slope, if any shall not have gradient greater than 5 percent. Selection of floor material shall be made suitably to
attract or to guide visually impaired persons. For parking of vehicles of disabled persons, surface parking for two equivalent car spaces shall be provided near the entrance for the physically challenged persons with maximum travel distance of three metres from building entrance. The information stating that the space is reserved for wheelchair users shall be conspicuously displayed. Guiding floor materials shall be provided or a device, which guides visually impaired persons with audible signals, or other devices, which serves the same purpose, shall be provided, the notice adds. It stipulates that the buildings will have to provide specified facilities such as approach to plinth level, corridor connecting the entrance/exit for the handicapped, stair-ways, lift, toilet and drinking water. While braille signage shall be provided at the above-specified facilities, the notice also calls for provision of ramps with non-slip material at the entry to the building. Guiding floor materials or devices that emit sound shall be provided to guide the visually impaired persons in the corridor connecting the entrance and exit for the handicapped. Stairways with open riser and provision of nosing are not permitted in such buildings. Wherever lift is required as per bye-laws, provision of at least one lift shall be made for the wheel-chair user with specified cage dimensions. The braille signage will be posted outside the lifts. It also lays down that "one special WC in a set of toilet shall be provided for the use of handicapped with essential provision of wash bin near the entrance". An alternative to immediate evacuation of a building via staircases and/or lifts is the movement of persons with disability to safety areas within a building. If possible, they could remain there until fire is controlled or extinguished or until rescued by fire fighters. It is useful to have the provision of a refugee area, usually at the fire-protected stair-landing on each floor that can safely hold one or two wheel chairs.
5.3.2.5: The Mental Act, 1987: Under this Act mentally ill persons are entitled to the following rights:

1. A right to be admitted, treated and cared in a psychiatric hospital.

2. Even mentally ill prisoners and minors have a right of treatment in psychiatric hospitals or psychiatric nursing homes of the Government.

3. Minors under the age of 16 years, persons addicted to alcohol or other drugs which lead to behavioral changes, and those convicted of any offence are entitled to admission, treatment and care in separate psychiatric hospitals or nursing homes established or maintained by the Government.

4. Mentally ill persons have the right to get regulated, directed and co-coordinated mental health services from the Government.

5. Treatment at Government hospitals and nursing homes mentioned above can be obtained either as in patient or on an out patients basis.

6. Mentally ill persons can seek voluntary admission in such hospitals or nursing homes and minors can seek admission through their guardians.

7. The police have an obligation to take into protective custody a wandering or neglected mentally ill person, and inform his relative, and also have to produce such a person before the local magistrate for issue of reception orders.

8. Mentally ill persons have the right to be discharged when cured and entitled to leave the mental health facility in accordance with the provisions in the Act.

9. Where mentally ill persons own properties including land, which they cannot themselves, manage, the district court upon application has to protect and
secure the management of such properties by entrusting the same to a Court of Wards, by appointing guardians of such mentally ill persons or appointment of managers of such property.

10. The costs of maintenance of mentally ill persons detained as in-patient in any government psychiatric hospital or nursing home shall be borne by the state government.

11. Mentally ill persons undergoing treatment shall not be subjected to any indignity (whether physical or mental) or cruelty. Mentally ill persons cannot be used without their own valid consent for purposes of research, though they could receive their diagnosis and treatment.

12. Mentally ill persons who are entitled to any pay, pension, gratuity or any other form of allowance from the government.

13. A mentally ill person shall be entitled to the services of a legal practitioner by order of the magistrate or district court if he has no means to engage a legal practitioner or his circumstances so warrant in respect of proceedings under the Act.

5.3.2.6: The Rehabilitation Council of India Act, (RCI Act 1992): The Rehabilitation Council of India (RCI) was set up as a registered society in 1986. However, it was soon found that a Society could not ensure proper standardization and acceptance of the standards by other Organizations.

The Parliament enacted Rehabilitation Council of India Act in 1992. The Rehabilitation Council of India becomes Statutory Body on 22nd June 1993. Major objectives of RCI are:
- To regulate the training policies and programs in the field of rehabilitation of persons with disabilities.
- To bring about standardization of training courses for professionals dealing with persons with disabilities.
- To prescribe minimum standards of education and training of various categories of professionals/personnel dealing with people with disabilities.
- To regulate these standards in all training institutions uniformly throughout the country.
- To recognize institutions/organizations/universities running master's degree/bachelor's degree/P.G. Diploma/Diploma/Certificate courses in the field of rehabilitation of persons with disabilities.
- To recognize degree/diploma/certificate awarded by foreign universities/institutions on reciprocal basis.
- To promote research in Rehabilitation and Special Education.
- To maintain Central Rehabilitation Register for registration of professionals/personnel.
- To collect information on a regular basis on education and training in the field of rehabilitation of people with disabilities from institutions in India and abroad.
- To encourage continuing education in the field of rehabilitation and special education by way of collaboration with organizations working in the field of disability.
- To recognize Vocational Rehabilitation Centres as manpower development centres.
- To register vocational instructors and other personnel working in the Vocational Rehabilitation Centres.
- To recognize the national institutes and apex institutions on disability as manpower development centres.
- To register personnel working in national institutes and apex institutions on disability under the Ministry of Social Justice & Empowerment.
The RCI Act was amended by the Parliament in 2000 to work it more broad based. It prescribes that any one delivering services to people with disability, who does not possess qualifications recognized by RCI, could be prosecuted. Thus the Council has the twin responsibility of standardizing and regulating the training of personnel and professional in the field of Rehabilitation and Special Education. This Act provides guarantees so as to ensure the good quality of services rendered by various rehabilitation personnel. Following is the list of such guarantees:

- To promote research in rehabilitation and special education.
- To register vocational instructors and other personnel working in the vocational rehabilitation centers and recognize vocational rehabilitation centers as manpower development centers.
- To register working personnel in national institutes and apex institutions on disability under the Ministry of Social Justice & Empowerment and recognize the national institutes as apex institutions on disability as manpower development centers.
- To have uniformity in the definitions of disabilities with the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995.

5.3.2.7: The National Trust for Welfare of Person with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999: The trust aims to provide total care to persons with mental retardation and cerebral palsy and also manage the properties bequeathed to the Trust. The Trust also supports programs that promotes independence and address the concerns of those special persons who do not have family
support. The Trust will be empowered to receive grants, donations, benefactions, requests and transfers.

There have been a significant change in the disability field after the passage of the Rehabilitation Council of India Act, 1992, The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 and The Persons with Disabilities Rules, 1996. The traditional approaches to tackling problems associated with disability have ranged from elimination to indifference to charity to sympathy to welfare. These legislative changes have sharpened the teeth to the cause of the PWD and The Status of Disability in India : 2000 projects the issues of disability in this country. The services for the disabled, their coverage and scope, are a reflection on the policy of providing welfare to the unfortunate segment/members of Indian Society.

5.3.2.8: The Persons with Disabilities (Equal Opportunities, Full Participation and Protection of Rights) Act, 1995 – The Persons With Disabilities (PWD) Equal Opportunities, Protection of Rights and full Participation Act, 1995: The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 had come into enforcement on February 7, 1996. It is a significant step, which ensures equal opportunities for the people with disabilities and their full participation in the nation building. The Act provides for both the preventive and promotional aspects of rehabilitation like education, employment and vocational training, reservation, research and manpower development, creation of barrier-free environment, rehabilitation of persons with disability, unemployment allowance for the disabled, special insurance scheme for the disabled employees and establishment of homes for persons with severe disability etc.
5.3.2.9: National Policy on Disability (NPD): The National Policy on Disability which "marks a departure from earlier such policies as the thrust in it is on ensuring equal opportunities, rehabilitation and prevention facilities to the disabled". "The policy focuses on prevention of disabilities, rehabilitation measures, early detection and intervention, provision for supportive devices and development of rehabilitation professionals," he said. It also lays emphasis on education and economic empowerment through self-employment, creation of a barrier-free environment and social security. The other major highlights of the policy are promotion of teaching and research in the area of disability studies by setting up departments or centers of disability studies in colleges in university.

5.4: PHYSICAL POLICY MEASURES:

5.4.1: Scheme of assistance to voluntary organizations for the rehabilitation of leprosy cured persons: Under this scheme assistance is given to NGOs to provide information rehabilitation service regarding leprosy in the areas of awareness generation, early intervention, educational and vocational training, economic rehabilitation, social integration and community based rehabilitation. Assistance to the extent of 90% of the recurring and non-recurring expenditure is provided. Grant-in-aid for construction of building would not exceed Rs.7.5 lakhs.

5.4.2: Scheme of Assistance to Disabled Persons (ADIP) for purchase/fitting of aids/appliances: The scheme is implemented through the voluntary organizations. Aids and appliances which do not cost less than Rs. 50 and more than Rs. 6,000 are covered under this scheme. For persons with an income up to Rs 5,000 per month, full cost of the aid will be given and for persons with an income of Rs5,001 to Rs.8000. 50% of the cost of aid is given. Traveling costs and boarding and lodging expenses are also given to the
beneficiaries. The implementing agencies have to apply for grants under this scheme. The Ministry of Social Justice & Empowerment provides aids and appliances to PWDs under ADIP scheme on subsidized rate.

U/S-42 of PWD Act, 1995, the appropriate Government shall by notification make scheme to provide aids and appliances to persons with disabilities. U/S 48-C of PWD Act, 1995, the appropriate Government and local authorities shall promote and sponsor research, inter alia in the area of development; of assistive device including their psycho-social aspects.

5.4.3: Pulse Polio Immunization program: Polio is still prevalent in India countable on fingers. A national effort was made for total eradication of polio mellitus from India. "Pulse polio immunization is part of the national effort to eradicate polio". All the children below 6 years must receive the polio vaccine on the designated dates twice in a year.

5.5: ECONOMIC POLICY MEASURES: Being independent and self-reliant are dreams nurtured by every person with disability. Various income generating programs help them today so that they can come closer to the tomorrow of their dreams. In tune with its own objectives to enable people with disabilities to become productive members of the society and become self-sustainable.

5.5.1: National Employment Service Scheme: It was in 1959 that the Directorate General of Employment and Training in the Ministry of Labor which is the headquarters of the National Employment Service in India started extending their role in the field of rehabilitation of the disabled also. In that year the first Special Employment Exchange
for the Physically Handicapped was set up in Bombay. At present there are 40 special employment exchanges, for physically handicapped and 41 special cells. These exchanges have been following the placement techniques in referring and placing the handicapped in Government/salaried jobs.

**Employment:** Section-32 to 38 and Section-41, 48 (d) and 48 (e) of PWD Act, 1995 have various legal provisions regarding identification/reservation of posts, power of inspect record of any establishment, carried forward, interchange, maintenance of record of employer, schemes for ensuring employment and incentive to employers.

**5.5.2: Self-employment:** Section-40 (b) and 43 (f) of PWD Act, 1995 have statutory provision to promote self-employment possibilities of PWD. These provisions are;

**Section-40:** the appropriate Government and local authorities shall reserve not less than three per cent in poverty alleviation schemes for the benefit of PWD.

**Section-43:** The appropriate Government and local authorities shall by notification frame scheme in favor of PWDs for the preferential allotment of land at concessional rates for – sub-section (b): Setting up business. Sub-section (f): Establishment of factories by entrepreneurs with disabilities.

**5.5.3: National Handicapped Finance and Development Corporation (NHFDC) Scheme:** The Ministry of Social Justice & Empowerment has set up NHFDC on 24.1.97 under Section 25 of the Companies Act, 1956 as a non-profit Government company. NHFDC has an authorized share capital of Rs. 400 crores divided into 40 lakhs equity shares of Rs.1000 each and paid up capital of Rs. 200 crores. The entire equity is held by
the Government of India. The NHFDC routes its funds through its channelising agencies authorized by the State Governments. The outlay for giving loan assistance during the year 1998-99 was Rs.28 crores. During the second year of its operation the NHFDC sanctioned 101 projects disbursing loan amount of Rs. 62.90 lakhs. Wide variety of self employment projects are sanctioned through the State Channelising agencies.

The National Handicapped Finance and Development Corporation have been incorporated by the Ministry of Social Justice and Empowerment, Government of India to promote infrastructure development schemes directly leading to income generation. This corporation provides self-employment opportunities to the persons with disabilities by providing loans at very low rates of interest.

5.5.4: Schemes of the Ministry of Rural Areas & Employment: The Ministry of Rural Areas & Employment has the following schemes for poverty alleviation and economic rehabilitation of persons living in rural areas. In all the four schemes there is 3 percent reservation for persons with disabilities. Schemes are IRDP, TRYSEM, DWCRA AND JRY.

5.6: POLITICAL POLICY MEASURES:

5.6.1: Transport fare concessions:

5.6.1.1: Train Fare Concession: Train fare concessions are given to both PWD and their escorts. 75% fare concession to VH, MR, OH and 50% fare concession to HH is provided in general class, sleeper class, AC-III tier, AC chair car and ordinary 1st class. 50% fare concession in AC-1st and AC-IIInd is also extended from year 2001. 50% fare concession is given in season ticket. The fare concession is not allowed in Rajdhani and
Shatabdi Express. The Railway Ministry provides the following concessions to different categories of handicapped persons:

5.6.1.2: **Air Fare concession:** Indian Airlines Corporation allows 50% fare concession in domestic flights to PWDs, who are having 80% or more disability. Escort of PWDs, if any has to pay full fare. The loco-motor disabled are allowed to carry a pair of crutches, braces or any other prosthetic devices free of charge.

5.6.1.3: **Bus fare concession:** The State Government/Union Territories provide bus fare concessions to PWDs. The extent of concession and eligibility criteria vary from one state to other.

5.6.2: **Benefits for Disabled Government Employees:** Section – 47 (1) & 47 (2), 48 (c), 67 (1) & 67 (2) of PWD Act, 1995 have following provisions to safeguard the rights of disabled Government employees and to ensure equal rights/participation.

5.6.2.1: **Dispense & Reduction in Rank not allowed:** *section -47 (1):* No establishment shall dispense with, or reduce in rank, an employee, who acquires a disability during his service. Provided that, if an employee, after acquiring disability is not suitable for the post he was holding, could be shifted to some other post with same pay scale and service benefits. Provided further that if it is not possible to adjust the employee against any post, he may be kept on a super-numery post until a suitable post is available or he attains the age of superannuation, whichever is earlier.

5.6.2.2: **Promotion shall not be denied:** *Section-47 (2):* No promotion shall be denied to a person merely on the ground of his disability. Provided that the appropriate Government may, having regard to the type of work carried on in any establishment, by
notification and subject to such conditions, if any, as may be specified in such notification, exempt any establishment from the provision of this section.

5.6.2.3: **Research for assistive devices:** *Section-48 (c)*: The appropriate Government and local authorities shall promote and sponsor research, inter alia in the area of development of assistive devices including their psycho-social aspects.

5.6.2.4: **Insurance scheme:** *Section-67(2)*: Notwithstanding anything contained in this section, the appropriate Government may instead of framing an insurance scheme frame an alternative security scheme for its employees with disabilities.

5.6.2.5: **Reservation in Promotion:** When promotions are being made; (i) Within Group ‘D’, (ii) from Group ‘D’ to Group ‘C’, and (iii) within Group ‘C’. 3% reservation will be provided against identified post for the three categories (1% each VH, HH, OH).

5.6.2.6: **Posting/transfer near native place:** Group ‘C’ and ‘D’ disabled employees of Central Government, who have been recruited on regional basis, may be given posting, as far as possible, subject to administrative constraints, near their native places in the region. Request for transfer to or their native places may also be given preference. This scope has been extended to disabled employees in Group ‘A’, ‘B’, ‘C’ and ‘D’ vide D.O.P.T., O.M.No.AB-14017/16/2002-Estt. (Res), dated 13.2.2002.

5.6.2.7: **Posting/Transfer of non disabled employees having Mentally Retarded children:** Mentally retarded children need special care for medication, education, vocational training etc. which may not be available at all station. Ministries/Departments are requested to take sympathetic view on the merit of each case and accommodate such requests made by Government employee, who have Mentally Retarded children.
5.6.2.8: **Family pension to disabled children:** According to Rule-54 (6) of CCS (Pension) Rule'72, son or daughter of a Government servant suffering from any disorder or disability of mind or is physically crippled or disabled, the family pension shall be payable to such son or daughter for life subject to some conditions, given in aforesaid rule.

5.6.2.9: **Spouse can furnish details of handicapped children:** The spouse of the deceased pensioner/government servant has been allowed to submit detail of disabled children, which were not furnished by the later, to the pension sanctioning authority to settle such family pension cases.

5.6.2.10: **Transport Allowance:** Transport allowance at double the normal rates prescribed under Ministry of Finance O.M. even No. dated 3.10.97 shall be given to blind and orthopaedically handicapped.

5.6.2.11: **Traveling Allowance for Interview:** Traveling Allowance concession as admissible to SC/ST candidates called for interview and / or written test for appointment to Group ‘C’ and ‘D’ advertised post, recruitment to which is made departmentally (i.e. other than through the UPSC) are also admissible in the same scale to the handicapped ex-military personnel.

5.6.2.12: **Discretionary allotment of residential accommodation based on Supreme Court Directions:** Under the provision of SR 317-B-25, in relaxation of the rules, the Government may provide discretionary allotment of residential accommodation to serving employees on medical ground within the overall ceiling of 5% of all types. The allotment shall be made in the case of employees and their spouses, dependent children/parents suffering from T.B., Cancer, Hear ailments, blindness or low vision, Hearing impairment, loco-motor disability/cerebral palsy.
5.6.2.13: **Escort Allowed for LTC:** An escort is allowed to accompany a handicapped Government servant availing LTC.

5.6.2.14: **National Award for best employees:** The GOI, MSJ&E provided National Awards to 20 employees with disabilities. 4 Awards (one each VH, HH, OH, MR) are given to best employees which carry a cash award of Rs. 25,000/-, a citation, a certificate and a metal medal. In addition, 16 awards will be given in these categories which will carry a cash award of Rs. 15,000/-, a citation, a certificate and a metal medal each. Seven awards are reserved for women with disabilities. If no eligible women applicants are found or no applications are received from them, these awards will be given to the eligible/selected male applicants. The awards are given on 3rd December every year. The MSJ&E provides AC-I / AC-II class fare and lodging-boarding at New Delhi to awardees.

5.6.2.15: **Financial Assistance to UGC blind teachers:** UGC has made provision that the university should consider to make annual provision for Reader’s allowance of Rs.3000/- for purchase of Brailler, recorded material etc. for the blind teachers. The expenditure on this account can also be met out of the allocations made for books and journals/equipments under the development plan of the university so university can claim UGC assistance for such expenditure. The college affiliated to university may have some provisions.

5.6.2.16: **Income Tax exemption** (Rs.50, 000 & Rs. 75,000/- to PWD who are having moderate and severe disability respectively) is allowed to PWD assesses under Section-80U. the amount may be deducted from the total income of the assessee. Similar exemption has been allowed to parents/guardians of handicapped dependent (section-80DD). If any expenditure incurred towards treatment/maintenance and
rehabilitation of a dependent person with disability and/or any deposit made in any scheme framed in this behalf for providing payment of annuity or lump sum to handicapped dependent of the assessee this benefit can be availed by either PWD or the guardian/parents.

5.6.2.17: National award for the welfare of handicapped: The Government of India has instituted National Awards and conferred on the 3rd December every year on the World Day of the Disabled, by the President of India for

1. Best Employees with disabilities
2. Best Employees of persons with disabilities
3. Best Placement officers of persons with disabilities
4. Best individual award working for the cause of persons with disabilities
5. Best institution award working for the cause of persons with disabilities
6. Best Technological innovation in the cause of disabled & adaptability of innovation to provide cost-effective technology.
7. Outstanding & creative person with disability
8. Outstanding work done in the creation of barrier-free environment for PWDs.

5.6.2.18: Exclusive government institutions for PWDs: 20 Vocational Rehabilitation Centers (VRC), 23 Special Employment Exchanges, 6 National Institutes (NIVH, NIOH, NIMH, NIHH, IPH, and NIRTAR) and their regional centers, 11 District Rehabilitation Centers (DRC), 130 District Disability Rehabilitation Centers (DDRC), 4 Regional Rehabilitation Centers for persons with spinal injuries, 5 Composite Rehabilitation Centers (CRC), Artificial Limb Manufacturing Corporation (ALIMCO) and its five Regional Marketing/Auxiliary Production Centers, Rehabilitation Council of
India (RCI), National Handicapped Finance Development Corporation (NHFDC), Chief Commissioner for PWD (CCD), State Commissioners for PWD etc. are rendering rehabilitation & guidance service to PWD across the country.

5.7: SOCIAL POLICY MEASURES: The Government has taken cognizance of this discriminatory attitude and enforced numerous laws like the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995, but the movement acknowledges that things can change only if the community makes a commitment to treat PWD as their equals, to give them space, as for as in public to make their presents felt and provide them an opportunity to live life, building on their abilities rather than their disability.

5.7.1: Non-discrimination: Constitution of India: Article 15, says "prohibition of discrimination on grounds of religion, race caste, sex or place of birth" is abandoned.

According to PWD Act, 1995, chapter VIII, non-discrimination under sections 44-47, states statutory support against discrimination and focuses on non-discrimination towards persons with disabilities in various areas. It instructs the appropriate Governments to take special measures to ensure that in Rail compartments, Public places, etc.

Section 31A is a new addition to promote non-discrimination in employment. Section-44: Establishment in the transport sector shall, within the limits of their economic capacity and development for the benefit of PWD, take special measures to (a) adopt rail compartments, buses, vessels and aircraft in such a way as to permit easy
access to such persons (b) adopt toilets in rail compartments, vessels, aircrafts and waiting rooms in such a way as to permit the wheelchair user to use them conveniently.

Section-45: The appropriate Governments and the local authorities shall within the limits of their economic capacity and development, provide for – (a) installation of auditory signals at red lights in the public roads for the benefit of persons with visual handicap, (b) causing curb cuts and slopes to be made in pavements for the easy access of wheelchair users; (c) engraving on the surface of the zebra crossing for the blind or for persons with low vision; (d) engraving on the edges of railway platforms for the blind or for persons with low vision; (e) devising appropriate symbols of disability; (f) warning signals at appropriate places.

5.7.2: Social security: For the PWDs social security measures additionally aim to facilitate physical and vocational rehabilitation, protect against unemployment by allowances, creation of jobs and provision of benefits such as insurance, compensation, rehabilitation and maintenance of their dependents.

Article 43 of our constitution speaks of the responsibility of the states to provide social security to all the citizens of the country. Within the general provisions of the social security for various categories of the citizens specific measures have been spelt out for persons with disabilities.

Under chapter XII of the P.W.D Act of 1995, social security covers under section 66 to 68 which recognize the right of the disabled persons to rehabilitation insurance scheme, alternative security schemes and employment allowances.
5.7.2.1: Section 66A: Insurance schemes for persons with disabilities: The Finance Bill, 1999 as introduced in Lok Sabha on 27.2.99, bill no122 of 1999 has made the remarkable provisions. Section 80DD for sub-section (1) and 80 DDB of the Income-tax Act has provided several provisions to the disabled.

5.7.2.2: The Life Insurance Corporation of India already has a scheme named Jeevan Adhar while Unit Trust of India had announced similar scheme under Children’s Growth Fund.

5.8: EDUCATIONAL POLICY MEASURES:

5.8.1: The PWD Act, 1995: It says that children with disabilities are to get free education by appropriate government and local authorities and to ensure that every child with a disability has access to free education in an appropriate environment till he attains the age of eighteen years.

In the PWD Act, section 26 is proposed about education. The appropriate Government and the local authorities shall ensure that every child with disabilities (CWDs) has access to free education and appropriate environment till he attains the age of 18 years—promote the integration of CWDs in normal schools—promote setting up of special schools in Government and private sector—to equip the special schools for CWDs with

Section 26 A: has proposed reservation of seats in educational institutions. Section 26 B: has a proposed reservation in hostels. Sections 26 C and 26E have proposed reservation in technical education programs. Sections 26D, 26F and 26G are new provisions proposed to protect the rights of people with disabilities.
deals with concessions, adaptations in curriculum and examination system. **Section 27** is proposed to be amended to include wide variety of support required by people with disability which by and large has already been provided by the State Governments. **Section-28:** The appropriate Government shall initiate research for designing and developing new assistive devices, teaching aid. **Section -29,** says the appropriate Government to set up teachers training institutes to develop training manpower to CWDs. **Section-30:** Without Prejudice to the foregoing provisions, the appropriate Government shall by notification prepare a comprehensive education scheme. **Section- 31** says, All educational institutions shall provide or cause to be provided amanuensis to blind students and students with low vision. **Section -39** of PWD Act 1995 provides that all Government educational institutions and other educational institutions receiving aid from Government, shall reserve not less than three percent seats for PWD. Accordingly 3% reservation of seats in education, vocational training, professional course, apprenticeship training and higher education have been provided to PWD.

**5.8.2: National Education Policy:** The National Education Policy has advocated free education to children in the age group of 6 – 14 years.

**5.8.3: Constitution of India:** **Article 41** says “Right to work, to education and to public assistance in certain cases.” The State shall, within the limits of its economic capacity and development, make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want.
5.8.4: **Sarva Shiksha Abhiyan:** The nationwide Sarva Shiksha Abhiyan (SSA) is the flagship program of Government of India instituted 'for the achievement of Universalization of Elementary Education'.

5.8.5: **Scheme of assistance to organizations for the disabled persons, 1987:** Under this scheme, assistance is provided for developing services for the disabled for education and training, prevention, detection and rehabilitation of disabilities.

5.8.6: **Scheme of assistance to voluntary organizations for special schools for the handicapped children:** Assistance under this scheme is given for setting up of new special schools and assistance under this scheme is given up to 90% of expenditure for salary of teaching/non teaching staff, boarding and lodging to hostellers, rent of building, construction of building, purchase of equipment /furniture, books, stationery, water, electricity etc

5.8.7: **Scheme of assistance to organizations for persons with cerebral palsy and mental retardation:** Under this scheme 90% assistance is given to social welfare organizations providing services of identification, treatment, rehabilitation etc., in the field of cerebral palsy and mental retardation for purchase of furniture, equipment, books, journals, salaries and allowances for the staff and maintenance charges of hostel. For construction of building maximum of Rs.7.5 lakhs is given.

5.8.8: **Other Facilities:**

- The Government of India provides Rs.1000/- P.M. scholarship and tuition fee of Rs. 12,000/- per annum whichever is less, for pursuing higher education.
- 50 selected polytechnics across the country are imparting formal and non-formal training (3 years Engineering Diploma and short duration; 3-6 months;
vocational /skill development training) to PWD free of cost under MHRD scheme. The PWD are provided scholarship, traveling allowance, books and uniform allowance, tool kits/escort & mid-day food allowance and free hostel facilities.

- The State Governments/Union Territories provide scholarship to disabled students from Class-1 to Post Graduation level and for vocational training / professional courses.
- There is special component (Rs.1200/- per annum per PWD) for PWD in Sarva Shikshya Abhiyan to ensure 100% enrolment.
- There are special schools for severe & profound categories of PWD, either run by the Government or financially supported by the Government.
- 3% seats in education, training (ITI, Polytechnic, Apprenticeship training, CT/B.Ed. etc) professional courses (Engineering, Medical, MCA, MBA etc.) have been reserved for PWD.
- A writer has been allowed for blind students to write their answer in examinations. Similar facilities have been provided to loco-motor disabled who are unable to write.
- Various kinds of facilities like books, uniform, reader’s allowance to VH, transport allowance to loco-motor students is provided under integrated education scheme for disabled.

5.9. Testing of Hypothesis: The present study has very few important hypotheses. One of them is “Social, Economical, Political, Psychological, Administrative policies and versatile development of disabled are related.” This hypothesis is ‘reformulated’ as “Causes of social discrimination and rehabilitation policies are interrelated OR Policies and development of disabled are related.” This hypothesis is tested in the following circumstances. One side there is parameters of discrimination and another side it has nature of economic rehabilitation.

The following table and graph clearly show the relationship between the cause of social discrimination and major economic rehabilitation aspects such as private job, government job, temporary job, self-employment, etc., 185 respondents are unemployed. They need unemployment eradication policies.
Table: 05.06 Statement of cross-tabulation of cause of social discrimination and seeking economic rehabilitation.

<table>
<thead>
<tr>
<th>Causes of social discrimination</th>
<th>Seeking economic rehabilitation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Private job</td>
</tr>
<tr>
<td>Social inequality</td>
<td>10</td>
</tr>
<tr>
<td>Poverty</td>
<td>14</td>
</tr>
<tr>
<td>Human physical disfigure</td>
<td>4</td>
</tr>
<tr>
<td>Disfigure</td>
<td>7</td>
</tr>
<tr>
<td>Physical disability</td>
<td>8</td>
</tr>
<tr>
<td>Physical attributes</td>
<td>9</td>
</tr>
<tr>
<td>Self devaluation</td>
<td>10</td>
</tr>
<tr>
<td>Lower status position labels</td>
<td>17</td>
</tr>
<tr>
<td>Others</td>
<td>2</td>
</tr>
<tr>
<td>Can't say</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>97</td>
</tr>
</tbody>
</table>

Table: 05.07 Chi-Square test of cross-tabulation of cause of social discrimination and seeking economic rehabilitation.

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>84.366*</td>
<td>40</td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>400</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 24 cells (43.6%) have expected count less than 5. The minimum expected count is .44.

There is statistically significance between the cause of social discrimination and economic rehabilitation. Poverty, physical disability, disfigures and other factors of cause of disability must be mainly taken in to consideration of economic rehabilitation. The related Chi-Square has 40 df. and the P- Value is 0.00. So the P- Value is highly significant.
The following table and Chi-Square test shows that the respondents have ideas to give suggestions to bring social rehabilitation.

Table: 05.08
Statement of means of social rehabilitation against the suggestions of respondents

<table>
<thead>
<tr>
<th>Social rehabilitation</th>
<th>Counseling</th>
<th>Health education</th>
<th>Domiciliary rehabilitation</th>
<th>Re-settlement</th>
<th>Barrier free facilities</th>
<th>Others</th>
<th>None</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents should be educated</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Society should be educated</td>
<td>14</td>
<td>1</td>
<td>32</td>
<td>2</td>
<td>2</td>
<td>25</td>
<td>13</td>
<td>89</td>
</tr>
<tr>
<td>Disabled rights implemented</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Strain legislation required</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Introduced in school syllabus</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>9</td>
<td>18</td>
<td>108</td>
</tr>
<tr>
<td>Social equality required</td>
<td>3</td>
<td>0</td>
<td>2</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Opportunities provided</td>
<td>1</td>
<td>0</td>
<td>5</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Full participation in society</td>
<td>2</td>
<td>7</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>7</td>
<td>4</td>
<td>37</td>
</tr>
<tr>
<td>Some</td>
<td>9</td>
<td>1</td>
<td>9</td>
<td>16</td>
<td>16</td>
<td>108</td>
<td>18</td>
<td>23</td>
</tr>
<tr>
<td>All</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>Others</td>
<td>46</td>
<td>0</td>
<td>33</td>
<td>19</td>
<td>20</td>
<td>83</td>
<td>67</td>
<td>400</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>89</td>
<td>23</td>
<td>15</td>
<td>23</td>
<td>18</td>
<td>33</td>
<td>19</td>
</tr>
</tbody>
</table>

Table: 5.09
Chi-Square test of means of social rehabilitation against the suggestions of respondents

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>198.997*</td>
<td>60</td>
<td>.000</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>400</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 53 cells (68.8%) have expected count less than 5. The minimum expected count is .08.
The above Chi-Square Test shows that total valid cases clearly indicate that the social rehabilitation is possible through some valuable efforts like educating parents, educating society, implementing the rights of disabled, introducing equality thought in school text books, full participation of the respondents in social activities etc. The df. is 60, and P-Value is 0.00. Therefore the statement is highly significant.

5.10: REFERENCES:

7. ibid.
17. block-2, IGNOU, introduction to social work, BSWE-001, p-13.
18. ibid.
28. ibid.
29. ibid, P-3.
30. ibid, P-4.
33. ibid.
34. ibid, P-1-2.
35. ibid, P-2
36. ibid
37. ibid, P-2-3.
38. ibid, P-3
39. ibid.
41. ibid, P-9.
42. ibid, P-10, 11.