CHAPTER - II

CONCEPTS AND REVIEW OF RELATED LITERATURE

INTRODUCTION

Many studies are conducted to understand the situation of the people with disability, particularly to observe the quality of life of the people with disability population. Possible comparisons of the collected reviews supported the research findings to project its outcomes in unique dimension. The summary of related literature promotes and understanding of the problem and avoids unnecessary duplication. It helps the researcher to make a chance to gain an insight into methods, measures, subjects and approaches employed by other research work which in turn will lead to significant improvements of his/her own research design. In this chapter deals with the concepts and the researcher has attempted to note down some points which are relevant to the study on previous literature and a theoretical overview of the study.

CONCEPTS

Disability Definition

The Disability Act 2005 set out the following definition: “disability”, in relation to a person, means a substantial restriction in the capacity of the person to carry on a profession, business or occupation in the State or to participate in social or cultural life in the State by reason of an enduring physical, sensory, mental health or intellectual impairment.
Different types of disabilities

**Locomotor Disability:** Locomotor disability is defined as the person’s inability to execute distinctive activities associated with moving both himself and the objects, from place to place and such inability resulting from affliction of musculoskeletal and/or nervous system.

**Visual Disability:** Visual Disability or Blindness refers to a person’s inability to see either fully or partially. A visually disabled person is known to be suffering from visual impairment.

**Mental Illness:** Mental illness can include both mental ill health and retardation. Mental retardation is defined as a state of arrested or incomplete development of the mind, which is specially characterized by impairment of skills manifested during the development period which contribute to the overall level of intelligence, i.e., cognitive language, motor and social abilities.

**Speech and Hearing Disability:** Speech and Hearing Disability is referred to a condition wherein the person is incapable of speaking and hearing any sound.

**Learning Disability:** Learning disability is a disorder, which affects the basic psychological processes of understanding or using written or spoken language. This disorder affects the development of language, speech, and reading and associated communication skills needed for social interaction.
**Women with disabilities:** Women with disabilities are often denied equal enjoyment of their human rights, in particular by virtue of the lesser status ascribed to them by tradition and custom, or as a result of overt or covert discrimination.

**Quality of life (QOL):** is the general well-being of individuals and societies, outlining negative and positive features of life. It observes life satisfaction, including everything from physical health, family, education, employment, wealth, religious beliefs, finance and the environment.

**REVIEW OF LITERATURE**

*Ojanuga and Gilbert (1992)* viewed that women in developing countries are frequently confronted with a myriad of socio-cultural factors which negatively impose upon physical well-being and accessibility to appropriate health care services. Institutional, economic, and educational barriers effect lowers their standard of living when compared to their male counterparts.

When focusing on the Indian context, *Vora, et al., (2009)* contended that the status of women is commonly low, except in the southern and eastern states. However, *Tahu (2010)* viewed positively that the women’s condition in northeastern are much better than the women in north and south states in the dimensions of freedom in mobility, no dowry system, no killings in the name of dowry, no female infanticide and cultural acceptance for women remarriage. But with a dent, Tahu asserted that despite all these privileges, the women of the northeastern States are forbidden to enjoy many rights.
Govindsamy and Ramesh (1997) opined that southern women typically enjoy greater freedom, an outcome of the Dravidian culture, and higher levels of literacy, education and employment, whereas, northern women are strongly subjected to the traditional conservatism and predominantly illiterate, less educated, and less likely to work outside the home. Bose and Trent (2006) disclosed that the data from the 1998–99 National Family Health Survey (NFHS-2) of India illustrated that southern women have relatively higher levels of literacy and labour force participation, lower levels of son preference, and smaller family size.

In Indian society, women have three roles – premarital status role (daughter), familial status role and extra-familial status role. The familial status role is categorized into three aspects – (i) as a wife – marital relation role, (ii) as a housewife – in regulative role and (iii) as a mother – socialize. The extra-familial roles are (i) status role in work situation and (ii) role orientation in corporate life (Chakrapani & Kumar, 1994).

Women are in an especially paradoxical situation. As per a government report, most Indian women belong to a single largest group of backward citizens, who suffer multible discrimination because they are both female and poor (Bumiller, 1991).

Chaudary and Nosheen (2009) observed that the status of women is much more vulnerable in rural and tribal areas and they have very limited access to all basic facilities. Noreen (2011) viewed that the older women have more independence and empowerment than the younger women as they have more experience with life, a better understanding of how to get what they want. Solomon and Adekoya (2006)
stated that older women generally have greater involvement in decision making within family than the younger women. However younger women also begin to participate in decision making when they are older.

Gender roles are affected by age, disability, class, race, ethnicity and religion, and by the geographical, economic and political environment (UNESCO, 2000). Women with disabilities experience violence, particularly family violence and violence in institutions, more often than disabled men (Meekosha, 2004). Women and girls with disabilities are often at greater risk than disabled men, both within and outside the home, of violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation (United Nations, 2006).

Among the disabled community, there is a large group of people who are even more disadvantaged and oppressed, mainly women and girls with disabilities from poor and marginalised families (Ghosh, 2004). Dixit (1998) argued that the rights created by constitutional and legal provisions have been treated as an end in themselves instead of means. They have created an illusion of equality and power, which is frequently used as an argument to resist special protective and acceleratory measures to enable women with disabilities to achieve their just and equal position in society.

Shakeela and Geetha (2004) viewed that a disabled man can easily access to public places. However, for a disabled woman owing to her disability and the negative cultural values on women, she finds difficult to access to public places. The
hostile attitude towards women in general thus thrusts the disabled women to a greater disadvantage and social isolation.

Sexual violence against disabled women is rampant, both within family and society (Sengupta and Mandal, 2013). Disabled women are most vulnerable at risk within their homes, not just because of their disability but because of gendered/abilist ideologies that consider them to be asexual and family members would rather deny and hide such instances rather than highlight them (Swabhiman, 2005).

Gosh (2015) strongly argued that the disempowerment of disabled women is further enforced by state mechanisms, which guided by dominant social constructions, legitimize and yet ignore the systematic and systemic violence meted out to disabled women. The stigma attached to both sexuality and disability ensure most often that voices remain silent or are silenced not only by patriarchal socio-cultural ideologies but also by overt state responses to address violence and discrimination against disabled women.

Edwardraj, Mumtaj, et al. (2010) explored people's cultural beliefs and attitudes about intellectual disability, perceived needs and burden associated with care in Vellore, south India. A qualitative methodology using focus groups was employed. Eight focus groups were conducted in three settings and included the mothers of children and adolescents with intellectual disability, community health workers and school teachers. The cultural and religious beliefs perpetuated negative attitudes towards disability. This meant that caregivers bore a high burden of care with little support from family or society. The study confirmed the presence of diverse, multiple
and contradictory models of disability drawing from biomedical and local religious, social and cultural constructs.

**Hiranandani and Sonpal (2010)** examined the implications of economic restructuring in the arenas of social programs, education, employment, accessibility, health, agriculture and food security, and water and land acquisition from a disability perspective. The analysis showed that while increased employment opportunities and accessibility have benefitted middle-class and highly-skilled disabled persons, the majority of people with disabilities have been left out of India's economic affluence. The authors contended that India's globalized economy and reduced state role necessitate renewed understanding of human rights, including disability rights.

**Kulkarni and Lengnick (2011)** examined how people with disabilities (PWD) viewed various aspects of their socialization process. Specifically, we looked at the role of coworkers, supervisors, organizational practices, and employee proactive behaviors in influencing organizational integration. The result showed that integration was most influenced by coworkers and supervisors. Organizational practices and employee proactive behaviors were less important. Respondent’s gender and tenure also influenced certain findings. Specifically, PWD with less tenure sought and accepted more help from coworkers and supervisors. Further, more men with disabilities than women with disabilities indicated that they were proactive in terms of obtaining training to make themselves employable, and more men with disabilities indicated that having coworkers with a disability helped them during socialization.
Denton, et al. (2012) found that persons with disability who involuntarily retire have lower median personal and household incomes and they are more likely to be under the low-income cut-off point than those who retire voluntarily. When socio-demographic, socio-economic and geographical characteristics are controlled; those who retired involuntarily are more likely to be under the low-income cut-off point than those whose retirement was voluntary. Added this, those who retired involuntarily are more likely to receive disability benefits whereas those who retired voluntarily are more likely to receive retirement income.

Jones (2011) observed that after controlling for a range of personal characteristics, the type, severity, duration and cause of the disability are found to be important determinants of employment, but there is less evidence to support the influence of within group heterogeneity on earnings.

Parish, Rose, et al. (2009) found that women with disabilities experience such hardships as food insecurity, housing instability, inadequate health care, and loss of phone service at rates that are higher than those among nondisabled women. Rates of hardship remain higher even after adjusting for a host of individual characteristics, including marital status, age, race, and education. Although hardship declines as incomes rise for all women, those with disabilities show worse outcomes at every income level and experience substantial levels of hardship well into the middle and upper income ranges.

the period 1995–2001 for 13 European countries, found that self-employment provides flexibility and a better adjustment between disability status and working life. Moreover, the levels of satisfaction with job, type of job and working conditions of self-employed disabled people are higher than those reported by disabled people who are wage and salary earners.

Jones (2008) reported that regardless of country, data source or time period disability serves to reduce labour market prospects. Understanding the reasons for this requires consideration of issues such as separating discrimination from unobserved differences in productivity and preferences, the influence of heterogeneity within the disabled group and the dynamic effects of disability.

Kidd, et al. (2000) examined to what extent differences in labour market outcomes between able-bodied and disabled men may be attributed to differences in endowments of human capital and associated productivity differences. Both labour force participation and selectivity corrected human capital equations are estimated and decomposition techniques applied to them.

Lechner, et al. (2011) found that reduction of individual employment chances of about 9 to 13%, the level depending on the degree of disability. The study results indicate that no statistically significant evidence for a reduction in income or an increase in unemployment due to disability.

Malo and Pagan (2007) found that in most of the European countries there exists a wage differential in favour of people with disabilities not limited for daily activities compared to people without disabilities, especially for males, whereby the
unexplained component contributes to raise this wage differential. The outcomes confirmed that in general wage differentials against people with disabilities are related with unobserved productivity differences and not only with employers' prejudices.

**Malo and Bullon (2006)** evaluated the influence that employment promotion measures and labour market intermediation services addressed to disabled individuals have on the latter’s quality of the job match through the use of matching analysis techniques. The study findings indicated that those measures do not improve the quality of the job match.

**Doucouliagos, et al. (2006)** found that some differences exist in the rate of promotion on the basis of gender, and to a lesser extent, of birthplace, but, importantly, most of these are due to differences in endowments. There are effectively no differences in promotion on the basis of disability. We find that the main driver of promotion in Victorian public sector labor markets is worker effort and performance. Compared to labor markets elsewhere, the Australian public sector is relatively free of discrimination in promotions.

**Claudia Malacrida (2009)** examined the contradictions and tensions embedded in disabled mothers’ performances of ideal motherhood, drawing on qualitative interviews with 43 Canadian mothers with a variety of disabilities. Despite these barriers, however, women with disabilities go to creative and extraordinary lengths in order to be seen as complying with ideal motherhood, perhaps as a way to lay claim to a maternal and sexual identity that society frequently denies them. The experiences of mothers with disabilities as they negotiate the tensions of ideal
motherhood permit us to see the challenges this construct poses for all women, and thus they call for a feminist politics that will challenge this ideal and work for change in the lived experiences of mothering.

**Lewis (2004)** reported that the multiple barriers facing women with disabilities who wish to obtain microfinance are outlined. Research from Zambia and Zimbabwe highlighted key issues facing disabled business women, and recommendations are made that would enable development organisations to mainstream the experience and analysis of disabled women into their programmes.

**Kiani (2009)** conducted a study to explore the experiences of women with disabilities in the North West province in both urban and rural areas. The findings of the study illustrate that women faced both physical and attitudinal barriers, lived in poverty and felt that they lacked opportunities for gaining an education, finding employment and forming meaningful social ties. There was significant complexity of relationships, marriage and children in their lives. Participants generated ideas on changes that needed to be made for the betterment of their lives.

**Souza, et al. (2012)** analysed the organization of daily life among women with disabilities in Belo Horizonte, Brazil, from the perspective of temporality. The study results indicated that although the daily lives of these women are hampered by their functional limitations, their lives are also directly influenced by their physical and social contexts and their attitudes.

**Cramm and Finkenflügel (2008)** reported that people with disabilities are barred from microcredit schemes. They concluded that most of the researchers
recommend inclusion of people with disabilities in mainstream institutional credit schemes. Some also recommend self-help schemes. However, the self-exclusion, exclusion by others, exclusion by staff and exclusion by design are all present, within both the institutional scheme and self-help scheme. Independent implementation of ad hoc schemes seems as a second best solution, which should only be chosen if inclusion within mainstream microcredit is not possible.

Anda, et al (2001) found the perspectives of people with significant physical disabilities regarding factors that have facilitated and hindered the development of a positive self-concept, participation in the broader society, and the formation of interpersonal relationships. Results of the study revealed that females reported the influence of significant others most often, and males the effectiveness of their personality characteristics. Societal barriers, both practical and attitudinal, were reported along with the process for developing a positive self-perception despite these.

Redmond, et al. (2012) reported that the disability identification predicted greater use of collective strategies, and higher collective and personal self-esteem, controlling for visibility and proportion of lifetime with disability. These findings support the prediction from social identity theory that group identification may be self-protective. Findings also supported the sociopolitical model within disability studies, providing theory-based empirical evidence that working for social change empowers both one's group and oneself.
**Campen and Cardol (2009)** reported that the relationship between happiness and work is different for people with a chronic illness and a physical disability, as compared to the other two populations. Fewer people with a chronic illness and disability were categorized as ‘satisfied people with work’ (i.e. participating in work and satisfied with their life), while most people belonged to a group of ‘satisfied people without work’ and, surprisingly, not to the expected group of ‘dissatisfied people without work’.

**Dijkvan (2010)** stated that the most outstanding work-related problems were psychosocial, including work home interference and a lack of acceptance of the chronic disease. Performing and finishing work tasks and social relationships with supervisors or colleagues were also felt to be slightly problematic. The most preferred work accommodations included fewer work hours, working from home, a slower work pace and more autonomy in planning work tasks.

In a cross-sectional study conducted among young adults aged 16–28 years (n = 45) with physical and complex disabilities, **Bent, et al. (2001)** indicated that the most important predictors of participation were energy and pain (NHP), disability and self-efficacy. Most of the health status measures were able to discriminate between disabled and nondisabled young people, but some measures lacked face validity for the ‘nonwalking’ disabled group. They concluded that both health status and psychosocial factors were found to impact on the participation of young people.

**Duvdevany (2010)** found that a significant moderating effect of marital status on the association between self-esteem and perceived quality of life only among
women with physical disabilities. In cases in which the general self-esteem level was the same, the perceived quality of life score was higher among married women with physical disabilities than among single women.

Kou and Feinstein (2011) examined the demographic, neurological, neuropsychological, and personality factors associated with unemployment of mental sclerosis. The findings of the study revealed that unemployment was associated with a progressive disease course, longer disease duration, and being female. While Global Cognitive Impairment did not differentiate between groups, unemployed patients scored significantly lower on three of five indices. Furthermore, a strong association was found between unemployment and the personality construct “agreeableness”, and severity of depression.

Tribe and McDonald (2010) indicated that men were more likely than women to leave their employment because of their mental sclerosis (MS), and older people were more likely than younger ones to do so. Level of occupational skill using Australian Bureau of Statistics categorisation was not predictive of maintaining or losing employment. They reported the main reasons for their loss of employment involved the ineffective management of symptoms of MS in the workplace, rather than workplace-related factors including insufficient flexibility of employment conditions or being asked to leave or sacked. The most frequently listed symptoms relating to employment loss, and perceived risk of losing current employment, were fatigue, mobility-related symptoms, arm and hand difficulties, and cognitive deficits.
Julian, et al. (2008) reported that specific problems in mobility, hand function, fatigue, and cognitive performance domains were associated with increased odds of becoming unemployed. Less severe problems in similar areas, including mobility, hand function, and cognitive functioning were also predictive of work initiation among patients not employed. The findings also highlighted that MS is associated with high rates of unemployment. Specific physical and mental health limitations confer risk of employment cessation over time, as well as the likelihood of employment initiation.

Alur (2001) viewed that although India addresses diversity in many ways it tends to exclude people with disability from national programmes. It argues that inclusive education should be context and culture-specific and that inclusive programmes can develop, albeit incrementally, despite the fact that systemic change has not taken place. The author suggested that moral and ethical considerations demand that people engaged with inclusion need to work towards inclusion of all children wherever necessary and that each individual first of all needs to internalize the change within themselves.

Sharma (2001) viewed that people, including parents and school personnel, are largely unaware of the full intent of the recent legislation passed by Indian Parliament. A large number of school personnel are also not aware of funding available to include students with disabilities in regular schools. There is some evidence that those educators who are knowledgeable about government policies and laws concerning integrated education tend to have positive attitudes toward implementing such programs. There is also evidence when parents are knowledgeable
and supportive of integrated education, they tend to have a positive effect on school personnel.

**Parasuram (2006)** investigated whether variable background characteristics such as age, gender, income level, education levels, years of teaching experience, acquaintance with a person with a disability, having a family member with a disability, frequency of contact and closeness to a person with disability affect the attitudes of teachers towards people with disabilities and towards inclusion of students with disabilities into regular schools. The analysis revealed that while some of the variables of interest did affect teachers’ attitudes towards disabilities, the only variable that affected teachers’ attitudes towards inclusion was prior acquaintance with a person with disability.

**Eleweke and Rodda (2002)** estimated that the majority of the world's population of people with disabilities live in developing countries of Africa, Asia, Latin America, Caribbean and the Middle East, some 150 million of them being children, but less than 2% are receiving any form of rehabilitation service. Thus successful implementation of inclusive education could increase the number of those with disabilities receiving educational and other services in developing countries. Evidence, however, indicated that inclusive education is not being satisfactorily implemented in most developing countries. Factors such as the absence of support services, relevant materials, inadequate personnel training programmes, lack of funding structure and the absence of enabling legislation are the major problems of effective implementation of inclusive education in these countries.
Sullivan and Knutson (2000) jointly conducted a population-based epidemiological study among a population of children identified as a function of an existing disability. They observed that children with disabilities are 3.4 times more likely to be maltreated than nondisabled peers.

In the study among women with cerebral palsy, Freeborn and Curry (2009) explained about the mistreatment experienced by women with cerebral palsy. The outcomes of mistreatment were divided into emotional, social, and physical outcomes. They highlighted that the health care providers need to understand the meaning and outcomes of mistreatment in their patients' lives to begin to address mistreatment, listen to patients, advocate when needed, and provide appropriate health care.

Manning and Emily (2012) described the prevalence of physical abuse before and during pregnancy among a representative sample of Massachusetts women with and without disabilities. Data from the 2007–2008 Massachusetts Pregnancy Risk Assessment Monitoring System (PRAMS) were analyzed in 2010. Multivariate analyses indicated that women with disabilities were more likely to report physical abuse before pregnancy, during pregnancy, or during either time period than women without disabilities while controlling for maternal age, education, race, marital status and household poverty status. No difference was observed by disability status in the likelihood of prenatal-care providers talking to women about physical abuse. These analyses reveal disproportionate prevalence of physical abuse before and during pregnancy among women with disabilities.
Yen, et al. (2009) reported that the rate of increase of sexual assault reported among people with disabilities was 2.7 times that of the general population during the period of 2002–2007. Intellectually disabled persons accounted for the largest proportion of reported sexual assault cases among the disabled, followed by persons with chronic psychosis, who accounted for one-third of the reported sexual assault cases among the disabled population.

Martin, et al. (2008) observed that women with severe disability impairments were four times more likely to be sexually assaulted than women with no reported disabilities. Little difference in the risk of sexual assault was found between women with moderate disability impairments and those reporting no disabilities. Women with severe and moderate disability impairments were at greater risk, although not quite significantly so, of physical-only assault than were women without a disability. Women with disabilities who have severely limit activities of daily living are at increased risk of sexual assault.

Ballan and Freyer (2012) stated that women with disabilities are frequent victims of domestic violence. Barriers to self-protection against domestic violence for women with diverse disabilities are highlighted and the use of nonfatal force as self-defense is explored.

Plummer and Findley (2012) studied the physical and sexual abuses of women with disabilities. They reported that the rate of abuse of women with disabilities is similar or higher compared to the general population, there continues to be a lack of attention to this issue. Women with disabilities are at particularly high
risk of abuse, both through typical forms of violence (physical, sexual, and emotional) and those that target one’s disability.

**McRee and Halpern (2011)** examined associations between unwanted sexual experiences and both physical disability and cognitive performance in a nationally representative sample of young adults. They used data from 11,878 participants (ages 26–32) in Waves I, III, and IV of the National Longitudinal Study of Adolescent Health. Logistic regressions determined associations between physical disability and level of cognitive performance (using a modified Peabody Picture Vocabulary Test) and the odds of experiencing physically forced and non-physically coerced sex. Approximately 24% of females and 4% of males reported unwanted sexual experiences. Compared to respondents without disabilities, females with a physical disability had greater odds of experiencing forced sex, while males with a physical disability had greater odds of coerced sex. Compared to those with average cognitive performance scores, females with scores above 110 had slightly higher odds of coerced sex.

**Lund (2011)** studied community-based services and interventions for adults with disabilities who have experienced interpersonal violence. They reported that the services articles revealed a noticeable disconnect between the violence services programs perceived accessibility and the perception of their accessibility in the disability community. Most of the intervention and prevention focused exclusively on abuse prevention for adults with intellectual disabilities and generally had small samples and lacked controlled conditions.
**Foster and Sandel (2008)** reported that abuse of women with disabilities is a significant societal problem of which practitioners, service providers, and other professionals must be aware, respond to, and work to alleviate. Practitioners in most settings will encounter client systems impacted by disability, and many of their clients might be victims of abuse.

**Slayter (2009)** conducted a study on “Intimate Partner Violence Against Women with Disabilities: Implications for Disability Service System Case Management Practice”. The result showed that women with disabilities were less likely to report past-year intimate partner violence in the form of verbal abuse, but more likely to report threats and physical violence.

In the study of domestic violence and individuals with disabilities, **Baladerian (2009)** showed that special attention is given to the unique issues of individuals with disabilities, and a call for the domestic violence field to embrace the needs of the 15 percent of the population. Collaboration and coalition building are noted as essential ingredients in addressing the needs of all members of disabled communities.

**Smith and Fadden (2005)** projected that women ever experiencing intimate partner violence (IPV) were more likely to report a disability due to generalized chronic pain and mental illness. IPV-related injuries were associated in a dose-dependent manner with having any disability and with disability from chronic pain, asthma and other respiratory diseases, mental illness, and chronic diseases.

**Lin, et al. (2010)** stated that people with voice or speech disability, chronic psychosis and intellectual disability were the most domestic violence reported
prevalence among the disabilities. The person with chronic psychosis, intellectual disability, vision disability, hearing disability and multi-disabilities show increased significantly in annual reported rate in curve estimation for linear model over the period of 2006–2009.

**Hughes, et al. (2006)** examined experiences of physical, sexual, and disability-related abuse within the past year and its associations with demographic, disability, and psychosocial characteristics in a sample of 415 predominantly minority women with physical disabilities recruited from private and public specialty outpatient clinics. The result showed that women with disabilities who were younger, more educated, less mobile, more socially isolated, and who had higher levels of depression may have a higher likelihood of having experienced abuse in the past year. This model correctly identified 84% of the abused women with disabilities.

**Gill (2010)** deconstructed the complex notions of competence as denying individuals’ legal recognition of their capacity for sexual expression. Most damaging perhaps is that, when individuals with intellectual disabilities, women especially, are seen as being vulnerable or at risk for sexual abuse, the perceived vulnerability acts as a mechanism to deny their sexual desire.

**Oschwald et al. (2011)** studied the experiences of crime victims with disabilities and barriers they faced when reporting crime. Fifty-two adults with disabilities whose interpersonal violence was reported to law enforcement participated in focus groups investigating their experiences and recommendations. Participants identified barriers and improvement strategies related to disability identification and
disclosure, victim involvement and blaming, credibility and misunderstandings, communication challenges, and accommodations. Barriers exist for people with disabilities navigating the criminal justice system.

Srinivasa Murthy et al. (2005) assessed the costs and effects of a community outreach program for untreated schizophrenia patients in a rural community. They recruited 100 cases and provided appropriate psychotropic medication and psychosocial support. They also assessed every three months over one and a half years on symptomatology, disability, family burden, resource use and costs. The results showed that summary scores of disability along with psychotic symptoms and family burden were all reduced over the follow-up period. These were also accompanied by reductions in the costs of informal-care sector visits and family care-giving time.

Deepak (2003) discussed the strategies for answering the rehabilitation needs of persons with leprosy related disabilities in integrated settings through Primary Health Care (PHC) services and Community Based Rehabilitation (CBR). While the provision of rehabilitation services through the PHC system remains problematic in most developing countries. The CBR programmes have potential for rehabilitation of leprosy affected persons in integrated settings. However, the limited coverage of CBR programmes may pose an obstacle to such an approach.

Yip and Mahal (2008) stated that both China and India have recently committed to injecting new public funds into health care. Both countries have decided how best to channel the additional funds to produce benefits for their populations. The
authors analysed how well the health care systems of China and India have performed and what determines their performance. Based on the analysis, they suggested that money alone, channeled through insurance and infrastructure strengthening is inadequate to address the current problems of unaffordable health care and heavy financial risk, and the future challenges posed by aging populations that are increasingly affected by non-communicable diseases.

Phillips, et al (2005) conducted a study based on secondary analysis of data derived from three qualitative studies of abuse of women with disabilities. They reported that Invalidation as a central process underlying maltreatment. Invalidation was characterized by health care providers Taking Over care, Discounting, Objectifying, and Hurting women with disabilities during health care encounters. The findings also highlighted the need to educate health care providers about social and interpersonal aspects of disability and address the problem of invalidation in health care settings.

Groce and Bakshi (2011) argued that while inclusive education efforts for children are important, more attention also needs to be directed to provide literacy skills to illiterate and marginally literate disabled adolescents and adults. A concerted effort to improve access to basic literacy and numeracy skills through both inclusion in general adult literacy programmes and disability-specific adult literacy programmes is urgently needed to reach the goals for education and poverty eradication established by the new United Nations Convention on the Rights of Persons with Disabilities and by the Millennium Development Goals.
Davies, et al. (2006) examined the experiences of women receiving homecare for chronic disabling conditions. They pointed that home care services do not always contribute sufficiently to the overall health and well-being of women living with chronic disabling conditions and, in fact, may negatively impact upon their health.

Honey, et al. (2011) found that young people with disabilities reported poorer mental health than their non-disabled peers. However, this relationship was moderated by both social adversity and social support, with minimal differences in mental health observed between the groups under conditions of high social support and low financial hardship. Disability represents a potential adversity that may be exacerbated or ameliorated by the effects of wealth/financial hardship and social support.

Tabuga and Mina (2011) reported that among persons with disability (PWD), the gap between men and women are more distinct, their conditions more dismal with poverty as their needs are different. Apart from poverty, discrimination and prejudice are the major challenges that persons with disabilities face in their everyday life. Because they face various social, physical, and economic barriers, policies should gear toward formulating rights-based and comprehensive actions to improve their well-being. The ESCAP noted that the lack of availability and the quality of demographic and socioeconomic indicators concerning disability continue to be major challenges.
Chaudhury, et al. (2006) assessed some aspects of disability associated with seven psychiatric disorders: Schizophrenia, bipolar affective disorder, anxiety disorder, depression, obsessive-compulsive disorder, dementia and mental and behavioral disorders due to the use of alcohol. They evaluated the nature and quantity of disabilities in the study groups, compare the degree of disability with the severity of the disorder, compare disability among various disorders and study the longitudinal stability of disability in the disorder groups. They assessed a total of 228 patients attending the outpatient department of Assam Medical College, Dibrugarh, India, between July 2003 and June 2004. Patients were initially diagnosed using the ICD-10 criteria. Further, for those who consented to participate in the study, interviewers administered Schedule for Clinical Assessment for Neuropsychiatry (SCAN). Severity of the disorders was assessed by applying commonly used rating scales for each specific disorder. Disability was assessed using the Indian Disability Evaluation and Assessment Scale (IDEAS). Patients were followed up at six and 12 months. Results showed that all seven disorders studied were associated with significant disability; schizophrenia being maximally disabling. The domains of disability varied across the various disorders studied. The disability tended to correlate with the severity of the disorders. Disability associated with alcohol use disorder and anxiety was comparable to disability due to obsessive-compulsive disorder. Though the follow-up rates were low, analysis of the available data showed that the disability across most disorders reduced at the end of six month follow-up and then tended to even out after that period.

Ittyerah and Kumar (2007) compared the responses of handicapped children, adolescents and adults to body image, skills/abilities, life experience, and social
interaction. The results indicated that children had a more positive self-concept than adults and adolescents. Men had a more positive self-concept than females. Further, social interaction and abilities were rated more positively than body image and life experience. Correlations between the actual and ideal selves revealed a positive relation between the actual self and the desired ideal self for all the groups and there were no gender differences. Narrative analysis of the groups revealed that adults held a more positive view of life as compared to adolescents or children. The positive views of the self were a consequence of factors that are largely internal to the respondent, such as the use of mature ways of thinking and maintaining one's self-respect. The negative views of the self were rooted in external factors over which the individual had little or no control such as poverty and negative attitudes of others. Although the female disabled group had a lower self-concept than males, there was a positive relationship between their actual and ideal selves indicating acceptance of their congenital defects as a challenge to integrate into the mainstream.

Das, et al. (2008) assessed the prevalence and pattern of mental disability in a rural taluk of Karnataka district. This was a community-based cross-sectional study. One thousand subjects were randomly selected from four villages and IDEAS was administered. Overall prevalence of mental disability was 2.3 percent. Among the disabled, majority had mild disability, followed by severe, moderate and profound severity. All disabled subjects were previously diagnosed with one or the other mental disorder such as: Affective disorders, mental retardation, epilepsy, neurosis, schizophrenia, alcohol addiction.
Chauhan and Sharma (2008) cross-sectional compared the inter-episode Quality of Life (QOL) and disability of patients with remitted bipolar affective disorder (BAD) or Recurrent Depressive Disorder (RDD) with and without co-morbid chronic medical illness. Assessments were carried out on the four subgroups (20 patients in each). QOL assessment was carried out using the World Health Organization (WHO)-QOL-Brief Kannada version and disability was assessed using the Schedule for Assessment of Psychiatric Disability (SAPD), which is the Indian modification of the WHO disability assessment schedule-II. In patients who had medical co-morbidity, BAD patients were significantly more disabled in ‘social role’ domain when compared with RDD patients ($P = 0.04$); while RDD patients were significantly more disabled in the ‘home atmosphere’ domain ($P = 0.001$). In patients who did not have medical co-morbidity, BAD patients were significantly more disabled in the overall behavior domain when compared to RDD patients ($P = 0.002$); while RDD patients were significantly more disabled in ‘assets and/or liabilities’ ($P = 0.004$) and home atmosphere ($P = 0.001$) domains. The QOL measures did not differ significantly between the two disorders. The authors concluded that the medical illnesses may have a role in increasing disability but less likely to have a significant impact on QOL in mood disorders when patients are euthymic.

Thirthalli et al. (2010) compared the course of disability in schizophrenia patients receiving antipsychotics and those remaining untreated in a rural community. Of the 215 patients identified, 58% were not receiving antipsychotics. Trained raters assessed the disability (IDEAS) in 190 of these at baseline and after one year. The course of disability in those who remained untreated was compared with that in those who received antipsychotics. Results showed that in patients who remained untreated,
the mean disability scores remained unchanged, but in those who continued receiving treatment and in those antipsychotics were initiated, the scores showed a significant decline (indicating decrement in disability). The proportion of patients classified as ‘disabled’, declined significantly in the treated group, but remained the same in the untreated group. The authors concluded that treatment with antipsychotics in the community results in a considerable reduction in disability.

**Halder (2013)** analysed the different contributory and causative factors of locomotor disability, disease states and the significance of poverty in relation to disability in Eastern part of India. Final data were collected from 200 people with locomotor disability by personally visiting each individual and their family at their home or institutes on the basis of personal interviews, discussions with them, their parents and teachers. Data were collected by situational sampling technique and tools used for the study were General Information Schedule (GIS) and Semi-structured interview schedule. The study revealed that various diseases which resulted in locomotor disability in some way were related to poverty. The nature and causative factors for various diseases which resulted in locomotor disability are malnutrition, unhygienic condition in the pre-natal and postnatal period of the mother as well as carelessness of the medical practitioners. Among the other associated significant indirect causes has been found to be illiteracy, ignorance of the parents, and various socio-cultural issues.

**Adamson, et al. (2008)** examined the risk factors for disability and systematically reviews the evidence from randomized trials of complex interventions for disability. They conducted a national prospective study of a representative sample
of 999 people aged 65 years or more plus in-depth interviews with a small subsample and a selected sample obtained from hospital sources. Secondary analysis of several large prospective studies was carried out and a systematic review and meta-analysis of published randomized controlled trials of the effects of complex interventions for disability. Very few participants subscribed to the constructs of longstanding illness, disability or infirmity that surveys often use. A wide range of social and psychological factors, independently of chronic diseases, were strongly associated with disability. People with greater functional reserve capacity and those with greater self-efficacy were generally less likely to suffer from catastrophic decline in ability and had better quality of life in the face of disability. The findings on the meaning and experience of disability suggest the need for modifications to routinely used survey questions and for different ways of understanding the need for and receipt of care among older people with disabilities. The diverse risk factors for disability suggest that novel approaches across social, psychological as well as more traditional rehabilitation and behavioural risk factor modification would be worth exploring. Complex interventions appeared to help older people to live independently and limit functional decline irrespective of age and health status.

Nayak (2013) explored the present status of Women with Disability (WWD) in the state of Odisha, their economic status, social status, subject to rejection and domestic violence, educational status, health, reproductive health, sexuality and marriage, government provisions and the gaps there in. It clearly showed that due to their disability, most of them are subject to violence, betrayed by husband; they are deprived of good education, livelihood for which they feel that they are being marginalized. There is association exists between monthly incomes and satisfied with
life significantly as the Chi-Square value is significant at < 1% level. There is
association exists between educational qualification and women empowerment
variable significantly as the Chi-Square value is significant at < 1% level. There is
association exists between educational qualification and facing physical/mental
harassment variable significantly as the Chi-Square value is significant at < 5% level.

Joseph and Sundar Rao (1999) analysed the nature and extent of decreases
in the quality of life (QOL) of an affected person. The World Health Organization
questionnaire on quality of life was given to a representative random sample of 50
leprosy-affected persons and 50 unaffected individuals in the Bommasamudram Taluk
of Chittoor District, Andhra Pradesh, India. The mean QOL score of the cases was
significantly lower than that of the controls with the exception of the spiritual domain.
The mean total score for women was higher than that of males in each domain and
age group. Males with deformities had a significantly lower score than those with no
visible deformities. Although the scores for females with deformities were also lower
than those without deformities, the differences were not statistically significant.
Analysis of economic status versus the QOL scores clearly showed that they were
positively correlated.

Dandona, et al. (2000) conducted a population-based epidemiologic study by
using the WHOQOL instrument for a of eye diseases in southern India, the Andhra
Pradesh Eye Disease Study (APEDS). A follow-up question was added to each item
in WHOQOL to determine whether the decrease in QOL was due to any health
reasons including eye-related reasons. This health-related QOL instrument is being
used in the population-based study APEDS to develop a vision-specific QOL
instrument which could potentially be used to assess the impact of visual impairment on QOL across different cultures and for use in evaluating eye-care interventions. This health-related QOL instrument could also be used to develop other disease-specific instruments as it allows assessment of the extent to which various aspects of QOL are affected by a variety of health problems.

Marquis and Jackson (2000) discussed findings of a study involving 14 agencies in Western Australia, which provide living environment services for young people with disabilities and older adults, to gain insight into service users' daily experiences and their perceptions of quality in receiving services. Immersion in different models of services over a 2-year period, and inductive analysis of interview data, has found that relationships between service users and workers lie on a continuum, with mutually supportive relationships between service users and workers at one end, and physical and psychological abuse at the other. Experiences were variable in single service contexts, highlighting the problems of using currently employed extant measures to evaluate quality in living services.

Lang (2001) compared and contrasted the experiences of disabled people in relation to the medical and social models of disability in the South Indian context. The result showed that the principal needs and aspirations of disabled people were twofold - employment and marriage. Despite the fact the majority of disabled people were employed, there was great concern that all disabled people should be seen to make an economic contribution to the domestic household. This raises the self-esteem and dignity of disabled people, both in their own perceptions, and also amongst the local community. Disabled people valued the need for basic medical rehabilitation services,
for this again directly assisted them in obtaining gainful employment. The level and severity of impairment had to be greater for women than for women, before it was socially acceptable for the latter to withdraw from economic activity within the domestic household. Men were more likely to received and have more spent on rehabilitation services than are women.

De Souza and Frank (2003) determined the benefits for patients who received an electric powered indoor/outdoor chair (EPIOC) and to quantify their perceived changes to their quality of life. Community-based cohort study of all patients provided with an EPIOC over 4 months; and followed up about 3 months later in a community served by a regional wheelchair service in North West London (population about 3.1 million) using the EuroQol EQ-5D with visual analogue scales for each of the five dimensions of the EQ-5D. Sixty-four wheelchair users were assessed initially and 51 completed follow up. Chair users showed no significant improvement in health state as measured by the EQ-5D after EPIOC provision. The visual analogue scales (VASs) indicated that, although perceived overall health state, independence and social life did not appear to improve, the dimensions of mobility, quality of life and pain/discomfort improved significantly on provision of an EPIOC.

Patrick and Topolski (2003) compared the self-perceived quality of life (QOL) of adolescents with and without disabilities. A school-based survey was conducted with 2,801 7th to 12th grade students in a rural area of the United States. The Youth Quality of Life Instrument-Surveillance Module and the Youth Quality of Life Group-Disability Screener were completed. Twenty-one percent of all students surveyed reported having one or more physical, emotional, or learning disabilities.
Adolescents with disabilities reported lower QOL than adolescent without disabilities. However, self-rated health, depressive symptoms, and contextual variables were significant covariates in the relationship between disability and QOL.

**Nourhaghighi, et al. (2003)** analysed the development and validation of the Quality of Life Profile for Adults with Physical Disabilities (QOLP-PD). This new cross-disability instrument is grounded in a well-developed conceptual framework. It reflects the underlying assumption that quality of life issues are the same for people with and without disabilities, although adults living with chronic physical disabilities may address those issues somewhat differently during the course of their daily lives. This instrument was developed on the basis of in-depth interviews, item review and refinement, and pilot testing with adults who have chronic acquired and life-long physical disabilities. Preliminary validation studies were carried out in separate studies with two Canadian samples for which separate results are reported.

**Maes and Vlaskamp (2005)** examined how parents and direct support staff operationalized these basic domains for people with profound multiple disabilities. They investigated the effect of the support setting and age of people with profound multiple disabilities on this operationalization. The result showed that more than half of the respondents as being salient for the quality of life of people with profound multiple disabilities. When asked explicitly, this value rose to between 88.2 and 100 percent. The operationalization of these basic domains by parents and direct support staff differed in several aspects from operationalizations for other target groups. Neither age nor support setting turned out to have a significant effect on the
operationalization. The results supported the multidimensionality of quality of life and
the validity of the basic domains for people with profound multiple disabilities.

Ezhil, et al. (2005) estimated the prevalence of disabled in the elderly
population (aged above 60 years) in a district of South India using International
Classification of Impairments, Disabilities and Handicaps (ICIDH) classification.
Thirty villages were selected using probability proportional to size linear systematic
sampling. A structured proforma was administered to 974 subjects to obtain
information on disability as perceived by rural geriatric population. Visual disability
was found to be the most important single preventable disability (56%). The
differences observed between males and females were not statistically significant for
functional limitation and activities of daily living. A decline in social interaction was
reported possibly because of enhanced immobility with increasing age.

Nutheti, et al. (2006) determined the impact of visual impairment and eye
diseases on quality of life (QOL) in an older population of Andhra Pradesh in
southern India. The World Health Organization (WHOQOL) instrument was adapted
as a health-related quality of life (HRQOL) instrument for administration to adults
participating in the Andhra Pradesh Eye Disease Study. Participants aged 40 years
and older ($n = 3702$), 99.4 percent of the 3723 eligible, who underwent interview and
detailed dilated ocular eye evaluation by trained professionals were included in this
study. Each item of the QOL scale had an adequate item–total correlation (range,
0.25–0.77) greater than 0.2. After adjusting for demographic variables and ocular
disease, Subjects with blindness had significantly lower QOL scores. Subjects with
glaucoma or corneal disease independent of visual acuity had lower scores than
subjects without those eye diseases. Subjects with cataract or retinal disease had significantly lower scores than those without cataract or retinal disease in the model without visual acuity but not when visual acuity was added to the model. Decreased QOL was associated with the presence of glaucoma or corneal disease independent of visual acuity and with cataract or retinal disease as a function of visual acuity.

**Ferrari, et al. (2007)** examined the relationship among and between personal characteristics, self-determination, social abilities and the environmental living situations of people with Intellectual Disabilities (ID). The study involved 141 people with ID residing in Italy. Healthcare professionals and social workers who had known participants for at least 1 year completed measures of self-determination, QOL and social skills. Analysis of variance was conducted to verify whether different levels of intellectual impairment were associated with different degrees of the dependent variables. The anova determined, as expected, that participants with more severe ID showed the lowest levels of self-determination, QOL and social abilities. Discriminant function analysis showed that (a) individuals attending day centres were distinguished from those living in institutions in that they were younger and showed greater autonomy of choice and self-determination in their daily activities; (b) basic social skills and IQ score predicted membership in the high or low QOL groups; and (c) the IQ score predicted membership in the high or low self-determination groups.

**Andresen, et al. (2007)** stated that the measurement of Health Related Quality of Life (HRQOL) in people with disability can be problematic. Ambiguous or paradoxical findings can occur because of differences among people or changes within people regarding internal standards, values, or conceptualization of HRQOL.
These “response shifts” can affect standard psychometric indices, such as reliability and validity. Attending to appraisal processes and response shift theory can inform development of HRQOL measures for people with disability that do not confound function and health and that consider important causal indicators such as environment. By design, most HRQOL measures equate function with health, necessarily leading to a lower measured HRQOL in people with functional impairments regardless of their level of self-perceived health.

**Higaki, et al. (2010)** analysed the effects of a 12-month multicomponent exercise program on physical performance, daily physical activity, and HRQOL among very elderly people with minor disabilities. The subjects consisted of 65 elders (median age: 84 years) who were certified to receive long-term care in the form of support only or Level 1 care (the lowest level of care required); 31 were allocated to the intervention group and 34 to the control group. After 12 months of exercise training, the intervention group had significant improvements in lower-limb strength and on the sit-and-reach test; these effects were not observed in the control group. The control group had significant decreases in grip strength, 6-minute walking distance, walking speed, and stride length; these decreases were not observed in the intervention group. No clear differences in HRQOL measurements or changes in physical activity were detected between groups.

**Kusuma and Babu (2010)** assessed the health-related QOL (HRQOL) of elderly people living in two settings: (i) rural community and (ii) homes for the elderly in a district of South India. The data are drawn from elderly (>60 years of age) sampled from both settings. The short form 36-item health survey (SF-36) was
administered to all respondents. The average scores for several domains, including total physical health, total mental health and overall health (total SF-36 score) were around 50, which can be interpreted as a moderate level of health-related QOL. Residents living in a home for the elderly scored better in all domains except for role-physical and role-emotional. Though univariate analysis revealed some associations between characteristics of elderly SF-36 scores, the multiple regression analysis indicated that working status yields a significant but negative coefficient for total SF-36 score among community dwelling elderly. The elderly reported that their lives are better when they are staying in homes for the elderly. Hence, despite the socio-economic conditions, provision of a better and conducive environment by setting up more charity-based homes for the elderly may be one of the options for relative betterment of the QOL of the elderly, particularly those who are socially and economically deprived.

Brakel, et al. (2011) evaluated differences in socio-economic characteristics, quality of life (QOL), perceived stigma, activity and participation among people affected by leprosy as a group and between this group and the general population, and to identify prime determinants of QOL among the leprosy-affected people. People with leprosy-related disabilities (N=100; 54DGI/46DGII) and community controls (N=100) were selected from Morang district, South-East Nepal, using quota sampling. QOL, perceived stigma and participation and activity limitations were measured using the Nepali abbreviated version of the World Health Organisation Quality of Life (WHOQOL) assessment and the Nepali versions of the Jacoby Scale, Participation Scale and Green Pastures Activity Scale, respectively. Regression analysis showed that the ability to maintain a family, satisfaction with health, vocational training, sex,
activity and participation limitations (the latter for QOL only), perceived stigma and living situation (i.e. joint family, type of house) were significantly associated with a deterioration in QOL and higher participation restriction in one or both of the grading groups.

**Velankar, et al. (2011)** assessed the knowledge, attitude and belief about leprosy in leprosy patients compared with community members. WHO Quality of life questionnaire (WHOQOL-BREF) was used to assess quality of life in leprosy patients and controls. Among the cases and control, 43.13 percent of cases were aware that leprosy is an infectious disease compared to 20.69 percent of control. 68.62 percent of cases had knowledge of hypo pigmented patches being a symptom of leprosy compared to the 25.86 percent in control. There was overall high level of awareness about disease, symptoms, transmission and curability in leprosy patients as compared to control. Among control group, 43.10 percent of population said that they would not like food to be served by leprosy patients as compared to 13.73 percent in study group. The mean quality of life scores for cases was significantly lower than those for control group in physical and psychological domain but not in the social relationship and environmental domain. The mean quality of life scores for male cases were lower in each domain as compared to male control group but the difference was not significant except in the physical and environmental domain. The mean quality of life scores for female cases were lower in each domain as compared to female control group and the difference was not significant except in the psychological domain.

**Rajkumar, et al. (2012)** assessed the nature and factors associated with disability among the elderly in a rural south Indian community by administering
WHO Disability Assessment Scale II, Geriatric Mental State, Community Screening Instrument for Dementia, and Neuropsychiatric Inventory. They recruited 1000 participants aged over 65 years from Kaniyambadi block, Vellore, India. They employed appropriate multivariate statistics to study the factors associated with a higher level of disability and to determine the population attributable fractions for various modifiable risk factors. Advanced age, illiteracy, hunger, poor nutrition, arthritis, hearing impairment, gastro-intestinal and respiratory diseases, dementia and travel costs to primary health facilities increased the risk of disability significantly. Hypertension, diabetes and depression were not associated with disability. Modifiable social determinants and medical diseases together contributed to disability in this population. Locally relevant social determinants combine with prevalent medical diseases to produce the disability burden among elderly.

Khan and Bhatia (2012) investigated the Quality of Life (QOL) in family caregivers of children with developmental disorders as compared to normal healthy children. This study investigated QOL in family caregivers of children with Mental Retardation (MR) and autism as compared to a Control Group (CG). The sample consisted of 240 parents (40 mothers and 40 fathers in each of the three groups) of 120 children having MR, autism and normal healthy children. Diagnostic assessments in children were carried out using Seguine Form Board test, Vineland Social Maturity scale, and Childhood Autism rating scale. QOL of parents was assessed by the WHOQOL-BREF questionnaire. Analysis using one way analysis of variance and post hoc analysis revealed that compared with parents of healthy children, parents in the MR and autism group reported impairment in all the four domains of QOL. Little differences were observed between MR and autism groups. Such impairments were
found both for fathers and mothers. Compared with parents of healthy children, parents in the MR and autism group reported impairment in all the four domains of QOL. Little differences were observed between MR and autism groups. Such impairments were found both for fathers and mothers. Thus, parents of children with MR and autism seem to display a higher burden and impaired QOL.

Dhanesh, et al. (2012) compared the functional independence and quality of life of persons with locomotor disabilities who undergo Institutional Based Rehabilitation (IBR) and similar persons who undergo Community Based Rehabilitation (CBR). Thirty males with locomotor disabilities -15 from IBR and 15 from CBR- were selected. Both the groups were first administered the Functional Independence Measure (FIM) questionnaire, followed by the Quality of Life (WHOQOL-BREF) questionnaire. There were no significant difference between IBR and CBR with regard to functional independence (t value = -1.810, P < 0.05), and with regard to Quality of Life (QOL) (t value of 0.468, P < 0.05). With regard to Quality of Life (QOL), the ‘t’ value was found to be 0.468 between persons with locomotor disability in CBR and IBR, and the differences were not statistically significant. No statistically significant differences were found between these two approaches in terms of Quality of Life as well as Functional Independence. This showed that both models are more or less equally effective in rehabilitating persons with locomotor disabilities.

Abraham (2013) analysed the Quality of Life (QOL) of adolescents with disability who attend normal school as part of integrated education. The study investigated the quality of life of disabled adolescents who attend 8-12th classes in
government and aided schools in Angamaly- Perumbavoor sub- District in Kerala. The research design is descriptive in nature. Twenty five physically disabled adolescents who attend 8th to 12th class formed the sample. Quality of life was measured using WHOQOL-BREF Scale (1997). The result showed that majority of the respondents were studying in government school 17 (68%) and only 8 (32%) studying in aided school. The respondents were either having upper limb disability (40%) or lower limb disability (60%). Out of 25 students 8 i.e., (72%) fell on average quality of life. The various domains in quality of life represented average level of score in physical, psychological, social relations and environment domains.

Srinivas and Rao (2013) examined the psychometric characteristics of the World Health Organization Quality of Life instrument-modified Indian version (modified WHOQOL) and its subscales in adults with visual impairment (VI) using Rasch analysis. Cross-sectional data were of people aged ≥40 years with VI (n = 1,333) who responded to the modified WHOQOL in the Andhra Pradesh Eye Disease Study, India. Rasch-guided iterative approach including category re-organization to enable threshold ordering and item deletion to overcome multidimensionality resulted in a unidimensional 9-item WHOQOL and a 6-item level of independence (LOI) subscale with adequate PSR (0.81 and 0.82, respectively). Targeting was sub-optimal for both (−1.58 logits for WHOQOL and −2.55 logits for the subscale). Remaining subscales were dysfunctional.

Shah, et al. (2014) recommended the Indian Disability Evaluation and Assessment Scale (IDEAS) for assessment and certification of disability by the Government of India. A total of 103 consenting patients with residual schizophrenia
were assessed for disability, QOL and psychopathology using the IDEAS, WHO QOL-100 and Positive and Negative symptom scale (PANSS) respectively. Internal consistency was calculated using Cronbach's alpha. For construct validity, relations between IDEAS, and psychopathology and QOL were studied. The inter-item correlations for IDEAS were significant with a Cronbach's alpha of 0.721. All item scores other than score on communication and understanding; total and global IDEAS scores correlated significantly with the positive, negative and general sub-scales, and total PANSS scores. Communication and understanding was significantly related to negative sub-scale score only. Total and global disability scores correlated negatively with all the domains of WHOQOL-100 ($P<0.01$). The individual IDEAS item scores correlated negatively with various WHOQOL-100 domains ($P<0.01$).

The sourced literature reviews highlighted the researches on – status of general women, situations of the disabled women, socio-economic and socio-cultural characteristics about disabled people, maltreatment, abuses and violence experienced by disabled women, health aspects, mental health and disability status of disabled people, education, welfare programmes and quality of life among persons with disabilities. Numerous studies were conducted on quality of life of disabled people at national and international levels by administered WHO developed WHOQOL instrument. The gap identified is sparse researches conducted in analyzing the quality of life of women with locomotor disabilities.
CONCLUSION

This study reviewed the literatures relevant to the various dimensions whirling around the status of disabled women and their quality of life. At national and international arenas, many studies are conducted to observe the quality of life of persons with disabilities. The perceived research gap is that the studies analyses the qualities of life of women with locomotor disabilities are minimum. This study attempts to fill up that gap and further it would expose the levels of quality of life domains of women with locomotor disabilities in Pudukkottai district of Tamil Nadu.

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