CHAPTER II

DISABILITY: AN APPRAISAL

2.1 Prelude

A disability is a condition or function judged to be significantly impaired, relative to the usual standard of an individual, or their group. The term is often used to refer to individual functioning, including physical impairment, sensory impairment, or mental health issues. Common usage refers to ‘a person with a disability’, or a person who is ‘disabled’ or more controversially, who is ‘handicapped’, ‘differently abled’, ‘lame’, ‘handicapable’ or a ‘cripple’. Some prefer to only refer to specific ‘disabilities’ rather than to a generalized sense of ‘disability’.

Irrespective of the term used, the phenomenon of disability is an indispensable part of the human experience, and cannot be divorced from the social milieu where it is produced. It can not exist outside the periphery of social structures. Of course, disability involves a broader conceptualization, as it is part and parcel of the social practice and social life.
On the definition of the disabled, there is no unanimity. In some countries even the diabetics are categorized as disabled, while in other the focus is on extreme physical handicap or mental retardation. Generally speaking disabled persons are those who suffer from malformations, deformities, and other deficiencies, be it physical or mental, which prevents their normal functioning. These defects cause special problems of education, employment, and adjustment in society. There is, however no clear demarcation between the ‘able-bodied’ and the ‘disabled’. The term disabled suggests a person who falls short of normal physical fitness. However, ‘Physical fitness’ itself is a vague term. Meenakshi (1983:3) in her article, “Physically Handicap: The Problem of Definition”, puts the problem succinctly and gives the view, the ‘physical fitness for an athlete or a soldier may be totally different from that for a white collar worker’. Social customs also govern the concept of physical fitness.

Sussman (1977:17) used the term ‘impairment’ instead of ‘disability’. Impairment is defined as any deviation from the normal, which results in defective function, structure and organization and development of the whole or any part of an individual’s faculty. Here, impairment is of anatomical nature. While coming back to the term ‘disability’, it refers to any limitation experienced by the impaired individual in comparison with the activities of the unimpaired individual of similar age, sex, and culture. It leads to a limitation of physical function, whether locomotory, sensory or
affecting any other specific organ. The effects of disability, however, are seldom confined to the pathological conditions alone.

While discussing disability, we tend to use the term ‘handicap’ as synonym for disability, however, there is a clear difference between a handicapped person and a disabled person. The term ‘handicap’ is not simply a corollary of ‘disability’. It is also partly imposed by society. The definition of ‘handicapped’ varies according to the country’s culture tradition and level of development. For instance, a blind person in a developed country has access to education and therefore, to a profession. This may not be true in case of a developing country. Accordingly, such a person is handicapped not only by disability but also by social and economic conditions prevailing in the country.

The most acceptable definition of a disabled person is given by the United Nations, which states that, ‘a person unable to ensure by himself or herself, wholly or partly, the necessities of normal individual and/ or social life, as a result of deficiency, either congenital or not, in his or her physical or mental capabilities. The disabled, thus includes both physically and mentally deficient individuals like the blind, the deaf, the mute, the orthopaedically deformed, the mentally retarded or deficient and also those suffering from incurable diseases such as polio, leprosy etc.

The International Classification of Functioning Disability and Health (ICF), produced by the World Health Organization (WHO), distinguishes
between body functions (physiological or psychological, e.g. vision) and body structures (anatomical parts, e.g., the eye and related structures). Impairment in bodily structure or function is defined as involving an anomaly, defect, loss or other significant deviation from certain generally accepted population standards, which may fluctuate over time. Activity is defined as the execution of a task or actions. The ICF lists 9 broad domains of functioning which can be affected and they are as follow:

(i) Learning and applying knowledge

(ii) General task and demands

(iii) Communication

(iv) Mobility

(v) Self care

(vi) Domestic life

(vii) Interpersonal interactions and relationships

(viii) Major life areas

(ix) Community, social and civic life

The introduction to the ICF states that a variety of conceptual models have been proposed to understand and explain disability and functioning. The major models among many are the medical model and the social model. A part from these two models there are others like the moral model, the expert/ professional model and the tragedy/ charity model etc.
(a) The Medical Model

The medical model views disability as a problem of the person, directly caused by disease, trauma, or other health condition, which, therefore requires sustained medical care provided in the form of individual treatment by professionals. In the medical model, management of the disability is aimed at "cure", or the individual's adjustment and behavioural change that would lead to an 'almost cure' or effective cure. In this model, medical care is viewed as the main issue and at the political level the principal response is that of modifying or reforming healthcare policy.

(b) The Social Model

The social model of disability sees the issues of "disability" mainly as a socially created problem, and basically as a matter of full integration of individuals in to society. In this model, disability is not an attribute of an individual but rather a complex collection of conditions, many of which are created by the social environment. Hence, this model, the management of the problem requires social action and thus it is the collective responsibility of society at large to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life. In this regard the late Prime Minister Olof Palme of Sweden, maintained that if it cost the country $ US 40,000 per year to enable a person with disability to work at a job that paid $ US 40,000, the society gained a net benefit,
because the society benefited by allowing this worker to participate cooperatively, rather than to be a drain on other people's time and money.

(c) The Moral Model

The moral model refers to the attitude that people are morally responsible for their own disability, including, at the one extreme, as a result of actions of parents if congenital or as a result of practicing witchcraft. This attitude can be seen as a religious fundamentalist offshoot of the original animal roots of human beings back when human killed any baby that could not survive on its own in the wild.

(d) The Expert/ Professional Model

This model has provided a traditional response to disability issues and can be seen as an offshoot of the medical model. Within its framework, professionals follow a process of identifying the impairment and its limitation (using the medical model), and taking the necessary action to improve the position of the disabled person. This has tended to produce a system in which an authoritarian, over active service provider prescribes and acts for a positive client.

(e) The Tragedy/ Charity Model

This model depicts disabled as victims of circumstance, deserving
of pity. This and medical model are probably the ones most used by non-disabled people to define and explain disability. To counter this trend, disabled activists are fond of the slogan, “piss on pity”.

2.2 The Disability Scenario in India

The magnitude of the subject of disability in India and the challenges it would pose to the society was realized long back. However, there were no factual data available on disability to judge the prevailing scenario in the country. The first major step towards having some realistic data regarding the size and nature of India’s disabled population was taken in 1872, when the Census of India in its year of inception collected information on disability. The questionnaire of the 1872 census, called the ‘House Register’ included question not only on the physically disabled but also the mentally disabled and the persons affected by leprosy.

Collections of information on infirmities were continued in each of the successive decadal censuses of 1881 to 1931. However, due to the serious doubts expressed by the then census commissioner about the authenticity and quality of data collected on disabled population, the enumeration of physically disabled persons was discontinued during the 1941 census. It was felt that question on disabled population did not yield much reliable data due to variety of reasons particularly due to the social stigma attached with this characteristic. After a gap of 50 years or four
decennial censuses since 1931, a question on disabilities was again canvassed at the 1981 census. Since, 1981 had been proclaimed as the 'International Year for the Disabled'. It resulted in inclusion of a question on disability during censuses the world over and India was no exception to it. However, question on three broad categories of physical disabilities, viz., 'Totally blind', 'Totally dumb', and 'Totally crippled' was canvassed during the house listing operation of 1981 census. When the results of 1981 census were finally available, it was felt that there was considerable under enumeration of physically handicapped persons. The 1981 census results also supported the view expressed by the earlier census commissioner that ordinarily by sheer design and nature; the census operations do not lend themselves to the determination or identification of people with special social and infrequent characteristics of this nature. It was felt that the enumeration and determination of the physically handicapped and their characteristics continued to be beyond the scope and capacity of census operations due to the complexity of the definition of disability and inherent reservations of the population to share this information with the enumerator, usually a local government official. There were the additional limitations of the absence of high-pitched publicity on disability, level of awareness in the public and weak background settings in terms of administrative and political milieu and virtually no support from the NGOs that hampered the collection of data on disability. The question on
disability was not canvassed again in the 1991 census of India. With the pressure from the network of NGOs coupled with international agencies and obligation under Persons with Disabilities (equal opportunities, Participation) Act 1995, the question on disability was again incorporated in the *Census of India 2001*.

In India different definitions of disability are introduced for various purposes and as such they have been based on various criteria. No single standard exists in India in order to evaluate disability. In common parlance, different terms such as disabled, handicapped, crippled, physically challenged are used inter-changeably. *Census of India: 2001* document mentioned, ‘defining and measuring disability is a complex issue and it is not easy to communicate these concepts during the census process, in which only a limited amount of questioning time is possible to be spent in a household for obtaining detailed information on every individual’. Census therefore used its own version of definition of disabilities. It defines five types of disabilities, viz., seeing, speech, hearing, movement, and mental.

(a) Seeing Disability

Seeing disability includes a person who cannot see at all or has blurred vision even with the help of spectacles, will be treated as visually disabled. A person with proper vision only in one eye and those who have
blurred vision and had no occasion to test whether his or her eyesight would improve by using spectacles would be treated as visually disabled.

(b) Speech Disability

A person will be recorded as having speech disability, if he or she is mute. Similarly, persons whose speech is not understood by a listener of normal comprehension and hearing he or she will be considered to having speech disability. Persons who stammer but whose speech is comprehensible will not be classified as disabled by speech.

(c) Hearing Disability

Hearing disability includes a person who can not hear at all (deaf), or can hear only loud sound will be considered as having hearing disability. A person who is able to hear using hearing aid will not be considered as disabled under this category. If a person can not hear through one ear but his or her other ear is functioning normally, should be considered having hearing disability.

(d) Movement Disability

A person who lacks limbs or is unable to use the limbs normally will be considered as having movement disability. Absence of a part of a limb like a finger or a toe will not be considered as disability. However,
absence of all the fingers or toes or a thumb will make a person disabled by movement. If any part of the body is deformed, the person will also be treated as disabled and covered under this category. Again, a person who cannot move himself or herself without the aid of another person or without the aid of stick, etc. will be treated as disabled. Similarly, a person would be treated as disabled in movement if he or she is unable to move or lift or pick up any small article placed near him or her. A person may not be able to move normally because of problems of joints like arthritis and has to invariably limp while moving will also be considered to have movement disability.

(e) Mental Disability

A person who lacks comprehension appropriate to his or her age will be considered as mentally disabled. This would not mean that if a person is not able to comprehend studies appropriate to his or her age and is failing to qualify the examinations is mentally disabled. Mentally retarded and insane persons would be treated as mentally disabled. A mentally disabled person may generally depend on his or her family members for performing daily routine. The population of disabled in India as per the 2001 census stands at 21, 906,769; that is 2.13 per cent of the total population of the country. The following table 2.1 shows the state and union territory wise distribution of disabled population in India.
Table 2.1: State/Union Territory wise population of persons with disabilities as per census 2001

<table>
<thead>
<tr>
<th>S.No</th>
<th>States/ Union Territory</th>
<th>Number of persons with disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Jammu &amp; Kashmir</td>
<td>302670</td>
</tr>
<tr>
<td>2</td>
<td>Himachal Pradesh</td>
<td>155950</td>
</tr>
<tr>
<td>3</td>
<td>Punjab</td>
<td>424523</td>
</tr>
<tr>
<td>4</td>
<td>Chandigarh</td>
<td>15538</td>
</tr>
<tr>
<td>5</td>
<td>Uttaranchal</td>
<td>194769</td>
</tr>
<tr>
<td>6</td>
<td>Haryana</td>
<td>455040</td>
</tr>
<tr>
<td>7</td>
<td>Delhi</td>
<td>235886</td>
</tr>
<tr>
<td>8</td>
<td>Rajasthan</td>
<td>1411979</td>
</tr>
<tr>
<td>9</td>
<td>Uttar Pradesh</td>
<td>3453369</td>
</tr>
<tr>
<td>10</td>
<td>Bihar</td>
<td>1887611</td>
</tr>
<tr>
<td>11</td>
<td>Sikkim</td>
<td>20367</td>
</tr>
<tr>
<td>12</td>
<td>Arunachal Pradesh</td>
<td>33315</td>
</tr>
<tr>
<td>13</td>
<td>Nagaland</td>
<td>26499</td>
</tr>
<tr>
<td>14</td>
<td>Manipur</td>
<td>28376</td>
</tr>
<tr>
<td>15</td>
<td>Mizoram</td>
<td>16011</td>
</tr>
<tr>
<td>16</td>
<td>Tripura</td>
<td>58940</td>
</tr>
<tr>
<td>17</td>
<td>Meghalaya</td>
<td>28803</td>
</tr>
<tr>
<td>18</td>
<td>Assam</td>
<td>530300</td>
</tr>
<tr>
<td>19</td>
<td>West Bengal</td>
<td>1847174</td>
</tr>
<tr>
<td>20</td>
<td>Orrissa</td>
<td>1021335</td>
</tr>
<tr>
<td>21</td>
<td>Chhattisgarh</td>
<td>419887</td>
</tr>
<tr>
<td>22</td>
<td>Madhya Pradesh</td>
<td>1408528</td>
</tr>
<tr>
<td>23</td>
<td>Gujarat</td>
<td>1045465</td>
</tr>
<tr>
<td>24</td>
<td>Daman &amp; Diu</td>
<td>3171</td>
</tr>
<tr>
<td>25</td>
<td>Dadra &amp; Nagar Haveli</td>
<td>4048</td>
</tr>
<tr>
<td>26</td>
<td>Maharashtra</td>
<td>1569582</td>
</tr>
<tr>
<td>27</td>
<td>Andra Pradesh</td>
<td>1364981</td>
</tr>
<tr>
<td>28</td>
<td>Kamataka</td>
<td>940643</td>
</tr>
<tr>
<td>29</td>
<td>Goa</td>
<td>15749</td>
</tr>
<tr>
<td>30</td>
<td>Jharkhand</td>
<td>448377</td>
</tr>
<tr>
<td>31</td>
<td>Lakshadwwe</td>
<td>1678</td>
</tr>
<tr>
<td>32</td>
<td>kerala</td>
<td>86079</td>
</tr>
<tr>
<td>33</td>
<td>Tamil Nadu</td>
<td>1642497</td>
</tr>
<tr>
<td>34</td>
<td>Pondicherry</td>
<td>25857</td>
</tr>
<tr>
<td>35</td>
<td>Andaman &amp; Nicobar Islands</td>
<td>7057</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>21906769</td>
</tr>
</tbody>
</table>

Source: Census of India: 2001

In addition to the Census of India, the disability information was collected also by the National Sample Survey organization (NSSO), which
conducted a survey of 'Disabled Persons in India' during 58th round (July-December 2002). The data reported by the NSSO is proportionately low when compared to the data provided by the Census of India 2001. The NSSO estimated the number of disabled persons in the country to be 18.49 million which formed about 1.8 per cent of the total population. The table 2.2 shows the number of person with disability in India according to the National Sample Survey Organization (58th round, July-December 2002).

Table 2.2: Estimated number of persons with disabilities in India

<table>
<thead>
<tr>
<th>NSSO 2002</th>
<th>Total</th>
<th>%</th>
<th>Male Nos</th>
<th>%</th>
<th>Female Nos</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locomotor Disability</td>
<td>10634000</td>
<td>58</td>
<td>6633900</td>
<td>36</td>
<td>4000100</td>
<td>22</td>
</tr>
<tr>
<td>Hearing Disability</td>
<td>3061700</td>
<td>17</td>
<td>1613300</td>
<td>9</td>
<td>1448400</td>
<td>8</td>
</tr>
<tr>
<td>Speech Disability</td>
<td>2154500</td>
<td>12</td>
<td>1291100</td>
<td>7</td>
<td>863400</td>
<td>5</td>
</tr>
<tr>
<td>Blindness</td>
<td>2013400</td>
<td>11</td>
<td>928700</td>
<td>5</td>
<td>1084700</td>
<td>6</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>1101000</td>
<td>6</td>
<td>664500</td>
<td>4</td>
<td>436500</td>
<td>2</td>
</tr>
<tr>
<td>Mental Retardation</td>
<td>994700</td>
<td>5</td>
<td>625800</td>
<td>3</td>
<td>368900</td>
<td>2</td>
</tr>
<tr>
<td>Low Vision</td>
<td>813300</td>
<td>4</td>
<td>369300</td>
<td>2</td>
<td>444000</td>
<td>2</td>
</tr>
<tr>
<td>Any Disability</td>
<td>18491000</td>
<td>100</td>
<td>10891300</td>
<td>59</td>
<td>7599700</td>
<td>41</td>
</tr>
</tbody>
</table>

Source: NSSO 58th round (July-December 2002)

Coming back to the Census of India: 2001, classification of disabled population by different categories of disability shows that the people with seeing disability are the highest followed by movement disability. The
following table 2.3 shows the number of disabled persons in India according to the types of disability.

**Table 2.3: Disabled persons in India by types of disability**

<table>
<thead>
<tr>
<th>Sl.No</th>
<th>Category</th>
<th>No. of Persons</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Seeing</td>
<td>10634881</td>
<td>48.55</td>
</tr>
<tr>
<td>2</td>
<td>Speech</td>
<td>1640868</td>
<td>7.49</td>
</tr>
<tr>
<td>3</td>
<td>Hearing</td>
<td>1261722</td>
<td>5.76</td>
</tr>
<tr>
<td>4</td>
<td>Movement</td>
<td>6105477</td>
<td>27.87</td>
</tr>
<tr>
<td>5</td>
<td>Mental</td>
<td>2263821</td>
<td>10.33</td>
</tr>
<tr>
<td>6</td>
<td>Total</td>
<td>21906769</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: *Census of India: 2001*

While focusing on the scenario in Assam, the total disabled population of the state is estimated to be 530300 persons (see table 1.1) and that of the Kamrup district, of which Guwahati, the micro field for the study is an integral part, the size of the disabled population stands at 43883 individuals. The following table 2.4 highlights the number of disabled persons in Kamrup district according to the types of disability.

**Table 2.4: Disabled in Kamrup district by types of disability.**

<table>
<thead>
<tr>
<th>Sl. No</th>
<th>Category</th>
<th>No. of Persons</th>
<th>Percentage (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Blind</td>
<td>23871</td>
<td>54.40</td>
</tr>
<tr>
<td>2</td>
<td>Deaf</td>
<td>3837</td>
<td>8.74</td>
</tr>
<tr>
<td>3</td>
<td>Dumb</td>
<td>4677</td>
<td>10.66</td>
</tr>
<tr>
<td>4</td>
<td>Movement</td>
<td>7408</td>
<td>16.88</td>
</tr>
<tr>
<td>6</td>
<td>Mental</td>
<td>4090</td>
<td>9.32</td>
</tr>
<tr>
<td>7</td>
<td>Total</td>
<td>43883</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: *Census of India, 2001.*
As it has already been mentioned in the previous chapter that the research includes only those disabilities for which there are specific rehabilitation centers located within Guwahati and as such the focus of the study revolves around the blind, the deaf, and the mentally retarded population.

2.3 The Blind

The story of the blind in India is as old as the Mahabharata and as recent as the republic of Bharat. As it unfolds we get the clear picture of the distinguished blind men who lived and glittered in the firmament of the age on which they left their indelible impression. Indeed, from Dhritarashtra to Surdas, from Surdas to Gatulal and from Gatulal to Sukhalal, we have a chain of illustrious blind individuals who have contributed in their own way to the political, social and religious life of their fellowmen. Few of these individuals are, their impact on the social and religious life of their times is immense, though not yet fully appreciated. Generally speaking by the term ‘blind’ we mean those individuals whose vision is of no practical value to them for the purpose of education or in general, business of living.

(i) Definition

The United Kingdom has two definitions, one for adults and the other for children. The definition for adults reads, ‘so blind as to be unable
to perform any work for which eyesight is essential’; whereas the definition for children reads that, ‘pupil who have no sight or whose sight is or likely to become so defective that they require education by methods not including the use of eyesight’. The report on ‘blindness’ in India submitted by the joint committee of the Central Advisory Board of Education and Health in 1944 defined a ‘blind’ person as, ‘one who cannot count the fingers from an outstretched hand, held at a yard’s distance’. The World Council had suggested the following definition of ‘blindness’.

(a) Total absence of sight or
(b) Visual acuity not exceeding 3/60 or 10/200
(c) Serious limitations in the field of vision

The Industrial Home for the Blind (1958) have also suggested the same parameters for ‘blindness’. The definition was endorsed by the second All India Conference of the Blind, convened by the National Association for the Blind in Bombay in June 1959. This definition has been generally accepted throughout the world. It would be clear that those falling under this definition will not be necessarily totally blind. In fact a large number of blind persons do possess residual vision or object perception, but this impaired vision does not enable them to go about their jobs without great difficulty.

The total blind population of the world is now estimated at 40 million and 80 per cent of them are in the third world countries. The data collected
by the WHO indicate that the number of the blind, the world over is increasing and without greater effort towards prevention and treatment, there would be 80 million sightless in a couple of decade. As far as India is concerned there is no provision for compulsory registration of the blind in India and therefore no reliable statistics about the number of blind persons are available. However, according to the *Census of India: 2001*, the number of people with seeing disability is 10634881. In addition to this, the National Sample Survey Organization during its 58th round (July-December, 2002) estimated the number of blind persons to be 813300. Out of these huge number of persons with seeing disability, a substantial percentage of cases are incurable and rehabilitating all these people is almost impossible for a developing country like India. Therefore, it is more economical to promote ocular health, prevent eye diseases and cure them in such a way that blindness is reduced to the minimum.

(ii) Causes of Blindness

The major causes of blindness in India are summarized as follows.

**Infancy and Childhood**

(a) Malnutrition

(b) Trachoma and associated conjunctivitis

(c) Ophthalmia neo natorum

(d) Dangerous game and defective toys
(e) Congenital abnormalities like infantile cataract

(f) Hereditary diseases

**Youth**

(a) Malnutrition

(b) Trachoma and associated conjunctivitis

(c) Injuries in hazardous industries and occupation

(d) Defective methods of residing and writing

(e) Venereal diseases

**Adulthood and Old Age**

(a) Cataract

(b) Glaucoma

(c) Venereal diseases

(d) Diabetes

(e) Hypertension

(f) Consumption of spurious liquor

(iii) **Integration of the Blind**

A full integration of the blind can be achieved at various levels, such as family, education, vocational training, employment and social life.
(a) Family

The moment a child is born blind or become blind, the parents are shocked and stunned. All their parental joys and hopes vanish. They are not ready to accept the handicap of their child. As a result; they either develop over protective attitudes or start rejecting him. They never allow him to play with other children fearing he may get hurt. All such factors leave a mark on the personality of a blind child and he starts thinking that he is different from others. Since there are many misconceptions and prejudices regarding the capabilities of the blind in society, the family members of a blind child need to be guided to get rid of the prejudices in the family. And once the parents are able to realize that their blind child too can become a useful member of the family, they will not regard him as a mere object of pity.

(b) Education

Education moulds the lives of all children. After a blind is fully integrated into his family facing neither rejection nor overprotection by his parents, the next stage of his integration is his admission into a school. It is a very important media to bring the blind and sighted together. But, unfortunately in our country there are not many schools providing an integrated education to the blind. A large number of the blind, who opt to
study, reside in special schools where they learn to identify themselves with a special class of children, are virtually isolated from the society.

(c) Vocational Training

The third step in the integration of the blind with the general trades, which later will equip them to be easily absorbed in appropriate jobs. So far vocational training is restricted only to simple trades like candle making, chair recaning and music. It is now repeatedly supported by the research studies that the disabled are not more accident prone than the able-bodied and can be trained for a variety of jobs for which they were earlier considered incapable, and that they can do various jobs as efficiently as anyone else. Thus, as a step towards integration, the blind should be given opportunities to receive vocational training along with the sighted.

(d) Employment

The right to work is basic to life. Full achievement of this right can alone confer on the blind the benison of equality and fraternity in the community. Research studies have shown that only 60 per cent of the disabled men between the age group of 20 to 70 years have a job, the corresponding figure for other men in this age group is more than 90 per cent. As for the kind of jobs the disabled have, it is generally found that they mainly have low-paid jobs in sheltered workshops or institutions only.
These people are segregated and hence constitute an isolated group which is made to look and feel like a population of second class citizens of the country and hence never achieve genuine social integration with the so-called mainstream society. Thus, providing opportunities to them for open employment is an urgent need. This means that all major obstacles to open employment should be removed as far as possible. Lack of favourable working conditions, shortage of suitable accommodation, lack of well-trained placement officers and employer's misconceptions and prejudices regarding the capabilities of the blind are some of the major hurdles which they confront on a regular basis while looking for a livelihood. Unless these hurdles are removed it will be very different to extend the scope of employment for the blind.

(e) Social Life

Even after having secured a gainful employment, a blind person cannot be said to be fully integrated with the mainstream society unless he has interpersonal relationship with sighted persons, has proper accommodation in a colony of sighted people, has the ability to move about confidently in various situations, and succeeds in leading a happy married life. But unfortunately, in spite of being well educated and economically independent, they neither succeed in finding a suitable partner nor do they get proper accommodation. Prejudices regarding the blind make this
problem more acute. As a result of these, a deep sense of frustration develops in the blind and thereby resulting in the loss of faith in their own capabilities. Therefore, a conscious effort is needed to spread awareness among the people about the problems faced by the blind in our society. And the best way to spread awareness among the general public is through mass media.

In India, the major causes of blindness are cataract, glaucoma, trachoma and infectious diseases of the cornea and conjunctivitis. It is estimated that 42,000 children in our country become totally blind due to xerophthalmia (a vitamin 'A' deficiency disease) each year before their 6th birthday. For the vast number of people suffering from curable and preventable blindness, India has approximately 5000 ophthalmic surgeons. In addition to that almost all the ophthalmic surgeons live in cities and towns while 80 per cent of the people suffering from various types of blindness are from the rural area.

The Government of India's National Programme for the Control of Blindness and Visual Impairment and the Royal Commonwealth Society for the Blind (RCSB) are working towards prevention and cure of blindness among the people. The Royal Commonwealth Society for the Blind,
through its eyes of India campaign has supported hundreds of rural eye camps.

In eye camps, people were treated for various eye ailments, restored sight to totally blind through cataract operations and were operated upon for prevention of blindness. To prevent blindness amongst children arising out of xerophthalmia, the RCSB has set up programmes in various parts of India. The Government of India through the Ministry of Health is successfully running the Integrated Child Development Services, which would help a great deal in the prevention of nutritional blindness.

2.4 The Deaf

This category of the disabled persons can neither hear nor communicates like normal hearing persons and they are classified as ‘deaf’ and ‘mute’. It is generally resented by the people who are deaf that their population is also pronounced as ‘mute’. Therefore the word ‘deaf’ is only used here. It is however understood that without a sense of hearing there is no proper development of speech and consequently such persons remains mute, may be totally or partially.

Deafness is disability which has so far attracted less attention of the society as compared to the other disabilities as it is not visible to the eyes. Deafness is exposed when there is an occasion of communication with other people.
(i) Definition

No standard definition of deafness has so far been accepted in India; but the following general definition is accepted in the United States of America. The deaf are those in whom the sense of hearing is non functional for the ordinary purpose of life. The loss of hearing is measured by means of a pure tone audiometer and is expressed in decibels. Persons with a loss of over 60 decibels are generally regarded as deaf.

The training centre for the adult deaf established by the central government in Hyderabad defines ‘deaf’ as those in whom the sense of hearing is non-functional for the ordinary purpose of life which would normally mean a loss of 70 decibels or above by air conduction in the better ear. The Industrial Home for the Blind (1958) suggested the following parameter for the ‘deaf’. ‘The term ‘deaf’ has been defined to mean inability to understand connected discourse through the ear’. The other definition developed by the conference of executives of American schools for the ‘deaf’ in 1975 was, “a deaf person is one whose hearing disability precludes successful processing of linguistic information without a hearing aid”. A hard of hearing person is one who generally with the use of hearing aid has residual hearing sufficient to enable successful processing of linguistic information through audition. Such losses were further categorized as mild (20 to 54 decibels) moderate (55 to 69 decibels), severe (70 to 89 decibels) and profound (90 decibels and above).
In 1938, special committees on nomenclature, for the conference of executives of American schools for the deaf put forwarded a statement which states that, deaf are those, in whom the sense of hearing is non-functional for the ordinary purpose of life. This general group is made up two district classes based entirely on time of loss of hearing.

(a) The congenitally deaf, those who are born deaf

(b) The adventitiously deaf, i.e., those who are born with normal hearing but in whom the sense of hearing become non-functional later through illness or accident.

(ii) The Hard of Hearing

Those in whom the sense of hearing although defective is functional with or without a hearing aid.

(iii) Categories of Deaf

The deaf are classified in to following groups –

(a) Those who were born deaf, who can speak intelligibly and read the lips;
(b) Those who were born deaf, who can read the lips but cannot intelligibly;
(c) Those who were born deaf, whose speech is intelligible but cannot, read the lips;
(d) Those who were born deaf or lost their hearing at an early age who neither speak nor read the lips (their main methods of communication is
through the language of signs and writing);

(e) Those who communicate through finger spelling, signs, partial lip reading and writing (among the above group are those who have excellent language, while at the other extreme are those who cannot construct simple sentences or comprehend simple instructions;

(f) Those adults who lost all of their hearing (suddenly or gradually) after the establishment of speech and language. (This group while not having the educational difficulties of those in 'a' to 'e', often have significant adjustment problems. Their chief means of communication is by speech and lip reading and also writing when necessary.

It is thus very clear that the problems of the deaf need very careful handling. Since the degree of deafness varies from person to person, there cannot be one common solution. Each group merits a different approach. At the same time, it is imperative that they are no longer kept in complete segregation for their education, training and employment. It is needed that they are integrated in to the society with normal hearing people. It is worthwhile to provide avenues for integration of disabled people of all categories with normal people at certain stages and platforms.

The process of integration should start from home to schools, play fields, cultural centers and work places. Parents of disabled children develop an attitude of indifference. It is invariably felt that where there are
normal children in same family, the disabled ones develop emotional problems of insecurity, inferiority and jealousy. The parents need to develop a healthy and harmonious atmosphere in the family to facilitate the development of the disabled child under normal circumstances.

Problems of the deaf are almost the same all over the world. There is great deal of legislation concerning the deaf and other disabled persons in many countries specially USA, Russia, UK, Australia, France, Italy, Japan and Denmark. There are very comprehensive laws in these countries dealing with the education, training, employment and other facilities concerning the disabled people. In Russia, there are voluntary associations which work for the people who have lost their hearing. All Russia Society for the Deaf is a leading such association which was setup in 1926. There are other similar societies to help the members to solve problems pertaining to their everyday life and work. They also organize educational training, cultural and recreational activities for the deaf. Russia with its socialist character has provided equal rights and facilities to the deaf persons as to all other citizens. Similarly, in all countries there are national /state level voluntary societies which are working for the welfare of the deaf. The government agencies are also taking necessary steps to look after the needs of the deaf people.
(iv) World Federation of the Deaf

The world federation of the deaf was established in 1951 with its headquarters in Rome, Italy. All India Federation of the Deaf was affiliated to this world body in 1957. The objective of the world federation of the deaf (here onwards, it will be referred as W.F.D) is to draw the attention of government and international bodies and organizations to the various problems of communication of the deaf. The W.F.D. has organized twelve international conferences on deafness to discuss specific themes related to this disability. World congress is organized every four years. At every congress there is a different theme for consideration, analysis and recommendations. These analysis and studies have been a source of series of recommendations. As it has already been mentioned that the problems of the deaf are similar everywhere and India is no exception. Economic rehabilitation of the deaf is very important in this country as in anywhere else. These people have the capacity to learn, to work and to undertake responsibility to share sorrows and pleasures, to act as disciplined soldiers, dedicated workers and enlightened citizens of the country, provided they are afforded enabling opportunities. They have proved to be better workers in offices, as well as in factories.

(v) Voluntary Efforts

Rehabilitation of the deaf is such a stupendous task that without
effective coordination between the government and non-government agencies, it is very difficult to achieve the objectives. Therefore, the voluntary sector has to be encouraged and the vast potential of human resources harnessed to meet these challenges. There are about 45 voluntary organizations in the country working for the deaf at the national, state and district level. The available services concerned with the deaf population are confined only to the urban areas and the vast rural population has not been reached. A deaf person is treated in our society as if he/she is a curse to the family. He/she neither gets medical aid to arrest deafness, nor education, to be able to earn his/her own livelihood.

To arrest deafness there is an imperative need of vast network of centers for early detection, diagnosis and treatment. Equally important is to take suitable steps to prevent deafness, which is due to prevent deafness, which is due to many factors. Maternity and child health centers as well as primary health centers must also cater to this aspect of the health problem. Parents have the greatest role to play in early detection of deafness in the child. Often ignorance of parents lead to tragic end. Training and orientation of parents for care of the deaf child is very important. Along with the awareness factor, the need of the hour is adequately equipped integrated schools or special schools all over the country, specially in rural areas. Vocational training will equip the deaf to be able to earn not only for themselves but also for their families. Employment does not mean ‘service’
in government or private agencies. There are vast avenues of self
employment after proper training; for example carpentry, painting,
photography, printing, tailoring and so on. Deaf can also make good stage
actors, dramatists etc. For the deaf, fields of culture and sports are very
attractive, only if they are provided with adequate opportunities which they
rightfully deserve.

2.5 The Mentally Retarded

In India, when one speaks about mental retardation, one tends to
speculate on the basis of one’s subjective impressions, as there is a lack of
empirical data to answer these questions. The foremost question that comes
up is the estimated prevalence of the condition in the country. Estimates
like, 3 per cent for the mild form and 1 per cent for the severe forms give a
false sense of precision, for they are not based on any systematic studies in
the country. Prevalence studies of different grades of retardation in
different age levels and different settings are required not only for planning
of services but also for discovering determinants. Several small scale
prevalence surveys have been carried out in the country. In some of these
surveys psychometric tests have been utilized to identify individuals who
are mentally retarded. The results of these tests suggest that, approximately
3 per cent of the general population could be labeled as mentally retarded
because of the inherent postulates on which the tests of intelligence are
constructed and standardized. On the other hand there are studies where individuals have been identified as mentally retarded on the basis of their inability to adapt, or because the community in which these individuals live felt that they are incapable of functioning as useful members of the society by discharging the normal functions expected of them. Studies which follow this method of identification as against the intelligence test have estimated the prevalence of mental retardation to be 4 to 5 per thousand of general population. Nearly eighty per cent of the individuals identified on the basis of intelligence test results as mentally retarded were not perceived to be so by the community when the norm utilized was one of adequacy in social functioning. It is important to mention that in simple rural agrarian community where stress on education is low and where collective and cooperative living rather than individual striving and competition is the general rule; many of the mildly retarded individuals do fulfill the social functions expected of them and hence do not get identified as mentally retarded.

(i) Definition

Crossman (1983:73) defines mental retardation as “significantly sub-average general intellectual functioning existing concurrently with deficit in adaptive behaviour and manifested during the developmental period”. A mentally retarded person is basically the same as a normal human being but
has a lower level of intelligence. He is lacking in intellectual endowment from birth or from a very early age. Mentally retarded persons suffer from disabilities caused by either incomplete or arrested growth of the brain. This fact makes them incapable of performing some essential intellectual functions such as coherent thinking, reasoning, inferring, discriminating, comparing, following directions, concentrating etc. For instance, a retarded child learns more slowly and at maturity his capacity to understand is less than normal. He finds difficulty in learning, social adjustment, and in economic participation.

(ii) Causes of Mental Retardation

There are a number of known and unknown causes that impair the brain cells and lead to mental retardation. It can be caused by conditions occurring before birth, during birth and after birth. During pregnancy the developing brain of the child can be hurt by many harmful influences such as infections and diseases of the mother, too much x-ray and screening exposures, low oxygen, malnutrition and anaemia, excessive drugging etc. At the time of birth too fast or a prolonged and difficult delivery can affect the child. After birth, there are number of factors such as injury from falls, other accidents, bacterial and viral infections, especially meningitis, encephalitis, tuberculosis, poliomyelitis, malnutrition, jaundice, dehydration etc. Intelligence can also be sharply affected if the
environment of the child during the early childhood years is devoid of stimulation.

(iii) Categories of Mentally Retarded

Intelligence is generally assessed by a number of different tests designed to find out various aspects of intellectual functioning. This gives an intelligent quotient or I.Q. in short. Psychologists and social scientists have divided the mentally retarded into three broad categories; severely retarded, mostly with I.Q. ranging from 25 to 50 and mildly retarded with I.Q. varying from 50 to 75. The first group has the intellectual capacity of a child between 2 to 4 years. The performance and behaviour of the second category is that of a child between 4 to 8 years, while the third group of people can develop and behave as a child between 8 to 12 years. Of the retarded, only 5 per cent have a profound or severe degree of retardation. They are incapable of guarding themselves against common physical dangers and need life long nursing care. About 20 per cent moderately retarded can be taught to care for themselves and to do simple routine tasks under supervision. With early and proper teaching and with suitable schooling and vocational training, the mildly retarded who constitute 75 per cent of the retarded population can learn to be fairly self-supporting adults. However, a rigid classification of the retarded is difficult as many of them can benefit with special education and training. They also benefit from all
types of attention and care. Even more severely retarded can improve quite a bit. Among the mildly retarded, the majority can learn to read and write, hold jobs and lead useful lives.

(iv) The Magnitude

The National Sample Survey Organization's estimate of the mentally retarded at the all India level is 994700, which is 5% of the total disabled population of the country, whereas the Census of India 2001, estimated that the number of persons suffering from mental retardation is 2263821, which accounts for 10 per cent of the disabled population in India. The incidence of mental retardation is much more in rural areas and among disadvantaged sections of society as compared to the people in urban areas and among those who are socially and economically well off. But it is equally important to mention that mental retardation occurs in all classes of people and in families rich and poor, learned and uneducated. The high incidence of mental retardation in India is due to extreme poverty, malnutrition, poor healthcare etc. Children from deprived backgrounds that constitute the bulk of the retarded population become mentally disabled due to lack of early opportunity for intellectual growth.

(v) Mental Retardation and Mental Illness

Mental retardation is different from mental illness. Mental
retardation is a condition which generally leads to a disability, where as mental illness is a disease. Mentally retarded persons are slow learners and mental age is below their actual age. On the other hand mentally ill persons do not show any developmental delay. They may show disturbance in behaviours such as being extremely moody, sleepless, withdrawn, seeing or hearing things which others do not see or hear, reduced appetite etc. In rare circumstances, however, a mentally retarded person can also have mental illness. Unlike a person who is mentally ill and who can be given medical treatment, mental retardation is not primarily a medical problem. Despite the fact that mental retardation can not be cured, the treatment for them is stimulation and education from the earliest possible moment to develop their limited potential. But, in order to provide the mentally retarded people with suitable therapies and special education early in their lives, there are perhaps not many well equipped clinics in India exclusively for diagnosis and treatment of people with mental retardation. It would not be wrong to assume that a good number of well-equipped centers for detection and treatment along with vocational training would help the mentally retarded person lead a life of respect and responsibility.

2.6 Disabled Persons in India and National Policy

There has been an increasing recognition of abilities of persons with disabilities and lately greater emphasis has been put on mainstreaming
them in the society based on their capabilities and talent. The constitution of India ensures equality, freedom, justice and dignity of all individuals and implicitly mandates an inclusive society for all including persons with disabilities. The human right movement has boldly and categorically shifted the attention of policy makers from mere charitable services to vigorously protecting their basic right to dignity and self respect. The national policy on disabled put stress on viewing the disabled as individuals with wide range of abilities and each one them capable of utilizing his/ her potential and talent to participate and contribute to the society. The Government of India has enacted three (3) legislation for persons with disabilities, viz., (i) Persons with Disability (equal opportunities, protection of rights, and full participation) Act, 1995, which provides for education employment, creation of barrier free environment, social security etc. ii) National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disability Act, 1999 has provisions for legal guardianship of the four categories and creation of enabling environment for as much independent living as possible. iii) Rehabilitation of India Act, 1992 deals with the development of manpower for providing rehabilitation services. The National Policy recognizes that persons with disabilities are valuable human resource for the country and seeks to create an environment that provides them equal opportunities, protection of their rights and full participation in society. Education is the most effective
vehicle of social and economic empowerment. In keeping with the spirit of the article 21A of the constitution guaranteeing education as a fundamental right and section 26 of the Persons with Disabilities (PWD) Act, 1995, free and compulsory education has to be provided to all children with disabilities up to the minimum age of 18 years. The PWD Act, 1995 provides for 3% reservation in employment in the establishments of Government of India and Public Sector Undertakings (PSUs) against identified posts. The status of reservation in government in various ministries / departments against identified posts in group A, B, C and D is 3.07%, 4.41%, 3.76%, and 3.18% respectively. In PSUs, the reservation status in group A, B, C and D is 2.78%, 8.54%, 5.04% and 6.75% respectively. Disabled persons, their families and care givers incur substantial expenditure for facilitating activities of daily living, medical care, transportation, assistive devices etc. Therefore, there is a need to provide them social security by various means. The Central Government of India has been providing tax relief to persons with disabilities and their guardians. At the same time the state governments and union territory administrations have been providing unemployment allowance or disability pension. Parents of severely disabled persons feel a sense of insecurity regarding the welfare of their wards after their death. The National Trust for Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities has been providing legal guardians through local level
committee. They are also implementing the ‘supported guardianship scheme’ to provide financial security to persons with the above mentioned disabilities, who are destitute and abandoned, by supporting the cost of guardianship. Therefore, it can easily be said that India’s national policy for the disabled aims to make our society not just tolerant but ‘inclusive’. An India, where all the people with or without a disability will have the status of human dignity, honour and equal partnership.