CHAPTER-I

INTRODUCTION

“Being disabled should not mean being disqualified from having access to every aspect of life”

-Emma Thompson

India is a vast country with a population of more than one billion. While estimates vary, there is growing evidence that people with disabilities comprise between 5 and 8 percent of the Indian population (around 55-90 million individuals). On the whole 41 percent of them are women. (NSSO 2002).

The disabled are deprived of all opportunities for social and economic development. The basic facilities like health, education and employment are generally denied to them. In spite of several international and national pronouncements, the rights of the disabled have remained on paper.

Both disability and gender are physical constructs that totally ignore the personhood. To be a disabled person is to fail to measure up to the general cultural definition of masculinity as strength, physical ability and autonomy. To be a disabled woman is to be considered unable to fulfil the role of homemaker, wife as also mother, and unable to conform to the stereotype of beauty and femininity in terms of physical appearance. But being a disabled woman also fits well into the stereotype of passivity and dependency.

Women’s movement in India too had not concentrated on the problems of such disabled women. By realizing how much efforts are to be taken on women’s development, plenty of awareness, education, career oriented education, health education, social security system, were being organised. Organizations like National Commission for Women, Human Rights Commission and other Civil Rights Group were being consulted to make policy for disabled women. The issues also received political attention. As per Article-6 regarding Women with Disabilities, appropriate measures were taken to empower such women. There is a rising need to include gender dimensions in the health
care policies and programmes by the State, and to review the existing programmes and policies as per the International Standards

Accordingly, the following actions were taken by UNO to create a positive attitude about disabled among society to celebrate International Year of Disabled Persons (IYDP) -1981 and 3rd December is observed as International Day of Disabled Persons, promoted by UN since 1992. It has been celebrated with varying degrees of success around the planet. The observance of the Day is celebrated to promote an understanding of disability issues and mobilize support for the dignity, rights and well-being of persons with disabilities. It also seeks to increase awareness of gains to be derived from the integration of persons with disabilities in every aspect of political, cultural life. It was originally called "International Day of Disabled Persons". Each year the day focuses on a different issue.

The theme of IYDP was full participation and equality, defined as the right of persons with disabilities to take part fully in the life and development of their societies, enjoy living condition equal to those of other citizens, and to have an equal share in improved conditions resulting from socio-economic development.

**Theme of IYDP**

1981: Full Participation and Equality

1998: Arts, Culture and Independent Living

1999: Accessibility for all for the new Millennium

2000: Making information technologies work for all

2001: Full participation and equality: The call for new approaches to assess progress and evaluate outcome

2002: Independent Living and Sustainable Livelihoods

2003: A Voice of our Own

2004: Nothing about Us, Without Us
2005: Rights of Persons with Disabilities: Action in Development

2006: e-Accessibility

2007: Decent Work for Persons with Disabilities

2008: Convention on the Rights of Persons with Disabilities: Dignity and Justice for all of us

2009: Making the MDGs Inclusive: Empowerment of persons with disabilities and their communities around the world

2010: Keeping the promise: Mainstreaming disability in the Millennium Development Goals towards 2015 and beyond

2011: Together for a better world for all: Including persons with disability development

2012: Removing barriers to create an inclusive and accessible society for all.

2013: Breaking barriers, open doors for an inclusive society and development for all.*

The World Health Organization defines “Disability or Differently abled as an umbrella term covering impairments, activity limitations, and participation restrictions. Impairment is a problem in body function or structure, an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations. Thus disability is a complex phenomenon, reflecting an interaction between features of a person’s body and features of the society in which he or she lives.

In common usage, the terms impairment, disability and handicap are tended to be used interchangeably. However, according to the authorities in this area, these terms can have different connotations in different cultural contexts (United Nations, 1964).

* Women watch – Information and Resources on G.E and Empowerment of women-Google
A Detailed Description of Disability:

1.1. CONCEPT OF DISABILITY

1.2. PREVALENCE OF DISABILITY

- GLOBAL INCIDENCE
- PREVALENCE IN INDIA
- INTERSTATE PREVALENCE

1.3. UNITED NATIONS & PERSONS WITH DISABILITIES

- REGIONAL COMMISSIONS
- MILLENIUM DEVELOPMENT GOALS
- 12 CRITICAL AREAS OF CONCERN

1.4. FIVE YEAR PLANS & DISABILITY

1.1 Concept of Disability: Types and Forms

Types of Disability:

**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 y or Blindness refers to a person’s inability to see either fully or partially. A person with low vision or poor eyesight is one who continues to have the problem even after going through medically approved corrective measures.

**Mental Illness:** Mental illness can include both mental ill health and retardation. Retardation is a state of arrested or incomplete development of mind, characterised by impairment of skills such as cognitive language, motor and social abilities while Mental
ill health is due to series of chemical changes in the brain such as depression, mania, schizophrenia.

**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:** It is a disorder, which affects the basic psychological processes of understanding or using written or spoken language.

**Multiple Disability:** A combination of two or more disabilities as defined in clause (i) of section 2 of the Persons with Disabilities Act 1995(PWD Act 1995).*

Disability is difficult to define since it varies in type, form and intensity. Understanding disability will require understanding these differences. According to the World Health Organization “Disability is any restriction or lack (resulting from an impairment) of ability to perform in a manner or within the range considered normal for a human being”.

The World Health Organization, in its International Classification of Impairments, Disabilities and Handicaps, makes a distinction between impairment, disability and handicap. These three concepts are defined by it as follows:

(a) Impairment is "any loss or abnormality of psychological, physiological, or anatomical structure or function". Impairments are disturbances at the level of the organ which includes defects in or loss of a limb, organ or other body structure, as well as defects in or loss of a mental function. Examples of impairments include blindness, deafness, loss of sight in an eye, paralysis of a limb, amputation of a limb; mental retardation, partial sight, loss of speech, mutism.

(b) Disability is a "restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being". It describes a functional limitation or activity restriction caused by an impairment. Disabilities are descriptions of disturbances in function at

* PWD (Equal Opportunities, Protection Of Rights And Full Participation) Act, 1995

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the level of the person. Examples of disabilities include difficulty in seeing, speaking or hearing; difficulty in moving or climbing stairs; difficulty in grasping, reaching, bathing, eating, and toileting.

(c) A handicap is a "disadvantage for a given individual, resulting from an impairment or disability that limits or prevents the fulfillment of a role that is normal (depending on age, sex and social and cultural factors) for that individual". The term is also a classification of "circumstances in which disabled people are likely to find themselves". Handicap describes the social and economic roles of impaired or disabled persons that place them at a disadvantage compared to other persons. These disadvantages are brought about through the interaction of the person with specific environments and cultures. Examples of handicaps include being bedridden or confined to home; being unable to use public transport; being socially isolated.

According to Article 1 of the United Nations Convention on Rights of Persons with Disabilities (2006) “Persons with Disabilities include those who have long-term physical, mental, intellectual, or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others.”

WHO reaffirmed this classification (WHO 1980), and in 2001 issued the International Classification of Functioning, Disability and Health (ICF). The ICF distinguishes between body functions (physiological or psychological, e.g. vision) and body structures (anatomical parts, e.g. the eye and related structures) (WHO 2002). 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 (WHO 2002). The ICF lists 9 broad domains of functioning which can be affected (WHO 2002).*

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* (The ICF was officially endorsed by all 191 WHO Member States in the Fifty-fourth World Health Assembly on 22 May 2001 -resolution WHA 54.21).
- Learning and applying knowledge
- General tasks and demands
- Communication
- Mobility
- Self-care
- Domestic life
- Interpersonal interactions and relationships
- Major life areas
- Community, social and civic life

The following definitions are developed from the perspective in the World Programme of Action Concerning Disabled Persons (UNO).

(a) Prevention is any measure aimed at preventing the onset of mental, physical and sensory impairments (primary prevention) or at preventing impairment, when it has occurred, from having negative physical, psychological and social consequences (secondary prevention);

(b) Rehabilitation is a goal-oriented and time-limited process aimed at enabling an impaired person to reach the optimum mental, physical and or social functional level, thus providing the individual with the tools to change her or his own life. It can involve measures intended to compensate for a loss of function or a functional limitation (for example, by technical aids) and other measures intended to facilitate social adjustment or readjustment;

(c) Equalization of opportunities is the process through which the general system of society, such as the physical and cultural environment, housing and transportation, social and health services, educational and work opportunities, cultural and social life, including sports and recreational facilities, are made accessible to all.

Persons with Disability Act 1995 defined as a person suffering from not less than forty per cent of any disability as certified by a medical authority. The disabilities
identified are, blindness, low vision, cerebral palsy, leprosy, leprosy cured, hearing impairment, locomotor disability, mental illness and mental retardation as well as multiple disabilities.

The NSSO (National Sample Survey Organization) considered disability as “Any restriction or lack of abilities to perform an activity in the manner or within the range considered normal for human being”. It excludes illness / injury of recent origin (morbidity) resulting into temporary loss of ability to see, hear, speak or move.

The social model of disability sees the issue of “disability” as a socially created problem and a matter of the full integration of individuals into society. In this model, disability is not an attribute of an individual, but a complex collection of conditions, many of which are created by the social environment. Hence, the management of the problem requires social action and is the collective responsibility of society to make the environmental modifications necessary for the full participation of people with disabilities in all areas of social life. The issue is both cultural and ideological, requiring individual, community, and large-scale social change. From this perspective, equal access for someone with an impairment/disability is a human rights issue of major concern.

The social model makes a distinction between ‘impairment’ and ‘disability’. It defines impairment as ‘lacking part or all of a limb or having a defective limb, organism or mechanism of the body.’ On the other hand, disability is ‘the disadvantage or restriction of activity caused by a contemporary social organisation which takes little or no account of people who have physical impairments and thus excludes them from the mainstream of social activities.’

The social model takes disability away from the individual alone and places the responsibility on society as a whole. It argues that disability is a result of social structures, not deficits in the body or brain. The present social structures – predominantly shaped by people’s attitudes and understanding of disability – deny access to resources and information which disables an individual. The social model argues that people with disabilities are not victims but agents resisting oppression, overcoming challenges and thereby changing social structures.
The rights-based model of disability builds on the insights of the social model to promote creation of communities which accept diversities and differences, and have a non-discriminating environment in terms of inclusion in all aspects of the life of society.

1.2 PREVALENCE OF DISABILITY:

GLOBAL INCIDENCE:

Internationally agreed definitions suggest that people with disabilities constitute at least 10% of the population. Further, a study by the United Nations Population Fund states that 80% of this population lives in developing countries.

The United Nations (UN) Disability Statistic’s Compendium (DISTAT) noted that disability rates are not comparable across the world because of differences in survey design, definitions, concepts and methods, as the proportion of disabled people per national population varies between less than 1% in Peru and 21% in Austria (UN 1990). In 1981, UN/WHO studies estimated that on average 10% of all national populations were disabled. However in 1992, this estimate was modified to 4% for developing countries and 7% for industrialised countries (Metts 2000, World Bank). There is no consensus as to which figures to use, for example: The UN Development Program estimates a total global proportion of disabled people of 5% (Coleridge 1993), USAID at 10% and DFID at 4-7%. Depending on survey or census data different estimates are derived across the world with the United States census data estimating a disability prevalence rate of 20% in 2000 and a survey data estimating a 5% rate in China in 1987 (Mont 2007).

SOUTH EAST ASIAN INCIDENCE:

Differences are also seen across member states of the WHO South- East Asian Region. In the 2001 and 2002 survey data, Bangladesh had the highest prevalence rates of 5.6% compared with a 1.5% rate in Timor-Leste. Census data suggests that Thailand had a prevalence rate for disability in 2007 of 2.9% compared with a rate of 1.6 in Sri Lanka in 2001 and India the prevalence rate was 2.1%.
Prevalence of disability in the Member countries of the WHO South-East Asia Region as per the estimate of UNESCO for Asia and the Pacific in 2002 prevalence was 1.8%.

- **Prevalence of Disability in India:**

  There is a common concern that disabled persons are among the most excluded ones in the development process of the country. For an effective and efficient policy intervention to improve the lots of the disabled persons, it is of utmost importance to get a clear idea of the dimension of disability in India. Different prevalence rates for disability are available in India as per different surveys. Population Census and NSSO surveys are the major two sources of official statistics in India. National Sample Survey Organisation has been conducting comprehensive nation-wide large scale sample surveys on disability almost once in 10 years. The third and the latest survey on the disabled persons were carried out in the NSSO 58th round (July-December 2002), where the coverage was extended to include mental disability also. But the two differ substantially in respect of overall estimates of persons with various types of disability and their composition, mainly due to differences in the concepts and definitions as also the data collection methodologies. Therefore in this section dimension of disability reflected by these two sources would be taken up separately. Even though the NSSO and the Population Census data are not comparable on account of methodological and definitional differences, NSSO data provides important insights into the causes of disability and age specific prevalence rates for different types of disabilities.

  According to the Census 2001, there are 21.9 million people with disabilities in India who constitute 2.13% of the total population. Out of the 21,906,769 people with disabilities, 12,605,635 are males and 9,301,134 females and this includes persons with visual, hearing, speech, locomotor and mental disabilities. In the year 2001, of the persons with disability (PWD) about 75% belonged to rural areas and only 25% were from urban areas. (Population Census 2001).

  In contrast, the National Sample Survey Organization (NSSO) estimated that the number of persons with disabilities in India is 1.8% (18.49 million) of the Indian population, 76% of persons with disabilities live in rural areas, 24% live in urban areas,
59% were males and 41% were females, 49% of the disabled population were literate and only 34% were employed. NSSO also includes the persons with visual, hearing, speech, locomotor and mental disabilities (mental retardation and mental illness), but the distribution in each category according to the two surveys differs drastically. The difference in estimates of Census (2001) and NSSO (2002) for different types of disabilities can be explained by the lack of universal definitions and criteria of disabilities used during the surveys. (source: NSSO Survey on Disability 2002).

However, estimates vary across sources and a new World Bank Report on disabled persons in India, has observed that there is growing evidence that people with disabilities comprise between 5 and 8 per cent of the Indian population (around 55 – 90 million individuals). *

<table>
<thead>
<tr>
<th>Type of Disability</th>
<th>Census of India (2001)</th>
<th>NSSO (2002)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locomotor</td>
<td>28%</td>
<td>51%</td>
</tr>
<tr>
<td>Visual</td>
<td>49%</td>
<td>14%</td>
</tr>
<tr>
<td>Hearing</td>
<td>6%</td>
<td>15%</td>
</tr>
<tr>
<td>Speech</td>
<td>7%</td>
<td>10%</td>
</tr>
<tr>
<td>Mental</td>
<td>10%</td>
<td>10%</td>
</tr>
</tbody>
</table>


About 10.63 per cent of the disabled persons suffer from more than one type of disability. Prevalence rates have shown declining trends during 1991-2002 for all disability types except locomotor disability and significant decline was registered for visually impaired persons during 1991-2002. Patel et.al. (2009) using NSSO 2002 data, observed that locomotor disabilities are the most prevalent type of disabilities affecting of all ages in India.

* People with Disabilities in India: From Commitments to Outcomes, by Human Development Unit, South Asia Region, The World Bank.
AGE OF ONSET OF DISABILITY:

Around 1/3rd of the persons with disability have acquired disability since their birth. The reasons for this are diverse, ranging from heredity, defective gene mutation, congenital defects, and inappropriate services at the time of delivery, low level of nutrition and healthcare provided to the pregnant mothers during their pregnancy period. Both rural and urban areas have reported around 33 per cent disability cases since birth. There are also cases of use of inappropriate methods adopted at the time of delivery, which were reported through several sample surveys as one of the causes of disability since birth. (Source: NSSO Rounds 58th, 2002)

Mental disabilities are the highest in the working age population, whereas visual and hearing disabilities are the highest in the aged. Further, onset of locomotor and speech disabilities mainly occur at early ages, whereas onset of visual and hearing disabilities are highly concentrated at later ages. Onset of mental disabilities peaks at early ages and younger working age population. Severe disability is broadly concentrated at later ages. (Patel et al. 2009).

GENDER SPECIFIC DISTRIBUTION:

Between the two sexes, the prevalence of disability was marginally higher among males than among females with a prevalence rate for males at 2.37% and for women 1.87% according to census 2001 (Population Census 2001)

According to the 2002 NSSO records among the males, the proportion of disabled (2%) was significantly higher than that among females (1.5%). ( NSSO 2002-58th round).

REGION SPECIFIC DISTRIBUTION:

According to NSSO (2002), about 8.4% and 6.1% of the total estimated households in rural and urban India, respectively, reported to have at least one disabled person. Among the rural residents, the prevalence of disability was 1.85% and that among the urban was 1.50%. The distribution of different types of disabilities among the urban and rural areas is depicted in the following diagram which indicates that locomotor disability is the most prevalent type.
In general, in all the survey rounds of NSSO 2002 prevalence of disability was found to be highest (more than 2000 per 100000 population) among rural males and lowest among urban females (about 1300 per 100000 population).

Diagram – 1.1 Types of disability in Rural India

SOURCE: NSSO 2002

Diagram – 1.2 Types of disability in Urban India

SOURCE: NSSO 2002
INTERSTATE PREVALENCE:

Interstate variation:

NSSO survey (2002): In the NSSO 2002 survey on disability, the proportion of disabled persons in the population was found to be relatively high (more than 2%) in H.P (2.6%), Orissa (2.5%), Kerala (2.2%), and Punjab (2%) while it was significantly low in Delhi (0.6%), Assam (1.0%), Jharkhand (1.2%), Rajasthan (1.5%) etc. However, in almost half of the states the prevalence was in the range of 1.7% to 1.8%, but for Tamilnadu it is 1.9%.

According to the Census records one positive trend which has been noticed throughout is that the prevalence rates have declined in 2002 as compared to 1991 in majority of the States. This decline is more visible in the urban areas than in the rural areas. Prevalence rates for both for men and women have registered a sharp decline. States like Orissa, Himachal Pradesh, and Haryana reported high prevalence rates among the males in rural areas whereas in the urban areas the States like West Bengal and Kerala reported high prevalence rate. For females the trends are such that in the rural areas the states of Orissa, Kerala, Tamil Nadu, Andhra Pradesh and some mountain states showed high prevalence rates. In case urban areas the prevalence rate was high for females in Orissa, Kerala, Tamil Nadu, West Bengal and Chattisgarh.

Age specific distribution: survey shows a decline in prevalence of different disability types in age groups of less than 15 years and above 45 years (NSSO 2002). Another negative factor, which has come into the light, is the increased prevalence rate among the younger population. It exhibits an increasing trend of prevalence rate for locomotor impairment for the 15-44 age groups in both rural and urban areas in 2001 as compared to 1991. This is a serious blow on the productive population of the society.

Analysis of total number and distribution of Disabled Persons in different age groups for various population categories shows that percentage of disabled in the working age-groups of 20 – 59 years is more in urban areas than in rural areas. This may be attributed to the fact that working age people in urban areas are much more exposed to mechanized modes at workplace and in day-to-day activities compared to the rural
people. The proportion of disabled in older ages (60 and above) is also found to be higher among women as compared to men.

**Disabled Persons: Place of Residence:**

The magnitude of disabled persons residing in rural areas is very high as compared to disabled persons residing in the urban areas. 76.14% of disabled live in rural areas while 23.86% of disabled live in urban areas. (NSSO-2002).

**Disabled Household, Number of Disabled Persons:**

According to 2002 Census records, the numbers of disabled persons who have other disabled people in their households are the following. About 92 per cent of these household have one disabled person, 7 per cent households have two disabled persons and the rest 1 per cent households have two or more than two disabled persons. No significant variations were registered in the rural and urban areas during 1991 and 2002. Significantly large proportions, 7-8 per cent households have more than one disabled person in their homes and this was uniform both in rural and urban areas.

**Severity of disability:**

This section presents information about the severity of disability among persons with disability. About 60 per cent disabled persons can function without aid/appliances, while 13 percent cannot function even with aid and appliance and another 17 percent can take self care with the help of aid and appliance. Around 10 percent of disabled have neither tried nor have access to aids and appliance and hence cannot take self-care. Significantly the proportion of severely disabled who cannot function even with the help of aid/ appliance is 13.1 per cent in rural areas and 14 per cent in urban areas in 2002. (NSSO 2002).

**Disabled Persons: Caste Composition:**

The caste composition of disabled persons in India depicts that a substantial proportion of them were scheduled castes (23.4 per cent in rural areas and 18.2 per cent in urban areas). About 8.4 per cent and 2.5 per cent disabled persons were scheduled tribes in rural and urban areas respectively. OBC category constituted 42.2 per cent in
rural and 37.6 per cent in urban areas while others constituted 26.2 per cent in and 41.4 per cent in urban areas. In terms of the prevalence rate not much variation was noticed between 1991 and 2002 in the urban and rural context. However there was a slight increase in the proportion of scheduled caste disabled persons in the urban areas in 2002(18.4) as compared to 1991(16.9).

**Disabled Persons, Marital Status:**

According to the NSSO 2002 Census, 43 per cent disabled have never married, while 39 per cent are currently married and a significant 15 per cent are widowed and around 1 per cent are divorced or separated. A very high proportion of disabled persons, were never married and that percentage has also increased from 38.3 percent to 43.2 per cent in rural areas between 1991-2002. Significantly 27.8 percent and 32.4 per cent disabled persons were never married in the ages above 15 years in rural and urban areas respectively in 2002.

**Disabled Persons, Literacy level:**

According to the survey records both 1991 and 2002, 59 per cent of disabled persons in rural areas and 40 per cent disabled persons in the urban areas were illiterate. Among the disabled who were literate, large sections were only educated up to the primary and middle level. According to the NSSO 2002, only 7 per cent of disabled persons in rural areas and 17 per cent disabled persons in urban areas were educated up to secondary level or above. Only 1.5 per cent of disabled persons in rural areas and 3.6 per cent in the urban areas have received any vocation training through the government initiative.

**Disabled persons and work status:**

According to the 2001 Census about 46 percent of the disabled persons in both rural and urban areas are without any work. The employment status of the disabled persons has not changed much between 1991 and 2002. This is in spite of the PWD Act 1995 which provides for reservation of 3 per cent of all Government jobs for the disabled. Only 1.8 per cent disabled persons in the rural areas and 7.3 per cent in the urban areas
are with any regular employer in 2002. This decline in the work force is noticed in all sections, like, self-employed, agricultural sector and casual labours.

**Disabled Persons in India: Types and Magnitude:**

The NSSO 2002 survey provided more detailed information about the disabled in India. It included mental disability along with the other criteria of disability and categorized it into mental retardation and mental illness groups. It also categorized visual impairment into blind and low vision groups.

**Table 1.2 Variation in Disability estimates of NSSO and Census figures on Disability:**

<table>
<thead>
<tr>
<th>TYPE OF DISABILITY</th>
<th>Total number of PWD (in 100000)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NSSO 2002</td>
</tr>
<tr>
<td>Locomotor</td>
<td>106.34</td>
</tr>
<tr>
<td>Visual</td>
<td>28.26</td>
</tr>
<tr>
<td>Hearing</td>
<td>30.62</td>
</tr>
<tr>
<td>Speech</td>
<td>21.55</td>
</tr>
<tr>
<td>Mental</td>
<td>20.96</td>
</tr>
<tr>
<td>TOTAL</td>
<td>184.91</td>
</tr>
</tbody>
</table>

As per the latest NSSO Disability Survey (July to December 2002) report, the number of disabled persons in the country was estimated to be 18.49 million, who formed about 1.8 per cent of the total population. On the other hand Population Census 2001 found 21.9 million of PWD in India (about 2.13 per cent of total population). The difference in total number as also prevalence of disability can partly be explained by major differences in concepts, definitions, methodology, type of question asked etc. Besides, multiple disabilities also accounted for some differences. About 10.63 per cent of the disabled persons suffered from more than one type of disabilities as revealed by
NSSO survey, while Population census 2001 collected data on only one type of disability for each disabled person.

In terms of the prevalence by individual type of disability, the differences were large between estimates from these two major official sources of disability statistics, especially for locomotor and visual disability. However, it is often argued that, the official disability estimates, obtained from either Population Census or dedicated NSSO surveys on the subject can at best be considered to be reliable estimates of severe disabilities only. This is because, both the methods rely more on traditional diagnostic identification of disability, rather than the functional disability consideration. Typically, the elderly population, large number of whom may be functionally disabled, are usually not identified so by the households and therefore not reported as disabled in any household level enquiry, the way the disability questions are asked. There are other socio-cultural reasons including social stigma attached to disability which may account for low reporting of cases. Even the 11th five-year Plan document had noted that, “it can be reasonably argued that persons with disabilities constitute anywhere between 5 to 6 per cent of our total population”. Thus, the official estimates can be considered as the lower bound estimates with a strong bias towards more serious disabilities only(Planning Commission of India-5th five year plan of India).

The census and NSSO figures are hugely contested by disability rights activists in India. Javed Abidi, a well-known disability rights activist and the founder of the National Centre for Promotion of Employment for Disabled People (NCPEDP) claims that India has about 70 million people with disabilities who constitute almost 7% of the total population. Out of the 70 Million Disabled in India and Only 2% are Educated and 1% Employed. In addition, according to the World Bank Report, the official estimates of disability enumerated by the 2001 census are low (around 2%) and alternative estimates using different methods and more inclusive definitions by other agencies like the NSSO suggest a higher incidence of disability (4-8%) in India. Alternative estimates suggest that the actual prevalence of disability in India could be easily around 40 million minimum, and as high as 80-90 million if more inclusive definitions of mental illness and mental retardation in particular were used.(World Bank Report. 2007). Further, the
enumeration does not include people with mild and moderate disabilities, leaving a large group out of the final statistics.

**Table – 1.3 Disabled statistics in Tamil Nadu:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non workers</td>
<td>389508</td>
<td>348423</td>
<td>737931</td>
</tr>
<tr>
<td>Non workers- rural</td>
<td>185893</td>
<td>192022</td>
<td>377915</td>
</tr>
<tr>
<td>Non workers -urban</td>
<td>197486</td>
<td>162530</td>
<td>360016</td>
</tr>
<tr>
<td>Locomotor disability -total</td>
<td>25393</td>
<td>22457</td>
<td>47850</td>
</tr>
<tr>
<td>LD-rural</td>
<td>13798</td>
<td>12929</td>
<td>26727</td>
</tr>
<tr>
<td>LD-urban</td>
<td>11595</td>
<td>9528</td>
<td>21123</td>
</tr>
</tbody>
</table>


**Table – 1.4 Disabled statistics- in Madurai district:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non workers</td>
<td>20853</td>
<td>25995</td>
<td>46848</td>
</tr>
<tr>
<td>Non workers- rural</td>
<td>8991</td>
<td>11004</td>
<td>19995</td>
</tr>
<tr>
<td>Non workers- urban</td>
<td>11862</td>
<td>14991</td>
<td>26853</td>
</tr>
<tr>
<td>Locomotor disability -total</td>
<td>4473</td>
<td>7057</td>
<td>11530</td>
</tr>
<tr>
<td>LD-rural</td>
<td>1871</td>
<td>2855</td>
<td>4726</td>
</tr>
<tr>
<td>LD-urban</td>
<td>2602</td>
<td>4202</td>
<td>6804</td>
</tr>
</tbody>
</table>

Source : Population census 2001

**Table – 1.5 Disabled statistics- in Madurai Corporation:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Locomotor disability</td>
<td>1453</td>
<td>1777</td>
<td>3230</td>
</tr>
</tbody>
</table>

CENSUS 2011(Source-Population Census 2011)

The Census 2011 is the 15th National Census Survey conducted by the Census Organization of India. The 2011 Indian National Census has been conducted in 2 phases - house listing and population. The National Census Survey covered all the 28 States of the country and 7 Union territories including 640 districts, 497 cities, 5767 taluks & over 6 lakhs villages.

Some definitional changes were adopted in Census 2011 for locomotor disability such as including Paralytic persons, those who crawl and walk with the help of aid, have acute and permanent problems of joints/muscles and stiffness or tightness in movement or involuntary movements of the body or have fragile bones, difficulty in balancing and coordinating body movement, loss of sensation in body, deformity of body like hunch back and dwarfism.

Highlights of census 2011:

- The population of India is 1,210,193,422 with 623,724,248 males and 586,469,174 females.
- Sex ratio has risen by seven points since 2001 from 933 to 940 in 2011 for overall India
- Sex ratio of Tamil Nadu has risen by eight points since 2001 from 987 to 995 in 2011.
- Percentage of Disabled to total population Tamilnadu is 1.64% while it is highest in Sikkim 2.98%
- Out of the total disabled persons (2,68,10,557) males are 1,49,86,202 (55.9%) and females are 1,18,24,355(44.1%).
- No of persons residing in rural areas is 1,86,31,931 and 81,78,636 are residing in urban areas.
- Out of the decadal increase in total number of disabled, 22,43,539 live in rural areas and 26,60,249 live in urban areas.
Proportion of disabled population is higher in rural areas. Percentage of Disabled to total population India, 2011 shows the percent of disabled population is 2.21 and in rural areas 2.24% while 2.17% in urban areas.

Considering the types of disability, LD contributes the highest 20.3%.

Disability in seeing and hearing is more among females, but Disability in movement is more among males 22.5% while in females it is 17.5%.

No of persons with LD is 54,36,604 out of whom males are 33,70,374 and females are 20,66,230.

Out of disabled, LD contributes 20.3% with males 22.5% and females 17.5% of their prevalence.

Percentage of disabled persons in India has increased both in rural (2.24% versus 2.21%) and urban areas (2.17 from 1.93% in 2001) during the last decade.

On comparison with 2001 census, there is a decadal increase in total no of disabled of about 49,03,788 of whom 23,80,567 are males and 25,23,221 are females.

Disability in movement and multiple disabilities are more in rural areas- 21.7% in rural areas on comparison with 17.1% in urban areas but disability in hearing and speech is more in urban areas.

1.3. United Nations and Persons with Disabilities

The United Nations was founded on the principle of equality for all. The Preamble to the United Nations Charter affirms the dignity and worth of every human being and gives primary importance to the promotion of social justice. Over the course of the United Nations' first half century, persons with disabilities have become increasingly proactive in asserting strength and confidence in their own abilities to lead self-reliant and independent lives. The following brief history highlights efforts by the UNO which have supported their efforts.

1948: The General Assembly established the foundation for the promotion and protection of human rights in 1948, when it proclaimed the Universal Declaration of Human Rights. Article 25 of the Declaration states that each person has "the right to
security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control”.

1950: During its sixth session, the Social Commission considered two reports, namely "Social rehabilitation of the physically handicapped" and "Social rehabilitation of the blind". And also examined a report by the International Programme for the Welfare of the Blind, which recommended education, rehabilitation, training and employment of persons with visual disabilities.

A conference was convened in Geneva, in March 1950 to discuss coordination among the specialized agencies UNO, ILO, WHO, UNESCO, International Refugee Organization (IRO), and UNICEF.

In 1956, the International Social Service Review was founded to raise awareness of disability issues and emphasize rehabilitation programmes around the world.

1960: The focus of the United Nations on disability issues shifted from a welfare perspective to one of social welfare and re-evaluation of policy led to de-institutionalization of services.

1966: Further anti-discrimination principles were established by human rights instruments such as the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights, together they form the most comprehensive international code of legally binding provisions in the area of human rights to be known as the International Bill of Human Rights.

1969: The Declaration on Social Progress and Development, adopted on 11 December 1969, affirmed the fundamental freedoms and principles set forth in the Charter of the United Nations and emphasized the need to protect the rights and welfare of persons with disabilities.

The 1970s marked a new approach to disability. The concept of human rights for persons with disabilities began to become more accepted internationally.
1971: The Declaration on the Rights of Mentally Retarded Persons on 20 December 1971 stated that persons with intellectual disabilities had, to the degree feasible, the same rights as others.


1976: Realizing the need to promote the full participation of persons with disabilities in the social life and development of their societies, on 16 December 1976, the General Assembly declared the year 1981 International Year of Disabled Persons (IYDP), stipulating that it be devoted to integrating persons with disabilities fully into society.

1981: The International Year of Disabled Persons, 1981 - The theme of IYDP was "full participation and equality", defined as the right of persons with disabilities to take part fully in the life and development of their societies, increasing public awareness, understanding and acceptance of persons with disabilities, and encouraging persons with disabilities to form organizations through which they can express their views and promote action to improve their situation. IYDP was celebrated with numerous programmes, research projects, policy innovations, recommendations, conferences and symposiums were held during the Year.

1982: The General Assembly took a major step towards ensuring effective follow-up to the International Year by adopting, on 3 December 1982, the World Programme of Action concerning Disabled Persons that restructured disability policy into three distinct areas: prevention, rehabilitation and equalization of opportunities.


1983: Implementation of the Programme of Action, using multi sectoral and multidisciplinary approaches, was addressed by the General Assembly on 3 December 1982 and 22 November 1983.
1989: The General Assembly adopted the "Tallinn Guidelines for Action on Human Resources Development in the Field of Disability" in 1989. They provided a framework for promoting participation, training and employment of persons with disabilities within all government ministries and on all levels of national policy-making in order to equalize opportunities for persons with disabilities.

In 1991, the General Assembly adopted the Principles for the Protection of Persons with Mental illness and for the improvement of mental health care.

**GLOBAL CONFERENCES (From Rio to Rome)**

Five United Nations world conferences held in the 1990s emphasized the need for a "society for all", advocating the participation of all citizens, including persons with disabilities, in every sphere of society: 1. In 1992, the Rio de Janeiro Conference on Environment and Development 2. The World Conference on Human Rights, held in Vienna in 1993, 3. The International Conference on Population and Development, held in Cairo in 1994, 4. During March 1995, the United Nations held the World Summit for Social Development in Copenhagen, Denmark. 5. The Platform for Action adopted by the Fourth World Conference on Women in September 1995 stipulated areas of special concern and recognized that barriers to full equality for women can include factors such as their disability. In addition to these five major conferences on 20 December 1993 the General Assembly adopted the Standard Rules on the Equalization of Opportunities for Persons with Disabilities. These conferences emphasised the following themes with special reference to marginalised groups as follows:

- **RIO**: Women to Play an Important Role in Protecting the Environment
- **VIENNA**: Women’s Rights are Human Rights
- **CAIRO**: Reproductive Rights and Safe Motherhood to Women
- **COPENHAGEN**: Women’s Contribution to National Development
- **BEIJING**: Equality, Development, & Peace
- **ISTANBUL**: Assured of the Right to Shelter
- **ROME**: Recognition of Women’s Role in Food Security

(Source: Online Working Group 3, 1999)
In the area of children’s rights, UNICEF worked with UNHCR (United Nations Centre on Human Rights) on the rights of children with disabilities.


**Regional Commissions**

The regional commissions pursued a number of assistance projects for persons with disabilities during the 1990s such as The Economic Commission for Europe (ECE), The Economic and Social Commission for Asia and the Pacific (ESCAP), The Economic and Social Commission for Western Asia (ESCWA), Arab Gulf Fund for the United Nations Development Organizations (AGFUND), The Economic Commission for Africa (ECA), The Economic Commission for Latin America and the Caribbean (ECLAC), the United Nations Voluntary Fund on Disability financed projects and programmes for persons with disabilities around the world.

2001: In December 2001, Mexico the General Assembly proposed to establish an Ad Hoc Committee to consider proposals for a comprehensive and integral international convention to protect the rights and dignity of persons with disabilities.

2006: On 13 December 2006, the resumed eighth session of the Ad Hoc Committee adopted the final draft of the Convention and its Optional Protocol with the technical amendments suggested by the drafting committee later UN General Assembly adopted it by consensus.

2007: On 30 March 2007, the Convention and Optional Protocol opened for signature at UN Headquarters in New York, with a record number of 82 opening signatories.
One of the major development goals of the United Nations continues to be promoting the quality of life of the world's disadvantaged, including people with disabilities. One of the most significant issues still to be addressed is the accessibility of the disabled to new and emerging information technologies through computer literacy. The United Nation’s future efforts will consist of reinforcing current programmes in cooperation with various departments within the United Nations and specialized agencies as well as in incorporating newly emerging needs of disabled persons and requirements for society to adapt itself to these needs. The issue of accessibility to various new technologies, such as information technology as well as to physical environment will remain as one of the most significant issue.

For the next 50 years, the United Nations’ commitment to "a society for all" will continue to make a difference in the lives not only of people with disabilities, but among all people. A new global community, creative and effective strategies for a "society for all", may be brought forth through its engagement in newly established discourse on human rights of all, especially people with disabilities.

**Millennium Developmental Goals**

The Millennium Development Goals (MDGs) are eight international goals with 21 targets that were established following the millennium summit of the UN in 2000, following the adoption of the UN millennium. The Declaration asserted that every individual has dignity; and hence, the right to freedom, equality, a basic standard of living that includes freedom from hunger and violence and encourages tolerance and solidarity. The MDGs set concrete targets and indicators for poverty reduction in order to achieve the rights set forth in the Declaration. All 189 United Nations member states at the time (there are 193 currently) and at least 23 international organizations committed to help achieve the following Millennium Development Goals by 2015:

1. To eradicate extreme poverty and hunger
2. To achieve universal primary education
3. To promote gender equality and empower women
4. To reduce child mortality
5. To improve maternal health
6. To combat HIV/AIDS, Malaria, and other diseases
7. To ensure environmental sustainability
8. To develop a global partnership for development

MDGs had to concentrate on the marginalised people such as disabled, underemphasise of local participation, insufficient emphasis on environmental protection, agriculture, gender inequalities etc. (Diane Mulligan and Kate Gooding 2009)

Disability is both a cause and consequence of poverty (DFID, 2000), and poor people themselves describe people with disabilities as among the most excluded ‘poorest of the poor’. (Narayan & Petesch, 2002)

According to the World Bank, 20 per cent of the world’s poorest people are disabled (UN Enable, 2009), yet disability is not mentioned in any of the 8 MDG goals, the 21 targets, or the 48 indicators. Anyhow People with disabilities’ life chances are relevant to all eight of the MDGs, making it an issue central to reducing poverty. Even if persons with disabilities are not explicitly cited in the MDGs, they are implicitly included in each of the 8 Goals and the accompanying Targets and Indicators as given below.

**MDG 1 Poverty reduction:** people with disabilities often struggle to find opportunities to earn income due to discrimination in education and employment.

**MDG 2 Education:** of the 75 million children of primary school age out of school, over a third have a disability (UNESCO, 2009) and yet the inclusion of children with disabilities in mainstream education has been shown to be successful (Bhatti, A. 2007).

**MDG 3 Gender equality:** women who are disabled face discrimination because of their impairment, but also face discrimination on the grounds of their gender. This double discrimination has been well documented in development polices (Abu Habib, L. 1995) Women with disabilities are also more likely to be subjected to violations of human rights than women without disabilities.
**MDG 4 Child mortality:** Mortality rates for disabled children under five can be as high as 80 per cent, and disabled children are less likely to receive standard immunizations (Groce, Ayorla & Kaplan, 2007).

**MDG 5 Reproductive health:** Women with disabilities face particular challenges in accessing reproductive health education because they are not considered sexually active people (Maxwell, Belses & David, 2007), nor do they receive timely antenatal care.

**MDG 6 HIV:** All risk factors associated with HIV are increased for people with disabilities (e.g. sexual activity, rape, substance abuse), yet they are less likely to be included in outreach or treatment activities (Groce, 2004).

**MDG 7 Ensure environmental sustainability:** Of all poor people, people with disabilities have the least access to safe water and sanitation facilities and this contributes to keeping them poor and unable to improve their livelihoods (Jones & Reed 2005).

**MDG 8: Develop a global partnership for development:** Article 32 of the UN Convention on the Rights of Persons with Disabilities explicitly states that international cooperation (partnerships) and development programmes are ‘inclusive of and accessible to persons with disabilities’ (Art 32 -1).

It implies the significance of inclusion of disabled population.

The worldwide disability rights movement organisations advocate for the involvement and participation of people with disabilities in all levels of planning for development, as well as providing guidance and jointly working with high-level development personnel. If people with disabilities are not included in the process then people with disabilities living in poverty will be further marginalised and more likely to experience chronic poverty. (Diane Mulligan and Kate Gooding, 2009).

The High Level Panel on the Post-2015 Development Agenda released a report* which sets out new post-2015 goals to drive five big transformative shifts including, Leave No One Behind to ensure that no person is denied basic economic

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opportunities and human rights, to put sustainable development at the core to integrate
the social, economic and environmental dimensions of sustainability, to transform
economies for jobs and inclusive growth with equal opportunities for all, to build peace
and effective, open and accountable Institutions for all and a new global partnership
based on a common understanding of our shared humanity, based on mutual respect and
mutual benefit.

The Microcredit Summit Campaign declared its commitment to the UN
Millennium Development Goals (MDGs), the unmet goals of the 1985 Nairobi Third
World Conference on women and the “12 critical areas of concern” of the 1995 in the
Fourth World Conference on Women.

The 12 critical areas of concern for women are as follows:

1. The persistent and increasing burden of poverty on women.
2. Inequalities and inadequacies in and unequal access to, education and training.
3. Inequalities and inadequacies in, and unequal access to, health care and
   related services.
4. Violence against women
5. The effects of armed or other kinds of conflict on women, including those
   living under foreign occupation.
6. Inequality in economic structure and policies, in all forms of productive
   activities, and in access to resources.
7. Inequality between men and women in the sharing of power and decision-
   making at all levels.
8. Insufficient mechanisms at all levels to promote the advancement of women.
9. Lack of respect for, and inadequate promotion and protection of, the human
   rights of women.
10. Stereotyping of women and inequality in women’s access to, and participation in all communication systems, especially in the media.

11. Gender inequality in the management of natural resources and in safeguarding of the environment; and

12. Persistent discrimination against and violation of the rights of the girl child

1.4. Five year Plans & Disability:

- **First Five Year Plan : (1951-1956)**

  During the first five year plan reliable statistics and no standard classification were not available. Mostly voluntary agencies were working without any contribution or support by government. Resources for these agencies or their ability to deal with these handicaps were not clear.

  Strategy was to formulate Uniform definitions, enumeration, education about handicap, encouragement of voluntary agencies by Central Social Welfare Board, Sample surveys, pilot projects for children.

  A provision of Rs. 4.00 crores was made and the amount was placed at the disposal of the Central Social Welfare Board for women welfare institutions, child welfare institutions, handicapped persons and delinquents.

- **Second Five Year Plan: (1956-61)**

  The scope of social welfare was widened to include and promote additional activities for welfare of women and children in the form of district welfare extension projects, welfare committees (Mahila Mandals) & training programmes for women, village level workers and midwives, providing work for women in their homes with setting up of match factories with the assistance of the Ministry of Commerce and Industry.

* Source: Evidence of Microfinance’s Contribution to Achieving the Millennium Development Goals, September-2006
In September, 1955 the Ministry of Education constituted a National Advisory Council for the Education of the Handicapped to provide additional facilities such as model schools for disabled, women's training school, and scholarships for physically and mentally handicapped persons. Some legislative measures were also undertaken to protect the interests of women such as, the Suppression of Immoral Traffic in Women and Girls Act, 1956, the Hindu Succession Act, 1956, the Dowry Prohibition Act, 1961 and the Maternity Benefit Act, 1961 were enacted.

The plan provides nearly Rs. 29 crores for schemes of social welfare. Rs. 19 crores at the Centre and nearly Rs. 10 crores in the States. A provision of about Rs. 11 crores is made for youth welfare and social welfare programmes in the plan of the Ministry of Education.

- **Third Five Year Plan: (1961-66)**

  Strategy was to develop special services and facilities for physically and mentally handicapped persons, to enable them to rehabilitate themselves through work. Services were further developed along the lines of teaching, training, surveys, providing work, special aids, and recreational facilities in home itself.

  In the Third Plan, provision was made for programmes involving a total outlay of Rs. 28 crores-Rs. 16 crores at the Centre and Rs. 12 crores in the States. Other schemes implemented were urban community welfare projects and Central Bureau of Correctional Administration.

- **Fourth Five Year Plan: (1969-74)**

  The Fourth Plan aimed at the consolidation of the initiatives taken in the previous plans. An outlay of Rs. 41 crores was provided for this purpose. It was proposed to improve the services in the National Centre for the Blind at Dehra Dunn, training centre for the adult deaf, a school for partially sighted children, model school for mentally retarded children in Delhi, a national centre for the physically handicapped, a school for the cerebral palsied children and a vocational training centre for the severely crippled. Strategy was to provide Scholarships for the physically handicapped, training facilities for the teachers of the handicapped, to promote Institutions in the State for the education
and training of the physically handicapped and establishment of special employment exchanges.

- **Fifth Five Year Plan: (1974-79)**

  Care was taken to ensure that important programmes like Integrated Child Care Services (ICDS), Working Girls Hostels, Scholarships, women and child welfare Programmes and Programmes of Social Defence in the State sector were provided adequate funds. Under ICDS, a package of 6 services viz. health check-ups, immunisation, supplementary feeding, referral services, non formal pre-school education and health and nutrition education were provided to children under 6 years and expectant and nursing mothers. Observance of the International Women's Year in 1975 and the preparation of a National Plan of Action for Women, enactment of important specific legislations like the Equal Remuneration Act, 1976, creation of a separate Bureau of Women's Development and a national committee with the Prime Minister as President to provide strong administrative support to women's development marked this plan. The revised Fifth Plan outlays for the Centre and States are Rs. 63.53 crores and Rs. 22.60 crores respectively. The Fifth Plan supported economic development, employment and training for women as the principal focus for their socio-economic development with an approach to view women as the beneficiaries of social services rather than as contributors to development.

- **Sixth Five Year Plan: (1980-85)**

  The main thrust was on prevention of disabilities by prenatal care, postnatal care, immunization, Legal frame-work for the prevention and treatment of accidents, provision of insurance coverage, and occupational Safety regulations. Training was promoted by scholarships, Vocational Rehabilitation Centres, employment with local industry and Modification of building plans favouring mobility of handicapped.

  The four National Institutes for the Handicapped, ALIMCO, National Institute of Prosthetic and Orthotic Training (NIPOT) were strengthened and expanded. Plan outlay for Welfare of Physically handicapped in 1980-85 was about 150 crores (Central & Centrally Sponsored).
The reservation of one per cent of vacancies each for the blind, deaf and orthopedically handicapped in Group 'C' and 'D' posts in Central services was introduced.

- **Seventh Five Year Plan: (1985-90)**

  The rates of scholarships were revised and a new scheme of "Assistance to disabled persons for purchase/fitting of aids and appliances" was introduced. Special cells in the normal employment exchanges were introduced. Major achievement in this period was raising the status of the CBCS to that of a national apex body and renaming it as the National Institute of Social Defence.

  A separate Department of Women's Welfare was carved out at the Centre in 1985 from the then existing Ministry of Social and Women's Welfare to give a separate identity and to provide a nodal point on matters relating to women's development. The National Institute for Rehabilitation, Training and Research (NIRTR), earlier known as NIPOT, four National Institutes for the Handicapped and District Rehabilitation Centers (DRC) were strengthened.


  Human development being the main thrust of the Eighth Plan (1992-97), the well being of the emerging problem groups such as street children, drug addicts, child sex workers, destitute and aged came into the serious reckoning of the planned development, giving rise to specific programmes for the welfare and development of these groups.

  The landmark legislation for the disabled viz. The Persons with Disabilities (PWD) (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 also came into action.

- **Ninth Five Year Plan: (1997-2002)**

  In the Ninth Plan the earlier paradigm shift in approach from ‘welfare’ to ‘development’ was moved further to ‘empowerment’. Strategies were to adopt a three-fold strategy of - Empowering the Persons with Disabilities; Reforming the Social Deviants; and Caring the Other Disadvantaged through various preventive, curative, rehabilitative and developmental policies and programmes. A ‘National Programme for
Rehabilitation of persons with disabilities’, was launched upto the village level. Provisions were made for effective enforcement of PWD Act of 1995, Community Based Rehabilitation (CBR), early detection and timely intervention, 3 per cent reservation and poverty alleviation programmes like NHFDC, IRDP, DWCRA, JRY, EAP etc.

Apart from five national institutes, The Indian Spinal Injuries Centre (ISIC) New Delhi and the Rehabilitation Council of India (RCI) were developed.

- **Tenth Five Year Plan (2002-2007)**

The following programmes were carried out including six Regional Composite Resource Centres for all categories of disabled, four Regional Rehabilitation Centres for those with spinal injuries, expansion of the on-going programmes viz. – training, rehabilitation and outreach services by the existing seven National and Apex level Institutes; strengthening of Rehabilitation Council of India (RCI); ALIMCO,NHFDC special school facilities etc. Monitoring the implementation of the PWD Act, 1995 through the Central Co-ordination Committee and Central Executive Committee, National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities, launching of an umbrella scheme by the Trust for long-term care and rehabilitation of the mentally disabled and their families also marked this plan.

A Committee under the DGHS was formed to review guidelines for the evaluation of various disabilities. A Committee of Experts was formed to identify occupations at the senior management level and at skilled/semi-skilled levels in the private sector suitable for the disabled.

- **Eleventh Five Year Plan (2007-2012)**

Towards Women’s Agency and Child Rights, Gender Budget (that is, women specific allocations) and Gender Outcome assessment was encouraged in all ministries/departments at Central and State levels. Data from these cells was collated on a regular basis and made available in the public domain. Total magnitude of the Gender Budget was recorded at 4.8% of total Union Government expenditure while in 2006–07, 24 departments of the Union Government were included and the magnitude of the Gender Budget was 3.8% of total budget estimates. In the Eleventh Plan, women with disabilities
will be specifically included in gender equity programmes, both as beneficiaries and as project workers. The Eleventh Plan sensitization programmes of government departments, police, and health care personnel will include sensitization to the needs of women with disabilities.

- **Twelfth Five Year plan: (2012-2017)**

  Twelfth Plan must adopt a two pronged strategy incorporating-(i) service delivery and (ii) generation of public awareness about disability rights. In the area of service delivery the challenges to be addressed were children with learning difficulties, Lack of information about the law and its specific entitlements. Plans strategy was towards (1) Inclusive growth with sharper focus on disadvantaged groups, (2) The rights-based approach to empower the PWDs through delineating clear cut responsibility between the concerned Departments (3) A new Department, namely Department of Disability Affairs has been set up in the Ministry of Social Justice and Empowerment on Twelfth May, 2012 to act as the nodal Department (4) enabling municipalities and panchayats in empowering disabled.

  Twelfth plan also emphasize provision of barrier free environment in health care facilities by ministry of health and family welfare, school facilities by ministry of human resource development, Ministry of Civil Aviation, and by Ministry of Railways.

  Budgetary provision of 125.00 crores for NHFDC, Modernisation and expansion of production units of ALIMCO, new Composite Regional Centres (CRCs) at Ahmadabad and Kozhikode and 21 new DDRCs were achieved in 2011-2012.

**Empowerment of Persons with Disabilities - Organisation under Division:**

**A) Statutory Bodies:**

1) Office of the commissioner for persons with disabilities, New Delhi.
2) National trust for the welfare of the persons with autism, cerebral palsy, mental retardation and mental disabilities, New Delhi.
3) Rehabilitation Council of India, New Delhi.
B) National Institutes:

1) Ali Yavar Jung National Institute for the Hearing Handicapped (AYJNIHH), New Delhi
2) Pandit Deen Dayal Upadhyaya Institute For the Physically Handicapped (IPH), New Delhi
3) National Institute of mentally Handicapped, Secundrabad
4) National Institute of Visually Handicapped (NIVH), Dehradun
5) National Institute for Orthopaedically Handicapped, Kolkata
6) National Institute for Rehabilitation, Training, and Research (NIRTAR), Cuttack
7) National Institute for Empowerment of Persons with Multiple Disabilities, Chennai (NIEPMD)
8) Indian sign language research and training centre(ISLRTC)

C) Public Sector Undertakings: ALIMCO, NHFDC

D) Composite regional centres for persons with disabilities (CRCs)

E) Public-Private partnership: Indian Spinal Injury Centre

STATUS OF WOMEN IN INDIAN SOCIETY:

Women are said to be the nerve centre of the society. Their association and participation in the work-force are undoubtedly higher than the men. But still they are considered as household material, destined to be confined to the household chores and for bearing and rearing of the children. Particularly, the women with disabilities are doubly helpless. Moreover, the women with minority ethnic and racial groups are further marginalized. But the situation is being changed gradually. There are opportunities for full participation of disabled persons in all spheres of life. If every opportunities available to all persons, the person with disability will be able to move fully enter into each part of daily life.

The Indian Women’s Movement started in the early 1970s by raising voice against violence, property rights, legal status, political participation and the rights of minority women. The disabled movement however started a decade later with the 1980 being declared as the International year of disabled.
The women with disabilities are being identified as an issue in the international level since 1975. More and more focus is laid on human rights for women at Convention of Elimination of all forms of Discrimination Against women (CEDAW) and this treaty was adopted by United Nations General Assembly in 1979 which came into force in 1981. The major initiative was taken after lobbying of Disabled People’s International (DPI) Women’s Committee in the 4th World Conference on Beijing, China. Only in recent years some changes are seen in the socio-political awareness creation.

The disability rights movement in India started only in the early 1990s. The launch of the Asian and Pacific Decade of Disabled Persons in 1993 gave a definite boost to the movement. In the same year, the Government of India organized a National Seminar in New Delhi to discuss the various issues concerning the disabled citizens. The main need that emerged from the seminar was for a comprehensive legislation to protect the rights of persons with disabilities. In India, different surveys indicate that there are 30 million women with disabilities, majority of them are living in rural areas. These problems coupled with lack of proper medical awareness and facilities further aggravate their quality of life. In our country 1.5 to 2 million disabled are being added to our population every year. Even now 80 percent of special rehabilitation facilities are available mainly in cities. Only 4 percent of physically disabled are able to avail those facilities and 2 percent are mentally retarded (Pati.R.N., 2011). It is also evident that disability policies have moved from medical model to a social model in 1995.

India is a country of diversity but in spite of social, religious, economic, political and geographic differences there is one common characteristic that is shared by one and all when it comes to women. That is tolerance that expectation is more when it comes to women disabled. Unless and until a social change takes place the status of women disabled will remain unchanged and they will continue to be subjugated and marginalized as individuals and as a community media and disability.

In today’s world, media plays a vital role in our life style and influences our social practices etc. On any given day, if one sits in front of TV from 6 pm to 10.30 pm, out of every five serials at least in three of the serials, a woman is being harassed by a male either it is a husband, brother, father or son. Such portrayal has been regularly shown in
the media. But when it comes to women disabled, there is absolutely no portrayal at all. Because the movies like Raja Paarvai a successful movie, the hero who was having disability was comforted by the heroine. In another movie kasi, in front of the visually disabled hero, his sister and another disabled girl used to be sexually harassed. Hardly if any movie has women disabled in the sense, they had to see the torture, agony and pain of their lovable ones.

Due to social isolation coupled with physical dependency, the body image of disabled women is generally likely to be low. The disabled movement in our country focuses a lot on education, barrier free environment, job opportunities etc. but rarely considers about sex education. They have to be given proper information to improve body image. Many women with disability have never had an opportunity to know about their reproductive health. By counselling both family and disabled women, they can be made aware of premarital, post marital, antenatal and post natal care counselling and menopause counselling. Awareness on obesity is also important, since malnutrition, decreased activity, and sedentary life style and wrong eating habits is the cause of obesity prevalent among disabled women.

So far, it was being seen many dimensions of women disability in India. But woman continues to suffer in silence. It insists strong parent children relationships herein Indian disabled women is to be given due care. However it is still a great penance to live and battle life as a disabled woman. The present study attempts to include the ways and means to make the disabled as abled the way they perform their activities.

A Woman’s status is often described in terms of her level of income, employment, education and health as well as the role she plays within the family, in the community and in the society.
The worth of women of civilization can be judged by the place given to women in the society.

One of the several factors that justify the greatness of Indian’s ancient culture is the honoured place granted to women. Manu, the great law giver, said long-ago “where women are honoured there reside the Gods”. According to ancient Hindu Scriptures no religious rite can be performed with perfection by a man without the participation of his wife. Wife’s participation is essential to any religious rite wives thus befittingly called “Ardhanari” (better half). They are given not only importance but also equal position with men. The Muslim influence on India caused considerable deterioration in the status of women. They were deprived of their rights of equality with men. Raja Ram Mohan Roy started a movement against this inequality and subjugation. The contact of Indian culture with that of British also brought improvement in the status of women.

The other important factor in the revival of women’s position was the influence of Mahatma Gandhi who induced women to participate in the Freedom Movement, As a
result of this retrieval of freedom, women in India have distinguished themselves as teachers, nurses, air-hostesses, receptionists, engineers, doctors and others of varying socio-economical status.

They have been given equality with men in shaping their future and sharing responsibilities for themselves, their family and their country. They put heart and soul together in whatever they undertake. There is no denying the fact that women in India have made a considerable progress in the last fifty years but yet they have to struggle against many handicaps and social evils.

**Disability and Women:**

Women and Disability is a growing concern and seems to be increasing rapidly. According to Pandit Jawaharlal Nehru “When women move forward, the family moves forward, the family moves, the village moves”. But disabled women are suffering with triple discrimination i.e., gender, disability and poverty. Though the world celebrated International Year of the Women in 1985 and International Year of Disabled in 1981, they are deprived of many opening available in the society. Especially women with disability deprived of access to many facilities.

Disabled women are the most vulnerable in Indian society. This vulnerability exists across class and caste. Deeper insight into the scenario reveals the fact that, though men and women suffer equally because of disability, some problems are exclusively women’s problems. In a patriarchal society if disability affects boys and girls in almost identical fashions female child, faces the humiliation more than a boy. In India usually birth of sons is always celebrated; the birth of a girl is never has such celebration and the birth of a disabled girl always considered as a curse. A disabled boy is more acceptable than a disabled girl. If a family has a disabled boy they will do their best to make him a productive male which is not so when it comes to girls.

Considering special schools, there are residential schools, mostly for the visually impaired girls are operating. So, girls with other disabilities are with their families, but what happens is that they are left unattended, without due care and respect. If the parents can afford one education they would rather educate the boy. Children are lineage capital
for families. If the family has a boy all the members try their best to educate or train him so that he may get a job and he will contribute to the family.

In India disabled women constitute around 42 per cent percent of the total disabled population. They are most marginalized in terms of their social, economic, political and health status. They are not considered as a priority group in any kind of research, state policies and programs, mass movements, and rehabilitation programs. They are further isolated from social and political participation due to the stigma and discrimination attached to disability.

As Irene Feika* puts it “due to numerous societal standards, they continue to be left out of the decision making processes. This reality is specifically true of women with disabilities in the cultures where the role of wife and mother is considered as a primary role for a female”. The story of entitlement failure continues as we move up the ‘value chain’; the disability certificates, access to skills, the wage/self employment opportunity thereof, aids and appliances, health check up, the security aspects and the decision making. Lack of awareness owing to lack of information appears to be the first and the major bottleneck. Beyond this too it is an uphill task for the WWDs to get their entitlements.

**Education:**

Education is crucial to development of disabled women. In a country like India where it’s been hard to implement compulsory education to non disabled girl children the condition of the disabled girl child is beyond comprehension. According to the National Sample Survey Organisation 1991 survey, among children in the age group of 0-14 years, approximately 3 per cent of the children are disabled. The data shows that the prevalence rate for physical disability was observed to be higher among boys i.e. 22.7/1000 than girls i.e. 16.74/1000. This discrepancy in the ratio on the basis of gender, instead of reflecting an advantageous position for girls raises the question of the possibility of under reporting of girl child with disability because of the social stigma attached to it.

* Deputy Chairperson of Underrepresented Groups, Disabled People International.
Education is one of the fundamental problems disabled girls face. They face problems with regard to access to schools, enrolment in schools and availing the opportunity of vocational training. According to a study conducted by the International Council on the Visually Handicapped, only 2 percent of visually challenged children in developing countries receive any formal schooling. In China, where there are 5 million disabled children in the age group of 7 and 15 years, only 6 percent are enrolled in schools. It is understandable that the number of girls who attend these schools will be reasonably low.

According to another study in Karnataka, study showed that gender disparity in literacy was higher in rural areas than in urban areas. Considering female literacy rate for 2001, rural female literacy rate for Dakshina Kannada was 72.69% and for Raichur district it was 28.86%. Correspondingly number of rural families below poverty line in Dakshina Kannada was 15.40% and in Raichur district it was 43.20%. (Suresha. R and B. C. Mylarappa).

In India education to the disabled is not provided as part of the mainstream but through other isolated institutions which operate on a service and charity mode. Most of the times these institutions are not fully integrated into the mainstream education system. There are only around 3000 special schools in India today. Of them only 900 are schools for the hearing impaired, 400 for children with visual impairment, 700 for those with loco motor disability and one thousand for the intellectually disabled. More than 50,000 children with disability are enrolled in the Integrated Education for Children, a government-sponsored programme. Only a few schools have special provisions like resource rooms, special aids and specially trained teachers. This is restricted only to big cities. Since there are no special schools or special education services in rural India, children with special needs either have to make do with the regular schools in the village or go without education. Pre-vocational and vocational training is provided only in specialized institutions and in select cities.

Disabled girls have multiple difficulties in availing education. Firstly, since the number of special schools is inadequate, disabled girls are the least likely to attend general schools. In extreme situations even if parents are prepared to send their disabled
male child to the general school, girls are not allowed. Secondly, most of the special schools are residential. Usually Indian families are reluctant to allow their girl child to be away from home. At times these special schools are isolated from the rest of the community and there are major security concerns for students. Thirdly, the few special schools that exist in India are concentrated around big cities, which are inaccessible to large number of disabled girls who are from the rural areas. Fourthly, since most of the special schools function in isolation, the students from these schools find it difficult to adjust with the children from the regular schools. Fifthly, the most important shortcoming these schools have is that there are educationally inferior. A study of disabled girls, both in special (usually residential) schools and in regular schools, found that those in the special schools were less proficient in basic literacy and numerical skills, had lower expectations about their own capabilities and lacked confidence in the social setting. Lack of education deprives the disabled girl child from access to information, opportunities for social and political participation, skill development and economic empowerment. The civil society has a great challenge ahead regarding the empowerment of the disabled girl. (Leni Chauhari)

Gender gap in literacy among PWDs is stronger than in the overall population, so is the gap in schooling, access to skills and avenues of self-employment through loans. This aggravation cuts across state boundaries. This is seen right from the stage of giving disability certificates, access to literacy or education, acquisition of skills, chance to convert the skill into income – whether through wage employment or self employment and so on. Even in non–economic issue like marriage, stability of marriage or violence in domestic as well as public sphere, gender and disability combine adversely. Regarding the gender gap in entitlements among the PWDs, it is noticed that the gap is lower in schemes where coverage of the target group is very high e.g. grant of certificates or schemes that involve direct transfer of resources e.g. pensions. Where mobilization or capacity building of PWDs is involved, the gender gap is large. This raises an important issue regarding implementation of different welfare schemes. It also raises an issue of strategy. Is universal coverage of certain small groups, through direct transfer, an effective way of reaching vulnerable WWDs? Widows among the WWDs are one such
Employment opportunities is also generally much lower for disabled than for others, but there is a further divide when it comes to involvement of WWDs in livelihood and other activities by disability. Education and Employment are closely linked to each other particularly in the context of disabled women, for whom vocational training is a pre requisite for employment. India large sections of disabled women are either unemployed or engaged in very low paid jobs. According to the Census, 2002 data the usual work activity status (Activity status during last 365 days preceding the survey) for the disabled persons depicts that 62 per cent and 89 per cent males and females respectively in rural areas and 63.5 per cent and 90.5 per cent males and females respectively in urban areas were out of labour force. Though the overall employment scenario for the disabled persons is bad it is more unfavourable in case of disabled women. (NSSO 2002)

According to the Census 2002, Disabled people constitute at least 6 percent of population; still their basic needs for social security, individual dignity and meaningful employment remain unmet. They are at the mercy of the government and the civil society. The disability Act 1995 provides for 3 per cent reservation in all categories of jobs in government sector which is being implemented slowly.

Disabled women have limited scope to get employment because of the multiple problems like stigma and discrimination, physical access, lack of technical expertise etc. There are also a lot of problems for disabled women to be self-employed. They face problems in obtaining raw materials and marketing their products, so they are left with no other option but to take up piecework. Evidences show that since ages disabled women have been doing routine and ill paid jobs like weaving, basket making, sewing, assembling of toys and production of handicraft items. The more disturbing aspect is the status of widows, 8 out of 10 the respondents being unemployed and worse in terms of economic status.
In fact the Census data shows that there has been a decline in proportion of self-employed in non-agricultural sectors in urban areas and in agricultural sector in rural areas during 1991-2002. Even the proportion of casual employees has declined during 1991-2002 for both rural and urban areas.

Social Exclusion:

Disabled women are the worst victims of social exclusion. Stigma and discrimination attached to disability deprives these women from enjoying their social and cultural rights. India, where marriages are universal, they are also considered as means of social acceptability and provide social status to the women. Marriages for disabled persons are a difficult proposition particularly for disabled women. Here again stigma and discrimination prevents families from making marital relations with disabled persons. (Leni Chaudhuri)

Analysis of the marital status brings out various nuances. Analysis of the marital status by disability types show a higher proportion of Orthopedically Handicapped (OH) among those married, followed by the Visually Impaired (VI) and Hearing Impaired (HI). First is the harsh reality of the low likelihood of marriage. This is particularly strong among the MR. Second is the hold of the norms of hyper gamy. Third is the emergence of widows as the more vulnerable among the married WWDs. The MR group of WWD do tend to remain unmarried.

According to the census 2001, 43 percent disabled have never married, while 39 percent are currently married and a significant 15 percent are widowed and around 1 percent are divorced or separated. Not much variation was recorded in the marital status of disabled population both in case of the rural and urban areas. But what is surprising is that the proportion of disabled persons, who never married has increased from 38.3 percent to 43.2 percent in rural areas between 1991-2002. Significantly 27.8 per cent and 32.4 percent disabled persons were never married in the ages above 15 years in rural and urban areas respectively in 2002. This reflects the reluctance still prevalent in the society in marrying persons with disability. Data on the current living arrangement of the disabled persons reveals that about 3 per cent disabled persons were living alone and 6-7 percent were staying with relations or non-relations. Only 5.5 per cent disabled people
were staying only with spouses and another 32 percent were staying together with spouses and other. Significantly nearly 38-40 percent-disabled persons were staying with parents without spouses. These women are looked as a burden to their natal families and are exposed to a lot of ill treatment. Often they are at the mercy of the elderly men in the family and face sexual exploitation. Disabled women who are single mostly live alone and are exposed to exploitation of various kinds. Same is the condition of disabled women who live in institutions. They are susceptible to sexual exploitation by employers, managers in institutions etc. The most shocking evidence one has is that of mass hysterectomies of mentally challenged girls in a State run institution in Shirur, Maharashtra 1994 to control problematic menstruation and related hygiene issues (Patel, D, 2010).

**Aids and Appliances:** Non-availability of aids and appliances to the respondents represents one more barrier to accessing education training and jobs. There is also a need to assess the appropriateness of aids being manufactured in a gender indifferent manner.

**Transportation:** Most while lack of it in rural areas was highlighted and was predictable, significantly the majority said that they are dependent on care-givers to accompany them and this needs understanding and support from a national perspective and implementation at the State level especially for rural women’s access to bus services. The respondents were highly critical of the treatment meted out to them by the bus staff, rude behaviour, refusal to carry them and extra money demanded for-carrying wheelchairs. Public transport vehicles are not provided with modifications to create a barrier free environment such as low level buses, modified foot board, wheelchair facility, and platform modification to ease getting in or out of buses.

**Access:** Accessibility is fundamental to realization and enjoyment of any right. Though the earlier definition of access included only ‘physical access’ and took only architectural barrier into consideration, the modern day analysis of access is more holistic in nature. It encompasses within itself accessibility to quality education, information and communication, entertainment and technology. Emanating from the Beijing Conference and the Disabilities Act, this understanding of access provides the scope for not only full personality development but also participation in social and political life. A close look at
the access related issues brings into light that in spite of international conventions and domestic legislations access is an issue of concern. Access to public transport, toilets, hospitals, government offices, public spaces like parks, educational institutions, places of worship are still in accessible to people.

Still whatever interventions are made are restricted to the physical access. The areas like education, teaching aids, books in Braille and interpreters for the hearing and speech impaired are still not available to large sections of the disabled.

**Sexuality and disability:**

Historically, persons with disabilities have been regarded by society in two contradictory ways – either as asexual or as sexually threatening. By and large, their sexual desires are assumed to be non-existent. Most literature related to disability fails to mention sexuality, and sexual and reproductive health related issues. (ALBRECHT, G. L. 2005) There are several assumptions at work here. People with disabilities are often assumed to be either ‘asexual’ or ‘oversexed’. Society largely considers them unattractive and therefore incapable of being in sexual or in intimate relationships. People with disabilities are looked upon with pity and considered to be undesirable especially sexually. Societal attitudes which define the individual with disability by his/her disability alone fail to acknowledge the person as a whole. The same understanding further leads to the belief that people with disabilities do not get sexually assaulted or abused as no one will desire them. (KAUFMAN, M., 2003)

Assuming them to be childlike makes people with disabilities even more marginalised as this perception leads to excluding them from information or awareness based programmes on sexual and reproductive health. This assumption also leads to the false belief that all people with disabilities are incapable of engaging in any sexual activity. These assumptions lead people to conclude that people with disabilities do not need sexuality education. The sexual and reproductive rights of persons with disabilities have not been adequately addressed unlike their other rights to social integration, education or employment. (NISHA 2006).
Even today, the woman is seen as the repository of the family’s honour in many if not most Indian families. Parents tend to be over-protective of daughters especially once they attain puberty. This may or may not be so in the case of girls and women with disabilities. Families that believe people with disabilities to be asexual, childlike and or sexually unattractive may not see the need to protect their daughters with disabilities from unwanted sexual advances. It is often an unconscious belief that is played out as carelessness with respect to looking out for the safety of children and adults with disabilities. On the other hand, parents of girls with disabilities may feel more pressured to ensure the safety of their daughters because they are aware of the vulnerabilities they face. This added pressure can take the form of protectionism, strictness, unwillingness to give their daughters any space/privacy to make friends or be with friends etc., The other issues are abandoning, disowning and elimination of disabled girls. The chances of disabled girls getting adopted is also very less.

Health: Right to health is one of the basic human rights. Women have been historically discriminated against, they are a group whose health concerns need to be prioritised, understood and researched. Ironically, in India despite the international commitment, women from the poorer classes and marginalised sections experience differential access to health care facilities. Women’s health is one of the areas that deserve special concern. There is also a need to explore and understand the health concerns of women belonging to marginalized sections, since they are doubly vulnerable to discrimination. Like other problems disabled women also face major health problems. As they are not a homogenous group, problems they face are also not uniform in nature. Women with different types of disability face different types of health problems. They face these problems on two accounts, one, identifying the health problem and the other is access to health care. In the coming years health problems of disabled women and elderly women is going to be an important issue, which the country has to be able to address.

Aging and Disability have a close association; older women constitute a distinct population that requires interventions very different from a population of younger women. Obviously health problems of women are not homogenous and cannot be addressed through the traditional maternal and child health services. The health of an elderly woman is largely dependent upon her health in her young age, the socio economic
strata to which she belongs, marital status, number of children she has and also the place of residence. Her problems are very cultural and region specific. Aged are encountered with disabilities such as sight and hearing deficiencies, which happen with age, but other types of disability are brought about by diseases and conditions. For eg, some locomotor disabilities are brought about by stroke, a weakening musculoskeletal system can cause osteoarthritis, which affects movement. About 41 per cent percent of rural elderly and about 37 percent of urban elderly suffer from one or other disabilities. (NSSO 2002). Among all the disabilities, visual disability had highest incidence followed by locomotor disability. Most visual impairment among elderly is due to cataract and glaucoma (25 percent). The incidence of blindness is higher among women that in men. The NHFS found that prevalence of partial blindness was 2839 per 100,000 for women of all ages and 2346 per 100,000 for men of all ages. (IIPS 1995) Pregnancy associated complications and lack of immediate medical attention can also cause cataract, while diabetes, glaucoma and metabolic disorders can increase the risk of cataract. Other potential causes can be vitamin deficient diet (vitamin C& E), severe attacks of diarrhoea and excessive exposure to the ultraviolet rays.

This fact is corroborated by the findings of the World Bank Study 1994, which states that 90 per cent of persons above age 65 exhibited signs of cataract. Other micro studies also present similar findings. A study conducted in Tamil Nadu found that visual disability 89 per cent of the elderly were affected by visual disability. (Rao1992). In Asia nearly three-quarters of Malaysia and Filipino elderly had vision problems, as did a third Korean elderly. According to the NSSO survey, 40 percent of the elderly reported suffering from at least one disability - slightly higher among females compared to males. Sex differentials were reported for the prevalence of two and three disabilities; 15 percent suffered from at least two disabilities and another 6 percent suffered from three disabilities in India.

Among the elderly paralysis and dysfunction of joints is a very common occurrence. Along with other things ‘stroke’ is a major contributor to this. Elderly women who are disabled have very minimal chances of receiving health care. They are encountered with physical and financial problems most of the times access is determined by the willingness and the ability of caregivers to provide treatment. According to a
study, women who needed treatment for visual disability reportedly had limited access to health facilities if they had no sons or could not find alternative escorts (World Bank 1994). Finally it is also well established that availability of health services is largely restricted to women in the childbearing age.

LOCOMOTOR DISABILITY

Locomotor disability means Orthopaedically handicapped, those who have a physical defect or deformity which causes an interference with the normal functioning of the bones, muscles and joints. It is the most prevalent type of disability affecting the population of all ages in India. Locomotor disability is not life threatening but greatly affects the quality of life led by the disabled people. Timely interventions go a long way in disability limitation. The treatment seeking behaviour of disabled persons reflects a wider differential according to different background. (Government of India-58th Round NSSO).

A person with –(a) Loss or lack of normal ability to execute distinctive activities associated with the movement of self and objects from place to place and (b) Physical deformities, other than those involving the hand or leg or both, regardless of whether the same caused loss or lack of normal movement of body- was considered.

Causes

The aetiology of locomotor disability can be classified as congenital and acquired. The various common causes are as follows:

Congenital and Developmental

1. Cerebral Palsy
2. Congenital Talipes Equino Varus (CTEV)
3. Meningocele, Meningo myelocele
4. Phocomelias (absence of extremities)
5. Congenital Dislocation of Hip
Acquired Causes: Infective Causes
1. Tuberculosis – (i) Spine (ii) Other Joints
2. Chronic Osteomyelitis
3. Septic Arthritis
4. Acute Poliomyelitis
5. G.B. Syndrome
6. Leprosy
7. Encephalitis
8. AIDS

Traumatic Causes
1. Traffic / domestic Accidents
2. Fall from height
3. Bullet injuries, explosions
4. Violence
5. Sports injuries
6. Natural Catastrophes like earthquakes, floods etc.

Vascular causes
1. Cerebrovascular Accidents
2. Amputations due to peripheral vascular disease (Atherosclerosis or Buerger’s disease)

Neoplastic Causes
1. Brain Tumors
   a. Astrocytoma
   b. Meningioma
2. Spinal Tumors
   a. Meningioma
   b. Astrocytoma
3. Osteosarcoma
Metabolic Causes

4. Rickets
5. Diabetic Neuropathy
6. Vit.B12 deficiency
7. Gout

Degenerative Causes

1. Motor Neuron Disease
2. Parkinson’s disease
3. Multiple Sclerosis
4. Osteoarthritis, Spondylosis

Miscellaneous

1. Muscular dystrophies
2. Lathyrisim
3. Rheumatoid Arthritis
4. Iatrogenic

Prevention of Locomotor Impairments

The prevention of locomotor impairments can be undertaken at three levels:

Primary Prevention

Health promotion by health education regarding prevention of accidents such as environmental modifications like safety measures at work place and at home, nutritional interventions providing diet Vitamin – A supplementation etc., life style and behavioural changes, general and personal hygiene and sanitation. Specific protection is provided by immunization (like polio vaccination), legislation measures e.g. compulsory wearing of helmets to protect from head injury, enforcing road traffic rules etc.

Secondary Prevention

Early detection and treatment of the disease to prevent secondary complications and long term disability e.g. in case of traumatic paraplegia, early treatment prevents
occurrence of pressure sores. Deformities in early stages of poliomyelitis can be prevented by proper positioning and exercises etc.

**Tertiary Prevention**

The measures available to reduce impairments minimize the suffering caused by existing deviations from good health. The patient should be rehabilitated properly to join the mainstream of life. Rehabilitation is the restoration of the physically disabled to the maximum possible physical, educational, economic independence and social integration.

**Principles of Management of Locomotor Impairments**

The aims of rehabilitation management are:

1. Prevention of disability, if possible
2. Maximum reduction or elimination of the disability
3. Training the person with residual abilities to achieve independent living.

The locomotor impaired patients may be classified into the following groups:

1. Patients for whom full recovery is expected e.g. neuropraxia, surgically repaired nerve injuries, Guillain-Barre Syndrome etc.
2. Patients with permanent, but stable disabilities e.g. amputations, post polio residual paralysis, non progressive paraplegia, hemiplegia etc.
3. Patients with unstable disabilities e.g. rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, myopathies, leprosy etc.

**The locomotor impaired patients often suffer from the following problems:**

Motor weakness, paralysis/paresis, spasticity, sensory loss, pressure sores, deformities and contractures, loss of limb or its parts, urinary and faecal incontinence, urinary retention, pain etc. There may be associated hearing, speech, visual problems, mental retardation or higher function problems. The resultant problems arising out of locomotor impairment subsequently limit the function of the patient in his various Activities of Daily Living (ADL).
Strategies to manage Locomotor Disability:

Motor weakness

Weakness may be complete (paralysis) i.e. negligible power or incomplete (paresis) i.e. partial weakness. Either one limb may be affected (monoplegia), both lower limbs (paraplegia), upper and lower limb of one side (hemiplegia), or all the 4 limbs (quadriplegia). Common causes are spinal injuries, nerve injuries, cerebrovascular accidents (CVA), cerebral palsy, post polio residual paralysis and myopathies. For example, weakness of hand causes complex disabilities like impaired dexterity, hand writing, grasp, hold, pinch and proprioception. Weakness of lower limbs causes varying degree of difficulty or inability to walk.

1. Maintaining the range of movement of joints of the affected limb.
2. Regaining or improving the muscle power in the weak muscles,
3. Strengthening of normal muscles,
4. Restoring the function of the extremity by appropriate training,
5. Provision of external appliance, splint or calliper if required.

After proper assessment and planning:

- Remedial therapeutic interventions in the form of passive movements wherein full range of movement is given to each joint to overcome contractures and joint stiffness.
- Gentle massage is given as a preliminary to starting exercises, to improve venous and lymphatic drainage and to help relaxation of muscles.
- Remedial exercises are advised to suit the muscle power of various groups. Assisted exercises are given to muscles whose power is grade – I and gravity eliminated exercises are given to muscles whose power is grade II.
- Occupational and vocational training may be give to make the patient socially productive.
Psycho-Social Problems

Psychological, social and economic rehabilitation of patients with motor handicaps are intimately inter-related. Painful conditions and physical disabilities always induce some anxiety and reactive depression in the patient and relatives, and the response to incapacity depends on the patient’s personality, education, and social and economic situation. Evaluation of the pre-morbid personality and adequate assessment of the social, educational and economic circumstances are as important in rehabilitation as a realistic delineation of the prognosis and likely functional handicap. Specific psychological problems of patients with motor handicaps include depression, anxiety, and feeling of insecurity, loneliness, behavioural disorders, affective disorders, personality disorders, suicidal tendencies, dependence, low self esteem, irritability, impaired psychomotor coordination, malingering and hysteria.

This research study deals with the STATUS OF DISABLED WOMEN WITH SPECIAL REFERENCE TO LOCOMOTOR DISABILITY IN MADURAI. It covers the persons who reside within the boundaries of Madurai Corporation. Through this study the researcher tries to find out the schemes offered to the physically challenged people. Further the researcher tries to find how these schemes are beneficial to them if not why? What is required for them are taken into consideration. Moreover, the study deals with how women are facing their life with their disability. Over all this study will mainly concentrate on Orthopedically Handicapped – Locomotor Disability.