CHAPTER – II

REVIEW OF RELATED LITERATURE

"Disability is a matter of perception. If you can do just one thing well, you're needed by someone." - Martina Navratilova

The Review of related literature is essential for the successful completion of research. A careful review of literature is one of the major stages or steps in any research study. The researcher must try to become familiar with his/her problem by going through the studies. It helps the researcher to lay a sound foundation for his/her investigation. Though, it is time consuming, it is a fruitful phase as it helps the researcher to find out what is already known or hidden.

Review of the previous research will yield clues to the techniques of research. The researcher would hope to gain help in deciding how to do his/her own project by seeing how others have studied in the area and the success they have achieved with different research approaches, methods and techniques (Fox, 1969). The summary of related literature promotes and understanding of the problem and avoids unnecessary duplication. It helps the researcher to make a chance to gain an insight into methods, measures, subjects and approaches employed by other research work which in turn will lead to significant improvements of his/her own research design.

Disability literally refers to some kind of restriction or lack of ability to perform an activity in the manner considered normal for a person in human society. As a result of disability the patient finds it increasingly difficult to carry on his day-to-day activities including that of daily living. The activities of daily living refer to practical skills needed to care for one’s basic survival needs and to function in the society. There are several studies conducted to highlight this aspect with regard to the chronically disabled in general and locomotor disability patients in particular. Some of the studies are discussed below.

In this chapter the investigator has attempted to note down some points which are relevant to the study on previous literature and a theoretical overview of the study.
Related literature in Abroad:

Bagilhole (1997), and Chadwick,(1996) are of opinion that the minimal stance taken by the Government of United Kingdom may encourage the employers to sideline the aspirations and achievements of women with disabilities regarding qualifications and employment.

According to Helandar, (1995) in many developing countries, particularly lower income countries, publicly funded programs, and even those funded largely by employers, are not an option for those outside the formal labor market. Disabled people in agrarian societies and urban dwellers in the informal sector have to rely on themselves, or be financially dependent on their families and communities. Rehabilitation and other services provided by the state are often inaccessible. Services provided by volunteer organizations tend to be small single sector projects, e.g. support to a school for blind children, etc.

A study conducted by (Emily, et.al 2002) demonstrated culturally appropriate form independent group living to have a beneficial impact on the women’s levels of sociability and their confidence to venture out in public or to social functions. Living among other women with disabilities and in non-judgmental environment helped in raising self esteem and in developing social skills. All of the women who resided in the group house felt accepted, sociable, and confident to venture. Together, confidence in their abilities was strengthened and they could carry out their business with mutual support. Thus independent and group living helps in Social Development (increased sociability, public confidence and the ability to support) and personal Development (improved self-image, independence and professional motivation). Within gender, widowhood represents another disadvantage.

Joy Adamson, Andy Beswick, and Shah Ebrahim (2004) showed that it is widely stated that stroke is the most common cause of severe disability. They aimed to examine whether this claim is supported by any evidence. Methods: they conducted secondary analysis of the Office of the National Statistics 1996 Survey of Disability, United Kingdom.
This was a multistage stratified random sample of 8683 non institutionalized individuals aged between 16 and 101 years, mean 62 years, response rate 83% (n=8816). The outcome used was the Office of Population Censuses and Surveys severity scale for disability. Odds ratios and population-attributable fractions were calculated to examine the associations between diagnoses and disability. Results: Logistic regression modeling suggests that, after adjustment for co morbidity and age, those with stroke had the highest odds of reporting severe overall disability (odds ratio 4.88, 95% confidence interval [CI] 3.37-6.10). Stroke was also associated with more individuals domains of disability than any of the other conditions considered. Adjusted population-attributable fractions were also calculated and indicated that musculoskeletal disorders had the highest population-attributable fraction (30.3%, 95% CI 26.2-34.1) followed by mental disorders (8.2%, 95% CI 6.9-9.5) and stroke (4.5%, 95% CI 3.6-5.3). Conclusion: Stroke is not the most common cause of disability among the non institutionalized United Kingdom population. However, stroke is associated with the highest odds of reporting severe disability. Importantly, stroke is associated with more individual domains of disability compared with other conditions and might be considered to be the most common cause of complex disability.

The result of Mattson’s (1994) study on Disabled student’s experience of dependence and autonomy in integrated/segregated environments revealed that student with motor handicaps, their choice of upper secondary school and how they looked upon their educational and social situation in school. The studies were accomplished by questionnaires and interviews and were made as a comparison of disabled and control students. The students with disabilities all expressed disappointment concerning the possibilities of making their own decisions (being autonomous). The study claimed that the students with disabilities were subjected to a sort of passivity from the general environment. In an upper secondary school with special resources, they were taken care of by professional ‘helpers’ and in the general upper secondary school the school influence did not differ much from that experienced by the control group.

According to social cognitive theory, “Social problem solving refers to the cognitive behavioural process by which people identify effective strategies of coping with problematic situations encountered in daily living (Zurilla, 1986)
This cognitive behaviour process in coping involves five specific components:

1. Problem orientation (the cognitive and motivational set with which one approaches and recognizes problems in general),
2. Problem definition and formulation,
3. Generation of alternatives,
4. Decision making,
5. Solution implementation and verification.

Thus any coping behavior which comprises these five stages and implemented effectively leads the individual to maintain well being during stress. The opposite of this leads to faulty coping and ultimately to depression.

Murt, et.al (1980) conducted a study on disability, utilization, and costs associated with musculoskeletal conditions in United States, in which it was observed that, musculoskeletal problems accounted for a total of 3.9 billion in lost productivity costs for employed persons in the work force and for homemakers and thus posed significant economic burden.

Shah Ebrahim; Joy Adamson; Salma Ayis; Andrew Beswick; Rachael Gooberman-Hill(2008) “Locomotor disability: meaning, causes and effects of interventions” This paper provides a synopsis of a long-term programme of MRC-funded work on locomotor disability in older people. Specifically it describes the meaning and experience of disability, examines the risk factors for disability and systematically reviews the evidence from randomized trials of complex interventions for disability. We undertook a national prospective study of a representative sample of 999 people aged 65 years or more plus in-depth interviews with a small subsample and a selected sample obtained from hospital sources. Secondary analysis of several large prospective studies was carried out and a systematic review and meta-analysis of published randomized controlled trials of the effects of complex interventions for disability. Very few participants subscribed to the constructs of longstanding illness, disability or infirmity that surveys often use. A wide range of social and psychological factors, independently of chronic diseases, were strongly associated with disability. People with greater functional reserve capacity and those with greater self-efficacy were
generally less likely to suffer from catastrophic decline in ability and had better quality of life in the face of disability. In reviewing 89 trials (over 97,000 participants) of complex interventions for disability, evidence of benefits was found although no relationship with intensity of intervention was apparent. Our findings on the meaning and experience of disability suggest the need for modifications to routinely used survey questions and for different ways of understanding the need for and receipt of care among older people with disabilities. The diverse risk factors for disability suggest that novel approaches across social, psychological as well as more traditional rehabilitation and behavioural risk factor modification would be worth exploring. Complex interventions appeared to help older people to live independently and limit functional decline irrespective of age and health status.

In a study in the general population among people aged 55 years and over they demonstrated that all, that is 16 diseases and impairments in six functional systems, were significantly associated with locomotor disability in women. In men only three of five locomotor, two of five cardiovascular, one of three metabolic, the pulmonary and visual diseases and impairments were associated with disability. The finding that stroke and Parkinson’s disease were not associated with disability in men can probable is explained by the small number of men with these diseases and impairments in the study. Other analyses from the Rotterdam Study data, among almost 8000 participants, showed higher prevalence of stroke in men aged 75-84 and 85 years and over, i.e. 8.9 respectively 11.6%. In an analysis, among almost 7000 participants, the prevalence of Parkinson’s disease was 1.2% for men and 1.5% for women. The occurrence of locomotor disability among men in the general population is explained by only five diseases and impairments: joint pain, COPD, morning stiffness, diabetes mellitus, and heart failure. In women only five diseases and impairments did not contribute to the explanatory model. Of the remaining 11 the seven most important diseases and impairments, that is those which could each explain more than 10% of the distribution of disability in the population, were joint pain, COPD, morning stiffness, radiological osteoarthritis, heart failure, diabetes and osteoporosis.
A study conducted by The Social Services Department in Newcastle(1999) upon Tyne recently made a detailed survey of a sample of chronically sick and disabled persons living within the city. Arthritis and related rheumatic conditions were reported by 163 individuals, 39% of the total sample, and in 120 (28%) these disorders were the major cause of disability. A special study is being made to assess the medical care needs of these persons with disorders of the bones and organs of movement, and this preliminary report is based on the first 78 individuals seen, 23 of whom were male and 55 female. They were predominantly elderly (mean age 69) and many lived alone. One in 6 was single and 1 in 2 widowed (though only 1 in 4 of males were widowed). Almost one-third were unable to attract attention in an emergency. Stairs within or at the entrance to the home caused difficulty for about half the respondents. The principal limiting disability was located in the knees in half, and elsewhere in the legs in a further quarter. In almost three-quarters the main pathology was osteoarthritis. Other, non-locomotor, disabilities were present in addition in two-thirds, and multiple pathology was not uncommon. The outlook for three-fifths was deterioration, though improvement could be expected in 8%. It was considered that special treatment in the past, if available, would have been unlikely to have made much difference to more than half the respondents, but one fifth could have benefited from surgery. In contrast, present specialist needs were thought to be considerable, although the biggest call was for out-patient rather than in-patient treatment. The need for other remedial assistance and for aids, appliances, and adaptations was even more marked, and the resource implications of these assessments are challenging. The biggest practical problems in life around the house were in cutting toenails, doing housework, having a bath or all over wash, getting out of the house, and coping with stairs, and for the three former of these at least a fifth of the respondents were dependent on other people. In sampling the respondent’s attitudes, it was striking that although 70% claimed that nothing had been done to help them, the majority had not asked their family doctor for help, even though more than half considered that something could have been done.

Data from a 1990 survey in the United States showed that the proportion of families with a member with a disability was 29.2%, when the proportion of individuals with a disability was 13.7%. Individuals living alone were more likely to be limited in
activity (27% of those living alone) than those living with others (12.2%) A large part, but not all, of this difference was accounted for by age—the average age of people living alone was 53 years, compared to 32.5 for those living with others. Adults living with a partner have the lowest rates of activity limitation in all age intervals, regardless of the severity of disability.

Welbourn (1991), a study found in “the wealth ranking exercise results did not suggest that local people consider disabled people to be poorer” and concluded that, provided that adequate support networks and labor contacts were important in preventing disability from resulting in poverty.

Access to rehabilitation and other services for disabled people is very limited in developing countries. Harriss-White.B., (1996) noted that a small fraction of rural disabled people in India have access to government or NGO programmes, and that the majority are “profoundly socially excluded.” In many poor communities, particularly in rural areas, access is likely to be constrained by lack of information, travel costs, etc. ESCAP notes that rehabilitation services in the region’s developing countries are still inadequate and poorly coordinated, and that commuting to rehabilitation centers poses serious difficulties for disabled women and girls, and is expensive for their families in terms of money, time, and effort. UNICEF has reported that women and children receive less than 20 percent of rehabilitation services.

Tezzeni, Lisa (2001) observed that roughly 54 million Americans have some disability; at older ages, women are more likely to be disabled than men. Many people with disabilities today live virtually normal life spans, and therefore routine screening and preventive services are essential to their overall quality of care. We used the 1994-1995 National Health Interview Survey (NHIS), with Disability, Family Resources, and Healthy People 2000 supplements, to examine screening and preventive service use for adult women with disabilities living in the community about 18.4% of women (estimated 18.28 million). Disability was associated with higher age-adjusted rates of poverty, living alone, low education, inability to work, obesity and being frequently depressed or anxious. Disabled women generally reported screening and preventive services at rates comparable to all women.
Women with major lower extremity mobility difficulties had much lower adjusted odds of Papanicolaou smears (odds ratio, 0.6; 95% confidence interval, 0.4-0.9), mammograms (odds ratio, 0.7; 95% confidence interval, 0.5-0.9), and smoking queries (odds ratio, 0.6; 95% confidence interval, 0.4-0.9), approaches exist to improve access for disabled women to health care services.

**Emmett, Tony, and Erna Alant (2006)** studied that in general, women with disabilities are more discriminated against and disadvantaged than men with disabilities. In the industrialized countries there are consistent, although not necessarily large, gender differences in income, employment and education for people with disabilities. Poverty and deprivation magnify these inequalities, and can determine access to food, care and social inclusion, and even threaten survival. Women with disabilities are also at greater risk of physical, mental and sexual abuse, and because of stigmatization have lower marriage prospects. There are more barriers to access and participation for women than for men, and mothers and caregivers in particular face enormous challenges when rearing children with disabilities or chronic illnesses, especially within the context of women-headed households and early pregnancy. This article emphasizes the need to approach disability as an integral part of development rather than as a separate need competing with other causes and manifestations of poverty.

**Yeo, Rebecca, and Karen Moore (2003)** argues that the exclusion of disabled people from international development organizations and research reflects and reinforces the disproportionately high representation of disabled people among the poorest of the poor. The paper commences with a brief exploration of the links between impairment, disability, poverty, and chronic poverty, followed by a discussion of ways in which disability is excluded from development policy. Evidence of the incidence and distribution of disability is then presented. In the final selection, the ways in which different institutions challenge poverty and exclusion among disabled people is reviewed. Survey with evidence of the limited inclusion of disabled people within development institutions and policies is presented.
Related Literature in India:

Agrawal G, et al. (2009) observed better socio-economic status is closely associated with greater utilization of health care services among older persons. Patel SK states that treatment seeking behaviour of disabled persons depends not only on socio-economic factors but also on cultural factors, area of residence, literacy status, sex etc. Hidray SZ observed that the physical access to health service is a major hurdle for people with disabilities to reach and utilize these services.

Audinarayana, N and Sheela J (2002) examined the prevalence of physical disabilities, their differentials and determinants based on the data collected from 750 old persons (aged 60+ years) selected from nine rural (450) and six urban (300) clusters of Tamil Nadu State, India. Findings of the study reveal that half of the elderly population in the study area is suffering from one or the other forms of physical disability. Logistic regression analysis shows that the likelihood of physical disabilities increases significantly with an increase in age. Elderly persons who live in urban areas have significantly lower proportion of physical disability as compared to their rural counterparts. It was also observed that elderly people who belong to the higher socio-economic class were found to have lesser disabilities. Among the sample elderly people from Tamil Nadu State, India, slightly less than half of the elderly (47%) persons are found to be suffering from one or the other physical disability conditions. The prevalence of visual impairment is the major reported disability closely followed by hearing and walking disabilities. Multivariate results suggest that among the elderly, as age advances, there is a great likelihood of becoming disabled, and thus, the net effect of current age on physical disability is very strong. Elderly persons belonging to urban areas have lower odds of physical disability as against their rural counterparts, since they have the advantage of better education, greater awareness of healthy living and access to medical and health facilities. The extent of being physically disabled is lower, in general, among the elderly belonging to higher socio-economic background viz., educated, engaged in own cultivation, higher salaried occupation, and belonging to higher family monthly income bracket.
Bleck (1991) has studied the mobility of disabled persons in seven villages near the city of Bangalore. The objective of the study was to determine the influence of medical and environmental factors on muscle-skeletal disabilities leading to handicaps in mobility. The prevalence of musculo-skeletal disabilities was 0.4% in villages studied. Fifty one disabled persons below 50 years were identified. This population was compared with the urban population of Bangalore and one significant finding was that the disabled people in rural areas had better mobility compared with their counterparts in urban areas. This was due to the absence of environmental barriers in rural areas. Moreover, acceptance of the disabled in the rural community than urban areas provided more employment opportunities. The author suggests that corrective surgery and use of aids and appliances can qualitatively improve the functioning of the disabled so that their activities of daily living may be carried out without much difficulty.

Baquer, (1997), While reviewing the programmes and policy of the Government of India and State Government in respect of women with disabilities, has criticized the manner of functioning of the State Government. Many State Government have not appointed the Commissioner on full time to address the problems of people with disabilities.

Bruyer, (2000), has strongly advocated that women with disabilities should take up their rights to approach the appropriate authorities to do the needful. He emphasizes that independent development and integration of women with disabilities in the mainstream of development for which they themselves should come forward to establish their rights.

Deenadayalan (1990) has examined the impact of regular employment activities on the building up of morale and self-esteem of orthopedically disabled persons. The case study was carried out in Titan watches, Tamilnadu, and the following findings were significant. When a employee with serious physical disability was compared with the employee who was not disabled, the production was the same on both cases. The job stability for the handicapped was greater, if they were placed properly. However, special work arrangements needed to be extended for disabled persons such as raised markers on doorways, lowered work benches or wide doorways for facilitating their physical
functioning and these alternatives could not be considered as unreasonable financial considerations.

**Egan and Warrant (1992)** has conducted a study of the activities of daily living of the patients who were in bed after hip fracture. Thirteen men and forty eight women ranging between the age group of 65 to 92 years were studied. These patients were subjected to Activities of Daily Living assessments during three days before discharge. The same was repeated after three weeks of discharge. The concordance between pre-discharge and post discharge activities of daily life scores were low, but statistically significant. Thirty one patients demonstrated greater dependence after discharge and fourteen patients demonstrated less dependence. The performance of more dependent activities of daily living (ADL) at home was not related to role loss or depression.

**Aronson and Pemuda (1990)** conducted a study on the relationship between orthopaedic disability and perceived social support. They tested the way in which the orthopaedic disability affects social support by using path analysis. Hundred patients with mild orthopaedic disability were selected for the study. Hypotheses were offered concerning the effect of vulnerability, uncertainty, personality and social resources on perceived social support. Patients were administered measures of social support, severity of disability, conspicuousness, sense of impediment, anxiety and social status. Among the patients, an older patient whose disability was not conspicuous and who suffered high anxiety, experienced least support while a younger non-anxious patient whose disability was clearly visible, experienced most support. The patient’s personality was more important in terms of perceived social support than was the actual disability and the uncertainty of an encounter between an able-bodied and disabled person contributed to the perception of less social support by the patient.

**Elliot, et.al., (1992)** conducted a study on negotiating reality after physical loss. The utility of different reality negotiation strategies among 57 persons who had traumatically acquired severe physical disabilities was examined. It was predicted that a sense of goal directed determination would predict lower depression and psychosocial impairment scores, soon after injury. To meet the demands of rehabilitation and social integration, however, it was hypothesized that a sense of ability to final ways to meet
goals (pathways) would predict lower depression and psychosocial impairment among persons who had been disabled for a longer period. The expected interaction was significant in the prediction of psychosocial impairment but not of depression. The sense of pathways was predictive of impairment and depression regardless of the time since injury. The results suggested that in the reality negotiation process, the different components of hope had salient effects on perception of ability to function in social capacities.

Elliot strongly stressed the use of external aids and appliances for the chronically disabled and its role in carrying out their day-to-day activities comfortably. Feasibility, simplicity, acceptability, interchangeability, portability, affordability, durability and serviceability are the essential criteria that must be kept in mind while fabricating such aids and appliances for the disabled. According to the author, these aids and appliances should serve specific purposes including aids for personal care, aids for household work, aids for transportation, aids for communication, aids for learning and aids for leisure time activities.

Gathwala G. and Gupta S. (2004) studied on “Family burden in mentally handicapped children” and concluded that Sixty percent of families were severely burdened in relation to the item “Effect on the physical health of other family members” and concluded that physical / psychological illness and members of the family becoming depressed and weepy. Forty-five percent of families felt severely burdened regarding family interaction and had almost ceased to interact with friends and neighbors. Forty percent had family leisure severely affected and they had stopped normal reaction and had frequently abandoned planned leisure with the affected child using up most of their holiday and spare time. Thirty-five percent of cases had their family routine severely affected, leading to neglect of rest of the family. Only twenty-five percent of families felt were severely burdened financially. Twenty percent had postponed planned activity due to financial constraints.

Among the different types of disabilities, the prevalence of locomotor disability is highest in the country. Quality of life and disability limitation is affected by the
availability and utility of rehabilitative services. Thus knowledge of the treatment seeking behaviour will help in implementing successful intervention programmes.

Govindarajan.P.K., Ethirajan.N., and felix. John William (2012) study on Locomotor disability in Rural population in Tamil Nadu. The Study found that the locomotor disability was 129 out of 6550 population in the sub-centre which was around 1-9 percent. The study showed that the locomotor disability was more as the age advances. The locomotor disability among male were 22/1000and female were 16/1000. The causes of locomotor disability were due to acquired causes (78.3%) and congenital causes (21.7%). Nearly 58% of persons with locomotor disability were without any occupation and 20% were without any occupation and 20% were doing unskilled labour.54% reported absence of any source of income. 53% of the persons were married and nearly 35% of the persons were widow and widower.

The most of the locomotor disability can be prevented by avoiding trauma particularly accident.

Ghai and Sen (1987) in a study concluded that the four groups the deaf, the blind, the orthopedically impaired and normal males; were significantly different in the context of deprivation, the blind being the most deprived followed by the deaf, the orthopedically impaired and the normal subjects, in that order. The four groups also differed significantly in the context of self-esteem, the disabled group showing relatively more negative selves as compared to the normal.

Ghai and Lttyerah (1980) did a comparative study of the personality patterns, life satisfaction and problem patterns of Orthopedically impaired and normal male adults; and found that the handicapped were less independent, less well adjusted, but more satisfied than the able-bodied normal. They were also found to have confronted with significantly higher number of problems in the domains of home and psychological and social adjustments.

According to Graham L.A (2002) there is reasonably strong evidence that younger age at amputation results in superior walking ability, which is not unexpected given that fitness levels tend to decrease with age. However, this should not be the only
factor considered when deciding whether someone would be suitable for provision of prosthesis, as it is still possible for individuals over 90 years of age to walk independently following lower limb amputation.

**Halder, Santhoshi (2009)** conducted a study that explores the various constraints faced by orthopaedically challenged women in their way towards higher education in Indian society. The tools used for the investigation are the General Information Schedule (GIS), Socioeconomic Schedule, and Interview Schedule. The sample consisted of 100 orthopaedically challenged women collected on the basis of a situational sampling technique from eastern parts of India (West Bengal).

The findings are discussed in relation to the barriers to higher educational opportunities for challenged women in India. The study found that the brute physical or architectural barriers, financial constraints and the attitudinal barriers have a significant influence on higher education of the challenged woman. Furthermore, the study also found huge rates of wastage and stagnation at the primary and secondary level of education. The paper concludes by recommending the need for an overall approach for counteracting various constraints that exist in the early level of their education, without which we can hardly dream of higher education of the challenged women in a country like India.

**Kaur Prithpal (2010)** “Critical analysis of the Disabled Persons (Problems & Solutions)” the result revealed that credit must be given to the UN-policy makers who seem to have accurately perceived the problem and given appropriate guidelines to the member states so as to enable the efforts to be orchestrated smoothly and efficiently. An endeavor was also made to co-ordinate the policies and actions among different specialized agencies of the Economic and Social Council (ECOSOC) and NGOs active in the field. Integration and reintegration of the disabled became the guiding principles. The noble intentions were embodied in the emblem of the year itself, which showed two persons holding hands in solidarity and in support of each other in a position of equality. The disabled were to be accepted for their abilities and not disabilities, the problems of the disabled were to be viewed as the problems of the society as a whole. It is pity that many do not know the significance of the World Disabled Day. Even the Disabled
themselves are to be blamed to some extent. They have failed, even after the IYDP, to have organized themselves as was the wish of the U.N. to be able to form a strong enough pressure group so as to impinge upon legislation and decision-making. They must not forget that the interests of a group are best guarded by the members of the group and that the self-help is the best help.

Laskar A.R., et.al (2010) observed that rehabilitative institutions such as Institute for Physically Handicapped (IPH), Delhi, providing specialized care such as occupational therapy or physiotherapy, aids and appliances and psychological counseling services were rarely consulted in the initial few consultations and about 40% patients approached private hospitals or clinics. Further they observed that 68% approached General Practitioner for treatment and 39.4% availed the alternate system of medicine. Similarly Joshi stated that the most popular type (system) of medicine preferred by those who were seeking treatment was Allopathic, which was adopted by nearly 92.2% people. The rest, 7.7% of the people, rely on either Ayurvedic or Homeopathic medicine. In the study conducted by All India Institute of Physical Medicine and Rehabilitation, it was observed that, out of 100 patients, 13 took local/herbal treatment and 30 approached a physician from alternate system or Allopathy.

In literature search it was observed that, various studies have observed different reasons for non utility of rehabilitative services. Laskar et.al. observed that the most common reasons cited for not using government specialty rehabilitative services were long hours in queue (57%), ill-treatment by staff especially those relying on aids and appliances (45%), complicated paper work (36%) and overall poor quality of care (28%) in government set-up.

Leni chaudhuri (2006) “Disability in India-issues and concerns” The Centre for Enquiry into Health and Allied Themes (CEHAT), Mumbai 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. . 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. 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. 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. 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. Problems of access, education, employment and discrimination are the major issues affecting the prospects of women with disability.

Lannigan E.G., (2004) studied the individuals with mental illness and found that lack of resolution between their work aspirations and their reduced skills left the participants feeling troubled by these discrepancies. Lack of adaptation to altered performance led to their inability to come to terms with their disabilities. A conclusion of the study was that the lack of resolution of these discrepancies limited clients far more than their reduced vocational skills. Adaption to “living with illness” was crucial to their successful entry into and maintenance of competitive work.

The literature indicates that sex is unlikely to have a significant influence on walking ability after lower limb amputation. There is greater uncertainty regarding the influence of co-morbidities however. This is surprising, in that it could be assumed that poorer health status would impact negatively on walking ability, particularly given the additional energy requirements to walk with prosthesis. The disagreement between studies may, at least in part, be related to variability in methodology, with definitions of medical conditions differing between studies. For example, only participants on diabetic medication were classified as diabetic by Moore, T.J., et.al (1989) while others included those using diet controls in their analyses. Moore et al. also included symptomatic vascular claudication in the contra lateral limb in their musculoskeletal disease category,
although the reasons for doing so were not stated. Another methodological consideration is that many studies did not control for confounding factors associated with co-morbid conditions, such as the association of diabetes with amputation at a younger age and a greater ratio of below to above knee amputations.

**Midgley, (2000)** has proposed a two-tier social development model for women with disabilities. At the first stage, the general policies, plans be actuated from Government level down to the community levels so that there will be general awareness for addressing the concerns of disability women. Secondly, the women with disabilities are provided with self help model like extending loans, training, running self employment ventures, etc. so that they will be sent free from oppressive and dehumanizing attitudes of the other people in the society.

**Morris Jenny (1991)** a disabled feminist and activist, provides a feminist analysis to the study of the experiences of women with disabilities. Basing her arguments on the feminist principle that the personal is political, Morris eloquently challenges such issues as prejudice, abortion, and the notion that people with disabilities lead lives that are not worth living. Pride against Prejudice is a commentary on political activism and rights, and stresses the need to fight back against the prejudice, stereotypes, and oppression of culture. Morris (1993) further discusses that there is absence of women with disabilities from feminist scholarship and feminist theory. She discusses her anger and frustration with feminism in two ways: first, that disability is generally invisible from feminism's mainstream agenda, and second, that when disability is a subject of research by feminists, the researchers objectifies disabled people so that the research is alienated from their experiences rather than attempting to understand the experiences of disabled women.

**Maya Dhungana, Bishnu (2006)** conducted a study that examines a broad range of problems faced by physically disabled women. Qualitative interviews with 30 women with physical disabilities (congenital and acquired) were administered to understand various aspects of their lives. The research explores the causes of disability, which include gender discrimination, poverty, an inactive state security system, inadequate family support, negative attitudes and a lack of commitment on the part of government. The available services from non-governmental organizations have been proved to be
unsatisfactory and gender biased in terms of training and employment. The importance of disability and its relation to gender has not been recognized by the state.

The study of Maya explains the domestic violence and disability inadequately explain several features that lead women who have a disability to experience violent situations. Maya’s article argues that material feminist interpretations and disability theory, with their emphasis on gender relations, disabilities and poverty, should be used as an alternative tool for exploring the nature and consequences of violence against women with a disability.

Menon Nidhiya, (2012) “The State of Persons with Disabilities in India- Susan Parish and Roderick Rose” this research provides evidence of state-wide disparities in the economic well-being of people with disabilities, In particular, households with individuals with disabilities have up to 14 percent lower average monthly per person spending as compared to families with able members. Similar trends hold when the analysis is disaggregated by gender of the individual with disabilities, however, in comparison to families with male adults with impairments, those with female adults with disabilities appear to experience no statistically discernible penalty. The burden for families with children with disabilities is higher than that experienced in households with adult male members with impairments (15 percent deficit versus 13 percent deficit, respectively). A way to ameliorate the economic well-being of people with disabilities in India may rest on improving services at the state level. In particular, a fruitful route might be to extend central government aid to this population, particularly households with persons with disabilities in poor states. State governments too have critical parts to play since anecdotal evidence suggests that people with impairments are often unaware of their rights and entitlements. A more dedicated role by state institutions to increase such awareness, perhaps in concert with non-government organizations, would be valuable. This is because with awareness of entitlements, families with members with disabilities will be in a better position to avail of resources dedicated towards them, thus helping to cushion declines in average monthly spending. Furthermore, as opposed to aid alone, a more pro-active state-government role in furthering access to small loans (perhaps by acting as a part-guarantor) may be invaluable in relaxing resource constraints for people with disabilities in India. Finally, better mechanisms for increasing service outreach to
smaller administrative units (villages, districts and Panchayati Raj institutions) within a state may bring tangible benefits to people with disabilities, and on the most vulnerable section of this population, families with children with disabilities.

**Patel S (2009)** studied about “An empirical study of causes of disability in India” at Ph.D. level. The results revealed that locomotor disability is the most prevalent type of disability affecting the population of all ages in India. Mental problems are highest among working aged population, and visual and hearing disability are highest among the aged population. The study also reveals that mental disability is occurring mainly due to serious illness during childhood, head injury in childhood and pregnancy and birth related causes. Old age, cataract, glaucoma and other eye disease are the main causes for having visual problems while polio, injury other than burns, other illness, stroke, arthritis, cerebral palsy are the main causes of locomotors disability. The study also shows that injury other than burns is a vital cause of having disability in India.

**Primone, Janet and Yates (1990)** conducted a study on social support for woman during chronic illness, the relationship among sources and types of adjustment. The “Norbeck social support questionnaire” was used for the study. Totally 125 chronically ill women (mean age 41.3 years) were selected for the study. Analysis of variance (Anova) was used to examine the support from four main sources; spouse, family, friends and others. Patients perceived more support from the partner than from any other source. Friends provided more affirmation than family or others. Next to the spouse, patients confided about their illness more to health care providers, counselors or religious personnel than to family or friends. Affect, affirmation and reciprocity from both the partner and family were associated with less depression, higher marital quality and better family functioning.

**Padhyegurjar Mansi.S, Padhyegurjar Shekhar.B, (2012)** studied the “Factors affecting treatment seeking Behaviour of individuals with locomotor Disabilities”, a community based cross-sectional observation study was conducted in an urban slum of Mumbai. Total sample of 3665 individuals were screened. 205 were identified with locomotor disabilities who were subjected to a structured questionnaire. The study was conducted over a period of 3 months. 95% confidence limits for prevalence were
calculated to estimate the prevalence in the general population and Chi-square test was applied to identify the association between two variables. The prevalence of locomotor disabilities is found to be 5.59%. Females were more affected than the males. 75% of the sample was unemployed and 49.3% was illiterate. Utility of rehabilitative services was found to be poor (35.6%). 50.7% of these were treated by General practitioners. Very few approached specialty rehabilitative services. Low literacy levels and poor awareness of rehabilitation facilities were the major factors affecting treatment seeking pattern of individuals with locomotor disability. Based on the data the study concludes that improving literacy rates, developing community based rehabilitation services, training medical undergraduates and creating awareness regarding the available facilities, will lead to greater utilization of rehabilitative services and thus early diagnosis and disability limitation.

It shows that locomotor disability in the community is not of severe nature as majority of the individuals detected with locomotor disability were ambulatory, low muscular power, multiple joint involvement and increased duration of disability. Thus advancing age and longer duration of disability will make rehabilitation difficult. However, the positive finding is that majority of affected individuals in the study are less than 45 years of age and with disability of less than 5 years. Thus if rehabilitative services are targeted to these groups, their deterioration can be effectively prevented by early diagnosis and prompt treatment. Females were found to be affected more than males. They should be specially targeted through existing programmes for women. Lastly, rehabilitative services need to be developed at grassroot level and awareness needs to be created regarding their availability. This will increase the number of people seeking treatment, limit the disability, and will eventually improve the employment rate and financial status of people with locomotor disability. Thus timely diagnosis and effective rehabilitation services will go a long way to restrict the deterioration of individuals with locomotor disability.

Patel, Vikram, Merlyn Rodrigues, and Nandita DeSouza (2002) conducted a study that described the natural history of depression in mothers who recently gave birth in a low-income country and to investigate the effect of risk factors, particularly related to infant gender bias, on the occurrence and outcome of depression. The authors studied a
group of pregnant mothers recruited during their third trimester of pregnancy from a district hospital in Goa, India. The mothers were interviewed at recruitment, 6-8 weeks, and 6 months after childbirth. Interview data included presence of antenatal and postnatal depression, obstetric history, economic and demographic characteristics, and gender-based variables (preference for male infant, presence of marital violence). The results shown by the authors were, depressive disorder was detected in 59 (23%) of the mothers at 6-8 weeks after childbirth; 78% of these patients had clinically substantial psychological morbidity during the antenatal period. More than one-half of the patients remained ill at 6 months after delivery. Economic deprivation and poor marital relationships were important risk factors for the occurrence and chronicity of depression. The gender of the infant was a determinant of postnatal depression; it modified the effect of other risk factors, such as marital violence and hunger. Depressed mothers were more disabled and were more likely to use health services than non depressed mothers. They concluded that Maternal and infant health policies, a priority in low-income countries, must integrate maternal depression as a disorder of public health significance. Interventions should target mothers in the antenatal period and incorporate a strong gender-based component.

Postnatal depression generally occurs within 6-8 weeks after childbirth. One meta-analysis has shown an average prevalence of postpartum depression of 13% (95% confidence interval [CI] =12.3-13.4) in the general population. In developed countries, the risk factors for postnatal depression are past history of psychological disorder, psychological disorder during pregnancy, low socioeconomic status, complicated delivery, and poor marital relationship. Women in many countries whose populations have low income face considerable inequalities, ranging from fewer opportunities in education and employment to less control over personal decisions, such as the use of contraception to plan pregnancies. In India, the cultural view that male children are preferred over female children is an important reason that the sex ratio is unbalanced in favor of men.

There are few studies regarding the influence of gender-based factors on the risk for and outcome of postnatal depression. The objective of this study was to describe the natural history of postnatal depression in a developing country in which gender inequality
is deeply entrenched. This study aimed to examine the etiological role of risk factors recognized to be relevant to the onset of postpartum depression in developed societies, as well as those that reflect the poverty and gender inequality faced by women in India.

**Pati, R.N., (2011)** studied about “Differently abled Women: Issues and Challenges” The department of health, Govt. of Philippines conducted study on disabled people development in 2004. This study has pointed out that inaccessibility or non-availability of health services attribute to prevalence of disabilities among children in age group 0-14 years living in urban slums and rural areas. Another vital cause of disability is the failure of pregnant mother in attaining prenatal checkups. The study has pointed out that the home deliveries conducted by traditional birth attendants caused accidents in many cases which lead to occurrence of disabilities among new born babies. The study also point out that the pregnant women and lactating mothers living in not more than 10% of households covered under survey receive iron and iodine supplements which could have prevented a good number of disability conditions at birth. In other words, 90% of families failed to provide iron and iodine supplements to pregnant and lactating mothers and expose them to disability prone living environment.

The studies conducted on social service and disabilities conclude that lack of access to basic social services including access to hospital or to benefit of Government Programmes of health, housing, livelihood, public infrastructures among poor is root cause of occurrence of disability in rural regions of India. Studies have indicated that persons with disabilities have denied access to basic social service, covering access to education, access to health care, access to employment and access to transportation. Lack of access to basic social services pushes them not only into vicious circle of poverty but also into gloomy arena social deprivation. In India 1.5 to 2 million disabled people are being added to our population every year. And even now 80% of special rehabilitation facilities are found mainly in cities.

In Orissa the population of people with disability is 1021335 which accounts for 2.77% of total population of the state. Women with disability constitute 44.29% of total disability population. The percentage of women with disability to total population of
disabled persons is 44.69% in a rural area and 48.80% in urban area. The rural region of Orissa accommodates 19.11% of women with locomotor impairments.

**Raymond Lang (2001) Understanding Disability from a South Indian Perspective** - Paper presented at the 14th Annual Meeting of the Disability Studies Association, Winnipeg, Canada. From the analysis of both primary and secondary sources, it is readily apparent that disabled women, both in India and internationally, have a relatively lower status than do their male counterparts, and are thereby less likely to receive and benefit from the provision of rehabilitation services. Within the Indian social context, women are regarded as inferior beings, both by able bodied and even disabled men. Being deprived of basic health services at birth and during early infancy, educational opportunities during their childhood, and often genuine love and affection, it is far from surprising that disabled women’s life in India are characterised by a lack of self dignity and worth.

Key problems are the widespread belief that disabled people are second-class citizens within their own society and the gender-bias in the provision of rehabilitation services. Key priorities are the need to ensure that rehabilitation services genuinely meet the explicitly stated needs and aspirations of disabled people; to ensure that, as far as possible, disabled people are engaged in gainful employment, thereby making a contribution to the domestic household; to address the gender bias in the provision of rehabilitation services; for NGOs to run disability-awareness programmes, dispelling some of the negative connotations associated with disability.

**Rajagopal Rao Kodali, Sitaramacharyulu P (2011) conducted “A study on the attitudes of societal members towards the disabled children in Loni, India.”** As per the prevalence of disability in rural India is 22.5 per 1000 population. Major disability is Hearing and Speech impairment followed by locomotor disability, visual impairment, mental retardation and less is multi disabilities. Majority of the parents of children with disabilities wanted their children to get married, to be educated, to share in property and to train them for community based rehabilitation. The negative attitudes of the parents were observed in cerebral palsy may be due to brain damage and mental deficiency in
severe mental retardation and because of complete dependency in locomotor disability and in multiple disability like deaf and mutism.

Rao S.N (1981) reported a study of handicapped individuals with regard to frustration. Individuals who were rehabilitated by providing them with artificial limbs, and were able to move about freely, showed remarkable change in their attitude. They were almost comparable to normal people and they did not suffer from inferiority feelings and any under ego-defensiveness, at least apparently. Rao reported that in contrast to popular notions, the disabled in most cases exhibited a better appreciation of the purpose of life and were better adjusted. They were relatively free from anxiety owing to the fact that they generally came to terms with their disability and set goals which were realistic; thus they tended to be more satisfied and happy.

Ravindran and Karunanithi (1983) found that the physically handicapped and the normal, when compared in respect of job involvement, did not significantly differ from each other. Physical impairment may impose limitations on the person as well as it may reflect limitations imposed on him, because of socially and culturally defined reactions.

They found that a higher proportion of households with self reported disabled members were below the poverty line, had lower total assets, smaller land holdings, and greater debt than households without disabled members. Disabled people are estimated to make up 15 to 20 percent of the poor in developing countries. In some communities, the disabled are regarded as the most disadvantaged by others in the community, and it is frequently observed that in low-income countries, the disabled poor are among the poorest of the poor. A study by ESCAP notes that the difficulties faced by disabled girls can start at birth, and that if disabled girls are allowed to survive, they can face discrimination within the family, receive less care and food, and be left out of family interactions and activities. They also have less access to health care and rehabilitation services, and fewer education and employment opportunities. Disabled girls and women are at high risk of being abused physically and mentally, sometimes by those within the household. Abuse from outside the family is often unreported because of the additional shame to the family which is already stigmatized for having a disabled daughter.
Sophie Mitra and Usha Sambamoorthi (2007) conducted a study in Tamilnadu, this study is the first systematic examination of employment outcomes across disability status in an agrarian labor market. This study has several findings that are noteworthy. Men with disabilities do not appear to have lower wages than men without disabilities. An analysis of the determinants of the probability of employment among persons with and without disabilities suggests that disability may represent a barrier to employment. Only 52.3% of males with disabilities work compared to 79.1% for males without disabilities. The study results suggest that there is an overall gap of 26.8 percentage points in employment rates among men in Tamil Nadu. A decomposition of this gap reveals that the gap is not attribute to differences in demographic, human capital, health, and other observed characteristics between males with and without disabilities.

Shekhar B Padhyegurjar, Mansi S Padhyegurjar (2011) conducted “Cross-sectional study of Locomotor Disabilities in urban slum area of Mumbai” which has focused attention on the locomotor disabilities in an urban slum area of Mumbai. The overall prevalence of loco motor disabilities is 5.59% showing gradual increase as age advances. India is witnessing a rise in geriatric population due to a steady rise in life span. This will also lead to the increase in the prevalence of loco motor disability in future. This study indicates significantly high prevalence among females. Thus this health issue needs to be focused on especially through the various health programmes for the females. Policies to control accidents and injury, which have been reported to be the major cause in the study, will be an effective prevention strategy. The problem of loco motor disability needs to be adequately addressed in the existing National Health Policies, and rehabilitative services at primary health care level especially for females and the geriatric age group, will help to improve the quality of life of affected.

Sethi (1981) quoted that a physical handicap may in some situations act as a stimulus and a challenge and call forth all the resources of personalities. However, it may be compensated for in other less desirable ways. The dissatisfaction arising from one’s personal defects may be lessened by adopting various defence mechanisms, such as by disparaging the particular goal one cannot reach or the activity in which one is inferior or by decrying the merits of the others and the like.
Tate, Denise Galuiuf, and Nancy Hanlan Weston (1982) observed in their study that the evidence of little importance being attributed to the topic of women with disabilities is reflected in the lack of available literature, studies, and documentation. Very little is known about the extent to which rehabilitation literature disability affects women differently than men, thus leaving open the question as to what different types of rehabilitation services might be needed. Most medical and vocational studies focus on men because they are the ones who are expected to return to “gainful employment.” It is most important to monitor the changes in the types and frequency of disabilities that may affect women as their roles expand to include gainful employment for long periods of their lives.

In discussing the problems of equalizing the availability of services to women with and without disabilities, Noble states that the Social Security System in the United States allows for legal inequality.

Men qualifying for benefits generally have longer tenure in the work force and higher wages than women. Consequently, men are entitled to higher level of benefits. Consequently, it takes the taxes on the lower wages of many women to pay for the generally higher benefits of each man who retires or leaves the work force prematurely due to ill health or disability. From a strictly economic viewpoint, it is less costly to hire women for jobs currently offered to men since women may accept lower wages and are entitled to lower levels of benefits. There are many approaches that can be taken with respect to providing women with job opportunities in traditional male areas. Whether these approaches seriously prevent attempts for equal participation and for upgrading women’s status in society is a difficult question.

From a sociological viewpoint, efforts to socially integrate any minority group, female or disabled, should concentrate on developing a better understanding, through documentation, of these persons. As a more complete and systematic picture of women with disabilities is yielded, the appropriate economic strategies to respond to both individual and societal needs can also be determined.

Several barriers were identified throughout this article that preclude women from equal opportunity in employment, education, health, and rehabilitation services and
benefits. In essence, these barriers relate directly to each country’s values, cultural patterns, and attitudes toward women and disability. The conceptualization of women’s role as one of reproduction and continuation of the human species is inherent in all societies. Unfortunately, in the process of enhancing this function, women have been short-changed.

Their status, in most cases, is severely limited and neglected. Furthermore, a woman with a disabling condition is also the object of society’s negative attitudes and stereotyped values toward disability. Although this dual discriminatory trend is quite common in most countries, there are differences in how countries continue to perceive and expand their views of the potential role of women with and without disabilities in society. Generally, women play a very important role in the prevention and the treatment of disabling conditions in most societies. The low status of women is not only detrimental to women themselves, but also to the human community. Society cannot continue to disregard the role, tasks, and services performed by women upon which the well-being of the human community so heavily depends.

Valentine, Laurette, Margret (1990) conducted a study of people with physical disability in the process of recovery from alcoholism. This exploratory field study with physical disabilities specifically investigated people sought to identify the barriers to the process of recovery and coping methods used by the subjects to overcome those obstacles. A qualitative research design was used, based primarily on “in depth” interview. Barriers and coping methods were extrapolated from responses to interview questions. Sixteen categories of barriers were identified. Nine methods of coping were also identified and defined including support, self-talk, spiritual faith, and service, minimizing physical limitation, minimizing attitudinal limitations, self-development activities and avoidance. Compared to early recovered participants, the respondents experienced fewer barriers and used more coping methods.

Vinod Kumar, (2012), studied “Employment Rights of Disabled Women in India: Submitted by Society for Disability and Rehabilitation Studies” It is a Study of Compliance & Impact of the PDA with Special Reference to UP, Rajasthan, Bihar,
Maharashtra and Tamilnadu Sponsored by National Commission for Women, Govt. of India:

The first critical factor that has an impact on the effectiveness of any act is the level of awareness about its existence amongst the target group. The level of awareness about these initiatives was not found to be high. There were wide variations in the level of awareness across States. 53% are unaware about the Persons with Disabilities Act, (1995). In Tamil Nadu only 35% were aware about PWD act 1995. 77.2% of the women respondents could not specifically name any legislation/act for empowering the persons with disabilities, especially the women with disabilities. Overall more than 76% of the women respondents were satisfied with the implementation of the specification of providing 3 per cent reservation quota in government jobs for the disabled individuals. Maximum satisfaction (approximately 85%) was revealed in Rajasthan whereas In Tamilnadu the percentage of satisfied respondents was lowest at 58% only. More than 77% of the respondents were of the view that 3% of job reservation quota for persons with disabilities provided inter alia the PWD Act is sufficient for empowering them. Majority of the respondents felt that the PWD Act has had some impact in empowering the women with disabilities. About 21% of the respondents felt that the Act has had no impact in empowering the women with disabilities.

World Bank reported (2007) that in India, disability is associated with lower socio-economic status. Survey data from villages in Uttar Pradesh and Tamil Nadu in 2005 showed a clear decline in the proportion of people with disabilities of all severity as the wealth of households rises and a similar pattern can be seen where the measure of disability is by community identification of whether or not a household has a disabled member (World Bank Report 2007).

National Sample Survey Organization (NSSO) estimated that the number of persons with disabilities in India is 1.8%(49.90 million) of the Indian population (NSSO 2002), that 75% of persons with disabilities live in rural areas, 49% of the disabled population is literate and only 34% are employed (NSSO 2002). NSSO also includes the persons with visual, hearing, speech, locomotor and mental disabilities. 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. 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. 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.

The NSSO study showed that, among the different types of disabilities, the prevalence of locomotor disability was highest in the country – it was 1046 in the rural and 901 in the urban per 100000 persons. Current demographic trends show that the number of older people is rapidly increasing. Accordingly, the prevalence of disability in basic, self-care activities of daily living is also rising, posing a great challenge to the health care and social systems that are already experiencing financial constraints.

Nityananda Kar, (2002), conducted a study in the Department of Physical Medicine and Rehabilitation, Burdwan Medical College and Hospital, Burdwan, a rural Medical College in West Bengal, during the period from January 1993 to December 1993. All Locomotor disabled irrespective of age, sex and cause, attending the department and medical board seeking physically handicapped certificates during this period, are included in the study. 780 rural based locomotor disabled are studied to find out the pattern and causes of disability. Males are four times more than females. Paralysis of limb is maximum 55.1% followed by stiffness of joint 27.7%, loss of limb 11.7%, Kyphoscoliosis 2.8% and others 2.7%. Paralysis affects mainly one lower limb (53.3%) followed by one upper limb (15.6%), both lower limbs 14.4%, all four limbs 8.4%, one upper and one lower limb 8.1%. Paralysis of limb is mainly due to residual poliomyelitis (81%) followed by spastic cases 17%. Stiffness of joint affects mainly foot and ankle (28%) followed by wrist and hand (14%), Hip (13%), knee (11%), elbow (9%) and others. Main causes of stiffness of joints are congenital deformity (51.9%) and post traumatic stiffness (35.6%). Loss of limb is mainly due to post traumatic amputation (84.6%) and congenital limb deficiency 14.3%. Upper limb loss is more (55%) than lower limb loss (45%). In this study on locomotor disability poliomyelitis is (45%),
congenital deformity (14.3%), post traumatic stiffness (10%), amputee (11.7%), spastics 9% and others 10% are causes of locomotor.

Definitions of both disability and poverty are complex. Disability is defined differently depending on the paradigm that is being considered. The medical model of disability is strongly normative, based on the individual and his or her medical condition and people are considered to be disabled on the basis of being unable or less able to function as a “normal” person (Mitra, 2006).

Article on the Hindu, Tuticorin. (5th Dec, 2013) Girl with a locomotor disability excels in regular school S.Yalini, has excelled in academics with 91% at Municipal Middle School in Tuticorin. This was the first experience in school for the class VIII student. She said it was possible to her only because of her grandfather. After being raised by her grandfather Mr. A. Sankaranarayanan Retd. Tahsildar at home. Mr. Sankaranarayanan says disability was not a barrier for her.

According to the UN Women Watch.

“Girls and women of all ages with any form of disability are generally among the more vulnerable and marginalized of society” (“Further actions and initiatives to implement the Beijing Declaration and Platform for Action”, General Assembly Resolution S-23/3 of 10 June 2000, annex, paragraph 63).

“Less than 5 percent of children and young persons with disabilities have access to education and training; and girls and young women face significant barriers to participating in social life and development” (Secretary – General of the United Nations in his report on the Implementation of the World Programme of Action concerning Disabled, A/56/169, paragraph 79).

“The global literacy rate for adults with disabilities is as low as 3 percent and 1 percent for women with disabilities, according to a 1998 UNDP study “(UNDPI fact sheet).

“People with disabilities in general face difficulties in entering the open labour market, but seen from a gender perspective, men with disabilities are almost twice as likely to have jobs than women with disabilities. When women with disabilities work,

“Every minute, more than 30 women are seriously injured or disabled during labor…However, those 15-50 million women generally go unnoticed” (World Bank, “Health, nutrition and population : Reproductive health and disability”).

“Women with disabilities, of all ages, often have difficulty with physical access to health services. Women with mental disabilities are particularly vulnerable, while there is limited understanding, in general, of the broad range of risks to mental health to which women are disproportionately susceptible as a result of gender discrimination, violence, poverty, armed conflict, dislocation and other forms of social deprivation”. (Committee on the Elimination of Discrimination against Women General Recommendation 24 Women and Health, in relation to the Convention on the Elimination of All Forms of Discrimination against Women (Article 12) (Twentieth session, 1999, paragraph 25).

“Depressive disorders account for close to 41.9 percent of the disability from neuropsychiatric disorders among women compared to 29.3 percent among men” (Women’s mental health: The Facts, World Health Organization)

“Women with disabilities face significant barriers in accessing adequate housing and services, Women with disabilities are more likely institutionalized than men with disabilities” (Study by Miloon Kothari, Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, “Women and adequate housing”. (E/CN.4/2005/43, paragraph 64).

The Summary of the above studies indicates the research needs to identify the integrated approach on the status of women with locomotor disability. Hence the researcher attempts to depict the clear views on the status of disabled women.
Significance of the Related Literature:

Reviews of related Literature provide information to the researcher about the standard of life of women with Locomotor Disability and the Governmental Schemes available for them by which they may be empowered. A thorough study above helped the researcher to select the correct methodology to proceed further. The related studies also gave an idea to know the previous life style of the disabled women and direction to uplift them further. It helped the researcher to gain back ground of the research topic.

The studies mentioned clearly indicate that very few attempts have been made to study the challenges encountered by the locomotor disabled in Tamilnadu, particularly rural based city like Madurai. This made the investigator to undertake a study of the locomotor disabled and the challenges encountered by them towards implementing the programme. A detailed description of the procedure followed by the investigator is described in Chapter III. Overview of the studies that are directly and indirectly related to the problem revealed that we must give much importance to the mainstreaming of the disabled persons and integrated development programme. The conclusion of most of the studies revealed the fact that the integrated development programme helps to equalize the opportunities of the disabled, especially locomotor disabled.