# MAR GREGORIOS COLLEGE OF ARTS & SCIENCE

Block No.8, College Road, Mogappair West, Chennai – 37

Affiliated to the University of Madras
Approved by the Government of Tamil Nadu
An ISO 9001:2015 Certified Institution

# PG DEPARTMENT OF SOCIAL WORK

**SUBJECT NAME: SOCIAL WORK & PERSONS WITH DISABILITY**

**SUBJECT CODE: HBWEJ**

**SEMESTER: IV**

**PREPARED BY: PROF. D.KAVITHA RANI**

**Objectives:**

- To develop understanding of the needs and problems of persons with disability.
- To understand policies, programmes and services available to persons with disability.
- To provide opportunities for social work intervention to the persons with persons

**Unit 1**

**Types of Disability:** Impairment, Handicap, disability & Differently Abled, meaning, nature, type. Extent of Disability in India; Various Categories of Persons with disability – Physical, orthopedic, visual, motor & sensory, mental – their needs and problem, multiple disability.

**Unit 2**

**Historical development of services & programmes** for the various categories of persons with disability. institutional and Non –institutional services for various groups, management of institutions of disabled people.

**Unit 3**

**Causation of Disabilities**: Disabled People in Society and societal response, Prevention of diseases causing disability, safety measures to avoid disabilities, Rehabilitation – concept, nature and efforts by Government and Non-Government Organizations, institutions and problems in rehabilitation, Community Based Rehabilitation, Rehabilitation Education and Management of Rehabilitation, Rehabilitation Council of India.

**Unit 4**

**UN Declaration of Human Rights of Disabled Persons:** International year for Disabled, Efforts by International organizations for prevention, welfare & rehabilitation of disabled. Legislation with reference to persons having disabilities. Mental Health Act, The Person with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995.
Welfare Services for disabled.

**Unit 5**

**Work, Occupation and Disability:** Factors specific to disabled elderly people; and Children, social work in traditional setting. The changing context of social work practice. Social Work intervention for creating supportive environment.

# Unit 1

# TYPES OF DISABILITY

## General Definition of Disability

A physical or mental condition that limits a person's movements, senses, or activities.

**According to UN**

Those who have long term physical, mental, intellectual or sensory impairments which in interaction with various barriers my hinder their full and effective participation in society on an equal basis with others.

## Definition and concept of Disability, Impairment and Handicap.

The terms impairment, disability and handicap are often used interchangeably, but have distinct meanings that help to describe the physical and social impact on an individual. According to the WHO International Classification of Impairment, Disabilities and Handicap (ICIDH: 1980 – replaced by ICF in 2001), impairment relates to bodily functions, disability to activities, and handicap to social roles.

The three are distinct but interrelated. An impairment is the loss or abnormality of a body function that can be anatomical, physiological or psychological, e.g., a missing limb or diagnosed mental disorder. A disability is an inability or restricted ability to perform an activity within the normal human range, e.g. being unable to walk. A handicap is a disadvantage resulting from impairment or disability that limits the social role of an individual, e.g. being unable to work somewhere due to limited access.

## Definitions of Disability

The definition of disability is highly contentious for several reasons. First, it is only in the past century that the term "disability" has been used to refer to a distinct class of people. Historically, "disability" has been used either as a synonym for "inability" or as a reference to legally imposed limitations on rights and powers. Indeed, as late as 2006, the Oxford English Dictionary recognized only these two senses of the term (Boorse, 2010).

Second, many different characteristics are considered disabilities. Paraplegia, deafness, blindness, diabetes, autism, epilepsy, depression, and HIV have all been classified as "disabilities."

The term covers such diverse conditions as the congenital absence or adventitious loss of a limb or a sensory function; progressive neurological conditions like multiple sclerosis; chronic diseases like arteriosclerosis; the inability or limited ability to perform such cognitive functions as remembering faces or calculating sums; and psychiatric disorders like schizophrenia and bipolar disorder. There seems to be little about the functional or experiential states of people with these various conditions to justify a common concept; indeed, there is at least as much variation among "disabled" people with respect to their experiences and bodily states as there is among people who lack disabilities. Indeed, some have questioned, in part because of this variation, whether the concept of disability can do much philosophical work (Beaudry, 2016).

At the same time, defining "disability" solely in terms of social responses like stigmatization and exclusion does not distinguish disability from race or sex (Bickenbach, 1993)—a result that some disability scholars might welcome, but that begs, or obscures, an important question. The challenge of distinguishing "disability" from other concepts, without taking a simplistic or reductive view of it, has been taken up by various specialized definitions.

Differently abled was first proposed (in the 1980s) as an alternative to disabled, handicapped, etc. on the grounds that it gave a more positive message and so avoided discrimination towards people with disabilities. The term has gained little currency, however, and has been criticized as both over-euphemistic and condescending. The accepted term in general use is still disabled

**According to The Rights Of Persons With Disabilities Act, 2016**

"Person with disability" means a person with long term physical, mental, intellectual or sensory impairment which, in interaction with barriers, hinders his full and effective participation in society equally with others.

"Person with benchmark disability" means a person with not less than forty per cent. of a specified disability where specified disability has not been defined in measurable terms and includes a person with disability where specified disability has been defined in measurable terms, as certified by the certifying authority.

**The 21 disabilities covered are as follows.**

**I. Physical disability**

**Locomotor disability** - (a person's inability to execute distinctive activities associated with movement of self and objects resulting from affliction of musculoskeletal or nervous system or both), including

"leprosy cured person" means a person who has been cured of leprosy but is suffering from

loss of sensation in hands or feet as well as loss of sensation and paresis in the eye and eye-lid but with no manifest deformity;

manifest deformity and paresis but having sufficient mobility in their hands and feet to enable them to engage in normal economic activity

extreme physical deformity as well as advanced age which prevents him/her from undertaking any gainful occupation, and the expression "leprosy cured" shall construed accordingly;

"**cerebralpalsy**" means a Group of non-progressive neurological condition affecting body movements and muscle coordination, caused by damage to one or more specific areas of the brain, usually occurring before, during or shortly after birth

"**Dwarfism**" means a medical or genetic condition resulting in an adult height of 4 feet 10 inches (147 centimeters) or less

"**Musculardystrophy**" means a group of hereditary genetic muscle disease that weakens the muscles that move the human body and persons with multiple dystrophy have incorrect and missing information in their genes, which prevents them from making the proteins they need for healthy muscles. It is characterized by progressive skeletal muscle weakness, defects in muscle proteins, and the death of muscle cells and tissue.

"**Acidattackvictims**" means a person disfigured due to violent assaults by throwing of acid or similar corrosive substance.

**Visual impairment**

- "**Blindness**" means a condition where a person has any of the following conditions, after best correction
- total absence of sight; or
- visual acuity less than 3/60 or less than 10/200 (Snellen) in the better eye with best possible correction; or
- limitation of the field of vision subtending an angle of less than 10 degree.
- "**Low-vision**" means a condition where a person has any of the following conditions, namely:
- Visual acuity not exceeding 6/18 or less than 20/60 upto 3/60 or upto 10/200 (Snellen) in the better eye with best possible corrections; or
- limitation of the field of vision subtending an angle of less than 40 degree up to 10 degree.

**Hearing Impairment**

- "**Deaf**" means persons having 70 DB hearing loss in speech frequencies in both ears;
- "**Hardofhearing**" means person having 60 DB to 70 DB hearing loss in speech frequencies in both ears;
- "**Speech and language disability**" means a permanent disability arising out of conditions such as laryngectomy or aphasia affecting one or more components of speech and language due to organic or neurological causes.

**II. Intellectual Disability**- a condition characterized by significant limitation both in intellectual functioning (reasoning, learning, problem solving) and in adaptive behaviour which covers a range of every day, social and practical skills, including.

"**Specificlearningdisabilities**" means a heterogeneous group of conditions wherein there is a deficit in processing language, spoken or written, that may manifest itself as a difficulty to comprehend, speak, read, write, spell, or to do mathematical calculations and includes such conditions as perceptual disabilities, dyslexia, dysgraphia, dyscalculia, dyspraxia and developmental aphasia;

"**Autismspectrumdisorder**" means a neuro-developmental condition typically appearing in the first three years of life that significantly affects a person's ability to communicate, understand relationships and relate to others, and is frequently associated with unusal or stereotypical rituals or behaviors.

**III. Mental behavior**

"Mental illness" means a substantial disorder of thinking, mood, perception, orientation or memory that grossly impairs judgment, behaviour, capacity to recognize reality or ability to meet the ordinary demands of life, but does not include retardation which is a condition of arrested or incomplete development of mind of a person, specially characterized by sub normality of intelligence.

**IV. Disability caused due to**

**Chronicneurologicalconditions**, such as

- "**Multiplesclerosis**" means an inflammatory, nervous system disease in which the myelin sheaths around the axons of nerve cells of the brain and spinal cord are damaged, leading to demyelination and affecting the ability of nerve cells in the brain and spinal cord to communicate with each other;
- "**Parkinson'sdisease**" means a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movement, chiefly affecting middle-aged and elderly people associated with degeneration of the basal ganglia of the brain and a deficiency of the neurotransmitter dopamine.

**Blooddisorder**

- "**Hemophilia**" means an inheritable disease, usually affecting only male but transmitted by women to their male children, characterized by loss or impairment of the normal clotting ability of blood so that a minor would may result in fatal bleeding;
- "**Thalassemia**" means a group of inherited disorders characterized by reduced or absent amounts of hemoglobin.
- "**Sicklecelldisease**" means a hemolytic disorder characterized by chronic anemia, painful events, and various complications due to associated tissue and organ damage; "hemolytic" refers to the destruction of the cell membrane of red blood cells resulting in the release of hemoglobin.

**V. MultipleDisabilities**

More than one of the above specified disabilities including deaf blindness which means a condition in which a person may have combination of hearing and visual impairments causing severe communication, developmental, and educational problems.

**VI. Any other category as may be notified by the Central Government**

According to Person with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995

"Disability" means-

- Blindness;
- Low vision;
- Leprosy-cured;
- Hearing impairment;
- Locomotor disability;
- Mental Retardation;
- Mental illness;

“Blindness" refers to a condition where a person suffers from any of the following conditions, namely:-

- Total absence of sight. or
- Visual acuity not exceeding 6/60 or 20/200 (Snellen) in the better eye with correcting lenses; or
- Limitation of the field of vision subtending an angle of 20 degree or worse.

"**Leprosy** cured person" means any person who has been cured of leprosy but is suffering from-

- Loss of sensation in hands or feet as well as loss of sensation and paresis in the eye and eye-lid but with no manifest deformity;
- Manifest deformity and paresis; but having sufficient mobility in their hands and feet to enable them to engage in normal economic activity;
- Extreme physical deformity as well as advanced age which prevent him from undertaking any gainful occupation, and the expression "leprosy cured" shall be construed accordingly.

"**Hearingimpairment**" means loss of sixty decibels or more in the better year in the conversational range of' frequencies.

"**Locomotordisability**" means disability of the bones, joints muscles leading to substantial restriction of the movement of the limbs or any form of cerebral palsy.

"**Cerebralpalsy**" means a group of non-progressive conditions of a person characterized by abnormal motor control posture resulting from brain insult or injuries occurring in the pre-natal, peri-natal or infant period of development.

"**Mentalretardation**" means a condition of arrested or incomplete development of mind of a person which is specially characterized by sub normality of intelligence.

"**Mentalillness**" means any mental disorder other than mental retardation.

**According to National trust for the welfare of persons with autism, cerebral palsy, mental retardation and multiple disabilities Act, 1999**

"**Autism**” means a condition of uneven skill development primarily affecting the communication and social abilities of a person, marked by repetitive and ritualistic behaviour.

"**CerebralPalsy**" means a group of non-progressive conditions of a person characterized by abnormal motor control posture resulting from brain insult or injuries occurring in the pre-natal, perinatal or infant period of development.

"**MentalRetardation**" means a condition of arrested or incomplete development of mind of person which is specially characterised by sub-normality of intelligence.

"**MultipleDisabilities**" means a combination of two or more disabilities as defined in clause (i) of section 2 of the Person with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995.

## CHALLENGES FACED BY DISABILITY IN INDIA

Disability is an important public health problem especially in developing countries like India. The problem will increase in future because of increase in trend of non-communicable diseases and change in age structure with an increase in life expectancy. The issues are different in developed and developing countries, and rehabilitation measures should be targeted according the needs of the disabled with community participation. In India, a majority of the disabled resides in rural areas where accessibility, availability, and utilization of rehabilitation services and its cost-effectiveness are the major issues to be considered. Research on disability burden, appropriate intervention strategies and their implementation to the present context in India is a big challenge.

1. **Accessibility** – The world around us is not a walk in the park. We have to face several obstacles in every step we take. This is much worse for physically disabled people. They mostly move around in wheelchairs or use crutches. So, moving around freely is not a luxury that they can afford. Moreover, the public places that we have, are rarely made keeping in mind the comfort of people with disabilities. There are no ramps, or the hallways are too narrow for them to move. Nowadays, many wheelchairs are automated, and buildings are constructing a private residential elevator to make the movement of the disabled people a little bit easier.

2. **Education** – education is a basic right for all humans, in a perfect world, education would be free and available to everyone, as dreamed by Gurudev Rabindranath Tagore, but the reality is far from it. A large number of children with disabilities remain out of school and thus they are deprived of basic education. They are not able to run the race of life like the other normal kids. To solve this issue, several education institutions have been opened which focuses on the education of these kids with special needs, they learn the Braille System and adaptive technology helps them lead a better life.

3. **Access to healthcare** – In a country of 1.3 billion people, the health care system is already very stretched. Poor people do not have access to proper healthcare and the people with disabilities are worse off. Often, people with intellectual disabilities are mistreated by the health workers and this makes matters worse. This can be only solved by proper awareness and empathy. The disabled people find the speck of good in these situations and help each other in whatever way possible. Thus, it is requested that everyone should make a donation to ensure NGOs are able to cater to their healthcare needs in a much better way.

4. **Myths and stereotypes** – Certain sections of the Indian population have had financial development in the last decades, there have been social upliftment and overall progress but still there remains a dark orthodox nature in our culture which seems to have stuck with us like a leech. When we interact with people with

disabilities, we fall victim to certain myths that are born out of our lack of knowledge and empathy towards such people.

5. **Feeling of being ignored** – When we interact with a physically challenged person, it does not mean that, he is also suffering from visual or hearing impairment. This thought process often stops us from interacting and communicating with such people. These disability barriers need to be torn down, which is only possible for more awareness.

6. **Lack of employment** – Employment of any citizen is based upon his education and skills he has picked up along the way. When these people are deprived of basic education, they are bound to fall behind other candidates for that job. The government has introduced schemes which should guarantee jobs for disabled people.

7. **Feeling of being incompetent** – Disabled people need more time to do a particular work than other normal people. The disability barriers stop him from performing basic tasks with ease. This makes the person with disabilities that he is pulling his mates down and if filled with sorrow and anger.

8. **Teased and abused** – Often people find satisfaction in putting others down. They find superiority in bullying the weak and underprivileged. Disabled people often find themselves at the receiving end of such violent and disgusting actions.

9. **Being patronized** – People with special needs often hear things like, “I know what you are going through” or “I know this must be hard.” These kinds of words never do justice to the problems those people face and the troubles they go through every day. A normal person can't know exactly what that person is feeling.

10. **Relationships** – Human beings are complicated. They judge others on a set of parameters that may or may not apply to all situations. These prejudices are the root cause of all mistrust and misunderstanding. Most disabled people are desired as life partners, this often brings sadness and loneliness to their lives.

All these issues can be dealt with if people become more understanding and have patience when they deal with people with special needs. Work for disabled should be made available, this will give them financial independence and provide them with satisfaction in life. We should make our surroundings more accessible to disabled people. The homes for the disabled should be designed in such a way that it is more comforting to them. All these issues can be dealt with if people become more understanding and have patience when they deal with people with special needs. Work for disabled should be made available, this will give them financial independence and provide them with satisfaction in life. We should make our surroundings more accessible to disabled people. The homes for the disabled should be designed in such a way that it is more

comforting to them. Also, no matter how small the contribution is, one can always help the needy in their own little ways.

Unit 2

**Historical Development of Programmes And Services of Disability**

The evolution of the disability rights movement (DRM) in India spans over four decades. Voices began demanding the rights of people suffering from disabilities in the early 1970s; it was, however, nowhere close to being a movement at that point. The various demands from groups and individuals were significantly scattered.

The 1980s witnessed the consolidation of demands from various groups and their organization under a cross-disability umbrella, representing the interests of the disabled. Many NGOs started operating in the disability sector during this decade and this subsequently provided further momentum to the DRM. After a series of petitions and protests, the government passed the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (or PWD Act), which reserved three percent of government posts for those in the PWD category. So, the year 1995 became a benchmark year for the DRM, which stands for the beginning of a new era altogether, in which people suffering from disability found visibility in educational institutions and government services.

In the new millennium, the United Nations adopted the Convention on the Rights of Persons with Disabilities in 2006. India signed and ratified this convention in 2007. By then, there was a demand for an increase in the reservation for the PWD category by various groups working on disability issues. By 2012, the Union Government of India came up with a disability bill, and after some amendments in the original draft, the bill was tabled in the parliament the very next year. After a wait of over three years, the Rights of Persons with Disabilities Bill, 2016 was passed by both houses of parliament just last week. More than 26 million differently-abled persons in India are waiting anxiously to see the bill officially become a law.

Overall, what started as scattered demands for rights for people suffering from disability has today developed into an issue area that is the subject of many academic works. Though many obstacles still exist in the path of the DRM, the achievements to date are worthy of praise and they need to be highlight

Until the 1970s, most of the people who suffered from any kind of disability were considered as outcasts from the mainstream society and were looked down upon. To put it bluntly, though it may sound politically incorrect, any disabled person was treated like dirt in Indian society. Most of these people were either seen as beggars or in better cases they were associated with the field of music. Even the system thought of them as a liability; these people were considered to be of little use to society and hence their concerns were severely disregarded. Many people thought of disability as the result of someone's previous life's sins and

thus held them responsible for their present condition. This absurdity led to various forms of injustices in India.

In contrast, things were changing rapidly and drastically in the Western countries at this time. In the West, the disability rights movement had gained momentum in the 1950s, and by the 1970s it had begun challenging governments with a much greater force. In India, such demands had only started to emerge. Even in Western societies, people suffering from disability were not exactly treated as they should have been. The world was still only 30 years removed from Adolf Hitler's attempt to eliminate the disabled population in Germany, due to his belief was that disabled persons were of no economic use.

In the West, things started to change after World War II, when thousands of soldiers returning home were left with several kinds of disabilities. These soldiers became an initial source of the DRM and they even saw some success in getting their rights, mainly because these soldiers were considered heroes of the war and thus their demands garnered immense public support.

No such thing happened in India. Most offers of assistance from Indian society toward its disabled population were viewed as charity rather than providing legitimate rights to PWD. Even the families associated with a disabled person were looked down upon and scrutinized in many ways by their relatives and neighbors. In many cases, this led to families disowning their disabled family members; disabled children were all too often left in orphanages. A severe kind of "shame" was associated with disability.

Throughout the 1970s and 1980s, the DRM remained largely a battle between a few individuals against the system and society. These individuals were very few in number since few families had the capacity and will to support their "differently-abled" children. The media was also completely mute over this since this issue was never interesting enough to create the hype that other issues could.

For politicians, the rights of disabled persons were a non-issue. Disabled people were not considered as a "vote bank" as they were people with no voice. Unlike the caste movements and women rights movements, the DRM had no leader. This dearth of leadership caused a very long wait for the movement to gain any kind of success.

Also, the society treated those who were born disabled differently from those who became disabled after some injury. Throughout the 1970s, many NGOs across the country were running with the help of foreign aids and charity from the economically well-off sections of the society. The disability sector was ruled and controlled by NGOs with either parents or professionals at the helm of affairs. They worked in silos, with no interaction or connection with each other. Most of them worked only for a particular disability, for instance, NGOs for the visually impaired, for the hearing impaired, for persons with intellectual disabilities, and so on.

Baba Amte, a renowned social activist, dedicated his whole life for the rehabilitation and empowerment of poor people suffering from leprosy. He was a very prominent figure who inspired many others in sensitizing people toward this cause. This resulted in many people realizing the importance and coming forward to become a part of DRM.

The 1980s saw a shift in the policy frame with the welfare model being transformed into a developmental model. This was a phase where the disabled persons, hitherto treated as recipients of charity, became participants in the developmental process. By the end of the 1980s, people also started focusing on disability on medical grounds, with the objective of trying to reduce suffering via medical treatments, medical equipment, and technical help, to make the lives of disabled people "normal." But these ideas were practiced only by a limited section of the society, which was literate, sensitized, economically well-off, and modern in a real sense.

When the United Nations announced 1982-1993 as The Decade of Disabled Persons, it marked another shift in the entire debate on the goals of rehabilitation. The Rehabilitation Council of India was set up by the

Government of India in 1986 to regulate and standardize training policies and programs for the rehabilitation of persons with disabilities. The very next year saw the Mental Health Act (1987) come into existence. The Mental Health Act is a civil rights legislation that focuses on regulating standards in mental health institutions.

Despite the existence of this Act for the protection of the person, property, and management of persons covered, until recently, most mentally ill persons were consigned to jails. Those living in mental health institutions were no better off, since the conditions both in prisons and in mental institutions were far below the stipulated standards.

**The 1990s**

The last decade of the millennium brought drastic changes in the disability sector of India. A distinct self-advocacy movement of people with disabilities, which started during the 1970s, began campaigning for protection and recognition of their human rights. It advocated the enactment of a comprehensive legislation with a rights-based approach, placing special emphasis on social and economic rights.

The government had recognized the need for such legislation in 1980. But since the legislative power regarding disability was kept on the State List, the matter could not be pursued. However, **Article 253** of the Constitution of India enables the Parliament to override the federal distribution of powers and to give effect to a treaty entered with a foreign power or an international body, even if the matter of legislation relates to an entry in the State List. With the signing of the Proclamation of Equality and Full Participation of People with Disabilities in the Asian and Pacific Region, the PWD Act was enacted by Parliament in 1995.

The PWD Act was focused more on rights. The substantive provisions of the Act relate to prevention and early detection, education, employment, affirmative action, non-discrimination/barrier free access, research and manpower development, and institutions for persons with severe disabilities. After the PWD ACT, 1995 was enforced, a 3 percent reservation (comprising 1 percent reservation each for those with locomotor disability, hearing disability, and visual disability) was offered to the PWD category in educational institutions and government services.

Different kinds of disability in the Act are classified based on medical grounds and not on social perception of disability. Critics of the PWD Act say that the Act is replete with numerous flaws, as it was passed by Parliament without a full-length debate. They say that the Act lacks teeth and provides ample escape routes to the concerned government.

The formal recognition of discrimination on grounds of disability is a recent development. Laws enacted 20 years ago generally did not include disability in the list of prohibited heads of discrimination. For instance, though the Indian Constitution in its Articles 15 and 16 prohibits discrimination in the matter of employment and access to public facilities on grounds of religion, race, caste, sex, and place of birth, it is silent on disability. In fact, until 1995 the Service Rules prevented the entry of persons with disability in higher grades of service.

**The New Millennium: The Story After 2000**

Disability status was not canvassed in India's census from 1941 to 1971. Thus, PWD were excluded from the population census until the 1980s. The 1981 census included information on three types of disabilities, an utterly inadequate semblance of inclusion. Again, persons with disabilities were totally left out from the purview of the 1991 census. This resulted in growing demand by PWD for their inclusion in the population census of India.

After a prolonged advocacy, a question on disability was finally included in the 2001 census questionnaire at the last minute. With minimal awareness and training, the enumerators found that 2.1 percent of the total population of the country consists of PWD. India finally accepted that 21 million of its citizens were PWD.

However, persons belonging to many more disabilities, including persons with mental and intellectual disabilities, were completely excluded (only five categories of persons with disabilities were included in the census).

The 2011 census revealed that over 26.8 million people in India suffer from some kind of disability. This is equivalent to 2.21 percent of the population. Among the total disabled in the country, 14.9 million are males and 11.8 million are females; 18.6 million PWD reside in rural areas while 8.2 million reside in urban areas. People who advocate against the likely increase in reservation for PWD from three percent to five percent point out that people born with disabilities are growing fewer in number, particularly after advancements in the field of medicine, when compared to those who become disabled after their birth. To cite one gruesome example, human traffickers force able-bodied people (mostly children) into the busin1ess of begging by kidnapping and then cutting off their limbs, making them disabled for life.

Looking at this situation and the demands from civil society, the Union Government came up with a National Policy on Disability in the year 2006. This was a comprehensive national policy on disability covering critical areas like education, employment, support services, access, social security, etc. However, this policy also needed to be comprehensively modified in the light of the UN Convention. Somehow, the national policy is nearly silent on the civil and political rights of persons with disabilities. Unfortunately, most of the states of India do not have a state-level disability policy in place yet, though a few states are in the process of evolving such a policy.

**The Current Decade and the new Disability Bill**

The Rights of Persons with Disabilities Bill (RPWD Bill), drafted in 2011, was meant to be an enactment to codify India's obligations under the UN Convention on the Rights of Persons with Disabilities (UNCRPD), which it ratified without reservations. There was a committee set up in 2009 by the Ministry of Social Justice and Empowerment to draft a bill to this effect. In accordance with the UNCRPD, the committee included different people with different disabilities to draft this bill.

The Rights of Persons with Disabilities Bill, 2014, defines for the first time the meaning of disability and extended it from seven to 21 categories. Categories include sickle cell disease, thalassemia, muscular dystrophy, autism spectrum disorder, blindness, cerebral palsy, chronic neurological conditions, mental illness, and multiple disabilities.

Based on vital amendments, the bill, for the first time, represented rights-based disability legislation. Its focus is on transforming the meaning of disability, expanding its definition from the existing medical framework to a social one. The amendments included hiking the quota of government jobs from three to five percent and underlining the need to make private companies responsible for creating a friendly workplace environment for employees with disabilities.

The bill has been approved by the Cabinet of Indian Government and, as of December 16, the parliament of India. It only awaits the signature of the president. Once that happens, the bill will become a law and will replace the 1995 disability law.

This would have a huge impact on India, which according to some sources has the largest disabled population in the world. The World Bank suggests that there are around 80 million disabled people in India. The actual numbers are contested but it is true that India has a fairly large share of the global disabled population. The disability law will bring long-awaited hope and change to the lives of persons with disabilities in India.

**Tamil Nadu government services**

**Identification**

**National Identity Card for the differently abled persons**

**Early Intervention**

1. Early Intervention Centre for infants and young children with hearing impairment in 32 districts
2. Early Intervention Centre for the mentally retarded children
3. Early Intervention Centre for visually impaired.

**Special Education**

1. Special Education
2. Preschool for young hearing-impaired children
3. Scholarship
4. Readers allowance for visually differently abled persons
5. Scribe assistance for visually impaired students
6. Distribution of Pre-recorded Cassettes and Tape recorders changed as CD players with text CD's to visually impaired persons
7. Starting of Degree courses for the hearing impaired students
8. Assistance to Law graduates for differently abled students
9. Cash prize and assistance to pursue higher education for the visually impaired students
10. Cash prize and assistance to pursue higher education for the hearing impaired students
11. Government Institute for the Mentally challenged, Chennai
12. Supply of Braille books for visually impaired students
13. Distribution of Lap top computers to +2 differently abled students studying in Government and Government aided schools
14. Honorarium to Teachers
15. Financial assistances to Non-Governmental organizations

**Training and Employment**

1. Secondary Grade Teachers Training Institute for the Orthopedically differently abled persons (Diploma in Teacher Education)
2. Diploma in Medical Laboratory Technology training
3. Cell phone Service and Maintenance Training Course
4. Computer Training Course
5. Multimedia Training
6. Training to the visually differently abled persons (male)
7. Training to the speech and hearing impaired (male)
8. Vocational training center with hostel facility
9. Unemployment allowance to the differently abled persons
10. Self-employment loan subsidy for the differently abled persons
11. Motorized Sewing machines
12. Loan assistance from National Handicapped Finance and Development Corporation (NHFDC)
13. Prime Minister's Employment Generation Programme

**3% Reservation in educational institutions and in employment**

1. 3% reservation of seats in Educational Institutions
2. Reservation of teaching posts in educational institutions for visually impaired
3. Reservation of jobs in Government Departments / Government Undertakings
4. Reservation of Non-Teaching posts in educational institutions for speech and hearing-impaired persons

**Assistive devices for differently abled persons**

1. Tricycles

2. Wheel chairs
3. Hearing aids and Solar rechargeable batteries
4. Goggles and folding sticks
5. Braille watches
6. Calipers and crutches
7. Artificial limbs
8. Retrofitted petrol scooters
9. Modular functional artificial limbs
10. 'Behind the ear' hearing aids
11. Magnifiers
12. Reflecting folding sticks

**Maintenance allowance**

1. Maintenance allowance to mentally retarded persons
2. Maintenance allowance to differently abled persons (severely affected)
3. Maintenance allowance for persons affected with muscular dystrophy
4. Maintenance allowance for leprosy affected persons

**Marriage assistance**

1. Marriage assistance to normal persons marrying visually impaired persons
2. Marriage assistance to normal persons marrying orthopedically differently abled persons
3. Marriage assistance to normal persons marrying speech and hearing-impaired persons
4. Marriage assistance to differently abled persons marrying differently abled persons

**Other schemes for Differently abled persons**

1. Homes for the mentally retarded above the age of 14 years
2. Government rehabilitation homes
3. Government care camp, Melpakkam
4. Day care center for persons affected by muscular dystrophy
5. Rescue scheme for persons with mental illness
6. Home for the mentally ill
7. Travel concession to the differently abled persons in state owned transport corporation buses
8. Registration of complaints under persons with disabilities act, 1995
9. Appointment of guardians to special categories of differently abled persons under national trust act, 1999

**Social Security Schemes – Tamil Nadu Welfare Board for the differently abled persons**

1. Personal accident relief for differently abled persons
2. Financial assistance to meet the funeral expenses of a differently abled person:
3. Financial assistance on the natural death of a differently abled person:
4. Scholarship to son and daughter of differently abled persons
5. Assistance for marriage
6. Assistance for delivery / miscarriage of pregnancy / termination of pregnancy to a female differently abled person
7. Assistance for purchase of spectacles by a differently abled person

**Reservation in Government Job:**

In Gr.'C' and ' D' posts under the Government reservation are provided in direct recruitment for physically handicapped persons as indicated below:

Educational Institutions: 3% of the seats in educational institutions/training centers/professional courses (except in medicines) are reserved for disabled persons.
Age relaxation**:**

The upper age limit is relaxed by 10 years for handicapped persons for applying in Government jobs.
Scholarship /stipend:

- Disabled students studying in Class IX onwards (including colleges and vocational/professionals/ technical courses) get scholarship. The rate of scholarship varies from Rs.4000/– to Rs.7000/– p.m. depending upon the course.
- Disabled children aged 5 years and above get free boarding and lodging facility under special education programme. They also get free supply of 2 sets of uniform every year.
- Speech and Hearing-impaired children in the age group of 3 to 5 years get free special Education, Speech Therapy and boarding and lodging facilities.

**Maintenance Allowance**

- Rs.500/– p.m. as maintenance allowance is given for severely disabled with disability 75% and above to physically handicapped and mentally retarded persons.

**Bus concession**

- Free travel facility to the handicapped children in buses of State Transport Corporation except TTC.
  O/I – M.D. Transport Corporation

**Incentive for marrying disabled**

- Marriage assistance is given to the normal person who marry a hearing and speech impaired person as follows:(Total assistance is Rs.25000/– to Rs.50000/-)
  Rs.25000/– in the form of National Savings Certificate, Rs.25000/– as cash towards marriage expenses.
  Normal person should marry a hearing handicapped person. The age of the couples (both) should be above 18 years.

**Assistance for purchase of aids & appliances**:

- Free supply of tri–cycles, wheel chairs, hearing aids, calipers, artificial limbs or given at subsidized rates.
  O/I – Director of Social Welfare.

**Key reference for contact**
For further details on Concession please contact the Director, Social Welfare of State or the following persons in respective State/U.T. Governments.

**1. For education/scholarship**:
i. District Inspector of Schools.
ii. District Education Officer.
iii. District Social Welfare Officer.
iv. Directorate of Education.
v. Superintendent, Vocational Rehabilitation Centre for Handicapped.
vi. Principal of School

**2. For training**:
i. Principal, Industrial Training Institute.
ii. Superintendent, Vocational Rehabilitation Centre for Handicapped.

iii. Directorate of Employment & Training.
iv. Director, Directorate of Technical Education & Training.
v. Vocational Training Institute specifically meant for the disabled persons.
vi. Industrial Promotion Officer, Block Development Agency of your area.
vii. Project Officer, District Rural Development Agency of your district.
viii. Manager (Cottage Industries), District Industries Centre of your district.
ix. Head of Government Training Institute of your area.

**3. For employment**:
i. Superintendent, Vocational Rehabilitation Centre.
ii. Employment Officer of Special Employment Exchange for Physically Handicapped of your state.
iii. Employment Officer In–charge, Placement cell of Handicapped, District Employment Exchange of your district.
iv. Placement Officers of leading voluntary organizations working for employment of disabled persons.
v. Refer advertisements of Staff Selection Commission, Union Public Service Commission, Banking Service Recruitment Board, Post & Telegraph department, State Public Service Commission and collectorate advertisements in which number of vacancies are being advertised as reserved for the disabled persons.
vi. Director, Directorate of employment.

**4. For self-employment**:
i. Superintendent, Vocational Rehabilitation Centre.
ii. Director, Directorate of Social Welfare.
iii. District Social Welfare Officers.
iv. Project Officer, District Rural Development Agency of your district.
v. Manager (Cottage Industries), District Industries.
vi. All the nationalized banks.
vii. Sub–Divisional Officer, Telephone Division of your area for telephone booth.
viii. Chairman of Municipal Corporations, Municipalities, N.A.C's for allotment of kiosks, selling outlets, license for cart puller etc.
ix. President, Lions Club, Rotary Club, Y's Men Club and other social clubs/societies.

**Grievances**

Principal Secretary / State Commissioner for the Differently Abled,
State Resource cum Training Centre Campus, Jawaharlal Nehru Inner Ring Road,
K.K. Nagar, Chennai – 600 078. Ph: 044-24719947 / 48 / 49 /
District Collector.
**Concerned Officer**:
**The Director**
Department of Social Welfare,
Government of Tamil Nadu,
Secretariat Building,
Chennai – 35

## INSTITUTIONAL AND NON-INSTITUTIONAL SERVICES

There are nine National Institutes under this Ministry working in the field of disability. National Institutes are autonomous bodies established for different types of disabilities. These institutes are engaged in Human

Resources Development in the field of disability, providing rehabilitation services to the persons with disabilities and Research and Development efforts:

(i) National Institute for the Empowerment of Persons with Visual Disabilities (NIEPVD), Dehradun

(ii) Ali Yavar Jung National Institute of Speech and Hearing Disabilities (AYJNISHD), Mumbai

(iii) National Institute for the Empowerment of Persons with Intellectual Disabilities (NIEPID), Secunderabad

(iv) National Institute for Empowerment of Persons with Multiple Disabilities (NIEPMD), Chennai

(v) Pt. Deendayal Upadhyaya National Institute for Persons with Physical Disabilities (PDUNIPPD), Delhi

(vi) Swami Vivekanand National Institute of the Rehabilitation Training and Research (SVNIRTAR), Cuttack.

(vii) National Institute for Locomotor Disabilities (NILD), Kolkata

(viii) Indian Sign Langauge Research & Training Centre (ISLRTC), New Delhi

(ix) National Institute of Mental Health and Rehabilitation (NIMHR), Sehore, Madhya Pradesh

**Objectives of NIs**

National Institutes are engaged in Human Resource Development in the field of disability, providing rehabilitation services to the Persons with Disabilities and undertaking Research and Development efforts. National Institutes also provide vocational skill training, placement and distribution of assistive aids and appliances to PwDs.

**National Institute for the Empowerment of Persons with Visual Disabilities (NIEPVD), Dehradun**

National Institute for the Empowerment of Persons with Visual Disabilities (NIEPVD), Dehradun was established in 1979. The main objectives of the Institute are to undertake or sponsor the training of trainers and rehabilitation professionals, to conduct, sponsor, co-ordinate or subsidies research into biomedical engineering leading to the effective evaluation of special appliances/instruments or suitable surgical or medical procedures or the development of new special appliances/instruments.

**Ali Yavar Jung National Institute of Speech and Hearing Disabilities (AYJNISHD), Mumbai**

The Institute has been established in 1983 with the objectives of manpower development, research, clinical services, outreach & extension services, socio-economic rehabilitation services, material development and collection of information, documentation and dissemination of information for persons with speech and hearing disabilities.

**National Institute for the Empowerment of Persons with Intellectual Disabilities (NIEPID), Secunderabad**

The Institute has been established in 1984 with the objective to prepare human resources equipped to deliver services through quality models of rehabilitation, based on life cycle needs. The institute is an apex body having tripartite functions of training, research and services in the field of intellectual disability in the country.

**National Institute for Empowerment of Persons with Multiple Disabilities (NIEPMD) or (NIEPED), Chennai**

National Institute for Empowerment of Persons with Multiple Disabilities (NIEPMD) under the Ministry of Social Justice & Empowerment, Department of Disability Affairs, Govt. of India was established in the year 2005, with the objective to serve as a National Resource Centre for Empowerment of person with multiple

disabilities. Persons having more than one disability as mentioned in the Persons with Disabilities (1995) Act and National Trust (1999) Act are provided need-based rehabilitation services. Keeping in view of the paucity of available services in the country, this institute has been set up with a mission to provide comprehensive rehabilitation through team approach - facilitating inclusion, ensuring empowerment of persons with multiple disabilities and their families. To reach maximum number of persons with multiple disabilities, rehabilitation services were provided both at the Centre and in the community. "Thirami Model Special School" has been established with units for children with cerebral palsy, autism, deafblindness and early childhood special education. This model school serves as a lab to provide practical exposure to the trainees.

**Recent updates**

The Disabilities enumerated as per RPWD Act (2016) are Blindness, Low-vision, Leprosy Cured persons, Hearing Impairment (deaf and hard of hearing), Locomotor Disability, Dwarfism, Intellectual Disability, Mental Illness, Autism Spectrum Disorder, Cerebral Palsy, Muscular Dystrophy, Chronic Neurological conditions, Specific Learning Disabilities, Multiple Sclerosis, Speech and Language disability, Thalassemia, Hemophilia, Sickle Cell disease, Multiple Disabilities including deaf blindness, Acid Attack victim, Parkinson's disease and as per The National Trust (1999) Act, are Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities

**Pt. Deendayal Upadhyaya National Institute for Persons with Physical Disabilities (PDUNIPPD), Delhi**

Pt. Deendayal Upadhyaya National Institute for Persons with Physical Disabilities (PDUNIPPD), Delhi was established in 1960. Major objective of the Institute is to develop trained manpower for rehabilitation of orthopaedically disabled persons, provide outreach services and conduct research. The Institute runs three long term graduate level courses –Bachelor of Physiotherapy (BPT), Bachelor of Occupational Therapy (BOT), Bachelor of Prosthetics & Orthotics (BPO).

**Swami Vivekanand National Institute of the Rehabilitation Training and Research (SVNIRTAR), Cuttack**

Swami Vivekananda National Institute of Rehabilitation Training & Research (SVNIRTAR), Cuttack (Odisha) was established in 1975. The objective of the Institute is human resource development, implementation of service delivery programmes, research and outreach programmes. It undertakes sponsors and coordinates the training of personnel such as Doctors, Engineers, Prosthetists, Othotists, Physiotherapists, Occupational Therapists, Multipurpose rehabilitation therapists and such other personnel for rehabilitation of persons with physical disabilities.

**National Institute for Locomotor Disabilities (NILD), Kolkata**

The Institute was established in 1978 with the objective of Human Resource Development to develop manpower for providing services to the Orthopaedically Handicapped population. The Institute runs Graduate courses in Physiotherapy, Occupational Therapy, Prosthetics and Orthotics. It runs a Post-graduate Diploma Course in Disability Rehabilitation and Management. Besides other Diploma Course and Certificate Courses are run in the field of multipurpose rehabilitation, Prosthetics and Orthotics.

**Indian Sign Language Research & Training Centre (ISLRTC), New Delhi**

Indian Sign Language Research and training Center (ISLRTC) is an autonomous organization under the administrative and financial control of Department of Empowerment of Persons with Disabilities (Divyangjan) Ministry of Social Justice & Empowerment, Government of India. In Accordance with the provisions of societies registration act,1860. ISLRTC established on 26th of September, 2015.The objective of the Center as under:-

1. To develop manpower for using Indian Sign Language (ISL) and teaching and conducting research in ISL, including bilingualism.
2. To promote the use of Indian Sign Language as educational mode for deaf students at primary, secondary and higher education levels.
3. To carry out research through collaboration with universities and other educational institution in India and abroad and create linguistic records/ analyses of the Indian Sign Language, including creation of Indian Sign Language corpus (Vocabulary).
4. To orient and train various groups, i.e. Govt. officials, teachers, professionals, community leaders and the public at large for understanding and using Indian Sign Language.
5. To collaborate with organizations of the deaf and other institutions in the field of disability to promote and propagate Indian Sign Language.
6. To collect information relating to Sign Language used in other parts of the world so that this input can be used to upgrade the Indian Sign Language.

**National Institute of Mental Health and Rehabilitation (NIMHR), Sehore**

Cabinet has approved the proposal of establishment of National Institute of Mental Health Rehabilitation (NIMHR) at Sehore, Madhya Pradesh, as a Society under the Societies Registration Act, 1860 under the aegis of the Department with the estimated cumulative cost of Rs. 179.54 crore in first three years (non-recurring – Rs. 128.54 crore and recurring expenditure of Rs 51 crore).

The objectives of the proposed institute are:

- To promote mental health rehabilitation using an integrated multidisciplinary approach.
- To promote and undertake capacity building and to involve in developing trained professionals in the area of mental health rehabilitation.
- To engage in research and development and policy framing towards promoting mental health rehabilitation services

The Institute will serve outdoor patients only through its well trained work force of medical, para-medical and other professionals. There will also be provision for 20 studio apartments for patients suffering from mental illness and their families to provide them temporary stay at institute during their treatment time.

Institute will also run various courses of Diploma, Degree, Masters and Undergraduate in Mental Health rehabilitation.

**Composite Regional Centre for Skill Development, Rehabilitation & Empowerment of Persons with Disabilities (CRCs)**

Nineteen Composite Regional Centre for Skill Development, Rehabilitation & Empowerment of Persons with Disabilities (CRCs) are working under supervision of NIs and administrative control of the Ministry. These CRCs for Persons with Disabilities in certain region of the country which are lacking institutional support, covering all the area of disabilities were established.

**Objectives of CRCs**

CRCs are working as extended arms of National Institutes and provide human resource development, rehabilitation services for catering to multiple and different disabilities at one place. CRCs also provided vocational skill training, placement, undertaking Research and Development efforts and distribution of aids & appliances to PwDs.

**Central Government Schemes**

- ADIP
- DeenDayal Rehabilitation Scheme

- National Awards for People with Disabilities
- An Integrated Programme for Older Persons
- Vocational Rehabilitation Centre
- Incentives to Private Sector Employers for providing employment to persons with Disabilities

**Scheme of Assistance to Disabled Persons for Purchase / fitting of Aids and Appliances. (ADIP)**

The scheme is centrally aided and implemented through the voluntary organizations. Aids and Appliances, Artificial limbs which do not cost less than Rs.50/- and more than Rs.6000/- are covered under this scheme. The full cost of the aid is subsideas to those whose income is below Rs.5000/- per month and 50% of the cost of the aid is subsideas whose income is in between Rs.5000/- - 8000/- per month. Traveling, boarding and lodging cost of the beneficiaries are also provided under this scheme. The implementing NGO has to apply for grants under this scheme through the Dist. Disabled Welfare Officer of the respective district. Details of this scheme, prescribed application for can be obtained from GOI website www.ministryofsocialjustice&empowerment

**Scheme to Promote Voluntary Action For Persons With Disabilities (DeenDayal Rehabilitation Scheme)**

The Scheme of the Ministry of Social Justice & Empowerment, Government of India, simplifies and facilitates procedure for easy access to govt. support for NGOs with the aim to widen the scope and range of programmes. It will address the unmet needs of the over 95% Indian citizens with disabilities who have not had access to services so far.

The objectives of the scheme:

- To ensure effective implementation of the Act.
- To encourage voluntary action.
- To create enabling environment.
- To ensure equal opportunities, equity and social justice to persons with disabilities.
- To empower persons with disabilities.
- To implement outreach and comprehensive Community-Based Rehabilitation programmes in urban and rural environments.
- To enhance education opportunities at all level and in all forms.
- To enlarge the scope of vocational and professional opportunities, income generation and gainful occupations.
- To support all such measures as may be necessary for promoting formal as well as non-formal employment and placement opportunities.
- To support people with disabilities in projects which are environment friendly and Eco promotive.
- To support effort to ensure protection of human, civil and consumer rights to persons with disabilities.
- To support legal literacy, including legal counselling, legal aid and analysis and evaluation of existing laws.

- To support the development publication and dissemination of information documentation and training materials.
- To support the conduct of surveys and other forms of epidemiological studies.
- To support (a) construction and maintenance of buildings, (b) furniture and fixtures, and (c) installation and maintenance of machinery and equipment.
- To support and facilitate the availability of appropriate housing, homes and hostel facilities.
- To establish and support facilities for sport, recreation, leisure-time activities, excursions, creative and performing arts, cultural and socially inclusive activities.
- To promote research in various development areas, innovative strategies, assistive devices and enabling technologies and support production of such devices ensuring quality control.
- To support manpower development activities to train required personnel at different levels for all programmes/projects/activities for persons with disabilities.
- To set up well equipped resource centers at different levels.
- To promote and support the development of self-help groups, parent organizations and independent living.
- To encourage coordination, cooperation and networking and multisectoral linkages.
- To support such other measures, which may meet the needs of the persons with disability and fulfill the obligations as prescribed in the Disability Act of 1995.

ELIGIBLE NGOS who opt for financial assistance must submit the proposals through State Govt. State Govt. will scrutiny the proposals and as per feasibility recommend for financial assistance. The present around 90 special schools / VTCs are assistance under Central Grant-in-Aid.

**National Awards for People with Disabilities**

The Ministry of Social Justice & Empowerment has been awarding National Awards since 1969 on the International Day of Disabled Persons on 3rd December every year. The Awards are classified in different categories, namely best employer of disabled, outstanding employee, placement officer, best individual, institution, barrier-free environment, creative disabled person and National Technology Awards involved in the rehabilitation and welfare of persons with disabilities.

Institution of Awards has created awareness among the disabled persons both in public and private sector and brought them in the mainstream.

## UNIT 3

## Causes of disability

Some women have been disabled since birth. Some women become more disabled over time. Some women become disabled suddenly, because of an accident or disease.

It is not possible to prevent all impairments. Some babies form differently inside the womb and no one knows why.

But many disabilities in babies are caused by harmful conditions of women's lives. If women can get enough nutritious food to eat, can protect themselves from work with toxic chemicals, and can get good health care, including care at the time of childbirth, then many disabilities could be prevented

**Poverty And Malnutrition**

Poverty is one of the biggest causes of disability. Poor people are most vulnerable to disability because they are forced to live and work in unsafe environments with poor sanitation, crowded living conditions, and with little access to education, clean water, or enough good food. This makes diseases such as tuberculosis and polio--and the severe disabilities they cause-- much more common because diseases get passed from one person to another more easily.

Many babies who are born in poor families may be born with disabilities or may die in infancy. This may be because the mother did not get enough to eat when she was pregnant. Or it may be because she did not get enough to eat when she was a girl. Starting in childhood, a girl is often given less food to eat than a boy. As a result, she may grow more slowly and her bones may not develop properly, which can later cause difficulty during childbirth-- especially if she does not receive good health care.

If a baby or young child does not get enough good food to eat, she or he may become blind or have trouble learning or understanding.

**War**

In today's wars, more civilians than soldiers are killed or disabled, and most of them are women and children. Explosions cause people to become deaf, blind, and lose their limbs, as well as causing other injuries. Their mental health is also badly affected by the violence. The destruction of homes, schools, health centers, and means of livelihood that results from conflicts and wars leads to increased disability, poverty, and disease.

Land mines, cluster bombs, bullets, and chemicals used in warscause more disabilities in the world today than anything else. They often injure women who are carrying out their daily activities, such as farming, or gathering water and wood.

Explosions and landmines cause many leg and arm injuries, and often a child's or a woman's leg has to be amputated. But only about 1 of every 4 amputees gets an artificial leg to replace a lost leg, because they are usually expensive or difficult to get. The Mukti and Satti limbs and the Jaipur Foot are good quality, low-cost, artificial legs made by groups in India. For more information,

see Other Resources: Disability and Development Partners.

The international treaty to outlaw land mines could save many lives and prevent many disabilities, but some governments still refuse to sign it. If it has not, pressure your government to sign it.

Nuclear accidents

Many people have suffered after being exposed to massive amounts of radiation. This happened after accidents in nuclear power plants at Three Mile Island in the USA in 1979, and at Chernobyl in the Ukraine in 1986. And it also happened when the USA dropped nuclear bombs on Japan in 1945. These incidents caused widespread destruction and death from exposure to radiation.

The people who survived these accidents and bombing attacks have suffered mainly from cancers--either tumors in various parts of the body, especially in the thyroid gland—or leukemia (cancer of the blood), all of which bring an early death. In communities where these nuclear incidents happened, there has also been an increase in the number of children born with learning difficulties, such as Down syndrome.

**Poor access to health care**

Good health care can prevent many disabilities. Difficult labor and birth can cause a baby to be born with a disability such as cerebral palsy. Trained birth attendants who can identify risks and handle emergencies can prevent babies from being born with many disabilities. Immunization can also prevent many disabilities. But many times, vaccines are not available, or people who are poor or live far from cities cannot afford them, or there are not enough for everyone.

Some illnesses a pregnant woman may get can cause physical or learning problems when her baby is born. Illnesses that can cause birth defects include German measles (rubella), which is a common cause of deafness in newborn babies. There is a vaccine that gives protection against rubella, but a woman who gets an immunization of the rubella vaccine should not get pregnant for one month afterward.

Syphilis, herpes, and HIV can also be passed from a mother to her baby and can cause birth defects. So, women need to be tested and treated for sexually transmitted infections to protect the baby developing in the womb.

Some illnesses a baby or small child may get can also cause disability, such as meningitis, polio, and measles. It is important for newborn babies to get immunizations for protection. Children who live in places where leprosy (Hansen's disease) is common need to be tested as early as possible.

**Medicines and injections**

When used correctly, certain injected medicines, like some vaccinations, are important to protect health and prevent disability. However, there is a worldwide epidemic of unnecessary injections. Each year these unnecessary injections sicken, kill, or disable millions of persons, especially children.

**Avoid unnecessary injections.**

Giving injections with an unclean needle or syringe is a common cause of infection and can pass the germs that cause serious diseases such as HIV/AIDS or hepatitis. Unclean injections are also a common cause of infection that can lead to paralysis or spinal cord injury or death. Also, some injected medicines can cause dangerous
allergic reactions, poisoning, and deafness to a baby in the mother's womb.

A needle or syringe must never be used to inject more than one person without disinfecting it each time.

Some medicines and drugs taken during pregnancy can cause disability in the baby. The overuse of injectable medicines, such as oxytocin, to speed up childbirth and 'give force' to the mother's labor, deprives

the baby of oxygen during birth. It is a major cause of brain damage. Alcohol and tobacco used during pregnancy can also damage a developing baby.

Everyone must consider the possible risks and benefits of using any medication. Doctors, nurses, other health workers, pharmacists, and everyone else must stop the misuse and overuse of medicines—especially of injections. For ideas on teaching about the danger of unnecessary injection.

**Dangerous work conditions**

Women who work long hours without enough rest are likely to have accidents. Women who work in factories, mines or on agricultural plantations can be exposed to dangerous machinery, tools, or chemicals. Accidents, overwork and exposure to chemicals can all cause disability.

A growing number of women have also been permanently injured due to violence at work. Supervisors sometimes use violence and threats to try and make women work harder and faster. Sometimes the authorities bring in the military or police to stop women from striking or protesting unsafe working conditions.

**Accidents**

Many women and children get disabling injuries at home by burns from cooking fires, falls, road accidents, and breathing or drinking toxic chemicals. Workplace accidents, especially in less regulated sectors such as construction, agriculture, mining, and smaller businesses, are a common source of disability.

**Poisons and pesticides**

Poisons such as lead found in paints, pesticides such as rat poison, and other chemicals can cause disabilities in people and cause birth defects in babies growing in the womb. Smoking or chewing tobacco, breathing smoke, and drinking alcohol during pregnancy can also harm a child before she is born.

Workers often use chemicals on the job or in the fields without being taught how to use them safely, or without even knowing if they are dangerous. Accidents in factories can release poisons into the air, water, or ground, causing terrible health problems, including permanent disabilities.

Inherited disabilities

**Physical characteristics of Down syndrome.**

small mouth, hangs open; roof of mouth is high and narrow; tongue hangs out eyes that slant upward; sometimes cross-eyed or poor sight ears low

Some disabilities are known to be inherited, such as spinal muscular atrophy and muscular dystrophy (diseases of the muscles and nerves). Women who already have one or more children with an inherited

disability are more likely to give birth to another child with the same problem. Other disabilities can result when close blood relatives (such as brothers and sisters, first cousins, or parents and children) have children together. Children born to mothers 40 years of age or older are more likely to have Down syndrome. However, most disabilities are not inherited. In most cases, the parents of a baby born with a disability did nothing to cause the disability. They should never be blamed.

Prevention at three levels

**PrimaryPrevention** – Action taken prior to the onset of the disease/disability, which will remove the possibility that a disease/disability will occur.

**SecondaryPrevention** – Action, which halts the progress of the disease/disability at its incipient stage and prevents complications. The specific interventions are early diagnosis and adequate treatment.

**TertiaryPrevention** – All measures available to reduce or limit impairments and disabilities, and minimize suffering caused by existing disability. This phase is also called rehabilitation, which includes physical, psychosocial and vocational measures taken to restore the patient back to normal or near normal condition

It is extremely important that the women undertake adequate and effective preventive measures during their pregnancy and immediate postnatal period and also for their children especially during the early childhood period, in order to significantly reduce the incidence of impairment and disabilities in them. Therefore, in this chapter examples of easily understood primary preventive measures, for mother and child are summarized.

**General Preventive Measures**

- Marriage between very close blood relations like uncle, niece, first cousin should be avoided for prevention of hereditary disorders.
- Avoid pregnancies before the age of 18 years and after the age of 35 years.
- Consult a doctor before planning the pregnancy;
- If there is incidence of birth defects in your family.
- If you have had difficulty in conceiving or have had a series of miscarriages, still births, twins, delivery by operation (Caesarean), obstructed labour/prolonged labour(more than 12 hours) and/or severe bleeding in previous pregnancy .
- If you have RH - negative blood type.
- If you have diabetes.
- Care During Pregnancy
- Avoid hard physical work such as carrying heavy loads, especially in fields, and other accident - prone activities such as walking on slippery ground or climbing stools and chairs.
- Avoid unnecessary drugs and medications. Even the normally considered safe drugs which are sold commonly can potentially cause serious defects in an unborn child.
- Avoid smoking, chewing tobacco, consuming alcohol and narcotics.
- Avoid X - rays, and exposure to any kind of radiation.
- Avoid exposure to illnesses like measles, mumps etc, especially during the first 3 months of pregnancy.
- Avoid sexual contact with a person having venereal disease.
- Take precautions against lead poisoning.
- Avoid too much use of ‘Surma’ and ‘Kohl’.
- Eat a well-balanced and nourishing diet supplemented with green leafy vegetables, proteins and vitamins.

- All women of the child bearing age need 0.4mg of folic acid daily. It is also available in folic acid plus iron tablets which should be taken for at least 3 months during the third trimester when the risk of developing iron deficiency anemia is greatest.
- Ensure weight gain of at last 10 kgs. Have regular medical checkups.
- All pregnant women should be given tetanus injection.
- Woman at 'high - risk', whose weight is < 38 Kg, height is less than 152 cm, weight gain during pregnancy <6 kg or who is severly anemia c (Hb < 8mg), having frequent pregnancies, having a history of miscarriage/ abortion/premature deliveries, must get expert prenatal care so as to have a normal baby.
- Must consult a doctor, in case of edema (swelling) of feet, persistent headache, fever, difficulty or pain in passing urine, bleeding from the vagina, and yellowness of eyes (jaundice)
- Care at the time of birth
- Delivery must be conducted by trained personnel, preferably in a hospital where all facilities are available.
- If a baby does not cry immediately after birth, resuscitation measures should be undertaken at once.
- Babies born prematurely and with a low birth weight (<2.5 Kg) may need Neonatal Intensive Care.
- If the baby's head appears to be abnormally small or large then a physician should be consulted, preferably a pediatrician. The approximate head size for a male child at birth is 35 cm and for female child is 34.5 cm.
- To protect a child from infections, breast - feeding must be started immediately after birth. First milk (colostrum) must be fed to the baby and should not be thrown away, as it has antibodies which are protective.
- Early Childhood Care
- Do not allow a child's temperature to rise above 101-degree F because of any reason. It can cause febrile seizures
- If a child gets a fit take him to doctor immediately.
- Every child should be immunized against infectious diseases as per the recommended schedule of immunization.
- Do not allow a child to have too much contact with paint, newsprint ink, lead etc. as they are toxic.
- Take precautions against head injury, and other accidents.
- Ensure that the child gets a well-balanced diet and clean drinking water.
- Introduce additional foods of good quality and in sufficient quantity when the child is 4 -6 months old.
- Vitamin A deficiency and its consequences including night blindness can be easily prevented through the use of Vitamin A supplementation.
- Protect a child from Meningitis and Encephalitis by providing a hygienic environment which is free of overcrowding.
- Common salt must be iodized as a precaution against goiter and cretinism.
- Do not allow a child to use hairpins, matchsticks and pencils, to remove wax from the ears.
- Use ear protectors to reduce the exposure to high levels of noise, if children are living or working in a noisy environment.
- Do not slap a child over the face as this may lead to injury of the eardrum and consequent hearing loss

Rehabilitaion

Central government schemes for the rehabilitation of persons with disabilities

**Tamil Nadu Government services**

Tamil Nadu has always been a pioneer in the implementation of welfare schemes for all sections of socially disadvantaged groups.

In order to provide effective rehabilitation services to the differently abled persons, during 1993, a separate Directorate for the Rehabilitation of the Differently Abled Persons was formed by bifurcating the Directorate of Social Welfare. A comprehensive State Policy for the Welfare of the Differently Abled Persons was released first time by this Government during 1994. As per the provisions of the Persons with Disabilities (Equal opportunities, Protection of Rights and Full Participation) Act, 1995, this Directorate was upgraded as Office of the State Commissioner for the Differently Abled during 1999 and a Officer in the cadre of Indian Administrative Service was appointed as a State Commissioner for the Differently Abled Persons.

With a view to eliminate the social view attached to the description of persons based on their disability namely physically handicapped, blind, deaf etc., it was announced by the Government to refer to them as Differently Abled Persons. For the Welfare of the differently abled persons a separate administrative department was formed at the Secretariat, ie. Welfare of the Differently Abled Persons Department.

Awareness is being spreaded among public to accept them as natural partners of growth and provide them access to various services and equal participation in social life to form an inclusive society.

The Government of Tamil Nadu through various policies and initiatives have extended full support to the Differently Abled Persons in their pursuit of full and equal involvement in every aspect of society. Various schemes have been announced by the Government to make sure that the differently abled persons are in equal status with Society.

The thrust areas of Government are as follows

1)Prevention of disabilities

2)Early detection and intervention

3)Rehabilitation measures

4)Providing Special Education

5)Development of professionals for rehabilitation

6)Provision for assistive devices

7)Education and economic empowerment including self-employment

8)Formation of barrier free environment Social security.

**The Individuals with Disabilities Education Act (IDEA)** requires public schools to provide special education and related services to eligible students. But not every child who struggles in school qualifies. To be covered, a child's school performance must be "adversely affected" by a disability in one of the 13 categories below.

1. **Specific learning disability (SLD)**

The umbrella term "SLD" covers a specific group of learning challenges. These conditions affect a child's ability to read, write, listen, speak, reason, or do math. Here's what could fall in this category:

- Dyslexia
- Dysgraphia
- Dyscalculia

- Auditory processing disorder
- Nonverbal learning disability

SLD is the most common category under IDEA. In 2018, 34 percent of students who qualified did so under this category.

2. **Other health impairment**

The umbrella term "other health impairment" covers conditions that limit a child's strength, energy, or alertness. One example is ADHD, which impacts attention and executive function.

**3.ASD** is a developmental disability. It covers a wide range of symptoms, but it mainly affects a child's social and communication skills. It can also impact behavior.

4. **Emotional disturbance**

Various mental health issues can fall under the "emotional disturbance" category. They may include anxiety disorder, schizophrenia, bipolar disorder, obsessive-compulsive disorder, and depression. (Some of these may also be covered under "other health impairment."

**5. Speech or language impairment**

This category covers difficulties with speech or language. A common example is stuttering. Other examples are trouble pronouncing words or making sounds with the voice. It also covers language problems that make it hard for kids to understand words or express themselves.

6. **Visual impairment, including blindness**

A child who has eyesight problems is considered to have a visual impairment. This category includes both partial sight and blindness. If eyewear can correct a vision problem, then it doesn't qualify.

**7. Deafness**

Kids with a diagnosis of deafness fall under this category. These are kids who can't hear most or all sounds, even with a hearing aid.

**8. Hearing impairment**

The term "hearing impairment" refers to a hearing loss not covered by the definition of deafness. This type of loss can change over time. Being hard of hearing is not the same thing as having trouble with auditory or language processing.

**9. Deaf-blindness**

Kids with a diagnosis of deaf-blindness have both severe hearing and vision loss. Their communication and other needs are so unique that programs for just the deaf or blind can't meet them.

**10. Orthopedic impairment**

An orthopedic impairment is when kids lack function or ability in their bodies. An example is cerebral palsy.

**11. Intellectual disability**

Kids with this type of disability have below-average intellectual ability. They may also have poor communication, self-care, and social skills. Down syndrome is one example of an intellectual disability.

**12. Traumatic brain injury**

This is a brain injury caused by an accident or some kind of physical force.

**13. Multiple disabilities**

A child with multiple disabilities has more than one condition covered by IDEA. Having multiple issues creates educational needs that can't be met in a program designed for any one disability.

Learn how to find out if a child is eligible for special education. When kids are found eligible, the next step will be to create an Individualized Education Program (IEP). For kids who are in preschool or younger, you may want to learn about early intervention.

Seven government initiatives that aim to improve lives of the people with disability

After Digital India, Clean India, and Skill India, the government is all set to launch the Accessible India Campaign which will focus on making India a disabled-friendly country.

A joint venture by the Department of Empowerment of Persons with Disabilities and Ministry of Social Justice and Empowerment, Accessible India Campaign will be first launched in seven cities including Delhi, Tamil Nadu, Gujarat, Assam, Rajasthan, Maharashtra and Haryana. The programme will focus on grievances of people with disabilities and the problems they face in mobility.

Here are the seven key initiatives by the government which will be a part of the Accessible India Campaign –

1. An audit of 100 government buildings will be done and by July 2016, they will all be converted into fully accessible buildings

A team of experts will work extensively to conduct awareness programmes and workshops for sensitising all the main stakeholders, including builders and activists.

3. A web portal will also be created where people can upload pictures and comment on the accessibility of any building.

**Government is also planning to introduce set-top boxes to make TV programmes more useful for the visually impaired.**

Set top boxes will be modified by introducing a button on the box, and a remote control that will convert text on the TV screen to voice.

5. Sign languages will be introduced in more than 25 percent of the programmes, starting with Doordarshan, to make television more disabled-friendly

Currently there is only one news bulletin with sign language. The government will be training 200 persons in sign language every year, for next five years.

6. Content on government website will also be converted from text to speech mode through screen reader programmes for the visually impaired

A mobile app will be launched to provide information on disabled-friendly public utilities in a city.

**India launches programme for child-health screening**

The Indian Government announced a new and ambitious child-health screening initiative last month that will run nationally, covering 270 million children. Tamoghna Biswas reports.

Birth defects affect 6% of all children in India, which translates to a staggering 1·7 million birth defects annually. Developmental delays are also a substantial cause of morbidity in early childhood, affecting around 10% of children. That's why many experts have welcomed a new government initiative to screen

children for birth defects and intervene early, although concerns have been raised about implementation of the programme.

The Ministry of Health and Family Welfare launched the Child Health Screening and Early Intervention Services initiative last month under the umbrella of the National Rural Health Mission to provide targeted, comprehensive care to children aged 0–18 years.

Rohit Agrawal, president of the Indian Academy of Pediatrics in 2012, welcomed the news. “Early screening is prudent and will be of great benefit in reducing morbidity and mortality of these children. Screening would give us an opportunity of early intervention in conditions like congenital cardiac diseases, and would also allow us the option of genetic counselling in certain conditions.”

Louis-Georges Arsenault, representative of UNICEF India, shares a similar view: “There is an unacceptably high incidence of birth defects, deficiencies, diseases in childhood, and developmental disorders, including disabilities, in India and it is high time we started to pay attention to their early detection and intervention.”

“If properly implemented with scale, quality, and equity, the dividends of early intervention could be significant. This would include improvement of survival and nutrition outcomes, reduction of malnutrition related deaths, enhancement of cognitive development and school performance, educational attainment, and overall improvement of quality of life of our citizens”, he adds.

The programme has identified 30 health conditions for screening and management including birth defects like club foot, cleft lip, congenital heart diseases, deficiency conditions like anaemia, goitre, rickets, developmental delays and certain childhood diseases like rheumatic heart disease, otitis media, and dental caries.

“The screening would be implemented at various levels by facility-based screening for newborns born at health facilities (public sector) and for home deliveries by accredited social health activists”, says Manpreet Singh Khurmi, national consultant for newborn and child health at the Ministry of Health and Family Welfare.

He tells The Lancet that special teams will undertake at least twice yearly visits to anganwadicentres (centres in villages that provide basic health care) to screen children aged 6 weeks to 6 years and, at least once a year, they will visit all government and government-aided schools to screen children in the age group of 6–18 years. The children identified as requiring further management will be referred to District Early Intervention Centres (DEIC) for confirmation of their diagnosis and further care. Khurmi adds that technical guidelines and training manuals are being developed for the DEICs.

According to Khurmi, considerable challenges include the operationalisation of DEIC, training of DEIC staff in the various tests that would be undertaken for confirmation of diagnosis, and monitoring the data that is expected to come from more than 270 million children. “A software tool would be used to monitor the programme as a whole for all children and would cover details of children identified after screening for further management”, he explains. According to him, the success of the programme depends upon the strengthening of three pillars: recruitment of human resources and their capacity building; supply of logistics, training manuals, equipment and so on; and lastly, information, education, and communication, including behaviour-change communication.

Chandrakant S Pandav, head of the Centre for Community Medicine at the All India Institute of Medical Sciences, New Delhi, and past president of the Indian Public Health Association, however, highlights another important concern regarding implementation. “The programme focuses on those who are enrolled in ICDS (Integrated Child Development Services) or any government or government-aided schools. There are many children, who are outside this umbrella, who are more vulnerable and are in need of these services. The more vulnerable children are more likely to be out of schools because of developmental delays. Provisions should be built in the programme to address this segment”, Pandav says.

"Currently, the health-care system focuses more on treatment, disability prevention, and rehabilitation. In a resource-constrained setting, focus should be on health promotion and specific protection for a better outcome", he adds.

**CENTRAL GOVERNMENT SCHEMES FOR THE REHABILITATION OF PERSONS WITH DISABILITIES**

- Ministry of Social Justice and Empowerment
- Scheme to promote Voluntary Action for Persons with Disabilities (Umbrella Scheme).
- Scheme of Assistance to disabled persons for purchase/fitting of aids & appliances.
- Ministry of Rural Areas & Employment
- Convergence of Poverty Alleviation Programme of the Ministry of Rural Areas and Employment with the ADIP (Assistance Scheme of Ministry of Social Justice and Empowerment.
- TRYSEM training to disabled.
- Financial assistance to group of persons with disability in rural areas.
- Revision/Modification of Jawahar Rozgar Yojana guidelines, earmarking of funds for persons with disability.
- 3% reservation to persons with disability in the Rural Sanitation programme.
- Earmarking of 3% of funds for the benefits of persons with disability under Indira Awas Yojana.

**Ministry of Social Justice and Empowerment**

Scheme to promote Voluntary Action for Persons with Disabilities (Umbrella Scheme) :The enactment of the people with disabilities, equal opportunities and protection of Right Act of 1995 is a landmark legislation and an expression of India's commitment of social justice.

The Disability Division of the Ministry of Social Justice and Empowerment has so far been administering the following five grant-in-aid schemes which are being implemented through NGO's :

- Scheme of Assistance to organizations for the disabled.
- Scheme of Assistance to Disabled Persons for Purchase/Fitting of Aids/Appliances.
- Scheme of Assistance of Voluntary Organization for the Rehabilitation of Leprosy Cured Persons.
- Scheme of Assistance to voluntary Organizations for Special School for Handicapped Children; and
- Scheme of Assistance of Organizations for Persons with Cerebral Plasy and Mental Retardation.

In order to make these schemes more effective and better result oriented it has been decided that the Four Schemes mentioned at (1) ,(3) ,(4), and (5) be replaced by the present 'Scheme to promote Voluntary Actions for Persons with Disabilities' also known as Umbrella Scheme, which incorporates all the components of the earlier schemes and also cover the new areas in the field of disabilities. So far as the Scheme at (2) is concerned, It has already been revised.

The Umbrella Scheme simplifies and facilitates procedure for easy access to Government support for NGOs with the aim to widen the scope and range of programmes . It will address the unmet needs of the over 95% Indian citizens with diabilities who have not had access to services so far.

**Objectives of the scheme:**

- To encourage effective implementation to the Act
- To encourage voluntary action.
- To create enabling environment.
- To ensure equal opportunities, equity and social justice to persons with disabililties.
- To empower persons with disabilities.

- To implement outreach and comprehensive Community-based Rehabilitation programmes in urban and rural environments.
- To enhance education opportunities at all levels and in all forms.
- To enlarge the scope of vocational and professional opportunities, income generation and gainful occupations.
- To support people with disabilities in project with are environment friendly and eco promotive.
- To support effort to ensure protection of human, civil and consumer rights to persons with disabilities.
- To support legal literacy, including legal counseling, legal aid and analysis and evaluation of existing laws.
- To support the development publication and discrimnation of information documentation and training materials.
- To support the conduct of surveys and other forms of epidemiological studies.
- To support (a) construction and maintenance of building, (b) furniture and fixtures, and (c) installation and maintenance of machinery and equipment.
- To support and facilitate the availability of appropriates housing homes and hostel facilities.
- To establish and support facilities for sport, recreation, leisure-time activities, excursions, creative performing arts, cultural and socially inclusive activities.
- To promote research in various development areas, innovative strategies, assistive devices and enabling technologies and support production of such devices ensuring equality control
- To support manpower development activities to train required personnel at different levels for all programmes /projects/ activities for persons with disabilities.
- To set up well equipped resource centers at different levels.
- To promote and support the development of self-help groups, parent organization and independent living.
- To encourage coordination, cooperation and networking and multisectoral linkages.
- To support such other measures, which may meet the needs of the persons with disability and fulfil the obligation as prescribed in the Disability act of 1995.

**Eligible Organization:**

The organization should be:

- Registered under the Societies Registration Act, 1860 (XXI of 1860) or any relevant Act of the State/Union Territory, or
- A public trust registered under the law for the time being in force; or,A charitable company licensed under section 25 of the company Act, 1958.For at least 2 years at the time of applying for grant under this scheme in case relaxation to this condition is required detailed justification should be given. Secretary (SJ &E) is empowered to waive this condition, for reasons to be recorded in writing (in exceptional cases)
- It should have a legally constituted managing body.
- It is not run for profit to any individual or a body of individuals.
- Extent of Support:
- The quantum of support shall be determined on the scope and merits of the project proposal which could be upto 90%.
- The norms of payment is mentioned in the scheme booklet.

- If an organization has already received or is expecting to receive a grant from some other official source for a project for which application is being made under this scheme, the grant under this scheme will be sanctioned after taking that into account. The applicant will have to give information/declaration to that effect.
- The grant will be released in two instalments normally. The first instalment of 50% of the admissible amount will be released on adhoc basis, subject to nothing adverse.

**Introduction of 3 new projects under the Umbrella Scheme:**

The following 3 new projects have been introduced in addition to the 4 existing projects mentioned at S.No.(1), (3), (4) & (5) in the second para of the Umbrella Scheme:

Project for community Based Rehabilitation.

Project for Legal Literacy, including Legal Counselling, Legal Aid and Evaluation of Existing Laws.

Environment friendly and Eco-Promotive Projects for the handicapped.

Scheme of Assistance to disabled persons for purchase/lifting of aids & appliances (ADIP): The Scheme aims at helping the disabled persons by bringing suitable, durable, scientifically-manufactured, modern, standard aids and appliances within their reach.

The main objective of the Scheme is to assist the needy disabled persons in procuring durable, sophisticated and scientifically manufactured, modern, standard aids and appliances that can promote their physical, social and psychological rehabilitation, by reducing the effects of disabilities and "enhance their economic potential.

The Scheme will be implemented through the implementing Agencies. The agencies will be provided with financial assistance for purchase, fabrication and distribution of such standard aids and appliances that are in conformity with the objectives of the Scheme. The implementing agencies will take care of/make suitable arrangements for fitting and post-lifting care of the aids and appliances distribute under ADIP Scheme. The scope of the scheme has been further enlarged to include use of mass media, exhibitions, workshops etc., for exchange of information and promoting awareness and distribution and use of aids/appliances.

**Eligibility of Implementing Agency :**

The following agencies would be eligible to implement the scheme on behalf of Ministry of Social Justice and Empowerment, subject to fulfillment of laid down terms and conditions.

Societies registered under the societies registration Act, 1860 and their branches, if any, separately.

Registered charitable trusts.

District Rural Development Agencies, Indian Red Cross Societies and other Autonomous bodies headed by District Collector/Chief Executive Officer/District Development Officer of Zilla Parishad.

National/Apex Institutes including ALIMCO functioning under administrative control of the Ministry of Social Justice and Empowerment/Ministry of Health and family Welfare.

State handicapped Development Corporations.

Local Bodies – Zilla Parishad, Muncipalities, District Autonomous Development Councils and Panchayats.

Nehru YuvakKendras.

Eligibility of the Beneficiaries:

A person with disabilities fulfilling following conditions would be eligible for assistance under ADIP Scheme through authorized agencies:

He/She should be an Indian Citizen of any age.

Should be certified by a Registered Medical Practitioner that he/she is disabled and fit to use prescribed aid/appliance.

Person who is employed/self-employed or getting pension and whose monthly income from all sources does not exceed Rs.8,000/- per month.

In case of dependents, the income of parents/guardians should not exceed Rs.8,000/- per month.

Persons who have not received assistance from the Government, local bodies and Non-Official Organizations during the last 3 years for the same purpose. However for children below 12 years of age this limit would be 1 year.

Quantum of Assistance to Disabled:

Only those aids/appliances which do not cost less than Rs.50/- and more than Rs.6,000/- are covered under the scheme. However, for visually, mentally, speech and hearing or multiple disabled, the limit should be Rs.8,000/- during their study period upto XII standard. The limits will apply to individual items of aid and where more than one aids is required, the ceiling will apply separately. The amount of assistance will be follows :

| Total Income | Amount of Assistance |
|---|---|
| Upto Rs.5,000/- per month | Full cost of aid/appliance |
| Rs.5,001/- to Rs.8,000/- per month | 50% of the cost of aid/appliance |

Further, travelling cost would be admissible limited to bus fare in ordinary class or railway by second class sleeper subject to limit or Rs.250/- for beneficiary irrespective of number of visits to the centre and a Certificate from Doctor or Rehabilitation professional, travel expenses subject to the same limit would be admissible to an attendant/escort accompanying the beneficiary. The beneficiary should attend the Rehabilitation Centre nearest to his/her place of residence, except in the North-Eastern Region where he may be allowed travel cost for traveling outside the region till such facilities become available with that region.

Boarding and lodging expenses at the rate of Rs.30/- per day for maximum duration of 15 days would be admissible, only for those patients whose total income is upto Rs.5,000/- per month.

Types of Aids/Appliances to be provided :

The following aids and appliances may be allowed for each type of disabled individual. However, any other item as notified from time to time by the Ministry of Social justice and Empowerment for the purpose will be allowed.

**Locomotor Disabled:**

All types of prosthetic and orthotic devices.

Mobility aids and like tricycles, wheelchairs, crutches/walking sticks and walking frames/rotators.

All types of surgical footwears and MCR chappals.

All types of devices for ADL (activity of daily living).

**Visually Disabled :**

- Learning equipments like arithmetic frames, abacus, geometry kits etc., Gaint Braille dosts system for slow-learning blind children. Dictaphone and other variable speed recording system. Tape recorder for blind student upto XII standard.
- Science learning equipments like talking balance, talking thermometers, measuring equipments like tape measures, micrometers etc.
- Braille writing equipments including baraillers, Braille shorthand machines, type-writers for blind students after the XII Class. Talking calculators, Geography learning equipment like raised maps and globes.
- Communication equipment for the deaf blind Braille attachments for telephone for deaf-blind persons.
- Low vision aids including hand-held stand, lighted and unlighted magnifiers, speech synthesizers or Braille attachments for computers.
- Special mobility aids for visually disabled people with muscular dystrophy or cerebral palsy like adapted walkers.

**Hearing Disabled :**

- Various types of hearing aids.
- Educational kits like tape recorders etc.
- Assistive and alarming devices, including devices for hearing of telephone, TV, doorbell, time alarm etc.
- Communication aids, like, portable speech synthesizer etc.

**Mentally Disabled :**

- All items include in locomotor disabled.
- Tricycle and wheel chair including the modification to suit the individual.
- All types of educational kits required for the mentally disabled.
- Any suitable device as advised by the Rehabilitation professional or treating physician.

**Multiple Disabled :**

Any suitable device as advised by Rehabilitation Professional or treating Physician.

**MINISTRY OF RURAL AREAS & EMPLOYMENT**

Convergence of Poverty Alleviation Programme of the Ministry of Rural Areas & Employment with the ADIP Scheme of Ministry of Social Justice &Empowerment.There is 3% reservation for disabled in the poverty Alleviation Programme i.e.the implementing agencies have a mandatory to extend assistance to a minimum 35 persons with disability in the total number of beneficiary. To achieve this target there is a need to promote the mobility of the disabled persons by giving them aids and appliances. Keeping in view of this the Ministry of Rural Areas and Employment has decided to converge the ADIP Assistance of Ministry of Social Justice&Empowerment with the Poverty Alleviation programme of the Ministry of Rural Areas & Employment (Annexure-XXVII)

TRYSEM training to disabled :Under TRYSEM programme of Ministry of Rural Areas & Employment training is provided to the local artisans for repairing of aid/appliance of the disabled. Disabled youth having aptitude could also themselves be chosen for such training. Under TRYSEM programme also there is a provision of 3% reservation for person with disability.(Annexure-XXVIII)

Financial Assistance to group to people with disability in rural areas : Under this programme there is a scheme to organize group of person with disability in rural areas into Sangam/Group and provide them Rs.25,000/- to each group for taking up viable economic activities suitable to them (Annexure-XXIX)

Revision/Modification of Jawahar Rojgar Yojana (JRY) :It has been decided to earmark 3% of the JRY funds for the benefit of the persons with disbility (Annexure-XXX).

3% reservations to persons with disability in the Rural Sanitation Programme :It has been decided that there should be 3% reservation for persons with disability in works relating to sanitary latrines for individuals below the poverty line. In the case of works relating to groups, it should be ensured that there is a barrier free environment for the disabled (Annexure-XXXI).

Earmarking of 3% of funds for the persons with disability in the Indira AwasYojana :It has been decided to earmark 3% of funds for the benefit of persons with disability under the Indira Awas Yojana (Annexure-XXXII)

**COMMUNITY BASED REHABILITATION**

Community Based Rehabilitation (CBR) is a community development strategy that aims at enhancing the lives of persons with disabilities (PWDs) within their community. Community-based rehabilitation (CBR) was initiated by WHO following the Declaration of Alma-Ata in 1978 in an effort to enhance the quality of life for people with disabilities and their families; meet their basic needs; and ensure their inclusion and participation. While initially a strategy to increase access to rehabilitation services in resource-constrained settings, CBR is now a multi-sectoral approach working to improve the equalization of opportunities and social inclusion of people with disabilities while combating the perpetual cycle of poverty and disability. CBR is implemented through the combined efforts of people with disabilities, their families and communities, and relevant government and non-government health, education, vocational, social and other services(WHO).

It emphasizes utilization of locally available resources including beneficiaries, the families of PWDs and the community. According to the UN Convention on the Rights of Persons with Disabilities, comprehensive rehabilitation services focusing on health, employment, education and social services are needed to enable PWDs/CWDs attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life (UN, 2006).
Community-based rehabilitation CBR is “a strategy that can address the needs of people with disabilities within their communities in all countries. This strategy promotes community leadership and the full participation of people with disabilities and their organizations. It promotes multisectoral collaboration to support community needs and activities, and collaboration between all groups that can contribute to meeting its goals” (2004: ILO, UNESCO, WHO). CBR cannot be delivered by one ministry or even one sector. People with disabilities and their families, organizations and communities must be central to the implementation of CBR along with the relevant governmental and nongovernmental health, education , vocational ,social and other services.
CBR makes a difference at the grassroots level, through individual empowerment, group empowerment and community change, which together contribute to meeting basic needs, reducing poverty, and creating access to health, education and livelihood. Disability is no longer viewed as merely the result of impairment. The social model of disability has increased awareness that environmental barriers to participation can be major causes of disability. Rehabilitation is now viewed as a process in which people with disabilities or their advocates make decisions about what services they need in order to enhance their participation in all aspects of their daily lives. The role of professionals is to provide relevant information so that people with disabilities can make informed choices and decisions. CBR promotes the enjoyment of human rights and fundamental freedom of people with disabilities to live as equal citizens within their own communities, with equal opportunities for full participation in all dimensions of community life

The Rehabilitation Council of India(RCI) was set up as a registered society in 1986.On September,1992 the RCI Act was enacted by Parliament and it became a Statutory Body on 22 June 1993.The Act was amended by Paliament in 2000 to make it more broadbased.The mandate given to RCI is to regulate and monitor services given to persons with disability,tostandardise syllabi and to maintain a Central Rehabilitation Register of all qualified professionals and personnel working in the field of Rehabilitation and Special Education.The Act also prescribes punitive action against unqualified persons delivering services to persons with disability.

## Unit 4

## INTERNATIONAL YEAR FOR DISABLED, EFFORTS BY INTERNATIONAL ORGANIZATIONS FOR PREVENTION, WELFARE

A major outcome of the International Year of Disabled Persons was the formulation of the World Programme of Action concerning Disabled Persons, adopted by the General Assembly on 3 December 1982. The World Programme of Action (WPA) is a global strategy to enhance disability prevention, rehabilitation and equalization of opportunities, which pertains to full participation of persons with disabilities in social life and national development. The WPA also emphasizes the need to approach disability from a human rights perspective.

Its three chapters provide an analysis of principles, concepts and definitions relating to disabilities; an overview of the world situation regarding persons with disabilities; and set out recommendations for action at the national, regional and international levels.

"Equalization of opportunities" is a central theme of the WPA and its guiding philosophy for the achievement of full participation of persons with disabilities in all aspects of social and economic life. An important principle underlying this theme is that issues concerning persons with disabilities should not be treated in isolation, but within the context of normal community services.

History of the World Programme of Action

### Objectives

The purpose of the World Programme of Action concerning Disabled Persons is to promote effective measures for prevention of disability, rehabilitation and the realization of the goals of"full participation" of disabled persons in social life and development, and of "equality". This means opportunities equal to those of the whole population and an equal share in the improvement in living conditions resulting from social and economic development. These concepts should apply with the same scope and with the same urgency to all countries, regardless of their level of development.

### Background

More than 500 million people in the world are disabled as a consequence of mental, physical or sensory impairment. They are entitled to the same rights as all other human beings and to equal opportunities. Too often their lives are handicapped by physical and social barriers in society which hamper their full participation. Because of this, millions of children and adults in all parts of the world often face a life that is segregated and debased.

An analysis of the situation of disabled persons has to be carved out within the context of different levels of economic and social development and different cultures. Everywhere, however, the ultimate responsibility for remedying the conditions that lead to impairment and for dealing with the consequences of disability rests with Governments. This does not weaken the responsibility of society in general, or of individuals, or of organizations Governments should take the lead in awakening the consciousness of populations regarding the gains to be derived by individuals and society from the inclusion of disabled persons in every area of social, economic and political life. Governments must also ensure that people who are made dependent by severe disability have an opportunity to achieve a standard of living equal to that of their fellow citizens. Non-governmental organizations can, in different ways, assist Governments by formulating needs, suggesting suitable solutions and providing services complementary to those provided by Governments. Sharing of financial and material resources by all sections of the population, not omitting the rural areas of

developing countries, could be of major significance to disabled persons by resulting in expanded community services and improved economic opportunities.

Much disability could be prevented through measures taken against malnutrition, environmental pollution, poor hygiene, inadequate prenatal and postnatal care, water-borne diseases and accidents of all types. The international community could make a major breakthrough against disabilities caused by poliomyelitis, tetanus, whooping-cough and diphtheria, and to a lesser extent tuberculosis, through a world-wide expansion of programmes of immunization.

In many countries, the prerequisites for achieving the purposes of the Programme are economic and social development, extended services provided to the whole population in the humanitarian area, the redistribution of resources and income and an improvement in the living standards of the population. It is necessary to use every effort to prevent wars leading to devastation, catastrophe and poverty, hunger, suffering, diseases and mass disability of people, and therefore to adopt measures at all levels to strengthen international peace and security, to settle all international disputes by peaceful means and to eliminate all forms of racism and racial discrimination in countries where they still exist. It would also be desirable to recommend to all States Members of the United Nations that they maximize the use of their resources for peaceful purposes, including prevention of disability and satisfaction of the needs of disabled persons. All forms of technical assistance that help developing countries to move towards these objectives can support the implementation of the Programme. The realization of these objectives will, however, require extended periods of effort, during which the number of disabled persons is likely to increase. Without effective remedial action, the consequences of disability will add to the obstacles to development. Hence, it is essential that all nations should include in their general development plans immediate measures for the prevention of disability, for the rehabilitation of disabled persons and for the equalization of opportunities.

**Definition**

The following distinction is made by the World Health Organization, in the context of health experience, between impairment, disability and handicap:

- Impairment: Any loss or abnormality of psychological, physiological, or anatomical structure or function.
- Disability: Any 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.
- Handicap: 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, social and cultural factors, for that individual.2

Handicap is therefore a function of the relationship between disabled persons and their environment. It occurs when they encounter cultural, physical or social barriers which prevent their access to the various systems of society that are available to other citizens. Thus, handicap is the loss or-limitation of opportunities to take part in the life of the community on an equal level with others.

Disabled people do not form a homogeneous group. For example, the mentally ill and the mentally retarded, the visually, hearing and speech impaired and those with restricted mobility or with so-called ”medical disabilities” all encounter different barriers, of different kinds, which have to be overcome in different ways.

The following definitions are developed from that perspective. The relevant terms of action proposed in the World Programme are defined as prevention, rehabilitation and equalization of opportunities.

- Prevention means measures 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.
- Rehabilitation means a goal-oriented and time-limited process aimed at enabling an impaired person to reach an optimum mental, physical and/or social functional level, thus providing her or him 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.

- Equalization of opportunities means 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.

**Prevention**

A strategy of prevention is essential for reducing the incidence of impairment and disability. The main elements of such a strategy would vary according to a country's state of development, and are as follows:

- The most important measures for prevention of impairment are: avoidance of war; improvement of the educational, economic and social status of the least privileged groups; identification of types of impairment and their causes within defined geographical areas; introduction of specific intervention measures through better nutritional practices; improvement of health services, early detection and diagnosis; prenatal and postnatal care; proper health care instruction, including patient and physician education; family planning; legislation and regulations; modification of life-styles; selective placement services; education regarding environmental hazards; and the fostering of better informed and strengthened families and communities;
- To the extent that development takes place, old hazards are reduced and new ones arise. These changing circumstances require a shift in strategy, such as nutrition intervention programmes directed at specific population groups most at risk owing to vitamin A deficiency; improved medical care for the aging; training and regulations to reduce accidents in industry, in agriculture, on the roads and in the home; and the control of environmental pollution and of the use and abuse of drugs and alcohol. In this connection, the WH0 strategy for Health for All by the Year 2000 through primary health care should be given proper attention.

Measures should be taken for the earliest possible detection of the symptoms and signs of impairment, to be followed immediately by the necessary curative or remedial action, which can prevent disability or at least lead to significant reductions in the severity of disability and can often prevent its becoming a lasting condition. For early detection it is important to ensure adequate education and orientation of families and technical assistance to them by medical social services.

**Rehabilitation**

Rehabilitation usually includes the following types of services:

- Early detection, diagnosis and intervention;
- Medical care and treatment;
- Social, psychological and other types of counselling and assistance;
- Training in self-care activities, including mobility, communication and daily living skills, with special provisions as needed, e g., for the hearing impaired, the visually impaired and the mentally retarded;
- Provision of technical and mobility aids and other devices;
- Specialized education services;
- Vocational rehabilitation services (including vocational guidance), vocational training, placement in open or sheltered employment;
- Follow-up.

In all rehabilitation efforts, emphasis should be placed on the abilities of the individual, whose integrity and dignity must be respected. The normal development and maturation process of disabled children should be given the maximum attention . The capacities of disabled adults to perform work and other activities should be utilized.

Important resources for rehabilitation exist in the families of disabled persons and in their communities. In helping disabled persons, every effort should be made to keep their families together, to enable them to live in their own communities and to support family and community groups who are working with this objective. In planning rehabilitation and supportive programmes, it is essential to take into account the customs and structures of the family and community and to promote their abilities to respond to the needs of the disabled individual.

Services for disabled persons should be provided, whenever possible, within the existing social, health, education and labour structures of society. These include all levels of health care; primary, secondary and higher- education, general programmes of vocational training and placement in employment; and measures of social security and social services. Rehabilitation services are aimed at facilitating the participation of disabled persons in regular community services and activities. Rehabilitation should take place in the natural environment, supported by community-based services and specialized institutions. Large institutions should be avoided. Specialized institutions, where they are necessary, should be organized so as to ensure an early and lasting integration of disabled persons into society.

Rehabilitation programmes should make it possible for disabled persons to take part in designing and organizing the services that they and their families consider necessary. Procedures for the participation of disabled persons in the decision-making relating to their rehabilitation should be provided for within the system. When people such as the severely mentally disabled may not be able to represent themselves adequately in decisions affecting their lives, family members or legally designated agents should take part in planning and decision-making.

Efforts should be increased to develop rehabilitation services integrated in other services and make them more readily available. These should not rely on imported costly equipment, raw material and technology. The transfer of technology among nations should be enhanced and should concentrate on methods that are functional and relate to prevailing conditions.

**Equalization of opportunities**

To achieve the goals of "full participation and equality", rehabilitation measures aimed at the disabled individual are not sufficient. Experience shows that it is largely the environment which determines the effect of an impairment or a disability on a person's daily life. A person is handicapped when he or she is denied the opportunities generally available in the community that are necessary for the fundamental elements of living, including family life, education, employment, housing, financial and personal security, participation in social and political groups, religious activity, intimate and sexual relationships, access to public facilities, freedom of movement and the general style of daily living.

Societies sometimes cater only to people who are in full possession of all their physical and mental faculties. They have to recognize the fact that, despite preventive efforts, there will always be a number of people with impairments and disabilities, and that societies have to identify and remove obstacles to their full participation. Thus, whenever pedagogically possible, education should take place in the ordinary school system, work be provided through open employment and housing be made available as to the population in general. It is the duty of every Government to ensure that the benefits of development programmes also reach disabled citizens. Measures to this effect should be incorporated into the general planning process and the administrative structure of every society. Extra services which disabled persons might need should, as far as possible, be part of the general services of a country.

The above does not apply merely to Governments. Anyone in charge of any kind of enterprise should make it accessible to people with disabilities. This applies to public agencies at various levels, to non-governmental organizations, to firms and to private individuals. It also applies to the international level.

People with permanent disabilities who are in need of community support services, aids and equipment to enable them to live as normally as possible both at home and in the community should have access to such services. Those who live with such disabled persons and help them in their daily activities should

themselves receive support to enable them to have adequate rest and relaxation and an opportunity to take care of their own needs.

The principle of equal rights for the disabled and non-disabled implies that the needs of each and every individual are of equal importance, that these needs must be made the basis for the planning of societies, and that all resources must be employed in such a way as to ensure, for every individual, equal opportunity for participation. Disability policies should ensure the access of the disabled to all community services.

As disabled persons have equal rights, they also have equal obligations. It Is their duty to take part in the building of society. Societies must raise the level of expectation as far as disabled persons are concerned, and in so doing mobilize their full resources for social change. This means, among other things, that young disabled persons should be provided with career and vocational opportunities – not early retirement pensions or public assistance.

Persons with disabilities should be expected to fulfil their role in society and meet their obligations as adults. The image of disabled persons depends on social attitudes based on different factors that may be the greatest barrier to participation and equality. We see the disability, shown by the white caner crutches, hearing aids and wheelchairs, but not the person. What is required is to focus on the ability, not on the disability of disabled persons.

All over the world, disabled persons have started to unite in organizations as advocates for their own rights to influence decision-makers in Governments and all sectors of society. The role of these organizations includes providing a voice of their own, identifying needs, expressing views on priorities, evaluating services and advocating change and public awareness. As a vehicle of self-development, these organizations provide the opportunity to develop skills in the negotiation process, organizational abilities, mutual support, information-sharing and often vocational skills and opportunities. In view of their vital importance in the process of participation, it is imperative that their development be encouraged.

Mentally handicapped people are now beginning to demand a voice of their own and insisting on their right to take part in decision-making and discussion. Even those with limited communication skills have shown themselves able to express their point of view. In this respect, they have much to learn from the self-advocacy movement of persons with other disabilities. This development should be encouraged.

Information should be prepared and disseminated to improve the situation of disabled persons. The cooperation of all public media should be sought to bring about presentations that will promote an understanding of the rights of disabled persons aimed at the public and the persons with disabilities themselves, and that will avoid reinforcing traditional stereotypes and prejudices.

## CONCEPTS ADOPTED WITHIN THE UNITED NATIONS SYSTEM

In the Charter of the United Nations, the reaffirmation of the principles of peace, the faith in human rights and fundamental freedoms, the dignity and worth of the human person and the promotion of social justice are given primary importance.

The Universal Declaration of Human Rights affirms the right of all people, without distinction of any kind, to marriage; property ownership; equal access to public services; social security; and the realization of economic, social and cultural rights. The International Covenants on Human Rights,
the Declaration on the Rights of Mentally Retarded Persons, and the Declaration on the Rights of Disabled Personsgive specific expression to the principles contained in the Universal Declaration of Human Rights.
The Declaration on Social Progress and Developmentproclaims the necessity of protecting the rights of physically and mentally disadvantaged persons and assuring their welfare and rehabilitation. It guarantees everyone the right to and opportunity for useful and productive labour.

Within the United Nations Secretariat, a number of offices carry out activities related to the above concepts as well as to the World Programme of Action. They include: The Division of Human Rights; the Department

of International Economic and Social Affairs; the Department of Technical Cooperation for Development; the Department of Public Information; the Division of Narcotic Drugs; and the United Nations Conference on Trade and Development. The regional commissions also have an important role: the Economic Commission for Africa in Addis Ababa (Ethiopia), the Economic Commission for Europe in Geneva (Switzerland), the Economic Commission for Latin America in Santiago (Chile), the Economic and Social Commission for Asia and the Pacific in Bangkok (Thailand) and the Economic Commission for Western Asia in Baghdad (Iraq).

Other organizations and programmes of the United Nations have adopted approaches related to development that will be significant in implementing the World Programme of Action concerning Disabled Persons. These include: – The mandate contained in General Assembly resolution 3405 (XXX) on new dimensions in technical cooperation, which directs the United Nations Development Programme, interalia, to take into account the importance of reaching the poorest and most vulnerable sections of society when responding to Governments' requests for help in meeting their most urgent and critical needs and which encompasses the concepts of technical cooperation among developing countries;

- The concept adopted by the United Nations Children's Fund (UNICEF) of basic services for all children and the strategy adopted by it in 1980 to emphasize strengthening family and community resources to assist disabled children in their natural environments;
- The Office of the United Nations High Commissioner for Refugees (UNHCR), with its programme for disabled refugees;
- The United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA), which is concerned, among other things, with the prevention of impairments among Palestine refugees and the lowering of social and physical barriers which confront disabled members of the refugee population;
- The concepts of specific measures of disaster preparedness and prevention for those already disabled, and of the prevention of permanent disability as a result of injury or treatment received at the time of a disaster, advanced by the Office of the United Nations Disaster Relief Coordinator (UNDRO);
- The United Nations Centre for Human Settlements (UNCHS), with its concern about physical barriers and general access to the physical environment;
- The United Nations Industrial Development Organization (UNIDO); the activities of UNIDO cover the production of drugs essential for the prevention of disability as well as of technical devices for the disabled.

The specialized agencies of the United Nations system, which are involved in promoting, supporting and carrying out field activities, have a long record of work related to disability. Programmes of disability prevention, nutrition, hygiene, education of disabled children and adults, vocational training, job placement and others represent a store of experience and know-how which opens up opportunities for further accomplishments and, at the same time, makes it possible to share these experiences with governmental and non-governmental organizations concerned with disability matters. These agencies and their programmes include:

- The basic needs strategy of the International LabourOrganisation (ILO) and the principles set forth in ILO recommendation No. 99 concerning vocational rehabilitation of the disabled, 1955;
- The Food and Agriculture Organization of the United Nations (FAO), with its emphasis on the relation between nutrition and disability;
- The concept of adapted education recommended by an expert group of the United Nations Educational, Scientific and Cultural Organization (UNESCO) on education of disabled persons, which has been reinforced by two guiding principles of the Sundberg Declaration:7
    - Disabled persons shall receive from the community services adapted to their specific personal needs;

- Through decentralization and sectorization of services, the needs of disabled persons shall be taken into account and satisfied within the framework of the community to which they belong;

- The World Health Organization's programme of health for all by the year 2000 and the related primary health care approach, through which the member States of the World Health Organization have already committed themselves to preventing diseases and impairments leading to disabilities. The concept of primary health care, as elaborated by the International Conference on Primary Health Care held at Alma-Ata in 1978, and the application of this concept to the health aspects of disability, are described in the World Health Organization's policy on this subject, approved by the World Health Assembly in 1978;
- The International Civil Aviation Organization (ICAO), which has approved recommendations to contracting States concerning facilities of movement and provision of facilities for disabled passengers;
- The Executive Committee of the Universal Postal Union (UPU), which has adopted a recommendation inviting all national postal administrations to improve access to their facilities for disabled persons

**The legislation with reference to the disabled**

**The disabled and the constitution**

The Constitution of India applies uniformly to every legal citizen of India, whether they are healthy or disabled in any way (physically or mentally)
Under the Constitution the disabled have been guaranteed the following fundamental rights:

1. The Constitution secures to the citizens including the disabled, a right of justice, liberty of thought, expression, belief, faith and worship, equality of status and of opportunity and for the promotion of fraternity.
2. Article 15(1) enjoins on the Government not to discriminate against any citizen of India (including disabled) on the ground of religion, race, caste, sex or place of birth.
3. Article 15 (2) States that no citizen (including the disabled) shall be subjected to any disability, liability, restriction or condition on any of the above grounds in the matter of their access to shops, public restaurants, hotels and places of public entertainment or in the use of wells, tanks, bathing ghats, roads and places of public resort maintained wholly or partly out of government funds or dedicated to the use of the general public. Women and children and those belonging to any socially and educationally backward classes or the Scheduled Castes & Tribes can be given the benefit of special laws or special provisions made by the State.
4. There shall be equality of opportunity for all citizens (including the disabled) in matters relating to employment or appointment to any office under the State.
5. No person including the disabled irrespective of his belonging can be treated as an untouchable. It would be an offence punishable in accordance with law as provided by Article 17 of the Constitution.
6. Every person including the disabled has his life and liberty guaranteed under Article 21 of the Constitution.
7. There can be no traffic in human beings (including the disabled), and beggar and other forms of forced labour is prohibited and the same is made punishable in accordance with law (Article 23).
8. Article 24 prohibits employment of children (including the disabled) below the age of 14 years to work in any factory or mine or to be engaged in any other hazardous employment. Even a private contractor acting for the Government cannot engage children below 14 years of age in such employment.
9. Article 25 guarantees to every citizen (including the disabled) the right to freedom of religion. Every disabled person (like the non-disabled) has the freedom of conscience to practice and propagate his religion subject to proper order, morality and health.

10. No disabled person can be compelled to pay any taxes for the promotion and maintenance of any particular religion or religious group.
11. No Disabled person will be deprived of the right to the language, script or culture which he has or to which he belongs.
12. Every disabled person can move the Supreme Court of India to enforce his fundamental rights and the rights to move the Supreme Court is itself guaranteed by Article 32.
13. No disabled person owning property (like the non-disabled) can be deprived of his property except by authority of law though right to property is not a fundamental right. Any unauthorized deprivation of property can be challenged by suit and for relief by way of damages.
14. Every disabled person (like the non-disabled) on attainment of 18 years of age becomes eligible for inclusion of his name in the general electoral roll for the territorial constituency to which he belongs.

**Education Law for the Disabled**

- The right to education is available to all citizens including the disabled. Article 29(2) of the Constitution provides that no citizen shall be denied admission into any educational institution maintained by the State or receiving aid out of State funds on the ground of religion, race, caste or language.
- Article 45 of the Constitution directs the State to provide free and compulsory education for all children (including the disabled) until they attain the age of 14 years. No child can be denied admission into any education institution maintained by the State or receiving aid out of State funds on the ground of religion, race, caste or language.
- Various Acts
    - The Person with Disabilities Act, 1995
    - The Mental Health Act, 1987
    - The Rehabilitation Council of India, 1992
    - The National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation, and Multiple Disabilities Act, 1999
    - Declaration On The Rights Of Mentally Retarded Persons

**The persons with disabilities (PWD) (equal opportunities, protection of rights and full participation) act, 1995**

"The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995" had come into enforcement on February 7, 1996. It is a significant step which ensures equal opportunities for the people with disabilities and their full participation in the nation building. The Act provides for both the preventive and promotional aspects of rehabilitation like education, employment and vocational training, reservation, research and manpower development, creation of barrier- free environment, rehabilitation of persons with disability, unemployment allowance for the disabled, special insurance scheme for the disabled employees and establishment of homes for persons with severe disability etc.

**Main Provisions of the Act**

- Prevention and Early Detection of Disabilities
- Education
- Employment
- Non-Discrimination
- Research and Manpower Development
- Affirmative Action
- Social Security
- Grievance Redressal

**Prevention and early detection of disabilities**

- Surveys, investigations and research shall be conducted to ascertain the cause of occurrence of disabilities.
- Various measures shall be taken to prevent disabilities. Staff at the Primary Health Centre shall be trained to assist in this work.
- All the Children shall be screened once in a year for identifying 'at-risk' cases.
- Awareness campaigns shall be launched and sponsored to disseminate information.
- Measures shall be taken for pre-natal, peri natal, and post-natal care of the mother and child.

**Education**

- Every Child with disability shall have the rights to free education till the age of 18 years in integrated schools or special schools.
- Appropriate transportation, removal of architectural barriers and restructuring of modifications in the examination system shall be ensured for the benefit of children with disabilities.
- Children with disabilities shall have the right to free books, scholarships, uniform and other learning material.
- Special Schools for children with disabilities shall be equipped with vocational training facilities.
- Non-formal education shall be promoted for children with disabilities.
- Teachers' Training Institutions shall be established to develop requisite manpower.
- Parents may move to an appropriate forum for the redressal of grievances regarding the placement of their children with disabilities.

**Employment**

3% of vacancies in government employment shall be reserved for people with disabilities, 1% each for the persons suffering from:

- Blindness or Low Vision
- Hearing Impairment
- Locomotor Disabilities & Cerebral Palsy
- Suitable Scheme shall be formulated for
- The training and welfare of persons with disabilities
- The relaxation of upper age limit
- Regulating the employment
- Health and Safety measures and creation of a non- handicapping, environment in places where persons with disabilities are employed

Government Educational Institutes and other Educational Institutes receiving grant from Government shall reserve at least 3% seats for people with disabilities.
No employee can be sacked or demoted if they become disabled during service, although they can be moved to another post with the same pay and condition. No promotion can be denied because of impairment.

**Affirmative Action**

Aids and Appliances shall be made available to the people with disabilities.
Allotment of land shall be made at concessional rates to the people with disabilities for:

- House
- Business
- Special Recreational Centres
- Special Schools
- Research Schools

- Factories by Entrepreneurs with Disability,

**Non-Discrimination**

- Public building, rail compartments, buses, ships and air-crafts will be designed to give easy access to the disabled people.
- In all public places and in waiting rooms, the toilets shall be wheel chair accessible. Braille and sound symbols are also to be provided in all elevators (lifts).
- All the places of public utility shall be made barrier- free by providing the ramps.

**Research and Manpower Development**

- Research in the following areas shall be sponsored and promoted
- Prevention of Disability
- Rehabilitation including community based rehabilitation
- Development of Assistive Devices.
- Job Identification
- On site Modifications of Offices and Factories
- Financial assistance shall be made available to the universities, other institutions of higher learning, professional bodies and non-government research- units or institutions, for undertaking research for special education, rehabilitation and manpower development.

**Social Security**

- Financial assistance to non-government organizations for the rehabilitation of persons with disabilities.
- Insurance coverage for the benefit of the government employees with disabilities.
- Unemployment allowance to the people with disabilities who are registered with the special employment exchange for more than a year and could not find any gainful occupation

**Grievance Redressal**

- In case of violation of the rights as prescribed in this act, people with disabilities may move an application to the
- Chief Commissioner for Persons with Disabilities in the Centre, or
- Commissioner for Persons with Disabilities in the State.

**The Mental Health Act, 1987**

Under the Mental Health Act, 1987 mentally ill persons are entitled to the following rights:

1. A right to be admitted, treated and cared in a psychiatric hospital or psychiatric nursing home or convalescent home established or maintained by the Government or any other person for the treatment and care of mentally ill persons (other than the general hospitals or nursing homes of the Government).
2. Even mentally ill prisoners and minors have a right of treatment in psychiatric hospitals or psychiatric nursing homes of the Government.
3. Minors under the age of 16 years, persons addicted to alcohol or other drugs which lead to behavioral changes, and those convicted of any offence are entitled to admission, treatment and care in separate psychiatric hospitals or nursing homes established or maintained by the Government.
4. Mentally ill persons have the right to get regulated, directed and co-ordinated mental health services from the Government. The Central Authority and the State Authorities set up under the Act have the

responsibility of such regulation and issue of licenses for establishing and maintaining psychiatric hospitals and nursing homes.

5. Treatment at Government hospitals and nursing homes mentioned above can be obtained either as in patient or on an out-patients basis.
6. Mentally ill persons can seek voluntary admission in such hospitals or nursing homes and minors can seek admission through their guardians. Admission can be sought for by the relatives of the mentally ill person on behalf of the latter. Applications can also be made to the local magistrate for grants of such (reception) orders.
7. The police have an obligation to take into protective custody a wandering or neglected mentally ill person, and inform his relative, and also have to produce such a person before the local magistrate for issue of reception orders.
8. Mentally ill persons have the right to be discharged when cured and entitled to 'leave' the mental health facility in accordance with the provisions in the Act.
9. Where mentally ill persons own properties including land which they cannot themselves manage, the district court upon application has to protect and secure the management of such properties by entrusting the same to a 'Court of Wards', by appointing guardians of such mentally ill persons or appointment of managers of such property.
10. The costs of maintenance of mentally ill persons detained as in-patient in any government psychiatric hospital or nursing home shall be borne by the state government concerned unless such costs have been agreed to be borne by the relative or other person on behalf of the mentally ill person and no provision for such maintenance has been made by order of the District Court. Such costs can also be borne out of the estate of the mentally ill person.
11. Mentally ill persons undergoing treatment shall not be subjected to any indignity (whether physical or mental) or cruelty. Mentally ill persons cannot be used without their own valid consent for purposes of research, though they could receive their diagnosis and treatment.
12. Mentally ill persons who are entitled to any pay, pension, gratuity or any other form of allowance from the government (such as government servants who become mentally ill during their tenure) cannot be denied of such payments. The person who is in-charge of such mentally person or his dependents will receive such payments after the magistrate has certified the same.
13. A mentally ill person shall be entitled to the services of a legal practitioner by order of the magistrate or district court if he has no means to engage a legal practitioner or his circumstances so warrant in respect of proceedings under the Act.

**The Rehabilitation Council of India Act, 1992**

This Act provides guarantees so as to ensure the good quality of services rendered by various rehabilitation personnel. Following is the list of such guarantees:

1. To have the right to be served by trained and qualified rehabilitation professionals whose names are borne on the Register maintained by the Council
2. To have the guarantee of maintenance of minimum standards of education required for recognition of rehabilitation qualification by universities or institutions in India.
3. To have the guarantee of maintenance of standards of professional conduct and ethics by rehabilitation professionals in order to protect against the penalty of disciplinary action and removal from the Register of the Council
4. To have the guarantee of regulation of the profession of rehabilitation professionals by a statutory council under the control of the central government and within the bounds prescribed by the statute

**The national trust for welfare of persons with autism, cerebral palsy, mental retardation and multiple disabilities act, 1999**

1. The Central Government has the obligation to set up, in accordance with this Act and for the purpose of the benefit of the disabled, the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disability at New Delhi.
2. The National Trust created by the Central Government has to ensure that the objects for which it has been set up as enshrined in Section 10 of this Act have to be fulfilled.
3. It is an obligation on part of the Board of Trustees of the National Trust so as to make arrangements for an adequate standard of living of any beneficiary named in any request received by it, and to provide financial assistance to the registered organizations for carrying out any approved programme for the benefit of disabled.
4. Disabled persons have the right to be placed under guardianship appointed by the 'Local Level Committees' in accordance with the provisions of the Act. The guardians so appointed will have the obligation to be responsible for the disabled person and their property and required to be accountable for the same.
5. A disabled person has the right to have his guardian removed under certain conditions. These include an abuse or neglect of the disabled, or neglect or misappropriation of the property under care.
6. Whenever the Board of Trustees are unable to perform or have persistently made default in their performance of duties, a registered organization for the disabled can complain to the central government to have the Board of Trustees superseded and/or reconstituted.
7. The National Trust shall be bound by the provisions of this Act regarding its accountability, monitoring finance, accounts and audit.

**UN Declaration on the Rights of Mentally Retarded Persons**

This declaration on the rights of mentally retarded person's calls for national and international actions so as to ensure that it will be used as a common basis and frame of reference for the protection of their rights:

1. The mentally retarded person has, to the maximum degree of feasibility, the same rights as under human beings.
2. The mentally retarded person has a right to proper medical care, physical therapy and to such education, training, rehabilitation and guidance which will enable him to further develop his ability, and reach maximum potential in life.
3. The mentally retarded person has a right of economic security and of a decent standard of living. He/she has a right to perform productive work or to participate in any other meaningful occupation to the fullest possible extent of capabilities.
4. Whenever possible, the mentally retarded person should live with his own family or with his foster parents and participate in different forms of community life. The family with which he lives should receive assistance. If an institutional care becomes necessary then it should be provided in surroundings and circumstances as much closer as possible to that of a normal lifestyle.
5. The mentally retarded person has a right to a qualified guardian when this is required in order to protect his personal well-being or interests.
6. The mentally retarded person has a right to get protection from exploitation, abuse and a degrading treatment. If prosecuted for any offence; he shall have right to the due process of law, with full recognition being given to his degree of mental responsibility.
7. Whenever mentally retarded persons are unable (because of the severity of their handicap) to exercise their rights in a meaningful way or it should become necessary to restrict or deny some or all of their rights then the procedure(s) used for that restriction or denial of rights must contain proper legal safeguards against every form of abuse. This procedure for the mentally retarded must be based on an evaluation of their social capability by qualified experts, and must be subject to periodic review and a right of appeal to the higher authorities.

# UNIT 5

## Work, Occupation and Disability

In most of the developed world, the accepted definition of "elderly" or "older person" is the chronological age of 65 years minimum; there "is no United Nations standard numerical criterion, but the UN agreed cutoff is 60+ years to refer to the older population." The Government of India adopted the National Policy on Older Persons in January, 1999 and this policy defines "'senior citizen' or 'elderly' as a person who is of age 60 years or above.In India the elderly population accounted for 8.2% of the total population in 2011, and the number is expected to increase dramatically over the next four decades (to 19% in 2050).

## The International Classification On Disability

The International Classification of Functioning, Disability and Health (ICF) defines disability as an umbrella term for impairments, activity limitations, and participation restrictions. Disability has been defined as a restriction or lack of ability to perform an activity in the manner or within the range considered normal for a human being."

In India, the elderly people suffer from dual medical problems, i.e., both communicable as well as non–communicable diseases. This is further compounded by impairment of special sensory functions like vision and hearing. A decline in immunity as well as age-related physiologic changes leads to an increased burden of communicable diseases in the elderly

Elderly people are highly prone to mental morbidities due to ageing of the brain, problems associated with physical health, cerebral pathology, socio-economic factors such as breakdown of the family support systems, and decrease in economic independence. The mental disorders that are frequently encountered include dementia and mood disorders. Other disorders include neurotic and personality disorders, drug and alcohol abuse, delirium, and mental psychosis.

The elderly are also prone to abuse in their families or in institutional settings. This includes physical abuse (infliction of pain or injury), psychological or emotional abuse (infliction of mental anguish and illegal exploitation), and sexual abuse.

Persons with disabilities comprise at least 4 to 8 percent of the Indian population. Children with disabilities in India are subject to multiple deprivations and limited opportunities in several dimensions of their lives. Their families and caregivers also go through lot of stress and challenges in having a person with disability at home which ultimately leads to grave discriminatory practices towards these children.

Despite differing estimates, about 4-8% of the population in India are differently abled. One in every 10 children is born with or acquires a physical, mental or sensory disability.These translate into 40-90 million children's, which is a substantial number. Only 35.29% of all people living with disabilities have access to schools.

Despite improvement in the health care system in the country, the situation of differently abled children remains deplorable, particularly in rural areas and among the lower socio-economic population. Differently abled children in India are subject to multiple deprivations and limited opportunities in several dimensions of their lives. Some these include, not being enrolled to schools, lower employment rates, limited awareness of entitlements and services available and lack of social welfare support.

### Differently abled children are subjected to ugly forms of discrimination

Due to stigma associated with disabilities, families become victims of discrimination and human rights abuse. When poverty, physical neglect and social marginalization intersect, the impact on the disabled can be devastating. Differently abled children are kept hidden away at their home, denied basic rights of mobility, education and employment. They are viewed as dependent persons. Such discrimination in some

cases starts from the family members and spreads right up to the policy makers and state authorities. As a result of such discrimination the differently abled children's face chronic ill health, socio-economic burden and destitution. Sometimes it is so difficult to define the marginalization — they are outside the margin or within the community meaning, locked in the rooms, institutionalized, families isolating themselves, enrolling in special schools, not admitting that they have children with disabilities (CWDs), in the hospitals, etc.Social attitudes and stigma play an important role in limiting the opportunities of disabled people for full participation in social and economic life, often even within their own families.

**Denial of disability**

Predominantly in the cases of mental or intellectual disability, the family members are reluctant to accept the disability or refer to it as a physical illness and treatable condition. The pseudo-stigma attached to such disabilities, makes them hide the fact of having a disabled or challenged member at home ultimately leading to social isolation and restrictive behaviors.There is a fear that they would be victims of disgrace and indignity and thereby family members lose the status or acceptance they enjoy in the community. This denial becomes a hurdle for early identification and treatment.Such persons would be hidden somewhere and they expect, unrealistically, to overcome the situation without realizing the log term consequences of such self-imposed denial.

**Physical restraints**

Superstitions prevailing in the communities also play a big role in subjecting the people with disabilities to various harmful treatments. The black-magicians and quacks physically hurt people, subject them to food restrictions etc. Claiming to cure the “disability” leading to acquiring disability. Families often lock or chain their children with intellectual disability having behavioral issues, due to helplessness, ignorance and/or under social pressure.

**Social boycott**

It is preventing of CWDs participating in any social events. Even the family members of the disabled often tend to avoid such social gatherings in shame or fear that someone would ask about their family member with disability.Differently abled children's are not exposed to any social gathering, nor does our community recognize the need for children's participation.CWDs are not been given opportunities in the areas of education, training and employment. Under these circumstances it is natural that the CWDs feel rejected or unwanted in the society.

**Denial of property rights**

As per the Indian laws, all kith and kin in the family are eligible to get their share of inherited property, but in reality, persons with disabilities are denied these rights. The siblings take responsibility of providing care and they would enjoy the property meant for the person with disability. Families perceive that CWD are incapable of managing their property, they are denied of their property rights and made dependent on the able-bodied siblings.Worst of all would be when family members ensure the chronic condition of the disability by denying treatment or other aids, so that the siblings enjoy the property.

**Decreased marital life prospects due to a disabled member in the family**

In India the elders arrange majority of the marriages. If a family has person with disability, eligible boys and girls finding a prospective spouse is almost next to impossible because of the stigma and the disability being seen as a family illness. There are occasions where they hide the information and after marriage the problems erupts. It is also common a close relative getting pressurized to marry such a person.

Implications on sexuality of a person with disability

Sexual identity is a critical component of overall personality development and self-esteem, which matures during adolescence. CWDs are at a particular disadvantage in this regard as well. There is a strong attitude of overprotection toward the disabled child. Parents infantilize disabled children and imply that sex is only for the able-bodied and of no relevance to the disabled. These parental attitudes are transmitted to the child

in subtle ways making him/her feel that she/he is inferior and unworthy of love. Parents of CWDs encourage dependence and share the general societal perception of disabled persons as essentially child-like, innocent and asexual.

**Women with disabilities**

Due to differential gender-based role expectations, education is not considered a priority for disabled girls. Dropout rates for disabled girls are higher than for disabled boys.[7] There is an over-representation of disabled boys in education, both in special and mainstream schools. Parents become more protective and restrictive, especially after a disabled girl reaches puberty. Travelling to school is a huge problem, since, besides transport difficulties, the danger of sexual abuse and violation looms large. There is also the reasoning that there's little point investing in a disabled girl's education as they will anyhow never be able to earn.[17] Unfortunately a girl child with disability is seen as a lifelong burden on the natal family because marriage is not a realistic option. Hence, it is concluded to be economically unsound to invest in her education or vocational training.

When we analyzed the annual report of an NGO, we found that men and women with disabilities identified, enrolled in self-help groups was 60: 40 even though there is no difference in prevalence of disabilities among males and females.

**Discrepancies in state program**

Children with disabilities come under the purview of the ministry of social justice and empowerment. Some of the issues like prevention and curative aspects are dealt by the health ministry. However, no single ministry has taken the responsibility of meeting the holistic needs of CWDs. Disability continues to fall in the area of “social welfare”. Although efforts are on to bring it into the “rights” perspectives, the thinking process is dominated by the charity mode, while providing services for people with disabilities. As disability being state subject, each state have their own program for persons with disability, but none of the states are able to see in holistic needs of people with disabilities.

Some states have been pro-active in increasing awareness among people with disabilities about commitments and entitlements (Tamil Nadu, Karnataka, and New Delhi) whereas others have lagged in implementing many of the basic entitlements enshrined in the PWD Act of 1995 (Bihar, Maharashtra, Orissa, Uttar Pradesh).In Karnataka, disability welfare department introduced personnel at the panchayat like Village Rehabilitation Workers, and Multipurpose Rehabilitation Workers to meet the needs of people with disabilities in their respective jurisdictions. Similar program, are adopted in other states.

**Measurement of disability**

Worldwide it is accepted to use International Classification of Functioning (ICF), disability and health,known more commonly as ICF, as measurement for quantifying disability, classification of health and health-related domains. These domains are classified from body, individual and societal perspectives by means of two lists: A list of body functions and structure, and a list of domains of activity and participation. Since an individual's functioning and disability occurs in a context, the ICF also includes a list of environmental factors. Despite this common measurement tool for assessing disability are lacking. In some states Individuals with Disabilities Education Act/WHO Disability Assessment Schedule/ICF are used. Due to nonharmonization of assessment tools generating national statistics are difficult.

**Challenges In Disability Sector In India**

There are several unmet challenges, which need to be addressed among disability sector in India.

1. Need for dignified life for children and people with disabilities.
2. Need to remove attitudinal barriers among communities and provide rehabilitation of CWDs.
3. Need to improve infrastructures in mainstream schools to make them disabled friendly and train teachers for optimal support.

4. Need to converge between various departments providing services for CWDs.
5. Need for national harmonization of disability welfare program.
6. Need to give executive powers and necessary resources to the commissioner of disabilities for effective implementation and safeguarding rights of PWD.
7. Need for promoting and monitoring mechanisms for service outreach below district level.
8. Need to improve effective collaborations between Government and NGO to avoid duplications.
9. Need to adopt to a down to top approach in policy design.
10. Need to improve community participation programs.

**Community care for addressing discrimination against children with disabilities**

Disability sector has recognized the importance of dignity, respect, inclusion, participation, equalization of opportunities and empowerment as key issues of rehabilitation.[6,27,28] The negative attitudes and cultural representations of disability in society are challenged through vigorous awareness-generation and attitudinal change strategies. The issue of disability must consciously move beyond issues of special education and medical rehabilitation and be mainstreamed into other discourses such as the economy, polity, entertainment, sports, fashion and lifestyle.

During the last two decades, there has been a growing realization that institutional care for the disabled is not entirely suitable for their individual needs, dignity and independence. There has been relentless advocacy for community care despite the enormous stigma of having a disabled person at home.[3,29] In India, where family support is the norm and the only form of support available for thousands of years, community care is been thought as a suitable program for meeting the challenges in the disability sector.

**Community-based rehabilitation programs**

Community-based rehabilitation is implemented through a joint effort between people with disabilities, their families and communities, and the appropriate health, education, vocational and social services. CBR attempts to combine physical rehabilitation through medical care with empowerment and social inclusion. CBR depends heavily on the development of positive attitudes and approaches among the people involved.[30] Basic services are provided or facilitated by CBR workers who are minimally qualified, nonprofessionals, but who are highly qualified change agents from their own communities. CBR recognizes that breaking down barriers to inclusion in society is as important to the mission of the CBR program as is the functional rehabilitation of individuals with disabilities. Thus, the universal mission of CBR is to:

1. Enhance activities of daily life of disabled persons.
2. Create awareness in disabled person's environment to achieve barrier free situations around him and help him in meeting all human rights.
3. Create a situation in which the community of the disabled persons, participates fully and assimilate ownership of their integration in to the society. The ownership lies with the affected persons.[30,31,32]

Community-based rehabilitation is very appropriate in the Indian cultural setting, where social and community bonds are strong and deep-rooted. The challenge is to harness the potential of these bonds for rehabilitation related social action programs. Nevertheless, CBR programs need to draw their resources from existing community development programs and should integrate with them. The concept and practice of CBR has come down a long road in India. CBR builds on and validates existing indigenous knowledge and information systems, while facilitating access to relevant information and ideas from outside the community.The community-based rehabilitation (CBR) is a dynamic program globally for supporting differently abled children to lead better quality of life and lead life with dignity, where in their rights are

respected and guarded within their own communities and it creates platform for addressing the discriminatory practices in the community.

**The changing context of social work practice**

Working with the persons with disabilities can be an extremely rewarding area of work which involves supporting disabled people to lead fuller, more independent lives, taking up education and employment opportunities and contributing to their communities. People who have mental or physical disabilities often face a unique set of challenges in their everyday life.

The challenges individuals with disabilities face largely depends on their specific impairments as well as their severity.

This module explains the role of social work in addressing issues of persons with disabilities. At the end of this module, the student will be able to:

- Understand the relevance of social work practice in the field of disabilities
- Learn about the role of a social worker

2. Relevance of Social Work in the Field of Disabilities:

The people with disabilities and handicap have the same needs as others. They need friendship, a satisfying job, an adequate income, recreation and comfortable housing. Unfortunately, the prevailing social attitude towards them is unhealthy. This stems from the stigma attached to the family with a disabled member. Some families do not have the love and patience needed for such a person.

Originally a disabled person is the sole responsibility of the family. Now Government recognize their rights and make efforts to give formal and non formal education services for them. These services are provided by co-operative efforts between voluntary agencies and the ministries. Professional social work is based on problem solving and change management. Social worker utilizes a variety of skills, techniques and activities consistent with a holistic focus on disabled individuals and their environment.

The aim of social worker is to work in partnership with service users, families, careers, staff and service providers to identify needs, provide practical and emotional support and empower service users and their families to enhance their quality of life. Social work bases its intervention on a systematic body of evidence-based knowledge and practice.

The primary area of Social Work intervention is therapeutic work. Different therapeutic methods can be used by social workers such as casework, meditation, counseling, group work, crisis intervention, family therapy, solution focused Brief Therapy and Bereavement Work. Social workers work with individuals with a disability, with families who have a child or family member with a disability as well as with communities both domestically and internationally.

Our work in these spheres encompasses, direct practice, group work, community development, policy practice, research and advocacy. Social workers have played key roles in the development of antidiscrimination legislation, policies that support persons with disability and the development of disability programs. Social workers work alongside people with disabilities and families to realize social inclusion, community living, employment, family support, and rehabilitation Social work theory and practice in the field of disability has been greatly influenced by values and philosophy of the independent living movement.

This movement has shifted practice from creation of clients dependent on service controlled by professionals to work in partnership with the disabled people to secure their rights as equal citizens of the country

**Social work and the meaning of disability:**

The dominant view of disability in social work and social services has been the medical model, which views disability as a functional limitation, as individual ‘problem’, ‘pathology’, ‘dysfunction’, or ‘deviance’ (Brzuzy, 1997; Finkelstein, 1991). Oliver (1996) emphasized that the individual / medical model locates the

"problem" of disability within the individual and considers functional limitations or psychological losses to arise naturally from the individual deficit. This view is also called the personal tragedy theory of disability, which posits that disability is a natural disadvantage suffered by disabled individuals when placed in competitive social situations. Instead of viewing disability as inextricably linked to social, cultural and political milieu, the medical or personal tragedy framework infers that the disabled individual is plagued by deficits and is in need of medical fixing (Quinn, 1995b).

Social work also addresses the issue of grief, loss and bereavement associated with mental and physical disability. Disabled individuals are commonly depicted as suffering subjects, characterized by the devastating changes and crises for both themselves and their families. Recognizing, accepting and coming to terms with the disability are viewed as the targeted outcomes of social work intervention (e.g. Hartman, Macintosh, & Engelhardt, 1983; Krausz, 1988; Parry, 1980).

Social work has also addressed disability from an ecological or psychosocial perspective. Social workers have, indeed, articulated the importance of inclusion and accommodation for individuals with disabilities; however, they have largely stayed away from active involvement in the disability rights movement that has been initiated by people with disabilities and their advocates.

The strengths perspective assumes that strengths, such as talents, capacities, knowledge, and resources exist in all individuals and communities. With regard to disability, strengths perspective takes the view that disability is an opportunity for growth as well as a source of impairment.

As such, practice with people with disabilities attempts to take into account their abilities instead of disabilities in service planning, delivery, and assessment (Raske, 2005).." While disabled heroes can be inspiring to people with disabilities and comforting to the able-bodied, they may perpetuate the false notion that anyone can "overcome" the disability and accomplish unusual feats. As Wendell (1997) pointed out, most disabled heroes have exceptional social, economic, and physical resources that most people with disabilities do not have access to.

**Areas of Social Work Intervention in the field of Disability Social work practice with persons with disabilities includes the following key roles;**

- Maximizes clients' involvement in exploring an expanded range of options and choices;

• Prepares clients to be more effective in dealings with professionals, bureaucrats and agencies that often do not understand nor appreciate their need for self-determination; and At the organizing level, mobilizes and helps to empower groups of people with disabilities to consider policy and program alternatives that can improve their situation

• Social Work bases its interventions on a systematic body of evidence based knowledge and practice. The primary area of Social Work intervention is therapeutic work. Different therapeutic methods can be used i.e. Casework, Meditation, Counselling Group Work, Crisis Intervention, Family Therapy, Solution focused Brief Therapy and Bereavement Work. Central to the role of Social Work is developing and maintaining relationships with service users and their families. Social Work involves seeking, developing and delivering appropriate services to service users and their families / carers.

• Participation in Person-Centred Plans with service users their families and other team members.

• Administration and report writing. • Referral to and liaising with other relevant internal and external services and resources.

• Maintaining communication and networking with relevant people and services. • Advocacy and empowerment.

• Protection and welfare work.

• Empowering people to access information / service around entitlements benefits and legislation.

•Organising / Accessing residential and family based respite schemes and a range of home support services. • Facilitating access to Residential Care and Independent Living. 5. Other Areas of Social Work Involvement • Identifying gaps in current provision and seeing or developing new services.

• Highlighting inequality and working to bring about change in social policy, agency policy and societal attitudes. • Promotion of Equal Opportunities and nondiscriminatory practices.

• Developing and maintaining best practice in the field of disability in line with professional social workers association.

• Person Centered Plan enable people with a disability to direct the planning process to the greatest extent possible and make their own choices about how they wish to live their life, plan in a way that respects the needs of family members and careers and their role in the person's life, be assisted to identify goals and the way these can be achieved, explore supports that are flexible and wide-ranging and be included and fully participate in community life.

Person centered Plan may assist people with a disability to continue living in the community by providing a range of supports to maintain independence, keep living in their own home, move to more independent living arrangements, learn new skills and participate in the local community.

**CONCLUSION**

Community-based rehabilitation as a strategy helps to address the ugly forms of discrimination existing in the community. The strategy also focuses on enhancing the quality of life for CWDs and their families, to meet their basic needs and ensuring inclusion and participation in their own development and also participating in the community development. The CBR aims not only creates awareness about the rights of people with disabilities among the community members but also guarantees opportunities for their participation in social activities and also excising their rights with in their own communities rather than getting isolated into institutions. The CBR has become a multi-sectoral approach that empowers persons with disabilities to access and benefit from education, employment, health and social service.

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