Journal of Advances and Scholarly Researches in Allied Education

Vol. IV, Issue No. VIII, October-2012, ISSN 2230-7540

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AN INTERNATIONALLY INDEXED PEER REVIEWED & REFEREED JOURNAL

www.ignited.in

Journal of Advances and Scholarly Researches in Allied Education
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An Analysis upon Various Policies and Rehabilitation Needs of the Orthopedically Handicapped Persons in India

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Abstract – Disabled persons have traditionally been stigmatized by society. For long they have been subjected to systematic discrimination and neglect. Persons with disabilities must share the same rights as are enjoyed by all human beings. In this paper, we have discussed the sociological study of rehabilitation needs of orthopedically handicapped people in India.

In India, according to the census 2001, there were 21,906,769 thousand people with disability who constituted 2.13 percent of the total population. Out of 21,906,769 people with disabilities, 12,605,635 were males and 9,301,134 were females and these included persons with visual, hearing, speech, locomotors and mental disabilities. In contrast, the National Sample Survey Organization (NSSO) estimated that the number of persons with disabilities in India is 1.8 percent of the Indian population. The difference in the estimates of the census and NSSO for different types of disabilities can be explained by the lack of universal definition. The prevalence of disability is marginally higher among males than among females throughout the world. The understanding of various programmes and policies related to the rehabilitation and welfare for disabled people in India has been taken in detail. The Government of India has implemented numbers of policies and schemes for disabled people for their rehabilitation and education.

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INTRODUCTION

Rehabilitation is referring to the mental health of the orthopedically handicapped people and disability studies is a relatively new interdisciplinary academic field focusing on the roles of people with disabilities in history, literature, social policy, law, architecture, and other disciplines. Disabled persons have traditionally been stigmatized by society. For long they have been subjected to systematic discrimination and neglect. Persons with disabilities must share the same rights as are enjoyed by all human beings Disabilities commonly cause “a cycle of deconditioning” in which physical functioning deteriorates, leading to further reduction in physical activity levels . In India, there is no availability of complete statistics of the disabled but it is estimated that India has 100 million disabled people. According to the National Survey of 1991, there were approximately 16 million people with visual impairment, hearing impairment and locomotor disabilities in India in that year, constituting about 1.9 per cent of the population.3 In a separate survey of children below the age of 14 years with delayed mental development, it was found that 29 out of 1,000 children in the urban areas (2.9 per cent) and 30 out of 1,000 children (3 per cent) in the rural areas had developmental delays associated with mental disability .

The Constitution of India applies uniformly to all citizens of India whether or not they are healthy and normal or disabled (physically or mentally) and irrespective of their religion, caste, gender, creed etc. The only requirement is that the people to whom the Constitution will apply have Indian citizenship.

‘Disability’ has not been defined in the Constitution. But what has been said is that no citizen shall suffer any disability on the ground of his religious belonging, gender ,race, caste, sex, place of birth or any of them in regard to their access to public places, shops and the use of wells, tanks, etc. The Constitution has, however, described the following social groups as those for whom special legislations may be made without discriminating with the rest of the people of India. These are women, children and those belonging to the socially and educationally backward classes. The Constitution makers did not find it necessary to identify other social groups such as the aged or the disabled for whom separate legislation could be made. Under the Constitution the disabled

have been guaranteed the following fundamental rights:

1. The Constitution secures to the citizens including the disabled justice, liberty of thought, expression, belief, faith and worship, equality of status and of opportunity and for the promotion of fraternity just as it does for other citizens who are not disabled. Article 14 ensures that the State shall not deny to any person equality before the law or the equal protection of the laws within the territory of India.

2. Article 15(1) enjoins on the Government not to discriminate against any citizen of India (including the disabled) on the ground of religion, race, caste, sex, place of birth or any of them.

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. 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.

4. 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.

5. Every person including the disabled has his life and liberty guaranteed under Article 21 of the Constitution. All children of the age of six to fourteen years will be entitled to free and compulsory education provided by the state. (Article 21A).

6. 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).

7. 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.

8. 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.

9. No disabled person can be compelled to pay any taxes for the promotion and maintenance of any particular religion or religious group.

10. No disabled person will be deprived of the right to the language, script or culture which he has or to which he belongs.

11. 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,

12. 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.

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.

The disabled also have by implication certain rights which though not enforceable, provide effective guidelines for the government to make provisions including legislative provision for the disabled.

UNDERSTANDING REHABILITATION

Rehabilitation measures and outcomes - Rehabilitation measures target body functions and structures, activities and participation, environmental factors, and personal factors. They contribute to a person achieving and maintaining optimal functioning in interaction with their environment, using the following broad outcomes:

- Prevention of the loss of function
- Slowing the rate of loss of function
- Improvement or restoration of function
- Compensation for lost function
- Maintenance of current function.

Rehabilitation outcomes are the benefits and changes in the functioning of an individual over time that are

attributable to a single measure or set of measures. Traditionally, rehabilitation outcome measures have focused on the individual's impairment level. More recently, outcomes measurement has been extended to include individual activity and participation outcomes. Measurements of activity and participation outcomes assess the individual's performance across a range of areas – including communication, mobility, self-care, education, work and employment, and quality of life. Activity and participation outcomes may also be measured for programmes. Examples include the number of people who remain in or return to their home or community, independent living rates, return-to-work rates, and hours spent in leisure and recreational pursuits. Rehabilitation outcomes may also be measured through changes in resource use – for example, reducing the hours needed each week for support and assistance services.

The following examples illustrate different rehabilitation measures:

A middle-aged woman with advanced diabetes. Rehabilitation might include assistance to regain strength following her hospitalization for diabetic coma, the provision of a prosthesis and gait training after a limb amputation, and the provision of screen-reader software to enable her to continue her job as an accountant after sustaining loss of vision.

A young man with schizophrenia. The man may have trouble with routine daily tasks, such as working, living independently, and maintaining relationships. Rehabilitation might mean drug treatment, education of patients and families, and psychological support via outpatient care, community based rehabilitation, or participation in a support group.

A child who is deaf blind. Parents, teachers, physical and occupational therapists, and other orientation and mobility specialists need to work together to plan accessible and stimulating spaces to encourage development. Caregivers will need to work with the child to develop appropriate touch and sign communication methods. Individualized education with careful assessment will help learning and reduce the child's isolation.

Rehabilitation medicine - Rehabilitation medicine is concerned with improving functioning through the diagnosis and treatment of health conditions, reducing impairments, and preventing or treating complications. Doctors with specific expertise in medical rehabilitation are referred to as physiatrists, rehabilitation doctors, or physical and rehabilitation specialists.

Medical specialists such as psychiatrists, pediatricians, geriatricians, ophthalmologists, neurosurgeons, and orthopedic surgeons can be involved in rehabilitation medicine, as can a broad range of therapists. In many parts of the world where specialists in rehabilitation medicine are not available, services may be provided by doctors and therapists.

Rehabilitation medicine has shown positive outcomes, for example, in improving joint and limb function, pain management, wound healing, and psychosocial well-being.

Therapy - Therapy is concerned with restoring and compensating for the loss of functioning, and preventing or slowing deterioration in functioning in every area of a person's life. Therapists and rehabilitation workers include occupational therapists, orthotists, physiotherapists, prosthetists, psychologists, rehabilitation and technical assistants, social workers, and speech and language therapists.

Assistive technologies - An assistive technology device can be defined as "any item, piece of equipment, or product, whether it is acquired commercially, modified, or customized, that is used to increase, maintain, or improve the functional capabilities of individuals with disabilities" .

Common examples of assistive devices are:

- Crutches, prostheses, orthoses, wheelchairs, and tricycles for people with mobility impairments;
- Hearing aids and cochlear implants for those with hearing impairments;
- White canes, magnifiers, ocular devices, talking books, and software for screen magnification and reading for people with visual impairments;
- Communication boards and speech synthesizers for people with speech impairments;
- Devices such as day calendars with symbol pictures for people with cognitive impairment.

Assistive technologies, when appropriate to the user and the user's environment, have been shown to be powerful tools to increase independence and improve participation. A study of people with limited mobility in Uganda found that assistive technologies for mobility created greater possibilities for community participation, especially in education and employment. For people in the United Kingdom with disabilities resulting from brain injuries, technologies such as personal digital assistants, and simpler technologies such as wall charts, were closely associated with independence. In a study of Nigerians with hearing impairments, provision of a

hearing aid was associated with improved function, participation and user satisfaction.

Assistive devices have also been reported to reduce disability and may substitute or supplement support services – possibly reducing care costs. In the United States of America, data over 15 years from the National Long-Term Care Survey found that increasing use of technology was associated with decreasing reported disability among people aged 65 years and older.

Another study from the United States showed that users of assistive technologies such as mobility aids and equipment for personal care reported less need for support services. In some countries, assistive devices are an integral part of health care and are provided through the national health care system. Elsewhere, assistive technology is provided by governments through rehabilitation services, vocational rehabilitation, or special education agencies, insurance companies, and charitable and nongovernmental organizations.

Rehabilitation settings - The availability of rehabilitation services in different settings varies within and across nations and regions. Medical rehabilitation and therapy are typically provided in acute care hospitals for conditions with acute onset. Follow-up medical rehabilitation, therapy, and assistive devices could be provided in a wide range of settings, including specialized rehabilitation wards or hospitals; rehabilitation centers; institutions such as residential mental and nursing homes, respite care centres, hospices, prisons, residential educational institutions, and military residential settings; or single or multi-professional practices (office or clinic).

Longer-term rehabilitation may be provided within community settings and facilities such as primary health care centres, schools, workplaces, or home-care therapy services.

Needs and unmet needs - Global data on the need for rehabilitation services, the type and quality of measures provided, and estimates of unmet need do not exist. Data on rehabilitation services are often incomplete and fragmented. When data are available, comparability is hampered by differences in definitions, classifications of measures and personnel, populations under study, measurement methods, indicators, and data sources – for example, individuals with disabilities, service providers, or programme managers may experience needs and demands differently.

Unmet rehabilitation needs can delay discharge, limit activities, restrict participation, cause deterioration in health, increase dependency on others for assistance, and decrease quality of life. These negative outcomes can have broad social and financial implications for individuals, families, and communities.

SOME OF THE PROJECTS RUNNING IN INDIA

India was the first country in South Asia to become a signatory to the Proclamation on the Full Participation and Equality of People with Disabilities in the Asian and Pacific Decade of Disabled Persons 1993–2002. In January 1996, an Act of Parliament enabling implementation of this Proclamation was passed.

A. Viklang Sahayata Yojana

According to Viklang Sahayata Yojana, Helping the handicapped persons to fully participate in social and national life of the country is one of the important programmes of the Bharat Vikas Parishad. Beginning with the establishment of its first Viklang Centre in Delhi in 1990, there are now 13 Viklang Sahayata Kendras in various states, which provide artificial limbs free of cost to needy persons through their centres as well as by organising camps. These centres provide artificial limbs, calipers, hearing aids, medicines, special shoes, and tri- cycles. In addition, there are mobile workshops which manufacture artificial limbs and service Viklang Camps organised by various Branches. Some of the centres have taken up special programme to help polio victims by organising their operations.

B. Bharat Vikas Parishad Jana Seva Trust, Chennai

The Trust has launched a project to provide Titanium Prosthesis to cancer afflicted person's free of cost. These prosthesis help in avoiding amputation of God given limbs of the patient. The first patient got the prosthesis in October, 2009. Annually, about 10 to 12 patients would need this facility. The cost of prosthesis works out to Rs.35, 000 per limb, which is manufactured at DRDO, Hyderabad. This limb, if purchased from outside source, costs more than Rs. One Lakh .

C. ADD International

In India ADD International's work is focussed in rural areas of the four states of south India, working directly in three projects in Pudukottai district in Tamil Nadu; in Kolar district in Karnataka and Mahboobnagar district in Andhra Pradesh. These projects cover 1,776 villages reaching approximately 20, 0000 disabled people. Forty percent of the beneficiaries are disabled women, who are active members of the self-help groups. ADD India also works with other organisations giving their staff training in disability awareness and support in implementing it in their own projects.

A noticeable change in some parts of the world is the installation of elevators, transit lifts, wheelchair ramps and curb cuts, allowing people in wheelchairs and with other mobility impairments to use public sidewalks and public transit more easily and more safely.

IDENTIFICATION OF THE PROBLEMS OF THE DISABLED

Problems of the physically handicapped vary in time and space. Their problems are multi-dimensional physical, psychological, social, cultural, educational and vocational. Each category of the disability poses a different set of problems. The problems troubling the blind most are unknown to the disabled of other categories. Hence disabled themselves are blind to the problems of the blind. Problems of the persons with congenital deformity are different from those of the disabled by accident or disease caused later in life. Their problems vary with their place of residence - rural or urban. The problems experienced by disabled housewives are different from those of married disabled men. Age and sex of the disabled also have problems of their own type. A young unmarried disabled girl may experience problems totally unknown to an aged disabled male. Education, too, determines the nature of the problems faced by the disabled. For example, illiterates may face different problems than educated ones. Employment, again, is a decisive factoring determining the problems of the disabled. For example, a well-placed disabled may have least of social and psychological problems than his counter-parts seeking employment.

The problems relating to the handicapped people are in a cyclic order in relation to physical, educational, economic, social and psychological aspects. The existence of one problem becomes the root cause for the other which I further give rise to another and hence the cyclic order. For example, the social problems are relative to their economic status which further has dependence on education and the psyche of the disabled. As a child, a handicapped faces hardships at home and in society at large that breeds a complex psychological phenomenon. As one grows, educational process demands special characteristics and once into adulthood, economic problems cast their shadows largely resulting into psycho-social problems.

Problem of Physical Mobility - There are hundreds of activities which a person performs from the moment he wakes up in the morning till he goes to sleep at night. The activities comprise everything entailed in human life and relationships. Many of such activities require physical mobility of some degree or the other. A person with a normal body performs these activities without noticing the importance of mobility involved in the process. However, the physically handicapped person faces a great deal of uncertainty because of his restricted movements or limitation or the loss of locomotors abilities.

Educational Problems - Education moulds and builds a new and better society, a society that can face the challenges of life with courage and conscience. In spite of the UN proclamation of declaring 1992 as 'International Year of Literacy, illiteracy is particularly prevalent among disabled people and constitutes for them a double disadvantage. In addition to being disabled, they are isolated by illiteracy.3

Education is a link between medical and vocational rehabilitation which plays a vital role in the social rehabilitation of the disabled. It is more important than that of the muscular strength or swiftness in the movements of the joints in a body. It is that valuable tool with which the handicapped can conquer their disability. In it lies the greatest hope of overcoming physical handicaps. The education of the crippled child must follow the law of compensation i.e., the development of intellectual abilities to compensate for physical inadequacy".4 But a child who is born blind or crippled in the early life and who has to spend his prime years of schooling in getting strenuous, training for activities of daily living either at home or in some specialized institution, will have lesser opportunity to develop mental abilities, unless special effort is made to provide appropriate education for him. The child who learns walking with support at the age of seven, the child who utters the first word at the age of eight or the child who starts spelling at the age of nine cannot be expected to be normal in receiving education as his counterpart who starts walking, talking and writing at a much lower age. "Better late than never" applies fully when it comes to the education of the disabled.

Employment/Vocational Problems - The ancient physician, Galen, said as long back as 172 A.D. that “employment is nature's best physician and essential to human happiness work is more than an activity,”31 Work is often the measure of social as well as economic status. Occupation of a person is an important factor deciding the type of social life he/she can have. The social status of the individual depends upon the nature and type of job he is doing. By depriving the disabled individual of a job, society also deprives him of a 'congenial social life. The economic loss is, of course, always there. Work also has a psychological value. 'Time is a great healer', they say. But work is the greatest healer and quickest, of course. Work is a bridge spanning the gap between uselessness and usefulness, between hopelessness and hopefulness. A job to the disabled ensures him security and independence to counteract the feelings of insecurity and dependence that are commonly caused by his physical handicap.

Psycho-Social Problems - Educational and vocational problems of the physically handicapped, as discussed above, are relatively concrete and tangible problems which allow for objective assessment and analysis and, finally, look to be amenable to borne pragmatic resolution. However, of greater significance from the view-point of the social rehabilitation of the physically handicapped are the diffuse and relatively intangible problems - the

psycho-social problems - which have bearing on the inner affective world, the personal functioning and the overall adjustment of the physically handicapped to his, physical disability, as well as, interpersonal world which surrounds him. There are two main challenges before the physically handicapped individual: (a) how to come to terms with the specifically physical disability or impairment which creates many functional and psychological difficulties for him and (b) how to cope with the uncongenial attitudes of the society which tend to produce different types of complexes, conflicts and problems in his mind. He may perceive himself as 'damaged' or 'incomplete' person and develop feelings of inferiority, guilt and frustration. He may have fear of social ridicule as people find him different and unattractive. His limited sphere of social participation and inability to compete with his normal peers in social arena further undermines his self-rendering overall life adjustment difficult.

SERVICES RENDERED TO THE HANDICAPPED PERSONS BY THE VRCS

1. Interviewing adult handicapped persons for knowing their personal, social, family, educational, economic and vocational background causing adjustment problems.

2. Admission of the handicapped persons to examine medically to assess their physical efficiencies, measure their psychological strengths and weaknesses in respect of their intelligence, aptitude, areas of interest, psychomotor dexterity, personality traits and areas of adjustment.

3. Assessing the residual capacities, attributes, and functional skills different categories of handicapped.

4. Examination of the handicapped persons by a panel of medical specialists to identify the degree of disability and functional capacities and suggest remedial measures.

5. Testing of the handicapped persons on the job capabilities in different trades sanctioned under VRC's programs such as Electronics, Electrical, General Mechanic, Radio & TV repair, Commercial Practice, Air-conditioning & refrigeration, Automobile, Cutting and Tailoring, Computer Applications, Wood Work & Chair Canning, Arts & Crafts, Screen Printing, Photography, Metal Trades, Secretarial Practice, Painting, etc.

6. Imparting workshop training to develop vocational adjustment in respect of their work habits, on the job sustainability, to ensure their job adjustment best suited to their strengths and weaknesses.

7. Evaluating the handicapped clients at the Centre to assist them in preparing their vocational plan for enhancing their levels of knowledge & skills suited to local job market needs and also assisting, guiding and motivating them for diverting to self-employment.

8. Imparting in-plant training under the scheme of Ministry of Social Justice and Empowerment during which clients are given stipend to sustain their interest and motivation in the training.

9. Sponsoring and assisting the handicapped persons to utilize the facilities of reservations against the seats in various educational/training institutions.

10. Sponsoring the handicapped persons to the employers against vacancies notified to the VRCs and taking follow up action.

11. Recommending the handicapped persons for grant of loans by the concerned financial institutions under differential rate of interest or setting up of different ventures under various self-employment schemes.

CONCLUSION

To cater the needs and aspiration of different able-bodied people, various laws as well as policies have been formulated by the Governments of different countries. The efforts for the inclusion of disabled in the society from time to time have been taken. In India, where disability rate is very high as compared to other developing countries, efforts were made by the Government of India to include them into mainstream. Numbers of laws as well as policies and programmes have been made to fulfill the needs of this chunk of population.

In all areas, participation of disabled persons as role models, self-advocates and employed experts would increase quality and efficiency of the programs. Persons with disabilities should be included at all stages and levels and have distinct decision-making roles. The primary objective should be the improvement of the quality of life of persons with disabilities. "We have a moral duty to remove the barriers to participation for people with disabilities, and to invest sufficient funding and expertise to unlock their vast potential. It is my hope this century will mark a turning point for inclusion of people with disabilities in the lives of their societies".

In spite of these laws, policies and programmes large numbers of population is kept out of these programmes because of the faulty implementation of these policies and programmes. There are some centrally sponsored schemes with some minimum benefits to the disabled persons. But at the same time,

these are neither fully functional nor the entire disabled community has been covered. These facilities also do not have expert personnel, modern medical technology and other resources. The Government of India has implemented numbers of schemes for the education of disabled children. The principle aim of education policy of disabled children is to remove barriers to education and create an enabling environment.

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