

Factors Influencing Sexual Health of Persons with Disabilities in India

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Abstract

In India, the persons with disabilities are experiencing various forms of exclusion. This exclusion not only restrained their involvement in the developmental process of the country but also to a greater extent in personal and social life. The people with disabilities are also the normal humans and they too have sexual health needs. When these needs are not properly addressed, it further aggravates their disability. In this paper, the authors explained how the persons with disabilities in general are excluded from all important areas of life, social interactions such as friendships, marriages and parenthood. The paper also addressed about their exclusion in developmental activities i.e. in the areas of employment, earning money and maintaining control in their lives. The authors pointed out how different factors such as negative attitudes, poverty, lack of education and training and employment opportunities, non-removal of constraints/barriers with respect to accessibility of public facilities like technology, transport and movement etc., and abuse & violence in public and private places apart from lack of healthy human sexuality education that contributes to self sustainability and sexual empowerment of persons with disabilities. This paper also highlighted some of the strategies such as individual / self oriented, community oriented, socially & economic oriented, state and central policy planning and development oriented strategies that are required for sexual empowerment of disabled persons in India.

KEYWORDS : Disability, Sexuality, Education, Employment, Poverty and Attitudes

Introduction

The Registrar General of India (2001) highlighting the unreliability of the Indian data on disability, notes that it is well accepted that there are serious difficulties in carrying out a survey of persons with disabilities due to reasons such as the lack of well-trained field investigators and the reluctance on the part of families to disclose information about members with disability due to social stigma.

In a study of 1600 rural households in South India noted that “the factors that influenced the identification were: local perceptions and definitions of disability; social dynamics, particularly those of gender and age; ... type of disability and the associated social implications and stigma of that disability” (Kuruvilla & Joseph, 1999).

The current survey methods are unable to minimize and/or account for these factors. They are not only unsuccessful in providing a reliable picture of prevalence rates of disability, but there is also a greater likelihood of the identification and reporting of some easily identifiable impairments, while others get ignored, overlooked or hidden. Thus, it is difficult to state if differences in estimates provided by various data are 'real' differences in impairments or if these reflect differential reporting patterns due to reasons such as social roles, stigma etc. The lack of reliable estimates and underestimations impact on the kind of policies and provisions framed for people with disabilities. By considering the Government of India statistics on disability, local surveys, NCPEDP and WHO estimates, one can safely come to conclusion that 12 to 15 % of the Indian population is suffering with some form of disability or the other and they are experiencing in many forms of social exclusion. This exclusion not only restrained their involvement in the developmental process of the country but also to a greater extent in personal and social life. The people with disabilities are also the normal humans and they too have sexual health needs. When these needs are not properly addressed, it further aggravates their disability.

Sexuality is a normal part of development for all humans. Indian society often views sexuality of individuals with disabilities as a problem. As a result, these individuals' needs and rights are often ignored or denied. The level of discomfort experienced by the disabled people due to this is so high that even mild displays of affection, tenderness and simple human touch are sometimes discouraged.

Factors influencing Sexual Health of Persons with Disabilities

There are different factors that affect the sexuality and sexual health of the individuals with disabilities. They are - stereotypic attitudes, poverty, lack of education and training, employment opportunities, non-removal of constraints / barriers with respect to accessibility of public facilities like technology, transport and movement etc., and abuse & violence in public and private places apart from lack of healthy human sexuality education.

1. Stereotypic Attitude

The stereotyped and negative attitudes towards disabled people devalue the persons with disabilities. Much of the discrimination experienced by disabled people is based on an implicit notion that they are not same as other people and so cannot be expected to share the same rights and aspirations. The isolation and exclusion of disabled people even extends to mainstream disability movements, which deny their rights and identity.

Isolation and confinement based on culture and traditions, attitudes and prejudices often affect disabled people more than non-disabled people. This isolation of disabled people leads to low self-esteem and negative feelings. Lack of appropriate supportive services and lack of adequate education result in low economic status which in turn creates dependency on families or care-givers. Disabled women and men can experience different kinds of attitudes based on gender discrimination. Culture plays a big part in reducing disabled men / women's role in social, parental and economic life. Because disabled people are often excluded from society, the attitudes of the public are heavily influenced by how disabled people are portrayed in the media. Disabled people are seldom seen in ordinary roles as worker or mother or father.

Researches in the Western World have explored the attitudes of both caregivers and parents. The findings on caregivers' attitudes are inconsistent. Those working within institutions often recognize that sexual activity exists, but they do not necessarily condone it. Group home staffs are generally more liberal and accepting than institutional or nursing home staff (Brantlinger, 1983). The variation in caregivers' responses may be partially explained by such factors as the setting in which the caregiver works, the selection and phrasing of questions asked by the caregiver, and the area and country in which data are collected. For parents of children or adolescents with developmental disabilities, attitudes are influenced by concerns for the child's well being, lack of knowledge about how to provide sex education, and simple denial of the child's sexuality.

The common stereotypic attitudes that prevail among people about the sexuality of people who live with disabilities are: people with disabilities do not feel the desire to have sex, people with developmental and physical disabilities are child-like and dependent, people with disabilities are over-sexed and unable to control their sexual urges. In reality, people with disabilities are not asexual. All people including young people- are sexual beings, regardless of whether or not they live with physical, mental, or emotional disabilities. And, all people need affection, love and intimacy, acceptance, and companionship (Tepper, 2001 and; Ballan, 2001). At the same time, children and youth who live with disabilities may have some unique needs related to sex education. For example, children with developmental disabilities may learn at a slower rate than do their non-disabled peers; yet their physical maturation usually occurs at the same rate. As a result of normal physical maturation and slowed emotional and cognitive development, they may need sex education that builds skills for appropriate language and behavior in public (Tepper, 2001).

People with disabilities are childlike and dependent. This idea may arise from a belief that a disabled person is somehow unable to participate equally in an intimate relationship. Societal discomfort—both with sexuality and also with the sexuality of people who live with disabilities—may mean that it is easier to view anyone who lives with disabilities as an ‘eternal child.’ This demeaning view ignores the need to acknowledge the young person’s sexuality and also denies her/his full humanity. (Tepper, 2001; Ballan, 2001, Neufeld et al., 2002 and; Terry, 2001).

People with disabilities cannot control their sexuality. This stereotypic attitude spins off the other two—if people with disabilities are neither asexual nor child-like, then perhaps they are ‘oversexed’ and have ‘uncontrollable urges’. Belief in this stereotypic attitude can result in a reluctance to provide sex education for youth with disabilities. The reality is that education and training are keys to promoting healthy and mutually respectful behavior, regardless of the young person’s abilities. (Tepper, 2001).

2. Poverty

In any country, the odds are stacked against the disabled people in terms of provision of basic rights, such as a decent income, education, health care and employment. Disabled people in general are also grossly over-represented among poor people. There is

increasing evidence to suggest that being poor dramatically increases the likelihood of being born with impairment, it also increases the probability of becoming impaired and then disabled. This is not surprising as the poor have limited access to basic health care, have insufficient and/or unhealthy food, poor sanitation facilities, and an increased risk and likelihood of living and working in hazardous conditions. DFID notes that “disability is both a cause and consequence of poverty” (DFID, 2000, p.1). The World Health Organization (WHO, 1999) estimated that more than 500 million people, or 7- 10 percent of the world’s population is likely to be disabled by impairments that are preventable or treatable. This assertion is supported by a recent report “*The Indian Child*” (CRY, 2001) which lists factors such as communicable diseases, infections in early childhood, nutritional deficiencies, and inadequate sanitation as being the most significant factors causing disability in India. All these factors are preventable or treatable, but are most likely a reality for people living in poverty.

The vulnerability of those living in poverty thus continues to be very high. Brauholtz (2007) identifies two important exit routes for people living in poverty, namely high dependency by the chronically poor person on their own labour (in the absence of financial and material assets) and formal education, which improves the quality of their labor. In the case of individuals with disabilities, neither of these options seems viable. For example, people with disabilities are more likely to be prevented from becoming economically active, not because of the inherent quality of their condition, but more because of the discrimination and societal perceptions that they are likely to encounter related to their impairment. Similarly, limited opportunities (due to lack of trained teachers, restrictive curriculum, physically inaccessible buildings etc) and negative perceptions (stigma, low expectations etc) about their inability to participate in the formal education system, makes access to these institutions also very difficult. Thus, societal beliefs and norms may limit the possibilities of escape from poverty for this group of people. Also, they are at a greater risk of being systematically excluded from basic health care services, political and legal processes, pushing them into the margins of mainstream society.

Not only are poor people likely to be at a greater risk of impairments, but once disabled they are more likely to stay poor and are also at a greater risk of passing on this deprivation to their next generation. This cyclic relationship between disability and poverty results in a scenario where people with disabilities are usually amongst the poorest of the poor. World Bank estimates (Elwan, 1999) suggest that people with disabilities may account for as many as one in five of the world’s poorest. Yeo (2005) provides an even more disturbing picture, stating that, “50,000 people, including 10,000 disabled people, die every day as a result of extreme poverty”.

Indeed it would be immature to assume that all people with disabilities are always amongst the poorest in a community or indeed that the poorest are at the greatest risk of getting all impairments. With development there is an increase, rather than a decrease, in the proportion of population with disabilities, due to factors such as increased survival rates from disabling accidents and disease, and increasing life expectancy (Elwan, 1999). However, what cannot be overlooked is that a higher proportion of people with disabilities may experience severe and chronic poverty than the proportion of non-disabled people

(Yeo, 2001), in both developed and developing countries. Thus, Disabled people in general are deprived of getting even food, shelter and clothing.....and other basic needs that hinders the disabled people to think much about sexuality.

3. Environmental Barriers

Environmental barriers create disability, limit opportunities and deprive people of their human rights. Lack of environmental adjustments and the absence of accessible buildings hinder disabled people from enjoying freedom of movement around and between different countries and different parts of the built and natural environment.

Disabled women in particular lacks accessibility to services, such as refuges, rape crisis centers, health centers, family planning clinics, dress shops, hairdressers, etc. – which underlines the assumption that they are not really human beings, not interested in their appearance or in control of their own sexuality and health.

Accessibility to transport for all disabled people is an important key to the exercise of citizenship and participation in society. Disabled in general are less mobile than non-disabled people - less likely to have access to a car; more confined to the home due to social and cultural patterns and to the actual or perceived threat of danger, especially after dark. In most places, most disabled people cannot use public transport. Public transport is often inaccessible, uncomfortable and dangerous for disabled people traveling alone, particularly in India.

No access to transport has serious effects on disabled people's integration and economic activity. It prevents them forming self-help groups or taking control of their lives. Reasons for not providing accessible transport are generally based on cost and ignorance. Buildings ignore the existence of disabled persons. Public buildings are not accessible to move about from one floor to another floor. This is more in reality in India, both in public and private places. All these restricted environments curtail the freedom of disabled population to be social which in turn affects their interpersonal and intra-personal relationships that restrain them from healthy sexual life.

4. Education

Education is the key to the advancement of persons with disabilities as it provides access to information, enables them to communicate their needs, interests and experiences, brings them into contact with other people, increases their confidence and encourages them to assert their rights. Without a basic education, their chances for employment and other aspects of life are almost nothing.

There is a dearth of policies and programs that specifically address the educational needs of disabled people, and the failure of disability equity programs to serve them. Also the policies and programs in education for disabled people were more concentrating on residential special education centers, which segregates people with disabilities and promote only exclusion policies than inclusion.

When looking at the information on the educational participation of people with disabilities, the first problem is with the estimates of the number of children of school-going age with disabilities. The total population of children with disabilities in the 5 to 14 years age group estimates about 10.39 million i.e. 5 percent of the age group (Mukhopadhyay & Mani, 2002). In complete contrast, the Ministry of Human Resource Development, (2004) states that there are 1.6 million children with disabilities in the 6 to 14 years age group, while in 2005 the figure was 1.85 million children. Census figures from 2001, however, suggest that about 1.92 percent of the children of the 5-14 age groups have disabilities, at 3.88 million, while NSS figures are 3.12 million in 2002.

The second problem is that different sources generate very different estimates of the number of children with disabilities in school. The survey carried out by National Council for Educational Research and Training (NCERT, 1998) figures about 84,000 children with disabilities were enrolled in schools, also an unpublished data gathered for the Ministry of Human Resource and Development in 1999 suggested that approximately 55,000 children with disabilities were then enrolled in schools. Thus “the picture (of school enrolment for children with disabilities) is dismal” since (by these counts and using the highest estimate of the total population of children with disabilities) less than 1 percent of children with disabilities attend the school (Mukhopadhyay & Mani, 2002).

The Ministry of Human Resource Development, (2004) claimed that 1.08 million children with disabilities were being educated, and by using a very low estimate of the total number of children with disabilities, thus arriving at an estimate of 67.5 percent of children with disabilities receiving education and the position paper drafted by the NCERT (2005) notes that “the Office of the Chief Commissioner of Persons with Disabilities stated that not more than 4 percent of children with disabilities have access to education”. This contradicts to the figure using Census estimates for the total number of children with disabilities. These discrepancies are so huge – from less than 1 percent to over 67 percent – and so little information is provided in these sources about how the figures were calculated, that the obvious explanations (different definitions of disabilities, differences in what is considered to be education, whether enrolment or attendance data are used, and so on) are inadequate to make sense of what is going on.

Data gathered from the NSSO, (2003) 58th round survey (Jul- Dec 2002) suggest that about 45 percent of people with disabilities are literate. In contrast, the 2001 Census literacy rate of the total population is 64.8 percent. The NSSO data highlighted that 25 percent of the literate population with disabilities had received education up to the primary level, 11 percent up to the middle level, while a mere 9 percent continued up to or beyond the secondary level. In urban areas around 11 percent of those with disabilities in the 5 to 18 years age group were enrolled in special schools, while this was less than 1 percent in rural areas. This reflects the significant recent growth in the number of special schools, especially in urban areas. In the early 1990’s there were about 1,035 special schools (Ministry of Human Resource Development, 1992). Nearly a decade later it was estimated that there were about 2,500 special schools in the country (Rehabilitation Council of India, 2000). Most of these schools are in urban areas, with Mumbai having the highest number of schools (Mukhopadhyay & Mani, 2002). The rise of special schools has gone unchallenged

even though there is evidence from other countries that building such a parallel system will only perpetuate the continued exclusion of this group from mainstream society and support the continued fostering of stigma and prejudice.

Over the past decade or so there have been some important developments in the provision of educational opportunities for children and young people with disabilities. In 1987 the Integrated Education for Disabled Children (IEDC) scheme was launched at a national level. However, this scheme did not meet with much success as few people knew about the scheme and only a few children received any equipment and services, while teachers remained untrained and unable to respond to the needs of these children. In 1995 the education of children with disabilities came under renewed focus in the District Primary Education Programme (DPEP) and this has continued in the more recent Sarva Shiksha Abhiyan (SSA or Education for All).

The First Joint Review Mission of SSA in 2005 (Department of School Education and Literacy, 2005), referring to the education of children with disabilities, noted that “at the same time as invariably improving, coverage remains incomplete and an examination of the physical and financial progress reported by States thus far for the current year shows implementation to be poor, suggesting that this area is not receiving sufficient priority. Interventions reported tend to follow a medical model with attention to providing aids and appliances to physically challenged children”. Similar views were expressed in the Third Joint Review Mission for Bihar undertaken in Jan. 2006, where it was noted that while enrolment was being considered “attention will now need to be given to the provision of quality education to children with disabilities” (Department of School Education and Literacy, 2006).

The significant financial resources allocated to the SSA programme were actually a problem, noting that there is great pressure on education staff to spend, and be seen to be spending, their budgets. The result is that money is thrown at very visible and easy areas. Shiny new ramps and rails are a suitable quick fix (Thomas, 2005).

Still the education for persons with disabilities continues to be on identifying and assessing children with disabilities, and responding to their needs through the provision of assistive aids and appliances. This focus on changing structural issues, rather than reviewing the teaching and learning processes in the classroom, is rather limiting. The perception of disability being a problem which is located in the child and hence needs to be corrected still dominates and little focus is placed on examining the environmental factors that might be negatively impacting on the child’s ability to participate. Overall, the emphasis is primarily on giving access to children with disabilities, with little regard being given to their participation in the classroom, its culture or the curriculum (Singal, 2006 a, 2006 b).

While enrolments have seemingly increased for those with disabilities, data also suggest that only very few of them complete the primary cycle of education and even fewer make it to the secondary, let alone higher levels of education. This has a notable impact on their employment opportunities later in adult life, especially in the context of a rapidly

changing market economy. Primary education gives the basic three r's, rarely it provide skills necessary for employment—self employment or otherwise—that can ensure a reasonable level of wages and economic living (Tilak, 2005).

In the year 2003, the Ministry of Social Justice and Empowerment has introduced novel scheme of providing scholarships for people with disabilities to pursue higher education. The important feature of this programme is it reserves 50% of scholarships for women with disabilities. How much and how far this scheme have benefited the disabled women, any follow up services undertaken?

Thus the exclusion of persons with disabilities from education unarguably results in their exclusion from very significant opportunities for further development particularly reducing their access to vocational training, employment and social life.

5. Lack of Sex Education

According to a clinical report from the American Academy of Pediatrics (AAP), sexual development is intimately linked to the basic human needs of being liked and accepted, displaying and receiving affection, feeling valued & attractive and sharing thoughts and feelings. The World Bank, (2006), view that in addition to education and employment other important dimensions that are essential in the lives of young people are developing a healthy life style, beginning a family, and exercising citizenship. People with disabilities remain excluded from other important areas of social participation such as their rights to be an individual, a parent and to companionship that get overlooked.

Groce, (2004) notes that often health professionals refuse to provide reproductive health information to young people with disabilities because it is felt that they do not need it. Also evidence suggests that health care services have a very poor record in responding to the need of young people with disabilities. Mainstream sexual and reproductive health programmes do not consider their needs in the information provided and/or in the training of health workers.

According to the NSSO data (2002), 43 percent of people with disabilities have never married, while 39 percent are currently married, 15 percent are widowed and around 1 percent are divorced or separated. No differences between urban and rural areas were reported. Significantly, 27.8 percent and 32.4 percent of people with disabilities were never married in the ages above 15 years in rural and urban areas respectively. Information related to the current living arrangements of people with disabilities suggests that nearly 40 percent of people with disabilities were living with their parents without spouses (Zutshi, 2004).

Epstein and Johnson, (1998) point out that talking about sexuality and schooling in the same breath can be seen as disturbing in many societies. They suggest that this may be partly because schooling stands on the “public” side of the public/private divisions, while sexuality is definitely on the “private” side. This is more true in Indian culture.

The Supreme Court on 16 November, 2005 decided that sex education in schools cannot be brought under the ambit of fundamental rights by making it a part of the right to education. "We cannot make it (sex education) a fundamental right," a bench comprising Justice Ruma Pal and Justice A R Lakshmanan said while dealing with a Public Interest Litigation, which had suggested making sex education in schools compulsory. The NGO, Nari Raksha Samiti, had submitted that sex education in school curricula could play a role in checking the rise in rape cases. Though agreeing with the suggestion, the bench said it cannot be given the status of a fundamental right on the same footing as the right to education itself.

Hence, there is an urgent need to consider policies and programmes that will place greater emphasis on the participation of persons with disabilities in the mainstream education system. Certainly the challenges are great in imparting sex education to children with disabilities and without disabilities.

6. Employment

The ability and the opportunity to earn a livelihood – whether in a formal job or through some kind of self-employment – is an important determinant for an individual's well-being. In addition, and indeed apart from education, vocational training is an important way in which people with disabilities can become economically independent. While the Ministry of Labour has set up various Vocational Rehabilitation Centres (VRCs) only a small percentage of people with disabilities receive vocational training. In 2002 the figures were an appalling 1.5 percent and 3.6 percent of the people with disabilities in rural and urban areas respectively, who received any training. These figures have not changed much since 1991. Other government initiatives encourage people with disabilities to explore avenues for self-employment through schemes such as the Sampurn Gramin Swarozgar Yojana (SGSY). This scheme promotes self employment opportunities through self help groups and, according to official estimates, it has assisted 24,235 people with disabilities from 1999-2003 (Singh & Dash, 2005). Additionally, the National Handicapped Finance and Development Corporation (NHFDC) under the Ministry of Social Justice and Empowerment (MSJE) is involved in forwarding loans at low rates of interest for encouraging persons with disabilities to establish their own micro-enterprises either on an individual basis or by establishing self-help groups. However, there is no appreciable information to indicate how successful these attempts have been.

Since 1995, under the Persons with Disability Act (Ministry of Law and Justice, 1996), there has been a 3 percent reservation in all categories of jobs in the government sector and a strategy of giving incentives to private sector employers for promoting employment of people with disabilities.

Mitra and Sambamoorthi, (2006) using NSSO 2002 data, note that "among all working age persons with disabilities 37.6 percent were employed". Only 4.8 percent of all working age persons with disabilities 'salaried-wage employees', and in general, the chances of a persons with disabilities being in employment of any kind were roughly 60 percent of those of the general population.

In understanding work participation the type of impairment is also an important variable. NSSO, (2003) found 40 percent and 39 percent of people with locomotor impairments are not employed in rural and urban areas respectively. Approximately 60 percent and 52 percent of people with sensory impairments (hearing, visual and speech) are not employed in rural and urban areas respectively. Also mentally retarded are not employed in rural area and urban area at the percent of 82 and 80 percent respectively.

Data suggest that, across the board, irrespective of the type of impairments, most people with disabilities tend to be casual laborers, or attending domestic services or indeed begging. The 2001 Census reports that 52 percent of those not working are 'dependents', with another 15 percent engaged in 'household duties' and 25 percent 'students' (Registrar General of India, 2001, Table C 24).

Reporting the results a survey conducted of the top 100 companies by the NCPEDP during 1999, Zutshi, (2004) further noted that the average percentage of employees with disabilities in the public sector (23 companies) was 0.54 percent, in the private sector (63 companies) was 0.28 percent, and in multinationals (14 companies), 0.05 percent .

On the other side disabled women in particular, are not usually part of employment debates and initiatives. They are usually at least twice as unlikely as disabled men to get a job. For women with disabilities, this discrimination in employment sector is far greater. In situations where there is high unemployment, opportunities for remunerative work tend to be severely limited. When disabled women do find jobs, they receive considerably lower wages. Furthermore, in addition to the prejudice and discrimination barrier, the inaccessibility of the physical environment (e.g., buildings, roads, transport and toilet facilities) is a serious obstacle to disabled women working outside their homes. Since the lack of mobility limits disabled women from obtaining raw materials and marketing their products themselves, engaging in piece-work is the most common form of income-generation available to them. In addition, in working environment they are exposed to social stigma and stereotyping within their, which leads them to feel devalued, isolated, and ashamed.

Thus, apart from economic independence, work is an essential means of enabling a person to develop a sense of identity and self-esteem. Thus, **gainful employment** is an important means of promoting the social integration and sexual life of disabled people.

7. Abuse and Violence

There are different types of violence and abuses such as physical abuse, sexual assault, verbal abuse, emotional or psychological abuse, and neglect etc., these types of abuse can, and often do, occur together. For example, a girl with a disability may experience physical and verbal abuse. Leanne Cusitar (1994). Violence and abuse can happen when someone has power and control over a person with disability. The persons with disabilities are forced to face violence and abuse because of society's lack of understanding. Many people may think that girls with disabilities do not experience violence and abuse, but over two thirds of women with disabilities have been physically or sexually assaulted as children.

Vulgar Comments and negative attitudes can cause persons with disabilities to have a poor self-image. They many also feel helpless to change anything, or that they are not worthy of all the good things life has to offer. These feelings can make it more difficult to speak out against the violence. Girls and young women with disabilities experience higher rates of violence than non-disabled girls of the same ages because of the following factors.

- Disabled people may have many caregivers in their lives. The more people who are providing services for them, the more likely they are to experience abuse or violent actions against them. Power and authority is often used to punish persons with disabilities or control their behaviour.
- Due to limited sex education and isolation, some young people with disabilities may not understand what is happening to them in an abusive situation. They may not recognize it as abuse.
- People with disabilities may be isolated. They may not know where to go for help, who to talk to or what to do if they experience violence. Persons with disabilities who complain about abuse or violence many note be believed. Some people with disabilities who have experience violence are frightened. They fear that they will be separated from their families, or that they will lose need services.

The abuse and violence can happen anywhere in home, school, institutional settings, the doctor's office, work place, bus shelters, taxi etc., Family members or relatives, caregivers, doctors, friends, foster parents, neighbors, the loved person, teachers or strangers were some of the abusers.

Together, the various types of research strongly suggest that persons with disabilities experience higher rates of sexual harassment than their non-disabled peers, and that young women with disabilities experience higher rates than young men. Disabled persons who experience violence and abuse may feel much shame, guilt and self-hatred. They may have difficulty forming healthy relationships and knowing who to trust. They may experience depression or severe headaches, develop eating disorders or have difficulty concentrating. They may begin to drink alcohol or use drugs when they feel sad or when they don't want to remember things. Sometimes violence and abuse can worsen a disability, or even cause one. Thus, abuse and violence makes the disabled people hatred towards the any information related to social life, sex education, care givers, spouses etc., that isolate them from rest of the world.

Strategies to overcome the Problem Factors

A) Individual / Self oriented Strategies

Independent or self-determined living is the direct result of the self-advocacy of disabled people and should usually operate through local, non-residential centers of enablement. It is fundamentally important to stress that these centers should be under the direct control of disabled people themselves, to provide the necessary support and services

they require to lead fully independent lives, and to become fully participating members of an integrated community.

B) Community oriented Strategies

i) Family

- Families with disabled members should be provided with education about the needs and rights of disabled people and resources should be available for support in the community.
- The siblings, parents, grand parents should create an opportunities to learn healthy sexual behaviors in the disabled population.

ii) Schools

Accessible and relevant information on every subject is vital to disabled people. Similarly, accurate information about disability issues is vital to the community as a whole. The majority of disabled people do not receive an adequate education, due to access difficulties and prejudice, and this contributes considerably to their marginalization and exclusion. Investment in disabled people's education benefits the whole society.

- Increase the opportunity for education and training for disabled women.
- Schools should develop, widely disseminate and strictly enforce a policy prohibiting sexual harassment.
- Careful screening, training and supervision of service employees is needed especially those involved in the bodily care of students with disabilities.
- Comprehensive sexuality education should be offered to persons with disabilities.

iii) Society

Some of the social initiatives to promote healthy sexual life in disabled population are

- A scientific survey is needed to identify the different categories of disabled people living and working in the country as a whole by number, sex, age, family status, employment opportunities, health and education.
- Raise international, regional, national and local awareness of the issues affecting people with disabilities.
- Increase participation of people with disabilities in their communities and within disability organizations.
- Include disabled people in the mainstream disability movement to ensure full participation in development.

- Change societal attitudes and prejudices, and those of families and governments which stereotype disabled people through rally's and media.
- Increase access to services, facilities and transportation.
- Disabled people should be encouraged to form local groups and self-help organizations, which will help them to increase their self-esteem.
- Designers, architects, builders and engineers should design the buildings, toilets in such a manner that those are barrier free. An orientation regarding least restrictive environment should be given.
- Media campaigns should be organized to make the public aware of the needs and abilities of disabled people.
- Disabled people must be considered in all mainstream policy decisions and programmes. They form a significant part of every other group in society - such as refugees, children, and racial minority groups. Until disabled people are seen as an integral part of their communities and societies, with adequate provision for their needs within a community setting, the vast majority of the world's disabled women will remain isolated and destitute.

C) Socially / Economic oriented Strategies

- Income generation is the solution to poverty for disabled people. Through projects that generate a livelihood for individuals, disabled people are able to contribute to the economy of the community. Income generation projects bring improvements to all aspects of disabled people's lives. They increase skills, allow social interaction and independence, give a new role and status to disabled people within family and community. They require funding to start and expand but returns are considerable, not just in financial terms.
- Economic autonomy is, therefore, a key element of rehabilitation. Programmes must help disabled people to become economic contributors to their families and society.

D) State and Central Policy Planning Strategies

The state and central policies play a vital role in the equality improvement of people with disabilities. In this respect the following are some of the strategic quos one can adopt for better State and Central policy planning.

- Sexual empowerment of disabled people is possible only with the collaboration work of disabled people themselves, family members including parents, teachers, school management, social workers, policy makers, health care professionals (doctors, therapist etc.,). At present, all the parties at best defer to the other or at worst do not address the issue until some developmental crisis ensues.

- The school and parents need to work together to develop a living atmosphere which offers optimal opportunities for the social /sexual development of each disabled people as a unique individual personality. As with all areas of learning, perhaps even more so in the area of social/sex education, the need to balance staff expertise with parental cultural and/or other beliefs and with the uniqueness of each individual person with disabilities is essential for optimal growth in this area.
- Schools, group homes, residential facilities, and agencies who provide services to persons with disabilities should develop policies which outline clearly individual rights and staff and client responsibilities in the area of social/sex education and behaviors.
- In-services and trainings for both parents and staff should be offered to clearly communicate that the goals of the school or agency, as with all other areas of learning is to enable the disabled people to achieve the fullest level of social/sexual independence as possible.
- A clearly defined policy, developed wherever possible with the input and review of staff, parents, and consumers, should outline not only the school or agency's philosophy, but even more importantly the roles and responsibilities of the child, youth, or adult with disabilities and the staff to enhance social/sexual learning.

E) Development oriented Strategies

- Social /sex education continues to be a controversial and generally ignored part of curricula and training materials for people with disabilities. A proactive approach needs to be implemented in teaching social/sexual skills to persons with disabilities. The first step in developing and implementing a social / sex education program for disable people is to clarify our own personal values and attitudes toward sexuality and sexuality for the disabled.
- Disabilities and impairments may severely limit access to both incidental and direct social/sexual learning's and opportunities. The role of parents and staff is to mediate, facilitate, clarify, and provide opportunities for social/sexual learning for persons with disabilities. Attention should be given in developing self esteem and access to social / sexual learning opportunities. Parents and staff's role is to seize and create optimal moments for social/sex education within the real life experiences of persons with disabilities.
- Program planning and implementation need to consider the functioning level of persons with disabilities, their present and future living situation, and the utilization of appropriate communicative and interactive techniques.
- Schools and community agencies serving persons with disabilities should develop policy statements which facilitate opportunities for persons with disabilities to access their social/sexual rights and responsibilities to their fullest potential.

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