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Vulnerability Of Disable Persons With Formidable Barriers, Policies For Inclusion And Accessibility On An Equal Level For Complete And Effective Participation In The Workplace

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Abstract

Disability means physical or mental impairment which has a substantial and long-term adverse effect on her or his ability to carry out normal day-to-day activities. It is the loss or limitation of opportunities to take part in society on an equal level with others due to social and environmental barriers. In the medical model, individuals with certain physical, intellectual, psychological and mental conditions (impairment) are regarded as pathologic or abnormal; it is simply the abnormality conditions themselves that are the cause of all restrictions of activities. In contrast, the social model shifts the focus to the society; undue restrictions on behaviour of persons with impairment are seen to be imposed by dominant social, political, and economics ideologies; cultural and religious perceptions regarding persons with disabilities; paternalism in social welfare systems; discriminations by society; the inaccessibility of the environment and information; and the lack of appropriate institutional and social arrangements. Persons with disabilities are often among the most vulnerable in society, and typically face more formidable barriers to transport, housing, and other services. The key to social inclusion for people with disabilities is the creation of a barrier-free environment that may prevent individuals with disabilities from participating fully and effectively in the workplace. The most important reason for the de facto inequality of persons with disabilities is the existence of numerous social barriers in society, which prevent, on the one hand, access to basic urban and social resources and, on the other, the possibility of being included in social ties and interactions to the same extent as other people. These barriers lead to social exclusion and social dependence, and have a negative impact on both the quality of life of people with disabilities and on relations with persons with disabilities in local communities. 15 per cent of the world's population who live with a disability, (many of whom live in urban areas), available evidence reveals a widespread lack of accessibility to built environments, from roads and housing, to public buildings and spaces and to basic urban services such as sanitation and water, health, education, transportation, and emergency and disaster response and resilience building and access to information and communications. These accessibility limitations contribute greatly to the disadvantage and marginalization faced by persons with disabilities, leading to disproportionate rates of poverty, deprivation and exclusion. Accessibility established as a cross-cutting issue enables persons with disabilities to live independently and participate fully in all aspects of life.

Key words: Disability; Barriers; Exclusion: Inclusion; Accessibility; Society

Introduction

Disability means physical or mental impairment which has a substantial and long-term adverse effect on her or his ability to carry out normal day-to-day activities. In short, this definition says that disability is activity restricted by impairment. Disability is the result of negative interactions that take place between a person with impairment and her or his social environment. It is the loss or limitation of opportunities to take part in society on an equal level with others due to social and environmental barriers (Northern officers Group; Gazette of India, 2016).

In India different definitions of disability conditions have been introduced for various purposes, essentially following the medical model and, as such, they have been based on various criteria of ascertaining abnormality or pathologic conditions of persons. In absence of a conceptual framework based on the social model in the Indian context, no standardization for evaluating disability across methods has been achieved. In common parlance, different terms such as disabled, handicapped, crippled, physically challenged, are used inter-changeably, indicating noticeably the emphasis on pathologic conditions (PWD Act, 1995). Through the Act is built upon the premise of equal opportunity, protection of rights and full participation, it provides definitions of disabled person following the medical model.

According to the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation Act, 1995), "Person with disability" means a person suffering from not less than forty per cent of any disability as certified by a medical authority (any hospital or institution, specified for the purposes of this Act by notification by the appropriate Government). As per the act "Disability" means - (i) Blindness; (ii) Low vision; (iii) Leprosy-cured; (iv) Hearing impairment; (v) Loco motor disability; (vi) Mental retardation; (vii) Mental illness, which were defined as below. "Blindness" refers to a condition where a person suffers from any of the following conditions, (i) Total absence of sight. (ii) Visual acuity not exceeding 6/60 or 20/200 (snellen) in the better eye with correcting lenses; (iii) Limitation of the field of vision subtending an angle of 20 degree or worse; "Person with low vision" means a person with impairment of visual functioning even after treatment or standard refractive correction but who uses or is potentially capable of using vision for the planning or execution of a task with appropriate assistive device; "Leprosy cured person" means any person who has been cured of leprosy but is suffering from- (i) 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; (ii) Manifest deformity and paresis; but having sufficient mobility in their hands and feet to enable them to engage in normal economic activity; (iii) Extreme physical deformity as well as advanced age which prevents him from undertaking any gainful occupation, and the expression "leprosy cured" shall be construed accordingly; "Hearing impairment" means loss of sixty decibels or more in the better ear in the conversational range of' frequencies; "Loco motor disability" means disability of the bones, joints muscles leading to substantial restriction of the movement of the limbs or any form of cerebral palsy; "Mental retardation" means a condition of arrested or incomplete development of mind of a person which is specially characterized by sub normality of intelligence; "Mental illness" means any mental disorder other than mental retardation; However, these definitions were not found to be useful even for enumerating the disabled population, particularly in Population Census process for a large population like that of India (UNICEF, 2006).

Definitions adopted for Population Census (Census of India 2001) document mentioned "Defining and measuring disability is a complex issue and it is not easy to communicate these concepts during the census process, in which only a limited amount of questioning time is possible to be spent with a household for obtaining detailed information on every individual." With regard to definitions adopted by PWD Act, Census of India stated "the concepts and definitions of disabilities coupled with measuring its extent and its types (PWD Act, 1995) were found to be extremely difficult to canvass even in normal circumstances assuming people had time, were willing and forthcoming to share this information and there was an expert investigator to elicit this information." Census therefore used its own version of definitions of disabilities. Census of India 2001; defined five types of disabilities:- (i) seeing, (ii) speech, (iii) hearing, (iv) movement, and (v) mental.

Seeing disability: A person who cannot see at all (has no perception of light) or has blurred vision even with the help of spectacles. A person with proper vision only in one eye was also treated as visually disabled. A person may have blurred vision and had no occasion to test whether her/his eyesight would improve by using spectacles - such persons were treated as visually disabled. Speech disability: A person who is dumb or whose speech is not understood by a listener of normal comprehension and hearing, was considered to have speech disability. Persons who stammer but whose speech is comprehensible were not classified as disabled by speech. Hearing disability: A person who cannot hear at all (deaf), or can hear only loud sounds was considered to have hearing disability. A person who is able to hear using hearing aid, was not considered as disabled under this category. If a person cannot hear through one ear but her/his other ear is functioning normally, she/ he was still considered to have hearing disability. Movement Disability: A person, who lacks limbs or is unable to use the limbs normally, was considered to have movement disability. Absence of a part of a limb like a finger or a toe was not considered as disability. However, absence of all the fingers or toes or a thumb make a person disabled by movement. If any part of the body is deformed, the person was also treated as disabled and covered under this category. A person, who cannot move herself/himself without the aid of another person or without the aid of stick, etc., was treated as disabled. Similarly, a person who is unable to move or lift or pick up any small article placed near her/him was also treated as disabled in movement. A person, who may not be able to move normally because of problems of joints like arthritis and has to invariably limp while moving, too was considered to have movement disability. Mental disability: A person who lacks comprehension appropriate to her/his age was categorized as mentally disabled. This would not mean, however, that if a person is not able to comprehend her/his studies appropriate to her/his age and is failing to qualify her/his examination, she/ he was considered mentally disabled. Mentally retarded and insane persons were treated as mentally disabled. A mentally disabled person generally has to depend on her/his family members for performing daily routine. In Population Census, if a person suffered from two or more types of disability, only one of them was recorded. In all such cases it was left to the respondent to decide as to understand which type of disability the person should be categorized (Muzamil Jan, 2008, UNICEF,2006). The definitions, concepts and instructions were designed in such a manner that the question on disability can be canvassed appropriately without hurting the sentiments or feelings of the informant with a view to have good chances of netting the disability characteristics of the population.

Definitions adopted for NSSO Survey on Disability undertook a comprehensive survey of disabled persons for the first time in its 36th round during the second half of 1981, the International Year of the Disabled Persons. After a gap of ten years, a second survey on the disabled was carried out in the 47th round during July-December 1991 at the request of Ministry of Social Welfare, Govt. of India. In these surveys, the objective was to provide the database regarding the incidence and prevalence of disability in the country and the basic framework of these surveys viz., the concepts, definitions and operational procedures were kept the same. Prior to 1981, NSS surveys were restricted to only the physically handicapped persons. Since NSS 36th round (1981) an extended definition was used to cover all persons with one or more of the three physical disabilities – visual, communication (i.e. hearing and/ or speech) and loco-motor. The particulars of disability of the disabled persons, such as, the type of disability, degree of disability, cause, age at onset of disability, type of aid/appliance used, etc. were collected along with some socio-economic characteristics. Also, data on developmental milestones and behavioral pattern of all children of age 5-14 years were collected, regardless of whether they were physically handicapped or not. The third and the latest comprehensive survey on the disabled persons was carried out in the NSS 58th round (July-December 2002), where the coverage was extended to include mental disability also, keeping all other concepts, definitions and procedures for physical disability same as those of the 47th round. The broad definitions adopted for collection of data pertaining to this survey on disability were as follows: Disability: A person with restrictions or lack of abilities to perform an activity in the manner or within the range considered normal for a human being was treated as having disability. It excluded illness/injury of recent origin (morbidity) resulting into temporary loss of ability to see, hear, speak or move. The NSS definition of disability was much closer to the social model. However, the scope of the definition was not translated in questionnaire designing in compliance with CRPWD and as a

result of that, could not fully capture the population that the core definition meant to cover (UNICEF,2006; UNESCO, 2020). Mental disability: Persons who had difficulty in understanding routine instructions, who could not carry out their activities like others of similar age or exhibited behaviours like talking to self, laughing/ crying, staring, violence, fear and suspicion without reason were considered as mentally disabled for the purpose of the survey. The "activities like others of similar age" included activities of communication (speech), self-care (cleaning of teeth, wearing clothes, taking bath, taking food, personal hygiene, etc.), home living (doing some household chores) and social skills. Visual disability: By visual disability it was meant loss or lack of ability to execute tasks requiring adequate visual acuity. For the survey, visually disabled included (a) those who did not have any light perception - both eyes taken together and (b) those who had light perception but could not correctly count fingers of hand (with spectacles/ contact lenses if he/ she used spectacles/ contact lenses) from a distance of 03 metres (or 10 feet) in good day light with both eyes open. Night blindness was not considered as visual disability. Hearing disability. This referred to persons' inability to hear properly. Hearing disability was judged taking into consideration the disability of the better ear. In other words, if one ear of a person was normal and the other ear had total hearing loss, then the person was judged as normal in hearing for the purpose of the survey. Hearing disability was judged without taking into consideration the use of hearing aids (i.e., the position for the person when hearing aid was not used). Persons with hearing disability might be having different degrees of disability, such as profound, severe or moderate (UNICEF, 2006; UNESCO, 2020). A person was treated as having 'profound' hearing disability if he/she could not hear at all or could only hear loud sounds, such as, thunder or understands only gestures. A person was treated as having 'severe' hearing disability if he/she could hear only shouted words or could hear only if the speaker was sitting in the front. A person was treated as having 'moderate' hearing disability if his/her disability was neither profound nor severe. Such a person would usually ask to repeat the words spoken by the speaker or would like to see the face of the speaker while he/she spoke or would feel difficulty in conducting conversations. Speech disability: This referred to persons' inability to speak properly. Speech of a person was judged to be disordered if the person's speech was not understood by the listener. Persons with speech disability included those who could not speak, spoke only with limited words or those with loss of voice. It also included those whose speech was not understood due to defects in speech, such as stammering, nasal voice, hoarse voice and discordant voice and articulation defects, etc. Loco-motor disability: A person with - (a) loss or lack of normal ability to execute distinctive activities associated with the movement of self and objects from place to place and (b) physical deformities, other than those involving the hand or leg or both, regardless of whether the same caused loss or lack of normal movement of body – was considered as disabled with loco-motor disability. Thus, persons having locomotor disability included those with (a) loss or absence or inactivity of whole or part of hand or leg or both due to amputation, paralysis, deformity or dysfunction of joints which affected his/her "normal ability to move self or objects" and (b) those with physical deformities in the body (other than limbs), such as, hunch back, deformed spine, etc. Dwarfs and persons with stiff neck of permanent nature who generally did not have difficulty in the normal movement of body and limbs were also treated as disabled.

In NSS surveys since the data are collected by the non-medical investigators, it is imperative to define disability in a very careful and guarded way to minimize the bias of the investigators and respondents. To minimize these difficulties and to involve feasible and practical concepts and definitions of disability, the experts from the relevant medical disciplines were consulted. Moreover, besides the socio-economic characteristics, information on cause of disability, age at onset, degree of disability, treatment undergone, aids/ appliances acquired etc. was collected for each of the disability separately for the persons suffering from one or multiple types of disability. In the case of loco motor disability, a person suffering from multiple types of loco motor disability was considered to have multiple disabilities.

Technical Advisory Committee on Disability Statistics A Technical Advisory Committee (TAC) on Disability Statistics was constituted by the Ministry of Statistics & Programme Implementation in the year 2005. The Committee was entrusted with the work to review the conceptual framework and definition for the measurement of disability and to examine the reasons of variations in the estimates of disability as obtained from NSSO 2002, Survey and Census 2001. The Committee deliberated on the various aspects of the disability statistics including reasons for variations in the estimates of disability as available from the two sources of the data. a) Analysis of variation in definitions The Persons with Disability (PWD) Act, defines disability in terms of extent of impairment of body structure and body function. The context in which the definitions of disability and categories therein are being examined here relates to the classification of person, as disabled or not, by an enumerator who is given a short training in concepts and definitions. Therefore, the definitions under PWD Act need to be converted into definitions, which are simple and tangible from the point of view of the enumerator as well as the respondents. The NSS definition of disabled person i.e. 'A person with restrictions or lack of abilities to perform an activity in the manner or within the range considered normal for a human being' seems to be in order provided the deviation from normal manner is defined in a manner suitable to the above context. The above general definition of disability is based on activity limitation in execution of usual task and not the deviation from the accepted standard of biomedical status of the body of a person. This criterion has been used in examining the category-wise definitions and on the appropriateness of a definition. The definition used under population census limits mental disability to as characterized by sub normality of intelligence and thus, covers only 'Mental Retardation' category of the PWD Act.

On the other hand, NSS definition covers sub-normality of intelligence (as difficulty in understanding routine instructions) and goes further in an attempt to cover mental disability other than 'Mental retardation' by adding other characterization of the behaviours like talking to self, laughing/crying, staring, violence, fear and suspicion without reason. As NSS definition seems to be more comprehensive/ inclusive, although NSS 2002 figure of number of mentally disabled was less than the Census 2001 figure. However, in contrast to other categories of disability these figures obtained from two sources were close to each other. Visual Disability: Except including a person with proper vision only in one eye (Population Census) the definitions of Census and NSS are similar in practical terms. NSS has used the counting of fingers as practical measure to verify the blurred vision. Classifying person with proper vision only in one eye as disabled, is not in accordance with the PWD Act. Besides, categorization of a person as disabled is primarily based on activity limitation in execution of usual task in environment relevant to the person and not the deviation from the accepted standard of biomedical status of the body of a person. Inclusion of person with proper vision only in one eye under 'Visually disabled' is not in accordance with this criterion. As expected, the Census 2001 figure (10.64 million visually disabled person) is higher than the NSS estimate (2.83 million). The high extent of difference is not justifiable due to inclusion of 'one eyed' category only. It may be that many two eyed persons also suffer from low or lack vision in one of the eye due to some internal injury/defect which is not noticed by others from outside. Hearing Disability: Census and NSS definition differ in following respect). A person with only one ear functioning normally is classified as disabled in Census but not under NSSO survey. b) Under 'Moderate' disability NSS includes as disabled a person who would normally ask to repeat the words spoken by the speaker or would like to see the face of the speaker while he/ she spoke or would feel difficulty in conversations. PWD Act, 2016 does not classify a person as suffering from 'Hearing Impairment' if he/ she have one ear functioning normally. Here again Census definition has given undue weightage to the deviation of body structure from the accepted structure. On the other hand NSS definition of 'Moderate Hearing Disability' may be considered as covering more than what is required or intended under PWD Act, 2016. In spite of that, a Census figure (1.26 million) was much less than the NSS estimates (3.06 million). Besides sampling error, inclusion of moderate category of hearing disabled, inclusion of persons having hearing disability in combination with other disability (like speech disability) under both disability categories, may be other reasons for NSS figure being higher than Census figure. Speech disability the definitions of Census and NSS are similar so far as a person having speech disability is concerned. Census definition is simpler and qualifies the listener also. It may be noticed that the PWD Act does not include speech disability under its

purview. The reason for NSS figure being higher may be that some persons have speech disability in combination with other disability which is more pronounced than speech disability. These persons would be listed under that pronounced disability alone in Census but under NSS results the person would also be additionally listed as having speech disability. Locomotor Disability In case of 'Locomotor disability' the definition given under PWD Act itself is simple. Both, Census and NSS definitions are in accordance with the definition under the Act except NSS definition includes dwarfs and persons with stiff neck of permanent nature who generally did not have difficulty in the normal movement of body and limbs, as having locomotor disability. Besides sampling errors, inclusion of dwarfs and persons with stiff neck, and inclusion of persons having multiple disabilities under each category may be responsible for the large variation or at least part of the variation. Leprosy cured person Census and NSS definitions do not consider the loss of sensation or deformities in leprosy cured person for the purpose of disability unless it manifests in the type of disabilities defined under Census and NSS. Activity limitation has been the primary determinants in laying down the definition of disability. A close look at different definitions would show that deviation from the accepted standard of the body structure was judged based on this criterion for including or excluding a person under a disability category. Examining the proprietary of excluding the three categories of 'Leprosy cured person' from the purview of the disability of Census and NSS it is felt that third category of 'Leprosy Cured person' defined under PWD Act may be considered for inclusion in Census and NSS definition of disability, as in this case the person suffers from activity limitation due to social attitude.

The Convention of Rights of Persons with Disabilities (UNCRPWD: United Nation, 2006 w.e.f. 8 May 2008) and the Biwako Millenium Framework for Action and Biwako Plus Five (ESCAP 2003) reflect a shift from a medical to social model of disability. In the medical model, individuals with certain physical, intellectual, psychological and mental conditions (impairment) are regarded as pathologic or abnormal; it is simply the abnormality conditions themselves that are the cause of all restrictions of activities ((Yoma,2019). According to the medical model, disability lies in the individuals, as it is equated with those restrictions of activity. Faced with the line of thinking, individuals would feel pressured to work on 'their' restrictions, bearing the burden of adjusting to their environment through cures, treatment or rehabilitation. In contrast, the social model shifts the focus to the society; undue restrictions on behaviour of persons with impairment are seen to be imposed by: a) dominant social, political, and economics ideologies; b) cultural and religious perceptions regarding persons with disabilities; c) paternalism in social welfare systems; d) discriminations by society; e) the inaccessibility of the environment and information; and f) the lack of appropriate institutional and social arrangements. Thus in this model, disability does not lie in individuals, but in the interactions between individuals and society. In the social model, persons with disabilities are right holders, and are entitled to advocate for the removal of institutional, physical, informational and attitudinal barriers in society. Thus it is a concept based on the consequences of diseases/ infirmity on functional capacity and/ or social participation. It locates the definition of disability at the most basic level of activity/participation in core domains – defined as the ability or inability to carry out basic actions at the level of whole person (i.e. walking, climbing stairs, lifting packages, seeing a friend across the room etc).

Social inclusion implies equality of opportunity and equal participation of individuals in society. The key to social inclusion for people with disabilities is the creation of a barrier-free environment.

The first step to creating an inclusive environment is to identify and remove the barriers that may prevent individuals with disabilities from participating fully and effectively in the workplace. Barriers can be physical, such as inaccessible buildings, equipment, or transportation; communication, such as unclear instructions, jargon, or lack of alternative formats; attitudinal, such as stereotypes, stigma, or low expectations; or systemic, such as policies, procedures, or practices that exclude or disadvantage certain groups. You can use various tools and methods, such as surveys, audits, feedback, or consultations, to assess the accessibility and inclusiveness of your work environment and identify the areas that need improvement.

Urbanization is currently one of the most important global trends of the 21st century. Urbanization has the potential to be a great engineer to achieve sustainable and inclusive development for all. About 6.25 billion

people, 15 per cent of them with disabilities, are predicted to be living in urban centres by 2050. Urban environments, infrastructures, facilities and services, depending how they are planned and built, can impede or enable access, participation and inclusion of members of society (Nastina, 2019). For the 15 per cent of the world's population who live with a disability, (many of whom live in urban areas), available evidence reveals a widespread lack of accessibility to built environments, from roads and housing, to public buildings and spaces and to basic urban services such as sanitation and water, health, education, transportation, and emergency and disaster response and resilience building and access to information and communications. These accessibility limitations contribute greatly to the disadvantage and marginalization faced by persons with disabilities, leading to disproportionate rates of poverty, deprivation and exclusion (Nastina E A 2019). This situation also impedes the realization of the 2030 Agenda for Sustainable Development and other internationally agreed development goals. Initiatives and good practices have emerged that successfully promote accessibility and disability inclusion in cities and towns in all parts of the world. The Convention on the Rights of Persons with Disabilities (2006) further strengthened the international normative framework for the advancement of the rights and socio-economic development of persons with disabilities. Accessibility is established in the Convention as a cross-cutting issue that enables persons with disabilities to live independently and participate fully in all aspects of life. The Preamble to the Convention emphasizes the importance of mainstreaming disability issues as an integral part of relevant strategies of sustainable development (UNICEF 2014). The UN Department of Economic and Social Affairs (DESA) and UN-Habitat, have been actively promoting accessibility and disability inclusion in contexts of sustainable and inclusive development for all. The global community started to observe December 3rd as the International Day of Persons with Disabilities in 1992, following a decade of awareness raising and change making to improve the situation of – and fight for equal opportunities for – persons with disabilities. This year's theme, *The Future Is Accessible*, is an excellent opportunity to create a vision toward an inclusive world (UNESCO, 2020) where buildings, transportation, and communities are accessible, and where persons with disabilities have equal opportunities for learning, growing, and thriving in society with dignity and without fear of discrimination. More than one year after the launch of its 10 Commitments on Disability-Inclusive Development, the World Bank continues to make progress in achieving accessibility, particularly with commitment "ensuring all World Bank-financed urban mobility and rail projects that support public transport services are disability inclusive by 2025. In Africa, the *Dakar Bus Rapid Transit (BRT) Project* in Senegal is designed with specific accessibility features to address the mobility needs of women, children, the elderly, and persons with disabilities. The features include bus boarding and alighting infrastructure with ramp access to get to the stations, pedestrian infrastructure – such as sidewalks and walkways built or retrofitted along the corridor – as well as with adequate lighting at bus stations to ensure safer and easier access to public transport. In the *Vietnam Urban Upgrading Project*, persons with disabilities were partners in design and implementation of improving access to infrastructure. The project team partnered with NGOs in Japan and brought onboard an architect to incorporate universal design in the project. The architect, a person with disabilities himself, not only added value to the team with his professional expertise, but also amplified the accessibility needs in the project. In China, ongoing railway projects – *HaJia Railway* and *Zhang Hu Railway* – are addressing the needs of persons with disabilities or people with limited mobility within the station premises, such as boarding the trains and accessing platforms through elevators. In Latin America, ongoing metro projects in Quito, Limo, Bogota and Sao paulo incorporate universal accessibility features. For instance, in Lima the Bank piloted interventions and developed a design manual with meaningful consultations with persons with disabilities and civil society organizations. The manual was well received and adopted by the municipal transport agency and is being used in the design of the bus rapid transit system in the city (UNESCO, 2020; DIM, 2019).

To reach an accessible future, the next step is to go to scale. It is therefore encouraging to see disability inclusion is now a cross-cutting theme for the International Development Association, the World Bank's fund for the poorest countries. To further promote disability inclusion, IDA calls for investments in disability-disaggregated data, differentiated interventions across sectors, and promoting inclusion through accessible physical environments and technologies. Poverty is a reality for persons with disabilities. The proportion of

persons with disabilities living under the national or international poverty line is higher, and in some countries double, than that of persons without disabilities. The health and well-being of persons with disabilities are at greater risk. Persons with disabilities are three times as unlikely to receive health care when they need it. Children with disabilities are twice as more likely to have malnutrition and are ten times more likely to be seriously ill. Education and Employment opportunities are negligible. Persons with disabilities remain less likely to attend school and complete primary education and more likely to be illiterate than persons without disabilities. The employment-to-population ratio of persons with disabilities aged 15 and older is almost half that of persons without disabilities. Persons with disabilities are often among the most vulnerable in society, and typically face more formidable barriers to transport, housing, and other services. It is often harder for persons with disabilities to improve their livelihoods and take advantage of economic opportunities due to the exclusion they experience (DIM, 2019). The first step to creating an inclusive environment is to identify and remove the barriers that may prevent individuals with disabilities from participating fully and effectively in the workplace. Barriers can be physical, such as inaccessible buildings, equipment, or transportation; communication, such as unclear instructions, jargon, or lack of alternative formats; attitudinal, such as stereotypes, stigma, or low expectations; or systemic, such as policies, procedures, or practices that exclude or disadvantage certain groups. You can use various tools and methods, such as surveys, audits, feedback, or consultations, to assess the accessibility and inclusiveness of your work environment and identify the areas that need improvement. The second step to creating an inclusive environment is to provide reasonable accommodations to individuals with disabilities who need them to perform their job duties. Reasonable accommodations are modifications or adjustments that enable an employee with a disability to enjoy equal employment opportunities and benefits without imposing undue hardship on the employer. Examples of reasonable accommodations include flexible work hours, assistive technology, ergonomic furniture, or sign language interpreters. You can work with your human resources department and the employees themselves to determine the appropriate and effective accommodations for each situation. You should also review and update the accommodations regularly to ensure they meet the changing needs and preferences of the employees.

The third step to creating an inclusive environment is to educate and train yourself and your team on disability awareness and inclusion. Disability awareness is the knowledge and understanding of the diverse experiences, perspectives, and rights of people with disabilities. Inclusion is the practice and attitude of involving and empowering people with disabilities in all aspects of the workplace. You can use various resources and strategies, such as workshops, webinars, videos, or mentoring, to enhance your own and your team's disability awareness and inclusion skills. You should also promote a positive and respectful language and behavior that avoids stereotypes, labels, or assumptions about people with disabilities.

The fourth step to creating an inclusive environment is to communicate and collaborate effectively with individuals with disabilities in your team. Communication and collaboration are essential for any team to achieve its goals and solve its problems. However, they can also pose challenges and opportunities for inclusion. You can use various techniques and tools, such as active listening, feedback, accessibility features, or online platforms, to communicate and collaborate effectively with individuals with disabilities. You should also encourage and facilitate the participation and input of all team members in meetings, discussions, and decision-making processes. You should also recognize and celebrate the achievements and contributions of individuals with disabilities in your team (UNESCO, 2020, UNICEF, 2006).

The fifth step to creating an inclusive environment is to foster a culture of inclusion in your team and organization. A culture of inclusion is a set of values, beliefs, and norms that promote and support the diversity, accessibility, and inclusion of all employees. You can foster a culture of inclusion by modeling and reinforcing inclusive behaviors and practices, such as empathy, respect, flexibility, and collaboration. You can also create and sustain a network of allies and advocates, such as peer support groups, employee resource groups, or diversity committees, that can provide guidance, support, and feedback on inclusion issues and initiatives (Sanjeev and Kumar, 2013). You can also leverage and integrate the diverse talents, perspectives,

and experiences of individuals with disabilities in your team and organization to enhance innovation, productivity, and engagement.

Research has found that for many people with disabilities, finding and sustaining work is a challenge. “Indeed, it has been estimated that in the United States (US), only one in three (34.9 percent) individuals with disabilities are employed compared to 76 percent of their counterparts without disabilities, and this disparity appears to be increasing over time,” the research noted. Canada indicates a better picture with the corresponding statistics being 49% vs 79% percent, with the European Union being close at 47.3% vs 66.9%. United Nations, (CRPD, 2006).

People with disabilities do not fit into the usual way of social life, which adversely affects their social situation and access to public goods. The social status of people with persistent health problems who are not able to lead a normal life and fully exercise their rights is discriminated against, and the disabled themselves actually constitute a group of people excluded from pub lic life, being on the periphery of society. Social exclusion of persons with disabilities is often accompanied by stigma and negative identity, which is enshrined in the legal and cultural system and social institutions. Certain symbols and attributes of persons with disabilities in the form of technical means of rehabilitation (wheelchairs, crutches), language of social communication (sign language), internal culture (subculture) distinguish persons with disabilities from other members of society; designs not only internal public space, but also external space, and thus institutionalizes strata (UNICEF, 2020).

Disability therefore involves processes of social exclusion. In a situation of social exclusion, inclusion is intended to minimize differences between citizens. It is important to understand that social inclusion does not develop in a single subsystem or structure of society, but is the result of the development of all social systems at macro, meso and micro levels. With this in mind, (F. Farrington, 2002) discloses social inclusion as a multidimensional phenomenon involving the interactions of the economic, political, sociocultural, social, territorial and symbolic subsystems of society. The most important reason for the de facto inequality of persons with disabilities is the existence of numerous social barriers in society, which prevent, on the one hand, access to basic urban and social resources and, on the other, the possibility of being included in social ties and interactions to the same extent as other people. These barriers lead to social exclusion and social dependence, and have a negative impact on both the quality of life of people with disabilities and on relations with persons with disabilities in local communities. The removal of these barriers is a key point of inclusion for persons with disabilities.

The process of inclusion and accessibility has been carried out in accordance with the countries program "Inclusion and Accessible Environment." The program includes a set of measures aimed at creating conditions for the realization of the fundamental rights and freedoms of persons with disabilities, their independent life and the full participation of persons with disabilities in the life of the country [Nevayeva, 2015]. Given the ongoing inclusive processes taking place in modern India, it is important to understand the existing obstacles and difficulties faced by persons with disabilities, as well as the peculiarities of including these persons in society.

- Ensure accessibility through universal design of buildings, facilities, services and consultations. Provide reasonable accommodation as well as mobile or outreach services to facilitate access to services, delivery of assistance and feedback and complaint mechanisms.
- Ensure information in accessible formats and channels.
- Ensure protection-sensitive and inclusive targeting.
- Design activities in a manner that allows persons with disabilities to remain together with their care-givers, families, kinship groups and other support networks.
- Always allow persons with disabilities to be accompanied by a person of their choice if they require such support.

- Promote an organisational culture that respects the dignity, rights and capacities of persons with disabilities, including through training of staff.
- Ensure a functional referral system for individual protection assistance and specialised services.

A key function of the DIPAS is to establish a vision of a disability-inclusive world by 2030. It presents that vision, as well as a strategic framework that introduces the overarching goals, objectives and strategic priorities that will help guide UNICEF work and investments in disability-inclusive development for all children. The UNICEF Disability Inclusion Strategy, and the annexed Accountability Framework for Disability Inclusion, the Disability Inclusion Policy commits UNICEF to bold and innovative action with and for children with disabilities. All nations, societies, systems, communities, families and individuals promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms and actively work to ensure the inclusion, leadership and meaningful participation of all children with disabilities in all contexts on an equal basis with others (Giddens, 2013).The rights of children and adults with disabilities to live in supportive and inclusive families and communities are fully realized, and individuals and communities have the tools, equipment, resources and capacity to build a more inclusive world. Ableism and other forms of stigma and discrimination against persons with disabilities have been eliminated, and children with disabilities live in a world free from barriers, stigma and discrimination of all kinds.

UNICEF,2019; 2020 recognizes its mandate and responsibility to work with and for children with disabilities, their families, caregivers and communities, to support successful transitions through early childhood into and through education and into independent living as adults, by creating an enabling environment where inclusivity and diversity are embraced. This vision will necessitate expanding the organization's ability to work holistically and across sectors, taking a twin-track approach and using both disability-targeted and disability inclusive actions to ensure that children with disabilities are met at every turn with accessible information, AT, targeted outreach and engagement, policy and community support, social protection and inclusive programming. Children with disabilities are empowered and recognized as their own best advocates, and seen as essential to the expansion and sustainability of inclusion. UNICEF aims to create enabling environments for children with disabilities to participate fully in their communities and to bring their lived experiences to decision making processes. Ensuring the right to meaningful participation and leadership requires investments in, access to and the removal of barriers to education and communication, targeted and integrated skills-building, access to AT and support services, the availability of peer groups and role models, particularly for girls with disabilities, who may face additional barriers, and prioritized partnerships with OPDs and organizations of parents, families and caregivers, children with disabilities at all levels.

UNICEF is fully committed to empowering children with disabilities throughout childhood and adolescence, including: Elevating and amplifying the voices and ongoing leadership of young advocates with disabilities, their networks and organizations, by establishing prioritized funding mechanisms and partnerships, Expanding agency, by building leadership skills and capacity, as well as expanding the representation and participation of children in OPDs, including in development processes and cluster coordination, and humanitarian coordination platforms, among others. Increasing assets through accessible digital platforms as well as economic empowerment interventions targeting adolescents and youth with disabilities directly, such as through cash plus transfer programmes, or indirectly, such as through financial literacy training, skills for employability and mentorship programmes. UNICEF embraces a full life-cycle approach to child development, and therefore recognizes the ongoing support needed by children with disabilities and their parents, families and caregivers to overcome barriers and ensure healthy and successful transitions throughout the life course. This includes early identification and intervention; access to appropriate AT; support to cover disability-related expenses; the provision of inclusive and accessible sexual and reproductive health services and information; the delivery of mental health and psychosocial support and services that centre on the rights and dignity of children and persons with disabilities; family-friendly policies that allow parents to have adequate time, resources and services to care and provide for their children; and a society free from stigma and discrimination (Samarthyam, 2020). As children with disabilities transition into and during adolescence,

they may require age-appropriate support that allows them to be as autonomous as their peers without disabilities. When transitioning to adulthood, they may need support services to live independently, vocational skills and inclusive workplaces. At all ages, children and adults can benefit from the elimination of ableism and the associated stigma and discrimination within communities and social structures. This will require not only continued investments in inclusive and gender-transformative early childhood development (ECD), health, nutrition, social protection, education, WASH and child protection, but also social innovation and norm changes to develop disability-inclusive and responsive support services and systems.

A theoretical framework was developed to guide the mapping exercise in India. The framework conceptualized inclusive education through four main domains: (1) Enabling Environment, (2) Demand, (3) Service Delivery, and (4) Measuring and Monitoring Quality. Cross-cutting issues, albeit brief, were included in the review to provide an overview of the intersectionality between disability and gender, and disability and humanitarian issues. This country profile on India was developed as part of this regional mapping study on disability inclusive education. It aims to provide a snapshot of the key policies, practices and strategies implemented from 2010 to 2020 to ensure children with disabilities learn in inclusive settings in India. More information on the methodology and theoretical framework underpinning the mapping survey can be found in the full report, Mapping of Disability-Inclusive Education Practices in South Asia. As the second largest country in the world in terms of population, one of India's competitive assets is its human capital. Over the years, the country has shown significant reforms in improving its human capital through critical advances in literacy8 and the provision of free and compulsory education for all children between the ages of 6 and 14 years. 9 Despite these achievements, challenges in achieving quality educational outcomes remain. UNICEF, 2014, 2019 reported that about 135.5 million children and adolescents live in urban slums or periurban areas and are equally deprived as those living in rural areas in access to basic social country context services, including quality education (Zhigunova, 2020). Poor quality teaching and learning practices have been identified as key challenges in the education system, alongside the low school attendance rate due to child marriage, child labour and various reports of abuse.11 These challenges affect vulnerable groups such as children with disabilities,12 compounded by various inaccessibility issues, negative attitudes and practices towards disability, among other factors.13 In spite of these challenges, India remains committed to affirming the rights of all children to quality education, including children with disabilities (Muzamil Jan, 2008).

The Constitution of India guarantees education for all children aged 6 to 14 years (Article 21A). Although it prohibits discrimination "on grounds only of religion, race, caste, language or any of them" (Article 29.2) in access to state or state-supported educational institutions, the constitution lacks explicit mention of antidiscrimination of persons with disabilities in educational institutions. The main domestic laws enacted after the ratification of CRPD in 2007 support inclusive education, albeit in varying degrees: The Right of Children to Free and Compulsory Education Act 2009 (RTE Act, 2009) echoes the promotion of "free and compulsory education for all children in a neighborhood school", but is silent on specific provisions to support children with disabilities in school, such as reasonable accommodation and assistive devices, among others. State-level RTE rules provide for specific interventions for children with disabilities. Transportation for children with disabilities and participation of school management committees in implementing inclusive education are guaranteed by almost all states. Only 1 out of 29 states referred to special schools (Muzamil Jan, 2008). An UNESCO report describes the Rights of Persons with Disabilities Act 2016 to be highly aligned with CRPD (RPWD Act; 2016).

While there is no specific policy on inclusive education, the RPWD 2016 Act, provides a strong legislative framework for inclusive education, defining it as "a system of education wherein students with and without disability learn together and the system of teaching and learning is suitably adapted to meet the learning needs of different types of students with disabilities. While the focus on children with disabilities is notable, it is recommended to broaden the conceptualization of inclusive education as a process that encompasses all learners and not only those with disabilities (ADB, 2015; UDHR, 1948). Furthermore, the law sets out a definition of disability referring to the definition advocated by CRPD. The RPWD Act 2016, expressly

mandates all education institutions funded or recognized by the government and local authorities to provide inclusive education; admit children with disabilities (aged 6–18 years, beyond the 14 years age limit of the RTE Act, 2016) without discrimination; provide reasonable accommodation; ensure accessibility of facilities, infrastructure and transportation; and provide individualized support when necessary and attendants for children with high support needs (UN Convention RPWD,2010). Specific measures to promote inclusive education are articulated, ranging from identifying children with disabilities; establishing teacher training institutions and building capacities of teachers, professionals and staff at all levels of the system; setting up resource centres; promoting use of and providing free assistive learning materials and devices and alternative modes of communication (e.g., Braille, sign language); providing scholarships; and modifying curriculum and assessment methods. The law endorses education in the neighborhood school and special education as approaches for supporting the learning of children with disabilities. According to the RTE Act 2009, home based education is recommended for children with multiple or severe disabilities. The National Education Policy (NEP) 2020 reaffirms the provisions in the RPWD Ac, 2016 regarding inclusive education. The policy takes on a broader inclusion perspective and aims to achieve learning for all, particularly addressing the exclusion of socio-economically disadvantaged groups (Nevayeva D A 2015). The policy emphasizes the importance of inclusion of children with disabilities from early childhood education to higher education, with the provision of assistive devices and teaching and learning materials. Samagra Shiksha is India's flagship education programme implemented throughout the country through a single State Implementation Society at the state/union territory level. It subsumes three previous schemes: 1. Sarva Shiksha Abhiyan (SSA) 2. Rashtriya Madhyamik Shiksha Abhiyan 3. Teacher Education. The schemes were the primary strategies of the country to move towards the achievement of Sustainable Development Goal 4 targets. The Ministry of Education21 (MoE) envisions universal access, equity and quality, as well as vocationalizing education and strengthening teacher education institutes. Inclusive education is among the major interventions identified under Samagra Shiksha. A zero-rejection policy has been adopted under Samagra Shiksha. This ensures that no child is left behind. A continuum of educational options, learning aids and tools, mobility assistance and other support services are being made available to students with disabilities. "This includes education through an open learning system and open schools, alternative schooling, distance education, special schools, wherever necessary home based education, itinerant teacher model, remedial teaching, part-time classes, Community Based Rehabilitation (CBR) and vocational education" (Muzamil Jan, 2008).

1. Assistive devices, equipment and teaching and learning materials
2. Braille stationery material
3. Corrective surgeries
4. Environment building programme
5. Escort allowance
6. Identification and assessment (medical assessment camps)
7. In-service training of regular and special educators
8. Orientation of principals, educational administrators, parents/guardians
9. Provision of aids and appliances
10. Purchase/development of instructional and training materials
11. Reader allowance
12. Salaries
13. Sports events and exposure visits
14. Stipends for girls
15. Therapeutic services and resource rooms.

The Department of Empowerment of Persons with Disabilities in the Ministry of Social Justice and Empowerment is establishing a national database for persons with disabilities. The issuance of a unique disability identity card for all persons with disabilities is envisaged to increase transparency, efficiency and tracking the progress of service delivery. A useful tool for monitoring children with disabilities, the national database could link to the Unified District Information System for Education Plus (UDISE+) to enable the

development of comprehensive profiles of children in school and track those who remain outside the education system (. The national database can be the centralized source of uniform information on children with disabilities and presents an opportunity for better coordination among education, health and social protection ministries (Muzamil Jan, 2008). It should be noted, however, that in the database, the identification of disability is based on medical categories. The Washington Group on Disability Statistics (WG) question sets have not yet been integrated into the major data collection initiatives in the country (Ainscow, 2004). Adopting one disability measurement tool, such as the WG questions, across all databases, national surveys and censuses will generate more reliable statistics on children with disabilities.

More boys than girl in 6-11 years of age group are disabled in Jammu and Kashmir State. The disabled children are more in Kashmir region than in Jammu region. Disabled children in 6-14 years mainly suffer orthopaedic disabilities. The number of disabled children attending formal school of education is very less, more so among girls than in boys. Moreover, the number of disabled children attending school in the age group 11-14 years is less than disabled children attending school in age group of 6-11 years. Thus there is increased drop our rate in schools among disabled children with increase in their age. The number of disabled children in 6-14 years of age attending school is more in Kashmir region than in Jammu region. The number of disabled children in 6-14 years of age attending school is more in Kashmir region than in Jammu region. The number of disabled children in 6-14 years of age who are out of school is less than disabled children in same age group attending school (Muzamil Jan, 2008).

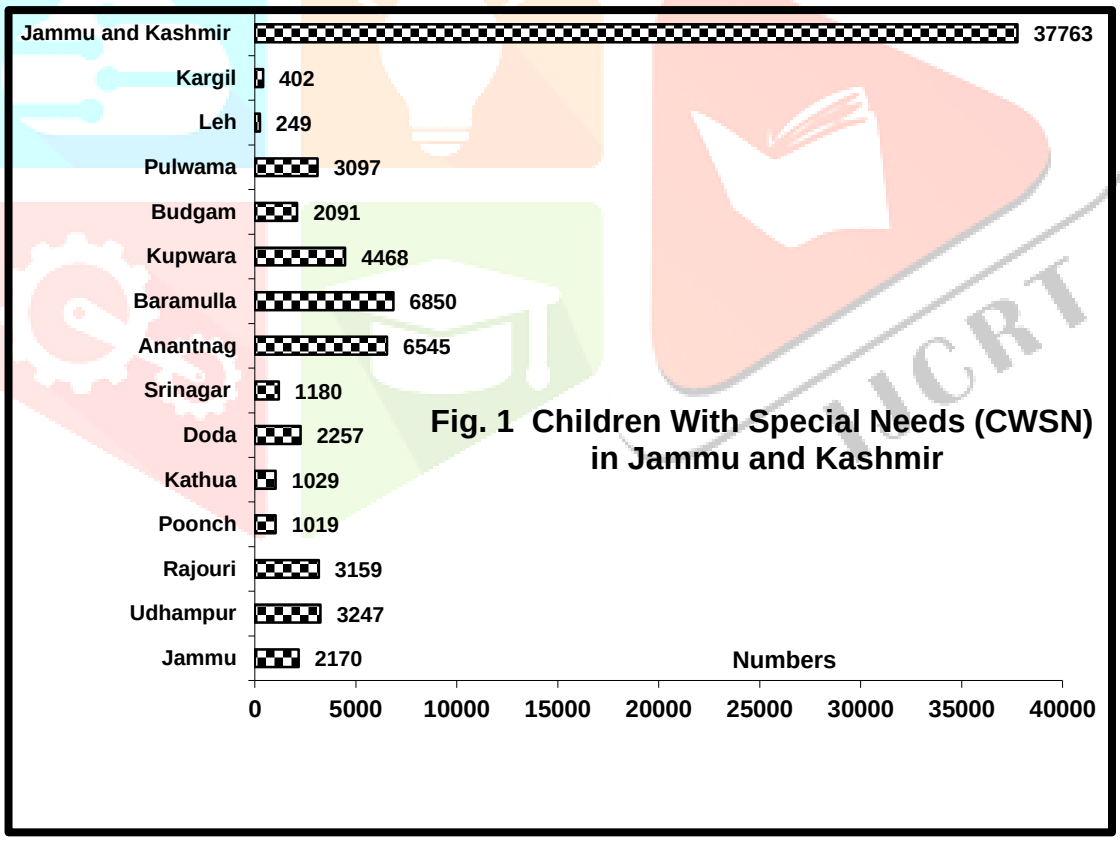

Fig. 1 Children With Special Needs (CWSN) in Jammu and Kashmir

Source: (**Muzamil Jan, 2008). Education for Disabled Children in Jammu and Kashmir.** Extension and Communication, Institute of Home Science, University of Kashmir, Srinagar, India.

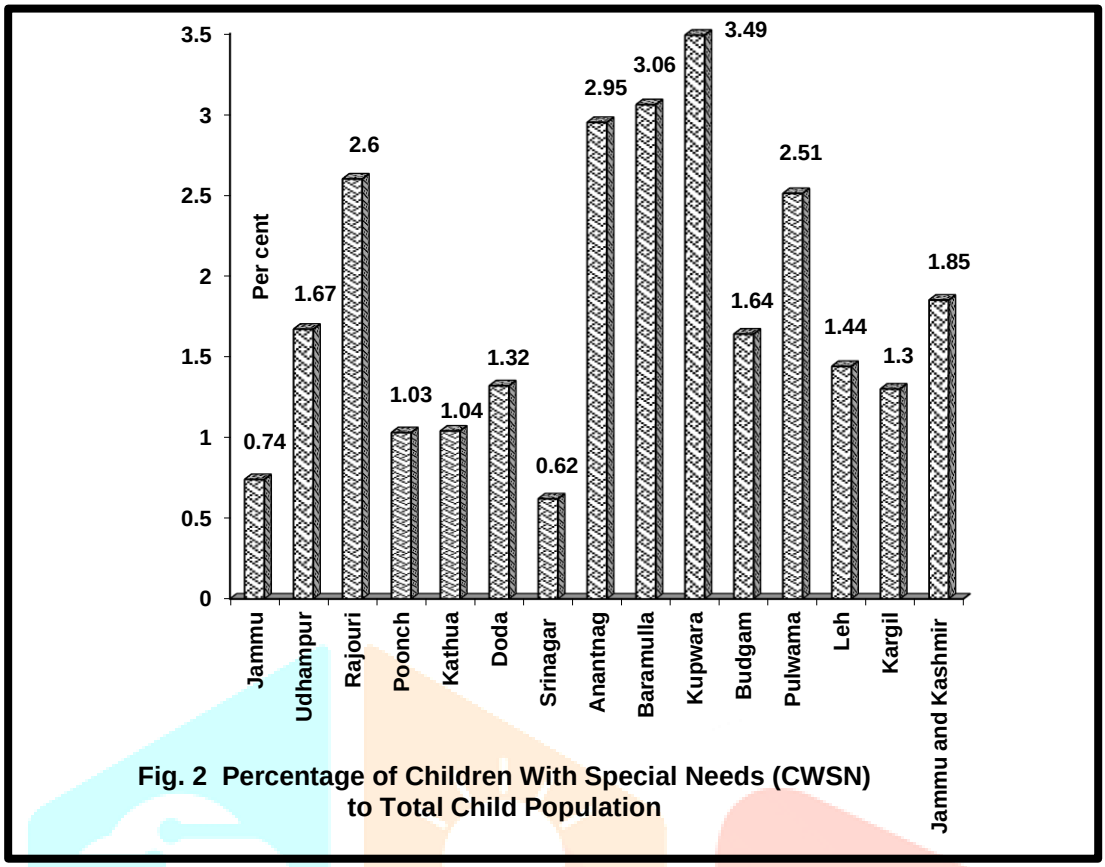

Fig. 2 Percentage of Children With Special Needs (CWSN) to Total Child Population

Source: (Muzamil Jan, 2008). Education for Disabled Children in Jammu and Kashmir. Extension and Communication, Institute of Home Science, University of Kashmir, Srinagar, India

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