REHABILITATION OF THE DISABLED IN COIMBATORE SLUMS

By

VEERAMACHINENI SARALA KANTHI

A THESIS SUBMITTED TO THE AVINASHILINGAM INSTITUTE FOR HOME SCIENCE AND HIGHER EDUCATION FOR WOMEN - DEEMED UNIVERSITY, COIMBATORE - 641 043

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SCIENCE IN HOME SCIENCE EXTENSION

APRIL - 1998

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Certified as Bonafide Research Work

Signature of the Head
of the Department

M. Kasthuri

Signature of the Guide

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INTRODUCTION

"The Disabled go Miles what the normal make by walk,
Yet they wish to run but the Programmes only walk;
I See Miles of Development in the March of the Disabled,
For I See, Almighty at the feet of the Disabled".

- Dwaraki

A Handicap is a disadvantage for a given Individual resulting from an impairment or disability that limits or prevents the fulfillment of a role that is normal depending on age, sex, social and cultural factors for that individual in the context of health (Dinesh Mohan, 1988 and WHO, 1981) There are 500 million disabled in the world today and 400 million among them live in isolated rural areas. Kharbana, (1989) and Chandrasekaran, (1989). The term 'Handicap' means the loss or limitation of opportunities to take part in society on an equal level with others. The phenomenon regarding Handicap may be represented as ....

Disease ---> Impairment ---> Disability ---> Handicap

- (Dinesh Mohan, 1988)

It is estimated that one in every ten children in the world is born with or acquires physical, mental or sensory disability (NIPCCD, 1991 and Mohan Kumar, 1993). In our society 4 percent babies born are physically or mentally handicapped and 8 percent pass away in weeks or months or years. There were 20 disabled per 1000 persons in rural

areas and 16 disabled per 1000 persons in urban areas and 20 percent children are affected (National Sample Survey Organisation, (NSSO) 1991). Population of disabled comprises of more than men. Many disabled people develop a feeling of insecurity associated with awareness of their physical deterioration (Philip, 1987 and Surrender, 1997).

In the world picture shows that 450 million Handicapped exist and annually 15 Million Handicapped are added as victims of wars, accidents, Malnutrition, diseases. According to National Sample Survey organisation in India in 1991 there are 16.15 million physically disabled persons in India constituting 1.9 percent of total population (Sushila, 1984; Desai, 1990, Shubhanker, 1996 and Naik, 1997).

Gandhiji remarked that no physically disabled person should be condemned and no person should be allowed to end his life by own. The disabled in the community are as godly as the unafflicted people. In no way are unafflicted people superior to the handicapped, neither are the handicapped inferior to the unafflicted. Nobody is high nobody is Low : All have the right to live, develop and enjoy life (Narayanasamy, 1996).

Handicapped do not need people's pity they need compassion. Disabled are not really disabled. They are just disabled in certain areas. They become handicapped when society imposes restriction on them (Sushila, 1984).

As regards the welfare of the Handicapped, larger coverage of the affected population by way of extensive services was provided through the District Rehabilitation centers, National Institutes, as well as voluntary organisations engaged in this sphere. The objective of government is "to do something to minimise and eliminate once for all the disabilities at the earliest rather than endlessly debating and struggling over what new things should be done for the disabled (Narayanasamy, 1996).

Mani, (1987), Natarajan, (1992), and Robert and Arthur (1994) viewed that rehabilitation is a beautiful terminology that is helping a disabled person to achieve maximum possible physical and psychological fitness and regain the ability to care for himself. It offers assistance with the learning or relearning of skills needed in everyday activities, with occupational, training and guidance and with psychological readjustment. Rehabilitation, thus is the restriction of the physically disabled to the maximum possible physical, vocational, economic independence.

Seetha Raman, (1988), Sen, (1988) and Hindu, (1997) pointed out that the National Handicapped Finance and Development Corporation (NHFDC) was established with the aim of developing entrepreneurship among handicapped person.

In the words of Narayanasamy (1996) Sarvodaya is not only meant for the development of normal people, but also for the development of disabled. Sarvodaya would bridge the

gap between the disabled and the normal people. And also it promotes not only the development of all but also the happiness of all.

The World Health Organisation Promotes an integrated approach to prevent disabilities by including all promotive, preventive, curative and rehabilitative care in primary health care. The Rehabilitation services should based on the needs of the disabled and also it ensure their full integration in the society. The normal people in the society also realise that persons with disabilities are citizens like everyone and hence to participate in the activities organised for the disabled in the community (World Health, 1995).

To fulfil this goal, it is important to take measures for early deduction of the disabled and to plan rehabilitative services for them either medical or socio-economic. The research study on "Rehabilitation of the Disabled in Coimbatore slums" was an effort taken in this direction.

The main objectives of the present study are as follows : To

1. identify the Disabled and Categorise them according to the type of disability.
2. understand the Rehabilitative services available in Coimbatore district.
3. utilise the Rehabilitative services.

Review of Literature

REVIEW OF LITERATURE

The Review of literature pertaining to the study entitled "Rehabilitation of the Disabled in Coimbatore Slums" is given under the following heads:

A. Concept of Disability

B. Rehabilitative Services, Laws and Recommendations for the Disabled

C. Research Highlights

A. Concept of Disability

It has been estimated that there are some 300 - 400 million disabled people in the world. According to the statistics 10 percent of population is disabled and 100 million people suffer from one or other disability. According to National Sample Survey Organisation (NSSO) it was found that 12 million persons have atleast one or other disability, which constitute 1.8 percent of total population, 5.43 million persons having Locomotor disabilities followed by those with visual disabilities (3.43 million) hearing disabilities (3.02 million) and speech disabilities (1.75 million). The prevalence of disability is more in rural areas (81.1 %) than in urban areas (19 %) (Sri Hari, 1992).

According to Davies the term Handicap refers to any disease or disability and is not restricted to surgical or orthopaedic disability. Handicap means the loss or

limitation of opportunities to take part in society on an equal level with other normal person.

According to Mukherjee (1988) a disabled person is a displaced person. Disability may be defined as difficulty in performing one or more functions that are generally accepted as normal and essential in daily life, such as self care, engagement in social-relationship and earning a living.

A person with disability is one "suffering from not less than 40 percent of any of the disability as certified by a medical authority" (Ram Kumar, 1990, Sruthi, 1995 and Velayutham, 1996).

Handicapped people are not really handicapped. They are just disabled in certain areas. They become handicapped whom society imposes restriction on them. Handicap is largely socially created disadvantage imposed on individual pattern of psychological, physical, vocational and community activities. As handicap are one of the weakest links of society the society should give utmost care and protection of handicapped (Robert and Arthur, 1994 and Mishra, 1995).

Physically handicap is any physical disability either of senses or of extremities, which impairs the physical, social functioning of individual (Mohsini and Gandhi, 1982). First among the physically Handicapped are classified as a Hearing impaired, Speech impaired, Cleft palate, Learning

disability, language disability, visually impaired, orthopaedically handicapped, Locomotor disability, followed by Mentally handicapped, Social disability such as delinquents, beggars, destitutes, orphans, neglected Children and unmarried mothers (Punani 1987).

The deafness can be called as "Hearing Impairment'. An estimated 30 million people suffer from some type of hearing loss (Hindu, 1998). Deafness means a hearing impairment which is so severe that the person is impaired in processing linguistic information through hearing with or without amplification which adversely effects educational performance, as said by public law (Sharma, 1988, Frank and Stewen, 1989). Common terms used to identify degree of hearing loss include

Mild hearing loss	: 15-30 db
Moderate hearing loss	: 31-50 db
Severe hearing loss	: 51-80 db
Anacusis or total hearing - loss	: 81-100 db

Speech is a tool used to develop and express language. It begins with birth cry and progresses. As for public Law : Speech impairment means a communication disorder, such as sturreing, impaired articulation, a language impairment or a voice impairment which adversely affects a childs educational Performance (Frank and Stewen, 1989). According to EISENSON (1980) speech is significantly defective when

the amount of distraction is sufficient to make it difficult to communicate with a normal listener. It may be defect in articulation voice, sturreing, cleft palate, delayed language development, defects associated with defective hearing.

Cleft palate or a cleft lip (Multiple speech and Language disorder) or the both are created when the two halves of the bony upper gum ridge or the two halves of the hard and soft palates fail to grow together and united in a normal fashion by the third month of prenatal development. It may be partial or total cleft (Kamala, 1989 and Kenneth, 1989).

Learning disability (LD) is a dynamic and expanding field. It is any average or above average child having academic performance below the normal can be labelled as learning disabled. (Cecil, 1987 and Sarangi, 1989).

Dyslexia is a language disability where defined by world federation of neurology as "a disorder manifested by difficulties in learning to read, despite, conventional instruction, adequate intelligence and socio-cultural opportunity. A Dyslexia child reads 'saw' as 'was', writes 91 as 61 etc. Dyslexia is responsible for learning disability (NIPCCD, 1986, Christine Miles, 1988, and Lakshmi, 1997).

The Blind which can be called the "visually impaired" means a visual impairment which even with correction, adversely affects a child's educational performance. The term includes both partially seeing and blind children (Frank and Stewen, 1989). Blind people are those who do not benefit from teaching in regular class because of low activity of their vision. Of 9.5 million persons in India estimated to be visually impaired 55 percent are due to cataract, 20 percent are due to corneal diseases and 25 percent due to various other ocular conditions (Stephenlilly, 1979, and Rawal and Nandini, 1993).

Orthopedical impairment which adversely affects a childs educational performance, the term includes the impairments caused by congenital anomaly impairments caused by diseases. Deformity is an alternation in the shape of a limb or spine. The presence of deformity in a long bone after injury is a definite sign of fracture (Natarajan,. 1992).

Locomotor disability is defined as a person who is unable to move themselves as well as objects from place to place due to paralysis of limb or body, deformity of the limb, amputation, dysfunction of Joints of the limbs and

other deformity of the body in spine, neck, hunch backs, dwarfs etc. (Survey of disabled persons, 1981).

Mental retardation is now termed mental handicap and this is different from Mental illness. According to W.H.O has defined it as an "incomplete or insufficient general development of Mental Capacities" (Parekh, Singh and Jain, 1987). According to Manual of American Association of Mental deficiency "Mental retardation refers to significant sub-average general intellectual functioning existing concurrently with deficits in adaptive behaviour and manifested during developmental period". The sub-division of I.Q. where degree of mental retardation can be notified as (Joseph Mehr, 1983, Madhavan, 1989, Verma 1989, Rao, 1990 and Mahesh, 1994):-

Mild Mental Retardation	: IQ	: 52-68
Moderate Mental Retardation		: 36-51
Severe Mental Retardation		: 20-35
Profound Mental Retardation		: 20 under

(Chauhan, 1989)

The W.H.O. Bulletin has given the estimated number of disabled in world and causes of disability in India and rural and urban handicaps:

i. Causes of Disability and Estimated number of disabled people in the world

Table 1 depicts the causes of disability and estimated number of disabled people in the world:

TABLE I

CAUSES OF DISABILITY AND ESTIMATED NUMBER OF DISABLED IN THE WORLD

Medical causeS	Millions	% age of disabled
Congenital disturbances		
i. Mental retardation	40	7.7
ii. Somatic hereditary defects	40	7.7
iii. Non-genetic disorder's	20	3.9
Communicable diseases		
i. Polio	1.5	0.3
ii. Leprosy	3.5	0.7
iii. Others	4.0	7.7
Non-communicable diseases		
i. Functional psychiatric disturbances	40	7.7
ii. Chronic alcoholism, drug abuse	40	7.7

ii. Causes of disability in India

Table II shows the causes of disability in India.

TABLE II

CAUSES OF DISABILITY IN INDIA

Type of disability	Cases
i. Visual	i. Vit 'A' deficiency ii. Squints iii. Complete blindness iv. Congenital abnormalities of eye v. Neglected eye infections
ii. Auditory and Speech	i. Chronic otitis media ii. Nerve deafness iii. Speech defects iv. Deaf mute v. Stammerers
iii.Mental Handicaps	i. Mild, moderate, severe and profound mental retardation
iv. Physical	i. Post polio problems ii. Neglected old fractures iii. Infected osteomyelitis iv. Myopathics v. Cerebral palsy
v. Multiple handicaps	i. Congenital malformations and various Syndromes

(W.H.O. Bulletin)

The incidence of handicaps in rural areas is two and half to three times more as compared to the urban areas. The high incidence is because of ignorance, illiteracy, poverty and lack of medical facilities and its awareness.

W.H.O. had given comparison of rural and urban handicaps is as follows :

iii. Comparison of Rural and Urban Handicaps

Table III illustrates the comparison of rural and urban handicaps.

TABLE III

COMPARISON OF RURAL AND URBAN HANDICAPS

Type of handicap	Rural (Pandit et al.) 30,000 (Percentage)	Urban Anand et al) 15,292 (Percentage)
1. Visual	22.6	17.4
2. Auditory speech	51.6	12.6
3. Locomotor	10.1	55.4
4. Mental	6.6	12.6
5. Multiple handicaps	3.6	3.6
6. No handicaps	5.4	-
7. Others	-	8.7

(W.H.O. Bulletin)

B. Rehabilitative Services, Laws and Recommendations for the Disabled

1. Rehabilitative services

The most prerequisite for the rehabilitation of disabled is a change in public attitude towards the disabled in general. The modern society has a responsibility towards poor, handicapped and disabled. The magnitude of problem is

very vast. So the government and social organisations started thinking in the direction of prevention and rehabilitation (Srinivasan, 1981, and ILO, 1985).

The increasing number of handicapped has put the concept of rehabilitation in a new perspective as a possible asset to a country's economy. Rehabilitation is the last link in the total welfare of the handicapped. According to definition adopted by International labour conference in June 1955, Rehabilitation means, the restoring of handicapped persons to the fullest possible physical, mental, social, vocational and economic usefulness of which they are capable.

Johnson viewed that rehabilitation as the process of returning a disabled person to an effective level of physical, mental and emotional health. Rehabilitation include educational, music, orthotics, prosthetics, physical therapy, occupational, Dance, recreational, corrective therapy. The total rehabilitation programme can be divided into the following 4 phases or categories (Mishra and Prem Kumar, 1995).

A. **Medical Rehabilitation**

The objectives of Medical Rehabilitation are : prevention of disability of possible, maximum reduction or

stimulation of the disability, training the persons, residual abilities to achieve independent living. There are many schemes and programmes, under medical rehabilitation. They are :

Assistance for Aids and Appliances, Assistance to voluntary organisations for persons with cerebral palsy and mental retardation, National Trust, Government of Tamil Nadu Welfare Scheme, Free polio Rehabilitation camps, Concessions relating to medical examination (Rao, 1990 and Banerjee, 1996).

B. Educational Rehabilitation

Gopalan (1991) Director of National council for educational research and training emphasizes the importance of handling the disabled in an intelligent, delicate, sympathetic and understanding manner. It aims in normalization of the disabled emphasizes interaction of the handicapped with their normal peers in educational settings. The government is providing assistance:

To voluntary organisations working for handicapped, Assistance for establishing special school, Scholarships to handicapped students, Integrated education, Special Teachers, Concessions in respect of educational qualifications, Education of special training for physically

handicapped, Training of Teachers of Blind and Deaf and Grant in aid programmes (Shukla 1990 and Advani 1982).

C. Vocational Rehabilitation

Vocational Rehabilitation is a process that involves vocational training, vocational guidance and selective placement, designed to enable a disabled person to secure and retain suitable employment. The government is providing:

Assistance to voluntary organisations for the rehabilitation of leprosy cured person's, Provision of National awards, Government of Tamil Nadu Welfare Schemes and subsides etc., Vocational Rehabilitation Centres and Training Centres, Concession for purpose of vocational training, Free vocational training exclusively to physically Handicapped woman by Shramik Vidya Peeth's (Omankunjamma, 1980, Vohra, 1989 and Department of Women and Child Development, 1993).

D. Social Rehabilitation

Aims that rehabilitation must be based on the resources of the community including the impaired disabled and the Handicapped persons their families and community as a whole (Vijayalakshmi, 1997). The schemes and programmes under this are :

Differential Rate of Interest Scheme, Reservation of Dealership/Agencies of oil components, Custom duty for blind, deaf, Scheme of assistance to organisations for handicapped person's, Free postage, District rehabilitation centre schemes, Loan provisions for employment, Age concessions, Special employment exchanges, Travel (Train, Bus) and other concessions, Free employment trainings, Other concessions for "blind literature packets (Yadav, 1981, Mohsini and Gandhi, 1982, and pandey, 1995).

2. Disability Act

The disabled persons all over India have been demanding legal rights over two decades. During 1971, Smt. India Gandhi, announced in the Loksabha that the government would bring forward a law for reservation of certain percentage of jobs for handicapped. In 1977, three percent vacancies were reserved for the handicapped in group C and group D posts by Government Orders.

The United Nation declared the year 1981 as the International Year of the handicapped. During 1981, a committee was appointed by the Ministry of Welfare of draft "Law for the handicapped" and a draft bill was submitted to the Government by the committee.

In 1987, Shri. Rajiv Gandhi, the then Prime Minister appointed one more committee under the Chairmanship of a Retired Supreme Court Judge, Justice Baharullslam. The

Committee urged for an immediate enactment of law to protect the rights of disabled.

Nearly after two decades of "Hide and Seek Game", at last the voices of the disabled are heard by the Law Makers at Delhi and the Welfare Minister Shri. Sitaram Kesari at last moved the bill in parliament on 26th August 95 "The persons with disabilities (Equal Opportunities, Protection of rights and full participation) Act 1995 (PWD Act)", passed by Parliament on 22nd Dec. '95.

3. **Sailent features of the Act**

- The Act fixes the responsibilities on the state viz.,

(i) Prevention and early detection of disabilities,

(ii) Protection of rights,

(iii) Education,

(iv) Training, (v) Employment and

(vi) Rehabilitation,

- Create Barrier free environment,
- Remove discrimination,
- Prevent abuse and exploitation of disabled,
- Main streaming of the disabled with normal persons,
- Development of programmes for equal opportunities,
- Create awareness among the masses through T.V. Radio and other medias on the case of disabilities and the preventive measures to be adopted,

- Access to free education till the age of 18,
- Integration of disabled children with normal children,
- Removal of Architectural Barriers from Schools, Colleges or other institutions imparting vocational and professional training,
- Redressel of grievances of parents regarding placement of their disabled children,
- Identification of posts that could be reserved and periodical review of such posts,
- Reservation of not less than three percent of posts for,
- Blind one percent,
- Hearing impaired one percent,
- Locomotor disability or cerebral palsy one percent,
- Notification of vacancies to special employment exchanges,
- Access of information by special employment exchanges about the vacancies arising and filled up in any establishment,
- Relaxation of upper age limit for employment,
- All Government educational institution receiving aid from the Government shall reserve not less than three percent seats to handicapped,
- Incentives to employers (both in private and public sector) to ensure five percent of the workforce is comprised of persons with disabilities.,

- Frame Schemes for preferential allotment of land at concessional rates for
  a. Housing
  b. Setting up of Business
  c. Establishment of factory by handicapped entrepreneurs etc.
- Adapt rail compartments, buses, vessels and air crafts in such a way as to permit easy access, adapt toilets to permit wheel chair users to use them conveniently.
- Non discrimination in roads and accessibility for easy usage of roads,
- Provision of lamps in public buildings,
- No establishment shall dispense with an employee who acquires disability during service,
- No promotion shall be denied to persons merely on the grounds of his disability,
- Community based rehabilitation (Mohan, 1995 and Devyani, 1997).

3. Recommendations

The prevention is most important and most cost-effective. Greatest emphases should be laid on the following :

1. Health services such as immunisation, natal and neo-natal care, maternal health, nutrition, breast feeding and effective medical facilities should be provided to the children in the early stages.

2. Provision of better housing, safe drinking water and sanitary disposed of excreta in rural areas and urban slums will be a boon in preventing many debilitating diseases.
3. Public and children should be educated about the traffic rules. Traffic laws should be strictly enforced. So we can avoid disability occurred through accidents.
4. To prevent child labour, specially against their employment in dangerous job. Public should be informed about childhood disabilities and prevention.
5. Early detection of impairments and disabilities in children in the community and their complete assessment and timely treatment will effect cure in many and will prevent further handicaps in others.
6. It is important to develop the remaining abilities of the disabled and to put them to best use with a view to ultimately make the disabled child a self dependent earning member of the society as far as possible.

C. Research Highlights

The study of Singhania, Bansal, Acharya, Sharma and Bansal (1987) reveals that children in age group of 3 - 6 are going through a critical sensitive period for learning. Speech, hearing and visual disability during this crucial period may lead to great harm to the child. It is essential to diagnose these disabilities early and intervene, so as to

prevent visual and hearing handicaps. They had developed simple, reliable, reproducible, economical, easily applicable and a rapid screening test for assessment of vision and hearing. With the help of it visual handicaps was detected in 12/247 and auditory handicaps in 15/247 children. The test was found to be reliable.

Desai (1987) studies revealed that the programme for the disabled should emphasize the primary responsibility for promoting measures for prevention of disability, rehabilitation and the realisation of the goals of full participation in social life and development and of equality of disabled persons rests with the individual countries.

Sunitha (1989) conducted "A study of the self concept and aspirations of the disabled Adolescents". Twenty five boys and girls normal, 25 boys and 25 girls crippled, 25 boys and 14 girls blind, 25 boys and 14 girls hard of hearing - all between the ages 16 - 21 constituted the sample for this study. The result of the study revealed that the normal adolescents had high vocational aspirations to become engineers and doctors. None of the disabled groups aspired to become professionals. Of the blind boys and girls aspired to become teachers and typists. Deaf adolescents were interested to become tailors. Normal adolescents had a positive attitude towards happy married life where as

crippled girls and of blind and deaf did not show any interest towards marriage. Normal adolescents had better self concept than the crippled, blind and hard of hearing.

Padmasundari (1990) made an attempt to the study "Involvement of parents in the achievement of Adoptive behaviour of their mentally retarded children before and after participation in the individualised institution programmes". This study was conducted with 50 mentally retarded children, selected from two institutions. Mentally retarded children receiving high co-operation from their parents had achieved more number of gross and fine motor skills. The level of involvement given by the parents showed a notable difference in their mentally retarded childrens achievement in the self help skills, such as eating, dressing, grooming and toileting. In language and communication skills, it was found that mentally handicapped children develop more slowly than their normal counterparts of the same chronological age, in both receptive and expressive language skills, the parents involvement had help to an extent in their children's achievement. The childrens participation in the institution programmes had not shown any responsible difference in their performance in communication skills inspite of their parent's involvement as most of the children has speech defects.

Corera (1990) has made an attempt "To study on visual motor learning disability among V standard children". The study was carried out in five corporation schools in Coimbatore city, where in 100 children comprising an equal number boys and girls from each of the schools were selected. The study revealed that there was no significant difference between the IQ of boys and girls. The IQ and academic achievement of the children was not found to be associated. The difference between the visual motor scores of the learning disabled and normal children were statistically significant at one percent level projecting that the identified learning disabled have visual-motor problems though they appear like normal children. The visual motor learning disabled children had a low behavioural profile compared to normal children.

Sumathi (1991) conducted a study on "Role perception of Anganwadi workers towards the disabled children". Three hundred Anganwadi workers who had a minimum of one year experience selected from the four, 'ICDS' - urban projects of Coimbatore. The study revealed that the anganwadi workers identified the disabled children from their physical appearance, lack of coordination in their movements, speech and language disorders, hand and leg peralysis, failure to understand and repeat and lack of concentration and also they had admitted disabled children in their anganwadis, 75 percent of the disability conditions occured due to heredity.

Anganwadi workers had been involved with referral services by sending the children to hospitals, primary health centres, specialists and to special institutions and also they were aware of the educational facilities for visually impaired, speech disorders, hearing impaired, motor disability and mental retardation.

Nainapandit (1992) has made an attempt to study "The personality traits of the orthopaedically handicapped youth". Sixty five orthopaedically handicapped youth in the age range 18 - 25 years from three institutions for handicapped who were undergoing vocational training comprised the sample. Eysenck's personality inventory was used to measure the personality traits, extraversion, stability etc. The study revealed that the 82 percent of the handicapped youth have a positive and hopeful outlook towards life. Age, sex and educational qualifications and institutionalisation did not effect the performance of the handicapped.

Mary (1995) made an attempt to find out "the effectiveness and use of improvised aids in developing the listening skills among the visually disabled". The findings of the study shows that the teachers who are using the improvised aids revealed that they are useful in developing the listening skills among the visually disabled. The

improvised aids not only induce the learning skills but also important in the life activities of visually disabled children.

Shanthi (1995) has conducted a study on "Assessment of visual functioning of low vision children". The sample consists of 25 low vision children in Ist and Vth class and resource teachers from 20 different integrated schools at Madurai and Coimbatore. The investigator developed a pre-training test kit to assess the visual functioning of low vision children. The test kit will enable the visually handicapped children to develop the skills like recognising, responding, naming, discrimination, identifying, describing, eye-hand co-ordination. As a result of it there is an improvement in the visual efficiency of low vision children.

Catanese, Coleman, King, Reddihough (1995) made an attempt to study the evaluation of an early child hood programme based on "principles of conductive education". He administered three standardised tests to know the cognitive ability of the children. And also parental care was also given at the beginning itself. The study proved that conducive education and greater parenatal support benefit the motor development of children with cerebral palsy.

Paddy and Samuel (1997) conducted a study on "promoting positive attitudes of Kindergarten age children towards

people with disabilities". Totally 46 children without disabilities ie., 23 girls, 23 boys participated. The study reveals that through social interaction, co-operation and group effort, the positive attitude was developed among the kindergarten children. They are mingling with the disabled without inhibition.

Cans, mazaubrun, verrier (1997) has conducted a study on the "prevalence and time trends of disabilities in school-age children". A population based survey was carried out in 1992-1993 in three french departments. All disabled children born between 1976 and 1985 and receiving a special education were systematically registered. The comparison of three cohorts of children borh in 1976-1978, 1979-1981 and 1982-1984 showed a significant decrease in the prevalence of severe mental retardation associated with psychosis. The time trend prevalence of cerebral palsy increased but was irregular. Whereas the prevalence of other disabilities motor defects severe sensory disabilities, did not have a change.

Methodology

III METHODOLOGY

The methodology pertaining to the study on "Rehabilitation of the Disabled in Coimbatore Slums" includes the following aspects :

A. To Understand the Socio-Economic Profile of the Disabled

B. Utilisation of the rehabilitative Measures to the Disabled

A. To Understand the Socio-Economic Profile of the Disabled

1. Identification of disabled

1. Identification of disabled

It includes the following aspects

a. Selection of the locale

b. Selection of sample

c. Selection of the method

d. Collection of data

e. Analysis and interpretation of the data

a. Selection of the locale

The Avinashilingam Education Trust, Coimbatore has been entrusted with the responsibility of initiating 40 Indira Mahila Kendras (IMKs) in Coimbatore Corporation. There were 631 disabled persons located by the IMK leaders from the 40 areas. It was too high a number to arrange for

rehabilitative services at one time, so it was decided to select only five areas to make a detailed study of the disabled and work towards rehabilitation.

The areas selected for the study were : Venkitapuram, Siddhapudur, Sivananda Colony, Avarampalayam, Selvapuram. These areas were selected owing to their accessibility and the good response evinced by the leaders of IMKs from these areas towards helping the disabled (Figure 1).

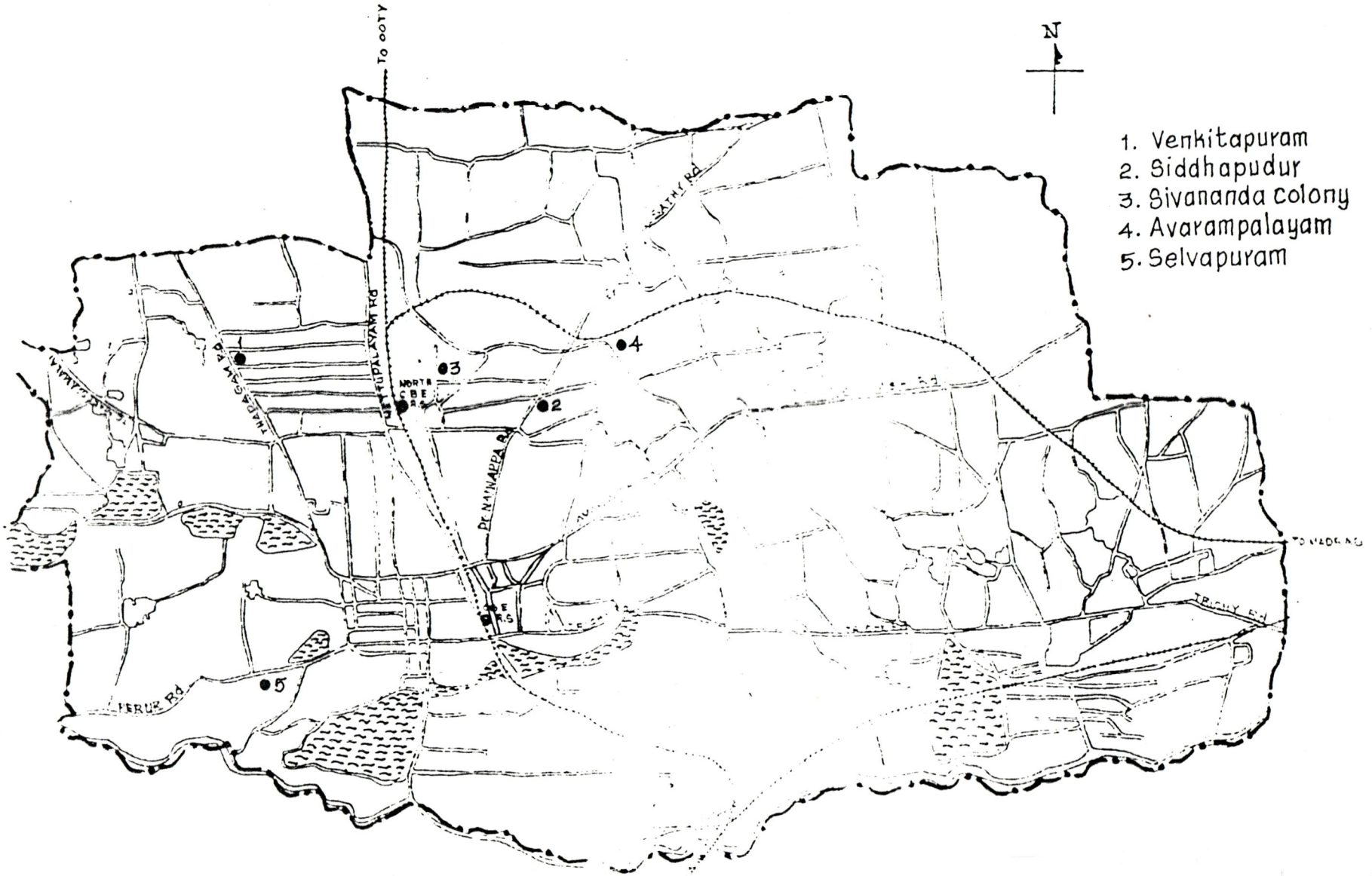
b. Selection of the sample

A sample is any group selected from a population for analysis. Hundred sample were selected based on the degree of disability. One hundred sample were selected by using purposive random sampling based on the priorities of rehabilitation. A purposive random sampling is a technique in which a desired number of sample units are selected deliberately and purposely depending upon the object of enquiry (Gupta, 1992, 1993, 1996).

c. Selection of the method

Interview schedule (Appendix I and II) was administered to gather socio-economic profile of the selected respondents, type of disability, causes, steps already taken etc. Interview schedule is a method which can be defined as a schedule for collection of data involving the presentation

MAP OF COIMBATORE CORPORATION



LOCALE OF THE STUDY

Figure 1

of oral verbal stimuli and reply interms of oral verbal responses. This method is used through personal interview's (Kothari, 1997).

d. Collection of data

The interview schedule was administered to collect the required information from the selected respondents after developing a good rapport with the sample.

e. Analysis and interpretation of the data

The obtained data were analysed, tabulated and discussed in succeeding chapters.

B. Utilisation of the Rehabilitative Measures to the Disabled

The aspect of the study has the following steps :

1. Contacting the agencies
2. Screening the disabled
3. Motivating the disabled to avail the services

1. Contacting the agencies

Kovai Rehabilitation Information Service Centre for Handicapped (KRISH) Tatabad, District rehabilitation centre (DRC) Coimbatore, Employment Exchange for physically handicapped, Coimbatore, Coimbatore Medical College Hospital (CMCH), Avinashilingam Shramik Vidyapeeth, Infant Jesus Convent for Hearing Impaired and Lions Club of

Perianaickenpalayam, Indian Speech and Hearing Association (ISHA), Coimbatore were contacted for the possible rehabilitative measures which could be utilised for the disabled located from selected areas.

2. Screening the disabled

Out of 100 disabled from five areas 50 were screened by the investigator with the help of the specialists on the possibility of treatment and willingness of the disabled and the family members could be selected for the study (Plate I).

3. Motivating the disabled to avail the services

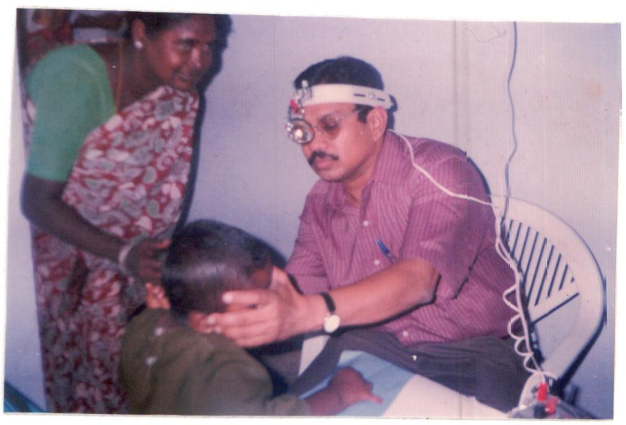
The investigator motivated the 50 disabled to avail the Rehabilitative services rendered by the "Kovai Rehabilitation Information Service Centre for Handicapped (KRISH), Tatabad, Coimbatore Medical College Hospital (CMCH), The District Rehabilitation Centre, Coimbatore, Employment Exchange for physically handicapped, Coimbatore, Avinashilingam Shramik Vidya Peeth, Infant Jesus Convent for Hearing Impaired, Periyanaickenpalayam, Lions club of Periyanaickenpalayam and Indian speech and Hearing Association (CBE ISHA Branch) (Appendix III),(Plate-II).

DISABLED PERSONS WHO WERE EXAMINED IN THE

FREE SCREENING CAMP TO DETECT SPEECH AND HEARING PROBLEMS

PLATE I

1



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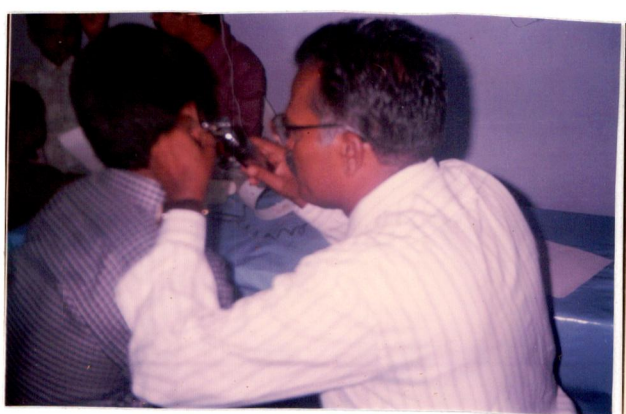

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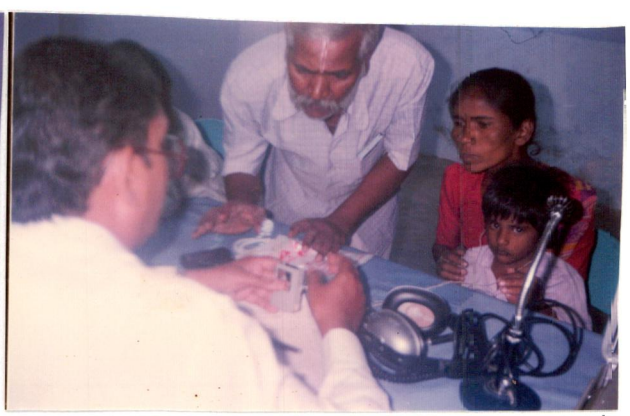


4

5

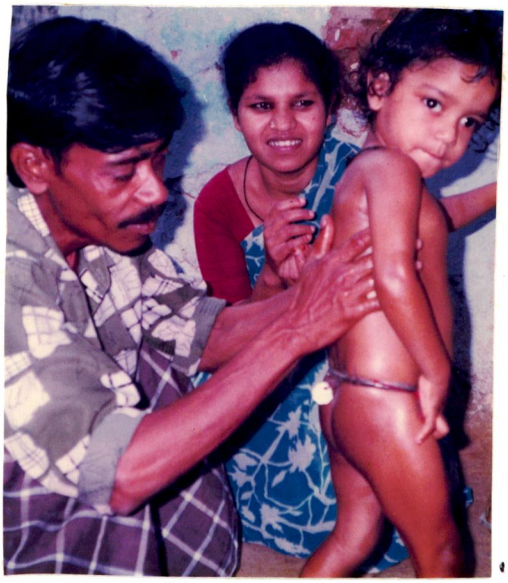
6

1.INAGURATION OF CAMP 2.3.SCREENING BY ENT SURGEON

4.HEARING-AID TEST 5.SCREENING BY SPEECH THERAPIST

6.AUDIOMETRY TEST

DISABLED WHO WERE AVAILING THE
REHABILITATIVE SERVICES
PLATE II



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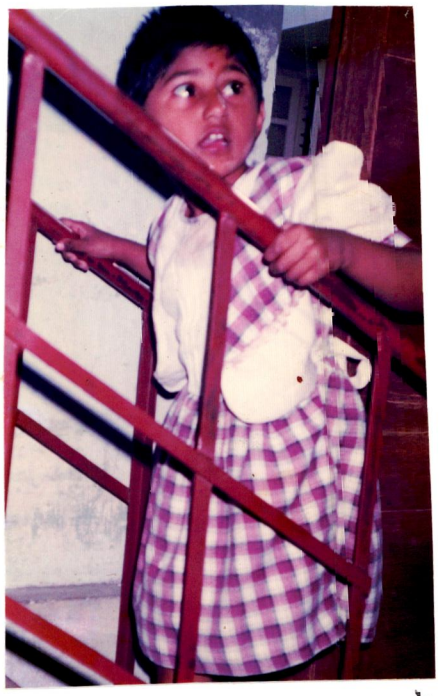

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5

1.OIL MASAGE

2.WATER TREATMENT

3.4.PHYSIOTHERAPY

5.SPEECH THERAPY

Results And Discussion

IV. RESULTS AND DISCUSSION

The results and discussion of the study on "Rehabilitation of the Disabled in Coimbatore Slums" includes the following aspects.

A. Background Information of the Disabled

B. Outcome of Utilisation of the Rehabilitative Measures"

C. Case Studies of the Beneficiaries Availing Intensive Medical Help

A. Background Information of the Disabled

The background information of the selected respondents is presented under the following headings :

1. General profile of the disabled

The general profile of the disabled has been discussed under the following headings :

a. Age wise distribution

b. Age at which disability occured

c. Educational level

d. Occupational status

e. Family income

f. Types of disabilities

g. Causes for the disabilities

a. Age wise distribution

Table IV depicts the age-wise distribution of the disabled.

TABLE IV

AGE WISE DISTRIBUTION

S.No.	Age in years	Percentage n : 100
1.	Below 20	30
2.	21 - 30	20
3.	31 - 40	20
4.	41 - 50	20
5.	50 and above	10

While 50 percent of the disabled were young within 30 years, 40 percent were in the age group of 31 - 50 years and 10 percent were above 50 years.

b. Age at which disability occured

Table V shows, age at which disability occured.

TABLE V

AGE AT WHICH DISABILITY OCCURED

S.No.	Age in years	Percentage n : 100
1.	Below 5	60
2.	6 - 10	10
3.	11 - 15	5
4.	16 - 20	5
5.	21 - 25	8
6.	25 and above	12

A majority of 60 percent became disabled at an early age of below five years, while 10 percent became disabled at an age group of six to ten years. For five percent the disability occured in the age group of 11 to 15 years and five percent at age of 16 to 20 years and eight percent at the age group of 21 to 25 years and remaining 12 percent respondents were disabled at the age of above 25 years.

c. Educational level

Table VI presents the educational status of the disabled.

TABLE VI

EDUCATIONAL LEVEL OF THE DISABLED

S.No.	Age in years	Percentage n : 100
1.	Illiterate	40
2.	Primary	27
3.	Middle	13
4.	Secondary	10
5.	Graduate	5
6.	Special education for the disabled	5

Forty percent of the disabled identified in the study were illiterates. On the other hand 27 percent of the disabled completed their primary education and 13 of them did middle and 10 percent completed secondary education and five percent of disabled had finished college education and

five percent completed special education. Educational attainment of the disabled proved that the disabled, proved that the disability was not a hindrance to their upliftment.

d. Occupational status

Table VII depicts the occupational status of the disabled.

TABLE VII

OCCUPATIONAL STATUS

S.No.	Occupational status	Percentage n : 100
1.	Employed	
	a. Unorganised sector	40
	b. Organised sector	10
	c. Self-employed	6
2.	Unemployed	44

Out of 100 disabled selected for the study 56 were employed. Out of 56 employed disabled, 40 percent were working in unorganised sector, 10 percent were in the organised sector and the six percent of the respondents were taking up self-employment for their livelihood and remaining 44 were unemployed

d. Family income

Table VIII presents the family income of the disabled.

TABLE VIII

FAMILY INCOME

S.No.	Family Income (per year)	Percentage n : 100
1.	10000 - 15000	75
2.	15001 - 30000	15
3.	30001 and above	10

Out of 100 respondents 75 percent of the selected disabled had a family income of Rs. 10,000 - 15,000 per year and 15 percent of disabled had a family income of Rs. 15,001 - 30,000 and a very few disabled had their family income of Rs. 30001 and above.

f. Types of disabilities

The categories of the disabled identified are presented in Table IX and Figure 2.

TABLE IX

TYPES OF DISABILITIES

S.No.	Areas	Physically Disabled					Mentally disabled	Total
		Speech impaired	Hearing impaired	Orthopaedically disabled	Visually disabled	Cleft palate		
1.	Venkitapuram	10	6	9	2	-	8	35
2.	Siddhapudur	1	1	3	2	-	3	10
3.	Sivananda Colony	12	18	-	1	1	3	35
4.	Avarampalayam	1	1	2	-	-	-	4
5.	Selvapuram	5	1	9	1	-	-	16
	Total	29	27	23	6	1	14	100

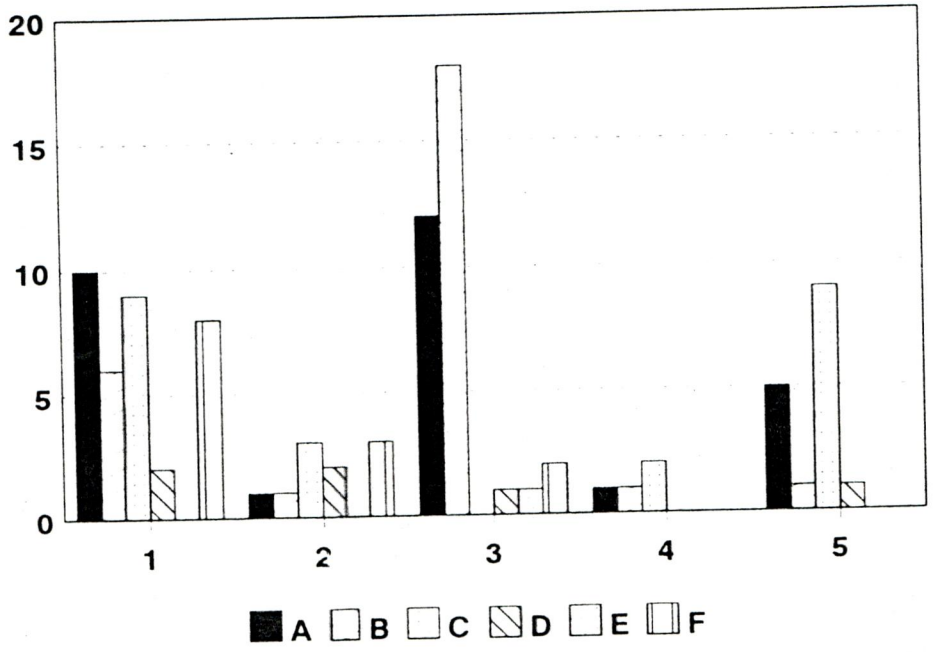


Figure 2

1. Venkitapuram
2. Siddhapudur
3. Sivananda Colony
4. Avaramplayam
5. Selvarpuaram

A. Speech impaired
B. Hearing impaired
C. Othopedically disabled
D. Visually disabled
E. Cleft palate
F. Mentally diabled

A majority 29 percent were found to be speech impaired and 27 percent disabled were suffering due to hearing disability and 23 percent respondents were orthopaedically disabled and six percent come under the classification of visually disabled only one suffers from cleft palate and 14 percent come under the category of mentally retarded.

g. Causes of disabilities

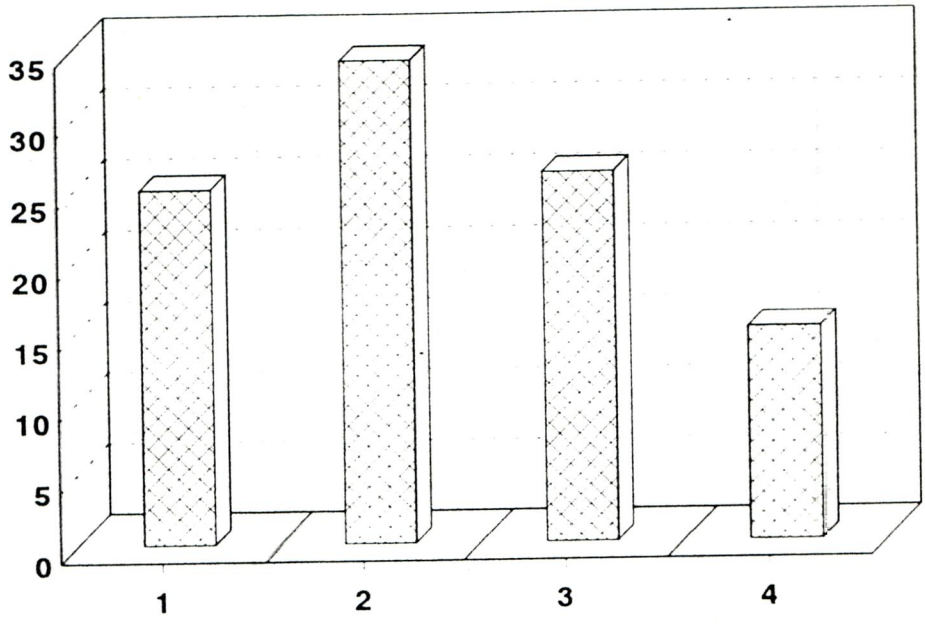
The causes of disabilities has been depicted in the Table X and Figure 3.

TABLE X

CAUSES OF DISABILITIES

S.No.	Causes	Percentage n : 100
1.	Genetic factors	25
2.	Diseases	34
3.	Lack of availability of immunization facilities	26
4.	Accidents	15

While genetic factors were responsible for the disabilities in the case of 25 percent and 34 percent revealed that they became impaired due to the communicable diseases and 26 percent were affected by not availing the immunization facilities. Accidents happened to be the causes for disability for 15 percent cases.



Causes of disabilities

Figure 3

1. Genetic factors
2. Diseases
3. Lack of availability of immunization
4. Accidents

B. Outcome of Utilisation of the Rehabilitative Measures

1. Details of rehabilitative services availed by the disabled

1. Details of rehabilitation services availed by the disabled

Table XI gives the rehabilitative services availed by the disabled.

TABLE XI

DETAILS OF REHABILITATIVE SERVICES AVAILED BY THE DISABLED

S. No.	Disability	Number	Rehabilitative services availed			
			Medical	Vocational	Social	Educational
1.	Speech impaired	20	20	-	-	-
2.	Hearing impaired	16	15	-	-	1
3.	Orthopaedically impaired	7	-	6	1	-
4.	Visually impaired	2	1	1	-	-
5.	Cleft palate	1	1	-	-	-
6.	Mentally retarded	4	4	-	-	-
	Total	50	41	7	1	1

Out of 50 disabled who received the rehabilitative services, 20 were speech impaired, 16 were hearing impaired, 7 were orthopaedically impaired, two were visually impaired, only one cleft palate while the remaining four were mentally retarded.

Out of 20 speech impaired, 10 received medical help rendered by Coimbatore Medical College Hospital (CMCH), while the remaining ten were taken to "Free screening camp to detect speech and hearing problems", organised by Infant Jesus Convent School for Hearing Impaired, Periyanaickenpalayam, and Lions Club of Periyanaickenpalayam Indian Speech and Hearing Association (CBE ISHA Branch) for treatment.

Out of 16 hearing impaired, ten persons attended the screening camp and received the medical help while the remaining 6 were taken to Coimbatore Medical College Hospital (CMCH) for medical help. out of these six hearing impaired, three were received hearing aids from District Rehabilitation centre, Coimbatore and one joined in deaf and dumb school [Kovai Rehabilitation Information Service Centre for Handicapped (KRISH)].

The Director, District Rehabilitation Centre helped, six orthopaedically impaired and one partial blind person to get loan with 20 percent subsidy, from, Indian Bank, Syndicate Bank, Canara Bank, Central Bank of India and State Bank of Mysore. One orthopaedically impaired was selected for the vocational skill training organised by Shramik Vidyapeeth. And one visually handicapped received medical help from CMCH.

One cleft palate had received medical help for speech improvement from Government Hospital, Coimbatore. All the four mentally retarded person were getting speech cum physiotherapy from CHCM.

C. Case Studies of the Beneficiaries Availing Intensive Medical Help

Case Studies of the sample are narrated in the following headings and shown in Plate III.

1. Hearing Impaired

Nagendra Rao is 14 years old boy studying 8th standard who is a hearing impaired from birth. The parents took the child to the private ENT specialist. The doctor adviced the use of hearing aid for the child. But the parents were not afford to buy a hearing aid for the child and so the child had to continue suffering.

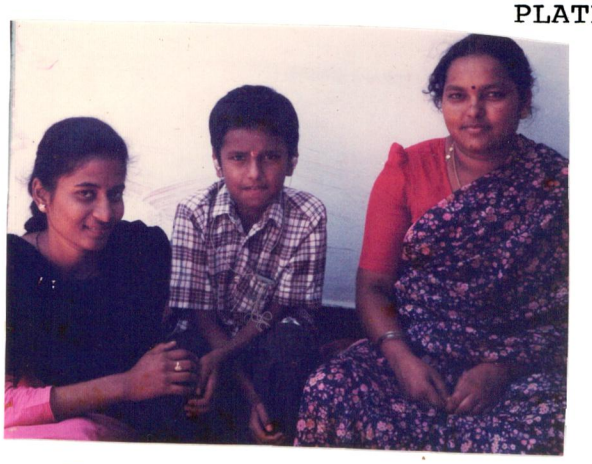
The investigator took the child to the CMCH, the ENT specialist took audition test and found that the degree of impairment was 82 percent. And so the child was given hearing aids for both the ears at free of cost through district rehabilitation centre Coimbatore. Now the child is able to hear and perform well in the school. His parents and himself bubbled with joy and happiness.

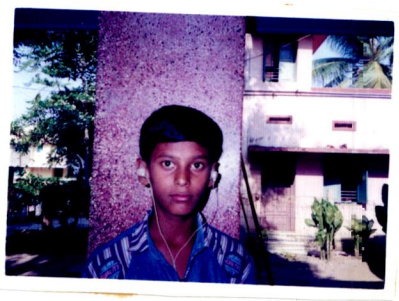
Santhosh, is a 14 years old boy studying in VII standard was hearing impaired who was using hearing aid, since hearing aid got broken, the parents could not buy new

BENEFICIARIES WHO WERE OBSERVED

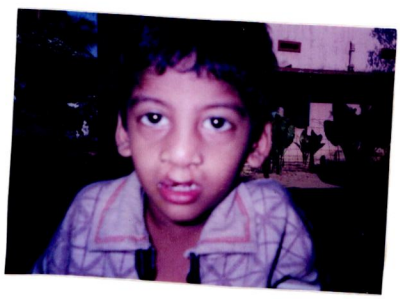
THROUGH CASE-STUDIES

PLATE III





1.2.SANTHOSH & NAGENDRAN WITH HEARING AIDS



3.SELVAN WITH CLEFT PALATE

5.ESWARAN WITH HIS SHOP

6.MUSTAFA RUNNING EXCITINGLY

one and so the boy found it difficult to move with others and listen to the class for a period of 6 months. The investigator approached the district rehabilitation centre and got the new one for the boy. Now the boy is happy with a new hearing aid.

Vikram, aged 9 years studying 5th standard who was suffering from hearing impairment from his birth. He is having one younger brother. He was using hearing aid for both the ears from his childhood.

He was taken to the ENT specialist CMCH by the help of the investigator. The ENT specialist took audition test and found that the degree of impairment was 85 percent. The doctor has advised the parents to use the hearing aid at all the times and suggested the parents to send him to the deaf and dumb school [Kovai Rehabilitation Information Service Centre for Handicapped (KRISH)] for attaining special education under the guidance of teachers and specialists. Thus he has been educationally rehabilitated and the parents also show a positive response for joining him in the day school.

Speech Impairment

Manimaran, aged 28 years was speech impaired and his right hand and right leg has no movements. He is depending on his parents for all the day-to-day activities. He was

taken to the ENT specialist CMCH. Manimaran got complaints of "Aphagia" delayed speech and has got articulation problem due to brain damage, as stated by the doctor. He is undertaking speech therapy and physiotherapy, and also given medicines. Because he is going for speech therapy regularly since four months (from January onwards) he had got improvement and he is able to utter few words and sentences. The regular physiotherapy is also helpful to the extent that he can show slight movements of his right hand and leg and finger's.

Nitya, aged 10 years was speech impaired girl right from her birth. She is having one brother who is a hearing impaired boy by birth. Their parents feel so sad for their condition.

She was taken to the ENT specialist CMCH in January month Nitya got complaints of "Aphagia" - delayed speech as stated by the doctor. The doctor has agreed to give speech therapy treatment regularly. She was also given medicines. As she is going for speech therapy treatment regularly, the could improve well and able to utter words slowly which her parents has bubbled with joy and happiness along with her. And doctor advised to continue the treatment till she improves.

Mentally retarded

Mustafa two and half years old boy is mentally retarded as well as physically impaired. He is not able to respond to external impulse, not able to stand as his spinal cord and the hip is affected. The child was taken to paediatrician and orthopaedic specialist at CMCH, Coimbatore. Now the child is given speech therapy and physiotherapy at CMCH every day. The child was also advised to give water treatment for the legs at home.

The improvement is very fast and the child is now able to utter some simple words and able to walk fastly and run even. The parents are very happy and convinced with the treatment given to him at CMCH.

Mauhammed Iaz, 15 year old is a mentally retarded boy suffering from cerebral palsy. His father is having a flower shop. He is having one younger brother. He was given proper care. He was found to be mentally retarded from his birth. Mauhammed alone was not immunised while the younger one was immunised in the appropriate time. The family members were not considered him as a burden. He could not feel anything happening around him and so he could not express his feelings. For all the activities he has to depend on the parent. So his parents feel too depressed of having a child with such a condition. He was taken to the Coimbatore Medical College Hospital (CMCH). The doctors examined and

gave him medical treatment. Accordingly to the doctors advice he had taken treatment daily. The condition will improve very slowly. And the treatment is being continued.

Orthopaedically impaired

Eswaran, is a 32 year old man where his leg is affected due to polio in his childhood days. He is an illiterate. He is married and having one son and daughter. He was taken to CMCH by his parents earlier. He was told by the specialist that more expenditure will be incurred for treatment. Years passed now that Easwaran preferred to take up some income generation programme.

Easwaran wanted to take up financial help for starting a petty shop. The investigator took efforts and contact district rehabilitation centre in getting a loan amount of Rs. 5000 (Rupees five thousand only) on 20 percent subsidy out an easy installment of repayment from State Bank of India, Ganapathi, Coimbatore. He has opened a petty shop (on the main road), Coimbatore and has paid two installments of loan and the shop thrives well.

Eswaran, was a 35 year old man who is physically handicapped, right leg is affected but can walk with support. He is married and got two sons. He was working in a radio repair shop and could earn meagre amount with which he could not support his family. He wanted to be self employed.

Hence Eswaran was recommended to "Avinashilingam Shramik Vidya Peeth" to undergo vocational training in Television and audio repairing. He was selected and undergoing training for a period of eight months. With the certificate after the training he can start a repair shop on his own with the financial help from any nationalised bank.

Cleft palate

Elakkia Selvan, 5 year old boy suffering from cleft palate and "Aphagia". Due to this problem he is not able to speak clearly like normal person. He becomes very frustated at times and emotionally upset when any one feels for his disability and wants to away from them. His parents were depressed on seeing his condition but were unable to help him due to the family condition. The investigator took the child, to the ENT specialist, CMCH on 7th January 1998. The doctor diagnosed the case and interpreted that the boy is suffering from cleft palate. He has prescribed some medicines and speech therapy at the first instance. The child is taking speech therapy at CMCH itself and continuing medication. There is fast improvement and the child is able to manage better to express his feelings through speech.

Summary and Conclusion

V. SUMMARY AND CONCLUSION

A study on "Rehabilitation of the Disabled in Coimbatore Slums" was carried out and the findings are summarised below :

Avinashilingam Education Trust, Coimbatore has been entrusted with the responsibility of initiating 40 Indira Mahila Kendras (IMKs) in Coimbatore Corporation. There were 631 disabled persons located by the IMK leaders from the 40 areas. It was too high a number to arrange for rehabilitative services at one time, so it was decided to select only five areas to make a detailed study of the disabled and work towards rehabilitation.

The areas selected for the study were : Venkitapuram, Siddhapudur, Sivananda Colony, Avarampalayam, Selvapuram.

A majority 50 percent disabled were young with 30 years and 40 per cent in age group of 31 - 50 years and 10 percent were above 50 years.

A majority of 60 percent became disabled at an early age of below five years, while 10 percent became disabled at an age group of six to 10 years. For five per cent the disability occured in the age group of 11 - 15 years and five percent at age of 15 - 20 years and eight percent at age group of 21 - 25 years and remaining 12 percent respondents were disabled at the age of above 25 years.

Forty percent of the disabled identified in the study were illiterates. On the other hand 27 percent of the disabled completed their primary education and 13 of them did middle and 10 percent completed secondary education and five percent of disabled had finished college education and five percent completed special education. Educational attainment of the disabled proved that the disability was not a hindrance to their upliftment.

Out of 100 disabled selected for the study 56 were employed. Out of 56 employed disabled 40 percent were working in unorganised sector, 10 percent were in the organised sector and six percent of the respondent were taking up self-employment for their livelihood and remaining 44 were unemployed,

Out of 100 respondents 75 percent of the selected disabled had a family income of Rs. 10,000 - 15,000 per year and 15 percent of disabled had a family income of Rs.15,001-30,000 and a very few disabled had their family income of Rs. 30,001 and above.

Out of 100 respondents selected a majority 29 percent were found to be speech impaired and 27 percent disabled were suffering from hearing disability and 23 percent respondents were orthopaedically disabled and six percent

Forty percent of the disabled identified in the study were illiterates. On the other hand 27 percent of the disabled completed their primary education and 13 of them did middle and 10 percent completed secondary education and five percent of disabled had finished college education and five percent completed special education. Educational attainment of the disabled proved that the disability was not a hindrance to their upliftment.

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Out of 100 respondents selected a majority 29 percent were found to be speech impaired and 27 percent disabled were suffering from hearing disability and 23 percent respondents were orthopaedically disabled and six percent

come under the classification of visually disabled and only one suffers from cleft palate and 14 percent come under the category of mentally retarded.

The genetic factors were responsible for the disabilities in the case of 25 percent and 34 percent revealed that they became impaired due to the communicable diseases and 26 percent were affected by not availing the immunization facilities. Accidents happened to be the causes for disability for 15 percent cases.

Among the 50 who received the rehabilitative services, 20 were speech impaired, 16 were hearing impaired, 7 were orthopaedically impaired 2 were visually impaired, only one cleft palate while the remaining 4 were mentally retarded.

Out of 20 speech impaired 10 received medical help rendered by Coimbatore medical college hospital (CMCH) while the remaining 10 were taken to "Free screening camp to detect speech and hearing problems" organised by Infants Jesus convent school for Hearing Impaired, Periyanaickenpalayam and Lions Club of Periyanaickenpalayam, Indian Speech and Hearing Association (CBE ISHA Branch) for treatment.

Out of 16 hearing impaired, ten persons attended the screening camp and received the medical help while the remaining 6 were taken to Coimbatore Medical College

hospital (CMCH) for medical help. Out of these six hearing impaired, three were received hearing aids from District Rehabilitation Centre, Coimbatore and one joined in deaf and dumb school [Kovai Rehabilitation Information Service Centre for Handicapped (KRISH)].

The Director, District Rehabilitation centre helped, six orthopaedically impaired and one partial blind person to get loan with 20 percent subsidy from, Indian Bank, Syndicate Bank, Canara Bank, Central Bank of India and State Bank of Mysore. One Orthopaedically impaired was selected for the Vocational Skill Training organised by "Shramik Vidya Peeth. And one Visually handicapped received Medical help from CMCH.

One cleft palate had received medical help for speech improvement from Government Hospital, Coimbatore. All the four mentally retarded person were getting speech cum physiotheraphy from CMCH.

The case studies revealed that the disabled after acquiring Rehabilitative measures were happy and they forget about their disability, move like normal person and try their level best to do their day-to-day activities by themselves.

Recommendations

* Disabled children have tremendous challenges to face. These unfortunate children have to carve out, find out and create opportunities for their welfare and existence.
* The study throws light on further followup studies in this field.
* Community Based Rehabilitation (CBR) need to be encouraged especially for the disabled children. Rehabilitative Services need to be decentralised.

Conclusion

The disabled children can also look forward to an eventful, useful and satisfying life provided rehabilitative measures taken at the initial stage itself. They will certainly do their best if the family, community and society allow them and encourage them to play their part in the field of their interest.

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Appendices

APPENDIX I

AVINASHILINGAM INSTITUTE FOR HOME SCIENCE AND HIGHER EDUCAITION FOR WOMEN (DEEMED UNIVERSITY), COIMBATORE - 641 043.

A SCHEDULE TO ELICIT INFORMATION ON REHABILITATION OF THE DISABLED IN COIMBATORE SLUMS

1. Name of the Interviewer :
2. Name of the Interviewee :
3. Name of the head of family :
4. Address of the respondent :
5. Religion :
6. Caste :
7. Occupation :
8. Educational status :
9. Type of family :
10. Family Background :

S. No.	Name of the family members	Educational Status						
		Age	Sex	Primary	Middle	High	Graduate	Illiterate	Occupation	Income

11. Details of Disability

S.No.	Name	Age	Disability			
			Physical	Mental	Reasons	Treatment

12. Did the disabled been immunized ? Yes No

13. If No, any consequences ?

14. Have you undergone any treatment ?

Measures undertaken by government and voluntary organisations to help the disabled

15. Have you heard about any government and voluntary welfare services for Handicapped ? Yes No

16. If yes source and details of Information ?

17. Have the receive any help from government and voluntary organisations Yes No

18. Have you undergone any vocational training ? Yes No

19. If yes, Are you benefitted ?

20. In what way do you need to be helped ?

Specify : a. Medical, b. Vocational, c. Social, d. Educational

APPENDIX II

AVINASHILINGAM INSTITUTE FOR HOME SCIENCE AND HIGHER EDUCATION FOR WOMEN (DEEMED UNIVERSITY), COIMBATORE - 641 043.

1. Name of the respondents :

2. Full address :

3. Family Background :

S.No.	Name	Sex	Age	Relation	Educational status	Occupation	Monthly income (Rs.)

4. Details about the disabled

S.No.	Name of the disabled	Sex	Age	Immunisation

5. Have you got any treatment with regard to disability ?

6. Have you received any free medical aid ? If yes, from whom ?

7. What is your opinion about their help ?

8. Do you need further help ? If yes, what type of help do you expect?

   a. Medical aid b. Educational facilities

   c. Job opportunities d. Others

9. What is your opinion about Government help ?

10. What is your opinion about Voluntary Organisations ?

S.No.	Category	Before	After
	Physical		
a.	Dependency for day to day activities		
b.	Psychological		
	1. Discomfort		
	2. Feeling of comfort		

APPENDIX III

Book-Post

SCREENING CAMP
TO DETECT
SPEECH & HEARING PROBLEMS.

☆

JOINTLY SPONSORED BY
INFANT JESUS CONVENT SCHOOL
FOR HEARING IMPAIRED

LIONS CLUB OF PERIYANAICKENPALAYAM
INDIAN SPEECH & HEARING ASSOCIATION
(CBE ISHA BRANCH)

☆

April 4th, 1998. 8.30 A.M
(National Speech & Hearing Day)

☆

Lions Club Kalyana Mandapam
Periyanaickenpalayam,
Coimbatore - 641 020.

To V.S.Kanthi
AOU, CBE

APPENDIX III

Programme

8.30 A.M.	**Prayer**
8.35 A.M.	**Welcome Address** *Sr. Ezechiel, C.M.C, Mother Provincial, Jai christo, Palakkad.*
8.40 A.M.	**School Report** *Sr. Jees Mary, Principal Infant Jesus Convent for Hg. Impaired CBE - 20*
8.45 A.M.	**Presidential Address**
8.55 A.M.	**Address by Chief Guest**
9.05 A.M.	**Exhibition inauguration**
9.15 A.M.	**Speech by Guest of Honour**
9.25 A.M.	**Felicitation by Special Invitees.**
9.40 A.M.	**Vote of Thanks** *Mr.T.Kannan, Sp.Therapist S.R.K. Hospital, CBE - 44.*
9.45 A.M.	**National Anthem.**

Services Rendered by Infant Jesus School for Hearing Impaired Children

- Academic training to Deaf Children upto the level of 12th Standard.
- Vocational Training to Adult Deaf individuals.
- Transport facility available.
- Residential Hostel facility is under consideration.

- April 4th every year is celebrated as National Speech and Hearing Day
- Speech and Hearing Professional Services are available in the following places in Coimbatore.
  1.) C.M.C. Hospital,
  2.) K.M.C.H.
  3.) P.S.G. I.M.S.
  4.) K.G. Hospital,
  5). Sri Ramakrishna Hospital

INFANT JESUS CONVENT SCHOOL FOR HEARING IMPAIRED CHILDREN

In Colloboration With

LIONS CLUB OF PERIYANAICKENPALAYAM

&

COIMBATORE BRANCH OF

INDIAN SPEECH & HEARING ASSOCIATION (ISHA)

Cordially invite you to the inauguration of

SPEECH & HEARING PROBLEM DETECTION SCREENING CAMP

Place:

Lions Club Kalyana Mandapam
Mettupalayam Road, Ranganayaki Nagar,
Periyanaickenpalayam, Coimbatore - 641 020.
(Near SRKV Bus Stop)

Date & Time :

Saturday the April 4th, 1998. 8.30 A.M
(National Speech & Hearing Day)

All are Welcome

Dr. D. Balasundaram M.S., DLO.,
(Prof. & Head, ENT Dept, C.M.C.H., CBE -18)

Will Preside Over the Function

Mr. M.R. Maruthappan
(President, Gudalur Town Panchayat, CBE - 20)

Will be the Chief Guest & Inaugurate the Camp

Mr. Fredric David
(Chief Engineer TNEB, CBE -12)

Will declare Open the Exhibition

Mr. R. Damodarasami Naidu
(Chairman - Lions Club Trust, Periayanaickenpalayam)

Will be the Guest of Honour.

Mr. L. Sivasamy
(Dt. Emp. Officer CBE - 29).

Ms.D. Puspha
(E.O., Gudalur Town Panchayat, CBE -20).

Mr.Thomas Antony
(M.O.Panchayat Union Periayanaickenpalayam, CBE - 20

Mr. P.Sekar
(Dt. Rehab.Officer for P.H. CBE - 18)

Mr. K. Narendiran
Sp.Therapist, ENT, C.M.C.H CBE - 18.)

Ms. Jothimani
(Junior Emp. Officer - P.H, CBE - 29.)

Will be the Special Invitees