Unit-03 ❑ Problem of Social Dependency : Aged, Disabled, Homeless

Structure :

3.1 Problem of Aged or Elders

3.2 Problem of Disabled

3.3 Problem of Homeless

3.4 Exercises

3.1 Problem of Aged or Elders

The definition of the aged officially accepted in India was 55 years—the age of superannuation when the employees retire from service. Subsequently it was raised to 58 years. In the western countries, however, person is considered aged if he reaches the age level ranging between 60 and 65 years. The determination of the old age is naturally linked with the average life expectancy. With the age expectancy having gone up, there is a demand that the government should raise the mandatory retirement age from 58 to 60 years.

The old age has come to represent all the classical characteristics of a social problem. Concern about the growing proportion of older people in the population her tended to rise and fall, to wax and wane as a social issue, being ignored at some times and rising to a crescendo of debate at others; in its presentation there is a persistent tension between the observable evidence and perceptions of the problem; it has become a site of conflict between substantial social interests, especially between the citizen, the family and the state. In particular, the needs of older people have frequently been presented as an unfair burden on others and thus as something deserving of public attention and social policy remedies. Among the concerns of those who perceive the ageing of population as a problem the following are frequently mentioned :

(i) that the growing proportion and unforeseen longevity of the retired population will put on unacceptable burden on pension systems, especially these funded out of current taxation;

(ii) that because the numbers of the oldest old people, these over 75 or 80, are growing fastest there will be exceptional demands for social care from dependent older people, which the state and the family may find difficult to meet;

(iii) that each succeeding generation of older people tends to be more demanding of income and services than the previous one and that will particularly apply to the 'baby-boomer' generation, who have become accustomed to high and rising standards of living—it is sometimes suggested that this footwar generation has been particularly selfish, exploiting those coming before and after it;

(iv) that the family, the traditional source of care for older people, will be less willing and less able to meet care needs than before; because of greater family instability and change due to divorce and single parenthood, and because the values that support family obligations to care are becoming less strong;

(v) that women, the main providers of social care from within the family, will be less able and willing to carry out the care tasks they traditionally have because their participation in paid work will leave them with less time to care and because fewer will accept the social norms that have hitherto defined family care as a women's duty. Personal and social issues are not generally portrayed as major social problem. Dependence on others at some points in life is a natural and inevitable condition. All of us experienced dependency as infants, many of us need support during lives at times of illness or disability, and almost all of us will require help because of the limitations that age brings. However, it is only the frailty and dependency of all age that has regularly come to be seen as a social problem. The needs of young children and of healthy but disabled adults, while understood as both.

A silent revolution has occurred in the last 100 years-unseen, unheard, and yet so close. The biggest achievement of the century is longevity. All over the world life expectancy has risen, leading to a sharp rise in the number of Older Persons.

The Indian Scenario

In India life expectancy has gone up from 20 years in the beginning of the 20th century to 62 years today. Better medical care and low fertility have made the elderly the fastest growing section of society. In France, it took 120 years for the grey population to double from 7% to 14%. But in India, the grey population has doubled in 25 years!

Statistical Dimension of Senior Citizens (2001)

- 77 Million elderly population (projected to 177 Mn by 2025)
- 90% with no Social Security
- 30% of older persons live below the poverty line
- 33% of older persons live just marginally over the poverty online
- 80% of older persons live in rural areas.
- 73% are illiterate, and can only be engaged in physial labor.
- 55% of elderly women are widows
- There are nearly 200,000 centenarians in India.

Elderly Populace is the Fastest Growing Section of Society in India

- Increased life expectancy
- Advancements in medical/health technologies
- Better nutrition
- Gradual fall in mortality rate
- Low fertility rates
- Increased awareness.

Solution to this ever-growing chasm lies with the society and the support groups. The support groups define the gaps, the needs and views for future responses to abuse, care and prevention.

Major Concerns

At times old age is associated with unacceptance, denial, depression, loneliness, and a certain *degree* of alienation from the mainstream of family life. Changing lifestyles, attitudes, values and increasing generation gap compound the problem.

Why is India Ageing or Greying Fast?

- Advancements in medical/health technolgoies
- Gradual fall in mortality rate
- Increased awareness
- Better nutrition
- Increased life expectancy

Key Issues for Concern

- Dignity
- Access of Health and other support systems
- Financial & Physical Insecurity
- Elder Abuse
- Violence
- Quality of Life
- Unacceptance
- Denial
- Depression
- Loneliness
- A certain degree of alienation from the mainstream of family life

International Plan of Action for Ageing

According to UN Projections, in the year 2025, a projected 1.2 billion elderly people will be living in the world; 71 percent of them are likely to be in the developing regions. And between 1950 and 2025, in both developing as well as developed regions, the ''Old'' Old (those who are 80 years and above) will grow twice as fast as the 60-plus age group. Population of Elderly People, above 60 years of age (Senior Citizens) is increasing at a faster rate than the general population, is now an established fact. This is because of increase in life expectancy rates and decline in the birth rate as a result of improved *health care* services.

Our life expectancy level which was 23 years at the beginning of the century, rose to 32 years in 1951 and in just three decades has risen to 58 years. It is soon expected to cross 60 years, in the next few years. And our elderly population which according to 981 census was about 43 million, has already crossed 50 million mark and is further expected to shoot up to 75 million and more by the turn of the century as per latest projections.

This century has been witness to a silent revolution—unseen, unheard, and yet so close. The biggest achievement of the century is longevity. All over the world life expectancy has risen, leading to a sharp rise in the number of Older Persons. In India life expectancy has gone up from 20 years in the beginning of the century to 62 years today. Better medical care and low fertility have made the elderly the fastest growing section of society. In France, it took 120 years for the gray population to double from 7% to 14%. But in India, the gray population has doubled in 25 years!

The story in figures :

1901—12 million older persons

1951—19 million

2001—70 million

By 2025, this gray population will be whopping 177 million!

While the numbers have gone up, quality of life has gone down. Industrialisation, migration, urbanisation and westernisation have severely affected value systems. The erstwhile joint family, the natural support system, has crumbled. The fast-changing pace of life has added to the

An Example of a WHO Programme to Show How Intervention Works

New programme orientations Programmes focused on those who already are old have serious limitations. Concentrating on old people who already have diseases tends to overlook the long-term developmental processes that have resulted in the disease. For this reason, the 95th Session of the Executive Board (January 1995) endorsed a proposal for the re-orientation and re-naming of HEE to become an integrated Programme on Ageing and Health (AHE). Ageing and Health concerns both old age and ageing, building on seven key orientations in response to the above-outlined key challenges of global ageing. These

perspectives will be examined by a WHO Expert Committee on Ageing and Health that will meet in 1998. This Committee's guidance will be sought as to how the Programme can best prepare WHO and its Member States to play a major role in highlighting the health component of the International Year of Older Persons (1999).

1. Life Course Perspective

Health in old age is determined by the patterns of living, exposures and opportunities for health protection over the life course. The patterns of living that enhance health are formed in early life and are not easily changed. Furthermore, the most frequently occurring ageing-related diseases-such as cardiovascular diseases and cancer—are long-term disease processes.

2. Cohort Perspective

Valid and meaningful approaches to cohort analysis, necessary for scientifically sound research on ageing, are especially crucial for understanding the consequences of rapid social change. Relatively little is known about ageing compared to other life phases. This is largely due to the fact that research has neglected cohort differences in both health and the factors that protect or damage it, contributing to pathological models of ageing.

3. Health Promoting Perspective

Pathogenic approaches cannot meet the challenges of global ageing outlined above. Statistical correlations relating age and disease/disability tend to result in a focus on ageing as problematic and the aged as ill, leading many to believe that the changing age distributions will only cause problems. Such pessimism is unwarranted and inhibits the development of effective health policy and services. Longitudinal studies have shown that physical and mental status can improve in successive older cohorts. The programme's challengeis to understand and promote the factors that keep people healthy, with a focus on both personal and external resources.

4. Cultural Perspective

An effective life course perspective must be embedded in a cultural perspective. Patterns of daily living are learned in cultural settings that shape values and goals. Peer group pressures, together with traditions, spirituality and religious values of society, habits of charity, duties of children and extended families, are among the major influences shaping and maintaining ways of living. They are clearly defined and need to be considered when interventions aimed at improving well-being in older age are planned. Health programmes must contribute towards a positive view of ageing.

5. Gender Perspective

In order to be effective, health research and programmes need to recognize gender differences in both health and ways of living. Men die earlier, while women experience greater burdens of morbidity and disability. Women constitute the majority of care givers; supporting them is a key health policy challenge.

6. Inter-generational Perspective

Ageing is a matter for both those who are already old and those approaching old age. One major social transformation that accompanies population ageing is the restructuring of inter-generational relationships. Policies with an inter-generational perspective are needed if new roles are to be developed for older people. Strategies to maintain cohesion between the generations are required if inter-generational conflict over competition for resources is to be avoided.

7. Ethical Perspective

As populations age, a range of ethical considerations come to the fore. They are linked to inequities, allocation of resources, choice of interventions, undue hastening or delaying of death, and a range of dilemmas linked to long-term care provision and the human rights of poor, disabled or demented elderly. WHO must support Member States in clarifying these complex issues, through advocacy and upholding the rights of all older people.

8. Key Programme Components

AHE is currently making a systematic effort to develop a healthy ageing global strategy. In doing so, it follows the conclusions and recommendations outlined by the 1987 Expert Committee through the development of six integrated Programme components : information strengthening; information dissemination; advocacy; informed research; training; and policy development. They are interconnected and often overlap :

9. Information Base Strengthening

Over the last few decades a substantial body of ageing-related information has been accumulated, to which new information particularly focused on health aspects of ageing is rapidly being added. Decision-makers, administrators and care professionals need to be kept abreast of policies and programmes both in health promotion and provision of care, as well as information on most recent research advances. AHE is currently establishing information centres/clearing houses on trends in ageing and health, and those studies and surveys most relevant to health and social services with a particular focus on developing countries. These functions are to be performed by different collaborating centres, making full use of electronic communication.

Examples of activities

A cross-national study, based on 35 community-based data sets, of the need of elderly populations for home care in both developed and developing countries. This study was performed by AHE staff under a grant from the National Institute on Aging (NIA), USA. The NIA is also providing the resources for an AHE project to bring together the data-base of longitudinal studies conducted worldwide and on projections related to the burden of diseases in older age in the early 21st century.

There is an elecronic library on healthy ageing, with a special focus on evidence-based effective interventions for healthy ageing, in collaboration with the University of

Oxford. A postal survey (involving the members of the WHO Expert Advisory Panel on Ageing and Health) provided the information base requirements for policy development. AHE is developing a gender database highlighting the health differentials within the ageing process related to men and women in different societies.

10. Dissemination of Information

Information on the health aspects of ageing, presented in a range of formats, needs eventually to be disseminated to ageing individuals, caregivers, professional carers, policy-makers and the academic community at large. Accordingly AHE has adopted multiple strategies which, in themselves, reinforce the network without which the programme could not be effective.

Examples of Activities

Information on healthy ageing has to be provided to those who can most benefit from it, in a direct and simple way. Accordingly, AHE has launched a series of guidelines on healthy ageing in partnership with WHO Collaborating Centres, academic institutions and non-gvernmental organizations. The guidelines relate to subjects such as physical activity, healthy eating for healthy ageing, prevention and management of back pain, and of incontinence.

Caregivers reqire practical information to facilitate their taks, increase the quality of life of those for whom they care and improve their own well-being. Hence, AHE is collaborating with institutes such as the School of Social Work, Catholic University of Sao Paulo, Brazil to produce a manual for caregivers on care at home for dependent elderly people.

Cultural settings determine the way individuals age. In order to highlight the opportunities and challenges related to rapid population ageing in different parts of the world, AHE has launched a series of position papers (the first of which focused on Africa) prepared by experts with first-hand-experience from different regions. AHE's adopted key perspectives need to be illustrated in a way that makes them easy to understand. The special issue of WORLD HEALTH Magazine (July-August 1997) on "Active Ageing" is an example of such an atempt.

AHE central themes—such as gender issues; physical activity; inter-generational perspectives—should be the subject of regular up-dates. The Ageing and Health Programme has therefore planned a series of review papers on topics such as women, ageing and health, cardiovascular diseases in *older women*; gender differentials in ageing; physical activity in older age; and information for decision-makers on healthy ageing.

The WHO Healthy Cities movement has accumulated a wide range of experience in ageing-related projects that merited broader dissemination. AHE conducted a survey aimed at recording some of this experience: the resulting paper was published in the Journal of Cross-Cultural gerontology.

11. Advocacy

In many countries there is only limited perception that ageing is a priority public health issue, while in others a negative approach persists which equates ageing with insurmountable problems. Above all, the contribution of older people to their families, their communities and to the economy is vastly understimated in virtually all countries. Thus advocacy is required at two levels.

- AHE works with government agencies, NGOs and the media on an advocacy strategy to influence public opinion and encourage support for community-based programmes that support healthy ageing.
- AHE aims to increase opportunities for older persons themselves to participate in policy development at local, regional, national and international level.

Examples of Activities

Geneva hosts a number of international agencies as well as large NGOs which maintain offices there. Further, it has a thriving gerontological research community. However, until recently, very little contact existed between these natural allies. AHE, in association with the Swiss National Research Programme on Ageing and the local representative of the American Association of Retired Persons (AARP), launched early in 1996 the Geneva International Network on Ageing (GINA) with a view to facilitating the exchange of information, promoting advocacy and encouraging collaborative projects. GINA is now a thriving informal network which has sucessfully mobilized the local community around the healthy ageing message (for instance, through celebrations of the International Day of Older Persons), with repercussions at national and international levels. Other key cities in a range of countries are now replicating the GINA model.

Among other activities, AHE participates in prominent international conferences, congresses and workshops in a way that promotes and disseminates its perspectives and establishes new partnerships. Keynote presentations at international meetings on all continents have been given by AHE staff since the Programme's establishment in 1995.

In order to reach wider audiences and for its key messages to have broader impact, involvement with the international media has been a priority for AHE. Accordingly, AHE messages have been given high visibility by the international media and that of selected countries. AHE is gradually building up its capacity to establish a global media strategy for healthy ageing that will be developed in close collaboration with main international networks.

1999 has been declared the International Year of Older Persons. AHE is developing a plan of activities aimed at highlighting the importance of health promotion as populations age. AHE is the WHO focal point for liaison with other UN Agencies, NGOs and national governments to ensure that healthy ageing will be a key message to be promulgated throughout the 1999 celebrations. In this connection, it has already been decided that the theme of the World Health Dey (7 April) that year will be "Healthy Ageing". (Plans for this

celebration are already underway.) And on 1 October 1999, AHE will launch a global movement highlighting the "Active Ageing" message which has been planned since 1996 and which is centred on multiple inter-generational celebratory walk events in cities throughout the world, to be inspired by the highly successful "rehearsals" that took place in Rio de Janeiro and Geneva in 1997.

12. Informed Research

In light of its key perspectives, AHE has shifted its research focus away from a disease-oriented paradigm towards one primarily concerned with health. For that, the previous three programme components are crucial : it is only by strengthening the information bases and disseminating the information gathered that knowledge gaps can be clearly identified. Further light can be thrown on the research agenda that is needed, through advocacy—involving new players (the consumers included) in the broad consultation. In particular, three main research areas are the subject of special attention by the programme.

1. studies of the epidemiological transition;
2. patterns of population ageing, looking in particular at results of longitudinal studies; and
3. determinants of healthy ageing.

Rather than funding the conduct of research projects, AHE efforts are concentrated on supporting the development of multidisciplinary research agendas and infrastructures at country level. AHE also fully recongizes the importance of adopting new approaches to research on ageing and health in order to establish the knowledge base for public health action in an ageing global population.

It is envisaged that AHE will launch a major research initiative by the beginning of 2000. To that effect, preliminary discussions with potential partners are now being held and a conference in Bellagio in collaboration with The Rockefeller Foundation is being planned for September 1998.

Examples of Activities

Based on review papers specially commissioned from leading experts and on the conduct of workshops involving a wide range of professionals from all regions, disciplines and backgrounds, a position paper on research priorities in ageing and health has been prepared and widely disseminated for feed-back. (The paper comprises a Delphi-style survey (involving 120 experts representing all Regions and disciplines) to ascertain research priorities on ageing and health in developing countries. State-of-that-art reviews have been commissioned from leading experts on issues such as healthy life expectancy; functional assessment; methodology for longitudinal studies on ageing; and the identification of priority research opportunities.

13. Training

AHE training activities should both reflect its newly-adopted dimensions and perspectives as well as being particularly focused on training primary health care workers. Given the pace and context of ageing worldwide, it is inconceivable that within the next two or three decades countries will be in a position to provide specialized care to over 1.2 billion elderly people. Thus an emphasis on basic training of primary health care workers assumes paramount importance. Mechanisms to ensure the gerontological content in the basic training curricula of all health and social service professionals are being pursued by AHE. In addition, due attention is being paid by AHE to training in epidemiology of ageing and the training of allied professionals in ageing and health.

Examples of Activities

In collaboration with the Department of Geriatrics at universities in Switzerland, Tunisia and Mexico, AHE is in the process of preparing a manual for primary health care workers on geriatric care. The manual consists of 20 modules covering the most common ageing-associated symptoms and syndromes presented by older people living in the community.

Considering that epidemiology is a basic discipline in fostering a clearer understanding of the process of population ageing and ensuring public health implications, regional courses on epidemiology of ageing would greatly assist health professionals in general and policy-makers in particular to developing effective policies in their home countries. Accordingly AHE has launched a series of short courses on epidemiology of ageing, modelled on successful previous experiences at the University of London. The first of these short courses was held in South Africa early in 1997.

Collaboration with other sectors in essential for the attainment of the highest level of health in older age. In this respect AHE has collaborated for instance, with the University of Geneva in the preparation of a manual for teaching instructors of physical education about appropriate physical activity for older people.

14. Policy Development

The ultimate objective of the Ageing and Health Programme is to collaborate with Member States in activities aimed at strengthening their capacity to respond to rapid population ageing through the development of appropriate policies. All the previously-described programme components contribute to this goal.

AHE is gradually establishing a meachnism for supporting countries-particularly in the developing world-in formulating health policies for their ageing populations. The main focus of the Expert Committee on Ageing and Health in December 1998 will be related to such policy—making mechanisms. It is envisaged that starting in 1999, a series of country-based inter-sectoral workshops will be conducted in cooperation with WHO Regional Offices and multiple agencies, with the objective of developing healthy ageing

policies. Such workshops will be supported through policy manuals; wherever possible, coutnries would previously have conducted national surveys of their elderly population using common protocols that are being developed.

Examples of Activities

In July 1996, under the sponsorship of the Brazilian government, AHE organized an international meeting focused on policy development which launched the "Brasilia Declaration on Ageing", a document that lays down the main principles to be considered in the process of policy making on healthy ageing.

In February 1997 AHE collaborated with the WHO Collaborating Centre at the National Institute for Research and Care on Aging, Florence, Italy to organize a consultation with the theme "Ageing, Health and the Home Environment". The final report of this consultation highlights the importance of promoting policies that create home environments conductive to maintaining independence and autonomy for older people living in the community for as long as possible.

In Febraury 1997 AHE organized a meeting in Hannover, Germany with sponsorship from the German Ministry of Health. The final report of this meeting-whose theme was "Population Ageing : health care costs and policy development"—is focused on the information base required by policy makers to promote health in older age.

AHE is planning the establishment of "global centres" on ageing and health with a particular focus on policy development for healthy ageing in developing countries. Negotiations are underway to establish the first of these centres in the prestigious University of Campinas, Sao Paulo, Brazil.

Central Govt. Schemes

An Integrated Programme For Older Persons

Objectives

The basic objective of the programme is to promote a Society for all Ages and to empower and improve the quality of life of older persons. The programme seeks to develop awareness and build the capacity of Government and Non-Governmental Organisations and the community at large to make productive use of older persons and to provide care to older persons in need. Under the programme as many as 186 Old Age Homes, 223 Day Care Centres, 28 Mobile Medicare Units and a few projects providing non-institutional services to older persons are already operational with the help of more than 400 Non-Governmental Organisations.

Annapurna Scheme : The Ministry of Rural Development launched the scheme in 2000-2001. Indigent senior citizens of 65 years of age or above who though eligible for old age pension under the National Old Age Pension Scheme (NOAPS) but are not getting the pension are covered under the scheme. 10 kgs of foodgrain per person per month are supplied free of cost under the scheme.

From 2002-03, it has been transferred to state plan along with the National Social Assistance Programme Comprising the National Old Age Pension Scheme and the National Family Benefit Scheme. The funds for the transferred scheme are being released by the Ministry of Finance as Additional Central Assistance (ACA) to the state plan and the states have the requisite flexibility in the choice of beneficiaries and implementation of the scheme. The implementation of the scheme at the ground level rests with the states/UTs.

Scheme of Assistance to Panchayati Raj Institutions/Voluntary Organisations/ Self Help Groups for Construction of Old Age Homes/Multi Service Centres for Older Persons

Scheme of Assistance to Panchayati Raj Institutions/Voluntary Organisations/Self Help Groups for Construction of Old Age Homes/Multi Service Centres for Older Persons.

Objectives

The basic objective of the programme is to provide financial assistance for construction and equipment of Old Age Homes and Multi Service Centres for Older persons to Voluntary Organisations/Self Help Groups and to Local Bodies.

Emergency Feeding Programme

Emergency Feeding Programme, is a food-based intervention targeted for old, infirm and destitute persons belonging to BPL households to provide them food security in their distress conditions. This was introduced in May, 2001. The Scheme is being implemented by Government of Orissa in eight KBK Districts namely Bolangir, Kalahandi, Koraput, Malkangiri, Nawarangpur, Naupada, Rayagada and Sonepur of Orissa covering 2 lakh beneficiaries. Under the scheme, foodgrains (rice) at BPL rates in being allocated to State Government on the recommendation of Minsitry of Social Justice & Empowerment since May, 2001 by Department of Food & Public Distribution. 14,400.00 MT of rice is allocated for the said 2 Lakhs beneficiaries @ 6 kgs/beneficiary/month.

3.2 Problems of Disabled People

The loss or impairment of a limb or deformity in one's physical or mental capability is the worst that can happen to a person, whether it is because of nature's foul play or as a result of an unexpected unfortunate accident. Welfare of the disabled and the handicapped is an extremely challenging task and it can be fulfilled only when all the citizens, voluntary organisations and Government realise their responsibilities in the respect collectively.

It is the primary duty of the industrialists and philanthropists to come forward with their vast financial resources to implement the various programmes so as to lay down a sound base for the integrated welfare and upliftment of the handicapped. The Declaration of the Rights of the Disabled passed by the United Nations in 1975 had clearly said, "Disabled persons are entitled to have their special needs taken into consideration at all

stages of economic and social planning.'' United Nations had designated 1981 as the International Year of the Disabled. The ''World Disabled Day'' is observed on third Sunday of March every year to create awareness among the people regarding the needs of the handicapped and their problems.''

The disabled are as much vital organs of society as the healthy persons. It is our moral duty to do our utmost for their rehabilitation and uplift. It has been observed that in most cases, the handicapped have a zest for life and desire to live as normally as possible and require only a chance to prove that they can be as effective as anyone else at the tasks assigned to them. With a little bit of help, the handicapped can tide over their misfortune. Their skills and talents can form an important input in nation building, activities. A sense of self-confidence, therefore, needs to be infused in them to enable them to join their brothern in the mainstream of life.

According to the report on survey conducted by the National Sample Survey Organization sponsored by the Ministry of Welfare, twelve millions Indians about 1.8 per cent of India's population have atleast one disability or the other. About 10% of the handicapped are having more than one type of disability.

* I considering each type of disability separately, those having locomotor disabilities constitute the maximum number (5.43 millions), followed by those with visual disabilities (3.47 millions) and hearing disabilities (3.02 million) and speech disabilities (1.75 million). The survey covers blind, crippled and dumb persons but does not cover other disabilities, including mental retardation.

Referring to congenital disability cases, the survey shows that visual and communicable diseases affect 5 per cent, and 8 per cent of the total number of visually handicapped in the rural and, urban areas respectively. In the case of hearing disability, congenital cases constitute 30% in the rural and 28% in the urban areas. As regards speech disability the corresponding proportion is 77 per cent and 67 per cent in the rural and urban areas.

The proportion of congenital cases was seen to be less for all types of disabilities in females as compared to males, except for speech disability. The prevalence rate is seen to increase with age and is maximum in the age group of 60 and above for all types of disabilities except in the case of speech disability, where the maximum rate was found in the 5 to 14 age group. The number of persons having locomotor disability (for one lakh population) is estimated to be 828 for the rural areas and 67 for the urban areas. The deformity of limbs, followed by paralysis, dysfunction of joints and imputation contribute to locomotor disabilities in that order. The number of disabled population is not static. It goes on multiplying every year. According to a rough estimate about 3 million persons are added to this section of society every year.

Welfare of Persons with Disabilities

During 2004-05, the allocation for Welfare of Persons with Disabilities (PWD) is Rs. 225.54 crore out of which an expenditure of Rs. 97.37 crore has been incurred upto 14th Janury, 2005. Action has been initiated to suitably emphasize disability concerns in Sarva

Shiksha Abhiyan (SSA) and ensure that most of the children with disabilities are covered through inclusive education programme. Mostly, this involves getting the disabled children enrolled in the regular school where those with locomotor disability and mild hearing impairment can easily be educated.

The programmes are implemented through the National and Apex Institutes dealing with different categories of disabilities such as visual, hearing, orthopaedic and mental. These institutes conduct short term and long-term courses for various categories of personnel for providing rehabilitation services to those needing them. Till 14th January, 2005, Rs. 13.57 crore (Plan) has been released to these Institutes.

Persons With Disabilities (PWD) Act, 1995 is under implementation. Five Composite Rehabilitation Centres (CRCs) have been set up at Srinagar, Lucknow, Bhopal, Guwahati and Sundernagar to expand facilities for manpower development and ensuring availability of rehabilitation services for all categories of persons with disabilities. Four Regional Rehabilitation Centres (RRCs) provide services to persons with orthopaedic and spinal injuries at Chandigarh, Cuttack, Jabalpur and Bareilly. 133 District Disability Rehabilitation Centres (DDRCs) have been sanctioned in the country for providing comprehensive rehabilitation services at the grass roots level. 107 DDRCs have started functioning.

Under the scheme of Assistance to the Disabled for Purchase/Fitting of Aids and Appliances, Rs. 39.56 crore has been released to benefit 1.18 lakh beneficiaries during 2004-2005 (up to 14th January, 2005). Artificial Limbs and Manufacturing Corporation manufactures different types of aids and appliances for disabled persons at low cost and aims to develop new prototype aids and appliances. A scheme of Science and Technology Project in Mission Mode is also being implemented.

The objective of the Scheme is to coordinate, fund and direct application of technology in development and utilization of suitable and cost effective aids and appliances such as functional mechanical hand, interpointing braille slate, braille micrometer, safety devices for the chaff cutter and threshers, plastic aspheric lenses, ground mobility devices, training module for prevention and early detection of childhood disabilities, electronic guide cane, low cost STD/PCO speech card, software and Mentally Retarded children for learning and teaching, motorized wheel chair etc.

Deen Dayal Disabled Rehabilitation scheme (earlier known as Scheme to Promote Voluntary Action for Persons with Disabilities) provides financial assistance to voluntary organizations for running rehabilitation centres for leprosy cured persons, for manpower development in the field of mental retardation and cerebral palsy and establishment and development of Special Schools for the major areas of orthopedic, speech, hearing, visual and mental disability. During the year, Rs. 34.29 crore have been released to 502 voluntary organizations (up to 14.1.2005) for implementing the scheme. A project funded by UNDP for Support to Children with Disabilities was implemented for a period of 2 years until June 2004. The objective of the project was to sensitize, mobilize and empower the community to participate in the local school management and ensure that every child with disability in the project area has access to education in an appropriate environment. A

Scheme of National Scholarship for Persons with Disabilities has been introduced from the year 2003-04. 313 awards each for male and female students in different categories of disabilities will be given for pursuing higher and technical education.

It has been decided that children with mental retardation, cerebral palsy and with severe hearing impairment will be provided scholarship for education in classes 9 and 10. This is a relaxation from the existing norm of providing scholarships to children with disabilities only in post-matric classes. An effort is being made to focus the activities in the backward and uncovered regions.

Forms of Disability

- Cerebral Palsy
- Deaf
- Leprosy
- Mentally Challenged
- Multiple Disability
- Physically Challenged
- Spastics

3.3 Problems of People

Homelessness is perhaps the most explicit of all social issues. It can certainly be viewed as the ultimate manifestation of social malaise in any society. Yet understanding it is for from straight forward. Even clarifying and defining the term homelessness is beset with difficulties, and this in turn has created innumerable obstacles for any agreed measurement or quantification of the problem.

The U.S. Department of Housing and urban Development (HUD) defines the term "homeless" or "homeless individual or homeless person" as (1) an individual who lacks a fixed, regular, and adequate nighttime residence, and (2) an individual who has a primary nighttime residence that is : (A) supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hostels, congregate shelters, and transitional housing for the mentally ill); (B) an institution that provides a tempoary residence for individuals intended to be institutionalized or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodations for human beings.

The following common categories of perceptions of homeless people have been identifed by a study on 'Attitudes to and interventions in homelessness : Insights from an International Study' by Global Urban Research Unit (GURU), Newscatle University, England, under the supervision of Dr. Graham Tipple and Mrs. Suzanne Speak, funded by DFID :

(a) **The 'Villain' :** The perception of homeless people as criminals is common throughout the world. Homeless people are more likely to be victims than perpetraters of crime. In almost all countries, it is uncommon for adult street homeless people to commit crimes, especially violent crimes. Negative attitudes allow authorities to criminalise homelessness and street sleeping.

(b) **The 'Beggar' :** One of the most common public perception of homeless people is that they are all beggars. However, in Kolkata, only 8% of homeless people are involved in begging. The majority of homeless people in India are casual labourers who often travel long distances across the city every day to reach work. In Ghana, whilst popular imagery and perception portray homeless people as beggers, only around 3% actually engage in begging.

(c) **The Mentally Ill :** A Common perception of people on the streets in of their being mentally ill or personally defective. In Peru, those who live on the streets, without shelter, are officially referred to as 'mentally ill people on the streets.' An official at Oxfam's office in Tamale described homeless people in Ghana or 'the mentally ill people whose movement cannot be easily controlled.'

(d) **The 'Immoral' :** The 'immoral' label is most often applied to homeless women. The Indonesian term often used for homeless women is 'tunasusila' meaning 'women having no morals'. This is repeated in Bangladesh, where young homeless divorcees or widowed mothers are publicty caleld a 'whose', regardless of their sexual activity.

(e) **The Transient :** A common perception is that homeless people are constantly moving or transient. In South Africa, the word 'malunda' (those who sleep away from home) is used. In Indonesia, 'gelandangan' meaning 'tramp', is derived from gelandang' meaning to wandar. In China, the new and growing group of homeless people are known as 'Mangliu' which means the 'blindly floating population' or Liulanghan' meaning 'people who are floating or vagrant. However, it has been seen that people very often remain in one place. If they move, it is often because they are forced to by others.

(f) **The Loner :** Perhaps one of the most common stereotypes is that of being alone : generally a lone male. Infact, homelessness is a condition of detachment from society characterised by the absence on attenuation of the affiliative bonds that link settled persons to a network of interconnected social structures. In India and Indonesia it is common to find homeless family units living together. Even in the poorest of conditions, strong social networks often form, homeless people often watch out for each other.

(g) **The Helpless :** Many advocacy or religious organisations portray homeless people as victims, emphasising their helplessness. NGOs routinely use emative pictures of homeless people to gain sympathy for their cause. Homeless people are also given labels such as 'unfortunate shelterless souls'. Such practices confuse

vulnerability with helplessness and do a disservice to homeless client groups labels of 'helpless' undermine the efforts homeless people make to support themselves. For street children the act of leaving home and taking up a life on the streets, can be a mark of control and strength. It has been noted that some street children can provide for themselves better than their parents could.

Most researchers attempt to make a distinction between : (1) why homelessness exists, in general, and (2) who is at-risk of homelessness, in specific. Homelessness has always existed since urbanization and industrialization.

Factors Placing an Individual at high-risk of Homelessness Include :

- **Poverty :** People living in poverty are at a higher risk of becoming homeless.
- **Drug** or **alcohol misuse :** An estimated 38% of homeless suffer from a substance abuse problem. Debate exists about whether drug use is a cause or consequence of homelessness. However, regardless when it arises, an untreated addiction "makes moving beyond homelessness extremely difficult."
- **Serious Mental Illness and Disability :** It has been estimated that approximately one-third of all adult homeless persons have some form of mental illness and/or disability. In previous eras, these individuals were institutionalized in state mental hospitals. According to the National Alliance for the Mentally ill (NAMI), there are 50,000 mentally ill homeless people in California alone because of deinstitutionalization between 1957 and 1988 and a lack of adequate local service systems. Various assertive outreach approaches, including a mental health treatment approach known as Assertive Community Treatment and the Path Program, have shown promise in the prevention of homelessness among people with serious mental illness.
- **Foster Care background :** This population experienced rates of homelessness nearly 8 times higher than the non-foster care population.
- **Escaping domestic abuse,** including sexual, physical and mental abuse : Victims who flee from abuse often find themselves without a home. Abused children also have a higher chance of succumbing to a drug addiction, which contributes to difficulties in establishing a residence. In 1990 a study found that half of homeless women and children were fleeing abuse.
- **Prison discharge :** Often the formerly incarcerated are socially isolated from friends and family and have few resources. Employment is often difficult for those with a criminal record. Untreated substance abuse and mental illness also may put them at high risk for homelessness onced discharged.
- **Civilian during war :** Civilians during war or any armed conflict are also are at higher risk for homelessness, because of possible military attacks on their property, and even after the war rebuilding their homes is often costly, and most

commonly the government is overthrown or defeated which is then unable to help its citizens.

- **Genocide Survivors :** e.g. Holocaust survivors; interned Japanese Americans

Reasons/Causes for homelessness:

- **Personal Choice :** Some make a choice not to have a permanent residence, including travelers and those who have personal spiritual/religious convictions (as yogis in India). Most researchers feel the population of individuals who choose not to have a permanent residence is negligible. Many people who respond that they "prefer" the homeless lifestyle suffer from mental illness, trauma or have adapted to the lifestyle and the response reflects a socially-desirable response or justification rather than having no real desire for stable shelter.
- **Drug and alcohol addiction :** Individuals who are incapable of maintaining employment and managing their lives effectively due to prolonged and severe drug and/or alcohol abuse make up a substantial percentage of the U.S. homeless population. One reason for this is that the behavioral patterns associated with addiction can result in alienation of an addicted individual from family and friends who could otherwise serve as a form of safety net against homelessness in hard economic times.
- **Income inequality :** Increased wealth and income inequality caused distortions in the housing market and pushes rent burdens higher and thereby decreasing general housing affordability.
- **High cost of housing :** A by-product of the general distribution of wealth and income. Also impact by the reduction of household size witnessed in the last half of the 20th century.
- **Lack of living wage jobs**
- **Natural disaster,** such as in the case of thousands of New Orleans, Louisiana residents losing their homes to Hurricane Katrina.

In a 2002 dissertation prepared for California Coast University entitled, *"New Testament Ethics : A Model for Helping the Homeless,"* doctoral candidate Robert E. Brickner reviewed the literature from 1984-2001 to determine causes of homelessness. Subsequently, the author identified ten root causes of homelessness. "The order of this list is random, presented without regard to frequency of occurrence, and reflects categories created by the author."

- **1. Unemployment**
- **2. Loss of/or inadequate income** (from job loss, underemployment, cutbacks in public assistance, or gifts from family and friends.)
- **3. Loss of housing** (including, but not limited to these causes : unaffordability, unavailability, or eviction).

- **4. Being victimized** by (including, but not limited to) : natural disasters...criminal behavior...or adverse circumstances.
- **5. Health problems**
- **6. Personal choice**
- **7. Breakdown of the family unit** (resulting in separation, divorce, domestic violence, and runaways).
- **8. Mental illness**
- **9. Substance abuse**
- **10. Detrimental lifestyle choices** (excluding substance abuse).

Developing and undeveloped countries

The number of homeless people worldwide has grown streadily in recent years. In some Third World nations such as Brazil, India, Nigeria, and South Africa, homelessness is rampant, with millions of children living and working on the streets. Homelessness has become a problem in the cities of China, Thailand, Indonesia, and the Philippines despite their growing prosperity, mainly due to migrant workers who have trouble finding permanent homes and to rising income inequality between social classes.

[This piece, first written in 1987 during the International Year of Shelter for Homeless, is still valid today as it was then—not only because the problem still persists today, but also because the issues and approaches outlined are still necessary, after all these years.]

For whatever reason, India lends herself rather easily to facile generalizations—the oft quoted one is that she lives largely in her villages. This is not however the truth-rapid industrialization, urbanization, depleting natural resources, biased development priorities, and many other factors have led to massive rural urban migration.

In the year 1900 there were only 11 cities with a population of 1 million, but by 2000 there where 300 of them. The number of cities with more than 15 million population will be about 50 in 2010.

Today India is a land of billion million people of which 164 million or about 23% of been based. This means that though India is a predominantly rural country it already has an urban population equal to that of USA!

Consider Bombay—20 years ago there where less than 400,000 squaters in a population of 4.5 million. Today there are 4.5 million in a population of 9 million. Thus, while the nation has grown by 50% and the city by 100%, the squatters have increased by more than 1100%.

The Great Migration

People are coming to the city's packing their belongings, moving, starting, in the

most massive moment of people the world has ever seen. People move for many reasons—to find employment, or to escape calamities like floods, famine and drought. Rural poverty is the most fundamental reason for the great migration to the city.

The vast majority of these men and women are farmers and farm labourers who in their villages lack resources and opportunitites for an economically active life. A migrants toehold in the city may be a squatter shanty or nearby marginal lands. They often stay with relatives or on undesirable public sites, hoping that the public authorities will not notice their invasion of public or private lands.

Where does the answer lie?

The solution to homelessness especially in the lower-income bracket, lies not in the supplier of finished homes,but in realizing and supporting the peoples creative energies in building and improving their homes and neighborhoods.

People have been building for centuries and one of the factors overlooked by the government agencies is that the people themselves are a resource. As a person improves his economic base and social standing, his position in the society consolidates, and he expresses this in terms of the finesse of his house. He may even change his location in the city.

Programmes that do not take this mobility pattern into consideration will most likely fail because they use criteria—availability of public lands or the desire to improve the aesthetics of the poor areas—different from those pursued by the squatters. Providing just ''homes'' misses out the point that they are already finished, and leave no room for flexibility. The quarter will not be able to enlarge or improve his own dwelling when his life improves.

People have the necessary skills, the necessary resources, the necessary involvement, the necessary commitment, to build a user oriented shelter complimentary to his needs and standing in the society.

The influx of rural families to the cities has transformed metropolitan areas into settlements of rural villages-and planners and government officials must take rural forms and traditions into consideration in formulating policies and programmes for the squatters.

Religion, folkways, social organization and life styles, must be interwoven with the more modern forms of the city. They lend variety and rich diversity to the management of our urban life. Survival of rural forms poses abasic challenge to urban architects and planners, as well aslocal authorities, in developing countries.

The need for new attitudes and perceptions

Architects and planners have been slow to understand the evolutionary processes involved in the housing of squatters. Thus, projects are often carbon copies of housing in the developed countries, despite the differences in climate and culture.

So what must happen now is for planners and government officials to recognize the mistakes of the past and to recognize the now-quite-clear new directions that planning and enlightened government intervention should take-directions that take into account the migrants traditional living patterns and integrate them into public efforts.

The problem of housing encompasses several fields, and this is why architects and planners may have to think outside their professional boundaries on such subjective topics as emotion, psychology, commitment, social service, mediatory politics etc. rather than entertain the blinkered eye view of only professional involvement.

Thus, what is required is a new holistic way of looking at a problem. What we need here is not a physical plan or layout, but an attitude (or change in attitude)—a new way of thinking. A revamping of the entire schedule of approach, of parameters, is needed.

The words—commitment, interrelationships, occupations, self-help, community skills, and upgrading should be as much a part of the vocabulary of an architect or planner, as standards, infrastructure, finance, services and land.

Conclusion

Housing is not only a technical problem, it is also a socio-political one.It requires an integrated approach and therefore, we need to decentralize and de-institutionalize the approach to solve the problems of housing. Self-help housing provides not only shelter, but also creates confidence and resourcefulness in the minds of the people. It helps to convert a house into a 'home'.

In spite of the gravity of problem and our limited resources, to shelter the homeless is not an insurmountable problem, it is a manageable challenge.

3.4 Exercises

(i) Enumerate the problems being confornted by the elderly persons in Indian Society.

(ii) Analyse the concept, forms and welfare measures of disabled persons.

(iii) What is homelessness? Why it is caused? What are its possible solutions ?