Disability trends in some African and Asian countries - policy implications and suggestions

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Introduction .

With creditable achievements on health front resulting in increases in expectation of life, the focus of governments is to further improving the quality of life of the people. However, the problems differ from one country to another and the experiences too vary from country to country and over time.

The United Nations declared the years 1983 - 1992 as the decade of the disabled, the theme of the decade being "Full participation and Equality". In this context, Governments started working for the integration of the disabled persons in the mainstream of society. A prime consideration therefore was the importance of relevant policy and programmes concerning the rehabilitation needs of and the equalisation of opportunity for persons with disabilities. Thus a study of disability has become an important requirement for putting in place necessary and appropriate policies, plans and programmes in countries striving to improve the quality of their peoples lives. Four countries are selected from among developing countries which had very similar health and living conditions in the past when all of them were under the British rule. India got its independence in 1947 whereas Mauritius became independent in 1968, Zambia in 1964 and Hong Kong in 1997. India and Hong Kong are Asian countries, Zambia has an African population whereas Mauritius even tough geographically located in the African Region, has a predominant Asian Population with substantial number of people of African origin. The progress in these countries differed very much. Mauritius made the biggest improvement in the health and living conditions of their people, Zambia made notable stride in the health and living conditions till the 1970s, but showed signs of deterioration whereas India made modest improvements but has not been able to achieve some of their goals and targets in health, education, nutrition, housing, hygiene etc because of the large size and huge growth rate of the population and some inherent deficiencies in administration and management and especially in the implementation phase. Hong Kong is a rapidly modernising society, moving from an industrial export base to service and entrepot functions. The impressive high life expectation in Hong Kong indicates the efficiency of its health care system. It also has a good educational system and more than 95% of the population are literate.

Towards this aim, data on disability were collected at the 1990 and 2000 Housing and Population Censuses of Mauritius, Zambia and the 1981 and 2001 population censuses and the 1991 and 2002 National Sample surveys in India and in the 1981 census and 2001 and 2006/7 surveys in Hong Kong.. Based on available data, an attempt has been made to study the trends in disability in these countries and review existing policies and programmes and recommend future improvements in regard to disability in these countries.

At independence in 1947, life expectation in **INDIA** was in the 30s and malaria, cholera , influenza and other contagious and infectious diseases played havoc on the population. Thanks to concerted efforts in the socio-economic and health front, life expectation has consistently improved but progress has not been as significant as in some other developing countries. Poverty, malnutrition, lack of access to safe drinking water and general imbalance in socio-economic conditions of the people have all contributed to continuing high infant, child and maternal death rates and consequent less

improvement in life expectation. Even though life expectation is moderately high and communicable diseases do not play as high a role as in the past, still there are several factors which are important like malnutrition, illiteracy/ignorance and poverty which need to be addressed to improve the quality of life of the people. In addition to rather high infant and child mortality and an unacceptable level of maternal mortality, there is yet another dimension to the health front that shows up in the morbidity and disability profile.

A major threat to a country like <u>MARITIUS</u> with even high and improving expectation of life, is the problem of disability brought in by non communicable diseases (NCD) such as diabetes, hypertension, cardiovascular diseases, cancer, mental illness, diseases linked to tobacco, alcohol and substance abuse, life style and accidents. From low life expectation only a few decades ago, heavy mortality caused by communicable and infectious diseases, and heavy toll through malaria, Mauritius has been able to usher in a health profile which is similar to that in advanced societies in the span of thirty to forty years. Yet more need to be done to improve quality of life of the people especially those physically or mentally disabled.

In ZAMBIA, life expectation is still relatively low and communicable diseases play vital role. In fact, life expectation was reduced between 1980 and 1990 and only recently has there been some recovery. HIV/AIDS has played important role in increasing child, maternal and general mortality. Zambia after independence in 1964 had significant improvement in health and living conditions resulting in increasing life expectation till the mid 70s. The oil price crisis coupled with falling value of its main export- copper- resulted in an era of difficulty and economic stress for the people. Overall poverty of 70% and extreme poverty constituting 55-60% of the population in the 1990s and even later and the HIV/AIDS infection with a reported 16% of population affected, aggravated the situation. Survival rates deteriorated during 1980-2000, more so between 1990-2000 especially at ages 15-54 due to HIV/AIDS. Between 1980-90 more female than male adults survived from age 10, but after 1990 the situation changed. Overall more male than female adults survived especially in the younger ages 15-39. At age 15 both sexes lost at least 12 years between 1980-2000 and 10 years between 1990-2000. Population growth rate reduced from 3.1% between 1969-80, to 2.7% between 1980-90 and to 2.4% during 1990-2000. Infant mortality rate increased from 99 in 1980 to 123 in 1990 and was still high at 110 in 2000.

Similarly Child mortality increased from 71 in 1980, to 95 in 1990 and expectation of life which was 52 in 1990 fell to 47 in 1990 and showed some improvement to 50 only by 2000. It has been estimated that if HIV/AIDS mortality is excluded, expectation of life would be higher by 15-20 years. UN Human Development Index (HDI) declined so much that by 1995 it was even lower than in 1975. In 1999 DALE (Disability adjusted expectation of life) for Zambia was 30.3 years. Of 191 WHO Member countries only 3 others (Malawi, Niger and Sierra Leone) had lower DALE. The epidemiological transition is not on the near horizon for Zambia. The leading cause of disability adjusted life (DALY) lost are respiratory infections, diarrhoeal diseases, malaria, TB, HIV/AIDS and measles. Many communicable diseases that are less fatal, such as schistosomiasis ,leprosy, filariasis, trachoma, onchocerciasis., polio, and hepatitis as well as some Non

Communicable Diseases (NCD), chronic illnesses such as anaemia, diabetes, and trauma result in a heavy burden on disability striking the population in rural areas and the urban periphery. In fact, mortality plus disability gap between Zambia and wealthy countries of the world is even wider than the mortality gap. In addition to increasing mortality, there has been a deterioration in the quality of life brought in by morbidity and disability. In many respects, disability is a socio-economic indicator, a type of poverty index or index of development which is unique in that it estimates the quality of life of survivorship or of persons who escape mortality and who continue living with significant modification of function and thus have to put up with a life of pain and suffering. In addition to physical pain, the bigger dimension of disability is the social, economic and cultural discrimination, neglect, exclusion from society and being objects of pity and sometimes even of aversion. The negative perception that disabled persons are less important members of society, cannot lead independent life and being left out in initiation ceremonies has brought in the psychological trauma of isolation and the feeling of being not wanted.

The <u>HONG KONG</u> economy, like similar economies in the Region, has encountered critical hardships, including accelerated economic downturn, a rise in unemployment, an increase in the fiscal deficit and a delayed recovery. All these have happened since the Asian financial crisis which started in May 1997 from Thailand, deflated the bubble economy, and has changed the way people spend and invest their money. The terrorist attacks on the United States on 11 September 2001 have further dampened export markets and consumer spending. The situation has become even more complex because of the transformations happening in both the world's and Hong Kong's economy. The world is rapidly transforming from an industrial economy to a knowledge-based economy. Globalisation has also brought about tremendous challenges and opportunities.

An urgent agenda of the of the country is to take adequate measures to check life style problems like unhealthy food habits, over eating and obesity, smoking, alcohol and other dangerous drug consumption and inculcating healthy habits, increased exercise and avoidance of risky behaviour. Hong Kong does not face problems like exposure to infectious and communicable diseases, but diseases and disabilities consequent on life style changes like diabetes, high blood pressure, cardiac and lung related ailments and arthritis, and other ailments of old age are particularly expected to hamper the enjoyment of the already high life expectation.

Based on available data, an attempt has been made to study the trends in disability in these countries and review existing policies and programmes and recommend future improvements in regard to disability in these countries.

I. Disability trends in INDIA

I.1 Introduction

The history of data collection in INDIA pertaining to the disabled/ infirmity/ handicapped population dates back to the earliest census taken in 1872 followed by the decennial censuses up to 1931. I The questionnaire of 1872 Census, called the 'House Register' included questions not only on the physically disabled but also the mentally disabled and persons affected by Leprosy. Collection of information on infirmities was continued in each of the subsequent Censuses from 1881 to 1931. In the censuses of 1872-1931, information collected included those on insanity, deaf-mute, blind and leprosy. However, due to doubts expressed by the then Census Commissioners about the authenticity and quality of data collected on disabled population, the enumeration of physically disabled persons was discontinued in the 1941 Census. It was felt that Census Operations do not lend themselves to the determination or identification of people with special characteristics of this nature. Therefore, in the censuses of 1941-71 question on disability was not included.

In India for the Second Five Year Plan, welfare of the handicapped had received due attention. Nevertheless, paucity of data on size of the population of handicapped belonging to different categories needed for understanding the magnitude of the welfare services for their rehabilitation was a major impediment to evolving a realistic approach to their problems. To address issues arising out of the need for the Five Year Plans, Government instituted the National Sample Survey Organization to collect needed data and information on a national scale which will be sufficiently representative at State and local levels. Therefore, data on disability was collected by the National Sample Survey Organization (NSS) during

their rounds at the 15th round (July 1959-June 960) only for rural areas which was extended to urban areas in the 16^{th} round (July 1960-June 1961). In the 24^{th} , 28^{th} round (October 1973-June 1974), 36^{th} , 47^{th} (1990/91) and 58^{th} (2001/02) rounds...

After a gap of 50 years, a question on disability was again canvassed at the 1981 Census and collected during the house listing operations. Information was collected on the blind, deaf and physically handicapped. However, when the results of 1981 Census were collated, it was felt that there was considerable under enumeration of physically handicapped persons. The question on disability was not canvassed at the 1991 Census of India.

At the Census of India 2001 the question on disability – physical and mental - was included in the Household Schedule chiefly to meet the requirement of data for implementing the provisions of 'The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995'. The PWD Act, 1995 which came into effect on 7th February 1996 imposes obligations on the Central and State Governments for taking up various measures to ensure equal participation of people with disabilities in different walks of life. Section 25(a) of the Act imposes specific obligation on the government to undertake surveys, investigation and research concerning causes of disability.

I.2 Concepts & Definitions

Early efforts were made in the 15th, 16th, 24th and 28th rounds of NSS, to collect information on disability- of which the efforts of 15th and 16th round were exploratory in nature. Renewed efforts made in the NSS 36th and 47th rounds.

No attempt was made to define <u>disability</u> as such during the early efforts of the NSS. In the renewed efforts, disability was defined as "restrictions or lack of abilities to perform an activity in the manner or within the range considered normal for a human being". Blind was defined in the NSS 28 th round as "a person who cannot see for all practical purpose, being blind in both the eyes". In comparison, a visually disabled person was identified in the recent surveys (NSS 36 th and 47 th round) on the basis of more clear and precise definition. A person who did not have any light perception - both eyes taken together - or a person who had light perception but could not count fingers of a hand (with spectacles/contact lenses if he/she used spectacles/contact lenses) from a distance of 3 metres (or 10 feet) in good day light with both eyes open - was considered as visually disabled in these rounds.

A person who could not hear for all practical purposes, being deaf in both the ears was treated as deaf in the NSS 24th and 28th rounds. More elaborate descriptions were provided in the recent surveys of NSS 36th and 47th rounds to identify persons with <u>hearing disability</u>. Hearing disability was judged taking into consideration the disability of the better ear. Unlike the earlier surveys, no attempt was made in the recent rounds to define deafness as such.

A 'Dumb' was briefly described in the 24th and 28th rounds as a person who could not talk; In contrast, the coverage of speech disability was much wider in the recent rounds. Speech disability was referred to as a person's inability to speak properly; Persons with speech disability included those who could not speak, could speak only with limited words or those with loss of voice. It also included those having speech but with defects in speech, such as, stammering, nasal voice, hoarse and discordant voice, articulation defects, etc.

A person who was deformed in either or both of the legs and was disabled thereby, was considered as lame in the earlier surveys. A person who was found to limp but otherwise did not require any external aid irrespective of whether he/she could afford to have an external aid or not was not treated as lame, but if the person required or was using crutches, he/she was considered as lame; In the 16th, 24th and 28th rounds, 'crippled' was identified as a separate category of physically handicapped persons. A person who was deformed in any part of the body other than legs and was disabled thereby, was considered as crippled in those rounds; In the surveys of recent rounds, the 'crippled' was not defined separately but was included among persons having locomotors disability. In the recent surveys, locomotors disability was defined as loss or lack of normal ability of an individual to execute distinctive activities associated with moving himself and/or objects from one place to another. Persons with loss or absence or incapacity of whole or part of a hand or leg or both due to amputation, paralysis, deformity and dysfunction of joints and persons with physical deformities in the body (other than limbs) which affected normal movement such as, hunch back, deformed spine etc. were treated as having locomotors disabilities. Dwarfs and persons with stiff-neck of permanent nature who generally did not have difficulty in the normal movement of body and limbs were also included under this category.

Of the early surveys, information in respect of mentally affected persons was collected only in the NSS 28th round. A person, who is mentally disordered as considered by the informant, whether or not under psychiatric treatment, was considered as a mentally affected person. No attempt was made in the recent rounds to collect information in respect of mentally affected persons as such. information on behavioural pattern and developmental milestones for all the children aged 5-14 years regardless of whether they were physically disabled, was obtained to examine the extent and prevalence of delayed mental development amongst the children. In the 58th round of NSS - the latest one - also covered mental disability. Persons who have difficulty in understanding routine instructions, who do not carry out their activities like others of similar age or exhibit behaviour like talking to self, laughing/crying, staring, violence, fear and suspicion without reason would be considered as mentally disabled for the purpose of the survey. The "activities like others of similar age" will include activities of communication (speech), self-care (cleaning of teeth, wearing clothes taking bath, taking food, personal hygiene, etc.) home living (doing some household chores) and social skills.

While the concepts and definitions used in the early surveys of 24th and 28th rounds were more or less same, they differ widely from those adopted in the recent rounds. Again, the definitions provided in the early rounds are, generally, very brief but not necessarily very precise and based on objective criteria. In those rounds, the physically handicapped persons were enumerated either at the stage of household listing or collecting information on other topics. Consequently, there was little scope of deep probing. As a result, the data were comparatively less refined. On the other hand, the concepts and definitions adopted in the recent NSS 36th , 47th and 58th rounds are based on the objective criteria formulated on the advice of the medical experts, keeping in view the feasibility and practicability aspects of collecting information by the non-medical persons, and the estimates more reliable.

In the 1981 census only information on the <u>Blind</u> (total absence of light, visual acuity less than 6/60 or 20/20 in the better eye with correcting lenses, limitation of field of vision subtending an angle of 20 degree or worse; <u>Deaf</u> (sense of hearing non functional for ordinary purposes of life) and <u>physically handicapped</u> those with physical defect or deformity which causes undue interference with normal functioning of bones, muscles or joints) In 2001 information on mentally retarded and mentally ill persons also were collected.

The question on disability was asked of all persons in the household during the 2001 census operations to find out if any member of the household is suffering from any physical or mental disability. Being a sensitive question the probe, after first explaining the actual purpose of the question by emphasizing that the information on the number and type of disability would help the governments in planning for the welfare of the disabled, was done delicately so as not to offend the respondent or any other member of the household.

The five types of disabilities identified for census purpose are given below:

In Seeing: A person who cannot see at all (has no perception of light) or has blurred vision even with the help of spectacles was treated as visually disabled. A person with proper vision only in one eye will also be treated as visually disabled. In a situation where a person may have blurred vision and had no occasion to test whether her/his eye-sight would improve by using spectacles would be treated as visually disabled.

In Speech: A person aged more than 3 years was recorded as having speech disability, if she/he is dumb. Similarly a person whose speech is not understood by a listener of normal comprehension and hearing, she/he was considered to having speech disability

In Hearing: A person who cannot hear at all (deaf) or can hear only loud sounds was considered as having hearing disability. If a person cannot hear through one ear but her/his other ear is functioning normally, was considered having hearing disability.

In Movement: A person who lacks limbs or is unable to use the limbs normally, was considered having movement disability .Absence of all the fingers or toes or a thumb will make a person disabled by movement. If any part of the body is deformed, the person will also be treated as disabled and covered under this category. A person who cannot move herself/himself or without the aid of another person or without the aid of stick, etc., was treated as disabled Similarly, a person would be treated as disabled in movement if she/he is unable to move or lift or pick up any small article placed near her/him. A person may not be able to move normally because of problems of joints like arthritis and has to invariably limp while moving, will also be considered to have movement disability.

Mental: A person who lacks comprehension appropriate to her/his age was considered as mentally disabled. Mentally retarded and insane persons were treated as mentally disabled.

A person may have two or more types of disability but only one of these is to be recorded. In such cases, it is left to the respondent to decide as to the type of disability she/he wants the member of her/his household to be classified into.

I.3 Disabled population by age, sex, residence

At the late 19^{th} and early 20^{th} century, communicable diseases like small pox, measles and polio played significant role in disability. In addition, leprosy, malaria, filarial and other diseases also resulted in large number of persons suffering from disabilities. Malnutrition, ignorance, poor health and hygienic conditions etc played important role in mortality, morbidity and disability of the population. Hence information was collected only to reflect some of these major causes and types of disabilities. Thus the censuses of 1872 - 1931 included questions only on four broad categories- insanity, deaf mute, blind and leprosy.

Around a million persons were recorded with these types of disabilities which represented around 0.3 percent of the total population. Gross under reporting/recording was suspected mostly attributed to difficulties in getting reliable information on such a sensitive topic like disability in a massive operation like a census. Table I.1 clearly indicates that the total number of disabled categorized in the 4 types fluctuated between less than a million to slightly more than a million in a total population of 25 to 35 million persons. Consistently blindness recorded more than half of those reported as with one of the disabilities with insanity showing the least number. In India, as in many developing countries, even today insanity is considered as a sin and a shame and rarely will people admit having members in their households with this disability.

Disability						
Туре			Censu	is Year		
	1881	1891	1901	1911	1921	1931
Insanity	81132	74279	66205	81006	88305	120304
Deaf Mute	197215	196861	153168	199891	189644	230895
Blind	526748	458868	354104	443653	479637	601370
Leprosy	131938	126244	97340	109094	102513	147911
Total	937033	856252	670817	833644	860099	1100480
Total						
Population	256123000	287388000	294554000	315285000	318729000	353051000
		Disability rate	e (per 000) p	opulation by c	lisability type	
Insanity	0.32	0.26	0.22	0.26	0.28	0.34
Deaf Mute	0.77	0.69	0.52	0.63	0.6	0.65
Blind	2.06 1.6		1.2	1.41	1.5	1.7
Leprosy	0.52	0.44	0.33	0.35	0.32	0.42
Total	3.66	2.98	2.28	2.64	2.7	3.12

 Table I.1
 Disabled population by disability type: 1881-1931

Disability data reported for the more than 50 years in the country indicated that blindness was the predominant type of disability among the people. Malnutrition, prevalence of infectious diseases like small pox, unhealthy living conditions, poverty and illiteracy/ignorance played significant roles in bringing in the situation. Concerted efforts in the direction of improving the level of living of the people in terms of education, health, housing would drastically reduce blindness and other disabilities.

To address issues arising out of the need for the Five Year Plans, Government instituted the National Sample Survey Organization to collect needed data and information on a national scale which will be sufficiently representative at State and local levels. Disability data was canvassed in rural areas in the 15th round and urban areas were included in the 16th round.

The number of handicapped by disability type per 1000 population as reported during the 28th round (1973/74) and census 1980/81 are presented in table I.2. It can be noted that whereas the national sample survey reported a higher disability rate, census showed a much lower rate. The main difference may be because of differences in definitions better quality of smaller number of enumerators and coverage in small scale surveys and the difficulties in obtaining data in a massive operation requiring an army of enumerators as in a census.

Table I 2. Disability Rate per 100 Population (DR) by type, 1973/74 and 1980/81

	DR by disability type							
Source	Blind	Dumb	Crippled					
NSS 28th Round, 1973/74	1.26	0.61	1.1					
Census 1980/81	0.73	0.42	0.55					

Disability data collected during later rounds of NSS during the 1980s, 1990s and 2000s also indicated much higher disability rates than those depicted by census. Table I 3 presents disability rates by rural/urban as reported in the 36th, 47th and 58th rounds of NSS

It can be noted that urban rates are consistently lower than rural and males have higher rates. On the whole, the rates are very similar during the three rounds spanning more than 20 years

Table I 3 Disability rate per	100 Populat	on by residence	and sex, N	SS 36 , 41	7 and 58 $^{\rm m}$	rounds
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		Disability rate (DR) per 100 Population													
	NSS 38	th round	NSS 47	th round	NSS 58th round										
Sex	Rural	Urban	Rural	Urban	Rural Urban										
Male	2.045	1.532	2.277	1.774	2.118	1.67									
Female	1.632	1.297	1.694	1.361	1.556	1.311									
Total	1.844	1.42	1.995	1.579	1.846	1.499									

Disability data obtained during house listing operations in 1980 in preparation for the 1981 census indicated much lower rates than what the national surveys brought out. WHO and other international and national agencies were even suspicious about the rather low rates thrown up by the surveys themselves. The lower rates returned is attributed to stigma, shame, social insecurity and lack of awareness/understanding /perception among the people and mostly because of enumerator/investigator not being properly trained/ equipped to collect such information It is even speculated that survival rate of severely disabled may be much lower , especially female mortality which has been higher than that of males at reproductive ages and even at other ages because of the known discrimination of the female in several parts of the country. A rate of around 10 percent of the population as having one of the specified disabilities was conjectured by WHO. Table I 4 presenting the 1981 census data indicated a disability rate of less than 2 percent .

Table I 4. Disabled population by disability type and residence, 1980/81

	Disabled	Total	DR per		DR per		DR per		DR per
Residence	Population	Population	100	Blind	100	Dumb	100	Crippled	100
Total	11189480	654576000	1.709	478657	0.731	276691	0.423	363600	0.555
Rural	9694010	501557000	1.933	424307	0.846	240454	0.479	304640	0.607
Urban	1495470	153019000	0.977	54350	0.355	36257	0.237	58960	0.385

As mentioned earlier, information on disability was not canvassed at the 1991 census, but the 47^{th} round of NSS around 1991 included disability among its many other topics for investigation. Table I.5 presents the sample number of disabled by urban/rural residence and under six types of disabilities. We note again that rural rates are higher . But we see a reversal in the disability type – physical and locomotors disabilities predominate and visual disability is even lower than hearing disabilities.

NSS 47 th round Populat	ion by ty	pe of disal	oility and s	sex, 1991		
Disability	Ru	ural	Urban			
Туре	Male	Female	Male	Female		
Physical	7442	5210	2071	1424		
Visual	1539	1796	301	362		
Hearing(5+)	1409	1164	339	330		
Speech(5+)	942	557	298	169		
Hearing/Speech(5+)	2009	1490	559	426		
Locomotor	4396	2411	1370	762		
Estimated Pop(000)	32682	30754	11712	10464		
1991 Census Pop(000)	32432	304370	114909	102702		
Total disabled, sample	17737	12628	4938	3473		
Estimated						
disabled(000)	13	641	3785			
Disability rate %	2	.15	1.71			

Table I .5 Disability by type by rural urban residence, NSS 47th round (1990/91)

Looking at the age-sex pattern (Table I.6) also it is clear that locomotors disabilities are by far the largest with visual disabilities taking second place. Disability rates are high at very young and old ages, but comparatively lower at the adolescent and middle ages. Males depict higher rates (Table I.6)

Table I.6 Disabled population by age, sex and type of disability, 1991 (NSS 47th round)

Male			Disa	ability Type		
Age	Visual	Hearing	Speech	Locomotor	Multiple	Total
0-4	934	1028	1014	14419	0	17395
5 – 9	689	1110	542	4123	2504	8968
10 - 14	501	669	205	2990	4405	8770
15 – 19	205	425	72	2221	4406	7329
20 – 24	245	408	99	2121	2536	5409
25 – 29	232	376	94	1710	2160	4572
30 -34	304	452	56	2100	1192	4104
35 – 49	1032	1061	162	3481	2594	8330
45 – 59	3859	2455	385	4781	1158	12638
60 +	7261	3312	372	4412	7372	22729
All Ages	15262	11296	3001	42358	28327	100244
Female						
0-4	504	597	552	8207	0	9860
5 – 9	353	521	183	2053	2534	5644
10 -14	211	504	112	1235	2843	4905
15 – 19	166	426	61	737	2206	3596

20 – 24	163	404	68	645	1143	2423
25 – 29	213	372	51	690	848	2174
30 -34	244	451	47	653	859	2254
35 – 49	1041	886	70	1421	858	4276
45 – 59	5158	2219	143	3130	0	10650
60 +	8517	3816	180	4272	6217	23002
All Ages	16570	10196	1467	23043	17508	68784

Table I.7 showing the distribution of disability by age and sex clearly indicates that for both males and females, visual and hearing disabilities are mostly for the aged whereas speech and locomotor predominate among the younger ones. Disability generally increased by age . However, a look at the type of disability by age indicates about three quarters of disability among children are affected by mobility problems . One reason for such big difference could be the difficulty in diagnosing visual and hearing disabilities among young children.

Table I.7 Disability by type, age and sex, 1991

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Disability Type	Visual	Hearing	Speech	Locomotor	Multiple	Total
Male		Percent	in each age	e group by disab	ility type	
0-9	10.6	18.9	51.8	43.8	8.8	26.3
10 - 19	4.6	9.7	9.2	12.3	31.1	16.1
20 – 34	5.1	10.9	8.3	14.0	20.8	14.1
35 – 59	32.0	31.1	18.2	19.5	13.2	20.9
60 +	47.6	29.3	12.4	10.4	26.0	22.7
All Ages	100.0	100.0	100.0	100.0	100.0	100.0
Female			-			-
0 – 9	5.2	11.0	50.1	44.5	14.5	22.5
10 – 19	2.3	9.1	11.8	8.6	28.8	12.4
20 – 34	3.7	12.0	11.3	8.6	16.3	10.0
35 – 59	37.4	30.5	14.5	19.8	4.9	21.7
60 +	51.4	37.4	12.3	18.5	35.5	33.4
All Ages	100.0	100.0	100.0	100.0	100.0	100.0
Male		Perce	ent for each	n disability type b	y age	
0-9	6.2	8.1	5.9	70.3	9.5	100.0
10 – 19	4.4	6.8	1.7	32.4	54.7	100.0
20 – 34	5.5	8.8	1.8	42.1	41.8	100.0
35 – 59	23.3	16.8	2.6	39.4	17.9	100.0
60 +	31.9	14.6	1.6	19.4	32.4	99.9
All Ages	15.2	11.3	3.0	42.3	28.3	100.1
Female						
0-9	5.5	7.2	4.7	66.2	16.3	99.9
10 - 19	4.4	10.9	2.0	23.2	59.4	99.9
20 – 34	9.0	17.9	2.4	29.0	41.6	99.9
35 – 59	41.5	20.8	1.4	30.5	5.7	99.9
60 +	37.0	16.6	0.8	18.6	27.0	100.0
All Ages	24.1	14.8	2.1	33.5	25.5	100.0

The total Population of 1991 was 85611700 with 32682000 males and 30753700 females in rural and 11712100 males 10464000 females in urban areas. At the NSS 47th round (1990/91) the total disabled was estimated as 17526000 with 13641000 in r4 ural and 3785000 in urban areas giving a disability rate of 2.15% for rural and 1.71% for urban and 2.07% for the total population. Of the disabled population male was 58.5% and female 41.5%, rural 78.3% urban 21.7%, rural male was 78.2%, rural female 78.4%, urban male 21.5 and urban female 21.6%. NSS 47th round reported a disability rate of around 2% as against a WHO estimate of 10%.

During the NSS 47th round, causes of disability was investigated and it was noted that :

visual disability was due to : 24.4% old age, 3.8% glaucoma, 1.2% diarrhoea, 25.8% cataract, 3.4% injury, eye discharge 11.9, small pox 3.2%, other 26.4%.

Speech disability was due o: paralysis 21.6%, cleft palate 2%, multiple illness 9.1%, other illness 21.4%, since birth 7.7%, old age 2.3%, injury 4, hearing impairment 3.4%, other 28.8%

Locomotor disability due to : palsy 33.7%, cerebral 4.6%, burns 21.8%, leprosy 3.5%, polio 2.5%, old age 5.2%, smoking 2%, other illness 1.9%

Hearing disability due to : noise induced 2.5%, ear discharge 23.1%, old age 5.6%, other illness 27.9, other 40.8%

More than 21 million persons were reported in the census carried out in 2001 with one of the five types of disabilitiesvision, speech, hearing, movement and mental. As mentioned earlier this census included mental disabilities.. Both among males and females in urban and rural areas, around half of the population were recorded as having problems of seeing and a quarter were having mobility problems. About 80% of the disabled resided in rural areas. Males generally had higher disability rates than females. Table I.8 gives further details.

Disability rates increased by age for both sexes in rural and urban areas (Table I.9). Male disability rate was 2.37% compared with a female 1.87%. Rural rates were more than ten percent higher than female rates . Compared with previous census there seems to be an increase in disability which may be due to better coverage and inclusion of mental disabilities in addition to physical disabilities in the recent enumeration.

In each disability category as presented in table I.10 there was an increasing trend in disability rate but it was more pronounced in the disability categories of vision and mental.

Type of disability	Tot	al disabled popula	ation	Per	centage disa	bled							
	Person	Male	Female	Person	Male	Female							
			Total			•							
Total	21,906,769	12,605,635	9,301,134	100.0	100.0	100.0							
In Seeing	10,634,881	5,732,338	4,902,543	48.5	45.5	52.7							
In Speech	1,640,868	942,095	698,773	7.5	7.5	7.5							
In Hearing	1,261,722	673,797	587,925	5.8	5.3	6.3							
In Movement	6,105,477	3,902,752	2,202,725	27.9	31.0	23.7							
Mental	2,263,821	1354,653	909,168	10.3	10.7	9.8							
	Rural												
Total	16,388,382	9,410,185	6,978,197	100.0	100.0	100.0							
In Seeing	7,873,383	4,222,717	3,650,666	48.0	44.9	52.3							
In Speech	1,243,854	713,966	529,888	7.6	7.6	7.6							
In Hearing	1,022,816	549,002	473,814	6.2	5.8	6.8							
In Movement	4,654,552	2,975,127	1,679,425	28.4	31.6	24.1							
Mental	1,593,777	949,373	644,404	9.7	10.1	9.2							
			Urban										
Total	5,518,387	3,195,450	2,322,937	100.0	100.0	100.0							
In Seeing	2,761,498	1,509,621	1,251,877	50.0	47.2	53.9							
In Speech	397,014	228,129	168,885	7.2	7.1	7.3							
In Hearing	238906	124,795	114,111	4.3	3.9	4.9							
In Movement	1,450,925	927,625	523,300	26.3	29.0	22.5							
Mental	670,044	405,280	264,764	12.1	12.7	11.4							

Table I.8 Distribution of disabled population by type of disability, sex and residence, 2001

	Total P	opulation	Rural P	opulation	Urban I	Population
Age	Male	Female	Male	Female	Male	Female
0-4	1.13	1.04	1.15	1.05	1.07	0.99
5 – 9	1.73	1.46	1.77	1.49	1.6	1.31
10 - 19	2.19	1.76	2.26	1.8	1.99	1.66
20 – 29	2.21	1.56	2.31	1.58	1.99	1.53
30 – 39	2.31	1.61	2.42	1.64	2.08	1.54
40 – 49	2.67	1.89	2.81	1.93	2.57	1.75
50 – 59	3.21	2.45	3.42	2.53	2.83	2.17
60 – 69	4.41	3.72	4.65	3.96	3.69	2.99
70 – 79	5.97	5.62	6.37	6.09	4.77	4.24
80 +	7.69	7.29	8.3	8.53	5.74	5.75
Total	2.37	1.87	2.47	1.93	2.12	1.71

Table I.9 Disability rate by age, sex and urban/rural residence, 2001

Table 1.10 Percentage of disabled to total population ($\mbox{Disability rate DR}$) by broad age-groups=2001

٨٣٥	Tata		blad		Type of Disability													
Age	тога	DISa	upied	In	In Seeing			In Speech		In Hearing		In N	loven	nent	Mental			
Group	Ρ	Μ	F	Ρ	Μ	F	Ρ	Μ	F	Ρ	М	F	Ρ	Μ	F	Ρ	Μ	F
Total	2.13	2.37	1.87	1.03	1.08	0.99	0.16	0.18	0.14	0.12	0.13	0.12	0.59	0.73	0.44	0.22	0.25	0.18
0-9	1.36	1.46	1.27	0.76	0.77	0.75	0.12	0.14	0.11	0.04	0.05	0.04	0.33	0.38	0.27	0.11	0.12	0.10
10-19	1.99	2.19	1.76	0.79	0.82	0.77	0.21	0.23	0.19	0.08	0.09	0.07	0.66	0.78	0.53	0.24	0.27	0.20
20-39	1.92	2.25	1.58	0.90	0.97	0.83	0.16	0.18	0.14	0.07	80.0	0.06	0.53	0.70	0.35	0.26	0.32	0.20
40-59	2.51	2.89	2.10	1.29	1.41	1.16	0.14	0.15	0.13	0.16	0.16	0.16	0.67	0.87	0.44	0.26	0.30	0.22
60+	4.92	5.20	4.66	2.55	2.56	2.55	0.16	0.17	0.15	0.62	0.62	0.62	1.36	1.60	1.12	0.24	0.25	0.22

Looking at Table I.11 it can be noted that more than 50% of the persons at every age had vision problems and a quarter had mobility problems.. Rural areas indicated slightly higher rates. Mental disability was slightly higher in urban than rural areas, presumable because of better reporting and perhaps availability of facilities.

Table I. 11 Percentage of disabled in each type of disability, by age , sex and residence - 2001

Age							Туре	of disa	ability						
group	lr	n Seein	ıg	In	Speed	ch	In	Hearir	ng	In I	Novem	ent		Mental	
	Р	Μ	F	Р	М	F	Р	Μ	F	Р	Μ	F	Р	Μ	F
								Total							
Total	48.5	45.5	52.7	7.5	7.5	7.5	5.8	5.3	6.3	27.9	31.0	23.7	10.3	10.7	9.8
0-9	55.8	53.0	59.3	9.0	9.3	8.6	3.2	3.2	3.2	23.9	26.0	21.3	8.1	8.5	7.6
10-19	40.0	37.3	43.6	10.8	10.7	10.8	4.2	4.2	4.1	33.2	35.5	29.9	11.9	12.2	11.5
20-39	46.8	43.1	52.3	8.3	8.0	8.6	3.8	3.7	4.0	27.4	31.0	22.1	13.7	14.2	12.9
40-59	51.2	48.7	55.1	5.6	5.3	6.0	6.2	5.4	7.4	26.5	30.1	21.0	10.5	10.5	10.5
60+	51.9	49.2	54.7	3.2	3.3	3.2	12.6	11.9	13.3	27.5	30.8	24.0	4.8	4.8	4.8
								Rural							
Total	48.0 44.9 52.3 7.6 7.6 7.6 6.2 5.8 6.8 28.4 31.6 24.1 9.7 10.1 9.2														
0-9	55.4	52.5	59.1	9.1	9.5	8.6	3.3	3.3	3.4	24.6	26.8	21.9	7.5	7.9	7.0

10-19	39.0	36.3	42.8	11.0	10.9	11.1	4.4	4.5	4.4	34.4	36.9	30.9	11.2	11.4	10.9
20-39	45.7	41.9	51.3	8.6	8.3	9.0	4.2	4.1	4.5	28.1	32.0	22.4	13.4	13.8	12.8
40-59	50.4	47.8	54.1	5.7	5.4	6.1	7.0	6.2	8.1	27.0	30.6	21.5	10.1	10.0	10.1
60+	52.5	49.7	55.4	3.1	3.2	3.1	12.9	12.3	13.5	27.1	30.3	23.7	4.4	4.5	4.4
								Urban							
Total	50.0	47.2	53.9	7.2	7.1	7.3	4.3	3.9	4.9	26.3	29.0	22.5	12.1	12.7	11.4
0-9	57.1	54.6	60.2	8.6	8.9	8.3	2.7	2.7	2.6	21.4	23.2	19.2	10.2	10.7	9.6
10-19	42.8	40.5	45.9	10.2	10.2	10.2	3.4	3.4	3.3	29.7	31.5	27.2	13.9	14.3	13.3
20-39	49.7	46.1	54.8	7.4	7.2	7.7	2.8	2.6	2.9	25.7	28.8	21.2	14.5	15.4	13.3
40-59	53.6	50.9	58.0	5.2	5.0	5.6	4.2	3.4	5.3	25.2	28.7	19.6	11.7	11.9	11.5
60+	49.5	47.2	52.1	3.7	3.9	3.6	11.3	10.1	12.6	29.2	32.5	25.4	6.3	6.3	6.3

Disability information was included in the 58th round of NSS taken during 2002. Information was collected under seven categories with two divisions each for vision- blindness and low vision - and for mental - mental retardation and mental illness. Table I. 13 shows that disability rate was around 2 percent – slightly higher for males and for rural population. Mobility type disability was reported by around half of the disabled.

Table I.12 Disability per 10000 population by age and disability type, 2002

Age	Disability Type Rural Population													
	Rural Population Mental Low In Hearing Any													
	Mental	Rural Population Mental Low In Hearing Any etardation Illness Blindness Vision Hearing Speech /Speech Locomotor Disability												
	Retardation	Illness	Blindness	Vision	Hearing	Speech	/Speech	Locomotor	Disability					
0 - 4	59	12	32	5	55	129	86	334	523					
5 - 9	115	32	48	12	172	297	209	716	1167					
10 -14	148	53	52	22	196	281	212	999	1549					
15 - 19	172	91	56	21	193	243	208	1181	1748					
20 - 24	141	111	65	23	200	263	245	1039	1627					
25 - 29	105	151	68	17	205	207	198	895	1487					
30 - 34	91	173	77	16	207	169	175	852	1448					
35 - 44	53	179	98	37	247	168	152	863	1509					
45 - 59	22	181	273	126	405	136	119	1312	2308					
60 +	11	180	1733	747	1551	190	132	2796	6401					
All Ages	92	110	210	86	310	210	173	1046	1846					
				Urba	an populat	ion								
0 - 4	75	16	30	5	55	132	86	291	487					
5 - 9	153	35	73	16	142	285	215	557	1015					
10 -14	165	55	82	10	209	338	326	758	1317					
15 - 19	164	73	44	13	145	223	158	875	1337					
20 - 24	137	92	56	18	118	175	158	819	1242					
25 - 29	87	100	43	20	120	149	129	620	1000					
30 - 34	86	102	30	19	134	116	101	669	1054					
35 - 44	71	129	65	24	139	115	112	791	1216					
45 - 59	33	124	172	78	258	123	95	1209	1859					
60 +	7	167	1087	459	1385	223	137	2888	5511					
All Ages	100	89	140	54	236	187	153	901	1499					

		Disabled pop	ulation- Rur	al	C	isabled popu	lation – Urb	an
	М	ale	Fer	nale	M	ale	Fer	nale
by Disability		Rate per		Rate per		Rate per		Rate per
Туре	Number	100 Pop	Number	100 Pop	Number	100 Pop	Number	100 Pop
Mental								
Retardation	4434	0.11	2561	0.07	1824	0.12	1121	0.08
Mental								
Illness	5022	0.13	3377	0.09	1623	0.11	988	0.07
Blindness	7494	0.19	8536	0.23	1723	0.11	2311	0.17
Low Vision	2982	0.08	3563	0.10	711	0.05	877	0.06
In Hearing	12516	0.32	11171	0.30	3617	0.23	3313	0.24
In Speech	9495	0.24	6532	0.18	3416	0.22	2102	0.15
Locomotor	49987	1.27	29839	0.80	16352	1.06	10162	0.73
Any Disability	83102	2.12	57748	1.56	25811	1.67	18249	1.31
Total								
Population	3923611	100.00	3711319	100.00	1545555	100.00	1391996	100.00

Table I.14 Estimated number of disabled (00s) by disability type, age and sex, 2002

Disability	Mentally	Mental		Low					Any	
Туре	retarded	illness	Blind	Vision	Hearing	Speech	Locomotor	Multiple	disability	Total
Age Group		Estir	nated nun	nber of disa	bled by age	group an	d disability typ	e- Male	1	
0 - 9	1028	249	597	130	672	1808	8372	2264	15128	30248
10 – 19	1873	912	766	313	1344	1876	16535	2760	26379	52758
20 - 34	1471	2221	1081	288	1545	1319	15004	2630	25555	51114
35 – 59	530	2976	2975	1287	4148	1119	18265	2248	33549	67097
60 +	54	829	7533	3218	5691	332	13183	3994	34842	69676
Total	4956	7187	12952	5236	13400	6454	71359	13896	135453	270893
Age Group		Pe	rcentage o	of disabled b	y age and	for each di	sability type –	Male		
0-9	20.7	3.5	4.6	2.5	5.0	28.0	11.7	16.3	11.2	11.2
10 - 19	37.8	12.7	5.9	6.0	10.0	29.1	23.2	19.9	19.5	19.5
20 - 34	29.7	30.9	8.3	5.5	11.5	20.4	21.0	18.9	18.9	18.9
35 – 59	10.7	41.4	23.0	24.6	31.0	17.3	25.6	16.2	24.8	24.8
60 +	1.1	11.5	58.2	61.5	42.5	5.1	18.5	28.7	25.7	25.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Age Group		Estima	ated numb	er of disabl	ed by age g	roup and	disability type	- Female		
0-9	335	82	217	47	103	413	1854	709	3769	7529
10 - 19	593	271	327	57	292	539	4170	1199	7447	14895
20 - 34	554	567	280	116	368	350	4650	844	7728	15457
35 – 59	233	777	705	284	840	239	6211	751	10045	20085
60 +	9	226	1508	580	1797	115	4472	1132	9841	19680
Total	1724	1923	3037	1084	3400	1656	21357	4635	38830	77646
Age Group		Per	centage of	disabled by	age and fo	or each dis	ability type –	Female		
0 - 9	19.4	4.3	7.1	4.3	3.0	24.9	8.7	15.3	9.7	9.7
10 - 19	34.4	14.1	10.8	5.3	8.6	32.5	19.5	25.9	19.2	19.2
20 - 34	32.1	29.5	9.2	10.7	10.8	21.1	21.8	18.2	19.9	19.9
35 - 59	13.5	40.4	23.2	26.2	24.7	14.4	29.1	16.2	25.9	25.9
60 +	0.5	11.8	49.7	53.5	52.9	6.9	20.9	24.4	25.3	25.3

Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
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Table I.14 indicates that both among males and females, mental disability – retardation and illness – and speech disability were mostly in the young ages, blindness and low vision and hearing disability predominated among the old and mobility problems were more or less evenly distributed among all ages, but with a slight tendency towards older ages.

I.4 Socio-economic characteristics of the disabled

Disabled persons usually face economic and social problems. An important social indicator of acceptance by the population is that of marital status. Generally, persons with disabilities face many problems in getting married and staying married. Another fact is the usual higher mortality among the disabled resulting in higher deaths of spouses. Also divorce is usually higher .especially when one partner gets disabled. Table I.15 presents marital status data from the census of 2001. Around half of the disabled population is never married – more among male than female, but it varies from a low 30% among hearing impaired to a high more than 60% among the speech impaired and the mentally affected. The currently married constitute slightly less than half of the persons – with an edge for males again. Consequently only around a tenth of the disabled reported as widowed- with women having about four times the rate for males. Similarly, divorced/separated constitute just about one percent of the disabled , with females showing a more than double those for males. The pattern for each type of disability was similar to the total disabled but with some variations. For instance, among the married who are mentally disabled, females and males had parity.

Table I.15	Percentage	of disabled by	marital sta	atus and	sex to	total	disabled	population	by age	e and
			type of d	isability,	2001					

Type of	Marital status											
disability	Nev	er mar	ried		Married	ł	V	Vidowe	d	Divor	ced/Se	eparate
											d	
	Р	М	F	Р	М	F	Р	М	F	Р	Μ	F
		n	1	n	n	15-59	years	5	n			
Tot-dis-pop	34.4	38.9	27.8	59.6	58.1	61.9	4.5	2.2	8.0	1.4	0.9	2.3
In Seeing	22.4	27.2	16.4	72.2	70.4	74.4	4.7	2.0	8.2	0.7	0.4	1.0
In Speech	48.9	53.4	42.6	45.3	43.6	47.6	3.8	1.9	6.5	2.0	1.1	3.3
In Hearing	26.9	32.5	19.9	63.4	63.3	63.4	8.0	3.2	14.0	1.7	1.0	2.7
In Movement	43.2	44.7	40.1	51.5	52.3	49.9	4.0	2.2	7.5	1.3	0.7	2.5
Mental	53.4	58.1	46.1	38.1	36.7	40.4	4.3	2.6	7.0	4.1	2.6	6.5
					60	years	and al	oove				
Tot-dis-pop	3.2	4.4	2.0	56.7	76.5	35.4	39.3	18.5	61.9	0.7	0.6	0.8
In Seeing	2.3	3.2	1.4	56.7	78.1	35.9	40.5	18.3	62.2	0.5	0.4	0.6
In Speech	9.3	11.7	6.7	56.6	71.6	39.6	32.9	15.7	52.5	1.1	1.0	1.3
In Hearing	1.9	2.7	1.2	52.2	74.2	31.0	45.1	22.5	67.0	0.7	0.6	0.7
In Movement	3.8	4.8	2.4	59.3	76.4	35.6	36.2	18.2	61.1	0.7	0.6	0.8
Mental	9.7	13.0	6.2	54.4	69.8	37.7	33.7	15.4	53.7	2.1	1.9	2.4
						All	Ages					
Tot-dis-pop	45.8	48.9	41.7	43.8	46.3	40.5	9.4	4.2	16.4	0.9	0.6	1.4
In Seeing	39.1	42.1	35.6	50.3	53.4	46.8	10.1	4.3	16.9	0.5	0.3	0.7
In Speech	63.3	66.5	58.9	30.7	30.6	31.0	4.7	2.2	8.0	1.3	0.7	2.0
In Hearing	29.5	33.9	24.5	48.7	56.1	40.3	20.7	9.3	33.7	1.1	0.7	1.5
In Movement	50.7	51.7	48.9	40.0	43.6	33.6	8.5	4.2	16.1	0.9	0.5	1.5
Mental	60.8	64.6	55.2	30.5	30.6	30.5	5.6	2.9	9.7	3.0	2.0	4.5
Total												
population	49.8	54.4	44.9	45.6	43.6	47.7	4.3	1.8	6.9	0.3	0.2	0.5

Between ages 15 - 59, only a third are never married and around 60% are married- with males showing higher proportion Widowed constitute only less than one in twenty, but females have rates which are almost 3-4 times those for males.

Similarly, divorced/separated constitute only around 1.5 percent, with females having a rate more than double those for males. In the older ages 60 and above, very few are never married - around 3.2 percent, again with males having a slight edge over females. However, among the married the pattern is very interesting. Whereas among males, more than three quarters are married, among females it is only around a third and correspondingly among the widowed females report around two thirds while males have only a fifth. Divorce/separated are slightly lower in the older ages- possibly due to higher mortality among the disabled and the rates are similar for both sexes.

	Rural –Male			Rura			l –Female	
Marital								
Status	Never	Married	Widowed	Divorced/	Never	Married	Widowed	Divorced/
Disability Type	Married			Separated	Married			Separated
Mentally								
Retarded	920	63	3	13	899	47	23	31
Mentally III	506	398	35	61	338	393	171	97
Blind	264	538	187	11	132	275	580	13
Low Vision	146	662	173	18	92	277	626	5
Speech	349	529	113	10	292	318	365	24
Hearing	728	240	23	8	697	187	74	32
Locomotor	483	456	53	8	437	334	206	23
Any	471	448	68	12	376	316	281	26
Disability Type		Urba	n – Male			Urbar	n – Female	
Mentally								
Retarded	963	27	4	6	941	29	10	20
Mentally III	640	283	32	46	522	220	190	68
Blind	269	589	136	6	297	198	495	10
Low Vision	236	612	146	6	88	305	599	8
Speech	391	488	110	11	298	297	386	18
Hearing	767	207	16	11	721	158	98	22
Locomotor	483	453	48	6	418	319	248	16
Any	484	450	52	9	415	284	283	18

Table I.16 Disabled population by marital status, disability type and rural/urban, India 2002 (per 1000 Pop)

Around half of rural males with any disability is never married and it is highest at around 92% among mentally retarded and lowest at 14.6% among those with low vision. Females have slightly lower rates. The urban rates are consistently higher. Also the situation is slightly different – with males showing 96.3% for those mentally retarded and 23.6% for low vision. As for rural, urban never married females also have lower rates for each of the disability. For married males and females , the lowest is for mentally retarded and highest for low vision. With the social stigma and shame attached to mental disorders, it is but to be expected that such afflicted persons would find it very difficult to get married. Those with low vision and even blindness or speech disabilities may not face similar neglect and aversion. IN fact, in many cases persons with any of these disabilities may marry those of the opposite sex with similar disability. Widowed persons show similar proportion among rural and urban dwellers for the males and females. As can be expected in a highly illiterate society (more in rural than urban) with low esteem for the female, divorce rates are higher in rural than urban and more among females than males.(Table I.16).

Another important socio-economic indicator is education. Persons with disability are in a vicious cycle – poverty and concomitant deprivation of opportunities compounded by physical barriers of distance, accessibility and affordability of facilities. Illiteracy is higher in rural than urban and highest among the mentally retarded and lowest among those with mobility problems. Most have no education or less than primary. Very few go beyond primary , especially in rural areas. Male-Female inequality is very obvious and is most manifested among the mentally challenged.

	Rural – Male					Rural -	- Female	
Disability	Not				Not			
Туре	Literate	<primary< td=""><td>Middle</td><td>Secondary+</td><td>Literate</td><td><primary< td=""><td>Middle</td><td>Secondary+</td></primary<></td></primary<>	Middle	Secondary+	Literate	<primary< td=""><td>Middle</td><td>Secondary+</td></primary<>	Middle	Secondary+
Mentally								
Retarded	871	100	24	4	918	71	13	1
Mentally III	537	231	125	103	743	176	55	25
Blind	716	182	62	39	923	53	15	8
Low Vision	645	250	65	35	882	80	18	15
Speech	662	236	62	31	793	172	29	6
Hearing	592	271	85	51	811	145	31	11
Locomotor	388	331	159	121	652	220	75	52
Any	485	293	128	92	741	174	52	32
		Urba	n – Male			Urban	– Female	
Mentally								
Retarded	788	163	44	5	850	101	42	7
Mentally III	431	253	126	188	580	209	115	88
Blind	426	271	128	175	638	247	37	76
Low Vision	390	292	109	204	727	190	43	40
Speech	478	330	92	100	605	288	70	35
Hearing	325	354	137	183	610	253	81	55
Locomotor	242	319	182	256	440	273	131	153
Any	311	309	160	219	523	258	104	113

Table I.17 Disabled population aged 5+ by education level, rural/urban, India 2002 (per 1000 Pop.)

Yet another vital economic indicator is activity status in the labour force. According to table I.18 more than two thirds of the disabled were non workers with males having a slightly higher than fifty percent and females showing a whopping more than two thirds. As expected the highest level of inactivity was among the mentally challenged and the lowest among the vision impaired. In each category of disability, the male-female disparity persisted. Main workers constituted only a quarter of the disabled with females showing only a tenth. Whereas vision impaired had highest percent of main workers, hearing impaired indicated highest rate among marginal workers. Highest inactivity rate was among mental for those aged 15-59 , but it was mobility among the oldest aged 60 and over.

Table I.18 Percentage of disabled among main workers, marginal workers and non-workers by sex, age and type of disability, 2001

Type of	Main workers Marginal workers Non workers								
disability	Р	Μ	F	Р	М	F	Ρ	Μ	F
				15	5-59 yea	rs			
Tot-dis-pop	40.2	54.8	18.6	10.9	9.2	13.5	48.9	36.0	67.9
In seeing	49.0	70.0	22.6	12.0	9.4	15.4	38.9	20.7	61.9
In speech	36.8	50.8	17.5	12.2	10.8	14.1	51.0	38.3	68.4
In hearing	45.5	63.7	22.4	15.3	12.5	18.8	39.3	23.8	58.8
In movement	34.3	44.2	14.1	9.6	9.0	10.7	56.1	46.7	75.2
Mental	20.5	28.0	8.7	7.4	7.0	8.0	72.1	65.0	83.3
				60 yea	ars and a	above			
Tot-dis-pop	20.3	32.8	6.6	6.3	6.7	5.8	73.4	60.4	87.5
In seeing	22.8	38.3	7.6	6.8	7.3	6.3	70.4	54.4	86.0
In speech	24.4	37.7	9.3	7.6	7.4	7.9	68.0	54.9	82.8
In hearing	20.0	33.7	6.7	7.4	8.2	6.7	72.6	58.1	86.7

In movement	15.7	23.9	4.3	4.9	5.4	4.2	79.4	70.7	91.5
Mental	17.3	28.2	5.3	5.0	5.4	4.6	77.7	66.4	90.1
					Total				
Tot-dis-pop	26.7	37.9	11.6	7.8	6.9	8.9	65.5	55.2	79.5
In seeing	31.6	46.8	13.8	8.4	7.0	9.9	60.1	46.2	76.3
In speech	23.8	33.1	11.4	8.4	7.6	9.6	67.7	59.3	79.0
In hearing	28.6	42.5	12.7	10.3	9.3	11.4	61.1	48.2	75.9
In movement	22.7	30.8	8.5	6.8	6.7	6.9	70.5	62.6	84.5
Mental	15.7	21.9	6.5	5.8	5.6	6.1	78.5	72.5	87.4
Total									
Population	30.4	45.1	14.7	8.7	6.6	11.0	60.9	48.3	74.4

 Table I.19 Distribution of non-workers in the total population and disabled non-workers by main non-economic activity, type of disability, sex and residence, India - 2001

Activity of	Total non-	Total non-worker Distribution of the disabled non-workers by type of disability							oility			
Non-worker	Popula	tion	In Se	eing	In Sp	eech	In He	aring	In Mov	ement	Mei	ntal
	Μ	F	Μ	F	Μ	F	Μ	F	М	F	М	F
		All Ages										
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Student	48.7	26.5	37.3	19.6	33.0	20.2	28.1	12.7	31.7	21.5	14.3	10.8
Household duties	1.8	35.8	2.3	30.6	3.0	25.3	3.2	26.6	2.0	19.6	2.3	19.2
Dependent	41.6	33.4	50.8	44.1	55.8	49.0	54.7	53.1	54.2	52.1	72.8	63.2
Pensioner	1.7	0.5	3.4	1.5	1.2	0.7	6.6	3.1	3.3	1.8	1.0	0.7
Beggar, Vagrants, etc.	0.1	0.1	0.6	0.3	0.5	0.4	0.7	0.6	1.0	0.6	1.0	0.7
Others	6.2	3.8	5.6	3.8	6.4	4.3	6.6	3.9	7.8	4.4	8.5	5.3

Among the non workers, whereas students constituted around half among males, among females it was a third each among housewives and dependents. Those visually challenged had the highest proportion as student among males but among females it was among those with mobility problems with a slight edge over those with sight difficulties. Dependents constituted around half of all non workers in each of the disability types for both sexes. Housewives, as anticipated, had much higher proportions among females than males with a 10 - 15 times advantage.

I.5 Conclusion and policy overtones

With a very large population still growing at moderately large rates, with increasing proportions who are aged, India faces tremendous challenges to meet the aspirations of its people. Despite creditable progress in the health front, still there are huge numbers of people who are illiterate, hungry and malnourished. Even though disability rates as reported in the censuses and surveys indicate low prevalence, it is suspected that quite a large proportion is unreported, perhaps due to several social, cultural, economic, psychological and physical factors. More than three quarters of disabilities are caused by serious illness during childhood, pregnancy related problems, polio, ear discharge, eye disease, accident, violence and untreated injuries/diseases. Most are related to poverty. With 360 million people below poverty line these most vulnerable segment suffers from malnutrition, over crowded/ unsanitary living conditions, limited access to basic amenities like safe drinking water and facilities like medical/health care (still depending on fake traditional and sometimes other medical practitioners), poor or no education, lack of knowledge and inadequate or no immunisation etc. An estimated 70 million disabled population are home bound with inaccessible physical infrastructure, health facilities/ care, dependent on families and being burden on society, there is imminent need for concerted efforts to identify the true level of disability in the country and institute measures and policies to address the issues. Sincere efforts have been made by the government through legislation, but implementation and operationalising are not adequate. Non governmental and voluntary agencies in the country have and still do have very important and vital roles to play to address the various issues related to the disabled and destitute populations.

Successive Five Year Plans have taken cognizance of the needs of the disabled. For instance, the Mental Health Act 1987 focussed in protecting the rights of persons with intellectual/psychological impediments., The Rehabilitation Act India 1992 aimed to regulate and standardise training planning and programmes. The main thrust of the People with Disability (PWD) Act of 1995 was to ensure equal opportunities to the disabled and protect their rights and ensure full participation in the economy and society. The National Trust for Welfare of persons with Autism, cerebral palsy, mental retardation and multiple disabilities Act 1999 was yet another instrument for taking care of those challenged. Recently, the National Policy for persons with disability(PWD) Act 2006 recognised PWD as valuable human resources and sought to create an environment that provide them equal opportunities, protect their rights and ensure full participation in society.

India is a signatory to the UNESCO declaration of Asia Pacific Decade of Disability Rights Act 2002 covering the period 2003-2012 and the Biswako millennium frame work for action. India also played active role in drafting comprehensive and integrated International Convention on Protection and Promotion of the Rights and Dignity of PWD.

II. Disability trends in MAURITIUS

II.1 Disability Data Collection

The 2000 census of **MAURITIUS** followed the recommendations set out in the UN manual : Principles and Recommendations for Housing and Population Censuses – Revision 1 (UN,1998).

The question asked at the 2000 Population Census was :.

"Does the person experience any disability (i.e., any limitation to perform a daily-life activity in a manner considered normal for a person of his/her age) because of a longterm physical/mental condition or health problem?"

if the person stated "Yes", he was requested to insert as many disabilities as applicable as follows:

walking, running and other ambulation disabilities (MTION); manual activity disabilities such as fingering, gripping and holding (MANU); seeing disabilities even with glasses (EYE); hearing and listening disabilities even with hearing aid (EAR); speaking and talking disabilities (SPCH); disturbance of ability to learn and acquire education (LEARN); disturbances of behaviour, including antisocial behaviour, maladjustment and liability to self injury (BEH); inability to look after oneself with regard to personal care and hygiene, feeding, etc. (CARE); other disabilities OTHER).

In 1990, the question, _"Does the person have any long-term disabilities or handicaps which limit his/her participation in individual and/or social activities which are considered normal for a person of his/her age?"

was asked and respondents were requested to report as many disabilities as applicable as follows:

incomplete use of legs/feet (LF); incomplete use of arms/fingers (AF); partial or total loss of sight even with glasses (EYE); partial or total loss of hearing (EAR); partial or total loss of speech (SPCH); slow development/learning difficulties (SLOW); behaviour problems/mental disability (BEH); loss of consciousness, fits, blackouts (CFB); other disabilities (OTH)

Although respondents were asked to list all disabilities that they had, only the first three disabilities were coded in the recent census. After examination of a sample of returns, it was found that most disabled persons fell in one of the 12 categories and 4 groups listed below.

I. MOBILITY (MOB)	II. COMMUNICATION (III. DEVELOPMENT (IV. OTHER (
	COM)	DEV)	OTH)

	2000	1990		2000	1990		2000	1990		1990/2000
1	MTION	LF ,	4	EYE	EYE	9	LEARN	SLOW	12	OTHER
		AF								
2	MANU		5	EAR	EAR	10	BEH	BEH		
3	MTION&MANU		6	EYE&EAR		11	CARE	CFB		
			7	SPCH	SPCH					
			8	EAR&SPCH						

Classifications used at the 1990 and 2000 Censuses are not strictly comparable. The differences lie in the category "BEH". Also, the category "CARE" was not in 1990 but there was a category "CFB". The residual category "Other" therefore also differs. To allow comparison between 1990 and 2000, some categories were grouped into the above 12 categories and 4 broad groups.

II.2. Prevalence of disability

At the 2000 Population Census, there were 40,790 persons in the Republic of <u>Mauritius</u> who were reported as being disabled compared to 27,852 in 1990, an increase of 46.5% during the inter-censal period. In 2000 among the disabled population there were 20,576 males and 20,214 females, giving a sex ratio (number of disabled males per 100 disabled females) of 101.8 compared to 14,613 disabled males and 13,239 disabled females in 1990 with a sex ratio of 110.4, indicating that in both censuses there were more males than females among the disabled population. However, the decline in the sex ratio in 2000 denotes that female disabled population has been growing at a faster rate than the corresponding male population or that coverage (awareness) has improved more for females.

In 2000, the crude disability rate, defined as the number of disabled per 1,000 mid-year population, was 34.6 (35.2 for males and 34.0 for females) as against 26.4 (27.7 for males and 25.0 for females) in 1990. The higher prevalence rates observed at the last census may be due to a change in the age structure. This is removed by standardising the rates for year 2000 using the population of 1990 as standard. The rate was 30.6 for both sexes (31.6 for males and 29.7 for females). The results still point to higher prevalence in 2000 but at a lesser extent.

II.3. Disability by age, sex and types:

The type of disability prevalent is important for designing preventive and protective action programs. Some types of disability have a greater incidence on the population than others. Broader meaningful categorisation of disabilities for Mauritius in table II.1 shows that both in 1990 and 2000, "MOB" was more frequent among the males and accounted for around a third of disabled male population compared to slightly more than a quarter for the female disabled population. Conversely, " COM" was most frequent among the females accounting for more than a third compared to less than a third for the male. The pattern by sex could be partially due to age structure.

TableII.1.Disabled population by broad group of type of disability and sex- 1990 and 2000

Broad type of 1990	2000
--------------------	------

		Perce	Femal	Perce		Perce	Femal	
Disability category	Male	nt	е	nt	Male	nt	е	Percent
Mobility (MOB)	4819	33	3419	25.8	6734	32.7	5508	27.2
Communication (
COM)	4278	29.3	5202	39.3	6112	29.7	6877	34
Development (DEV)	4488	30.7	3762	28.6	5139	25	5251	26
Other (OTH)	1028	7.0	836	6.3	2591	12.6	2578	12.8
All	14613	100	13239	100	20576	100	20214	100

Table II.2 indicates that the disabled population was relatively older than the overall population. About two thirds of the disabled persons were aged 45 years and over compared to less than a quarter for the overall population. The median age of the disabled population works out to 53.0 years compared to 29.2 for the total population. Furthermore, the female disabled population was relatively older than its male counterpart, the median age of the female disabled being 57.4 years against 48.7 for the male. It is to be noted that in 2000, nearly half of the total female disabled were aged 60 years and over. Between 1990 and 2000, the increase in number of disabled was more among females and at ages 35 and above. 61^b

Table II.2. Percentage age distribution of the disabled population and of the total population by sex: 1990 and 2000

	Disabled	d Populat	tion, (
	percentage)				Total Po	pulation,(percentag	e)	
Year	2000	1990	2000	1990	2000	1990	2000	1990	
Age group	Male Female		M	Male		Female			
0-14	8.3	9.9	6	8.3	25.7	30	24.7	29.4	
15 - 44	36.1		24.17		51.5		50		
45 – 59	25	60.1 ^ª	23.4	50 ^a	14.8	62.6 ^a	15	61.4 ^ª	
60 - 74	19.9		22.7		6.3		7.4		
75 +	11.6	30.1 ^b	23.2	41.7 ^b	1.7	7.3 ^b	2.8	9.2 ^b	
All Ages									
(Number)	20576	14613	20214	13239	583756	527760	595092	528900	

Note:: ^a the % is for ages 15-59 and ^b the % is for ages 60+

Table II.3 shows that the likelihood of having a disability increases with age . In 2000, among children aged 0 to 14 years, 10 out of 1,000 had some form of disability. In the age groups 15 to 39 years it was around 20, at ages 40-59 it increased to around 60, further increased to around 100 at ages 60-74 and was more than 200 at ages 75 and over. Prevalence of disability was higher among males than among females at all age groups except at very old ages, because of much larger proportions of oldest old among females. Similar patterns were noted at the 1990 Census. Also, the likelihood of having a disability was higher in 2000 than in 1990. This is true for all age groups irrespective of sex.

Table II.3. Number of disabled population and disability rate (DR per 1000) by age and sex: 1990 and 2000

		20	000		1990			
Age	Male	DR	Female	DR	Male	DR	Female	DR
0-4	277	5.8	231	5	203	4,2	161	3.4
5 – 9	656	12.4	448	8.6	484	9.2	406	8
10 - 14	780	15.8	539	11.2	763	13.4	530	9,5
15 - 19	833	16.1	592	11.7	733	14.9	541	11.3
20 - 24	901	16.3	597	10.7	947	18.1	593	11.8
25 - 29	915	19.6	582	12.4	1059	19.7	733	14.1

30 - 34	1,255	25.1	814	16.4	989	20.7	709	15.5
35 - 39	1,702	33	1,159	23	999	24.2	744	18.6
40 - 44	1,621	35.4	1,236	27.7	888	29.5	861	28.4
45 - 49	1,797	45.9	1,499	38.6	1,039	47.4	835	36/6
50 - 54	1,675	60.3	1,619	55.5	981	53.1	785	40.1
55 - 59	1,667	86.7	1,616	76	1,127	71.8	815	49.5
60 - 64	1,413	92.3	1,396	78.4	1,180	80	1,000	62.2
65 - 69	1,264	107.5	1,413	100.9	1,128	99.8	1.063	82.1
70 – 74	1,417	149.3	1,776	145.5	857	132.3	1,034	125.1
75+	2,396	239.7	4,682	276.4	1,236	199.6	2,429	210.3
All ages	20,576	35.2	20,214	34	14,612	27.2	13,239	25

A summary measure of mortality and disability is disability free life and duration of disability. Whereas life expectation in 1990 was 65.6 for males and 73.4 for females, in 2000 there was increase for both sexes to 68.2 for males and 75.3 for females. Taking into consideration the prevailing disability rates, disability free expectations came to 62.8 for male and 70.1 for females in 1990 and 64.7 for male and 70.9 for female in 2000. Thus, there seem to be disability life of about 2.8 years for male and 3.3 years for females on an average at birth in 1990. In 2000, corresponding figures are 3.5 years for males and 4.4 years for females. Though mortality conditions improved, the increased disability of recent period more than wiped off the gain.

Table II.4 presents disability by broad age categories and sex. Among males of all ages, "MOB "was the most prevalent. While among females. "COM "predominated." DEV "type of disabilities prevailed almost equally among males and females, but at a lower intensity than "MOB "and "COM ".However, disability pattern changed with age. Thus, among both sexes for the very young ages (0-14 years) and oldest (75 years and above), "COM "was most prevalent, while among those aged 15-44 years, "DEV "dominated. Disabilities prevailing most in ages 45-74 years was "MOB " for males, but for females it was "MOB " at ages 45-59 and "COM " at 60-74. It seems that males face more " mobility" related issues and females encounter "communication " problems.

		Ma	le		Female			
Age	MOB	СОМ	DEV	Total	MOB	СОМ	DEV	Total
				20	00			
0-14	2.7	4.2	3.1	11.4	1.6	3.5	2.1	8.3
15 – 44	6.5	5.5	8.5	24	3.5	4.6	5.9	16.7
45 – 59	23.9	14.5	11.9	59.7	16.7	14.1	12.2	53.1
60 – 74	43.7	40.5	17.4	112	33	41.6	18.8	104.2
75 +	73.7	109.3	45.9	239.7	75.9	112.3	74.1	276.4
All Ages	11.5	10.5	8.8	35.2	9.3	11.5	8.8	33.9
				19	90			
0-14	2.1	2.7	3.8	9.8	1.6	2.5	2.5	7.1
15 – 59	8.2	6	10.2	26.5	5	5.7	8.2	20.4
60 +	46	47.8	13.3	113.7	31.9	60.7	14.9	113.2
All Ages	9.1	8.1	8.5	27.9	6.5	9.9	7.2	25.1

Table II.4 Disability prevalence (per 1000) by age , sex and broad category of disability- 1990 and 2000

II.4. Disabled persons by living arrangements

Of the 40,790 persons with disabilities , 96.5% (39,361) were living in private households and only 3.4% (1,380 persons) were living in institutions . In 1990 a slightly higher proportion (07%) were living in private households. Thus, in the country, the family still caters for most of the disabled, despite break up of families and reduction in family size, but a trend towards breakdown of families is evident . More over, among the disabled population in institutions a higher proportion were females - some 58.7% compared to 49.3% in private households. They were also older – about 52.4% were aged 60 years and over compared to about 38.1% in private households. Only 2.0% of the institutional population were single compared to about 38.1% for the total disabled population . Some 17.0% were widowed.

Among those residing in private households, just over 50% were males. In 2000, there were 2,266 disabled persons living alone compared to 1,537 in 1990. Furthermore, some 639 two-member households and 91 three-member households comprised disabled members only. The corresponding figures for year 1990 were 368 and 42 respectively. Thus around 3000 households in 2000 were composed of disabled persons only, as compared to about 2000 households in 1990. Even though, number of disabled persons in institutions is small, the wholly disabled person households may have some problems which need looking into.

About 34,000 or 11.5% of all households enumerated in 2000 had one or more disabled members against 23,600 or 10.0% in 1990. The proportion of households with disabled persons decreased from 12.3% for one-member households to 7.9% for four-member households; the proportion then steadily increased to a maximum of 25.3% for households of size ten and above. Small households (1-2 members) had around 13% of their members disabled. It decreased to 10% for middle sized households (3-4 members), then it steadily increased to reach 33% in households with 10 or more members.

The burden on members of household increased when household size increased. Whereas the average size of households with no disabled members was 4.0 in 2000, it increased, but relatively slowly to 5.5 in households with 3 or more members, implying that whereas one disabled member households had 3.3 non disabled, it reduced steadily to less than 2.5 among households with 3+ disabled. In 1990, corresponding figures were more favourable with 3.9 non disabled members among households with one disabled member to more than 3 non disabled members in large households, implying that there is reduction of almost one non disabled member per household in recent period.

Table II.5. Disabled population in private households by size of household: 1990 and 2000

Household size	Tot	al	Households with indicated number of disabled					
	Disabled Households population		0	1	2	3+		
			2000					
All households	296,294	39,361	262,307	29,373	3,987	627		
1 person hh	18,484	2,266	16,218	2,266	0	0		
2 persons . III 3 +persons .hh	39,184	5,407	34,416	4,129	639	0		
•	238626	31688	211673	229978	3348	627		
Average hh size	4	4.4	4	4.3	4.7	5.5		

		1990								
All households										
	236,110	27,177	212,523	20,589	2,534	463				
1 person. Hh										
	12,336	1,537	10,799	1,537	0	0				
2 persons .hh										
	25,092	2,998	22,462	2,262	368	0				
3 +persons .hh										
	198682	22632	179262	16801	2166	463				
Average hh size	4.5	5	4.4	4.9	5.3	6.4				

Out of 39,361 disabled persons living in private households, 14,747 (10,437 males and 4,310 females) were reported as heads of households in 2000, giving headship rates of 37.5% (52.3% for male and 22.2% for female). This is a slight increase from 1990 of 35.1 for both sexes - 49.2 for male and 21.5 for female. Female disabled heads of households were relatively older than their male counterparts. Thus, in 2000, the mean age of disabled heads was 57.8 years for males and 65.1 years for females; the corresponding figures for year 1990 were 56.6 and 61.6 years respectively. Furthermore, disabled heads are relatively much older than other heads of households, the mean age of all heads being only 46.0 years for the males and 56.2 years for the females.

Table II.6 shows the relationship of the disabled with the head of household. Headship rate increased slightly for both sexes between 1990 and 2000 and was around 50% among males and slightly above 20% for females. Proportion of spouses remained similar between 1990 and 2000 and was naturally very much higher among females, reaching more than a fifth. There was fall in proportion of children mostly comprising single children. Parents in the households indicated a desirable trend of an increase, especially female.

Relationship to head	1900	1900	2000	2000
	Male	Female	Male	Female
Head	49.1	21.5	523	22.2
Spouse	1.6	20.3	1.5	22.5
Children	33.8	27.9	30.1	21.5
Spouse of child & grand child	1.8	1.6	2	1.5
Parent of head	3.2	12.4	4.7	15.9
Other relative	9.9	15.5	9.1	16.3
Total Number	14344	12833	19956	19405

Table II.6 Percent distribution of disabled population in private households by relationship to head and sex, 1990 and 2000

It is worth noting that the proportion of parent of head among disabled was much higher than among the overall population (2.0%) at Census 2000. This is a good sign that even in households headed by disabled, parents constitute a higher presence than in the total households. As regards children, the proportion decreased by about 5 percent points between 1990 and 2000 reflecting the general decline in fertility. Naturally, female heads are older, but among spouses, males are older, as expected. There are also sizeable number of other relatives, especially older females.

II.5. Marital characteristics

Among the 36,412 disabled aged 20 years and over enumerated in 2000, the single, married, widowed and divorced/separated were respectively 27.4%, 42.9%, 24.1%, and 5.4%. Disaggregated figures by sex show that the proportion of married among males (56.9%) was much higher than the corresponding proportion among the females (29.2%) while the proportion of widowed was much higher among females, that is 40.3%, compared to only 7.5% among the males. This may be due to: (1) a higher proportion of elderly among disabled women, (2) male mortality is higher than female and (3) husbands are older than wives. The proportions of single was higher in 1990 (30.7%). However, for all other marital categories, there was increase in 2000

When comparison is made with the overall population of the corresponding age group, we find that the proportion of single or never married persons, especially among females, was higher for the disabled than for the overall population. In 2000, there was only a 10% difference for males as against a 70% difference for females.(Table II. 7). One possible reason may be that disabled persons have a lower propensity/opportunity to get married because of their disabilities which may also be most acute for females and indicates the social deprivation the disabled have to undergo. Especially the situation of the female disabled is pitiable, as she is precluded from the most basic social organization of the family.

		19	990		2000				
	Disabled				Di	sabled			
Marital status	population		l otal p	opulation	pop	oulation	l otal	population	
	Male	Female	Male	Female	Male	Female	Male	Female	
Single	32.6	28.5	39.4	26.3	30.3	24.5	26.9	14.7	
Married	54.8	28.2	57.3	57.6	56.9	29.2	68.6	65.9	
Widowed	6.8	37.6	1.8	12.5	7.5	40.3	2	14.7	
Divorced/separated	4.5	5.6	1.5	3.6	4.8	6	2.3	4.2	

Table II.7. Proportion of disabled population by marital status and sex : 1990 and 2000

II.6. Educational Characteristics

One of the major problem faced by the disabled is the lack of acceptance and access to education. First of all, the shame and stigma attached to disability in the socio cultural context existing in the country and the limited and far flung educational facilities available, makes it very difficult, if not impossible, for the disabled to participate fully in the schooling system. Even the few who do somehow enter the system, are unable to continue because of several reasons, the least of which is the lack of special teachers and teaching facilities, the distance and location of schools and the poverty of the people in general and the disabled and especially the females among them in particular. With these constraints, still thanks to efforts made by government and several national and international organisations, some disabled children do enrol in schools. It is therefore important to assess the participation in education among these children and delineate their progress over time.

There has been a general improvement in the school participation of the disabled in <u>Mauritius</u> during the inter-census period and it was more perceptible for females. Thus, the proportion of disabled females aged 2 years and over who never attended school decreased by about 5 percent points between 1990 and 2000. Correspondingly, the proportion

of those who attended in the past increased. On the other hand, for males, there was only slight increase in proportion who are attending and those who attended in the past with corresponding decline in the never attended group.

Thus, the proportion of males currently attending school and those who attended school in the past were significantly higher than those of females. while the proportion of disabled females who never attended school was almost twice as high as the males, indicating the persistence of gender disparity in school participation of the disabled. Disabled persons are also less likely to attend school than the non-disabled persons which can be noted by comparison with overall population. Disabled persons had a currently attending school rate in both 2000 and 1990 of only a fifth of those for overall population. Moreover, there was enormous gap in the proportion of those never attended school between disabled and overall population and gender gap was also more pronounced. (Table II.8). These observations may be explained to some extent by the fact that the disabled population was relatively older than the overall population, but really seem to be more due to accessibility or availability of opportunities.

Table II.8 Percentage of population (disabled and overall) aged 2 years and over by school attendance and sex:1990 and 2000-

		19	90		2000				
	Disabled				D	isabled			
School attendance	population		Total p	population	population		Total population		
					Mal		Mal		
	Male	Female	Male	Female	е	Female	е	Female	
Now	5.9	5	26.1	25	6.7	4.6	26	24.8	
Past	64.7	46.3	65.3	58	68.6	50.8	67.8	62.8	
Never	28.2	48	8.5	16.9	23.5	43.3	6	12.3	

Table II.9 shows the distribution of the disabled and the overall population aged 5 years and over in <u>Mauritius</u> by educational attainment. Broadly, there has been an improvement in the educational attainment of both the disabled males and females during the period 1990 – 2000. The proportion of disabled with no education and with only primary level of education decreased with some corresponding improvement in secondary and tertiary level education. Thus, the proportion of disabled persons with no education and with only primary level of education decreased from 82.4% for male and 89.6% for female in 1990 to 76% and 86.1% respectively in 2000. However it was way above that for the overall population with only 51.1% among males and 57.5 among females . Correspondingly, during the same period Secondary level of education increased for both sexes by about 50% but still was only half the level of overall population among males and a quarter among females.

A study of the educational attainment by sex reveals that disabled females are more disadvantaged than their male counterparts. About half of the females had no formal education compared to a quarter for the males. At all levels of education males were ahead of females. Marked differences are observed between the educational attainment of the disabled and that of the overall population. The proportion of disabled with no formal education (34.2%) was significantly higher than that of the overall population (8.7%). The proportion of the overall population with secondary level of education was about 3 times that for the disabled

Table II.9. Percent of (disabled and overall) population aged 5+ years by educational attainment and sex: 1990 and 2000

Level of Educational	-	1990	2000					
	Di	sabled	Di	sabled				
Attainment	Рор	oulation	Рор	oulation	Total F	Total Population		
	Male	Female	Male Female		Male	Female		
Nil and Pre Primary	28.8	48.8	24.1	44.4	5.3	12.1		
Primary	53.6	40.8	51.9	41.7	45.8	45.4		
Secondary and								
higher	15.3	8.6	21.6	21.6 11.5		42.5		

II.7. Economic Characteristics

The UN Committee on Economic, Social and Cultural rights noted that States have the obligation to " take positive action to reduce structural disadvantages and to give appropriate preferential treatment to people with disabilities in order to achieve the objective of full participation and equality with society for all persons with disability". In this light, let us examine the participation of the disabled in economic activities in the country.

Physical and/or mental conditions of the population of disabled amplified by lower educational/training qualifications may impose serious restrictions on the quantity and types of jobs that they are able or perceived able to perform and made available and hence may have an impact on their level and variety of activity.

At the 2000 Population Census in Mauritius, there were 40,790 persons with disabilities, among whom 38,614 were aged 12 years and over. Only 4,751 were economically active representing 12.3% of the disabled population of whom 11.5% also were unemployed. (Table II.10)

Table II.10. Disabled population aged 12 years and above by current activity status and sex: 1990 and 2000

	1	990	2000		
Activity status	Male	Female	Male	Female	
Economically Active	3198	923	3523	1228	
Employed	2972	873	3133	1070	
Unemployed	226	50	390	158	
Economically inactive	10239	11447	15397	17561	
Household duties	184	5053	205	6531	
Studies	313	208	486	329	
Disability	6465	5100	9754	8690	
Retired	3150	953	4816	1730	

Disaggregated figures by sex show that the proportion of active among the disabled males, even though low compared with overall population, was almost three times higher than that of disabled females (18.2% for male versus 6.4% for female). Almost a tenth of the active males and females were unemployed. These were slightly higher in 1990 but the same disparity existed. Among the inactive population, the main cause of inactivity was disability accounting for about two thirds for males and near half for females. The next most important reason of inactivity among the males was

"retirement" reported by around less than a third, while among the females it was "household duties" with more than a third. Only a tenth of the inactive females reported "retirement" as the reason for their inactivity perhaps because very few were in employment assuring retirement benefits Comparison with the 1990 Census results shows that the activity rate of the disabled, already rather low, has further regressed from 25.5 for male and 7.4 for female in 1990 to 18.2 for male and 6.4 for female in 2000. Also the proportion of employed among the actives dropped from 93.3% in 1990 to 88.5% in 2000. Conversely, the proportion of the inactive has increased from 83.2% in 1990 to 85.7% in 2000.When compared with the overall population, we find that activity rates among the disabled population were quite low – only a fourth for male and around a seventh for females of that for the total population. The standardized rates using the 2000 population as standard show some improvements, but still indicate a much lower level of activity among the disabled Table II.11).

Table II.11. Activity rate (%) of overall and disabled population by sex,1990 and 2000

		2000	1990		
Category	Male	Female	Male	Female	
Activity rate of overall population Activity rate of disabled	73.9	36.4	74.9	32.2	
population	19.2	6.4	25.5	7.4	
Standardised rate	21.5	9.3			

In 2000, there were 4203 disabled persons in employment in <u>Mauritius</u> - 3133 male and 1070 female. Table II.12 gives the employed persons by major industry and occupation groups and sex for 1990 and 2000. The four major industry and occupation groups considered are:

INDUSTRY GROUPS

- AGRI Agriculture, hunting, forestry, fishing, mining and quarrying
- MANU Manufacturing, electricity, gas, water and construction
- **TRAD** Whole sale and retail trade, restaurants, hotels, transport, storage and communication Finance, insurance, real estate, business services, community, social and personal
- SERV services
 OCCUPATION GROUPS

Legislators, senior officials, managers, professionals, technical and associate

PROF professionals

CLER Clerks, service workers, shop and market sales workers,

SKIL Skilled agricultural and fishery workers, craft and machine operators and assemblers

ELEM Elementary occupations

Table II.12. Employed disabled persons aged 12 years and over by industry/occupation by sex, 1990 and 2000

IINDUSTRY		1	990		2000					
	Mal				Mal	Perce	Femal			
	е	Percent	Female	Percent	е	nt	е	Percent		
AGRI	551	18.6	152	17.6	512	16.4	164	15.5		
MANU	1195	40.3	364	42.1	1062	33.9	375	35.4		
TRAD	581	19.6	75	8.7	760	24.3	169	16.0		
SERV	636	21.5	274	31.7	795	25.4	350	33.1		
OCCUPATION										
PROF	343	11.6	67	7.8	292	9.3	119	11.2		
CLER	313	10.6	101	11.7	582	18.6	219	20.7		

SKIL	1356	45.8	336	38.9	1315	42.0	293	27.7
ELEM	951	32.1	360	41.7	939	30.0	426	40.4

The employed disabled of both sexes were mainly working in "MANU", group industries followed by "SERV" categories. Whereas there was a fall in "MANU" in the inter census period, a corresponding increase was noted among "SERV" group.

As regards occupation, whereas "SKIL "group was predominant among males, it was "ELEM" which showed largest for females for both periods. However for both groups there was a decrease over time. Thus it seems that even though generally the disabled are in lower paying/ position jobs, yet males do have an advantage over females in types of jobs available and this may reflect their training and other skills opportunities and acquisitions.

!!.8. Policy implications and recommendations

Increasing disability by age coupled with the fact of an ageing population will result in a dramatic increase in disabled population- a good majority would be females. This will necessitate increasing resources to be allocated for rehabilitation.

Even though institutional population of disabled is still small, about half are aged 60 years and over and predominately female. Also there are increasingly many households comprising only of disabled persons who have high propensity to depend on kinship groups. With the break up of the extended family system, they are more vulnerable. The future of this category of disabled persons is at stake and more and more may turn to institutional help. Also, among households with at least one disabled person, more than one sixth of such households are very small, which means that these people have little family support. Effort towards amelioration of this category is required While better services should be provided in these institutions, special income support to caretakers should be provided to prevent these people from moving away from their homes.

The social bondage and security of marriage seems less attainable for the disabled which may be due to other reasons also like economic and educational. This barrier seems more acute for females. Special efforts to assist such individuals may be called for.

The disabled population, especially females also face several problems in respect of education, employment and family support.

Two pieces of legislation, namely the Trust Fund for Disabled Persons Act and the Employment of Disabled Persons Act, were passed in Parliament in November 1988. Their respective objectives were (i) "to set up training centers and sheltered workshops for, developing and providing appropriate training to, disabled persons with a view to enabling them to secure employment or to work on their own account" and (ii) "to provide for the employment of disabled persons or in the alternative, a contribution to a Trust Fund from employers".

The National Development Plan 1992-94 took cognizance of the special requirements and needs of the disabled and stated that in light of the objective of integrating the disabled in society and in providing them with equal opportunities in terms of education, employment and other facilities, needed changes will be effected. Another piece of legislation, the Training and Employment of Disabled Persons Act, which reinforced the existing ones, was passed in 1996, which stipulated, *inter alia* that the work force of all employers having 35 employees or more should include 3% of disabled persons. Moreover with the amendment of the Building Act, 1999 a number of buildings have been retrofitted to increase accessibility to disabled persons. The African Decade of Persons with Disabilities Declaration endorsed by Mauritius aims to bring about

full participation, equality and empowerment of people with disabilities and in November 2000 a National Committee under the aegis of the National Council for the Rehabilitation of Disabled Persons (NCRD) to work out and monitor programmes for the decade was set up.

The Government, through the Ministry of Social Security, National Solidarity & Senior Citizen Welfare and Reform Institutions in conformity with the United Nations Standards Rules on Equalisation of Opportunities for persons with disabilities has worked towards the empowerment of the disabled. In this respect, several institutions within the Ministry – the Rehabilitation Unit, the National Council for the Rehabilitation of Displaced Persons (NCRD) and the Training and Employment of Disabled Persons Board - were set up.

Fewer disabled persons tend to attend school and even among them, many abandon education at primary level. At Census 2000, only two thirds of the disabled persons were currently attending or attended school in the past compared to more than 90 percent of the overall population. Activity rate of the disabled population also was less than a quarter of that for the total population. Training and Employment is a key to successful integration of disabled persons in the social and economic development. Government and Non–Governmental Organisations should encourage the participation of people with disabilities in education and economic activity to enable them to play fully their role in society. Attempts should therefore be made so that they could enrol and pursue their studies and acquire academic / vocational / skill training to improve employment opportunities The " Trust Fund for Disabled Persons " helps in providing vocational training so that they could be integrated in the working environment. The legislation " The Employment of Disabled Persons Act 1988 " is a further step in this direction. Various awards are also being given so as to encourage the disabled to pursue their studies further and also to employers to encourage them to employ more disabled persons.

Males show higher disability rate than females and the most frequent type of disability is " ambulatory ". Greater exposure to accidents and injuries on the work site and road plus the higher incidence of diabetes resulting in amputation is responsible. This is true to a lesser extent for females also. Action programmes to create awareness about diet, exercise and general life style and ensuring safe workplace and for the provision for education on proper dieting for a healthy life seems called for..

Mauritius has been able to collect excellent information on various aspects of the disabled in the last two decennial censuses. With preparations for the next census scheduled for 2010, it would be pertinent if the following additional information are also added. The first one is regarding the "causes of disability ". Next in importance is "aids and equipments used by disabled and their needs". An important information which will be helpful is "vocational/skill training – availability, accessibility, needs etc.".

III. Disability trends in Zambia

III.1. Introduction:

Zambia after independence in 1964 had significant improvement in health and living conditions resulting in increasing life expectation till the mid 70s. The oil price crisis coupled with falling value of its main export- copper- resulted in an era of difficulty and economic stress for the people. Overall poverty of 70% and extreme poverty constituting 55-60% of the population in the 1990s and even later and the HIV/AIDS infection with a reported 16% of population affected, aggravated the situation. Survival rates deteriorated during 1980-2000, more so between 1990-2000 especially at ages 15-54 due to HIV/AIDS. Between 1980-90 more female than male adults survived from age 10, but after 1990 the situation

changed. Overall more male than female adults survived especially in the younger ages 15-39. At age 15 both sexes lost at least 12 years between 1980-2000 and 10 years between 1990-2000. Population growth rate reduced from 3.1% between 1969-80, to 2.7% between 1980-90 and to 2.4% during 1990-2000. Infant mortality rate increased from 99 in 1980 to 123 in 1990 and was still high at 110 in 2000. Similarly Child mortality increased from 71 in 1980, to 95 in 1990 and expectation of life which was 52 in 1990 fell to 47 in 1990 and showed some improvement to 50 only by 2000. It has been estimated that if HIV/AIDS mortality is excluded, expectation of life would be higher by 15-20 years. UN Human Development Index (HDI) declined so much that by 1995 it was even lower than in 1975. In 1999 DALE (Disability adjusted expectation of life) for Zambia was 30.3 years. Of 191 WHO Member countries only 3 others (Malawi, Niger and Sierra Leone) had lower DALE.

The epidemiological transition is not on the near horizon for Zambia. The leading cause of disability adjusted life (DALY) lost are respiratory infections, diarrhoeal diseases, malaria, TB, HIV/AIDS and measles. Many communicable diseases that are less fatal, such as schistosomiasis ,leprosy, filariasis, trachoma, onchocerciasis., polio, and hepatitis as well as some Non Communicable Diseases (NCD), chronic illnesses such as anaemia, diabetes, and trauma result in a heavy burden on disability striking the population in rural areas and the urban periphery. In fact, mortality plus disability gap between Zambia and wealthy countries of the world is even wider than the mortality gap.

In addition to increasing mortality, there has been a deterioration in the quality of life brought in by morbidity and disability. In many respects, disability is a socio-economic indicator, a type of poverty index or index of development which is unique in that it estimates the quality of life of survivorship or of persons who escape mortality and who continue living with significant modification of function and thus have to put up with a life of pain and suffering.

In addition to physical pain, the bigger dimension of disability is the social, economic and cultural discrimination, neglect, exclusion from society and being objects of pity and sometimes even of aversion. The negative perception that disabled persons are less important members of society, cannot lead independent life and being left out in initiation ceremonies has brought in the psychological trauma of isolation and the feeling of being not wanted.

One of the more devastating handicapping effects of disablement among children is the loss of opportunity to attend school. Another area of serious concern is the financial and social implications of unemployment rates among disabled persons. the differential policies of payment of disability pensions to unemployed disabled persons, the economic burden on the family and the psychological feeling of not being a productive member of the society. Marriage, family formation and living arrangements which become less attainable by the disabled are particularly important for assessing equal opportunities and social integration.

Poverty and disability are tightly linked together in a vicious cycle of cause/effect paradox- poverty-deprivation – exclusion- discrimination especially women/children. Thus a study of disability has become an important requirement for putting in place necessary and appropriate policies, plans and programmes in the country.

III.2. Disability Data Collection

Zambia collected disability information in its censuses of 1969,1980 ,1990 and 2000. As can be noted from the following table, there has been an evolution in the field of data collection on disability in the country reflecting the emerging needs for integration of the disabled into the society. The recent census has endeavoured to capture more of the disabled than the previous enumerations. The categories canvassed at the various censuses were:

1969	1980	1990	2000
 Blind Deaf and/or mute Loss of limb Sick 	 Blind Deaf and/or mute Crippled or loss of limb Sick Combination of two or more categories 	 Blind Deaf – dumb Crippled Mentally retarded Multiple disabilities 	 Blind Partially sighted Deaf/dumb Hard of hearing Mentally ill Ex-mental Mentally retarded Physically handicapped

A deliberate attempt at capturing more relevant information on the disabled is evinced in the latest census in line with the recognition that " persons with disabilities have the same rights as other citizens to opportunities for self actualisation and participation in the economic and social development of the country and information on persons with disabilities is important to addressing barriers that limit their enjoyment of these human rights and their integration into the mainstream of society". The international classification of functioning (ICF) disability and health provided theoretical frame work for classifying health related human functioning and provided standardized concepts that provide a standardized classification framework for data compilation and contributed to greater comparability of data at national and international levels and made it relevant to various uses." (UN,2001).

According to the 2000 census definition, disability refers to a person who is limited in the kind or amount of activities that he or she can do because of on-going difficulties due to a long term physical, mental or health problem. This is in line with the National Policy on Disability which defines disability as any restriction or lack of ability to perform any normal day to day functions.

In addition, information on cause of disability was collected for the first time at the census of 2000 under the following headings:

1. Congenital/pre-natal- disabilities which one is born with , 2. disease/illness e.g. , leprosy, tuberculosis, polio, cataract etc, 3. injury/accident/trauma and 4. other e.g., unsuccessful medical operation, wrongful applications/misuse of traditional and conventional medicine.

It may not be possible to compare the data from the various enumerations, because biases and errors have cropped in at every one of the censuses. For instance, classifications did not take into account the detailed international definitions of disability which includes variations in the intensity of disability. Also, some cultural and social factors posed problems in the identification of disabled persons. In some communities, disability may be regarded as a curse and hence a shame in the family which should not be discussed or divulged. Census enumerators may not see such persons and the respondent may not provide accurate information. The other problem is regarding the inclusion/ exclusion of the sick, the elaboration of categories of blindness, deaf/dumb and mental illness in recent censuses. For instance, in the earlier censuses

questions in the censuses solicited for information only on severe impairment such as blindness, deaf etc. and hence was restricted. In the year 2000 there was an attempt to link disability to participation under the CIF framework- although not followed to the letter. At least there was a recognition that disability is a continuum, therefore the high disability rate of 2000 compared to the earlier years.

Nevertheless, the results presented, do provide useful information for the understanding of the levels, patterns and trends of disability in Zambia.

III.3 .Disability prevalence:

At the 1980 census, out of a total population of 5661741, there were 91467 disabled. The sex ratio (Male per 100 Female) of the population was 95.7 as against a sex ratio of 103.1 among the disabled. Thus the males reported a higher disability rate. It can be noticed from Table 1 that at most ages, there are more disabled males than female and that there is a definite tendency for the disability rate (DR: number of disabled per 1000 population) to be higher for males. Table 2 shows the disability rate by sex and broad age groups which clearly brings out the skewed sex ratio and increasing DR by age. At every age group, the sex ratio of the disabled is higher than that of the population. Disability rate is low at young ages of up to age 15, almost tripled in the next age group of 15-49 and again triples in the highest age group of 60 and over. The overall disability rate DR is 16.5 for males and slightly lower at 15.3 for females. It is quite possible that there could have been under reporting of the disabled especially among females because of the social stigma attached for disability.

	Popu	lation	Disabled Pop.			Popu	lation	Disal	oled Pop.
Age	Male	Female	Male	Female	Age	Male	Female	Male	Female
0 – 4	507782	512245	3181	3043	35 - 39	107611	129833	2417	2777
.5 – 9	491381	492890	3367	3017	40 -44	99857	112673	2573	2720
10 14	384016	384377	4253	3864	45 - 49	91743	85351	2564	2363
15 – 19	284668	308304	3800	4069	50 - 54	75309	70200	2475	2401
20 – 24	213545	260234	3515	3903	55 - 59	52957	44676	2049	1710
25 – 29	158386	178547	2888	3039	60 +	132338	115745	9258	7720
30 – 34	133179	159221	2707	3061	All Ages	2732772	2854296	45047	43687

Table III. 1. Population and disabled population by sex and age, 1980.

Table III.2 Population and disabled population by age group and sex and disability rate DR and sex ratio. 1980

					Disat	oility Rate			
	Popu	lation	Disabled Pop.			DR	Sex Ratio 100M/F		
Age	Male	Female	Male	Female	Male	Female	Population	Disabled Pop	
0 - 14	1383179	1389512	10801	9924	7.8	7.1	99.5	108.8	
15 - 59	1217255	1349039	24988	26043	20.5	19.3	90.2	95.9	
60 +	132338	115745	9258	7720	70.0	66.7	114.3	119.9	
All									
Ages	2732772	2854296	45047	43687	16.5	15.3	95.7	103.1	

In 1990, only 69073 persons were reported as disabled, which indicates a drastic fall in disability rate. This seems to have occurred because in 1980 the category ' sick ' which might have included a large number of persons (in a country with high prevalence of malaria and other tropical diseases) could have bloated the disabled category.

In 1969 and 1980, those counted as sick accounted for 50.8 and 37.8 percent of disabled. Even if one assumes that (1) the prevalence rate for sickness dropped between 1980-90 in a similar manner to drop between 1969-80 and (2) some persons who may have been reported as sick were reported in other categories in 1990, the elimination of that category has an effect on how data are interpreted. If trend between 1980-90 is examined employing 1990 disability reporting situation, the prevalence rate for 1000 did not decline from 16.15 to 9.36 but actually increased from 6.10 to 9.36. Thus the observed decline between 1980-90 was totally caused by elimination of category 'sick' in 1990. However, the disability rate increased from 1990 to 2000 from 9.4 to 27.5 mostly because of (a) better coverage and (b) inclusion of partially sighted, hard of hearing , mentally ill and ex-mental cases etc.

Also, the elimination of 'multiple disabilities 'makes interpretation of the latest census data more meaningful. For a better understanding of the effect of differing criteria used in various enumerations, table III.3 presents disability rate (by category) for the past four censuses. It is quite difficult to compare the figures for 1980 and 1990. and hence more attention will be focussed on the 1990 and 2000 census enumerations.

Category	Year	1969	1980	1990	2000
Disabled		10.6	6.1	9.4	27.5
Sick		10.3	10.1	0	0
Total		20.9	16.2	9.4	27.5

Table III.3. Disability data from the past four censuses- Rate per 1000 population

In 1990, Of the 69073 persons reported as disabled, 36892 were male and 32181 were females, giving a sex ratio of 114.6 as against the population sex ratio of 96.1. In 2000, the disabled population increased almost four fold to 256690 (135613 male and 121077 female – sex ratio :112, slightly lower than in 1990) whereas the total population increased only by 27% from 7383092 to 9337425(sex ratio 96.1 – same as in 1990). Part of the increase in number of disabled is because whereas in 1990 only totally blind, deaf and dumb persons were included, in 2000 even those partially affected were counted. Another problem in comparing data from 1990 and 2000 is that whereas a category " multiple disabilities " was included in 1990 , this category was excluded in 2000. Also the mentally retarded were categorised into three-mentally ill, ex-mental and mentally retarded.

Table III.4 shows the disabled population by rural/urban residence and sex. In 1990 whereas 71 percent were residing in rural areas, in 2000 there was a slight increase to 74 percent. The increase was more among males than females. Whereas only 69 percent of the male disabled were residing in rural areas in 1990, it was 73 percent in 2000. Among females there was only marginal increase from 73 percent to 74 percent. The sex ratio among the disabled decreased from 115 in 1990 to 112 in 2000. This decrease was mostly brought out by the drastic reduction in sex ratio among the disabled in

urban areas despite an increase in rural sex ratio. One of the possible reasons for the fall in sex ratio could be the assumed improvement in coverage among females in line with the overwhelming increase in number of disabled during the inter census period.

		Disabled Population by sex and residence											
Year			1990		2000								
Sex Residence	Zambia	Rural	Urban	Percent Rural	Zambia	Rural	Urban	Percent Rural					
Male	36892	25479	11413	69	135613	99289	36324	73					
Female	32181	23381	8799	73	121077	89656	31429	74					
Total	69073	48888	20185	71	256690	188945	67745	74					
Sex Ratio													
100M/F	115	109	130		112	111	116						

Table III. 4. Disabled	persons by sex and	d rural – urban residence,	1990 and 2000.
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Table III.5 presents age – sex distribution of the total population and disabled population for 1990 and 2000. In 1990, disability rate was only 9.4 whereas in 2000 it increased tremendously to 27.5 – almost a three fold increase. The increase was over all age groups, but more pronounced among the youngest and sizeable among the oldest. In both 1990 and 2000, disability rate increased by age starting with a low rate of 5.8 among age under 15, doubling in age group 15-59 and again tripling in the oldest ages. In 2000 a similar trend was depicted. With a DR of 29. 2 at the youngest age bracket , there was a reduction to 19.5 among the ages 15-59 but spurted to more than 100 at the oldest ages. It is not possible to explain the fall in DR from the younger to the middle age group, excepting the possibility of age misreporting errors and the greater chance of under reporting among the middle age groups because of the shame and stigma attached with disability.

As against a decadal growth rate of 26 percent in total population, the growth of the disabled was a whopping 272 percent. The growth rate was not very different from one age group to another among the total population, but among the disabled it varied from 524 percent at age 0 - 14 to a comparatively lower 137 percent among those aged 15 - 59. This uneven growth is reflected in the drastic differences in disability rate and the apparent fall in disability rate among those aged 15 - 59.

		Popul	ation		Disabled Population				
Year		199	90			1	990		
Age	0 - 14	15 59	60 +	All Ages	0 14	15 -59	60 +	All Ages	
Male	1693026	1754524	170027	3617577	10618	20167	6108	36892	
Female	1810188	1814538	140794	3765520	10912	16477	4742	32181	
Total	3503214	3569062	310821	7383097	21580	35543	10850	69073	
Year		200	00		2000				
Male	2156249	2238519	199522	4594290				135613	
Female	2167199	2388703	187233	4743135				121077	

Table III.5. Total population and disabled population by age group and sex, 1990 and 2000.

Total	4323448	4627222	386755	9337425	126172	90439	40078	256690		
	Disability Rate (DR) Per 1000 Population									
Male	6.3	11.5	35.9	10.2				29.8		
Female	6.1	9.1	33.7	8.6				25.5		
Total	6.2	10.3	34.9	9.4	29.2	19.5	103.6	27.5		

Table III.6 shows the type of disability by sex and residence, In 1990.around a fourth of the disabled reported multiple disabilities. Among those with one disability, even though in the country as a whole, blind, deaf and dumb were very near those who are crippled, in rural areas blind, deaf and dumb were slightly higher and crippled were more in urban settings. Only around 10% reported mental problems. There could have been an under reporting of mental disability, because in the socio-cultural context of the country, mental illness is considered a curse and the stigma and such persons are hidden from outsiders .

It is not easy to discern to which category these persons with multiple disabilities - which accounted for a fifth of the disabled - really belong and as such it is not possible to pin point the predominant disability type in the country in 1990. In 2000, the multiple disability category being dropped, it is more clear that communication type problems are the most important one in Zambia – both in rural and urban areas. This pattern of disability brings the importance of nutrition, health, disease and illness and gives valuable guidance for implementing policies to address such issues. Poverty alleviation, education and provision of adequate food and safe water will pay high dividends in the efforts towards reduction of disability.

Table III.6. Disability type by residence, 1990 and 2000

	Year			1990						
Total	Рор	Disabled Pop	Blind/Deaf/Dumb	Crippled	Mentally Disturbed	Multiple				
Zambia	7383097	69073	21896	19617	8220	19340				
Rural	4477814	48888	48888 16553		4991	13517				
Urban	2905253	20185 5347 59		5905	3224	5822				
		DR per 1000	Perc	Percent under each category of disability						
Zambia		9.4	31.7	28.4	11.9	28				
Rural		10.9	33.9	28	10.2	27.6				
Urban		6.9	26.5	29.3	16	28.8				
	Year		2000							
Total	Рор	Disabled Pop	Blind/Deaf/Dumb	Blind/Deaf/Dumb Crippled Mentally Disturbed						
Zambia	9337425	256690	125734	90896	40059					
Rural	4594290	188130	91645	68134	28351					
Urban	4743135	68560	34090	22762	11708					
DR per 1000			Perc	ent under each	category of disability					
Zambia		27.5	49.0	35.4	15.6					
Rural		40.9	48.7	36.2	15.1					
Urban		14.5	49.7	33.2	17.1					

Among those with one disability, more than a third were reported with communication type disabilities including blindness, deafness and dumbness. A slightly less proportion were in the crippled category indicating mobility problems.

Only around a tenth were reported with mental disability – perhaps reflecting the social and cultural stigma attached to mental disorders.

In 2000, out of the 256690 disabled population nearly a half (125734) were reported with communication type disabilities involving blindness, deafness and dumbness. Mobility problems including the crippled comprised of more than a third of the disabled with 90896 reported in this category. As expected only around 20% were reported with mental disorders.

In 1990, around half of the communication related disabled persons were aged under 15 and the pattern in 2000 was not much different. However, in the mobility related disabled population, whereas around two thirds were in the middle age group of 15 - 59 in 1990, in 2000 the largest proportion was among children. Unlike the situation in 1990 with the mentally disturbed persons being mostly in the middle age group, in 2000 the youngest age group showed the largest concentration. With a large section reporting with multiple disabilities, it is difficult to come to any specific conclusion as to the type of disability predominant in 1990.

Disability Type		199	0			2000)			
	All Ages	0 – 14	15 - 59	60 +	All Ages	0 - 14	15 - 59	60 +		
Blind/Deaf/Dumb	21896	5644	10774	5390	143474	63479	54777	25218		
Crippled	19617	4329	12302	2943	53301	24414	17277	11660		
Mentally Disturbed	8220	1719	5769	630	59914	38279	18385	3250		
Multiple	19340	8537	9360	1363						
All Types	69073	20229	38205	10326	256690	126172	90439	40078		
		Percent under disability type by age								
Blind/Deaf/Dumb	100	25.8	49.2	24.8	100	44.2	38.2	17.6		
Crippled	100	22.1	62.7	15	100	45.8	32.4	21.9		
Mentally Disturbed	100	20.9	70.2	7.7	100	63.9	30.7	5.4		
Multiple	100	44.1	48.4	7						
All Types	100	29.3	55.3	14.9	100	49.2	35.2	15.6		
			Percent	of disability	type under eac	h age				
Blind/Deaf/Dumb	31.7	27.9	28.2	52.2	55.9	50.3	60.6	62.9		
Crippled	28.4	21.4	32.2	28.5	20.8	19.3	19.1	29.1		
Mentally Disturbed	11.9	8.5	15.1	6.1	23.3	30.3	20.3	8.1		
Multile	28	42.2	24.5	13.2						
All Types	100	100	100	100	100	100	100	100		

Table III.7 presents the disabled population by age group and disability type in 1990 and 2000.

III.4. <u>Causes of disability:</u>

Having noted the pattern of disability, it is important to know what are the predominant causes of disability. This will give clues as to what action programmes and policy measures have to be implemented to achieve reduction of the scourge of disability from the country. In 2000 census the following questions were directed to the disabled:(a) Congenital/pre natal – disabilities which one is born with; (b) disease/illness eg leprosy, polio, cataract etc.;(c) injury/accident/trauma-road

accidents, injuries from accidental falls, fire etc; and (d) Other – e.g. unsuccessful medical operation, wrongful application/misuse of traditional and conventional medicine.

Following table presents the disabled population by sex categorised by the cause of disability.

Cause of disability	Total	Percent	Male	Percent	Female	Percent
All Causes	256690	100	135613	100	121077	100
Congenital/pre natal	35167	13.7	18579	13.7	16588	13.7
Disease/illness	99852	38.9	49228	36.3	50731	41.9
Injury /Accident/Trauma	44151	17.2	28072	20.7	15982	13.2
Other	23872	9.3	12070	8.9	11744	9.7
Unknown	51853	20.2	26309	19.4	25476	21.0

Table III.8. Disabled persons by cause of disability by sex- 2000

As expected in a country with high illiteracy and the difficulty in collecting even information on disabilities, around a fifth of the disabled reported " unknown causes " and as such, the remaining 80% only indicated broad types of causes of disability. With high incidence of infectious diseases, it is but to be expected that diseases/illnesses would constitute a substantial proportion among the disabled and around 40% of reported disease/illness as cause for disability – slightly higher among females than among males. Injury/accident/trauma comprised the next large group with around 20% reported- as anticipated males with higher risk for accidents and injury reporting a higher incidence than females. With poor health facilities coupled with poverty, malnutrition and unhygienic environment, congenital/pre natal causes also account for an eighth of disability causes among both sexes.

This gives policy makers and program planners, sufficient clues as to the priorities in the integration of the disabled into the main stream of society. With attention focussed on poverty alleviation, equitable availability and access to food, health and shelter and inculcation of safe health practices and life styles, it is quite feasible that in the near future, some of the causes can be minimised and thus reduce the disability burden on society.

III.5. Educational characteristics of the disabled

One of the major problem faced by the disabled is the lack of acceptance and access to education. First of all, the shame and stigma attached to disability in the socio cultural context existing in the country and the limited and far flung educational facilities available, makes it very difficult, if not impossible, for the disabled to participate fully in the schooling system. Even the few who do somehow enter the system, are unable to continue because of several reasons, the least of which is the lack of special teachers and teaching facilities, the distance and location of schools and the poverty of the people in general and the disabled and especially the females among them in particular. With these constraints, still thanks to efforts made by government and several national and international organisations, some disabled children do

enrol in schools. It is therefore important to assess the participation in education among these children and delineate their progress over time.

Table III.9 clearly shows that the spread of education was commendable with a less than half the persons aged 5 and above with some education to almost two thirds in 1990. Males indicated higher levels, but the improvement was higher among females (29% for males versus 35% for females among the total population and 5% for disabled males versus 12% for female disabled). In 1980 the disabled to total population with some education was 82%- with males having a slight edge over females of around 16 percentage. In 1990 this ratio declined to 68% with the gender gap closing.

Table III.9. Percentage of persons (disabled and total population) aged 5 and over with some education by sex

Year	All persons (P)	Disabled persons (D)	All Males (P)	Disabled Males (D)	All Females (P)	Disabled Females (D)
1980	47.4	39	52.8	47	42.1	30.7
1990	62.5	42.5	68.2	49.4	57.1	34.5
Increase%:1980- 90 ^a	131.9	109	129.2	105.1	135.6	112.4
D/P%:1980 b	82.3		89		72.9	
D/P%:1990 b	68		72.4		60.4	

NOTE: ^a denotes increase between 1980-90 in education ;

^b denotes ratio of proportion of disabled with some education to the total population with some education respectively for 1980 and 1990.

Looking at the type of disability among the educational levels (Table III.10), whereas in 1990 it seems that communication problems dominated among the nil educated group (NE), mobility was the major disability among the primary (Pr) and higher educated (Se) groups. But the pattern could be different, because among the three education levels, a significant proportion were reported with multiple disabilities. In 2000, the picture becomes more clear and communication problems do account for almost half for each of the education categories. Mental development related disabilities accounted for only less than a fifth of the total during both periods. This is perhaps due to the social stigma and other deprivation faced by people with such disabilities.

Table III.10. Educational level of the disabled by disability type, 1990 and 2000

Education level	NE	Pr	Se	NE	Pr	Se
Disability Type						
Year		1990			2000	
Blind,Deaf,Dumb						
COM	13963	4923	1083	58233	48954	20246
Crippled						
MOB	9410	6652	2180	35736	38320	16145
Mentally Disturbed						
DEV	4993	2002	706	19400	13873	5778

Multiple Disabilities MUL	7873	5286	2314									
Total	36239	18863	6283	113371	101149	42170		1990			2000	
		Percent I	oy disabi	lity level by	education		Percent by Education level by disability typei					ity typei
Education level	NE	Pr	Se	NE	Pr	Se	NE	Pr	Se	NE	Pr	Se
Blind,Deaf,Dumb COM Crippled	38.5	26.1	17.2	51.4	47.9	48.0	69.9	24.7	5.4	45.9	38.2	16.0
MOB	26.0	35.3	34.7	31.5	38.4	38.3	51.6	36.5	12.0	39.4	42.8	17.8
Mentally Disturbed DEV Multiple Disabilities	13.8	10.6	11.2	17.1	13.7	13.7	64.8	26.0	9.2	49.7	35.5	14.8
MUL	21.7	28.0	36.8				50.9	34.2	15.0			
Total	100	100	100	100	100	100	59.0	30.7	10.2	44.2	39.4	16.4

Also it can be noted that there is a huge improvement by education level between the two censuses and it is more pronounced among the secondary and higher levels. As against 59% with no education in 1990, there was tremendous improvement during the decade, so much so that not only did the nil educated group fall to 44.2% in 2000, but actually the primary educated group increased from 30.7% in 1990 to 39.4% in 2000 and more spectacular improvement was among the secondary and higher educated from 10.2% in 1990 to 16.4% in 2000. Yet another indicator of the enormous progress made by the disabled is illustrated by the fact in 1990 even among the total population 34.6% had no education, and only 41.9% had primary and 22.2% had secondary or higher level education. In other words, the disabled in 2000 have almost caught up with the total population with a lag of about 10 years. Unfortunately, corresponding figures for 2000 are not available for total population. In fact, gross primary school attendance for those aged 7-13 years fell slightly from 83.3 to 79.1 between 1990 and 2000 among the total population and the secondary level gross attendance among children aged 14-19 did'nt show any improvement and was stagnant at around 54% in 1990 and 2000. Thus the more than 60% improvement in secondary level among disabled clearly highlights the achievements by the disabled in education front. All these are brought out by the concerted efforts of government, national and international agencies and the general awareness among the people in general and the disabled persons themselves.

To address the issues of less access, negative attitude, prohibitive costs, distance, social problems, etc. Zambian Education Policy gives room for everybody and primary education is free. Moreover special schools for PWD have been established. By enactment of Disability Act of 1996 all discriminations were banned- but it is difficult to enforce the Act due to cultural hindrances and ignorance. NGOs International Aid Agencies will have to get actively involved in disentangling the vicious cycle.

III.6. Economic characteristics of the disabled

The UN Committee on Economic, Social and Cultural rights noted that States have the obligation to " take positive action to reduce structural disadvantages and to give appropriate preferential treatment to people with disabilities in order to achieve the objective of full participation and equality with society for all persons with disability". In this light, let us examine the participation of the disabled in economic activities in the country.

Labour Force Participation rates (LFPR) rose for all men and women between 1980-90. For women it rose from 16 to 32%. For sick and disabled women the rate did'nt increase at that rate- it was 13 to 23. If only disabled women are considered the rate increased in 1980 from 10 to 23% While less drastic, the inclusion of sick in 1980 inflated the rate. Even after removal of sick in 1980, in Zambia, the rate for disabled women -the difference in rates between disabled and all women in 1990 is greater in 1990 than in 1980. Thus the faster growth rate for disabled women than for all women can be viewed as progress, but the increasing disparity in the rates could be viewed as a lack of progress.

		1980			2000		
	Male	Female	Total	Male	Female	Total	Total
All Persons	49.5	16.1	33	62.2	31.9	46.6	55.7
Sick&Disabled	35.1	12.9	24				
Disabled	30.2	10	20	38.6	22.7	34	46.5

Table III.11. Labour Force Participation rates for persons aged 15+ by sex, disability type:1980-2000

Table III.12. Disabled population 12 years + by type of disability and economic activity category, 1990 and 2000

	Dis	abled popu	lation by ty	pe of disab	oility	Percent by	disability t	ype and ec	o. Activity
Year					1990				
Economic activity	Total	COM	MOB	DEV	MUL	COM	MOB	DEV	MUL
Total	53444	17526	16558	7041	12319	32.8	31.0	13.2	23.1
Working	16675	5732	5729	1718	3474	34.4	34.4	10.3	20.8
Seek work&av ailable for work	3153	814	1043	428	776	25.8	33.1	13.6	24.6
Home maker	6467	2221	1821	584	1786	34.3	28.2	9.0	27.6
Student	6627	1457	2003	479	2661	22.0	30.2	7.2	40.2
Not available for work	18812	6696	5580	3387	2500	35.6	29.7	18.0	13.3
Year					2000				
Total	231155								
Working	107692	55921	40800	10970		51.9	37.9	10.2	
Seek work & av ailable for work	5045	2327	1879	839		46.1	37.2	16.6	
Home maker	17075	6374	5810	2890		37.3	34.0	16.9	
Student	64227	29269	21494	13463		45.6	33.5	21.0	
Not available for work	37116								

Table III.12 presents economic activity of the disabled population by type of disability. As against 53444 disabled persons included in respect of activity category in 1990, only 16675 were reported as working with an additional 3153 evincing interest in taking up work. Thus the proportion of those working and seeking work comes to slightly more than a third of those included in the economic activity categories. In 2000 more than half of those in the economically active age were reported as working or seeking work. Thus during the inter census interval, there seems to be a tremendous spurt in the economic activity rate for the disabled and accordingly, the home makers who represented more than 12% of the working age in 1990 reduced to less than 9% in 2000. This increase in economic activity among disabled clearly brings out the success of the government in encouraging the disabled to be involved in the developmental activities of the country. On the other hand, the proportion of students increased from around an eighth to more than a third in the ten year period, is yet another pointer indicating creditable progress in the integration of the disabled into the main stream of society especially in regard to education.

Among the disabled population, the least integrated seem to be those with mental disorders- pointing to the economic and social distancing of this category of the disabled because of the shame and stigma attached to them. However, a true measure of fuller integration of the disabled could be brought out only if we compare their plight with that of those without any disability. Labour force participation rate among the population in 1990 was 46.6% and increased to 55.7% in

2000. Thus we note that the disabled with only a third in 1990 and slightly more than half in 2000, indicates that the disabled ,even though have made significant progress during the decade, still they have to go some way before catching up with those without disability. Those working and seeking work which constituted 37% in 1990 and 49% in 2000 depicts creditable improvement, yet compared with the total population with around 80% in 2000 and similar proportion in 1990, clearly points out the progress the disabled have yet to make to catch up with those who are not disabled

Looking at the economic activity category among the working population in 1990, both communication and mobility issues seem dominant whereas among those seeking work, mobility showed highest proportion. Home makers also indicated communication related disabilities whereas students were more among the mobility disabled. Mental developmental issues showed highest proportion among those not available for work. With a substantial proportion with multiple disabilities, the picture emerging from the 1990 data is blurred. In 2000, the picture clarifies and communication related disabilities predominate in all categories of economic endeavours.

III.7 Conclusions - Policy implications and actions

Analysis of the available data on disability in Zambia has brought out the need for preparation and presentation of data by age and sex. Especially for the socio (including education and marital status), economic and household characteristics such detailed age – sex information will bring forward the situations and problems faced by the different segments of the disabled like the children, youth, women, old persons etc. Moreover, analysis of disability characteristics will be more meaningful only when their situation is compared with that of their non disabled compatriots – which necessitates data by similar characteristics for the non disabled or total population by sex and age. Unfortunately, such detailed data were not readily available, and to that extent, the analysis can be considered to be not full. With preparations for the next census scheduled for 2010 and the availability of computers and experiences of the past, it should be endeavoured that this lacuna is addressed. One of the recommendations has been to make data sets available for potential users, in addition to preparation of analytical monographs. An important point to keep in mind while preparing such monographs is that it would be more meaningful if subject matter specialists are involved along with those from the statistical office and that there should be coherence and comparability between characteristics considered in the various aspects of analysis. For instance, if education level attained is used as an indicator to assess achievement of the disabled, then such data should be available for the total population .

The main thrust of the study is to discern the trends in age – sex and socio- economic characteristics of the disabled. There is evidence of increase in prevalence of disability by age and males seem to have slightly higher prevalence. There could be some non reporting of especially mental disorders because of the shame and stigma. Rural areas have higher rates. Communication related disability through problems related to eye, ear and tongue (blindness, deafness, dumbness and speech) are the predominant ones mainly attributed to poor health, malnutrition, poor hygiene and environmental conditions as a consequence of poverty, ignorance, lack of education and economic opportunities, inadequacies in medical/health front, environmental hygiene, life style, risky behaviour and lack of empowerment. Thanks to efforts by government and non governmental national and international organisations, there seem to have been some improvement in the educational and economic activity aspects of the disabled.

Factors like ageing, poverty, medical/health, emerging conditions/environment, HIV/AIDS which are leading causes of disability adjusted life years globally also affect the Zambian population in a very deep manner. The worsening of health indicators is a challenge for the performance of the public health systems- in terms of access, efficiency, effectiveness, quality and equity. Policy challenges are to expand economic opportunities for poor, provide tools for participation in market led growth, reduce vulnerability of poor to risk , improve governance.

Poverty reduction, disability rehabilitation, empowerment and provision of equipments and tools, access to land resources, education and economic endeavours are to be operationalized through community based programmes. To achieve the aims of alleviating some of the hardships of the disabled not only should persons with disability be sensitized about their rights, but government and non governmental aid agencies should join hands in a concerted fashion with clear focus on the needs of the disabled.

Persons with disability Act 33 of 1996 Zambia Disability Act, the National Trust Fund for disabled persons. The Strategy and Disability Action Plan SADP of Zambia and other legislative policies and programmes should be Implemented.

IV. HONG KONG

IV. 1 Introduction .

Hong Kong is a small territory of some 415 square miles situated on the South China coast. It is a rapidly modernizing society, moving from an industrial export base to service and entrepot functions. By regional standards, many of Hong Kong's population have a good standard of living and adequate housing. However, there are considerable discrepancies in wealth and well-being. With low fertility and very high life expectancy of around 80, HK SAR is ageing rapidly. The elderly people are not always financially secure, and there are growing difficulties in maintaining the off-cited mode of family care for elderly members, despite the better economic situation of the population. Moreover, the widespread environmental pollution resulting from burgeoning industrial development during the 1970s remained unchecked until the start of control legislation in 1981. With a ten-year strategy put forward by the Government in 1989, environmental monitoring and controlling of water and air pollution together with the waste treatment and disposal strategies has ensured better living conditions. But, weak enforcement of environmental legislation occurred at a time when massive infrastructural projects and construction activities were in progress so that environmental protection lagged behind economic growth.

Also there is a growing number of unemployed with practically no chance for rejoining the workforce. They are the victims of the migration of manufacturing establishments to mainland China who are middle-aged and unskilled or whose skills are not in demand. The service sector has absorbed a large portion of manufacturing unemployed since the 1980s, but the continuation of this trend is unlikely, since the skills of the unemployed often do not match those of the available positions.

The role of the Hong Kong government in the economy is minimal, but it has an extensive role in providing essential services, including health care, education, and housing. The health-care system, which provides high-quality standard services, is accessible by the entire population. In addition to the absence of widespread malnutrition and the availability of safe water and adequate sanitation, Hong Kong has a very good system for basic education, thanks to significant government spending. The government provides free and compulsory education for children between the ages of 6 and 15. More than 95 percent of its population is literate.

IV. 2 Data Collection – concepts, definitions

Hong Kong has three major sets of statistics on people with disabilities, namely: statistics of the Central Registry for

Rehabilitation, statistics of the <u>Rehabilitation Program Plan (RPP)</u>, and statistics from General Household Surveys. The first two are compiled and managed by the Health and Welfare Bureau and the last one by the Census and Statistics Department.

The <u>Central Registry for Rehabilitation (CRR)</u> was set up in 1983 by a government policy bureau to collect and compile information on people with disabilities for purposes of planning and delivery of rehabilitation services and research. CRR covers eight categories of disabilities, same as those recognized by RPP.

The CRR collects information on people with disabilities (PWD) on a voluntary basis through relevant government departments and NGOs upon their first contact with a disabled client. To simplify disability certification and to encourage public acceptance, CRR issues a registration card to CRR registrants.

In spite of the efforts to encourage registration, the reliability of the CRR data set has always been a major problem. There is the problem of under-reporting and the information has been found to be seriously out-dated. Still CRR statistics is being used as a major reference for purposes of policy and services development.

The Census and Statistics Department collected selected disability prevalence rates during the 1976 Population By-census and the 1981 Population Census. Because of the limitations caused by enumerators' lack of experiences, respondents' unwillingness to provide information, complexity of the exercise and difficulties in definition and identification, the information collected was believed to suffer from serious under-reporting. As a remedy, the Census and Statistics Department (CSD) incorporated a territory-wide survey on persons with disabilities and chronic diseases, as a special topic enquiry, into its regular General Household Survey (GHS).

The GHS is a sample survey conducted by CSD on a regular basis primarily to collect data concerning labour force, plus a supplementary part on special topics required by other departments and policy bureaux. The GHS sample covers all Hong Kong land-based non-institutional population.

The special topic survey of the GHS collected data from PWDs living in domestic households extended over the entire year of 2000 in order to obtain a sufficiently large sample of people of different disabilities. A separate institutional survey was conducted in the same year, covering those residing in social welfare institutions, long-stay care hospitals and rehabilitation centers.

In both types of surveys, well-trained and experienced interviewers were employed to conduct face-to-face interviews. The following data were collected: (a) type disability, (b) degree of severity, (c) impact of disability on different aspects of life, (d) primary carer and caring services required, and (e) transportation.

The special survey adopted a different approach in defining disability from that of the CRR. It defined PWD as those who (i) had been diagnosed by qualified health personnel (such as practitioners of Western medicine and Chinese medicine) as having one or more of the following 7 conditions; or (ii) had perceived themselves as having one or more of the first 4 of the following 7 conditions which had lasted, or were likely to last, for a period of 6 months or more at the time of interview. The seven conditions are further tested by the following indicators to confirm their existence as well as the degree of severity:

1. <u>Restriction in body movement</u>: confirmed by medical diagnosis, or self reporting as having long-term difficulty in movement of upper/lower limb or other parts of the body; required wheelchair or similar assistive device, had used artificial limbs, needed the help of others to carry a heavy object, grasp a small object and walk up/down a flight of stairs.

2. <u>Seeing difficulty</u>: confirmed by medical diagnosis, or self reporting as having long-term difficulty in seeing with one eye or both eyes with or without correcting glasses; unable to see at all, required / not required a specialized visual aid.

3. <u>Hearing difficulty</u>: confirmed by medical diagnosis, or self reporting as having long-term difficulty in hearing; unable to hear at all, required/ not required a specialized hearing aid.

4, <u>Speech difficulty</u>: confirmed by medical diagnosis, or self reporting as having long-term difficulty in speaking or being understood by others; unable to speak at all, required/ not required a specialized aid.
5. Mental illness: confirmed by medical diagnosis (including ex-mentally ill)

6. Autism: confirmed by medical diagnosis

7. Mental handicap: confirmed by medical diagnosis.

The legislative definition of the term disability is not only precise but also rather broad in coverage. The definition of disability is found in Chapter 487, Disability Discrimination Ordinance (DDO)). According to DDO, disability means:

"(a) total or partial loss of the person's bodily or mental functions;

(b) total or partial loss of a part of the person's body;

(c) the presence in the body of organisms causing disease or illness;

(d) the presence in the body of organisms capable of causing disease or illness;

(e) the malfunction, malformation or disfigurement of a part of the person's body;

(f) a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction; or

(g) a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour, and includes a disability that, (i) presently exists; (ii) previously existed but no longer exists; (iii) may exist in the future; or (iv) is imputed to a person."

For policy and services planning purposes, the Government has adopted a more epidemiological and clinical approach. The official Hong Kong Rehabilitation Programme Plan (RPP) recognizes only eight categories of disability for policy and service to be included in its comprehensive rehabilitation policy: autism, hearing impairment, mental handicap, mental illness, physical handicap, speech impairment, visceral disability, and visual impairment (Health and Welfare Bureau, 1999). It is worthwhile to note that autism and visceral disability have been included in RPP only within the last five years.

IV. 3 Data collected : Age and Sex of disabled

In the 1981 census, out of a total population of 4986560, there were 41758 disabled persons. Disability rate showed an increasing tendency by age and was highest at the older ages. The median age of the disabled was 43.9 as against 26.5 among the total population. Disability rate overall was 8.4.

Age Group	No. of disabled	% disabled	Population	% of population	Disability rate
00 - 09	24220	5.8	797840	16	3
10 - 19	58710	14.3	1002290	20.1	6
20 - 29	73490	17.6	1067110	21.4	6.9
30 - 39	37580	9	633290	12.7	5.9
40 - 49	33410	8	508620	10.2	6.6
50 -59	40090	9.6	468730	9.4	8.6
over	149080	35.7	508620	10.2	29.3
All ages	417580	100	4986500	100	8.4

Table IV.1. Disabled and total population by age and disability rate by age, 1981

In 2001, a total of 106200 persons were reported with one disability and an additional 163300 persons reported multiple disabilities. In 2006/7 corresponding figures were 238900 and 122400. The highest prevalence were reported among those with restriction of body movement and seeing difficulty. Very few were reported with mental illness – perhaps a problem of underreporting because of the stigma and shame associated with such a condition.

Table IV.2. Disabled population by type and whether single or multiple disability, 2001 and 2006/7

year	2001		2006/7		2001	2006/7
					Dis	ability
Disability Type	Single	Multiple	Single	Multiple	R	ate
Restriction in body	29	74.5	92.7	95.1	1.5	2.7

movement						
Seeing difficulty	17.8	56.1	50.2	72.3	1.1	1.6
Hearing difficulty	25.3	44.2	37.4	54.8	1	1.3
Speech difficulty	3.7	14.8	2.6	25.6	0.3	0.4
Mental illness	28.3	22.1	48.1	38.5	0.7	0.1
Autism	1.7	1.3	1.4	2.3		0.1
All Disabilities	106.2	163.3	238.9	122.4	4	5.2

Thus in 2001, a total of 269500 disabled persons were reported among a total population of 6737500 giving a disability rate of 4 percent. In the 2006/7 survey, the disabled population was 361400 in a total population of 6948100 with a disability rate of 5.2 percent. Thus, a decline in disability rate is noticed between 1981 and the 2001 and 2006/7 surveys, but a slight increase is indicated between 2001 and 2006/7. Similar to 1981, disability rate increased by age in both periods, but the increase was slightly lower between 2001 and 2006/7.

The median age of the disabled increased to 64 in 2001 and 72 in 2006/7 as against a much lower increase in median age of total population of 36 in 2001 and 39 in 2006/7.

We note that between 1981 and 2001 and 2006/7, there is a decline in disability rate- though between 2001 and 2006/7 there was an increase. Data collection problems and coverage could be major reasons, even though some improvement in general health condition could not be ruled out. The increase between 2001 and 2006/7 could be also due to the ageing of the population and the addition of some other categories of disabilities.

The estimates of disability prevalence for both sexes followed the usual pattern – high in the early years and then decreased before rising steadily with age. In most age groups, severity – weighted prevalence of disability was higher for men than for women. The severity weighted prevalence rose with age and was substantially higher for men over the age of 45 years than for women.

Year	2001	2006/7	2001	2006/7	2001	2006/7	2001	2006/7
Age	Und	er 15	15 – 29		30 – 39		40 – 49	
Disability								
Rate	0.008	0.015	0.009	0.010	0.017	0.014	0.031	0.025
Year	2001	2006/7	2001	2006/7	2001	2006/7	2001	2006/7
Age	50 -	- 59	60 an	d over	All A	Ages	Media	an Age
Disability								
Rate	0.052	0.038	0.151	0.214	0.040	0.052	64	72

Table IV.3 Disability rate by age , 2001 and 2006/7

Disability types identified in 1981 were:- 1. Loss of limb, 2. One side paralysis, 3. polio/lower body paralysis, 4. spastic, 5. curvature of spine, 6 blind, 7. deaf, 8. mentally retarded and 9. mentally ill. Whereas the sex ratio of the total population was 1092, among the disabled it was 1165. Thus there was a preponderance of males among the population and those of the disabled- but much higher among the disabled. Highest sex ratio was among those with loss of limb and lowest among those with curvature of spine. In 2001, six types of disabilities were covered -= 1. restriction in body movement , 2. seeing difficulty, 3. hearing difficulty , 4. speech difficulty, 5. mental illness/ mood disorder , and 6. autism. In 2006/7, in addition to these six- specific learning difficulties and attention deficit hyperactivity disorder – were included. But the numbers reported in these categories were not very large . Only 9900 persons with specific learning difficulties and 5500 with attention deficit hyperactivity were reported – both these two categories had very high sex ratios of around 3000 males per 1000 females. Thus the majority of these cases were males . Whether any external factors like stigma/shame attached to such disabilities were involved in suppressing the actual numbers or not is not very clear.

There was a reversal in the sex composition of the disabled in 2001 and 2006/7 with an overall sex ratio of only 879 in 2001 and further decline to 779 in 2006/7. Autism had the highest sex ratio of more than 5000. Whereas those with hearing and speech difficulty had more male than female in 2001, in 2006/7 only those with speech difficulty had more

males. The lowest sex ratio was among those with speech difficulty followed by restriction in body movement in both periods.

Table IV. 4. Sex ratio (Male per 1000 Female) by disability type , 1981

NOTE : Disability Type-1. Loss of limb, 2. One side paralysis, 3. Polio/lower body paralysis, 4. Spastic

Disability Type*	1	2	3	4	5	6
Sex Ratio	1762	1070	1096	1415	626	825
Disability Typ**	7	8	9	10	11	
Sex Ratio	972	1304	1463	1165	1092	

5. Curvature of spine, 6. Blind, 7. Deaf, 8. Mentally Retarded, 9. Mentally Ill, 10 All Disabled 11. Total Population

Table IV. 5 Sex ratio	(Male per 1000 I	Female) by disability	type, 2001 and 2006/7
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Year		2001			2006/7		
Sex of the disabled Disability Type	Male	Female	Sex Ratio 1000M/F	Male	Female	Sex Ratio 1000M/ F	
Restriction in body movement Seeing difficulty Hearing difficulty	45200 30800 36800	58300 43100 32900	775 715 1119	71300 46300 42600	116400 76300 49500	613 607 861	
Speech difficulty Mental illness Autism All Disabilities Total Population	10200 22600 2500 126100 3274425	8300 27800 500 143400 3463075	1229 813 5000 879 946	14500 33900 3200 158200 3293399	13900 52700 600 203200 3654701	1043 643 5333 779 901	

In 1981, the mentally retarded, mentally ill and deaf constituted the bulk of the disabled. Spastic and those with curvature of spine constituted the lowest number. Those with loss of limb and one side paralysis and mentally ill were generally older, whereas spastics and mentally retarded were younger. The median age of spastics and those with mental retardation were the lowest being respectively only 25 and 17 whereas the highest age was among those with one side paralysis (64 years) and those with loss of limb (58 years) and the deaf (57 years).

Table IV. 6. Disability rate by type and age, 1981

Age Disability Type*	1	2	3	4	5
0 – 9	0.06	0.03	0.03	0.32	0.07
10 – 19	0.15	0.06	0.66	0.28	0.03
20 – 29	0.3	0.13	1.23	0.27	0.07
30 – 39	0.4	0.14	0.65	0.16	0.28
40 – 49	0.85	0.42	0.42	0.14	0.23
50 – 59	1.35	1.4	0.74	0.19	0.11
60 and over	3.25	6.56	4.1	0.38	1.41
All Ages	0.7	0.9	1.01	0.24	0.23
Age Disability Type*	6	7	8	9	10
0 – 9	0.08	0.35	2.23	0.05	3.03
10 – 19	0.06	0.64	3.79	0.27	5.94
20 – 29	0.2	0.8	2.46	1.4	6.67
30 – 39	0.38	0.83	1.02	2.07	5.53
40 – 49	0.75	0.84	0.4	2.43	6.54
50 – 59	1.23	1.36	0.17	2.05	8.58
60 and over	5.66	5.87	0.17	2.05	29.43
All Ages	0.88	1.27	1.85	1.17	8.37

NOTE : Disability Type- 1. Loss of limb, 2. One side paralysis, 3. Polio/lower body paralysis, 4. Spastic 5. Curvature of spine, 6. Blind, 7. Deaf, 8. Mentally Retarded, 9. Mentally III, 10 All Disabled

Table IV.7 Percentage by age group by disability type, 1981

Age Disability Type*	1	2	3	4	5
0 – 9	1.4	0.5	0.4	14.3	0.5
10 – 19	4.4	1.3	13.1	23.6	2.6
20 – 29	9.2	3.1	26.1	24.2	6.7
30 – 39	7.2	2	8.1	8.7	15.2
40 – 49	13	4.8	4.3	5.7	9.8
50 – 59	17.9	14.6	6.7	7.3	4.4
60 and over	45.9	73.8	41.3	16.1	60.9
Median age	58	64	45	25	62
Age Disability Type*	7	8	9	10	11
0 – 9	4.4	19.3	0.6	5.8	16
10 – 19	10.1	41.3	4.2	14.3	20.1
20 – 29	13.4	28.5	23.6	17.6	21.4
30 – 39	8.3	7	20.6	9	12.7
40 – 49	6.9	2.2	19.6	8	10.2
50 – 59	10	0.9	15.2	9.6	9.4
60 and over	46.8	0.9	16.4	35.7	10.2
Median age	57	17	41	44	26

NOTE : Disability Type- 1. Loss of limb, 2. One side paralysis, 3. Polio/lower body paralysis, 4. Spastic

5. Curvature of spine, 6. Blind, 7. Deaf, 8. Mentally Retarded, 9. Mentally Ill., 10. disabled population and 11. Total population

Table IV. 8 Disabled population by disability type and total population and age , 2001 and 2006/7

	2000/1	
(000s	

(0000)										
Disability Type, Age	Und	er 15	15	– 29	30 -	- 39	40	- 49		
Year	2001	2006/7	2001	2006/7	2001	2006/7	2001	2006/7		

Restriction in body							1	
movement	1.8	1.5	3.2	2.7	6.1	2.2	12.4	7.8
Seeing difficulty	2.1	1.5	2	1.5	1.9	1.7	5.1	4.1
Hearing difficulty	1.9	1.5	2.6	2.1	3.6	3.1	8.9	5.9
Speech difficulty	3.2	3	2.7	2.3	3.2	2.5	3.2	2.3
Mental illness	0.8	0.9	4.4	5	10.1	9	12.3	17.1
Autism	1.2	2.5	1.5	0.9	0.5			0.3
All Disabilities	9	13.4	13.2	14.1	22.1	15.5	37.7	32.4
Total Population	11588	9243.5	13947	14247.5	12936	11259	11993	13135.5
Disability Rate	0.78	1.45	0.95	0.99	1.71	1.38	3.14	2.47
Disability Type, Age	50 -	- 59	60 ar	nd over	All A	lges Medi		an Age
Year	2001	2006/7	2001	2006/7	2001	2006/7	2001	2006/7
Year Restriction in body	2001	2006/7	2001	2006/7	2001	2006/7	2001	2006/7
Year Restriction in body movement	2001 12.7	2006/7 13	2001 67.3	2006/7 160.4	2001 103.5	2006/7 187.6	2001 69	2006/7 78
Year Restriction in body movement Seeing difficulty	2001 12.7 6.9	2006/7 13 7.7	2001 67.3 55.9	2006/7 160.4 106	2001 103.5 73.9	2006/7 187.6 122.5	2001 69 70	2006/7 78 76
Year Restriction in body movement Seeing difficulty Hearing difficulty	2001 12.7 6.9 9.2	2006/7 13 7.7 9.3	2001 67.3 55.9 43.6	2006/7 160.4 106 70.2	2001 103.5 73.9 69.8	2006/7 187.6 122.5 92.1	2001 69 70 67	2006/7 78 76 75
Year Restriction in body movement Seeing difficulty Hearing difficulty Speech difficulty	2001 12.7 6.9 9.2 1.4	2006/7 13 7.7 9.3 2.4	2001 67.3 55.9 43.6 4.8	2006/7 160.4 106 70.2 15.7	2001 103.5 73.9 69.8 18.5	2006/7 187.6 122.5 92.1 28.2	2001 69 70 67 40	2006/7 78 76 75 69
Year Restriction in body movement Seeing difficulty Hearing difficulty Speech difficulty Mental illness	2001 12.7 6.9 9.2 1.4 8.6	2006/7 13 7.7 9.3 2.4 13.9	2001 67.3 55.9 43.6 4.8 14.3	2006/7 160.4 106 70.2 15.7 40.7	2001 103.5 73.9 69.8 18.5 50.5	2006/7 187.6 122.5 92.1 28.2 86.6	2001 69 70 67 40 47	2006/7 78 76 75 69 58
Year Restriction in body movement Seeing difficulty Hearing difficulty Speech difficulty Mental illness Autism	2001 12.7 6.9 9.2 1.4 8.6 0.3	2006/7 13 7.7 9.3 2.4 13.9	2001 67.3 55.9 43.6 4.8 14.3	2006/7 160.4 106 70.2 15.7 40.7	2001 103.5 73.9 69.8 18.5 50.5 3.5	2006/7 187.6 122.5 92.1 28.2 86.6 3.7	2001 69 70 67 40 47 17	2006/7 78 76 75 69 58 11
Year Restriction in body movement Seeing difficulty Hearing difficulty Speech difficulty Mental illness Autism All Disabilities	2001 12.7 6.9 9.2 1.4 8.6 0.3 35	2006/7 13 7.7 9.3 2.4 13.9 38.5	2001 67.3 55.9 43.6 4.8 14.3 152.5	2006/7 160.4 106 70.2 15.7 40.7 247.3	2001 103.5 73.9 69.8 18.5 50.5 3.5 269.5	2006/7 187.6 122.5 92.1 28.2 86.6 3.7 361.3	2001 69 70 67 40 47 17 64	2006/7 78 76 75 69 58 11 72
Year Restriction in body movement Seeing difficulty Hearing difficulty Speech difficulty Mental illness Autism All Disabilities Total Population	2001 12.7 6.9 9.2 1.4 8.6 0.3 35 6730	2006/7 13 7.7 9.3 2.4 13.9 38.5 10008	2001 67.3 55.9 43.6 4.8 14.3 152.5 10106	2006/7 160.4 106 70.2 15.7 40.7 247.3 11537	2001 103.5 73.9 69.8 18.5 50.5 3.5 269.5 6737.5	2006/7 187.6 122.5 92.1 28.2 86.6 3.7 361.3 6948.1	2001 69 70 67 40 47 17 64 36	2006/7 78 76 75 69 58 11 72 39

The median age of the total population was 36 in 2001 and 39 in 2006/7 as against 26.5 in 1981 This clearly shows the rapid ageing of the population and relatively less intensity in the ageing of the disabled. Similar to 1981, the mentally ill and Autistic persons had the lowest median ages whereas the highest ages were who had restricted body movement, and those with seeing and hearing difficulties. Mobility and communication problems are usually associated with ageing whereas mental illness, autism and other behavioural disorders could set in at an earlier age.

IV. 4 Socio – economic characteristics of disabled

An important social indicator is marital status. In many societies, disability may be cause for persons, especially females from getting married. Disability also could trigger divorce/separation. Thus the proportion of disabled in the various marital categories and disability types may give clue as to the relative discrimination faced by the disabled.

Table IV.9. Percentage by marital status and disability type, 1981

	Disability Type							
Marital Status	1	2	3	4	5			
Never Married	24.4	10.2	43.8	63.2	29.8			
Married	54.9	60.3	37.3	27.7	33.7			
Widowed	18.3	28.2	18.1	7.3	35.2			
Divorced/Separated	2.2	1.3	0.8	1.7	1			
		Di	sability Ty	ре				
Marital Status	6	7	8	9	10			
Never Married	14	25.3	93.6	56.4	41.3			
Married	4.9	48.2	5.2	32.2	38.7			
Widowed	35.8	24.4	1.1	3.8	18.5			
Divorced/Separated	1.3	2.1	0.1	2.6	1.5			

NOTE : Disability Type- 1. Loss of limb, 2. One side paralysis, 3. Polio/lower body paralysis, 4. Spastic 5. Curvature of spine, 6. Blind, 7. Deaf, 8. Mentally Retarded, 9. Mentally III, 10 All Disabled

Spastic, mentally retarded and mentally ill had most never married persons – these kinds of disabilities usually are those with a lot of stigma and shame attached. Loss of limb, one side paralysis and blind had larger proportion married- these are the least stigmatised among the disability categories Widowed were in the blind and curvature of spine categories – affecting older women disproportionately and divorced/separated were mostly in mentally ill group followed by loss of limb- one reason for divorce in many societies is mental illness.

	Never							
Marital Status	Married		Married		Widowed, Div	Total		
Disability Type,								
year	2001	2006/7	2001	2006/7	2001	2006/7	2001	2006/7
Restriction in body								
movement	14.9	19	51.7	82.3	37	86.5	103.5	187.7
Seeing difficulty	8.4	11.7	38.1	58.3	27.4	52.5	73.9	122.6
Hearing difficulty	8.8	10.5	40.5	47.2	20.4	34.5	69.7	92.2
Speech difficulty	10.8	11.6	4.8	8.8	2.9	7.7	18.5	28.4
Mental illness	18.3	25.1	22.2	35.7	10	25.8	50.5	86.6
Autism	2.8	3.7			0.2		3	3.8
All Disabilities	52.5	65	138.6	170.2	78.4	126.2	269.5	361.3

Table IV. 10 Marital status by disability type, 2001 and 2006/7

The largest segment were in married category followed by widowed/divorced/separated. Part of this may be due to the fact of children below 20 who are rarely married constituting some portion of these disabled persons. The increase in those who are widowed/divorced/separated is mostly due to the ageing of the population and the overall increase in disability. Whereas in 2001, proportionately there were more among the married category, 2006/7 there seem to be a spurt in the widowed/divorced/separated category.

Among those with restriction in body movement, seeing difficulty around 50% were married in 2001 but in 2006/7 the proportion reduced with some increase in those who are widowed/divorced/separated. Those with speech difficulty, autism and to a certain extent those with mental illness had less proportion married in both periods. The pattern is not much different from the one observed in 1981. Thus it is clear that persons with certain disabilities still face discriminatory problems despite the anti discriminatory policies and laws. Marriage is an individual choice and decision and governments cannot enforce their laws and regulations. It requires societies to recognise the enormity of the problem faced by a certain section of their population and educate and enlighten the people on this social problem. Unfortunately, corresponding distribution by marital status among the total population is not available. It would have been also more enlightening, if the marital status picture was available by sex- as it is noted in most societies that females face the discriminatory/exclusion problem more often than men.

An important socio – economic indicator is education. Though there may be provision for education for all children, the disabled children face several problems and difficulties to take advantage of the available facilities/amenities. Usually the vicious cycle of poverty and lower education is more evident among the physically and mentally disabled. Whether it is a cause or a consequence, is debatable. But the fact remains that even in the most enlightened and advanced societies, children with disabilities are less able to benefit than those who are not disabled.

Table IV. 11. Percentage by education level and disability type, 1981

	Disability Type								
Educational level	1	2	3	4	5				
No School / KG	38.7	45.4	32.8	42.7	52.2				
Primary	39.8	37.6	36.2	39.7	24.9				
Secondary	17.6	12	23.8	14.1	17.5				
Matric/Higher	3.8	5.1	7.2	3.5	5.5				
	Disability Type								

Educational level	6	7	8	9	10
No School / KG	56.6	39.8	45.2	29	41.2
Primary	31.4	42.5	42.7	44.9	39.6
Secondary	9.9	15.3	11.3	22.6	15.8
Matric/Higher	2.1	2.4	0.8	3.6	3.3

NOTE : Disability Type- 1. Loss of limb, 2. One side paralysis, 3. Polio/lower body paralysis, 4. Spastic 5. Curvature of spine, 6. Blind, 7. Deaf, 8. Mentally Retarded, 9. Mentally Ill, 10 All Disabled

	Educational AttainmentI										
	No School/K	Prim	nary	Secor	ndary	Matric/Higher					
Age	Disabled	Total	Disabled	Total	Disabled	Total	Disabled	Total			
15 – 24	25.5	1.6	40.5	21.7	30.5	64.6	3.9	12.1			
25 – 34	26.3	4.1	43.1	36.1	25	45.6	5.6	13.3			
35 – 44	24.9	11.9	48.5	41.4	22.2	33.2	4.4	13.5			
45 – 54	37.6	29.4	48.7	41.8	10.6	17.4	3.1	6.5			
55 and over	56.4	47.4	31.6	37.1	8.9	11.3	3.1	4.2			

Table IV. 12. Percentage by educational attainment of disabled and total population by age, 1981

Those with curvature of spine and the blind had highest proportion with no education (it has been surmised that females predominate among these two categories of disability), whereas among secondary and higher educated persons, those with polio/paralysis of lower limb predominated, Polio/paralysis of lower limb being generally among the younger ages with better prospects for being educated because of the recent measures and actions by the people and government, it is obvious that these groups have more opportunities and less hurdles in pursuing their education even at higher levels. Disabled population had much less education than the total population. Whereas among the disabled there was a uniform distribution over all ages, among the total population there was a general improvement in education by age upto atleast middle age.

	5	 5 /		
No School/pre				

Table IV. 13. Educational level of the disabled by type of disability, 2001 and 2006/7

	No School/pre							
Educational level	primary		Prii	mary	Seco	ondary	Tertiary	
Disability Type,	2001	2006/7	2001	2001 2006/7 2		2006/7	2001	2006/7
Restriction in body								
movement	38.2	81.2	39.1	68.2	21.8	31.4	4.4	7
Seeing difficulty	26.9	49.5	29.9	45.5	13.4	21.4	3.7	6.1
Hearing difficulty	19.8	31.9	30.2	35.1	15.9	19.9	3.9	5.3
Speech difficulty	7.6	13.6	6.4	8.5	4.3	5.6	0.2	0.5
Mental illness	8.3	22.9	19.3	26.2	20.1	29.9	2.8	7.6
Autism	0.7	23.7	1.1	1.5	1.2	1.3	0.1	
All Disabilities	80.2	114.6	107.9	135.3	68.3	89	13.1	22.4
Percent by level	29.8	31.7	40.0	37.4	25.3	24.6	4.9	6.2

Speech disability and autism indicated the lowest educational level whereas those with restriction in body movement, seeing and hearing disabilities showed better progress. Mobility related disabilities usually are the least affected as far as education is concerned, followed by those with communication problems like sight and hearing. But speaking difficulty is a handicap in an educational environment where verbal communication plays an important role, especially when special facilities are unavailable. Between 1981 and 2001 and 2006/7, there was tremendous spurt in education, especially tertiary education in recent years. However, there does not seem to be much improvement in lower level of education.

Table IV. 14. Labour force participation rate by sex and disability type, 1981

Age	15 –	24	25 –	25 – 34		35 – 44		45 – 54		55 and over	
Disability Type	Male	Female	Male	Female	Male	Female	Male	Female	Male	Feale	
1	54.9	61.8	90.4	50	91.5	34	29.6	12.2	54.7	27	
2	73.7	57.9	68.1	39.4	54.9	30.9	18	7.6	25.1	12.2	
3	61.5	55.5	82	61.3	63.2	34.2	16.5	5.2	47.7	36.8	
4	61.6	35.2	69.9	65.6	60.8	29.1	27.1	16.7	54.9	34.8	
5	44.4	100	95.7	72.6	95.2	56.5	23.7	10.1	60.7	22.1	
6	53.8	39.2	79.3	56.1	65.3	30.3	10.7	4	37.1	9.8	
7	66.5	56.5	93.4	49.5	86.7	45	24.9	8.7	61.6	25.3	
8	37.4	30.4	52.7	28.4	69.1	31.5	40	72	43.3	21.6	
9	44.1	38.5	36	39.5	36.7	28.2	23.6	7.8	35.6	25.4	
10	47.8	40.5	63.2	44	60	33,4	21.8	7.4	42.8	22.1	

NOTE : Disability Type- 1. Loss of limb, 2. One side paralysis, 3. Polio/lower body paralysis, 4. Spastic 5. Curvature of spine, 6. Blind, 7. Deaf, 8. Mentally Retarded, 9. Mentally III, 10 All Disabled

Labour force participation increased upto age 35, but female rates were consistently lower. Participation was highest among those with one side paralysis and the deaf but lowest among mentally retarded and mentally ill persons.

Table IV. 15 Economic activity rate by disability type, 2001 and 2006/7

	Econ	omically						
Economic Activity	a	ctive	Re	tired	Home	Makers	Students	
Disability Type	2001	2006/7	2001	2006/7	2001	2006/7	2001	2006/7
Restriction in body								
movement	17.5	8.2	59	146	7.3	6.5	0.4	1.3
Seeing difficulty	10.6	9.5	48.1	93.5	6.6	6.4	0.9	0.7
Hearing difficulty	17.6	12.8	39	65.1	5.5	5.4	1	0.8
Speech difficulty	2.9	2.8	4	14.3	0.7	0.4	0.6	0.6
Mental illness	14.4	17.4	11.5	37.8	7.1	6.8	0.4	0.6
Autism	0.6	0.4	0.1				0.3	
All Disabilities	59.7	45.8	131.5	221.5	25.1	21.4	3.1	5.1

In 2001 and 2006/7, only economic activity by disability type was available. We note that around 43% of the disabled aged 15 years and above were economically active . In 1981 only 43% of males and 22% of females were economically active. Thus overall there is an increase but much more so for the female. There was a slight increase in proportion retired and a corresponding decrease in home makers. Economic activity was highest among those with restriction in body movement and hearing difficulty as per the 2001 survey, but in 2006/7 the highest was in mental and those with hearing difficulty. Retired persons were largest among those with restriction in body movements in 2001 and 2006/7; homemakers were, as expected, more or less uniformly distributed among the different disability types, but it is difficult to understand why it was the smallest among those with speech difficulty. There were very few students – perhaps reflecting the fact that in the ages 15 and over, generally there will be less number of students – when very few children will still be in school even among those with no disability.

IV. 5 Disability Policies and programmes

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Since the late twentieth century, the development of disability laws have focused on achieving equal opportunity for the disabled, and government agencies have been responsible for developing guidelines and programs to ensure the compliance of the law. In the past decade, the Hong Kong government has set up some organizations and committees for formulating policies on rehabilitation matters for the disability group, such as employment and special education. Laws were enacted to ensure equal opportunities and protect the disabled against discrimination and harassment. In addition,

The Hong Kong government advocated equal opportunities for the disabled through education. These policies were aimed at creating an environment which gave the same rights to the disabled as other citizens.

Hong Kong was often described as a well-developed international city in terms of infrastructure, legal system and economic development. With the increasing voice from the disability group and with the exposure from the media, the life and difficulties of the disability group encountered in the community has recently been exposed to the public. However there is still discrimination especially in relation to employment and policy implementation is not as effective as in other advanced countries and the government comparatively takes a more passive attitude in ensuring the compliance from the public and private sector.

The Basic Law of the Hong Kong Special Administrative Region (HK SAR) of the People's Republic of China is a constitutional document. It stipulates the rights and freedoms enjoyed by all people in Hong Kong. It also stipulates that International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights and international labour conventions are applicable to the HKSAR.

Laws with Special Provisions for persons with disability (PWD)

Under the Disability Discrimination Ordinance, it is unlawful to discriminate against or harass people with disabilities and their associates in a range of areas, including employment fields.

The Inland Revenue Ordinance provides that a taxpayer may claim a Disabled Dependent Allowance for maintaining a disabled dependant.

The Crimes Ordinance offers special protection to mentally disordered and mentally handicapped persons from sexual offences.

Under the Criminal Procedure Ordinance, special rules and procedures are designed to protect mentally disordered and mentally handicapped persons in criminal proceedings involving them as victims or suspects of a crime.

Like all other permanent Hong Kong residents, PWD enjoy the right to vote and the right to stand for election except as otherwise provided under the Ordinance.

The Mental Health Ordinance has the following provisions for a person with mental disorder or mental handicap that affects his/her mental capacity: management of property and affairs; reception, detention and treatment in mental hospitals, guardianship, and consent to medical and dental treatment.

The Building (Planning) Regulations, together with the supplementary Design Manual, ensure a barrier-free environment, and apply to private buildings, e.g. composite building, domestic building, public entertainment and hotels.

Under the Motor Vehicles (First Registration Tax) Ordinance, a PWD who has considerable difficulty in walking, does not have to pay first registration tax provided that he is fit to drive that vehicle.

Under the Road Traffic Ordinance, a PWD may be exempted from a range of fees, e.g. learner's driving license fee, driving license fee, and annual vehicle license fee.

As applicable to all people of the territory, children aged 6 to 15, are required to attend school to receive free education. Also, law protects the wages of employees, and regulates general conditions of employment and other related areas, ensures the safety and health of persons at work, provides for compensation to all employees for work-related injuries and provides eligible persons with legal representation in certain civil or criminal proceedings - either free, or with fee.

The Equal Opportunities Commission (EOC) was established by statute in May 1996 and is responsible for administering four anti-discrimination laws in Hong Kong: the Sex Discrimination Ordinance (SDO); the Disability Discrimination

Ordinance (DDO); the Family Status Discrimination Ordinance (FSDO); and the Race Discrimination Ordinance (RDO)[1]. The EOC is currently charged with the responsibility of eliminating discrimination on the grounds of sex, marital status, pregnancy, family status and disability, eliminating sexual harassment and disability harassment and vilification, and promoting equality between men and women, between persons with disabilities and without disabilities, and persons with family status and without family status.

The Standing Committee of the National People's Congress of the People's Republic of China (PRC) has ratified the Convention on the Rights of Persons with Disabilities on 26 June 2008, which was a major move of the Central Government to reaffirm its commitment to protect and promote the rights and dignity of persons with disabilities.

The enactment of the Disability Discrimination Ordinance (DDO) in 1995, giving rights to individuals to take action against disability discrimination, signalled a significant shift towards the individualistic, rights-based anti-discrimination approach, that is, the civil rights model of disability. The DDO came into effect in December 1996, prohibits unlawful discrimination on the grounds of disabilities in specific areas of activity, such as employment, education and provision of goods, services and facilities. The Ordinance is binding on the HKSAR government as well as all other public bodies and agencies. It is also applicable to discriminatory acts committed by commercial entities in the private sector as well as by individuals. The Ordinance also outlaws disability harassment as well as discriminatory practices in many facets of daily life, including the publication of discriminatory advertisements. The Equal Opportunities Commission of Hong Kong is entrusted with the responsibility to handle disability related complaints and encourages conciliation between parties in dispute, provide assistance to aggrieved persons and undertake public education and research programmes to promote equal opportunities in Hong Kong.

Several other government bureaux also deal with disability rights issues from different perspectives. The Constitutional and Mainland Affairs Bureau (CMAB) has policy responsibility for matters relating to human rights. While overall human rights issues relating to disability discrimination are placed under the purview of the CMAB, the rehabilitation and other support issues in connection with disabilities are handled by the Labour and Welfare Bureau.

At the policy level, the Rehabilitation Advisory Committee (RAC) of the Government's Labour and Welfare Bureau, an advisory body to the Government, advises the HKSAR government on disability-related issues.

IV. 6 Some suggestions

Because census may not be an appropriate forum for collecting disability data, the use of intensive surveys has definitely provided some of the needed data and information on the size, age-sex structure and selected socio-economic characteristics of the disabled. The practice of carrying out surveys pertaining to various aspects of the information on the disabled every five or six years should be continued and strengthened.

In order to optimise the use of the information, efforts must be made to publish tables on the disabled population with sufficient details on age and sex for the various types of disability and by some of the socio-economic variables like education, economic activity and household characters like household size.

For better understanding of the plight of the disabled and to assess their situation, it is necessary that all disability related tables should have similar information on the total or non disabled population.

A recent development with the wide scale use of computers and data capture methods, is the provision of data on various aspects collected in forms easily accessible to users – especially through the web.

Another innovation is for the census/statistics department to collaborate with relevant subject ministries/departments and many times with NGOs in the analysis and wide spread dissemination of the information through preparation of analytical monographs/studies and seminars.

Hong Kong seems to have well articulated policies on the disabled. It is essential that implementation does not lag behind

Since life style and individual choices are very difficult, if not impossible, to modify or change, government and NGOs

should intensify their efforts towards inculcating healthier life styles and take appropriate actions and programmes to wean people from unhealthy/ harmful food and drinks, habits and practices etc. An important place where the impact will be the highest is at the stage of early education of children, say in primary and secondary schools.